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Presidential Documents

Title 3—

The President

Proclamation 8505 of April 28, 2010

National Foster Care Month, 2010

By the President of the United States of America

A Proclamation

Nearly a half-million children and youth are in foster care in America, all entering the system through no fault of their own. During National Foster Care Month, we recognize the promise of children and youth in foster care, as well as former foster youth. We also celebrate the professionals and foster parents who demonstrate the depth and kindness of the human heart.

Children and youth in foster care deserve the happiness and joy every child should experience through family life and a safe, loving home. Families provide children with unconditional love, stability, trust, and the support to grow into healthy, productive adults. Unfortunately, too many foster youth reach the age at which they must leave foster care and enter adulthood without the support of a permanent family.

Much work remains to reach the goal of permanence for every child, and my Administration has supported States that increased the number of children adopted out of foster care, providing over $35 million in 2009 through the Adoption Incentives program. We are also committed to meeting the developmental, educational, and health-related needs of children and youth in foster care. The American Recovery and Reinvestment Act provided a significant increase in funding for the Title IV-E adoption and foster care assistance program. States can use these funds to ensure those placed in foster care will enter a safe and stable environment.

In addition, we are implementing the Fostering Connections to Success and Increasing Adoptions Act. This law promotes permanency and improved outcomes for foster youth through support for kinship care and adoption, support for older youth, direct access to Federal resources for Indian tribes, coordinated health benefits, improved educational stability and opportunities, and adoption incentives and assistance. Former foster youth will also benefit from the Affordable Care Act, which, beginning in 2014, will ensure Medicaid coverage for them in every State.

This month, caring foster parents and professionals across our Nation will celebrate the triumphs of children and youth in foster care as they work to remove barriers to reaching a permanent family. Federal, State, and local government agencies, communities, and individuals all have a role to play as well. Together, we can ensure that young people in foster care have the opportunities and encouragement they need to realize their full potential.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim May 2010 as National Foster Care Month. I call upon all Americans to observe this month with appropriate programs and activities to honor and support young people in foster care, and to recognize the committed adults who work on their behalf each day.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-eighth day of April, in the year of our Lord two thousand ten, and of the Independence of the United States of America the two hundred and thirty-fourth.

[FR Doc. 2010–10572
Filed 5–3–10; 8:45 am]
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Presidential Documents

Proclamation 8506 of April 28, 2010

Older Americans Month, 2010

By the President of the United States of America

A Proclamation

Older Americans have lived through momentous and trying times in our history, and they have strengthened our national character. Their experience and wisdom connect us to the past and help us meet the challenges of the present. During Older Americans Month, we show our support and appreciation for these treasured individuals who have contributed so much to our Nation.

This year's theme for Older Americans Month, "Age Strong, Live Long," recognizes the efforts of people of all ages to promote the well-being, community involvement, and independence of senior citizens. As Americans live longer, healthier, and more productive lives, many are starting second careers and continuing to be involved in their communities. Dedicated older Americans are also answering the call to serve through the Corporation for National and Community Service's Senior Corps.

My Administration is committed to ensuring older Americans can age strong and live long. By strengthening Medicare and Medicaid, while protecting Social Security, we help ensure all Americans can age with dignity. The recently enacted Affordable Care Act strengthens Medicare by providing free preventive care starting next year, enhancing care coordination, and gradually closing the "donut hole" gap in prescription drug coverage. In addition, this law includes provisions to help prevent and eliminate elder abuse, neglect, and exploitation. Along with the Middle Class Task Force's Caregiver Initiative, we are investing in wellness and prevention programs to help seniors remain healthy and close to their loved ones. The Administration on Aging's network of State and local organizations provides services to older Americans that help prevent unnecessary hospitalization or institutionalization. We must also protect seniors by expanding efforts to fight fraud, waste, and abuse in Medicare and Medicaid through national and State efforts, as well as community-based programs that empower retirees to detect and defend against health care fraud.

Many of our Nation's older men and women have worked tirelessly and sacrificed so their children could achieve something greater. Their passion and experience inspire us all and we are privileged to honor and care for the generations whose legacy continues to enrich our Nation and shape our future.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim May 2010 as Older Americans Month. I call upon citizens of all ages to honor older Americans this month with appropriate ceremonies and activities.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-eighth day of April, in the year of our Lord two thousand ten, and of the Independence of the United States of America the two hundred and thirty-fourth.

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Presidential Documents

Proclamation 8507 of April 28, 2010

Workers Memorial Day, 2010

By the President of the United States of America

A Proclamation

This year marks the 40th anniversary of both the Occupational Safety and Health Act and the Federal Coal Mine Health and Safety Act, which promise American workers the right to a safe workplace and require employers to provide safe conditions. Yet, today, we remain too far from fulfilling that promise. On Workers Memorial Day, we remember all those who have died, been injured, or become sick on the job, and we renew our commitment to ensure the safety of American workers.

The families of the 29 coal miners who lost their lives on April 5 in an explosion at the Upper Big Branch Mine in West Virginia are in our thoughts and prayers. We also mourn the loss of 7 workers who died in a refinery explosion in Washington State just days earlier, the 4 workers who died at a power plant in Connecticut earlier this year, and the 11 workers lost in the oil platform explosion off the coast of Louisiana just last week.

Although these large-scale tragedies are appalling, most workplace deaths result from tragedies that claim one life at a time through preventable incidents or disabling disease. Every day, 14 workers are killed in on-the-job incidents, while thousands die each year of work-related disease, and millions are injured or contract an illness. Most die far from the spotlight, unrecognized and unnoticed by all but their families, friends, and co-workers—but they are not forgotten.

The legal right to a safe workplace was won only after countless lives had been lost over decades in workplaces across America, and after a long and bitter fight waged by workers, unions, and public health advocates. Much remains to be done, and my Administration is dedicated to renewing our Nation's commitment to achieve safe working conditions for all American workers.

Providing safer work environments will take the concerted action of government, businesses, employer associations, unions, community organizations, the scientific and public health communities, and individuals. Today, as we mourn those lost mere weeks ago in the Upper Big Branch Mine and other recent disasters, so do we honor all the men and women who have died on the job. In their memory, we rededicate ourselves to preventing such tragedies, and to securing a safer workplace for every American.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim April 28, 2010, as Workers Memorial Day. I call upon all Americans to participate in ceremonies and activities in memory of those who have been killed due to unsafe working conditions.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-eighth day of April, in the year of our Lord two thousand ten, and of the Independence of the United States of America the two hundred and thirty-fourth.

[FR Doc. 2010–10574
Filed 5–3–10; 8:45 am]
Billing code 3195–W0–P

Presidential Documents

Memorandum of April 27, 2010

Delegation of Certain Functions Under Section 104(g) of the United States-India Peaceful Atomic Energy Cooperation Act of 2006, as Amended by Public Law 110–369

Memorandum for the Secretary of State

By the authority vested in me as President by the Constitution and the laws of the United States, including section 301 of title 3, United States Code, I hereby delegate to you the functions and authority conferred upon the President by section 104(g) of the United States-India Peaceful Atomic Energy Cooperation Act of 2006 (Public Law 109–401), as amended by section 105 of Public Law 110–369, to make the specified report to the Congress.

You are authorized and directed to publish this memorandum in the *Federal Register*.

THE WHITE HOUSE,
Washington, April 27, 2010

[FR Doc. 2010–10584
Filed 5–3–10; 8:45 am]
Billing code 4710–10–P

Rules and Regulations

Federal Register

Vol. 75, No. 85

Tuesday, May 4, 2010

This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.

The Code of Federal Regulations is sold by the Superintendent of Documents. Prices of new books are listed in the first FEDERAL REGISTER issue of each week.

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

7 CFR Parts 272 and 273

RIN 0584–AD30

Food Stamp Program: Eligibility and Certification Provisions of the Farm Security and Rural Investment Act of 2002; Approval of Information Collection Request

AGENCY: Food and Nutrition Service (FNS), USDA.

ACTION: Final rule, notice of approval of Information Collection Request (ICR).

SUMMARY: The final rule entitled, Food Stamp Program: Eligibility and Certification Provisions of the Farm Security and Rural Investment Act of 2002, was published on January 29, 2010. This final rule implemented 11 provisions of the Farm Security and Rural Investment Act of 2002 (FSRIA), which established new eligibility and certification requirements for the receipt of food stamps. Those provisions simplified program administration, allowed States greater flexibility, and provided enhanced access to eligible populations. The Food, Conservation, and Energy Act of 2008 changed the program name from Food Stamp Program to Supplemental Nutrition Assistance Program (SNAP). The Office of Management and Budget (OMB) cleared the associated information collection requirements on March 26, 2010. This document announces approval of the ICR.

DATES: The ICR associated with the final rule was approved by OMB on March 26, 2010, under OMB Control Number 0584–0064.

FOR FURTHER INFORMATION CONTACT: Angela Kline, Chief, Certification Policy Branch, Program Development Division, FNS, U.S. Department of Agriculture, 3101 Park Center Drive, Room 812, Alexandria, VA 22302. *E-mail: Angela.Kline@FNS.USDA.GOV.*

SUPPLEMENTARY INFORMATION: This document announces approval by OMB of the information collection requirements contained in the final rule entitled, Food Stamp Program: Eligibility and Certification Provisions of the Farm Security and Rural Investment Act of 2002, which was published on January 29, 2010 (75 FR 4912).

Dated: April 27, 2010.

Julia Paradis,

Administrator, Food and Nutrition Service.

[FR Doc. 2010–10391 Filed 5–3–10; 8:45 am]

BILLING CODE 3410–30–P

DEPARTMENT OF THE TREASURY

Office of Thrift Supervision

12 CFR Part 535

[Docket ID OTS–2010–0009]

RIN 1550–AC38

Unfair or Deceptive Acts or Practices; Amendment

AGENCY: Office of Thrift Supervision, Treasury (OTS).

ACTION: Final rule.

SUMMARY: OTS is amending its regulations at 12 CFR part 535 titled "Prohibited Consumer Credit Practices" to avoid duplication and inconsistency with the Credit Card Accountability Responsibility and Disclosure Act of 2009 and the rules of the Board of Governors of the Federal Reserve implementing that statute.

DATES: This rule is effective on July 1, 2010.

FOR FURTHER INFORMATION CONTACT: Richard Bennett, Senior Compliance Counsel, Regulations and Legislation Division, (202) 906–7409; or April Breslaw, Director, Consumer Regulations, (202) 906–6989, at Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552.

SUPPLEMENTARY INFORMATION:

On December 18, 2008, OTS used its authority under the Federal Trade Commission Act (15 U.S.C. 41–58) and the Home Owners' Loan Act (12 U.S.C. 1461 *et seq.*) to adopt a final rule titled "Unfair or Deceptive Acts or Practices" amending its rule at 12 CFR part 535 titled "Prohibited Consumer Credit Practices." The rule was published in the **Federal Register** on January 29, 2009 (January 2009 UDAP rule). 74 FR 5498. OTS issued its rule jointly with rules issued by the Board of Governors of the Federal Reserve (Board) and the National Credit Union Administration (NCUA). The rule was scheduled to go into effect on July 1, 2010.

The January 2009 UDAP rule contained three subparts to part 535 and an Appendix to part 535 containing an Official Staff Commentary. Subparts A and B addressed general provisions and credit practices respectively. Subpart C addressed unfair consumer credit card account practices. The Supplementary Information to the January 2009 UDAP rule described all these changes in detail.

On May 5, 2009, OTS published proposed amendments to the January 2009 UDAP rule (May 2009 proposed amendments). *See* 74 FR 20804.

On May 22, 2009, the President signed into law the Credit Card Accountability Responsibility and Disclosure Act of 2009 (Credit CARD Act). Public Law 111–24, 123 Stat. 1734 (2009). The Credit CARD Act primarily amended the Truth in Lending Act (15 U.S.C. 1601 *et seq.*) and established a number of new substantive and disclosure requires to establish fair and transparent practices pertaining to open-end consumer credit plans, including credit card accounts. On July 22, 2009, the Board published an interim final rule amending Regulation Z (12 CFR pt. 226) and the staff commentary to implement those provisions of the Credit CARD Act that became effective on August 20, 2009. *See* 74 FR 36077. On February 22, 2010, the Board published a new final rule amending Regulation Z and the staff commentary in order to implement the Credit CARD Act. *See* 75 FR 7658.

The Credit CARD Act and the Board's implementing rule do not affect the provisions of subparts A and B and the corresponding portion of the Appendix in the January 2009 UDAP rule. Accordingly, today's final rule repromulgates those provisions, subject only to necessary conforming amendments. These provisions will take effect on July 1, 2010 as previously scheduled.

In contrast, the practices addressed in subpart C and the corresponding portion of the Appendix in the January 2009 UDAP rule, as proposed to be revised by the May 2009 proposed amendments are subsumed within, though not identical to, the practices addressed by Credit CARD Act and the Board's implementing rule. In some respects, the Credit CARD Act and the Board's implementing rule address the same practices addressed in the January 2009 UDAP rule, but in somewhat different ways that afford greater consumer protection. In order to avoid duplication and inconsistency, OTS is removing subpart C and the corresponding portion of the Appendix. For procedural reasons, OTS is making these changes effective July 1, 2010. Consequently, subpart C and the corresponding portion of the Appendix will not take effect. Likewise, OTS does not intend to finalize the May 2009 proposed amendments.

The Credit CARD Act and the Board's implementing rule do not affect the standards for unfairness or deception under the FTC Act. Accordingly, in analyzing whether an act or practice is unfair, OTS will continue to apply the standards described in the Supplementary Information to the January 2009 UDAP rule. *See* 74 FR at 5502–04. Under these standards, an act or practice is unfair where: (1) It causes or is likely to cause substantial injury to consumers; (2) the injury cannot be reasonably avoided by consumers themselves; and (3) the injury is not outweighed by countervailing benefits to consumers or to competition. Established public policy may also be considered in the analysis of whether a particular act or practice is unfair, but public policy may not serve as the primary basis for a determination that an act or practice is unfair. An act or practice is deceptive where: (1) there is a representation or omission of information that is likely to mislead consumers acting reasonably under the circumstances; and (2) that information is material to consumers.

Further, as noted in the Supplementary Information to the January 2009 UDAP rule, the fact that a particular act or practice is not addressed in a rule on unfair or deceptive acts or practices, does not limit the ability of an agency to make a determination that the practice is unfair or deceptive. 74 FR at 5504. Accordingly, OTS will continue to consider the analysis of consumer credit card account practices contained in the Supplementary Information to the January 2009 UDAP rule and the May 2009 proposed amendments, even though OTS is removing subpart C and the corresponding portion of the Appendix.

OTS issued its January 2009 UDAP rule and the May 2009 proposed amendments jointly with rules issued by the Board and the NCUA. Today's final rule, however, applies only to the OTS rule and does not affect the rules issued by the Board and NCUA. OTS notes that on February 22, 2010, the Board issued a corresponding final rule (75 FR 7925) and on February 10, 2010, the NCUA issued a corresponding final rule (75 FR 6558).

Administrative Procedure Act

Under 5 U.S.C. 553(b)(B) of the Administrative Procedure Act (APA), an agency may, for good cause, find (and incorporate the finding and brief statement of reasons therefore in the rule issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest. The conforming amendments to subparts A and B and the corresponding portion of the Appendix are technical in nature. The substance of subparts A and B was previously subject to notice and comment, as described in detail in the **SUPPLEMENTARY INFORMATION** contained in January 2009 UDAP rule.

The consumer protections contained in subpart C to part 535 as proposed to be revised by the May 2009 proposed amendments are subsumed within, though not identical to, the protections of the Credit CARD Act and the Board's implementing rule. Accordingly, the removal of subpart C is necessary to avoid duplication and inconsistency. Therefore, OTS has determined that publishing a notice of proposed rulemaking and providing opportunity for public comment are unnecessary.

Regulatory Flexibility Act

Pursuant to section 605(b) of the Regulatory Flexibility Act (Pub. L. 96–354, 5 U.S.C. 601), the OTS Director certifies that these amendments to 12 CFR part 535 will not have a significant economic impact on a substantial number of small entities. OTS previously certified that the January 2009 UDAP rule would not have a significant economic impact on a substantial number of small entities. *See* 74 FR at 5549–50. Since this final rule removes subpart C, any impact of the January 2009 UDAP rule will be even further reduced. Accordingly, this final rule will not have a significant economic impact on a substantial number of small entities.

Paperwork Reduction Act of 1995

Office of Management and Budget (OMB) regulations require OMB to review and approve information collection requirements imposed by agency rule. OTS is submitting notification to OMB of revisions to an approved paperwork section. In this final rule, OTS has removed the paperwork requirements for subpart C, which were contained in section 535.24(a).

Executive Order 12866

OTS previously provided a regulatory impact analysis under Executive Order 12866. 74 FR at 5551–5558. The analysis addressed the impact of the consumer credit card practices in subpart C to part 535. Since this final rule removes subpart C, its impact will be eliminated.

Unfunded Mandates Reform Act of 1995

OTS has determined that the requirements of this final rule will not result in expenditures by State, local, and tribal governments, or by the private sector, of $100 million or more in any one year. Accordingly, a budgetary impact statement is not required under section 202 of the Unfunded Mandates Reform Act of 1995. OTS previously certified that the January 2009 UDAP rule would not result in expenditures by State, local, and tribal governments, of $100 million or more in any one year, but may result in expenditures by the private sector in excess of that threshold. *See* 74 FR at 5558. Since this final rule removes subpart C, any impact of the January 2009 UDAP rule will be even further reduced. Accordingly, this final rule will not result in expenditures by State, local, and tribal governments, or by the private sector, of $100 million or more in any one year.

Executive Order 13132 Determination

OTS previously certified that the January 2009 UDAP rule does not have any federalism implications for purposes of Executive Order 13132. See 74 FR at 5558. That determination continues to apply.

List of Subjects in 12 CFR Part 535

Consumer credit, Consumer protection, Credit, Credit cards, Deception, Intergovernmental relations, Savings associations, Trade practices, Unfairness.

Authority and Issuance

■ For the reasons discussed in the preamble, OTS revises 12 CFR part 535 to read as follows:

PART 535—UNFAIR OR DECEPTIVE ACTS OR PRACTICES

Subpart A—General Provisions

Sec.
535.1 Authority, purpose, and scope.

Subpart B—Consumer Credit Practices

535.11 Definitions.
535.12 Unfair credit contract provisions.
535.13 Unfair or deceptive cosigner practices.
535.14 Unfair late charges.

Appendix to Part 535—Official Staff Commentary

Authority: 12 U.S.C. 1462a, 1463, 1464; 15 U.S.C. 57a.

Subpart A—General Provisions

§ 535.1 Authority, purpose and scope.

(a) *Authority.* This part is issued by OTS under section 18(f) of the Federal Trade Commission Act, 15 U.S.C. 57a(f) (section 202(a) of the Magnuson-Moss Warranty—Federal Trade Commission Improvement Act, Pub. L. 93–637) and the Home Owners' Loan Act, 12 U.S.C. 1461 *et seq.*

(b) *Purpose.* The purpose of this part is to prohibit unfair or deceptive acts or practices in violation of section 5(a)(1) of the Federal Trade Commission Act, 15 U.S.C. 45(a)(1). Subpart B defines and contains requirements prescribed for the purpose of preventing specific unfair or deceptive acts or practices of savings associations. The prohibitions in subpart B do not limit OTS's authority to enforce the FTC Act with respect to any other unfair or deceptive acts or practices. The purpose of this part is also to prohibit unsafe and unsound practices and protect consumers under the Home Owners' Loan Act, 12 U.S.C. 1461 *et seq.*

(c) *Scope.* This part applies to savings associations and subsidiaries owned in whole or in part by a savings association ("you").

Subpart B—Consumer Credit Practices

§ 535.11 Definitions.

For purposes of this subpart, the following definitions apply:

(a) *Consumer* means a natural person who seeks or acquires goods, services, or money for personal, family, or household purposes, other than for the purchase of real property, and who applies for or is extended *consumer credit.*

(b) *Consumer credit* means credit extended to a natural person for personal, family, or household purposes. It includes consumer loans; educational loans; unsecured loans for real property alteration, repair or improvement, or for the equipping of real property; overdraft loans; and credit cards. It also includes loans secured by liens on real estate and chattel liens secured by mobile homes and leases of personal property to consumers that may be considered the functional equivalent of loans on personal security but only if you rely substantially upon other factors, such as the general credit standing of the borrower, guaranties, or security other than the real estate or mobile home, as the primary security for the loan.

(c) *Earnings* means compensation paid or payable to an individual or for the individual's account for personal services rendered or to be rendered by the individual, whether denominated as wages, salary, commission, bonus, or otherwise, including periodic payments pursuant to a pension, retirement, or disability program.

(d) *Obligation* means an agreement between you and a consumer.

(e) *Person* means an individual, corporation, or other business organization.

§ 535.12 Unfair credit contract provisions.

It is an unfair act or practice for you, directly or indirectly, to enter into a consumer credit obligation that constitutes or contains, or to enforce in a consumer credit obligation you purchased, any of the following provisions:

(a) *Confession of judgment.* A cognovit or confession of judgment (for purposes other than executory process in the State of Louisiana), warrant of attorney, or other waiver of the right to notice and the opportunity to be heard in the event of suit or process thereon.

(b) *Waiver of exemption.* An executory waiver or a limitation of exemption from attachment, execution, or other process on real or personal property held, owned by, or due to the consumer, unless the waiver applies solely to property subject to a security interest executed in connection with the obligation.

(c) *Assignment of wages.* An assignment of wages or other earnings unless:

(1) The assignment by its terms is revocable at the will of the debtor;

(2) The assignment is a payroll deduction plan or preauthorized payment plan, commencing at the time of the transaction, in which the consumer authorizes a series of wage deductions as a method of making each payment; or

(3) The assignment applies only to wages or other earnings already earned at the time of the assignment.

(d) *Security interest in household goods.* A nonpossessory security interest in household goods other than a purchase-money security interest. For purposes of this paragraph, *household goods:*

(1) Means clothing, furniture, appliances, linens, china, crockery, kitchenware, and personal effects of the consumer and the consumer's dependents.

(2) Does not include:

(i) Works of art;

(ii) Electronic entertainment equipment (except one television and one radio);

(iii) Antiques (any item over one hundred years of age, including such items that have been repaired or renovated without changing their original form or character); or

(iv) Jewelry (other than wedding rings).

§ 535.13 Unfair or deceptive cosigner practices.

(a) *Prohibited deception.* It is a deceptive act or practice for you, directly or indirectly in connection with the extension of credit to consumers, to misrepresent the nature or extent of cosigner liability to any person.

(b) *Prohibited unfairness.* It is an unfair act or practice for you, directly or indirectly in connection with the extension of credit to consumers, to obligate a cosigner unless the cosigner is informed, before becoming obligated, of the nature of the cosigner's liability.

(c) *Disclosure requirement*—(1) *Disclosure statement.* A clear and conspicuous statement must be given in writing to the cosigner before becoming obligated. In the case of open-end credit, the disclosure statement must be given to the cosigner before the time that the cosigner becomes obligated for any fees or transactions on the account. The disclosure statement must contain the following statement or one that is substantially similar:

Notice of Cosigner

You are being asked to guarantee this debt. Think carefully before you do. If the borrower doesn't pay the debt, you will have to. Be sure you can afford to pay if you have to, and that you want to accept this responsibility.

You may have to pay up to the full amount of the debt if the borrower does not pay. You may also have to pay late fees or collection costs, which increase this amount.

The creditor can collect this debt from you without first trying to collect from the borrower. The creditor can use the same collection methods against you that can be used against the borrower, such as suing you, garnishing your wages, etc. If this debt is ever in default, that fact may become a part of your credit record.

(2) *Compliance.* Compliance with paragraph (d)(1) of this section

constitutes compliance with the consumer disclosure requirement in paragraph (b) of this section.

(3) *Additional content limitations.* If the notice is a separate document, nothing other than the following items may appear with the notice:

(i) Your name and address;

(ii) An identification of the debt to be cosigned (*e.g.,* a loan identification number);

(iii) The date (of the transaction); and

(iv) The statement, "This notice is not the contract that makes you liable for the debt."

(d) *Cosigner defined.* (1) *Cosigner* means a natural person who assumes liability for the obligation of a consumer without receiving goods, services, or money in return for the obligation, or, in the case of an open-end credit obligation, without receiving the contractual right to obtain extensions of credit under the account.

(2) *Cosigner* includes any person whose signature is requested as a condition to granting credit to a consumer, or as a condition for forbearance on collection of a consumer's obligation that is in default. The term does not include a spouse or other person whose signature is required on a credit obligation to perfect a security interest pursuant to state law.

(3) A person who meets the definition in this paragraph is a *cosigner,* whether or not the person is designated as such on a credit obligation.

§ 535.14 Unfair late charges.

(a) *Prohibition.* In connection with collecting a debt arising out of an extension of credit to a consumer, it is an unfair act or practice for you, directly or indirectly, to levy or collect any delinquency charge on a payment, when the only delinquency is attributable to late fees or ydelinquency charges assessed on earlier installments and the payment is otherwise a full payment for the applicable period and is paid on its due date or within an applicable grace period.

(b) *Collecting a debt defined—Collecting a debt* means, for the purposes of this section, any activity, other than the use of judicial process, that is intended to bring about or does bring about repayment of all or part of money due (or alleged to be due) from a consumer.

Appendix to Part 535—Official Staff Commentary

Subpart A—General Provisions

Section 535.1 Authority, Purpose, and Scope.

1(c) Scope

1. *Penalties for noncompliance.* Administrative enforcement of the rule for savings associations may involve actions under section 8 of the Federal Deposit Insurance Act (12 U.S.C. 1818), including cease-and-desist orders requiring that actions be taken to remedy violations and civil money penalties.

2. *Application to subsidiaries.* The term "savings association" as used in this Appendix also includes subsidiaries owned in whole or in part by a savings association.

Dated: April 27, 2010.

By the Office of Thrift Supervision.

John E. Bowman,

Acting Director.

[FR Doc. 2010–10196 Filed 5–3–10; 8:45 am]

BILLING CODE P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2009–1250; Directorate Identifier 2008–NM–169–AD; Amendment 39–16276; AD 2010–09–11]

RIN 2120–AA64

Airworthiness Directives; BAE Systems (Operations) Limited Model BAe 146–100A, –200A, and –300A Series Airplanes, and Model Avro 146–RJ70A, 146–RJ85A, and 146–RJ100A Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: We are superseding an existing airworthiness directive (AD) for the products listed above. This AD results from mandatory continuing airworthiness information (MCAI) originated by an aviation authority of another country to identify and correct an unsafe condition on an aviation product. The MCAI describes the unsafe condition as:

In 1991, the UK Civil Aviation Authority (CAA) issued AD 015–08–91 [which corresponds to FAA AD 93–01–11], requiring the accomplishment of inspections of, and in case of crack findings, corrective actions on, the wing top skin at rib '0' of pre-modification HCM00851C BAe 146 series aircraft in accordance with British Aerospace Service Bulletin (SB) 57–41 dated 26 July 1991. Recently, BAE Systems (Operations) Ltd has determined that a revised inspection programme for the wing top skin and joint strap at rib '0' on all BAe 146 and AVRO 146–RJ aircraft is necessary to assure the continued structural integrity of this area. Cracking of the wing centre section top skin, if undetected, could lead to structural failure and consequent loss of the aircraft.

* * * * *

We are issuing this AD to require actions to correct the unsafe condition on these products.

DATES: This AD becomes effective June 8, 2010.

The Director of the Federal Register approved the incorporation by reference of a certain publication listed in this AD as of June 8, 2010.

On March 2, 1993 (58 FR 6081, January 26, 1993), the Director of the Federal Register approved the incorporation by reference of a certain other publication listed in this AD.

ADDRESSES: You may examine the AD docket on the Internet at *http://www.regulations.gov* or in person at the U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Todd Thompson, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue, SW., Renton, Washington 98057–3356; telephone (425) 227–1175; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION:

Discussion

We issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 to include an AD that would apply to the specified products. That NPRM was published in the **Federal Register** on January 12, 2010 (75 FR 1563), and proposed to supersede AD 93–01–11, Amendment 39–8465 (58 FR 6081, January 26, 1993). That NPRM proposed to correct an unsafe condition for the specified products. The MCAI states:

In 1991, the UK Civil Aviation Authority (CAA) issued AD 015–08–91 [which corresponds to FAA AD 93–01–11], requiring the accomplishment of inspections of, and in case of crack findings, corrective actions on, the wing top skin at rib '0' of pre-modification HCM00851C BAe 146 series aircraft in accordance with British Aerospace Service Bulletin (SB) 57–41 dated 26 July 1991. Recently, BAE Systems (Operations) Ltd has determined that a revised inspection programme for the wing top skin and joint

strap at rib '0' on all BAe 146 and AVRO 146–RJ aircraft is necessary to assure the continued structural integrity of this area. Cracking of the wing centre section top skin, if undetected, could lead to structural failure and consequent loss of the aircraft.

For the reasons described above, this new EASA [European Aviation Safety Agency] AD supersedes UK CAA AD 015–08–91 and requires repetitive high-frequency eddy current (HFEC), radiographic, ultrasonic, and detailed visual inspections [for cracking and corrosion] of the wing top skin and joint strap at rib '0', the reporting of all inspection results to BAE Systems and, in case of findings, the accomplishment of corrective actions.

The corrective actions include repairing cracking and corrosion, and contacting BAE Systems (Operations) Limited for repair instructions and doing the repair. You may obtain further information by examining the MCAI in the AD docket.

Comments

We gave the public the opportunity to participate in developing this AD. We received no comments on the NPRM or on the determination of the cost to the public.

Conclusion

We reviewed the available data and determined that air safety and the public interest require adopting the AD as proposed.

Differences Between This AD and the MCAI or Service Information

We have reviewed the MCAI and related service information and, in general, agree with their substance. But we might have found it necessary to use different words from those in the MCAI to ensure the AD is clear for U.S. operators and is enforceable. In making these changes, we do not intend to differ substantively from the information provided in the MCAI and related service information.

We might also have required different actions in this AD from those in the MCAI in order to follow our FAA policies. Any such differences are highlighted in a NOTE within the AD.

Explanation of Change to Costs of Compliance

After the NPRM was issued, we reviewed the figures we have used over the past several years to calculate AD costs to operators. To account for various inflationary costs in the airline industry, we find it necessary to increase the labor rate used in these calculations from $80 per work hour to $85 per work hour. The cost impact information, below, reflects this increase in the specified hourly labor rate.

Costs of Compliance

We estimate that this AD will affect about 1 product of U.S. registry.

The actions that are required by AD 93–01–11 and retained in this AD take about 4 work-hours per product, at an average labor rate of $85 per work hour. Based on these figures, the estimated cost of the currently required actions is $340 per product.

We estimate that it will take about 4 work-hours per product to comply with the new basic requirements of this AD. The average labor rate is $85 per work-hour. Based on these figures, we estimate the cost of this AD to the U.S. operators to be $340.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. "Subtitle VII: Aviation Programs," describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in "Subtitle VII, Part A, Subpart III, Section 44701: General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this AD:

1. Is not a "significant regulatory action" under Executive Order 12866;

2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this AD and placed it in the AD docket.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov*; or in person at the Docket Operations office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains the NPRM, the regulatory evaluation, any comments received, and other information. The street address for the Docket Operations office (telephone (800) 647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by removing Amendment 39–8465 (58 FR 6081, January 26, 1993) and adding the following new AD:

2010–09–11 BAE Systems (Operations) Limited: Amendment 39–16276. Docket No. FAA–2009–1250; Directorate Identifier 2008–NM–169–AD.

Effective Date

(a) This airworthiness directive (AD) becomes effective June 8, 2010.

Affected ADs

(b) The AD supersedes AD 93–01–11, Amendment 39–8465.

Applicability

(c) This AD applies to all BAE SYSTEMS (Operations) Limited Model BAe 146–100A, –200A, and –300A series airplanes, and Model Avro 146–RJ70A, 146–RJ85A, and 146–RJ100A airplanes; certificated in any category.

Subject

(d) Air Transport Association (ATA) of America Code 57: Wings.

Reason

(e) The mandatory continuing airworthiness information (MCAI) states:

In 1991, the UK Civil Aviation Authority (CAA) issued AD 015–08–91 [which corresponds to FAA AD 93–01–11], requiring the accomplishment of inspections of, and in case of crack findings, corrective actions on, the wing top skin at rib '0' of pre-

modification HCM00851C BAe 146 series aircraft in accordance with British Aerospace Service Bulletin (SB) 57–41 dated 26 July 1991. Recently, BAE Systems (Operations) Ltd has determined that a revised inspection programme for the wing top skin and joint strap at rib '0' on all BAe 146 and AVRO 146–RJ aircraft is necessary to assure the continued structural integrity of this area. Cracking of the wing centre section top skin, if undetected, could lead to structural failure and consequent loss of the aircraft.

For the reasons described above, this new EASA [European Aviation Safety Agency] AD supersedes UK CAA AD 015–08–91 and requires repetitive high-frequency eddy current (HFEC), radiographic, ultrasonic, and detailed visual inspections [for cracking and corrosion] of the wing top skin and joint strap at rib '0', the reporting of all inspection results to BAE Systems and, in case of findings, the accomplishment of corrective actions.

The corrective actions include repairing cracking and corrosion, and contacting BAE Systems (Operations) Limited for repair instructions and doing the repair.

Restatement of Requirements of AD 93–01–11, With No Changes

(f) Unless already done, for Model BAe 146–100A, –200A, and –300A series airplanes: Prior to the accumulation of 24,000 landings, or within 60 days after March 2, 1993 (the effective date of AD 93–01–11), whichever occurs later: Perform an X-ray inspection to detect fatigue cracks in the left and right wing upper skins, joint straps, and stringers in the vicinity of rib "0," in accordance with British Aerospace Inspection Service Bulletin 57–41, dated July 26, 1991. Doing the inspection required by paragraph (g)(1) of this AD terminates the inspection required by this paragraph.

(1) If cracks are found, prior to further flight, repair in accordance with a method approved by the Manager, Standardization Branch, ANM–113, Transport Airplane Directorate, FAA; or the Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA. As of the effective date of this AD, repair in accordance with a method approved by the Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA. Thereafter, repeat the inspection required by paragraph (f) of this AD at intervals not to exceed 9,000 landings, in accordance with British Aerospace Inspection Service Bulletin 57–41, dated July 26, 1991, until the initial inspection required by paragraph (g)(1) of this AD is accomplished.

(2) If no cracks are found, repeat the inspection required by paragraph (f) of this AD at intervals not to exceed 9,000 landings, in accordance with British Aerospace Inspection Service Bulletin 57–41, dated July 26, 1991, until the initial inspection required by paragraph (g)(1) of this AD is accomplished.

New Requirements of This AD

(g) Unless already done, do the following actions.

Note 1: The instructions of BAE Systems (Operations) Limited Inspection Service Bulletin ISB.57–070, dated October 15, 2007, which is the subject of this AD, are divided into two parts; consequently, the statement in paragraph 1.C. of BAE Systems (Operations) Limited Inspection Service Bulletin ISB.57–070, dated October 15, 2007, that there are three parts is incorrect and can be disregarded.

(1) At the applicable compliance time specified in paragraph (g)(1)(i) or (g)(1)(ii) of this AD: Do an HFEC inspection of the front and rear spar flanges, a detailed visual inspection of the stringers, and a detailed visual inspection of the stringer crown fittings, all at the rib "0" joint strap, for cracking and corrosion, and do all applicable corrective actions, in accordance with "Part 1" of paragraph 2.C., "Inspection," of BAE Systems (Operations) Limited Inspection Service Bulletin ISB.57–070, dated October 15, 2007. Repeat the inspections thereafter at intervals not to exceed 4,000 flight cycles. Do all applicable corrective actions before further flight. Accomplishment of these initial inspections terminates the inspections required by paragraphs (f), (f)(1), and (f)(2) of this AD.

(i) For airplanes on which an inspection was not done in accordance with Supplemental Structural Inspection (SSI) 57–10–101 (MPD 571001–DVI–10000–1) as of the effective date of this AD: Prior to the accumulation of 20,000 total flight cycles, or within 4,000 flight cycles after the effective date of this AD, whichever occurs later.

(ii) For airplanes on which an inspection was done in accordance with SSI 57–10–101 (MPD 571001–DVI–10000–1) as of the effective date of this AD: Within 3,000 flight cycles after the effective date of this AD.

(2) At the applicable compliance time specified in paragraph (g)(2)(i) or (g)(2)(ii) of this AD: Do detailed visual and HFEC inspections to detect cracking and corrosion of the rib "0" strap, a radiographic inspection of the rib "0" joint, and an ultrasonic inspection of the skin at the rib "0" joint strap, and do all applicable corrective actions, in accordance with "PART 2" of paragraph 2.C. "Inspection" of BAE Systems (Operations) Limited Inspection Service Bulletin ISB.57–070, dated October 15, 2007. Do all applicable corrective actions before further flight. Repeat the inspections thereafter at intervals not to exceed 4,000 flight cycles.

(i) For airplanes on which an inspection was not done in accordance with SSI 57–10–102 and 57–10–102A (MPD 571002–SDI–10000–1 and 571002–SDI–10000–2) as of the effective date of this AD: Before the accumulation of 24,000 total flight cycles, or within 4,000 flight cycles after the effective date of this AD, whichever occurs later.

(ii) For airplanes on which an inspection was done in accordance with SSI 57–10–102 or 57–10–102A (MPD 571002–SDI–10000–1 or 571002–SDI–10000–2) as of the effective date of this AD: Within 3,000 flight cycles after the effective date of this AD.

(3) Submit a report of the findings (both positive and negative) of the initial inspections required by paragraphs (g)(1) and (g)(2) of this AD to BAE Systems (Operations) Limited, at the applicable time specified in paragraph (g)(3)(i) or (g)(3)(ii) of this AD. The report must include the inspection results, a description of any discrepancies found, the airplane serial number, and the number of landings and flight hours on the airplane. Send reports to Customer Liaison, Customer Support (Building 37), BAE SYSTEMS (Operations) Limited, Prestwick International Airport, Ayrshire, KA9 2RW, Scotland; fax +44 (0) 1292 675432; e-mail *raengliaison@baesystems.com.*

(i) If the inspection was done on or after the effective date of this AD: Submit the report within 30 days after the inspection.

(ii) If the inspection was done before the effective date of this AD: Submit the report within 30 days after the effective date of this AD.

(4) Accomplishment of any repair does not constitute terminating action for the inspection requirements of this AD.

FAA AD Differences

Note 2: This AD differs from the MCAI and/or service information as follows: No differences.

Other FAA AD Provisions

(h) The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Branch, ANM–116, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. Send information to ATTN: Todd Thompson, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue, SW., Renton, Washington 98057–3356; telephone (425) 227–1175; fax (425) 227–1149. Before using any approved AMOC on any airplane to which the AMOC applies, notify your principal maintenance inspector (PMI) or principal avionics inspector (PAI), as appropriate, or lacking a principal inspector, your local Flight Standards District Office. The AMOC approval letter must specifically reference this AD.

(2) *Airworthy Product:* For any requirement in this AD to obtain corrective actions from a manufacturer or other source, use these actions if they are FAA-approved. Corrective actions are considered FAA-approved if they are approved by the State of Design Authority (or their delegated agent). You are required to assure the product is airworthy before it is returned to service.

(3) *Reporting Requirements:* For any reporting requirement in this AD, under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), the Office of Management and Budget (OMB) has approved the information collection requirements and has assigned OMB Control Number 2120–0056.

Related Information

(i) Refer to MCAI European Aviation Safety Agency (EASA) Airworthiness Directive 2008–0168, dated September 2, 2008; British Aerospace Inspection Service Bulletin 57–41, dated July 26, 1991; and BAE Systems (Operations) Limited Inspection Service Bulletin ISB.57–070, dated October 15, 2007; for related information.

Material Incorporated by Reference

(j) You must use British Aerospace Inspection Service Bulletin 57–41, dated July 26, 1991; and BAE Systems (Operations) Limited Inspection Service Bulletin ISB.57–070, dated October 15, 2007; as applicable; to do the actions required by this AD, unless the AD specifies otherwise.

(1) The Director of the Federal Register approved the incorporation by reference of BAE Systems (Operations) Limited Inspection Service Bulletin ISB.57–070, dated October 15, 2007, under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) The Director of the Federal Register previously approved the incorporation by reference of British Aerospace Inspection Service Bulletin 57–41, dated July 26, 1991, on March 2, 1993 (58 FR 6081, January 26, 1993).

(3) For service information identified in this AD, contact BAE Systems Regional Aircraft, 13850 McLearen Road, Herndon, Virginia 20171; telephone 703–736–1080; e-mail *raebusiness@baesystems.com*; Internet *http://www.baesystems.com/Businesses/RegionalAircraft/index.htm.*

(4) You may review copies of the service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington. For information on the availability of this material at the FAA, call 425–227–1221.

(5) You may also review copies of the service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Issued in Renton, Washington on April 22, 2010.

Jeffrey E. Duven,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2010–9944 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2010–0032; Directorate Identifier 2009–NM–213–AD; Amendment 39–16277; AD 2010–09–12]

RIN 2120–AA64

Airworthiness Directives; McDonnell Douglas Corporation Model DC–10–10, DC–10–10F, DC–10–15, DC–10–30, DC–10–30F (KC–10A and KDC–10), DC–10–40, DC–10–40F, MD–10–10F, MD–10–30F, MD–11, and MD–11F Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: We are adopting a new airworthiness directive (AD) for certain Model DC–10–10, DC–10–10F, DC–10–15, DC–10–30, DC–10–30F (KC–10A and KDC–10), DC–10–40, DC–10–40F, MD–10–10F, MD–10–30F, MD–11, and MD–11F airplanes. This AD requires a one-time installation of electrical bonding jumpers for the fill valve controllers of fuel tanks. This AD results from fuel system reviews conducted by the manufacturer. We are issuing this AD to prevent point-of-contact arcing or filament heating damage in the fuel tanks, which could result in fuel tank explosions and consequent loss of the airplane.

DATES: This AD is effective June 8, 2010.

The Director of the Federal Register approved the incorporation by reference of certain publications listed in the AD as of June 8, 2010.

ADDRESSES: For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Data & Services Management, 3855 Lakewood Boulevard, MC D800–0019, Long Beach, California 90846–0001; telephone 206–544–5000, extension 2; fax 206–766–5683; e-*mail dse.boecom@boeing.com;* Internet *https://www.myboeingfleet.com.*

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov;* or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD, the regulatory evaluation, any comments received, and other information. The address for the Docket Office (telephone 800–647–5527) is the Document Management Facility, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.

FOR FURTHER INFORMATION CONTACT: Philip Kush, Aerospace Engineer, Propulsion Branch, ANM–140L, FAA, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California 90712–4137; telephone (562) 627–5263; fax (562) 627–5210.

SUPPLEMENTARY INFORMATION:

Discussion

We issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 to include an airworthiness directive (AD) that would apply to certain Model DC–10–10, DC–10–10F, DC–10–15, DC–10–30, DC–10–30F (KC–10A and KDC–10), DC–10–40, DC–10–40F, MD–10–10F, MD–10–30F, MD–11, and MD–11F airplanes. That NPRM was published in the **Federal Register** on February 8, 2010 (75 FR 6160). That NPRM proposed to require a one-time installation of electrical bonding jumpers for the fill valve controllers of the fuel tanks.

Comments

We gave the public the opportunity to participate in developing this AD. We considered the comment received. FedEx supports the NPRM.

Conclusion

We reviewed the relevant data, considered the comment received, and determined that air safety and the public interest require adopting the AD as proposed.

Costs of Compliance

We estimate that this AD would affect 267 airplanes of U.S. registry. The following table provides the estimated costs for U.S. operators to comply with this AD.

TABLE—ESTIMATED COSTS

Action	Work hours	Average labor rate per hour	Parts	Cost per product	Number of U.S.-registered airplanes	Fleet cost
Installation	8 to 24 [1]	$85	$1,459 to $3,805 [1]	$2,139 to $5,845 [1]	267	$571,113 to $1,560,615 [1]

[1] Depending on airplane group or model.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. "Subtitle VII: Aviation Programs," describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in "Subtitle VII, Part A, Subpart III, Section 44701: General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

This AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a "significant regulatory action" under Executive Order 12866,

(2) Is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979), and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

You can find our regulatory evaluation and the estimated costs of compliance in the AD Docket.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new AD:

2010–09–12 McDonnell Douglas Corporation: Amendment 39–16277. Docket No. FAA–2010–0032; Directorate Identifier 2009–NM–213–AD.

Effective Date

(a) This airworthiness directive (AD) is effective June 8, 2010.

Affected ADs

(b) None.

Applicability

(c) This AD applies to McDonnell Douglas Corporation Model DC–10–10, DC–10–10F, DC–10–15, DC–10–30, DC–10–30F (KC–10A and KDC–10), DC–10–40, DC–10–40F, MD–10–10F, MD–10–30F, MD–11, and MD–11F airplanes; certificated in any category.

Subject

(d) Air Transport Association (ATA) of America Code 28: Fuel.

Unsafe Condition

(e) This AD results from fuel system reviews conducted by the manufacturer. The Federal Aviation Administration is issuing this AD to prevent point-of-contact arcing or filament heating damage in the fuel tanks, which could result in fuel tank explosions and consequent loss of the airplane.

Compliance

(f) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Installation

(g) Within 60 months after the effective date of this AD, install electrical bonding jumpers for the fill valve controllers of the fuel tanks, in accordance with the Accomplishment Instructions of Boeing Service Bulletin DC10–28–249, Revision 1, dated November 6, 2008 (for Model DC–10–10, DC–10–10F, DC–10–15, DC–10–30, DC–10–30F (KC–10A and KDC–10), DC–10–40, DC–10–40F, MD–10–10F, and MD–10–30F airplanes); or Boeing Service Bulletin MD11–28–135, Revision 1, dated November 6, 2008 (for Model MD–11 and MD–11F airplanes).

Alternative Methods of Compliance (AMOCs)

(h)(1) The Manager, Los Angeles Aircraft Certification Office (ACO), FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. Send information to ATTN: Philip Kush, Aerospace Engineer, Propulsion Branch, ANM–140L, FAA, Los Angeles ACO, 3960 Paramount Boulevard, Lakewood, California 90712–4137; telephone (562) 627–5263; fax (562) 627–5210.

(2) To request a different method of compliance or a different compliance time for this AD, follow the procedures in 14 CFR 39.19. Before using any approved AMOC on any airplane to which the AMOC applies, notify your principal maintenance inspector (PMI) or principal avionics inspector (PAI), as appropriate, or lacking a principal inspector, your local Flight Standards District Office. The AMOC approval letter must specifically reference this AD.

Material Incorporated by Reference

(i) You must use Boeing Service Bulletin DC10–28–249, Revision 1, dated November 6, 2008; or Boeing Service Bulletin MD11–28–135, Revision 1, dated November 6, 2008; as applicable; to do the actions required by this AD, unless the AD specifies otherwise.

(1) The Director of the Federal Register approved the incorporation by reference of this service information under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Data & Services Management, 3855 Lakewood Boulevard, MC D800–0019, Long Beach, California 90846–0001; telephone 206–544–5000, extension 2; fax 206–766–5683; e-mail *dse.boecom@boeing.com;* Internet *https://www.myboeingfleet.com.*

(3) You may review copies of the service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington. For information on the availability of this material at the FAA, call 425–227–1221.

(4) You may also review copies of the service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Issued in Renton, Washington, on April 22, 2010.

Jeffrey E. Duven,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2010–9945 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2009–0789; Directorate Identifier 2008–NM–185–AD; Amendment 39–16228; AD 2010–06–04]

RIN 2120–AA64

Airworthiness Directives; Airbus Model A300 B2–1C, B2–203, B2K–3C, B4–103, B4–203, B4–2C Airplanes; Model A310 Series Airplanes; and Model A300 B4–601, B4–603, B4–605R, B4–620, B4–622, and B4–622R Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule; correction.

SUMMARY: The FAA is correcting a typographical error in an existing

airworthiness directive (AD) that was published in the **Federal Register** on March 11, 2010. The error resulted in an imprecise compliance time in a table. This AD applies to certain Airbus Model A300 B2–1C, B2–203, B2K–3C, B4–103, B4–203, B4–2C airplanes; Model A310 series airplanes; and Model A300 B4–601, B4–603, B4–605R, B4–620, B4–622, and B4–622R airplanes. This AD requires repetitive inspections to detect cracks of the pylon side panels (upper section) at rib 8; and corrective actions if necessary.

DATES: This correction is effective May 4, 2010. The effective date of AD 2010–06–04 remains April 15, 2010.

ADDRESSES: You may examine the AD docket on the Internet at *http://www.regulations.gov*; or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD, the regulatory evaluation, any comments received, and other information. The address for the Docket Office (telephone 800–647–5527) is the Document Management Facility, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.

FOR FURTHER INFORMATION CONTACT: Dan Rodina, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue, SW., Renton, Washington 98057–3356; telephone (425) 227–2125; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION: On March 4, 2010, the FAA issued AD 2010–06–04, Amendment 39–16228 (75 FR 11428, March 11, 2010), for certain Airbus Model A300 B2–1C, B2–203, B2K–3C, B4–103, B4–203, B4–2C airplanes; Model A310 series airplanes; and Model A300 B4–601, B4–603, B4–605R, B4–620, B4–622, and B4–622R airplanes. The AD requires repetitive inspections to detect cracks of the pylon side panels (upper section) at rib 8; and corrective actions if necessary.

As published, Table 1 of this AD contained a typographical error in the second row in the second column. The compliance time of ">17,500 total flight [1]" has been corrected to read ">17,500 total flight cycles [1]." (The word "cycles" was omitted in the AD.)

No other part of the regulatory information has been changed; therefore, the final rule is not republished in the **Federal Register**.

The effective date of this AD remains April 15, 2010.

§ 39.13 [Corrected]

■ In the **Federal Register** of March 11, 2010, on page 11430, in the second row in the second column, Table 1 of AD 2010–06–04 is corrected to read as follows:

* * * * *

TABLE 1—COMPLIANCE TIMES FOR CONFIGURATION 1

For Model—	That have accumulated—	Whichever occurs later		And repeat the inspection at intervals not to exceed—
		Inspect before the accumulation of—	Or within—	
A300 B2–1C, B2–203, and B2K–3C airplanes.	≤17,500 total flight cycles [1]	5,350 total flight cycles	2,500 flight cycles [2]	4,300 flight cycles.
A300 B2–1C, B2–203, and B2K–3C airplanes.	>17,500 total flight cycles [1]	20,000 total flight cycles or 40,000 total flight hours, whichever occurs first.	250 flight cycles [2]	4,300 flight cycles.
A300 B4–103, B4–203, and B4–2C airplanes.	≤18,000 total flight cycles [1]	5,350 total flight cycles	2,000 flight cycles [2]	4,300 flight cycles.
A300 B4–103, B4–203, and B4–2C airplanes.	>18,000 total flight cycles [1]	20,000 total flight cycles or 40,000 total flight hours, whichever occurs first.	250 flight cycles [2]	4,300 flight cycles.
A300 B4–601, B4–603, B4–605R, B4–620, B4–622, and B4–622R airplanes.	≤18,000 total flight cycles [1]	4,200 total flight cycles	2,000 flight cycles [2]	3,600 flight cycles.
A300 B4–601, B4–603, B4–605R, B4–620, B4–622, and B4–622R airplanes.	>18,000 total flight cycles [1]	20,000 total flight cycles or 40,000 total flight hours, whichever occurs first.	250 flight cycles [2]	3,600 flight cycles.
A310–200 airplanes with GE CF6–80A3 or Pratt & Whitney engines.	≤18,000 total flight cycles [1]	9,700 total flight cycles or 19,400 total flight hours, whichever occurs first.	1,500 flight cycles [2]	6,700 flight cycles or 13,400 flight hours, whichever occurs first.
A310–200 airplanes with GE CF6–80A3 or Pratt & Whitney engines.	>18,000 total flight cycles [1]	19,500 total flight cycles or 55,500 total flight hours, whichever occurs first.	250 flight cycles [2]	6,700 flight cycles or 13,400 flight hours, whichever occurs first.
A310–200 airplanes with GE CF6–80C2 engines.	≤18,000 total flight cycles [1]	7,800 total flight cycles or 15,600 total flight hours, whichever occurs first.	1,500 flight cycles [2]	5,800 flight cycles or 11,600 flight hours, whichever occurs first.
A310–200 airplanes with GE CF6–80C2 engines.	>18,000 total flight cycles [1]	19,500 total flight cycles or 55,500 total flight hours, whichever occurs first.	250 flight cycles [2]	5,800 flight cycles or 11,600 flight hours, whichever occurs first.
A310–300 SR [3] airplanes with Pratt & Whitney JT9D engines.	≤18,000 total flight cycles [1]	8,600 total flight cycles or 24,000 total flight hours, whichever occurs first.	1,500 total flight cycles [2]	6,700 flight cycles or 18,700 flight hours, whichever occurs first.
A310–300 SR [3] airplanes with Pratt & Whitney JT9D engines.	>18,000 total flight cycles [1]	19,500 total flight cycles or 55,500 total flight hours, whichever occurs first.	250 flight cycles [2]	6,700 flight cycles or 18,700 flight hours, whichever occurs first.
A310–300 SR [3] airplanes with GE engines.	≤18,000 total flight cycles [1]	7,000 total flight cycles or 19,600 total flight hours, whichever occurs first.	1,500 flight cycles [2]	5,700 flight cycles or 15,900 flight hours, whichever occurs first.

TABLE 1—COMPLIANCE TIMES FOR CONFIGURATION 1—Continued

For Model—	That have accumulated—	Whichever occurs later		And repeat the inspection at intervals not to exceed—
		Inspect before the accumulation of—	Or within—	
A310–300 SR [3] airplanes with GE engines.	>18,000 total flight cycles [1]	19,500 total flight cycles or 55,500 total flight hours, whichever occurs first.	250 flight cycles [2]	5,700 flight cycles or 15,900 flight hours, whichever occurs first.
A310–300 SR [3] airplanes with Pratt & Whitney 4000 engines.	≤18,000 total flight cycles [1]	7,000 total flight cycles or 19,600 total flight hours, whichever occurs first.	1,500 flight cycles [2]	5,800 flight cycles or 16,200 flight hours, whichever occurs first.
A310–300 SR [3] airplanes with Pratt & Whitney 4000 engines.	>18,000 total flight cycles [1]	19,500 total flight cycles or 55,500 total flight hours, whichever occurs first.	250 flight cycles [2]	5,800 flight cycles or 16,200 flight hours, whichever occurs first.
A310–300 LR [4] airplanes with Pratt & Whitney JT9D engines.	≤18,000 total flight cycles [1]	5,900 total flight cycles or 29,500 total flight hours, whichever occurs first.	1,500 flight cycles [2]	6,000 flight cycles or 30,300 flight hours, whichever occurs first.
A310–300 LR [4] airplanes with Pratt & Whitney JT9D engines.	>18,000 total flight cycles [1]	19,500 total flight cycles or 55,500 total flight hours, whichever occurs first.	250 flight cycles [2]	6,000 flight cycles or 30,300 flight hours, whichever occurs first.
A310–300 LR [4] airplanes with GE engines.	≤18,000 total flight cycles [1]	4,800 total flight cycles or 24,100 total flight hours, whichever occurs first.	1,500 flight cycles [2]	5,100 flight cycles or 25,500 flight hours, whichever occurs first.
A310–300 LR [4] airplanes with GE engines.	>18,000 total flight cycles [1]	19,500 total flight cycles or 55,500 total flight hours, whichever occurs first.	250 flight cycles [2]	5,100 flight cycles or 25,500 flight hours, whichever occurs first.
A310–300 LR [4] airplanes with Pratt & Whitney 4000 engines.	≤18,000 total flight cycles [1]	4,800 total flight cycles or 24,000 total flight hours, whichever occurs first.	1,500 flight cycles [2]	5,200 flight cycles or 26,300 flight hours, whichever occurs first.
A310–300 LR [4] airplanes with Pratt & Whitney 4000 engines.	>18,000 total flight cycles [1]	19,500 total flight cycles or 55,500 total flight hours, whichever occurs first.	250 flight cycles [2]	5,200 flight cycles or 26,300 flight hours, whichever occurs first.

[1] As of the effective date of this AD.
[2] After the effective date of this AD.
[3] "SR" applies to airplanes with average flights less than 4 flight hours.
[4] "LR" refers to airplanes with average flights of 4 or more flight hours.

* * * * *

Issued in Renton, Washington on April 15, 2010.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2010–9521 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2008–1353; Directorate Identifier 2008–NE–46–AD; Amendment 39–16279; AD 2010–09–14]

RIN 2120–AA64

Airworthiness Directives; CFM International, S.A. CFM56–5B1/P, –5B2/P, –5B3/P, –5B3/P1, –5B4/P, –5B5/P, –5B6/P, –5B7/P, –5B8/P, –5B9/P, –5B1/2P, –5B2/2P, –5B3/2P, –5B3/2P1, –5B4/2P, –5B4/P1, –5B6/2P, –5B4/2P1, and –5B9/2P Turbofan Engines

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: The FAA is superseding an existing airworthiness directive (AD) for CFM International, S.A. CFM56–5B series turbofan engines. That AD requires reviewing exhaust gas temperature (EGT) monitoring records to determine EGT margin deterioration, and for airplanes where both engines have greater than 80 °centigrade (C) of EGT margin deterioration, borescope-inspecting the high-pressure compressor (HPC) of both engines. That AD also requires removing from service any engine that does not pass the borescope inspection and, if both engines pass, replacing one of the engines with an engine that has 80 °C or less of EGT margin deterioration. That AD also requires continuous monitoring of EGT margin deterioration on engines in service to prevent two engines on an airplane from having greater than 80 °C of EGT margin deterioration. This AD:

- Reduces the number of engine models affected;
- Continues to monitor EGT margin deterioration;
- Lowers the EGT margin threshold from 80 °C to 75 °C;
- Removes FADEC software version 5.B.Q and earlier versions from the engine as mandatory terminating action to the continuous EGT margin deterioration monitoring, for certain engine models;
- Removes the requirement to borescope inspect; and
- Removes the requirement to replace one of the engines with an engine that has 80 °C or less deterioration of EGT margin as a corrective action.

This AD results from a reduction of the affected engine models listed in AD 2009–01–01 from 25 to 19, a reduction in the engine EGT margin deterioration threshold from 80 °C to 75 °C, the introduction of terminating action to the continuous EGT monitoring for certain engines, and a change to the removal plan for the remaining engines if the EGT margin deterioration is greater than 75 °C. We are issuing this AD to prevent HPC stalls, which could prevent continued safe flight or landing.

DATES: This AD becomes effective June 8, 2010. The Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulations as of June 8, 2010.

ADDRESSES: You can get the service information identified in this AD from CFM International, S.A., Technical Customer Support, 1 Neumann Way,

Cincinnati, OH 45215; telephone (513) 552–3272; fax (513) 552–3329, Web address *http://customer.geae.com.*

The Docket Operations office is located at Docket Management Facility, U.S. Department of Transportation, 1200 New Jersey Avenue, SE., West Building Ground Floor, Room W12–140, Washington, DC 20590–0001.

FOR FURTHER INFORMATION CONTACT: Wayne Maguire, Aerospace Engineer, Engine Certification Office, FAA, Engine and Propeller Directorate, 12 New England Executive Park, Burlington, MA 01803; *e-mail: wayne.maguire@faa.gov;* telephone (781) 238–7778; fax (781) 238–7199.

SUPPLEMENTARY INFORMATION: The FAA proposed to amend 14 CFR part 39 by superseding AD 2009–01–01, Amendment 39–15779 (73 FR 80296, December 31, 2008), with a proposed AD. The proposed AD applies to CFM International, S.A. CFM56–5B series turbofan engines. We published the proposed AD in the **Federal Register** on December 21, 2009 (74 FR 67834). That action proposed to require continuous monitoring of EGT margin deterioration, removing FADEC software version 5.B.Q and earlier versions from the engine as mandatory terminating action to the repetitive recalculating and EGT monitoring for certain engine models, and removing other certain engine models from service if the EGT margin deterioration is greater than 75 °C.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov;* or in person at the Docket Operations office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Operations office (telephone (800) 647–5527) is provided in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

Comments

We provided the public the opportunity to participate in the development of this AD. We have considered the comments received.

Request To Clarify Engine Replacement Requirements

One commenter, CFM International, S.A., requests that we change the proposed AD to state, in part: "For airplanes where both engines indicate more than 75 °C EGT margin deterioration, within 150 CIS either remove one engine and replace it with an engine indicating less than 75 °C EGT margin."

We do not agree. When both installed engines have greater than 75 °C EGT margin deterioration, the proposed AD no longer allows replacing one of the engines with an engine that has 75 °C or less of EGT margin deterioration as a corrective action. We do not agree with the commenter's requested change, but we see an opportunity to clarify that the terminating action for this AD for certain engine models, is to remove FADEC software version 5.B.Q and earlier. For other engine models, the corrective action is to remove those engines from service that have greater than 75 °C of EGT margin deterioration. We added this clarification to the Summary of this AD. We kept the same engine replacement requirements in this AD, as those in the proposed AD.

Request To Reference the Latest Version of Software

CFM International, S.A. requests that we reference the latest version of software to be installed, which is version 5.B.R.

We do not agree. We intentionally referenced the software versions needing to be removed but not the version to be installed, as that version could become superseded in the future. We did not change the AD.

Request To Correct the Service Information Reference

CFM International, S.A. requests that we correct the service information reference in paragraph (k) to read "CFM International, S.A. Alert Service Bulletin No. CFM56–5B S/B 72–A0722, Revision 1, dated March 20, 2009."

We agree. We changed the AD to reflect the new service information reference throughout the compliance section.

Request To Indent Sub-Paragraphs

CFM International, S.A. requests that we indent the proposed AD numbered sub-paragraphs, as this further distinguishes the unique terminating actions for each group of identified CFM56 engine models.

We do not agree. Rulemaking procedures require that we do not indent sub-paragraphs. We did not change the AD.

Request To Alleviate

Two private commenters request that the prohibition against using engine control software version 5.B.Q or earlier versions, be alleviated for the CFM56–5B/2P (dual annular combustor) family of engine models. One other commenter requests that we move the contents of paragraph (h) to paragraph (f). The commenters state that the currently available engine control software version for those engines is earlier than version 5.B.Q.

We partially agree. We clarified paragraph (h) to apply to only those engine models where terminating action includes engine control software. We also added a second prohibition paragraph to apply to only those engines listed in paragraph (g). However, we did not move the contents of paragraph (h) to paragraph (f).

Conclusion

We have carefully reviewed the available data, including the comments received, and determined that air safety and the public interest require adopting the AD with the changes described previously. We have determined that these changes will neither increase the economic burden on any operator nor increase the scope of the AD.

Costs of Compliance

We estimate that this AD will affect 397 engines installed on airplanes of U.S. registry. We also estimate that it will take about one work-hour to install FADEC software. The average labor rate is $80 per work-hour. There are no required parts costs. Based on these figures, we estimate the total cost of the AD to U.S. operators to be $31,760.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in subtitle VII, part A, subpart III, section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States,

or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a "significant regulatory action" under Executive Order 12866;

(2) Is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a summary of the costs to comply with this AD and placed it in the AD Docket. You may get a copy of this summary at the address listed under **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the Federal Aviation Administration amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by removing Amendment 39–15779 (73 FR 80296, December 31, 2008) and by adding a new airworthiness directive, Amendment 39–16279, to read as follows:

2010–09–14 CFM International, S.A.: Amendment 39–16279. Docket No. FAA–2008–1353; Directorate Identifier 2008–NE–46–AD.

Effective Date

(a) This airworthiness directive (AD) becomes effective June 8, 2010.

Affected ADs

(b) This AD supersedes AD 2009–01–01, Amendment 39–15779.

Applicability

(c) This AD applies to CFM International, S.A. CFM56–5B1/P, –5B2/P, –5B3/P, –5B3/P1, –5B4/P, –5B5/P, –5B6/P, –5B7/P, –5B8/P, –5B9/P, –5B1/2P, –5B2/2P, –5B3/2P, –5B3/2P1, –5B4/2P, –5B4/P1, –5B6/2P, –5B4/2P1, and –5B9/2P turbofan engines. These engines are installed on, but not limited to, Airbus A318, A319, A320, and A321 series airplanes.

Unsafe Condition

(d) This AD results from a reduction of the affected engine models listed in AD 2009–01–01 from 25 to 19, a reduction in the engine exhaust gas temperature (EGT) margin deterioration threshold from 80 °C to 75 °C, the introduction of terminating action to the continuous EGT monitoring for certain engines, and a change to the removal plan for the remaining engines if the EGT margin deterioration is greater than 75 °C. We are issuing this AD to prevent high-pressure compressor stalls, which could prevent continued safe flight or landing.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified unless the actions have already been done.

(f) On the effective date of this AD, and at any time after the effective date of this AD, for CFM International, S.A. CFM56–5B1/P, –5B2/P, –5B3/P, –5B3/P1, –5B4/P, –5B4/P1, –5B5/P, –5B6/P, –5B7/P, –5B8/P and –5B9/P turbofan engines:

(1) Monitor and calculate engine EGT margin deterioration. Use paragraphs 3.A.(2) and 3.A.(3) of the Accomplishment Instructions and Appendix A of CFM International, S.A. Alert Service Bulletin (ASB) No. CFM56–5B S/B 72–A0722, Revision 1, dated March 20, 2009, to do the monitoring and calculating.

(2) As mandatory terminating action to the repetitive recalculating and monitoring of EGT margin deterioration, remove FADEC software version 5.B.Q and earlier versions from engines that have greater than 75 °C of EGT margin deterioration within 150 additional cycles-in-service (CIS).

(3) As mandatory terminating action to the repetitive recalculating and monitoring of EGT margin deterioration, remove FADEC software version 5.B.Q and earlier versions from engines that have less than or equal to 75 °C of EGT margin deterioration within 900 additional CIS.

(g) On the effective date of this AD, and at any time after the effective date of this AD, for CFM International, S.A. CFM56–5B1/2P, –5B2/2P, –5B3/2P, –5B3/2P1, –5B4/2P, –5B4/2P1, –5B6/2P and –5B9/2P turbofan engines:

(1) Monitor and calculate engine EGT margin deterioration. Use paragraphs 3.A.(2) and 3.A.(3) of the Accomplishment Instructions and Appendix A of CFM International, S.A. ASB No. CFM56–5B S/B 72–A0722, Revision 1, dated March 20, 2009, to do the monitoring and calculating.

(2) Remove engines from service that have greater than 75 °C of EGT margin deterioration within 150 additional CIS.

Installation Prohibitions

(h) For engines listed in paragraph (f) of this AD, after the effective date of this AD, do not install FADEC software version 5.B.Q or any earlier software versions.

(i) For engines listed in paragraph (g) of this AD, after the effective date of this AD, do not install an engine that has greater than 75 °C of EGT margin deterioration.

Interim Actions

(j) These actions are interim actions and we anticipate further rulemaking actions in the future, including further action to address the remaining engines in service that are above 75 °C deterioration of EGT margin.

Alternative Methods of Compliance (AMOCs)

(k) The Manager, Engine Certification Office, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19.

Related Information

(l) Refer to European Aviation Safety Agency Airworthiness Directive 2009–0088, Revision 1, dated April 28, 2009, for related information.

(m) Contact Wayne Maguire, Aerospace Engineer, Engine Certification Office, FAA, Engine and Propeller Directorate, 12 New England Executive Park, Burlington, MA 01803; *e-mail: wayne.maguire@faa.gov;* telephone (781) 238–7778; fax (781) 238–7199, for more information about this AD.

Material Incorporated by Reference

(n) You must use CFM International, S. A. Alert Service Bulletin No. CFM56–5B S/B 72–A0722, Revision 1, dated March 20, 2009, to perform the EGT calculating and monitoring required by this AD. The Director of the Federal Register approved the incorporation by reference of this service bulletin in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Contact CFM International, S.A., Technical Customer Support, 1 Neumann Way, Cincinnati, OH 45215; telephone (513) 552–3272; fax (513) 552–3329, Web address *http://customer.geae.com,* for a copy of this service information. You may review copies at the FAA, New England Region, 12 New England Executive Park, Burlington, MA; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

Issued in Burlington, Massachusetts, on April 23, 2010.

Peter A. White,

Assistant Manager, Engine and Propeller Directorate, Aircraft Certification Service.

[FR Doc. 2010–10177 Filed 5–3–10; 8:45 am]

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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2010–0463; Directorate Identifier 2010–CE–021–AD; Amendment 39–16280; AD 2010–10–01]

RIN 2120–AA64

Airworthiness Directives; GA 8 Airvan (Pty) Ltd Models GA8 and GA8–TC320 Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; request for comments.

SUMMARY: We are adopting a new airworthiness directive (AD) for the products listed above that will supersede an existing AD. This AD results from mandatory continuing airworthiness information (MCAI) issued by the aviation authority of another country to identify and correct an unsafe condition on an aviation product. The MCAI describes the unsafe condition as:

Inspection of a high time aircraft has revealed cracks in the Horizontal Stabiliser rear spar splice plate and inboard main ribs around the area of the Horizontal Stabiliser rear pivot attachment. Additionally, failure of some attach bolts in service may be due to improper assembly.

This amendment is issued to clarify the model applicability.

The previous amendment was issued because the requirement document now contains an inspection for cracking in horizontal stabilisers which have load transferring fittings installed.

This AD requires actions that are intended to address the unsafe condition described in the MCAI.

DATES: This AD becomes effective May 10, 2010.

As of March 2, 2009 (74 FR 8159; February 24, 2009), the Director of the Federal Register approved the incorporation by reference of Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008, listed in this AD.

We must receive comments on this AD by June 18, 2010.

ADDRESSES: You may send comments by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* (202) 493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.
- *Hand Delivery:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov;* or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Office (telephone (800) 647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Doug Rudolph, Aerospace Engineer, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4059; fax: (816) 329–4090.

SUPPLEMENTARY INFORMATION:

Discussion

On February 17, 2009, we issued AD 2009–05–01, Amendment 39–15825 (74 FR 8159; February 24, 2009). That AD required actions intended to address an unsafe condition on Model GA8 airplanes.

Since we issued AD 2009–05–01, the Civil Aviation Safety Authority (CASA), which is the aviation authority for Australia, has issued AD/GA8/5, Amdt 3, dated April 9, 2010 (referred to after this as "the MCAI"), to correct an unsafe condition for the specified products. The Australian AD clarifies the applicability of the AD to include Model GA8–TC320 airplanes. Model GA8–TC320 airplanes have the same tailplane configuration as Model GA8 airplanes. The MCAI states:

Inspection of a high time aircraft has revealed cracks in the Horizontal Stabiliser rear spar splice plate and inboard main ribs around the area of the Horizontal Stabiliser rear pivot attachment. Additionally, failure of some attach bolts in service may be due to improper assembly.

This amendment is issued to clarify the model applicability.

The previous amendment was issued because the requirement document now contains an inspection for cracking in horizontal stabilisers which have load transferring fittings installed.

You may obtain further information by examining the MCAI in the AD docket.

Relevant Service Information

Gippsland Aeronautics has issued Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008. The actions described in this service information are intended to correct the unsafe condition identified in the MCAI.

FAA's Determination and Requirements of the AD

This product has been approved by the aviation authority of another country, and is approved for operation in the United States. Pursuant to our bilateral agreement with this State of Design Authority, they have notified us of the unsafe condition described in the MCAI and service information referenced above. We are issuing this AD because we evaluated all information provided by the State of Design Authority and determined the unsafe condition exists and is likely to exist or develop on other products of the same type design.

Differences Between This AD and the MCAI or Service Information

We have reviewed the MCAI and related service information and, in general, agree with their substance. But we might have found it necessary to use different words from those in the MCAI to ensure the AD is clear for U.S. operators and is enforceable. In making these changes, we do not intend to differ substantively from the information provided in the MCAI and related service information.

We might have also required different actions in this AD from those in the MCAI in order to follow FAA policies. Any such differences are described in a separate paragraph of the AD. These requirements take precedence over those copied from the MCAI.

FAA's Determination of the Effective Date

An unsafe condition exists that requires the immediate adoption of this AD. The FAA has found that the risk to the flying public justifies waiving notice and comment prior to adoption of this rule because of potential cracking of the horizontal stabilizer structure, which could lead to failure of the tailplane assembly. Therefore, we determined that notice and opportunity for public comment before issuing this AD are impracticable and that good cause exists for making this amendment effective in fewer than 30 days.

Comments Invited

This AD is a final rule that involves requirements affecting flight safety, and we did not precede it by notice and opportunity for public comment. We invite you to send any written relevant data, views, or arguments about this AD.

Send your comments to an address listed under the **ADDRESSES** section. Include "Docket No. FAA–2010–0463; Directorate Identifier 2010–CE–021–AD" at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this AD. We will consider all comments received by the closing date and may amend this AD because of those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov,* including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this AD.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. "Subtitle VII: Aviation Programs," describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in "Subtitle VII, Part A, Subpart III, Section 44701: General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a "significant regulatory action" under Executive Order 12866;

(2) Is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this AD and placed it in the AD docket.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by removing Amendment 39–15825 (74 FR 8159; February 24, 2009), and adding the following new AD:

2010–10–01 GA 8 Airvan (Pty) Ltd: Amendment 39–16280; Docket No. FAA–2010–0463; Directorate Identifier 2010–CE–021–AD.

Effective Date

(a) This airworthiness directive (AD) becomes effective May 10, 2010.

Affected ADs

(b) This AD supersedes AD 2009–05–01, Amendment 39–15825.

Applicability

(c) This AD applies to the following model and serial number airplanes, certificated in any category:

(i) *Group 1 Airplanes* (retains the actions and applicability from AD 2009–05–01): Model GA8 airplanes, serial numbers GA8–00–004 and up; and

(ii) *Group 2 Airplanes:* Model GA8–TC320 airplanes, all serial numbers.

Subject

(d) Air Transport Association of America (ATA) Code 55: Stabilizers.

Reason

(e) The mandatory continuing airworthiness information (MCAI) states:

Inspection of a high time aircraft has revealed cracks in the Horizontal Stabiliser rear spar splice plate and inboard main ribs around the area of the Horizontal Stabiliser rear pivot attachment. Additionally, failure of some attach bolts in service may be due to improper assembly.

This amendment is issued to clarify the model applicability.

The previous amendment was issued because the requirement document now contains an inspection for cracking in horizontal stabilisers which have load transferring fittings installed.

Actions and Compliance

(f) *For Group 1 Airplanes:* Unless already done, do the following actions:

(1) Within the next 10 hours time-in-service (TIS) after March 2, 2009 (the effective date of AD 2009–05–01):

(i) For all aircraft not incorporating computer numeric control (CNC) machined elevator hinges, inspect and repair the left and right horizontal stabilizer rear pivot attachment installation following instruction "3. Rear Pivot Attachment Inspection," of Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008; and,

(ii) For all aircraft, inspect the left and right rear attach bolt mating surfaces for damage or an out of square condition and replace the left and right rear attach bolts following instruction "5. Rear Attach Bolt Replacement," of Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008. Reworking the mating surfaces by spotfacing is no longer acceptable. If the mating surfaces are damaged, not square, or were previously reworked by spotfacing the surface, replace the parts as specified in Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008.

(2) Within the next 10 hours TIS after March 2, 2009 (the effective date of AD 2009–05–01) and repetitively thereafter at intervals not to exceed 100 hours TIS or 12 months, whichever occurs first, for all aircraft:

(i) Inspect the horizontal stabilizer externally following instruction "2. External Inspection (Lower flange, Stabilizer rear spar)," of Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008; and

(ii) Inspect the horizontal stabilizer internally following instruction "4. Internal Inspection," of Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008.

(3) If during the inspection required by paragraph (f)(2) of this AD any excessive local deflection or movement of the lower skin surrounding the lower pivot attachment, cracking, or working (loose) rivet is found, before further flight, obtain an FAA-approved repair scheme from the manufacturer and incorporate this repair scheme. Due to FAA policy, the repair scheme for crack damage must include an immediate repair of the crack, not a repetitive inspection. Continued operational flight with un-repaired crack damage is not permitted.

(g) *For Group 2 Airplanes:* Unless already done, do the following actions:

(1) Within the next 10 hours TIS after May 10, 2010 (the effective date of this AD):

(i) For all aircraft not incorporating computer numeric control (CNC) machined elevator hinges, inspect and repair the left and right horizontal stabilizer rear pivot attachment installation following instruction "3. Rear Pivot Attachment Inspection," of Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008; and,

(ii) For all aircraft, inspect the left and right rear attach bolt mating surfaces for damage or an out of square condition and replace the

left and right rear attach bolts following instruction "5. Rear Attach Bolt Replacement," of Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008. Reworking the mating surfaces by spotfacing is no longer acceptable. If the mating surfaces are damaged, not square, or were previously reworked by spotfacing the surface, before further flight, replace the parts as specified in Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008.

(2) Within the next 10 hours TIS after May 10, 2010 (the effective date of this AD) and repetitively thereafter at intervals not to exceed 100 hours TIS or 12 months, whichever occurs first, for all aircraft:

(i) Inspect the horizontal stabilizer externally following instruction "2. External Inspection (Lower flange, Stabilizer rear spar)," of Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008; and

(ii) Inspect the horizontal stabilizer internally following instruction "4. Internal Inspection," of Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008.

(3) If during the inspection required by paragraph (g)(2) of this AD any excessive local deflection or movement of the lower skin surrounding the lower pivot attachment, cracking, or working (loose) rivet is found, before further flight, obtain an FAA-approved repair scheme from the manufacturer and incorporate this repair scheme. Due to FAA policy, the repair scheme for crack damage must include an immediate repair of the crack, not a repetitive inspection. Continued operational flight with un-repaired crack damage is not permitted.

FAA AD Differences

Note: This AD differs from the MCAI and/or service information as follows:

(1) "Requirement: 1. Daily Inspection (Stabilizer attach bolt)" of the service information requires a daily inspection of the stabilizer attach bolt. The daily inspection is not a requirement of this AD. Instead of the daily inspection, we require you to perform, within 10 hours TIS, "Requirement 3. Rear Pivot Attachment Inspection" and "Requirement 5. Rear Attachment Bolt Replacement" of the service information. Compliance with requirement 3. and 5. is a terminating action for the daily inspection, and we are requiring these within 10 hours TIS after the effective date of this AD.

(2) "Requirement: 2. External Inspection (Lower flange, Stabilizer rear spar)" of the service information does not specify any action if excessive local deflection or movement of lower skin, cracking, or working (loose) rivet is found. We require obtaining and incorporating an FAA-approved repair scheme from the manufacturer before further flight.

(3) The MCAI does not state if further flight with known cracks is allowed. FAA policy is to not allow further flight with known cracks in critical structure. We require that if any cracks are found when accomplishing the inspection required in paragraphs (f)(2) and (g)(2) of this AD, you must repair the cracks before further flight.

(4) The service information does not state that parts with spotfaced nut and bolt mating surfaces require replacement. However, the service information no longer allows reworking of the mating surfaces by spotfacing. We require that if any nut and bolt surfaces were previously reworked by spotfacing, you must replace the parts.

(5) The service information has not been revised to include Model GA8–TC320 airplanes; however, the procedures still apply to this model, and actions must be done following the service information.

Other FAA AD Provisions

(h) The following provisions also apply to this AD:

(1) Alternative Methods of Compliance (AMOCs): The Manager, Standards Office, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. Send information to ATTN: Doug Rudolph, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4059; fax: (816) 329–4090. Before using any approved AMOC on any airplane to which the AMOC applies, notify your appropriate principal inspector (PI) in the FAA Flight Standards District Office (FSDO), or lacking a PI, your local FSDO.

(2) Airworthy Product: For any requirement in this AD to obtain corrective actions from a manufacturer or other source, use these actions if they are FAA-approved. Corrective actions are considered FAA-approved if they are approved by the State of Design Authority (or their delegated agent). You are required to assure the product is airworthy before it is returned to service.

(3) Reporting Requirements: For any reporting requirement in this AD, under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et. seq.*), the Office of Management and Budget (OMB) has approved the information collection requirements and has assigned OMB Control Number 2120–0056.

Related Information

(i) Refer to MCAI Civil Aviation Safety Authority AD No. AD/GA8/5, Amdt 3, dated April 9, 2010; and Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008, for related information.

Material Incorporated by Reference

(j) You must use Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008, to do the actions required by this AD, unless the AD specifies otherwise.

(1) On March 2, 2009 (74 FR 8159; February 24, 2009), the Director of the Federal Register previously approved the incorporation by reference of Gippsland Aeronautics Mandatory Service Bulletin SB–GA8–2002–02, Issue 5, dated November 13, 2008.

(2) For service information identified in this AD, contact Gippsland Aeronautics, Attn: Technical Services, P.O. Box 881, Morwell Victoria 3840, Australia; telephone: + 61 03 5172 1200; fax: +61 03 5172 1201; Internet: *http://www.gippsaero.com.*

(3) You may review copies of the service information incorporated by reference for this AD at the FAA, Central Region, Office of the Regional Counsel, 901 Locust, Kansas City, Missouri 64106. For information on the availability of this material at the Central Region, call (816) 329–3768.

(4) You may also review copies of the service information incorporated by reference for this AD at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Issued in Kansas City, Missouri on April 20, 2010.

Steven W. Thompson,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2010–10220 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2000–NM–418–AD; Amendment 39–12964; AD 2002–23–20]

RIN 2120–AA64

Airworthiness Directives; DASSAULT AVIATION Model FALCON 900EX and MYSTERE–FALCON 900 Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule; correction.

SUMMARY: This document corrects a typographical error that appeared in airworthiness directive (AD) 2002–23–20 that was published in the **Federal Register** on November 29, 2002 (67 FR 71098). The typographical error resulted in an incorrect part number. This AD is applicable to Model FALCON 900EX and MYSTERE–FALCON 900 airplanes. This AD requires repetitive operational tests of the flap asymmetry detection system to verify proper functioning, and repair if necessary; repetitive replacement of the inboard flap jackscrews with new or reconditioned jackscrews; and repetitive measurement of the screw/nut play of the jackscrews on the inboard and outboard flaps to detect discrepancies, and corrective action if necessary. This AD also requires revision of the Airplane Flight Manual.

DATES: This correction is effective May 4, 2010. The effective date of AD 2002–23–20 remains January 3, 2003.

FOR FURTHER INFORMATION CONTACT: Tom Rodriguez, Aerospace Engineer,

International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue, SW., Renton, Washington 98057–3356; telephone (425) 227–1137; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION: AD 2002–23–20, amendment 39–12964, applicable to Model FALCON 900EX and MYSTERE–FALCON 900 airplanes, was published in the **Federal Register** on November 29, 2002 (67 FR 71098). That AD requires repetitive operational tests of the flap asymmetry detection system to verify proper functioning, and repair if necessary; repetitive replacement of the inboard flap jackscrews with new or reconditioned jackscrews; and repetitive measurement of the screw/nut play of the jackscrews on the inboard and outboard flaps to detect discrepancies, and corrective action if necessary. That AD also requires revision of the Airplane Flight Manual.

As published, paragraph (e)(1) of the AD specifies in error jackscrew part number 5818–1 Amdt A. P/N 5818–1 Amdt A. does not exist. The correct part number is 5318–1 Amdt A.

Since no other part of the regulatory information has been changed, the final rule is not being republished in the **Federal Register.**

The effective date of this AD remains January 3, 2003.

§ 39.13 [Corrected]

■ On page 71101, in the first column, paragraph (e)(1) of AD 2002–23–20 is corrected to read as follows:

* * * * *

(1) The jackscrew has been reconditioned and reidentified as P/N 5318–1 Amdt A, in accordance with Dassault Service Bulletin AVIAC 5318–27–01, dated September 16, 1999.

* * * * *

Issued in Renton, Washington, on April 22, 2010.

Jeffrey E. Duven,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2010–9943 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2009–1155; Airspace Docket No. 09–ACE–14]

Amendment of Class E Airspace; Mapleton, IA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action amends Class E airspace for Mapleton, IA, adding additional controlled airspace to accommodate Area Navigation (RNAV) Standard Instrument Approach Procedures (SIAPs) at James G. Whiting Memorial Field Airport, Mapleton, IA. The FAA is taking this action to enhance the safety and management of Instrument Flight Rule (IFR) operations at the airport.

DATES: Effective date 0901 UTC, July 29, 2010. The Director of the Federal Register approves this incorporation by reference action under 1 CFR part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Scott Enander, Central Service Center, Operations Support Group, Federal Aviation Administration, Southwest Region, 2601 Meacham Blvd., Fort Worth, TX 76137; telephone (817) 321–7716.

SUPPLEMENTARY INFORMATION:

History

On February 10, 2010, the FAA published in the **Federal Register** a notice of proposed rulemaking to amend Class E airspace for Mapleton, IA, reconfiguring controlled airspace at James G. Whiting Memorial Field Airport (75 FR 6595) Docket No. FAA–2009–1155. Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received. Class E airspace designations are published in paragraph 6005 of FAA Order 7400.9T signed August 27, 2009, and effective September 15, 2009, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This action amends Title 14 Code of Federal Regulations (14 CFR) part 71 by amending Class E airspace for the Mapleton, IA area, adding additional controlled airspace extending upward from 700 feet above the surface to accommodate SIAPs at James G. Whiting Memorial Field Airport. This action is necessary for the safety and management of IFR operations at the airport.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation: (1) Is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the U.S. Code. Subtitle 1, section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in subtitle VII, part A, subpart I, section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace at James G. Whiting Memorial Field Airport, Mapleton, IA.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

■ In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9T, Airspace Designations and Reporting Points, signed August 27, 2009, and effective September 15, 2009, is amended as follows:

* * * * *

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface.

* * * * *

ACE IA E5 Mapleton, IA [Amended]

Mapleton, James G. Whiting Memorial Field Airport, IA
(Lat. 42°10′42″ N., long. 95°47′37″ W.)
Mapleton NDB
(Lat. 42°10′50″ N., long. 95°47′41″ W.)

That airspace extending upward from 700 feet above the surface within a 6.3-mile radius of James G. Whiting Memorial Field Airport and within 3.1 miles each side of the 030° bearing from the Mapleton NDB extending from the 6.3-mile radius to 10 miles northeast of the airport, and within 4 miles each side of the 204° bearing from the airport extending from the 6.3-mile radius to 10.3 miles southwest of the airport.

Issued in Fort Worth, Texas, on April 23, 2010.

Anthony D. Roetzel,

Manager, Operations Support Group, ATO Central Service Center.

[FR Doc. 2010–10321 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2009–1153; Airspace Docket No. 09–ACE–13]

Amendment of Class E Airspace; Emmetsburg, IA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action amends Class E airspace for Emmetsburg, IA, adding additional controlled airspace to accommodate Area Navigation (RNAV) Standard Instrument Approach Procedures (SIAPs) at Emmetsburg Municipal Airport, Emmetsburg, IA. The FAA is taking this action to enhance the safety and management of Instrument Flight Rule (IFR) operations at the airport.

DATES: Effective date 0901 UTC, July 29, 2010. The Director of the Federal Register approves this incorporation by reference action under 1 CFR part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Scott Enander, Central Service Center, Operations Support Group, Federal Aviation Administration, Southwest Region, 2601 Meacham Blvd., Fort Worth, TX 76137; telephone (817) 321–7716.

SUPPLEMENTARY INFORMATION:

History

On February 10, 2010, the FAA published in the **Federal Register** a notice of proposed rulemaking to amend Class E airspace for Emmetsburg, IA, reconfiguring controlled airspace at Emmetsburg Municipal Airport (75 FR 6592) Docket No. FAA–2009–1153. Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received. Class E airspace designations are published in paragraph 6005 of FAA Order 7400.9T signed August 27, 2009, and effective September 15, 2009, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This action amends Title 14 Code of Federal Regulations (14 CFR) Part 71 by amending Class E airspace for the Emmetsburg, IA area, adding additional controlled airspace extending upward from 700 feet above the surface to accommodate SIAPs at Emmetsburg Municipal Airport. This action is necessary for the safety and management of IFR operations at the airport.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation: (1) Is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the U.S. Code. Subtitle 1, section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in subtitle VII, part A, subpart I, section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace at Emmetsburg Municipal Airport, Emmetsburg, IA.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

■ In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR Part 71.1 of the Federal Aviation Administration Order 7400.9T, Airspace Designations and Reporting Points, signed August 27, 2009, and effective September 15, 2009, is amended as follows:

* * * * *

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface.

* * * * *

ACE IA E5 Emmetsburg, IA [Amended]

Emmetsburg Municipal Airport, IA
(Lat. 43°06′07″ N., long. 94°42′17″ W.)
Emmetsburg NDB
(Lat. 43°06′04″ N., long. 94°42″26″ W.)

That airspace extending upward from 700 feet above the surface within a 6.5-mile radius of Emmetsburg Municipal Airport and within 2.6 miles each side of the 128° bearing from the Emmetsburg NDB extending from the 6.5-mile radius to 7.4 miles southeast of the airport, and within 3.8 miles each side of the 316° bearing from the airport extending from the 6.5-mile radius to 10.3 miles northwest of the airport.

Issued in Fort Worth, Texas, on April 23, 2010.

Anthony D. Roetzel,

Manager, Operations Support Group, ATO Central Service Center.

[FR Doc. 2010–10325 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

24 CFR Part 202

[Docket No. FR 5356–C–03]

RIN 2502–AI81

Federal Housing Administration: Continuation of FHA Reform—Strengthening Risk Management Through Responsible FHA-Approved Lenders; Correction

AGENCY: Office of General Counsel, HUD.

ACTION: Final rule; correction.

SUMMARY: HUD is correcting a final rule that appeared in the **Federal Register** of April 20, 2010 (75 FR 20718). This final rule adopted changes pertaining to the approval of mortgage lenders by the Federal Housing Administration (FHA) that are designed to strengthen FHA by improving its management of risk. Although the preamble to the final rule correctly provides that the revised net worth requirements will take effect for applicants to the FHA programs on May 20, 2010, the corresponding regulatory text incorrectly provides that the requirements will take effect on June 21, 2010. This document makes the necessary correction.

DATES: *Effective Date:* May 20, 2010.

FOR FURTHER INFORMATION CONTACT: Camille E. Acevedo, Associate General Counsel for Legislation and Regulations, Office of General Counsel, Department of Housing and Urban Development, 451 7th Street, SW., Room 10276, Washington, DC 20410–8000; telephone number 202–708–1793 (this is not a toll-free number). Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Information Relay Service at 800–877–8339.

SUPPLEMENTARY INFORMATION: In FR Doc. 2010–8837 appearing on page 20718 in the **Federal Register** of Tuesday, April 20, 2010, the following correction is made:

§ 202.5 [Corrected]

■ 1. On page 20733, in the third column, in § 202.5 General approval standards, in paragraph (n)(2)(i), "Effective on June 21, 2010, applicants shall comply with the net worth requirements set forth in paragraphs (n)(2)(iii) of this section." is corrected to read "Effective on May 20, 2010, applicants shall comply with the net worth requirements set forth in paragraph (n)(2)(iii) of this section."

Dated: April 29, 2010.

Camille E. Acevedo,

Associate General Counsel for Legislation and Regulations.

[FR Doc. 2010–10424 Filed 5–3–10; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF THE INTERIOR

Minerals Management Service

30 CFR Part 250

[Docket ID: MMS–2007–OMM–0068]

RIN 1010–AD47

Annular Casing Pressure Management for Offshore Wells

AGENCY: Minerals Management Service (MMS), Interior.

ACTION: Final rule.

SUMMARY: This final rule will establish regulations to address sustained casing pressure in oil and gas wells completed in the Outer Continental Shelf. Sustained casing pressure is a problem that, if left untreated, could cause serious harm to human life and the environment. The final rule will establish criteria for monitoring and testing of wells with sustained casing pressure, and will also incorporate the American Petroleum Institute's Recommended Practice for managing annular casing pressure. New regulations are needed because the current regulations do not adequately address the requirements for wells that have sustained casing pressure. This rule will promote human safety and environmental protection, and require Outer Continental Shelf lessees to follow best industry practices for wells with sustained casing pressure.

DATES: *Effective Date:* This rule becomes effective on June 3, 2010. The incorporation by reference of the publication listed in the regulation is approved by the Director of the Federal Register as of June 3, 2010.

FOR FURTHER INFORMATION CONTACT: For comments or questions on procedural issues, contact Kirk Malstrom, Office of Offshore Regulatory Programs, Regulations and Standards Branch, 703–787–1751. For questions on technical issues, contact Russell Hoshman, Technical Assessment and Operations Support Section, Gulf of Mexico Outer Continental Shelf Region, 504–736–2627.

SUPPLEMENTARY INFORMATION: On July 31, 2009, MMS published the proposed rule Annular Casing Pressure Management for Offshore Wells (74 FR 38147). The comment period for the proposed rule was open for 60 days. During the comment period, MMS received three comments. Two comments were in favor of this rule and the remaining comment was not associated with this rulemaking.

There are no changes between the proposed and final rule language. There are also no changes to the procedural matters discussion regarding information collection requirements, cost estimates, benefits, or impacts to small entities.

Public Comments: The MMS received three comments on the proposed rule 1010–AD47 Annular Casing Pressure Management for Offshore Wells. The comments received are summarized as follows:

- British Petroleum (BP)—BP, a large oil and gas company, expressed the importance of this rule and how they have been involved with MMS and industry to develop the industry standard.
- Offshore Operators Committee (OOC)—OOC, a large oil and gas industry organization, stated their support of this rulemaking and their involvement with the industry standard.
- Private citizen—This comment is not associated with this rulemaking.

The two applicable comments received on the proposed rule are fully supportive of this rulemaking.

Background: Sustained casing pressure (SCP) is pressure between the casing and the well's tubing, or between strings of casing, that rebuilds after being bled down. The SCP represents an ongoing safety hazard and can cause serious or immediate harm or damage to human life, the marine and coastal environment, and property. The oil and gas industry in the Gulf of Mexico (GOM) has suffered serious accidents as a result of high SCP, and the lack of proper control and monitoring of these pressures. With over 8,000 affected wells in the GOM with SCP in at least one annulus, immediate elimination of all SCP has proved to be impractical and exceedingly costly. The MMS has sought to identify and eliminate SCP in cases that represent a clear hazard to the safety of personnel or the environment, and establish a monitoring system for the rest, all the while working towards elimination of the problem.

The MMS is currently addressing the issue of casing pressure in a 1994 Letter

to Lessees (LTL) and a 2009 Notice to Lessees (NTL), 2009 G–22, August 3, 2009. Once the final rulemaking becomes effective, both the 1994 LTL and the 2009 NTL on casing pressure will be rescinded.

Included in this final rule is the incorporation of a jointly developed industry standard that addresses management of casing pressure. The American Petroleum Institute (API), industry, and MMS have worked collectively to produce API Recommended Practice (RP) 90. As explained in API RP 90, Section 3, Annular Casing Pressure Management Program, this RP is based on establishing an annular casing pressure management program that filters out non-problematic wells that present an acceptable level of risk, thus allowing for a more focused effort on wells that are problematic. The management program, as outlined in API RP 90, includes monitoring, diagnostic testing, determining maximum allowable wellhead operating pressure (MAWOP) for each annulus, documentation, and risk assessment considerations.

For further background information on this rulemaking, refer to the published proposed rule 1010–AD47 Annular Casing Pressure Management for Offshore Wells (74 FR 38147, July 31, 2009).

Procedural Matters

Regulatory Planning and Review (Executive Order (E.O.) 12866)

This final rule is not a significant rule as determined by the Office of Management and Budget (OMB) and is not subject to review under E.O. 12866.

(1) This final rule will not have an annual effect of $100 million or more on the economy. It will not adversely affect in a material way the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities. There will be some costs associated with this rulemaking, mostly for diagnostic testing, MAWOP calculations, and reporting to MMS. Taking into account paperwork burden requirements, diagnostic testing, and MAWOP calculations, the costs associated with this rulemaking will be approximately $5 million industry-wide. The final rule will not require any new equipment to be installed and diagnostic testing is currently being done throughout industry and is not new.

(2) This final rule will not create a serious inconsistency or otherwise interfere with an action taken or planned by another agency.

(3) This final rule will not alter the budgetary effects of entitlements, grants, user fees, or loan programs or the rights or obligations of their recipients. The changes in the final rule are strictly planning requirements for management of annular casing pressure in offshore wells.

(4) This final rule will not raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in E.O. 12866.

Regulatory Flexibility Act

The Department of the Interior certifies that this final rule will not have a significant economic effect on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*).

This rulemaking will affect lessees and operators of leases and pipeline right-of-way holders in the OCS. This could include about 130 active Federal oil and gas lessees. Small entities that operate under this rule are coded under the Small Business Administration's North American Industry Classification System (NAICS) codes 211111, Crude Petroleum and Natural Gas Extraction, and 213111, Drilling Oil and Gas Wells. For these NAICS code classifications, a small company is one with fewer than 500 employees. Based on these criteria, an estimated 70 percent (91) of these companies are considered small. This final rule, therefore, will affect a substantial number of small entities. This rule will affect every well in the OCS, and every operator both large and small will have the same criteria per well regardless of company size.

Nonetheless, this rulemaking will not have a significant economic effect on a substantial number of small entities because management of annular casing pressure will be a moderate cost, mostly attributable to diagnostic testing. Taking into account recordkeeping, diagnostic testing, and MAWOP calculations, the costs associated with this rulemaking will be approximately $5 million industry-wide. In comparison, to remediate the approximate 8,000 wells with SCP (approximately $250,000 per well) would cost approximately $2 billion. The costs that are associated with this rulemaking will be minor when compared to SCP remediation costs and will not impede a company of any size.

Your comments are important. The Small Business and Agriculture Regulatory Enforcement Ombudsman and 10 Regional Fairness Boards were established to receive comments from small businesses about Federal agency enforcement actions. The Ombudsman will annually evaluate the enforcement activities and rate each agency's responsiveness to small business. If you wish to comment on the actions of MMS, call 1–888–734–3247. You may comment to the Small Business Administration without fear of retaliation. Allegations of discrimination/retaliation filed with the Small Business Administration will be investigated for appropriate action.

Small Business Regulatory Enforcement Fairness Act

This final rule is not a major rule under the Small Business Regulatory Enforcement Fairness Act (5 U.S.C. 801 *et seq.*). This final rule:

a. Will not have an annual effect on the economy of $100 million or more.

b. Will not cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions.

c. Will not have significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of U.S.-based enterprises to compete with foreign-based enterprises.

Unfunded Mandates Reform Act of 1995

This final rule will not impose an unfunded mandate on State, local, or tribal governments or the private sector of more than $100 million per year. The final rule will not have a significant or unique effect on State, local, or tribal governments or the private sector. A statement containing the information required by the Unfunded Mandates Reform Act (2 U.S.C. 1501 *et seq.*) is not required.

Takings Implication Assessment (E.O. 12630)

Under the criteria in E.O. 12630, this final rule does not have significant takings implications. The final rule is not a governmental action capable of interference with constitutionally protected property rights. A Takings Implication Assessment is not required.

Federalism (E.O. 13132)

Under the criteria in E.O. 13132, this final rule does not have federalism implications. This final rule will not substantially and directly affect the relationship between the Federal and State governments. To the extent that State and local governments have a role in OCS activities, this final rule will not affect that role. A Federalism Assessment is not required.

Civil Justice Reform (E.O. 12988)

This rule complies with the requirements of E.O. 12988. Specifically, this rule:

Meets the criteria of section 3(a) requiring that all regulations be reviewed to eliminate errors and ambiguity and be written to minimize litigation; and

Meets the criteria of section 3(b)(2) requiring that all regulations be written in clear language and contain clear legal standards.

Consultation With Indian Tribes (E.O. 13175)

Under the criteria in E.O. 13175, we have evaluated this final rule and determined that it has no substantial effects on federally recognized Indian tribes. There are no Indian or tribal lands in the OCS nor tribally owned businesses subject to the regulation.

Paperwork Reduction Act (PRA)

The final rule contains no new reporting or recordkeeping requirements, and an Office of Management and Budget (OMB) submission under the PRA (44 U.S.C. 3501 *et seq.*) is not required. The PRA provides that an agency may not conduct or sponsor a collection of information unless it displays a currently valid OMB control number. Until OMB approves a collection of information and assigns a control number, you are not required to respond. The final regulations will replace the references to LTLs and NTLs with specific cites to the Code of Federal Regulations. The final rulemaking refers to, but does not change, information collection requirements under approved OMB Control Number 1010–0067 (18,756 hours, expiration 12/31/2010).

National Environmental Policy Act

This rule does not constitute a major Federal action significantly affecting the quality of the human environment. A detailed statement under the National Environmental Policy Act of 1969 is not required because we reached a Finding of No Significant Impact. A copy of the Environmental Assessment can be viewed at *http://www.Regulations.gov.* (type in "environmental assessment" for the document type and use the keyword/ID "MMS–2007–OMM–0068.")

Data Quality Act

In developing this rule, we did not conduct or use a study, experiment, or survey requiring peer review under the Data Quality Act (Pub. L. 106–554, app. C section 515, 114 Stat. 2763, 2763A–153–154).

Effects on the Energy Supply (E.O. 13211)

This rule is not a significant energy action under the definition in E.O. 13211. A Statement of Energy Effects is not required.

List of Subjects in 30 CFR Part 250

Administrative practice and procedure, Continental shelf, Environmental protection, Incorporation by reference, Oil and gas exploration, and Reporting and recordkeeping requirements.

Dated: April 2, 2010.

Ned Farquhar,

Assistant Secretary—Land and Minerals Management.

■ For the reasons stated in the preamble, the Minerals Management Service (MMS) is amending 30 CFR part 250 as follows:

PART 250—OIL AND GAS AND SULPHUR OPERATIONS IN THE OUTER CONTINENTAL SHELF

■ 1. The authority citation for part 250 continues to read as follows:

Authority: 31 U.S.C. 9701, 43 U.S.C. 1334.

■ 2. Amend § 250.198 by adding paragraph (h)(78) to read as follows:

§ 250.198 Documents incorporated by reference.

* * * * *

(h) * * *

(78) API RP 90, Annular Casing Pressure Management for Offshore Wells, First Edition, August 2006, Product No. G09001, incorporated by reference at § 250.518.

* * * * *

■ 3. Revise § 250.517(c) to read as follows:

§ 250.517 Tubing and wellhead equipment.

* * * * *

(c) When the tree is installed, you must equip wells to monitor for casing pressure according to the following chart:

If you have * * *	you must equip * * *	so you can monitor * * *
(1) fixed platform wells,	the wellhead,	all annuli (A, B, C, D, etc., annuli).
(2) subsea wells,	the tubing head,	the production casing annulus (A annulus).
(3) hybrid* wells,	the surface wellhead,	all annuli at the surface (A and B riser annuli). If the production casing below the mudline and the production casing riser above the mudline are pressure isolated from each other, provisions must be made to monitor the production casing below the mudline for casing pressure.

* Characterized as a well drilled with a subsea wellhead and completed with a surface casing head, a surface tubing head, a surface tubing hanger, and a surface christmas tree.

* * * * *

■ 4. Add an undesignated center heading and new §§ 250.518 through 250.530 to Subpart E—Oil and Gas Well-Completion Operations to read as follows:

* * * * *

Casing Pressure Management

Sec.

250.518 What are the requirements for casing pressure management?
250.519 How often do I have to monitor for casing pressure?
250.520 When do I have to perform a casing diagnostic test?
250.521 How do I manage the thermal effects caused by initial production on a newly completed or recompleted well?
250.522 When do I have to repeat casing diagnostic testing?
250.523 How long do I keep records of casing pressure and diagnostic tests?
250.524 When am I required to take action from my casing diagnostic test?
250.525 What do I submit if my casing diagnostic test requires action?
250.526 What must I include in my notification of corrective action?
250.527 What must I include in my casing pressure request?
250.528 What are the terms of my casing pressure request?
250.529 What if my casing pressure request is denied?
250.530 When does my casing pressure request become invalid?

§ 250.518 What are the requirements for casing pressure management?

Once you install your wellhead, you must meet the casing pressure management requirements of API RP 90 (incorporated by reference as specified in § 250.198) and the requirements of §§ 250.519 through 250.530. If there is a conflict between API RP 90 and the casing pressure requirements of this

subpart, you must follow the requirements of this subpart.

§ 250.519 How often do I have to monitor for casing pressure?

You must monitor for casing pressure in your well according to the following table:

If you have * * *	you must monitor * * *	with a minimum one pressure data point recorded per * * *
(a) fixed platform wells,	monthly,	month for each casing.
(b) subsea wells,	continuously,	day for the production casing.
(c) hybrid wells,	continuously,	day for each riser and/or the production casing.
(d) wells operating under a casing pressure request on a manned fixed platform,	daily,	day for each casing.
(e) wells operating under a casing pressure request on an unmanned fixed platform,	weekly,	week for each casing.

§ 250.520 When do I have to perform a casing diagnostic test?

(a) You must perform a casing diagnostic test within 30 days after first observing or imposing casing pressure according to the following table:

If you have a * * *	you must perform a casing diagnostic test if * * *
(1) fixed platform well,	the casing pressure is greater than 100 psig.
(2) subsea well,	the measurable casing pressure is greater than the external hydrostatic pressure plus 100 psig measured at the subsea wellhead.
(3) hybrid well,	a riser or the production casing pressure is greater than 100 psig measured at the surface.

(b) You are exempt from performing a diagnostic pressure test for the production casing on a well operating under active gas lift.

§ 250.521 How do I manage the thermal effects caused by initial production on a newly completed or recompleted well?

A newly completed or recompleted well often has thermal casing pressure during initial startup. Bleeding casing pressure during the startup process is considered a normal and necessary operation to manage thermal casing pressure; therefore, you do not need to evaluate these operations as a casing diagnostic test. After 30 days of continuous production, the initial production startup operation is complete and you must perform casing diagnostic testing as required in §§ 250.520 and 250.522.

§ 250.522 When do I have to repeat casing diagnostic testing?

Casing diagnostic testing must be repeated according to the following table:

When * * *	you must repeat diagnostic testing * * *
(a) your casing pressure request approved term has expired,	immediately.
(b) your well, previously on gas lift, has been shut-in or returned to flowing status without gas lift for more than 180 days,	immediately on the production casing (A annulus). The production casing (A annulus) of wells on active gas lift are exempt from diagnostic testing.
(c) your casing pressure request becomes invalid,	within 30 days.
(d) a casing or riser has an increase in pressure greater than 200 psig over the previous casing diagnostic test,	within 30 days.
(e) after any corrective action has been taken to remediate undesirable casing pressure, either as a result of a casing pressure request denial or any other action,	within 30 days.
(f) your fixed platform well production casing (A annulus) has pressure exceeding 10 percent of its minimum internal yield pressure (MIYP), except for production casings on active gas lift,	once per year, not to exceed 12 months between tests.
(g) your fixed platform well's outer casing (B, C, D, etc., annuli) has a pressure exceeding 20 percent of its MIYP,	once every 5 years, at a minimum.

§ 250.523 How long do I keep records of casing pressure and diagnostic tests?

Records of casing pressure and diagnostic tests must be kept at the field office nearest the well for a minimum of 2 years. The last casing diagnostic test for each casing or riser must be retained at the field office nearest the well until the well is abandoned.

§ 250.524 When am I required to take action from my casing diagnostic test?

You must take action if you have any of the following conditions:

(a) Any fixed platform well with a casing pressure exceeding its maximum allowable wellhead operating pressure (MAWOP);

(b) Any fixed platform well with a casing pressure that is greater than 100 psig and that cannot bleed to 0 psig

through a ½-inch needle valve within 24 hours, or is not bled to 0 psig during a casing diagnostic test;

(c) Any well that has demonstrated tubing/casing, tubing/riser, casing/casing, riser/casing, or riser/riser communication;

(d) Any well that has sustained casing pressure (SCP) and is bled down to prevent it from exceeding its MAWOP, except during initial startup operations described in § 250.521;

(e) Any hybrid well with casing or riser pressure exceeding 100 psig; or

(f) Any subsea well with a casing pressure 100 psig greater than the external hydrostatic pressure at the subsea wellhead.

§ 250.525 What do I submit if my casing diagnostic test requires action?

Within 14 days after you perform a casing diagnostic test requiring action under § 250.524:

You must submit either:	to the appropriate:	and it must include:	You must also:
(a) a notification of corrective action; or,	District Manager and copy the Regional Supervisor, Field Operations,	requirements under § 250.526	submit an Application for Permit to Modify or Corrective Action Plan within 30 days of the diagnostic test.
(b) a casing pressure request, ...	Regional Supervisor, Field Operations,	requirements under § 250.527.	

§ 250.526 What must I include in my notification of corrective action?

The following information must be included in the notification of corrective

(a) Lessee or Operator name;

(b) Area name and OCS block number;

(c) Well name and API number; and

(d) Casing diagnostic test data.

§ 250.527 What must I include in my casing pressure request?

The following information must be included in the casing pressure request:

(a) API number;

(b) Lease number;

(c) Area name and OCS block number;

(d) Well number;

(e) Company name and mailing address;

(f) All casing, riser, and tubing sizes, weights, grades, and MIYP;

(g) All casing/riser calculated MAWOPs;

(h) All casing/riser pre-bleed down pressures;

(i) Shut-in tubing pressure;

(j) Flowing tubing pressure;

(k) Date and the calculated daily production rate during last well test (oil, gas, basic sediment, and water);

(l) Well status (shut-in, temporarily abandoned, producing, injecting, or gas lift);

(m) Well type (dry tree, hybrid, or subsea);

(n) Date of diagnostic test;

(o) Well schematic;

(p) Water depth;

(q) Volumes and types of fluid bled from each casing or riser evaluated;

(r) Type of diagnostic test performed:

(1) Bleed down/buildup test;

(2) Shut-in the well and monitor the pressure drop test;

(3) Constant production rate and decrease the annular pressure test;

(4) Constant production rate and increase the annular pressure test;

(5) Change the production rate and monitor the casing pressure test; and

(6) Casing pressure and tubing pressure history plot;

(s) The casing diagnostic test data for all casing exceeding 100 psig;

(t) Associated shoe strengths for casing shoes exposed to annular fluids;

(u) Concentration of any H2S that may be present;

(v) Whether the structure on which the well is located is manned or unmanned;

(w) Additional comments; and

(x) Request date.

§ 250.528 What are the terms of my casing pressure request?

Casing pressure requests are approved by the Regional Supervisor, Field Operations, for a term to be determined by the Regional Supervisor on a case-by-case basis. The Regional Supervisor may impose additional restrictions or requirements to allow continued operation of the well.

§ 250.529 What if my casing pressure request is denied?

(a) If your casing pressure request is denied, then the operating company must submit plans for corrective action to the respective District Manager within 30 days of receiving the denial. The District Manager will establish a specific time period in which this corrective action will be taken. You must notify the respective District Manager within 30 days after completion of your corrected action.

(b) You must submit the casing diagnostic test data to the appropriate Regional Supervisor, Field Operations, within 14 days of completion of the diagnostic test required under § 250.522(e).

§ 250.530 When does my casing pressure request approval become invalid?

A casing pressure request becomes invalid when:

(a) The casing or riser pressure increases by 200 psig over the approved casing pressure request pressure;

(b) The approved term ends;

(c) The well is worked-over, side-tracked, redrilled, recompleted, or acid stimulated;

(d) A different casing or riser on the same well requires a casing pressure request; or

(e) A well has more than one casing operating under a casing pressure request and one of the casing pressure requests become invalid, then all casing pressure requests for that well become invalid.

■ 5. Revise § 250.617(c) to read as follows:

§ 250.617 Tubing and wellhead equipment.

* * * * *

(c) When reinstalling the tree, you must:

(1) Equip wells to monitor for casing pressure according to the following chart:

If you have * * *	you must equip * * *	so you can monitor * * *
(i) fixed platform wells, ...	the wellhead, ...	all annuli (A, B, C, D, etc., annuli).
(ii) subsea wells, ...	the tubing head, ...	the production casing annulus (A annulus).

If you have * * *	you must equip * * *	so you can monitor * * *
(iii) hybrid* wells, ...	the surface wellhead, ...	all annuli at the surface (A and B riser annuli). If the production casing below the mudline and the production casing riser above the mudline are pressure isolated from each other, provisions must be made to monitor the production casing below the mudline for casing pressure.

*Characterized as a well drilled with a subsea wellhead and completed with a surface casing head, a surface tubing head, a surface tubing hanger, and a surface christmas tree.

(2) Follow the casing pressure management requirements in subpart E of this part.

* * * * *

[FR Doc. 2010–10291 Filed 5–3–10; 8:45 am]

BILLING CODE 4310–MR–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket No. USCG–2010–0346]

Annual Seattle Yacht Club's "Opening Day" Marine Parade

AGENCY: Coast Guard, DHS.

ACTION: Notice of enforcement of regulation.

SUMMARY: The Coast Guard will enforce the Special Local Regulation in Portage Bay, Portage Cut (Montlake Cut), and Union Bay, WA during the Annual Seattle Yacht Club's "Opening Day" Marine Parade from 8 a.m. through 6 p.m. on May 2, 2010. This action is necessary to ensure participant and spectator safety while preventing vessel congestion in these waterways during the parade. During the enforcement period, no spectators shall anchor, block, loiter in, or impede the transit of participants or official patrol vessels in the regulated area. Further, due to the large number of craft confined within this small body of water, all vessels, both spectator and participants will maintain a "NO WAKE" speed.

DATES: The regulations in 33 CFR 100.1304 will be enforced from 8 a.m. through 6 p.m. on May 2, 2010.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, call or e-mail Ensign Ashley M. Wanzer, Sector Seattle Waterways Management Division, Coast Guard; telephone 206–217–6175, e-mail *SectorSeattleWWM@uscg.mil.*

SUPPLEMENTARY INFORMATION: The Coast Guard will enforce the Special Local Regulation for the annual Seattle Yacht Club's "Opening Day" Marine Parade in 33 CFR 100.1304 on May 2, 2010, from 8 a.m. to 6 p.m. These regulations can be found in the May 4, 1989 issue of the **Federal Register** (54 FR 19167).

Under the provisions of 33 CFR 100.1304, the regulated area shall be closed for the duration of the event to all vessel traffic not participating in the event and authorized by the event sponsor or Coast Guard Patrol Commander. All persons or vessels not registered with the sponsor as participants or not part of the regatta patrol are considered spectators. Spectator vessels must be at anchor within a designated spectator area or moored to a waterfront facility in a way that will not interfere with the progress of the event. The following are established as spectator areas: Northwest of the University Bridge, north of the log boom which will be placed in Union Bay, and east of Webster Point.

No spectators shall anchor, block, loiter in, or impede the through transit of participants or official patrol vessels in the regulated area during the effective dates and times unless cleared for such entry by the Patrol Commander.

Due to the large number of craft confined within this small body of water, all vessels, both spectator and participants, will maintain a "NO WAKE" speed. This requirement will be strictly enforced to preserve the safety of both life and property.

The Coast Guard may be assisted by other Federal, State, or local law enforcement agencies in enforcing this regulation.

This notice is issued under authority of 33 CFR 100.1304 and 5 U.S.C. 552(a). If the Captain of the Port determines that the regulated area need not be enforced for the full duration stated in this notice, she may use a Broadcast Notice to Mariners to grant general permission to enter the regulated area.

Dated: April 6, 2010.

Suzanne E. Englebert,

Captain, U.S. Coast Guard, Captain of the Port, Puget Sound.

[FR Doc. 2010–10310 Filed 4–30–10; 11:15 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket No. USCG–2010–0345]

Seattle Seafair Unlimited Hydroplane Race

AGENCY: Coast Guard, DHS.

ACTION: Notice of enforcement of regulation.

SUMMARY: The Coast Guard will enforce the special local regulation supporting the Seattle Seafair Unlimited Hydroplane Race on Lake Washington, WA from 10 a.m. on August 5, 2010 through 6 p.m. on August 8, 2010 during hydroplane race times. This action is necessary to ensure public safety from the inherent dangers associated with high-speed races while ensuring unencumbered access for rescue personnel in the event of an emergency. During the enforcement period, no person or vessel will be allowed to enter the safety zone without the permission of the Captain of the Port, on-scene Patrol Commander or Designated Representative.

DATES: The regulations in 33 CFR 100.1301 will be enforced on: August 5, 2010 from 10 a.m. to 3 p.m.; August 6, 2010 from 8:30 a.m. to 6 p.m.; August 7, 2010 from 8:30 a.m. to 6 p.m.; and August 8, 2010 from 7:30 a.m. to 6 p.m.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, call or e-mail Ensign Ashley M. Wanzer, Sector Seattle Waterways Management Division, Coast Guard; telephone 206–217–6175, e-mail *SectorSeattleWWM@uscg.mil.*

SUPPLEMENTARY INFORMATION: The Coast Guard will enforce the special local regulation for the annual Seattle Seafair Unlimited Hydroplane Race in 33 CFR 100.1301 on August 5, 2010 from 10 a.m. to 3 p.m.; August 6, 2010 from 8:30 a.m. to 6 p.m.; August 7, 2010 from 8:30 a.m. to 6 p.m.; and August 8, 2010 from 7:30 a.m. to 6 p.m.

Under the provisions of 33 CFR 100.1301, the Coast Guard will restrict general navigation in the following area:

The waters of Lake Washington bounded by the Interstate 90 (Mercer Island/Lacey V. Murrow) Bridge, the western shore of Lake Washington, and the east/west line drawn tangent to Bailey Peninsula and along the shoreline of Mercer Island.

The regulated area has been divided into two zones. The zones are separated by a line perpendicular from the I–90 Bridge to the northwest corner of the East log boom and a line extending from the southeast corner of the East log boom to the southeast corner of the hydroplane race course and then to the northerly tip of Ohlers Island in Andrews Bay. The western zone is designated Zone I, the eastern zone, Zone II. (Refer to NOAA Chart 18447).

The Coast Guard will maintain a patrol consisting of Coast Guard vessels, assisted by Auxiliary Coast Guard vessels, in Zone II. The Coast Guard patrol of this area is under the direction of the Coast Guard Patrol Commander (the "Patrol Commander"). The Patrol Commander is empowered to control the movement of vessels on the racecourse and in the adjoining waters during the periods this regulation is in effect. The Patrol Commander may be assisted by other federal, state and local law enforcement agencies.

Only authorized vessels may be allowed to enter Zone I during the hours this regulation is in effect. Vessels in the vicinity of Zone I shall maneuver and anchor as directed by Coast Guard Officers or Petty Officers.

During the times in which this regulation is in effect, the following rules shall apply:

1. Swimming, wading, or otherwise entering the water in Zone I by any person is prohibited while hydroplane boats are on the racecourse. At other times in Zone I, any person entering the water from the shoreline shall remain west of the swim line, denoted by buoys, and any person entering the water from the log boom shall remain within ten (10) feet of the log boom.

2. Any person swimming or otherwise entering the water in Zone II shall remain within ten (10) feet of a vessel.

3. Rafting to a log boom will be limited to groups of three vessels.

4. Up to six (6) vessels may raft together in Zone II if none of the vessels are secured to a log boom.

5. Only vessels authorized by the Patrol Commander, other law enforcement agencies or event sponsors shall be permitted to tow other watercraft or inflatable devices.

6. Vessels proceeding in either Zone I or Zone II during the hours this regulation is in effect shall do so only at speeds which will create minimum wake, seven (07) miles per hour or less. This maximum speed may be reduced at the discretion of the Patrol Commander.

7. Upon completion of the daily racing activities, all vessels leaving either Zone I or Zone II shall proceed at speeds of seven (07) miles per hour or less. The maximum speed may be reduced at the discretion of the Patrol Commander.

8. A succession of sharp, short signals by whistle or horn from vessels patrolling the areas under the direction of the Patrol Commander shall serve as signal to stop. Vessels signaled shall stop and shall comply with the orders of the patrol vessel; failure to do so may result in expulsion from the area, citation for failure to comply, or both.

The Coast Guard may be assisted by other Federal, State, or local law enforcement agencies in enforcing this regulation.

This notice is issued under authority of 33 CFR 100.1301 and 5 U.S.C. 552(a). If the COTP determines that the regulated area need not be enforced for the full duration stated in this notice, he or she may use a Broadcast Notice to Mariners to grant general permission to enter the regulated area.

Dated: April 6, 2010.

S.E. Englebert,

Captain, U.S. Coast Guard, Captain of the Port, Puget Sound.

[FR Doc. 2010–10315 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2009–1098]

Drawbridge Operation Regulation; Atlantic Intracoastal Waterway, Riviera Beach, FL

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, Seventh Coast Guard District, has issued a temporary deviation from the regulation governing the operation of the Parker (US–1) bridge across the Atlantic Intracoastal Waterway, mile 1,013.7, at Riviera Beach, Palm Beach County, Florida. The deviation is necessary to allow timely bridge rehabilitation and to provide for worker safety. This deviation allows the bridge to be placed on single-leaf operations. Double-leaf operations will be allowed with a four hour notice. The deviation may be cancelled at any time via Broadcast Notice to Mariners.

DATES: This deviation is effective from May 10, 2010 through October 31, 2010.

ADDRESSES: Documents mentioned in this preamble as being available in the docket are part of docket USCG–2009–1098 and are available online by going to *http://www.regulations.gov,* inserting USCG–2009–1098 in the "Keyword" box and then clicking "Search". They are also available for inspection or copying at the Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or e-mail Mr. Gene Stratton, Bridge Management Specialist, Seventh District, Bridge Branch, U.S. Coast Guard; telephone 305–415–6740, e-mail *allen.e.stratton@uscg.mil.* If you have questions on viewing the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION: The Florida Department of Transportation requests a temporary deviation from the published regulation for the Parker Bridge (US–1) across the Atlantic Intracoastal Waterway as required by 33 CFR 117.261(t): The draw shall open on the quarter and three-quarter hour.

The Florida Department of Transportation requests a deviation allowing for single-leaf operations from May 10, 2010 through October 31, 2010. Double-leaf openings will be available with a four hour notice to the bridge tender.

This deviation will allow the rehabilitation of the bridge to be completed in a timely fashion while not unreasonably affecting vessel traffic as it does provide for requested double-leaf opening with a four hour notice. This rehabilitation is necessary to extend the bridge life.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the designated time period. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: April 21, 2010.

R.S. Branham,

Rear Admiral, U.S. Coast Guard, Commander, Seventh Coast Guard District.

[FR Doc. 2010–10328 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2010–0347]

Safety Zone Regulations, Seafair Blue Angels Air Show Performance, Seattle, WA

AGENCY: Coast Guard, DHS.

ACTION: Notice of enforcement of regulation.

SUMMARY: The Coast Guard will enforce a safety zone on Lake Washington, WA for the annual Seafair Blue Angels Air Show from 10 a.m. on August 5, 2010 to 6 p.m. on August 8, 2010. This action is necessary to ensure the safety of the public from inherent dangers associated with aerial displays. During the enforcement period, no person or vessel may enter this safety zone unless authorized by the Captain of the Port or Designated Representative.

DATES: The regulations in 33 CFR 165.1319 will be enforced on: August 5, 2010 from 10 a.m. to 3 p.m.; August 6, 2010 from 8:30 a.m. to 6 p.m.; August 7, 2010 from 8:30 a.m. to 6 p.m.; and August 8, 2010 from 7:30 a.m. to 6 p.m.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, call or e-mail Ensign Ashley M. Wanzer, Sector Seattle Waterways Management Division, Coast Guard; telephone 206–217–6175, e-mail *SectorSeattleWWM@uscg.mil.*

SUPPLEMENTARY INFORMATION: On June 24, 2004, the Coast Guard published a Final Rule in the **Federal Register** (69 FR 35250) to establish a safety zone on the waters of Lake Washington for the annual Seafair Blue Angels Air Show Performance. The Coast Guard will enforce the safety zone regulation in 33 CFR 165.1319 on August 5, 2010 from 10 a.m. to 3 p.m.; August 6, 2010 from 8:30 a.m. to 6 p.m.; August 7, 2010 from 8:30 a.m. to 6 p.m.; and August 8, 2010 from 7:30 a.m. to 6 p.m.

Under the provisions of 33 CFR 165.1319, the following area is designated as a safety zone: All waters of Lake Washington, Washington State, enclosed by the following points: Near the termination of Roanoke Way 47°35′44″ N, 122°14′47″ W; thence to 47°35′48″ N, 122°15′45″ W; thence to 47°36′02.1″ N, 122°15′50.2″ W; thence to 47°35′56.6″ N, 122°16′29.2″ W; thence to 47°35′42″ N, 122°16′24″ W; thence to the east side of the entrance to the west high-rise of the Interstate 90 bridge; thence westerly along the south side of the bridge to the shoreline on the western terminus of the bridge; thence southerly along the shoreline to Andrews Bay at 47°33′06″ N, 122°15′32″ W; thence northeast along the shoreline of Bailey Peninsula to its northeast point at 47°33′44″ N, 122°15′04″ W; thence easterly along the east-west line drawn tangent to Bailey Peninsula; thence northerly along the shore of Mercer Island to the point of origin. [Datum: NAD 1983]

In accordance with the general regulations in 33 CFR Part 165, Subpart C, no person or vessel may enter or remain in the zone except for support vessels and support personnel, vessels registered with the event organizer, or other vessels authorized by the Captain of the Port or Designated Representatives. Vessels and persons granted authorization to enter the safety zone shall obey all lawful orders or directions made by the Captain of the Port or Designated Representative.

The Captain of the Port may be assisted by other federal, state and local law enforcement agencies.

This notice is issued under authority of 33 CFR 165.1319 and 5 U.S.C. 552(a).

Dated: April 6, 2010.

S.E. Englebert,

Captain, U.S. Coast Guard, Captain of the Port, Puget Sound.

[FR Doc. 2010–10312 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2010–0290]

RIN 1625–AA00

Safety Zones; Blasting Operations and Movement of Explosives, St. Marys River, Sault Sainte Marie, MI

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing four temporary safety zones in the vicinity of the downstream approach to the Sault Sainte Marie, Michigan locks. All vessels are prohibited from transiting the zones to ensure the safety of the maritime community during blasting and dredging operations.

DATES: Effective Date: This rule is effective in the CFR from May 4, 2010 until 10 p.m. August 31, 2010. This rule is effective with actual notice for purposes of enforcement beginning 5 a.m. April 23, 2010 through 10 p.m. August 31, 2010.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket USCG–2010–0290 and are available online by going to *http://www.regulations.gov,* inserting USCG–2010–0290 in the "Keyword" box, and then clicking "Search." They are also available for inspection or copying at the Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary rule, call or e-mail BMC Gregory Ford, Facility Inspection Division, U.S. Coast Guard Sector Sault Sainte Marie; telephone 906–635–3222, e-mail *Gregory.C.Ford@uscg.mil.* If you have questions on viewing the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

Regulatory Information

The Coast Guard is issuing this temporary final rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are "impracticable, unnecessary, or contrary to the public interest." Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because the publishing of an NPRM would be contrary to public interest, since immediate action is needed to ensure the public's safety during blasting and dredging operations. Delaying the implementation of the safety zone would subject the public to the hazards associated with blasting and dredging operations and the movement of explosives for those operations. The danger posed by the volume of marine traffic on the Saint Marys River makes safety zone regulations necessary. For the safety concerns noted, it is in the public interest to have these regulations in effect immediately and without waiting for a comment period to run. The Coast Guard will issue broadcast notice to mariners to advise vessel operators of navigational restrictions. The regular presence of Coast Guard and

local law enforcement vessels will also provide actual notice to mariners.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register** because to do otherwise, would be contrary to the interest of the public by jeopardizing public safety during blasting and dredging operations. Immediate action is necessary to prevent possible loss of life and property.

Basis and Purpose

As part of the Sault Sainte Marie replacement lock downstream approach channel deepening project, the Army Corps of Engineers must blast and dredge portions of the Saint Marys River downstream of the Sabin and Davis Locks. Due to the inherent dangers associated with blasting and dredging operations, a temporary safety zone is necessary to help ensure the safety of the maritime public operating near the work site. The worst case potential explosive arc for the work site of this project has been calculated to be approximately 975 feet. The blasting and dredging operations also require the movement of explosives via barge from Sault Sainte Marie, Michigan to the work site. Due to the inherent dangers associated with the movement of explosives, a safety zone is necessary to help ensure the safety of the maritime public operating near the barge when explosives are being loaded and while the barge is in transit with explosives onboard. The worst case potential explosive arc for safety zone has been calculated to be approximately 500 feet. The project is also required to comply with applicable state laws and local ordinances.

Discussion of Rule

The Coast Guard is establishing four temporary safety zones. The first temporary safety zone is a fixed zone on the western portion of the area where the blasting and dredging operations will be taking place. This temporary safety zone applies to the navigable waters downstream of the Sabin and Davis Locks, Sault Sainte Marie, Michigan, with east and west boundaries starting approximately 250 feet due east of the center of the Sabin Lock downstream gate, to approximately 1,750 feet due east of the center of the Davis Lock downstream gate. The zone is further bound by the southern pier face of the Northeast Pier, and the northern pier face of the East Center Pier. It also applies to a portion of the Army Corps of Engineers hydroelectric power plant effluence, and waters surrounding the eastern tip of the Northeast Pier. This portion of the zone extends west approximately 1,100 feet from the tip of the Northeast Pier, and out to the north, approximately 150 feet. The zone is bound by the following coordinates: 46°30′22.50″ N/ 084°20′40.81″ W; 46°30′22.50″ N/ 084°20′29.35″ W; 46°30′20.16″ N/ 084°20′25.29″ W; 46°30′18.81″ N/ 084°20′25.29″ W; 46°30′18.66″ N/ 084°20′28.36″ W; 46°30′12.90″ N/ 084°20′28.36″ W; 46°30′13.18″ N/ 084°20′39.17″ W; 46°30′15.27″ N/ 084°20′48.17″ W; 46°30′15.45″ N/ 084°20′51.00″ W; 46°30′16.41″ N/ 084°20′51.00″ W; 46°30′16.98″ N/ 084°20′40.81″ W; (NAD 83). This zone will be enforced continually from 5 a.m. April 23, 2010 through 10 p.m. August 31, 2010.

The second temporary safety zone is a fixed zone and applies to the navigable waters within a radius of 1,100 feet centered on the test blast location approximately 600 feet due east of the pier between the Sabin and Davis locks, Sault Sainte Marie, Michigan at 46°30′15.46″ N/084°20′39.12″ W; (NAD 83). This zone will be effective from 5 a.m. April 23, 2010 through 10 p.m. May 9, 2010. The public will be notified of enforcement of this zone by Broadcast Notice to Mariners in accordance with the procedures outlined in this regulation.

The third temporary safety zone is a moving zone and applies to the navigable waters within a radius of 500 feet from the barge "M2" at any time the barge is involved in explosives loading operations or while transiting with explosives on board. This zone will be effective from 5 a.m. April 23, 2010 through 10 p.m. August 31, 2010. The public will be notified of enforcement of this zone by Broadcast Notice to Mariners in accordance with the procedures outlined in this regulation.

The fourth temporary safety zone is a fixed zone on the eastern portion of the area where the blasting and dredging operations will be taking place. This temporary safety zone applies to the navigable waters downstream of the Sabin and Davis Locks, Sault Sainte Marie, Michigan, with east and west boundaries starting approximately 1,750 feet due east of the center of the Davis Lock downstream gate, to approximately 2,850 feet due east of the center of the Davis Lock downstream gate. The zone is bound to the south by the northern pier face of the East Center Pier. The northern boundary of the zone is approximately 600 feet north of the East Center Pier. The area is bound by the following coordinates: 46°30′18.66″ N/ 84°20′28.36″ W; 46°30′19.36″ N/ 84°20′14.23″ W; 46°30′19.20″ N/ 84°20′13.87″ W; 46°30′11.59″ N/ 84°20′12.96″ W; 46°30′11.78″ N/ 84°20′19.53″ W; 46°30′12.69″ N/ 84°20′19.68″ W; 46°30′12.90″ N/ 84°20′28.36″ W; (NAD 83). This zone will be effective from 5 a.m. April 23, 2010 through 10 p.m. August 31, 2010. The public will be notified of enforcement of this zone by Broadcast Notice to Mariners in accordance with the procedures outlined in this regulation.

Regulatory Analyses

We developed this rule after considering numerous statutes and executive orders related to rulemaking. Below we summarize our analyses based on 13 of these statutes or executive orders.

Regulatory Planning and Review

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order.

Although this regulation will restrict access to the areas, the effect of the rule will not be significant because maritime traffic will be minimally impacted. The water area near the primary work, which is protected by the first temporary safety zone, is blocked on three sides and receives very little vessel traffic. The remaining zones will be enforced as required by blasting and dredging operations, which will typically be only during times of reduced vessel traffic.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this rule would have a significant economic impact on a substantial number of small entities. The term "small entities" comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.

The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

The following entities may be affected by this rule, some of which may be small entities: The owners or operators of vessels intending to operate, transit, or anchor in portions of the Saint Marys River from April 23, 2010 through

August 31, 2010. The safety zones will not have a significant impact on a substantial number of small entities for the following reasons: Access to most of the primary work zone, which is protected by the first temporary safety zone, is blocked on three sides and receives very little vessel traffic. The remaining zones will be enforced as required by blasting and dredging operations, which will typically be only during times of reduced vessel traffic. Plus, the Coast Guard will make notifications via maritime advisories so mariners can adjust their plans accordingly. Overall, the Coast Guard expects the economic impact of this rule to be minimal traffic.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we offer to assist small entities in understanding the rule so that they can better evaluate its effects on them and participate in the rulemaking process.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on State or local governments and would either preempt State law or impose a substantial direct cost of compliance on them. We have analyzed this rule under that Order and have determined that it does not have implications for federalism.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

Taking of Private Property

This rule will not cause a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Protection of Children

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not create an environmental risk to health or risk to safety that may disproportionately affect children.

Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

Energy Effects

We have analyzed this rule under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use. We have determined that it is not a "significant energy action" under that order because it is not a "significant regulatory action" under Executive Order 12866 and is not likely to have a significant adverse effect on the supply, distribution, or use of energy. The Administrator of the Office of Information and Regulatory Affairs has not designated it as a significant energy action. Therefore, it does not require a Statement of Energy Effects under Executive Order 13211.

Technical Standards

The National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note) directs agencies to use voluntary consensus standards in their regulatory activities unless the agency provides Congress, through the Office of Management and Budget, with an explanation of why using these standards would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (*e.g.,* specifications of materials, performance, design, or operation; test methods; sampling procedures; and related management systems practices) that are developed or adopted by voluntary consensus standards bodies.

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have concluded this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule is categorically excluded, under figure 2–1, paragraph (34)(g), of the Instruction. This rule involves regulations establishing safety zones to protect the public from the dangers associated with blasting and dredging operations. An environmental analysis checklist and a categorical exclusion determination will be available in the docket where indicated under **ADDRESSES**.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

■ For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1226, 1231; 46 U.S.C. Chapter 701, 3306, 3703; 50 U.S.C. 191, 195; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T09–0290 to read as follows:

§ 165.T09–0290 Safety Zones; Blasting Operations and Movement of Explosives, St. Marys River, Sault Sainte Marie, MI.

(a) *Location.* The following areas are safety zones:

(1) All U.S. navigable waters downstream of the Sabin and Davis Locks, Sault Sainte Marie, Michigan, with east and west boundaries starting approximately 250 feet due east of the center of the Sabin Lock downstream gate, to approximately 1,750 feet due east of the center of the Davis Lock downstream gate. The zone is further bound by the southern pier face of the Northeast Pier, and the northern pier face of the East Center Pier. This zone also includes a portion of the Army Corps of Engineers hydroelectric power plant effluence, and waters surrounding the eastern tip of the Northeast Pier. This portion of the zone extends west approximately 1,100 feet from the tip of the Northeast Pier, and out to the north, approximately 150 feet. The zone is bound by the following coordinates: 46°30′22.50″ N/084°20′40.81″ W; 46°30′22.50″ N/084°20′29.35″ W; 46°30′20.16″ N/084°20′25.29″ W; 46°30′18.81″ N/084°20′25.29″ W; 46°30″18.66″ N/084°20′28.36″ W; 46°30′12.90″ N/084°20′28.36″ W; 46°30′13.18″ N/084°20′39.17″ W; 46°30′15.27″ N/084°20′48.17″ W; 46°30′15.45″ N/084°20′51.00″ W; 46°30′16.41″ N/084°20′51.00″ W; 46°30′16.98″ N/084°20′40.81″ W; (NAD 83).

(2) All U.S. navigable waters within a radius of 1,100 feet centered on the test blast location approximately 600 feet due east of the pier between the Sabin and Davis locks, Sault Sainte Marie, Michigan at 46°30′15.46″ N/084°20′39.12″ W; (NAD 83).

(3) All U.S. navigable waters within a radius of 500 feet from the barge "M2" at any time the barge is involved in explosives loading operations or while transiting with explosives on board.

(4) All U.S. navigable waters downstream of the Sabin and Davis Locks, Sault Sainte Marie, Michigan, with east and west boundaries starting approximately 1,750 feet due east of the center of the Davis Lock downstream gate, to approximately 2,850 feet due east of the center of the Davis Lock downstream gate. The zone is bound to the south by the northern pier face of the East Center Pier. The northern boundary of the zone is approximately 600 feet north of the East Center Pier. The area is bound by the following coordinates: 46°30′18.66″ N/84°20′28.36″ W; 46°30′19.36″ N/84°20′14.23" W;

46°30′19.20″ N/84°20′13.87″ W; 46°30′11.59″ N/84°20′12.96″ W;

46°30′11.78″ N/84°20′19.53″ W; 46°30′12.69″ N/84°20′19.68″ W;

46°30′12.90″ N/84°20′28.36″ W; (NAD 83).

(b) *Effective period.* This regulation is effective from 5 a.m. April 23, 2010 through 10 p.m. August 31, 2010. The safety zones established in paragraph (a) of this section will be enforced as follows:

(1) The zone described in paragraph (a)(1) of this section will be enforced continually from 5 a.m. April 23, 2010 through 10 p.m. August 31, 2010.

(2) The zone described paragraph (a)(2) of this section will be intermittently enforced from 5 a.m. April 23, 2010 through 10 p.m. May 14, 2010.

(3) The zone described in paragraph (a)(3) of this section is subject to enforcement from 5 a.m. April 23, 2010 through 10 p.m. August 31, 2010, any time the barge "M2" is transiting with explosives on board or involved in explosives loading operations.

(4) The zone described paragraph (a)(4) of this section will be intermittently enforced from 5 a.m. April 23, 2010 through 10 p.m. August 31, 2010.

(5) The Captain of the Port, Sector Sault Sainte Marie may suspend at any time the enforcement of any safety zone established under this section.

(6) The Captain of the Port, Sector Sault Sainte Marie, will notify the public of the enforcement and suspension of enforcement of a safety zone established by this section via any means that will provide as much notice as possible to the public. These means might include some or all of those listed in 33 CFR 165.7(a). The primary method of notification, however, will be through Broadcast Notice to Mariners and local Notice to Mariners.

(c) *Regulations.* (1) In accordance with the general regulations in section 165.23 of this part, entry into, transiting, or anchoring within an enforced safety zone established by this section is prohibited unless authorized by the Captain of the Port, Sector Sault Sainte Marie, or his on-scene representative.

(2) This safety zone is closed to all vessel traffic, except as may be permitted by the Captain of the Port, Sector Sault Sainte Marie, or his on-scene representative.

(3) The "on-scene representative" of the Captain of the Port, Sector Sault Sainte Marie, is any Coast Guard commissioned, warrant or petty officer who has been designated by the Captain of the Port, Sector Sault Sainte Marie, to act on his behalf. The on-scene representative of the Captain of the Port, Sector Sault Sainte Marie, will be aboard either a Coast Guard or Coast Guard Auxiliary vessel.

(4) Vessel operators desiring to enter or operate within an enforced safety zone shall contact the Captain of the Port, Sector Sault Sainte Marie, or his on-scene representative to obtain permission to do so. The Captain of the Port, Sector Sault Sainte Marie, or his on-scene representative may be contacted via VHF Channel 16. Vessel operators given permission to enter or operate in the safety zone must comply with all directions given to them by the Captain of the Port, Sector Sault Sainte Marie, or his on-scene representative.

Dated: April 20, 2010.

M.J. Huebschman,

Captain, U.S. Coast Guard, Captain of the Port, Sector Sault Sainte Marie.

[FR Doc. 2010–10316 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2010–0256]

RIN 1625–AA00

Safety Zone; Neuse River, New Bern, NC; Correction

ACTION: Temporary final rule; correction.

SUMMARY: In the **Federal Register** published on April 23, 2010, the Coast Guard established a temporary safety zone on the waters of the Neuse River in support of the New Bern, North Carolina Tercentennial Celebration. The City of New Bern, North Carolina is sponsoring a civil war naval bombardment reenactment on the waters of the Neuse River, New Bern, North Carolina on May 8, 2010. The safety zone published with an error in the temporary safety zone coordinates. The safety zone coordinates should have read "35°06′12″ N; 077°02′12″ W thence to 35°05′52″ N; 077°02′15″ W thence to 35°05′49″ N; 077°01′49″ W thence to 35°06′17″ N; 077°01′48″ W thence to 35°06′21″ N; 077°02′06″ W".

DATES: This correction is effective May 4, 2010.

FOR FURTHER INFORMATION CONTACT: For information about this correction, contact Jennifer Mehaffey, Office of Regulations and Administrative Law,

(202) 372–3859 *jennifer.a.mehaffey@uscg.mil.* For information about the original regulation, contact CWO4 Stephen Lyons, Waterways Management Division Chief, Coast Guard Sector North Carolina; telephone (252) 247–4525, e-mail *Stephen.W.Lyons@uscg.mil.*

SUPPLEMENTARY INFORMATION: In FR doc 2010–9497 appearing on page 21164 in the issue of Friday, April 23, 2010, the following corrections are made:

1. In the Discussion of the Rule section on page 21165, in the second column, revise the temporary safety zone coordinates to read "35°06′12″ N; 077°02′12″ W thence to 35°05′52″ N; 077°02′15″ W thence to 35°05′49″ N; 077°01′49″ W thence to 35°06′17″ N; 077°01′48″ W thence to 35°06′21″ N; 077°02′06″ W".

§ 165.T05–0256 [Corrected]

■ 2. In the regulatory text on page 21166, third column, revise paragraph (b) safety zone coordinates to read "35°06′12″ N; 077°02′12″ W thence to 35°05′52″ N; 077°02′15″ W thence to 35°05′49″ N; 077°01′49″ W thence to 35°06′17″ N; 077°01′48″ W thence to 35°06′21″ N; 077°02′06″ W".

Dated: April 29, 2010.

S. Venckus,

Office of Regulations and Administrative Law (CG–0943), U.S. Coast Guard.

[FR Doc. 2010–10496 Filed 4–30–10; 11:15 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 65

[Docket ID FEMA–2010–0003; Internal Agency Docket No. FEMA–B–1096]

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Interim rule.

SUMMARY: This interim rule lists communities where modification of the Base (1% annual-chance) Flood Elevations (BFEs) is appropriate because of new scientific or technical data. New flood insurance premium rates will be calculated from the modified BFEs for new buildings and their contents.

DATES: These modified BFEs are currently in effect on the dates listed in the table below and revise the Flood Insurance Rate Maps (FIRMs) in effect prior to this determination for the listed communities.

From the date of the second publication of these changes in a newspaper of local circulation, any person has ninety (90) days in which to request through the community that the Deputy Federal Insurance and Mitigation Administrator reconsider the changes. The modified BFEs may be changed during the 90-day period.

ADDRESSES: The modified BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

SUPPLEMENTARY INFORMATION: The modified BFEs are not listed for each community in this interim rule. However, the address of the Chief Executive Officer of the community where the modified BFE determinations are available for inspection is provided.

Any request for reconsideration must be based on knowledge of changed conditions or new scientific or technical data.

The modifications are made pursuant to section 201 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.,* and with 44 CFR part 65.

For rating purposes, the currently effective community number is shown and must be used for all new policies and renewals.

The modified BFEs are the basis for the floodplain management measures that the community is required either to adopt or to show evidence of being already in effect in order to qualify or to remain qualified for participation in the National Flood Insurance Program (NFIP).

These modified BFEs, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities. The changes in BFEs are in accordance with 44 CFR 65.4.

National Environmental Policy Act. This interim rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This interim rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This interim rule involves no policies that have federalism implications under Executive Order 13132, Federalism.

Executive Order 12988, Civil Justice Reform. This interim rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 65

Flood insurance, Floodplains, Reporting and recordkeeping requirements.

■ Accordingly, 44 CFR part 65 is amended to read as follows:

PART 65—[AMENDED]

■ 1. The authority citation for part 65 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 65.4 [Amended]

■ 2. The tables published under the authority of § 65.4 are amended as follows:

State and county	Location and Case No.	Date and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Arizona:					

State and county	Location and Case No.	Date and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Maricopa	Town of Buckeye (09–09–0764P).	November 19, 2009; November 26, 2009; *Arizona Business Gazette*.	The Honorable Jackie A. Meck, Mayor, Town of Buckeye, 530 East Monroe Avenue, Buckeye, AZ 85326.	March 26, 2010	040039
Maricopa	Unincorporated areas of Maricopa County (09–09–0764P).	November 19, 2009; November 26, 2009; *Arizona Business Gazette*.	The Honorable Andrew W. Kunasek, Chairman, Maricopa County Board of Supervisors, 301 West Jefferson Street, 10th Floor, Phoenix, AZ 85003.	March 26, 2010	040037
California:					
San Diego	Unincorporated areas of San Diego (09–09–1604P).	November 20, 2009; November 27, 2009; *San Diego Transcript*.	The Honorable Dianne Jacob, Chairwoman, San Diego County Board of Supervisors, 1600 Pacific Highway, San Diego, CA 92101.	March 29, 2010	060284
Santa Clara	City of Santa Clara (09–09–0375P).	October 21, 2009; October 28, 2009; *Santa Clara Weekly*.	The Honorable Patricia M. Mahan, Mayor, City of Santa Clara, 1500 Warburton Avenue, Santa Clara, CA 95050.	February 25, 2010	060350
Colorado:					
Douglas	Unincorporated areas of Douglas County (09–08–0908P).	November 12, 2009; November 19, 2009; *Douglas County News-Press*.	The Honorable Melanie Worley, Chairman, Douglas County Board of Commissioners, 100 3rd Street, Castle Rock, CO 80104.	March 19, 2010	080049
Grand	Town of Fraser (10–08–0009P).	November 19, 2009; November 26, 2009; *Middle Park Times*.	The Honorable Fran Cook, Mayor, Town of Fraser, P.O. Box 370, Fraser, CO 80442.	March 26, 2010	080073
Grand	Unincorporated areas of Grand County (10–08–0009P).	November 19, 2009; November 26, 2009; *Middle Park Times*.	The Honorable Gary Bumgarner, Chairman, Grand County Board of Commissioners, P.O. Box 264, Hot Sulphur Springs, CO 80451.	March 26, 2010	080280
Teller	Unincorporated areas of Teller County (09–08–0500P).	November 4, 2009; November 11, 2009; *Pikes Peak Courier View*.	The Honorable James Ignatius, Chairman, Teller County Board of Commissioners, P.O. Box 959, Cripple Creek, CO 80813.	March 11, 2010	080173
Teller	City of Woodland Park (09–08–0500P).	November 4, 2009; November 11, 2009; *Pikes Peak Courier View*.	The Honorable Steve Randolph, Mayor, City of Woodland Park, 220 West South Avenue, Woodland Park, CO 80866.	March 11, 2010	080175
Illinois:					
Will	Village of Plainfield (08–05–4590P).	November 30, 2009; December 7, 2009; *Herald News*.	The Honorable Michael P. Collins, President, Village of Plainfield, 24401 West Lockport Street, Plainfield, IL 60544.	December 21, 2009	170771
Will	Unincorporated areas of Will County (08–05–4590P).	November 30, 2009; December 7, 2009; *Herald News*.	The Honorable Lawrence M. Walsh, Executive, Will County, 302 North Chicago Street, Joliet, IL 60432.	December 21, 2009	170695
Louisiana: Livingston	Unincorporated areas of Livingston Parish (09–06–0692P).	November 10, 2009; November 17, 2009; *The Advocate*.	The Honorable Mike Grimmer, President, Livingston Parish, P.O. Box 427, Livingston, LA 70754.	March 17, 2010	220113
Minnesota: Anoka	City of Ramsey (09–05–4652P).	November 20, 2009; November 27, 2009; *Anoka County Union*.	The Honorable Thomas G. Gamec, Mayor, City of Ramsey, 7550 Sunwood Drive Northwest, Ramsey, MN 55303.	December 14, 2009	270681
Nevada: Lyon	Unincorporated areas of Lyon County (09–09–0238P).	November 25, 2009; December 2, 2009; *Dayton Courier*.	The Honorable Phyllis Hunewill, Chair, Lyon County Board of Commissioners, 30 Desert Creek Road, Wellington, NV 89444.	April 2, 2010	320029
South Dakota:					
Lincoln	Unincorporated areas of Lincoln County (09–08–0747P).	November 5, 2009; November 12, 2009; *Lennox Independent*.	The Honorable Dale L. Long, Chairman, Lincoln County Board of Commissioners, 27115 475th Avenue, Harrisburg, SD 57032.	October 28, 2009	460277
Lincoln	Town of Tea (09–08–0747P).	November 5, 2009; November 12, 2009; *Lennox Independent*.	The Honorable John Lawler, Mayor, Town of Tea, 600 East 1st Street, Tea, SD 57064.	October 28, 2009	460143
Tennessee: Bradley	City of Cleveland (09–04–1322P).	November 30, 2009; December 7, 2009; *Cleveland Daily Banner*.	The Honorable Tom Rowland, Mayor, City of Cleveland, P.O. Box 1519, Cleveland, TN 37311.	April 6, 2010	470015
Texas:					
Bell	City of Killeen (08–06–2994P).	October 13, 2009; October 20, 2009; *Killeen Daily Herald*.	The Honorable Timothy L. Hancock, Mayor, City of Killeen, P.O. Box 1329, Killeen, TX 76540.	October 30, 2009	480031
Lubbock	City of Lubbock (08–06–2723P).	November 16, 2009; November 23, 2009; *Lubbock Avalanche-Journal*.	The Honorable Tom Martin, Mayor, City of Lubbock, P.O. Box 2000, Lubbock, TX 79457.	March 23, 2010	480452
Virginia: Arlington	Unincorporated areas of Arlington County (09–03–1117P).	December 3, 2009; December 10, 2009; *Sun-Gazette*.	The Honorable Barbara A. Favola, Chairperson, Arlington County Board, 2100 Clarendon Boulevard, Suite 813, Arlington, VA 22201.	April 9, 2010	515500
Wisconsin: Milwaukee.	Village of Hales Corners (09–05–4413P).	November 12, 2009; November 19, 2009; *My Community Now*.	The Honorable Robert G. Ruesch, President, Village of Hales Corners, 5740 South 124th Street, Hales Corners, WI 53130.	March 19, 2010	550524

(Catalog of Federal Domestic Assistance No. 97.022, "Flood Insurance.")

Dated: April 27, 2010.

Sandra K. Knight,

Deputy Federal Insurance and Mitigation Administrator, Mitigation, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. 2010–10340 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket ID FEMA–2010–0003]

Final Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: Base (1% annual-chance) Flood Elevations (BFEs) and modified BFEs are made final for the communities listed below. The BFEs and modified BFEs are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

DATES: The date of issuance of the Flood Insurance Rate Map (FIRM) showing BFEs and modified BFEs for each community. This date may be obtained by contacting the office where the maps are available for inspection as indicated on the table below.

ADDRESSES: The final BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (email) *kevin.long@dhs.gov.*

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) makes the final determinations listed below for the modified BFEs for each community listed. These modified elevations have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Deputy Federal Insurance and Mitigation Administrator has resolved any appeals resulting from this notification.

This final rule is issued in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR part 67. FEMA has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR part 60.

Interested lessees and owners of real property are encouraged to review the proof Flood Insurance Study and FIRM available at the address cited below for each community. The BFEs and modified BFEs are made final in the communities listed below. Elevations at selected locations in each community are shown.

National Environmental Policy Act. This final rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This final rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This final rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

■ Accordingly, 44 CFR part 67 is amended as follows:

PART 67—[AMENDED]

■ 1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.11 [Amended]

■ 2. The tables published under the authority of § 67.11 are amended as follows:

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
Crittenden County, Arkansas, and Incorporated Areas Docket No.: FEMA–B–1045			
Mississippi River	Approximately at River Mile 700	+212	Unincorporated Areas of Crittenden County.
	Approximately at River Mile 727	+226	
	Approximately at River Mile 741	+234	
	Approximately at River Mile 750	+237	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Unincorporated Areas of Crittenden County

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
Maps are available for inspection at the County Courthouse, 85 Jackson Street, Marion, AR 72482.			
Mesa County, Colorado, and Incorporated Areas Docket No.: FEMA–B–1049			
Gold Star Canyon	Just above the confluence with the Colorado River	+4518	Unincorporated Areas of Mesa County, City of Grand Junction.
	Just upstream of South Broadway	+4805	
Kannah Creek	Just above the confluence with Indian Creek	+4766	Unincorporated Areas of Mesa County.
	Approximately 320 feet upstream of Upper Kannah Creek Road.	+6093	
Kannah Creek Lower Split Flow	Just above the confluence with Kannah Creek	+4806	Unincorporated Areas of Mesa County.
	Just below the divergence from Kannah Creek	+4826	
Kannah Creek Upper Split Flow	Just above the confluence with Kannah Creek	+4894	Unincorporated Areas of Mesa County.
	Just below the divergence from Kannah Creek	+4935	
Red Canyon	Just above the confluence with the Colorado River	+4546	Unincorporated Areas of Mesa County, City of Grand Junction.
	Approximately 5,670 feet above South Camp Road	+5020	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Grand Junction
Maps are available for inspection at 250 North 5th Street, Grand Junction, CO 81501.

Unincorporated Areas of Mesa County
Maps are available for inspection at 544 Rood Avenue, Grand Junction, CO 81502.

Dukes County, Massachusetts (All Jurisdictions) Docket No.: FEMA–B–1047			
Atlantic Ocean	Between Gilberts Cove and Quenames Cove	+11	Town of Chilmark, Town of Edgartown, Town of West Tisbury.
	Between Paqua Pond and Jobs Neck Pond	+9	
	Between Long Cove and Homer Road	+9	
Vineyard Sound	Approximately 300 feet east of the intersection of Lobsterville Road and West Basin Road.	+9	Town of Aquinnah, Town of Oak Bluffs, Town of Tisbury.
	Between Farm Pond and Hamlin Pond	+12	
	Between Algonquin Avenue and Yacht Club Lane	+12	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Town of Aquinnah
Maps are available for inspection at the Town Hall, 65 State Road, Aquinnah, MA 02535.

Town of Chilmark
Maps are available for inspection at the Town Hall, 401 Middle Road, Chilmark, MA 02535.

Town of Edgartown
Maps are available for inspection at the Town Hall, 70 Main Street, Edgartown, MA 02539.

Town of Oak Bluffs
Maps are available for inspection at the Town Hall, 56 School Street, Oak Bluffs, MA 02557.

Town of Tisbury
Maps are available for inspection at the Tisbury Town Hall, 51 Spring Street, Vineyard Haven, MA 02568.

Town of West Tisbury
Maps are available for inspection at the Town Hall, 1059 State Road, West Tisbury, MA 02575.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
Walthall County, Mississippi, and Incorporated Areas Docket No.: FEMA–B–1060			
Magees Creek	Approximately 4,050 feet downstream of State Highway 198.	+258	Unincorporated Areas of Walthall County.
	Approximately 2,300 feet upstream of State Highway 198	+264	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES
Unincorporated Areas of Walthall County
Maps are available for inspection at 200 Ball Avenue, Tylertown, MS 39667.

Middlesex County, New Jersey (All Jurisdictions) Docket No.: FEMA–B–1017			
Ambrose Brook	Approximately 1,820 feet upstream of Stelton Road (Route 529).	+78	Township of Edison.
	Approximately 1,875 feet upstream of Stelton Road (Route 529).	+78	
Bonygutt Brook	Approximately 700 feet downstream of Bound Brook Road	+46	Borough of Dunellen, Township of Piscataway.
	Approximately 0.4 mile upstream of South Washington Avenue (Route 529).	+54	
Bound Brook	Upstream side of South Avenue	+47	Township of Piscataway.
	Approximately 750 feet upstream of South Avenue	+48	
Boundary Branch Mill Brook No. 1.	At the confluence with Mill Brook No. 1	+45	Borough of Highland Park, Township of Edison.
	Approximately 25 feet downstream of Brookhill Avenue	+74	
Coppermine Brook	At the confluence with South Branch Rahway River	+40	Township of Edison, Township of Woodbridge.
	Approximately 1,870 feet upstream of Lincoln Highway (Route 27).	+59	
Green Brook	At the confluence with the Raritan River	+34	Borough of Middlesex.
	At the downstream side of New Jersey Central Railroad	+34	
Lake Lefferts	Entire shoreline within Middlesex County	+17	Township of Old Bridge.
Lawrence Brook	At the confluence with the Raritan River	+11	Township of East Brunswick.
	At the downstream side of Westons Mill Dam 1	+11	
Matawan Creek	At the downstream side of Old Bridge-Matawan Road	+17	Township of Old Bridge.
	Approximately 0.8 mile upstream of Old Bridge-Matawan Road.	+25	
Mill Brook No. 1	At the confluence with the Raritan River	+16	Borough of Highland Park.
	Approximately 955 feet upstream of Harrison Avenue	+45	
Rahway River	At the confluence with Arthur Kill	+7	Borough of Carteret, Township of Woodbridge.
	At the county boundary	+7	
Raritan River	Approximately 1.4 mile downstream of the New Jersey Turnpike.	+10	Township of East Brunswick, Borough of Highland Park, Borough of Middlesex, City of New Brunswick, Township of Edison, Township of Piscataway.
	At the confluence with Green Brook	+34	
South Branch Rahway River	At the upstream side of Wood Avenue	+40	Township of Edison, Township of Woodbridge.
	Approximately 450 feet upstream of County Route 657	+44	
West Branch Mill Brook No. 1	At the confluence with Mill Brook No. 1	+31	Borough of Highland Park.
	Approximately 760 feet upstream of Bartle Court	+51	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Borough of Carteret

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected

Maps are available for inspection at the Carteret Memorial Municipal Building, 61 Cooke Avenue, Carteret, NJ 07008.

Borough of Dunellen

Maps are available for inspection at 355 North Avenue, Dunellen, NJ 08812.

Borough of Highland Park

Maps are available for inspection at 3141 Bordertown Avenue, Parlin, NJ 08859.

Borough of Middlesex

Maps are available for inspection at 1200 Mountain Avenue, Middlesex, NJ 08846.

City of New Brunswick

Maps are available for inspection at 78 Bayard Street, New Brunswick, NJ 08901.

Township of East Brunswick

Maps are available for inspection at 1 Jean Walling Civic Center Drive, East Brunswick, NJ 08816.

Township of Edison

Maps are available for inspection at 100 Municipal Boulevard, Edison, NJ 08817.

Township of Old Bridge

Maps are available for inspection at 1 Old Bridge Plaza, Old Bridge, NJ 08857.

Township of Piscataway

Maps are available for inspection at 455 Hoes Lane, Piscataway, NJ 08854.

Township of Woodbridge

Maps are available for inspection at 1 Main Street, Woodbridge, NJ 07095.

Rolette County, North Dakota, and Incorporated Areas
Docket No.: FEMA–B–1049

Ox Creek	Approximately 501 feet upstream of the southern corporate limit of Belcourt.	+1903	Chippewa Indian Reservation (Turtle Mountain Band).
	Approximately 27 feet downstream of Belcourt Lake	+2015	
Ox Creek Breakout	Approximately 100 feet upstream of 99th Street Northeast	+1971	Chippewa Indian Reservation (Turtle Mountain Band).
	Approximately 2,154 feet upstream of 99th Street Northeast.	+1972	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Chippewa Indian Reservation (Turtle Mountain Band)

Maps are available for inspection at Highway 5 West, Belcourt, ND 58316.

Muskingum County, Ohio, and Incorporated Areas
Docket No.: FEMA–B–1047

Moxahala Creek	Approximately 1,300 feet downstream of Ransbottom Road.	+734	Unincorporated Areas of Muskingum County.
	Approximately 500 feet downstream of East 1st Street	+735	
Muskingum River	Approximately 0.4 mile downstream of East Muskingum Avenue (State Route 208).	+718	Village of Dresden.
	At the confluence with Wakatomika Creek	+720	
Muskingum River	Approximately 0.6 mile downstream of the confluence with Salt Creek.	+683	Village of Philo.
	Approximately 0.5 mile upstream of the confluence with Salt Creek.	+685	
Wakatomika Creek	Approximately 0.5 mile downstream of Main Street	+720	Unincorporated Areas of Muskingum County, Village of Dresden.
	Approximately 1,400 feet downstream of Frazeysburg Road.	+725	
Wakatomika Creek	Approximately 0.6 mile downstream of Shannon Road	+745	Unincorporated Areas of Muskingum County, Village of Frazeysburg.
	Just downstream of Canal Road	+751	

* National Geodetic Vertical Datum.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected

+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Unincorporated Areas of Muskingum County

Maps are available for inspection at 401 Main Street, Zanesville, OH 43701.

Village of Dresden

Maps are available for inspection at 904 Chestnut Street, Dresden, OH 43821.

Village of Frazeysburg

Maps are available for inspection at 7 West Second Street, Frazeysburg, OH 43822.

Village of Philo

Maps are available for inspection at 300 Main Street, Philo, OH 43771.

Yankton County, South Dakota, and Incorporated Areas
Docket No.: FEMA–B–1050

James River	Just upstream of the confluence with the Missouri River	+1167	Unincorporated Areas of Yankton County.
	Approximately 600 feet upstream of County Highway 213 (431st Avenue).	+1188	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Unincorporated Areas of Yankton County

Maps are available for inspection at 321 West 3rd Street, Yankton, SD 57078.

Spokane County, Washington, and Incorporated Areas
FEMA Docket Number: B–1009

Argonne Creek	Approximately 1,300 feet downstream of North Maringo Drive.	+1922	Unincorporated Areas of Spokane County.
	Approximately 600 feet upstream of North Boeing Road	+1987	
Forker Draw	Approximately at North Progress Road	+2065	City of Spokane Valley, Unincorporated Areas of Spokane County.
	Approximately 70 feet downstream of East Bigelow Gulch Road.	+2336	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Spokane Valley

Maps are available for inspection at 11707 East Sprague Avenue, Suite 106, Spokane Valley, WA 99206.

Unincorporated Areas of Spokane County

Maps are available for inspection at 808 West Spokane Falls Boulevard, Spokane, WA 99201.

Black River	Approximately 4,460 feet downstream of County Highway G.	+1113	City of Greenwood.
	Approximately 4,960 feet upstream of County Highway G	+1126	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Greenwood

Maps are available for inspection at City Hall, 102 North Main Street, Greenwood, WI 54437.

(Catalog of Federal Domestic Assistance No. 97.022, "Flood Insurance.")

Dated: April 27, 2010.

Sandra K. Knight,

Deputy Federal Insurance and Mitigation Administrator, Mitigation, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. 2010–10337 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket ID FEMA–2010–0003]

Final Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: Base (1% annual-chance) Flood Elevations (BFEs) and modified BFEs are made final for the communities listed below. The BFEs and modified BFEs are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

DATES: The date of issuance of the Flood Insurance Rate Map (FIRM) showing BFEs and modified BFEs for each community. This date may be obtained by contacting the office where the maps are available for inspection as indicated in the table below.

ADDRESSES: The final BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) makes the final determinations listed below for the modified BFEs for each community listed. These modified elevations have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Deputy Federal Insurance and Mitigation Administrator has resolved any appeals resulting from this notification.

This final rule is issued in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR part 67. FEMA has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR part 60.

Interested lessees and owners of real property are encouraged to review the proof Flood Insurance Study and FIRM available at the address cited below for each community. The BFEs and modified BFEs are made final in the communities listed below. Elevations at selected locations in each community are shown.

National Environmental Policy Act. This final rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This final rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This final rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

■ Accordingly, 44 CFR part 67 is amended as follows:

PART 67—[AMENDED]

■ 1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.11 [Amended]

■ 2. The tables published under the authority of § 67.11 are amended as follows:

State	City/town/county	Source of flooding	Location	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified
City of Burnside, Kentucky Docket No.: FEMA–B–1040				
Kentucky	City of Burnside	Lake Cumberland	Entire shoreline	+749

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Burnside
Maps are available for inspection at 7929 South Highway 27, Burnside, KY 42519.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
Clinton County, Kentucky, and Incorporated Areas Docket No.: FEMA–B–1040			
Cumberland River	Approximately 2,300 feet downstream of the confluence with Tearcoat Creek.	+568	Unincorporated Areas of Clinton County.
	Approximately 2,300 feet upstream of the confluence with Millers Creek.	+571	
Dale Hollow Lake (Wolf River)	At the confluence with the Wolf River	+663	Unincorporated Areas of Clinton County.
	Approximately 1,800 feet upstream of the confluence with Spring Creek.	+663	
Lake Cumberland	Just upstream of the Wolf Creek Dam	+760	Unincorporated Areas of Clinton County.
	At the confluence with Otter Creek	+760	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Unincorporated Areas of Clinton County

Maps are available for inspection at 100 South Cross Street, Albany, KY 42602.

Jefferson Davis Parish, Louisiana, and Incorporated Areas Docket No.: FEMA–B–1043			
Lake Arthur	Entire shoreline (north to 7th Street from the eastern to the western border of the Town of Lake Arthur).	+8–10	Town of Lake Arthur, Unincorporated Areas of Jefferson Davis Parish.
Lake Charles	Covering an area beginning at the southern border with Cameron Parish, proceeding north along the Calcasieu Parish border to West Niblett Road, to the east to State Route 99, then from State Route 99 below State Route 380 to the Town of Lake Charles border.	+7–11	Unincorporated Areas of Jefferson Davis Parish.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Town of Lake Arthur

Maps are available for inspection at 102 Arthur Avenue, Lake Arthur, LA 70549.

Unincorporated Areas of Jefferson Davis Parish

Maps are available for inspection at 304 North State Street, Jennings, LA 70546.

Tangipahoa Parish, Louisiana, and Incorporated Areas Docket Nos.: FEMA–B–7765 and FEMA–B–1064			
Ponchatoula Creek	Approximately 1,726 feet upstream of the confluence with Unnamed Tributary.	+79	Town of Independence.
	Approximately 1.92 mile upstream of the confluence with Unnamed Tributary.	+87	
Tangipahoa River	Approximately 1.18 mile upstream of the confluence with Big Creek.	+118	Town of Roseland.
	Approximately 1,809 feet downstream of I–10	+126	
Natalbany River	Approximately 2.5 mile upstream of State Route 40	+97	Town of Amite City, Unincorporated Areas of Tangipahoa Parish.
	Approximately 185 feet upstream of State Route 1048	+183	
Unnamed Tributary	Approximately 0.65 mile upstream of the confluence with Ponchatoula Creek.	+79	Town of Independence.
	Approximately 0.81 mile upstream of the confluence with Ponchatoula Creek.	+80	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected

∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Town of Amite City
Maps are available for inspection at 212 East Oak Street, Amite, LA 70422.

Town of Independence
Maps are available for inspection at P.O. Box 35, Independence, LA 70443.

Town of Roseland
Maps are available for inspection at 62438 Commercial Drive, Roseland, LA 70546.

Unincorporated Areas of Tangipahoa Parish
Maps are available for inspection at 15481 Club Deluxe Road, Hammond, LA 70403.

Marion County, Missouri, and Incorporated Areas
Docket No.: FEMA–B–1038

Bear Creek	Approximately 3,930 feet downstream of County Road 418.	+562	Unincorporated Areas of Marion County.
	At U.S. Route 36	+583	
Minnow Branch	At Munger Lane	+589	City of Hannibal, Unincorporated Areas of Marion County.
	At Veterans Road	+685	
Mississippi River	Approximately 2.175 miles downstream of the confluence with Bear Creek.	+476	City of Hannibal, Unincorporated Areas of Marion County.
	At the confluence with Bear Creek	+477	
	At U.S. Route 24	+487	
St. Clair Creek	Approximately 2,150 feet downstream of Veterans Road	+568	City of Hannibal, Unincorporated Areas of Marion County.
	Approximately 400 feet upstream of Highway MM	+652	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Hannibal
Maps are available for inspection at 320 Broadway, Hannibal, MO 63401.

Unincorporated Areas of Marion County
Maps are available for inspection at 100 South Main Street, Palmyra, MO 63461.

Custer County, Montana, and Incorporated Areas
Docket No.: FEMA–B–1020

Tongue River	Approximately 1,605 feet upstream of the confluence with the Yellowstone River.	+2359	City of Miles City, Unincorporated Areas of Custer County.
	Approximately 5,315 feet upstream of I–94	+2375	
Tongue River Split 1	Approximately 1,450 feet upstream of the confluence with the Yellowstone River.	+2353	City of Miles City, Unincorporated Areas of Custer County.
	Approximately 2,430 feet upstream of 4th Street	+2358	
Tongue River Split 2A	Approximately 2,135 feet upstream of the confluence with the Yellowstone River.	+2348	City of Miles City, Unincorporated Areas of Custer County.
	Approximately 185 feet upstream of Montana Avenue	+2358	
Tongue River Split 2B	Just downstream of the intersection of Palmer Street and 9th Street.	+2359	City of Miles City.
	Approximately 705 feet upstream of Pleasant Street	+2360	
Tongue River Split 2C	Approximately 380 feet upstream of Palmer Street	+2359	City of Miles City.
	Approximately 1,145 feet upstream of Pacific Avenue	+2363	
Tongue River Split 3A	Approximately 300 feet upstream of the confluence with Tongue River Split 2A.	+2346	City of Miles City, Unincorporated Areas of Custer County.
	Approximately 290 feet upstream of Leighton Street	+2358	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
Tongue River Split 3B	Just downstream of Pleasant Street	+2360	City of Miles City, Unincorporated Areas of Custer County.
	Approximately 75 feet upstream of 4th Avenue	+2365	
Tongue River Split 3C	Approximately 130 feet downstream of Palmer Street	+2358	City of Miles City, Unincorporated Areas of Custer County.
	Approximately 1,465 feet upstream of Balsam Drive	+2368	
Yellowstone River	Approximately 22,675 feet downstream of State Highway 59.	+2336	City of Miles City, Unincorporated Areas of Custer County.
	Approximately 11,500 feet upstream of State Highway 59	+2363	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Miles City

Maps are available for inspection at 17 South 8th Street, Miles City, MT 59301.

Unincorporated Areas of Custer County

Maps are available for inspection at 1010 Main Street, Miles City, MT 59301.

Fergus County, Montana, and Incorporated Areas
Docket No.: FEMA–B–1050

Flood Channel	Approximately 70 feet upstream of the Main Street Bridge	+3610	Town of Denton.
	Approximately 50 feet upstream of the Railroad Bridge	+3614	
Shallow Flooding	At the intersection of Bain Street and Main Street	#1	Town of Denton.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Town of Denton

Maps are available for inspection at 305 West Watson Street, Lewistown, MT 59457.

Ross County, Ohio, and Incorporated Areas
Docket No.: FEMA–B–1043

Kinnikinnick Creek	Approximately 1,850 feet upstream of the confluence with the Scioto River.	+645	Unincorporated Areas of Ross County.
	Approximately 11,050 feet upstream of the confluence with the Scioto River.	+666	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Unincorporated Areas of Ross County

Maps are available for inspection at 15 North Paint Street, Chillicothe, OH 45601.

Tuscarawas County, Ohio, and Incorporated Areas
Docket No.: FEMA–B–1050

Beggar Run (Backwater from Tuscarawas River).	At the confluence with Conotton Creek	+909	Unincorporated Areas of Tuscarawas County.
	Approximately 0.78 mile upstream of the confluence with Conotton Creek.	+909	
Browns Run (Backwater from Tuscarawas River).	At the confluence with Conotton Creek	+909	Unincorporated Areas of Tuscarawas County.
	Just downstream of Henderson School Road	+909	
Conotton Creek (Backwater from Tuscarawas River).	At the confluence with the Tuscarawas River	+909	Unincorporated Areas of Tuscarawas County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
	Approximately 0.76 mile upstream of Miller Hill Road (Carroll County boundary).	+909	
Dog Run (Backwater from Tuscarawas River).	At the confluence with Conotton Creek	+909	Unincorporated Areas of Tuscarawas County.
	Approximately 0.42 mile upstream of Norfolk and Western Railway.	+909	
Huff Run (Backwater from Tuscarawas River).	At the confluence with Conotton Creek	+909	Unincorporated Areas of Tuscarawas County, Village of Mineral City.
	Approximately 1.38 mile upstream of New Cumberland Road.	+909	
Indian Fork (Backwater from Tuscarawas River).	At the confluence with Conotton Creek	+909	Unincorporated Areas of Tuscarawas County.
	Just downstream of State Route 212	+909	
Middle Run (Backwater from Tuscarawas River).	At the confluence with the Tuscarawas River	+909	Unincorporated Areas of Tuscarawas County.
	Approximately 0.72 mile upstream of Dover-Zoar Road	+909	
Small Middle Run (Backwater from Tuscarawas River).	At the confluence with the Tuscarawas River	+909	Unincorporated Areas of Tuscarawas County.
	Approximately 500 feet downstream of Dover-Zoar Road	+909	
Stillwater Creek	Just downstream of Baltimore and Ohio Railroad	+844	City of Midvale.
	Approximately 0.45 mile upstream of U.S. Route 250	+845	
Tuscarawas River	Approximately 1,000 feet upstream of the confluence with Clewell Run.	+831	Village of Gnadenhutten.
Tuscarawas River	Approximately 0.66 mile downstream of Tuscarawas Road	+838	Village of Tuscarawas.
Tuscarawas River	Just upstream of the Dover Dam	+909	Unincorporated Areas of Tuscarawas County, Village of Bolivar, Village of Zoar.
	Approximately 2.18 miles upstream of State Route 212 (Stark County boundary).	+909	
Wolf Run (Backwater from Tuscarawas River).	At the confluence with the Tuscarawas River	+909	Unincorporated Areas of Tuscarawas County.
	Approximately 0.89 mile upstream of Norfolk and Western Railway.	+909	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Midvale
Maps are available for inspection at City Hall, 311 Barnhill Road, Midvale, OH 44653.

Unincorporated Areas of Tuscarawas County
Maps are available for inspection at the Tuscarawas County Administrative Offices, 125 East High Avenue, New Philadelphia, OH 44663.

Village of Bolivar
Maps are available for inspection at the Village Hall, 109 Canal Street Northwest, Bolivar, OH 44612.

Village of Gnadenhutten
Maps are available for inspection at the Village Hall, 131 South Walnut Street, Gnadenhutten, OH 44629.

Village of Mineral City
Maps are available for inspection at the Village Hall, 8728 North High Street, Mineral City, OH 44656.

Village of Tuscarawas
Maps are available for inspection at the Village Hall, 522 East Cherry Street, Tuscarawas, OH 44682.

Village of Zoar
Maps are available for inspection at the Tuscarawas County Administrative Offices, 125 East High Avenue, New Philadelphia, OH 44663.

Pittsburg County, Oklahoma, and Incorporated Areas
Docket No.: FEMA–B–1034

Tributary AA	Approximately 2,790 feet downstream of 14th Street	+715	City of McAlester.
	Approximately 2,160 feet downstream of 14th Street	+724	
Tributary B	Approximately 470 feet downstream of C Street	+686	City of McAlester, Unincorporated Areas of Pittsburg County.
	Approximately 1,700 feet upstream of Swallow Drive	+728	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
Tributary E	Approximately 1,200 feet upstream of Highway 270	+654	Unincorporated Areas of Pittsburg County.
	Approximately 5,000 feet upstream of Highway 270	+658	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of McAlester

Maps are available for inspection at 28 East Washington Street, McAlester, OK 74502.

Unincorporated Areas of Pittsburg County

Maps are available for inspection at 115 East Carl Albert Parkway, McAlester, OK 74501.

Sanborn County, South Dakota, and Incorporated Areas
Docket No.: FEMA–B–1049

James River	Approximately 2,133 feet downstream of 243rd Street	+1226	Unincorporated Areas of Sanborn County.
	Approximately 1,162 feet upstream of 221st Street	+1237	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Unincorporated Areas of Sanborn County

Maps are available for inspection at 604 West 6th Street, Woonsocket, SD 57385.

Val Verde County, Texas, and Incorporated Areas
Docket No.: FEMA–B–1049

Calveras Creek	At the confluence with San Felipe Creek	+924	Unincorporated Areas of Val Verde County.
	Approximately 0.6 mile upstream of Gilberto Road	+1015	
Cantu Branch	Just upstream of Dodson Avenue	+1035	Unincorporated Areas of Val Verde County.
	Approximately 1,222 feet upstream of Grace Drive	+1046	
San Felipe Creek	Just upstream of Gilchrist Lane	+911	Unincorporated Areas of Val Verde County.
	Just upstream of River Road	+929	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Unincorporated Areas of Val Verde County

Maps are available for inspection at the Del Rio City Hall, 109 West Broadway Street, Del Rio, TX 78840.

Marathon County, Wisconsin, and Incorporated Areas
Docket No.: FEMA–B–1022

Bull Junior Creek	At the mouth of the Wisconsin River	+1147	City of Mosinee.
	Approximately 450 feet downstream of U.S. Route 51	+1149	
Eau Claire River	At the Brooks and Ross Dam	+1168	City of Schofield, City of Wausau.
	Approximately 1.1 mile upstream of the Brooks and Ross Dam.	+1169	
Wisconsin River	Just upstream of the dam in the City of Mosinee	+1147	City of Mosinee, Unincorporated Areas of Marathon County, Village of Kronenwetter, Village of Rothschild.
	Just downstream of the Rothschild Dam	+1159	

* National Geodetic Vertical Datum.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL) Modified	Communities affected

+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Mosinee
Maps are available for inspection at City Hall, 225 Main Street, Mosinee, WI 54455.

City of Schofield
Maps are available for inspection at the Public Works/Building Inspection Department, 200 Park Street, Schofield, WI 54476.

City of Wausau
Maps are available for inspection at the Inspections Department, 407 Grant Street, Wausau, WI 54403.

Unincorporated Areas of Marathon County
Maps are available for inspection at the Marathon County Conservation, Planning, and Zoning Office, 210 River Drive, Wausau, WI 54403.

Village of Kronenwetter
Maps are available for inspection at the Municipal Center, 1582 Kronenwetter Drive, Kronenwetter, WI 54455.

Village of Rothschild
Maps are available for inspection at the Village Hall, 211 Grand Avenue, Rothschild, WI 54470.

Outagamie County, Wisconsin, and Incorporated Areas
Docket No.: FEMA–B–1045

AAL Tributary	At the confluence with Apple Creek	+742	City of Appleton.
	Approximately 410 feet upstream of North Lightning Drive	+746	
Apple Creek	Approximately 0.92 mile upstream of Garrity Road	+646	City of Appleton, Unincorporated Areas of Outagamie County, Village of Little Chute.
	Approximately 0.33 mile upstream of U.S. Route 41	+774	
Apple Creek North	At the confluence with Apple Creek	+729	City of Appleton, Unincorporated Areas of Outagamie County.
	Approximately 90 feet upstream of County Highway E	+780	
Apple Creek North Overland Flow.	At the confluence with Apple Creek	+737	City of Appleton, Unincorporated Areas of Outagamie County.
	At the divergence from Apple Creek North	+744	
Apple Creek Northeast	At the confluence with Apple Creek	+721	City of Appleton, Unincorporated Areas of Outagamie County.
	Approximately 0.35 mile upstream of Lanser Lane	+761	
Apple Creek Overland Flow	At the confluence with Apple Creek	+757	City of Appleton.
	Approximately 0.23 mile above the confluence with Apple Creek.	+767	
County Highway JJ Swale	At the confluence with Apple Creek	+729	Unincorporated Areas of Outagamie County.
	Approximately 920 feet upstream of the confluence with Apple Creek.	+730	
Fox River	Approximately 0.27 mile downstream of the Rapids Croche Dam.	+603	Unincorporated Areas of Outagamie County.
	Approximately 0.87 mile downstream of the Thilmany Dam.	+610	
Fox River	Approximately 0.56 mile upstream of State Highway 441	+703	City of Appleton, Unincorporated Areas of Outagamie County.
	Approximately 200 feet downstream of the Appleton Upper Dam.	+728	
French Road Overland Flow	At the confluence with French Road Swale	+738	City of Appleton.
	Approximately 960 feet above the confluence with French Road Swale.	+743	
French Road Swale	At the confluence with Apple Creek	+733	City of Appleton.
	At the divergence from Apple Creek North	+747	
Garners Creek	At the confluence with the Fox River	+660	City of Appleton, Unincorporated Areas of Outagamie County, Village of Combined Locks, Village of Kimberly, Village of Little Chute.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL) Modified	Communities affected
	Approximately 0.28 mile upstream of Stoney Brook Road	+773	
Garners Creek Tributary 1	At the confluence with Garners Creek	+666	Unincorporated Areas of Outagamie County, Village of Combined Locks.
	Approximately 1.28 mile upstream of Block Road	+747	
Garners Creek Tributary 2	At the confluence with Garners Creek	+698	Unincorporated Areas of Outagamie County.
	Approximately 30 feet upstream of Greenspire Way	+748	
Garners Creek Tributary 3	At the confluence with Garners Creek	+711	Unincorporated Areas of Outagamie County.
	Approximately 401 feet upstream of Fenceline Drive	+757	
Garners Creek Tributary 3.1	At the confluence with Garners Creek Tributary 3	+733	Unincorporated Areas of Outagamie County.
	Approximately 0.20 mile upstream of the confluence with Garners Creek Tributary 3.	+740	
Garners Creek Tributary 4	At the confluence with Garners Creek	+753	City of Appleton, Unincorporated Areas of Outagamie County.
	Approximately 50 feet downstream of State Highway 441	+753	
Glory Lane Swale	At the confluence with Apple Creek	+733	City of Appleton.
	Approximately 120 feet south of Glory Lane	+734	
Mud Creek	Approximately 1.33 miles downstream of West Spencer Street.	+744	Unincorporated Areas of Outagamie County.
	Approximately 170 feet downstream of North Mayflower Drive.	+837	
Mud Creek Tributary 3.2	At the confluence with Mud Creek Tributary 3	+774	Unincorporated Areas of Outagamie County.
	Approximately 0.51 mile upstream of Elsner Road	+805	
Mud Creek Tributary 3.3	At the confluence with Mud Creek Tributary 3	+774	Unincorporated Areas of Outagamie County.
	Approximately 500 feet upstream of State Highway 15	+846	
Mud Creek Tributary 3.3.2	At the confluence with Mud Creek Tributary 3.3	+791	Unincorporated Areas of Outagamie County.
	Approximately 100 feet downstream of County Highway JJ.	+800	
Mud Creek Tributary 3.3.3	Approximately 370 feet downstream of Barley Way	+797	Unincorporated Areas of Outagamie County.
	Approximately 150 feet downstream of County Highway JJ.	+800	
Wolf River	Approximately 1.19 mile downstream of U.S. Route 45	+761	City of New London.
	Approximately 1.13 mile downstream of U.S. Route 45	+761	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Appleton
Maps are available for inspection at 100 North Appleton Street, Appleton, WI 54911.

City of New London
Maps are available for inspection at 405 West Wolf River Avenue, New London, WI 54961.

Unincorporated Areas of Outagamie County
Maps are available for inspection at 410 South Walnut Street, Appleton, WI 54911.

Village of Combined Locks
Maps are available for inspection at 405 Wallace Street, Combined Locks, WI 54113.

Village of Kimberly
Maps are available for inspection at 515 West Kimberly Avenue, Kimberly, WI 54136.

Village of Little Chute
Maps are available for inspection at 108 West Main Street, Little Chute, WI 54140.

(Catalog of Federal Domestic Assistance No. 97.022, "Flood Insurance.")

Dated: April 27, 2010.

Sandra K. Knight,

Deputy Federal Insurance and Mitigation Administrator, Mitigation, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. 2010–10345 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket ID FEMA–2010–0003]

Final Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: Base (1% annual-chance) Flood Elevations (BFEs) and modified BFEs are made final for the communities listed below. The BFEs and modified BFEs are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

DATES: The date of issuance of the Flood Insurance Rate Map (FIRM) showing BFEs and modified BFEs for each community. This date may be obtained by contacting the office where the maps are available for inspection as indicated in the table below.

ADDRESSES: The final BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) makes the final determinations listed below for the modified BFEs for each community listed. These modified elevations have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Deputy Federal Insurance and Mitigation Administrator has resolved any appeals resulting from this notification.

This final rule is issued in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR part 67. FEMA has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR part 60.

Interested lessees and owners of real property are encouraged to review the proof Flood Insurance Study and FIRM available at the address cited below for each community.

The BFEs and modified BFEs are made final in the communities listed below. Elevations at selected locations in each community are shown.

National Environmental Policy Act. This final rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This final rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This final rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

■ Accordingly, 44 CFR part 67 is amended as follows:

PART 67—[AMENDED]

■ 1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.11 [Amended]

■ 2. The tables published under the authority of § 67.11 are amended as follows:

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL) Modified	Communities affected
Hamilton County, Florida, and Incorporated Areas Docket No.: FEMA–B–1018			
Little Alapaha River	At the confluence with Unnamed Tributary	+81	Unincorporated Areas of Hamilton County.
	At the confluence with Little Alapaha River Unnamed Tributary.	+85	
Little Alapaha River Unnamed Tributary.	At the confluence with the Little Alapaha River	+85	Unincorporated Areas of Hamilton County.
	Approximately 950 feet upstream of U.S. Route 129	+125	
Suwannee River Unnamed Tributary.	Just upstream of Jewett Street	+88	Town of White Springs
	Approximately 600 feet upstream of 1st Street	+109	
Timber Lake	Entire shoreline	+135	Unincorporated Areas of Hamilton County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
Turket Creek	Just upstream of the confluence with the Alapahoochee River.	+92	Unincorporated Areas of Hamilton County, Town of Jennings.
	Approximately 1,000 feet upstream of Hamilton Avenue	+138	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Town of Jennings
Maps are available for inspection at the Town Hall, 1199 Hamilton Avenue, Jennings, FL 32053

Town of White Springs
Maps are available for inspection at the Town Hall, 10363 Bridge Street, White Springs, FL 32096

Unincorporated Areas of Hamilton County
Maps are available for inspection at the Hamilton County Clerk's Office, 207 1st Street Northeast, Room 106, Jasper, FL 32052.

Middlesex County, Massachusetts (All Jurisdictions)
Docket Nos.: FEMA–B–7781 and FEMA–B–7798

Aberjona River	At the outlet to Lower Mystic Lake	+7	Town of Arlington, City of Medford, City of Woburn, Town of Reading, Town of Winchester.
	At the divergence of the Aberjona River—North Spur	+83	
Aberjona River—North Spur	At the confluence with the Aberjona River	+64	Town of Reading, City of Woburn, Town of Wilmington.
	Approximately 300 feet upstream of Willow Street	+83	
Alewife Brook (Little River)	At the confluence with the Mystic River	+7	Town of Arlington, City of Somerville.
	Approximately 320 feet downstream of Henderson Street	+7	
Assabet River	Entire reach within the Town of Hudson	+181	Town of Hudson.
Assabet River	At the upstream side of I–495	+213	City of Marlborough.
	Approximately 800 feet upstream of I–495	+214	
Beaver Brook 1	Approximately 4,040 feet upstream of Beaver Street	+54	Town of Belmont.
	Approximately 5,765 feet upstream of Beaver Street	+75	
Beaver Brook 3	Approximately 1,000 feet downstream of Pleasant Street	+71	Town of Dracut.
	At Pleasant Street	+71	
Butter Brook	Approximately 1,600 feet upstream of Main Street	+176	Town of Westford.
	Approximately 2,100 feet downstream of Old Road	+176	
Concord River	Approximately 450 feet upstream of I–495 East	+104	Town of Billerica, Town of Chelmsford, Town of Tewksbury.
	Approximately 2,280 feet upstream of I–495 East	+105	
Cummings Brook	At the confluence with Shakers Glen Brook	+47	City of Woburn.
	Approximately 130 feet upstream of Winn Street	+102	
Fort Meadow Brook	At the confluence with the Assabet River	+181	Town of Hudson.
	Approximately 100 feet downstream of Main Street	+181	
Fort Meadow Reservoir	Entire shoreline within the City of Marlborough	+262	City of Marlborough.
Guggins Brook	Approximately 1,000 feet upstream of the confluence with Inch Brook.	+207	Town of Boxborough.
Hales Brook	Approximately 1,350 feet east of Industrial Avenue East and Lowell Connector intersection (backwater area).	+102	City of Lowell, Town of Chelmsford.
Hales Brook	At the confluence with River Meadow Brook	+102	City of Lowell.
	Approximately 1,500 feet upstream of Industrial Avenue East.	+102	
Hales Brook	Approximately 2,200 feet downstream of I–495	+102	Town of Chelmsford.
	Approximately 200 feet downstream of I–495	+102	
Halls Brook	At the confluence with the Aberjona River	+54	City of Woburn.
	Approximately 220 feet upstream of Merrimac Street	+95	
Horn Pond Brook/ Fowle Brook	At the confluence with the Aberjona River	+23	City of Woburn, Town of Winchester.
	At the confluence with Shakers Glen Brook	+47	
Little Brook	At the confluence with Cummings Brook	+67	City of Woburn.
	Approximately 400 feet upstream of Bedford Road	+95	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
Lubbers Brook	Approximately 1,800 feet downstream of Cook Street	+102	Town of Wilmington.
	Approximately 3,090 feet upstream of Cook Street	+103	
Marginal Brook	Entire reach within the Town of Tewksbury	+126	Town of Tewksbury.
Merrimack River	Approximately 6,000 feet upstream of the county boundary.	+57	Town of Chelmsford, Town of Dracut, Town of Tewksbury, Town of Tyngsborough.
	Approximately 10,730 feet downstream of Tyngsborough Bridge.	+104	
Mill Brook	Approximately 315 feet downstream of the confluence with Tributary to Mill Brook.	+119	Town of Bedford.
	Approximately 315 feet upstream of the confluence with Tributary to Mill Brook.	+119	
Mill Brook 3	Upstream side of Mystic Valley Parkway	+7	Town of Arlington, Town of Lexington.
	Approximately 70 feet upstream of Boston and Maine Railroad.	+168	
Mystic River	Upstream side of Mystic Valley Parkway (State Route 16)	+5	Town of Arlington, City of Medford.
	At the outlet to Lower Mystic Lake	+7	
Nonesuch Pond	Entire reach within the Town of Natick	+174	Town of Natick.
North Lexington Brook	Approximately 400 feet upstream of the confluence with the Shawsheen River.	+116	Town of Lexington.
	At Boston and Maine Railroad	+117	
Pages Brook	Approximately 250 feet northwest of Larsen Lane and Outlook Road intersection (backwater area).	+119	Town of Billerica.
Peppermint Brook	At the confluence with Beaver Brook 3	+71	Town of Dracut.
	Approximately 50 feet downstream of State Route 113	+74	
Richardson Brook	At the confluence with the Merrimack River	+57	Town of Dracut.
	Downstream side of State Route 10 Dam	+58	
Schneider Brook	At the confluence with the Aberjona River	+45	City of Woburn.
	Approximately 880 feet upstream of Forbes Street	+84	
Shakers Glen Brook	At the confluence with Fowle Brook	+47	City of Woburn.
	At Russell Street	+62	
Shawsheen River	At the upstream side of Boston and Maine Railroad	+91	Town of Wilmington.
	Approximately 1.9 mile downstream of Boston Road (State Road 3A).	+97	
Shawsheen River	Approximately 2,125 feet upstream of Bridge Street	+113	Town of Lexington.
	Approximately 300 feet upstream of Summer Street	+116	
Snake Brook	Approximately 2,420 feet downstream of Main Street	+138	Town of Natick.
	Approximately 2,760 feet downstream of Commonwealth Avenue.	+147	
Sweetwater Brook	At the confluence with the Aberjona River	+36	City of Woburn, Town of Stoneham.
	Approximately 120 feet upstream of Lindenwood Road	+63	
Town Line Brook	Approximately 370 feet upstream of Lynn Street	+8	City of Everett.
	Approximately 1,650 feet upstream of Lynn Street	+8	
Town Line Brook	Approximately 1,850 feet downstream of the county boundary.	+8	City of Everett.
Trull Brook	At the confluence with the Merrimack River	+57	Town of Tewksbury.
	Approximately 100 feet upstream of Golf Course Bridge	+57	
Valley Pond	Entire shoreline within the Town of Weston	+175	Town of Weston.
Wellington Brook	Approximately 600 feet upstream of the confluence with Alewife Brook (Little River).	+7	City of Cambridge, Town of Belmont.
	Approximately 1,700 feet upstream of Concord Avenue	+20	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Cambridge

Maps are available for inspection at the Department of Public Works, 147 Hampshire Street, Cambridge, MA 02139.

City of Everett

Maps are available for inspection at City Hall, Office of the City Engineer, 484 Broadway, Room 26, Everett, MA 02149.

City of Lowell

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL) Modified	Communities affected

Maps are available for inspection at City Hall, 375 Merrimack Street, Lowell, MA 01852.

City of Marlborough
Maps are available for inspection at City Hall, Office of Inspectional Services, 140 Main Street, Marlborough, MA 01752.

City of Medford
Maps are available for inspection at City Hall, Engineering Division, 85 George P. Hassett Drive, Room 300, Medford, MA 02155.

City of Somerville
Maps are available for inspection at City Hall, Public Works Department, 93 Highland Avenue, Somerville, MA 02143.

City of Woburn
Maps are available for inspection at City Hall, Engineering Department, 10 Common Street, Woburn, MA 01801.

Town of Arlington
Maps are available for inspection at the Town Hall, 730 Massachusetts Avenue, Arlington, MA 02476.

Town of Bedford
Maps are available for inspection at the Town Hall, 10 Mudge Way, Bedford, MA 01730.

Town of Belmont
Maps are available for inspection at the Community Development Office, 19 Moore Street, Belmont, MA 02478.

Town of Billerica
Maps are available for inspection at the Building Department, 365 Boston Road, Billerica, MA 01821.

Town of Boxborough
Maps are available for inspection at 29 Middle Road, Boxborough, MA 01719.

Town of Chelmsford
Maps are available for inspection at the Public Works Department, 50 Billerica Road, Chelmsford, MA 01824.

Town of Dracut
Maps are available for inspection at the Town Hall, 11 Spring Park Avenue, Dracut, MA 01826.

Town of Hudson
Maps are available for inspection at the Inspections Department, 78 Main Street, Hudson, MA 01749.

Town of Lexington
Maps are available for inspection at the Engineering Department, 1625 Massachusetts Avenue, Lexington, MA 02420.

Town of Natick
Maps are available for inspection at the Town Hall, 13 East Central Street, Natick, MA 01760.

Town of Reading
Maps are available for inspection at the Town Hall, Building Department, 16 Lowell Street, Reading, MA 01867.

Town of Stoneham
Maps are available for inspection at the Department of Public Works, 16 Pine Street, Stoneham, MA 02180.

Town of Tewksbury
Maps are available for inspection at the Town Hall, Building Department, 1009 Main Street, Tewksbury, MA 01876.

Town of Tyngsborough
Maps are available for inspection at the Town Hall, Building Department, 25 Bryants Lane, Tyngsborough, MA 01879.

Town of Westford
Maps are available for inspection at the Town Hall, Building Department, 55 Main Street, Westford, MA 01886.

Town of Weston
Maps are available for inspection at the Town Hall, 11 Town House Road, Weston, MA 02493.

Town of Wilmington
Maps are available for inspection at the Town Hall, 121 Glen Road, Wilmington, MA 01887.

Town of Winchester
Maps are available for inspection at the Town Engineer's Office, 71 Mount Vernon Street, Winchester, MA 01890.

St. Joseph County, Michigan (All Jurisdictions)
Docket No.: FEMA–B–1016

Adams Lake	Entire shoreline	+843	Township of Leonidas.
Clear Lake	Entire shoreline	+876	Township of Fabius.
Corey Lake	Entire shoreline	+877	Township of Fabius.
Fishers Lake	Entire shoreline	+815	Township of Park.
Flowerfield Creek	Approximately 0.8 mile downstream of Marcellus Highway	+817	Township of Flowerfield.
	Approximately 0.3 mile upstream of Main Street on the St. Joseph/.	+842	
	Kalamazoo county border		
Kaiser Lake	Entire shoreline	+877	Township of Fabius.
Lake Templene	Entire shoreline	+831	Township of Sherman.
Long Lake	Entire shoreline	+892	Township of Fabius.
Mud Lake	Entire shoreline	+877	Township of Fabius.
Pleasant Lake	Entire shoreline	+853	Township of Fabius.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
Spring Creek	At the confluence with Flowerfield Creek	+821	Township of Flowerfield, Township of Park.
	Approximately 0.6 mile upstream of Quake Road on the Kalamazoo County. border.	+844	
St. Joseph River	Approximately 0.7 mile downstream of Wakeman Road	+829	Township of Mendon.
	Approximately 350 feet downstream of Wakeman Road	+829	
Unnamed Pond	Entire shoreline	+815	Township of Park.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Township of Fabius
Maps are available for inspection at 13108 Broadway, Three Rivers, MI 49093.

Township of Flowerfield
Maps are available for inspection at 12020 Marcellus Highway, Marcellus, MI 49067.

Township of Leonidas
Maps are available for inspection at 53312 Fulton Road, Leonidas, MI 49066.

Township of Mendon
Maps are available for inspection at 136 West Main Street, Mendon, MI 49072.

Township of Park
Maps are available for inspection at 53640 Parkville Road, Three Rivers, MI 49093.

Township of Sherman
Maps are available for inspection at 64962 Balk Road, Sturgis, MI 49091.

Ramsey County, Minnesota, and Incorporated Areas
Docket No.: FEMA–B–1035

Bald Eagle Lake	Entire shoreline in Ramsey County.	+913	Township of White Bear.
Casey Lake	Entire shoreline	+928	City of Maplewood.
Gervais Lake	Entire shoreline	+863	City of Maplewood.
Josephine Lake	Entire shoreline	+886	City of Roseville.
Lake Owasso	Entire shoreline	+889	City of Roseville.
Little Lake Johanna	Entire shoreline	+879	City of Roseville.
Otter Lake	Entire shoreline in Ramsey County	+913	Township of White Bear.
Silver Lake	Entire shoreline	+991	City of Maplewood, City of North St. Paul.
Twin Lake	Entire shoreline	+872	City of Little Canada, City of Vadnais Heights.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Little Canada
Maps are available for inspection at the Little Canada City Center, 515 Little Canada Road East, Little Canada, MN 55117.

City of Maplewood
Maps are available for inspection at City Hall, 1830 County. Road B East, Maplewood, MN 55109.

City of North St. Paul
Maps are available for inspection at City Hall, 2400 Margaret Street, North St. Paul, MN 55109.

City of Roseville
Maps are available for inspection at City Hall, 2660 Civic Center Drive, Roseville, MN 55113.

City of Vadnais Heights
Maps are available for inspection at City Hall, 800 East County. Road East, Vadnais Heights, MN 55127.

Township of White Bear
Maps are available for inspection at the Township Administration Building, 1281 Hammond Road, White Bear Township, MN 55110.

Lake County, Tennessee, and Incorporated Areas
Docket No.: FEMA–B–1053

Mississippi River	At the Dyer/Lake county boundary (River Mile 845)	+281	Unincorporated Areas of Lake County, Town of Tiptonville.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
	At the Lake County/New Madrid County, Missouri/Fulton County, Kentucky, boundary (River Mile 907.3).	+311	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Town of Tiptonville

Maps are available for inspection at the Town Hall, 130 South Court Street, Tiptonville, TN 38079.

Unincorporated Areas of Lake County

Maps are available for inspection at the County Courthouse, 229 Church Street, Tiptonville, TN 38079.

Sequatchie County, Tennessee, and Incorporated Areas
Docket No.: FEMA–B–1051

Big Brush Creek	At the confluence with the Sequatchie River	+702	Unincorporated Areas of Sequatchie County.
	Just upstream of Union Road	+784	
Little Brush Creek	Approximately 0.4 mile downstream of Old Union Road	+791	Unincorporated Areas of Sequatchie County.
	Approximately 588 feet upstream of Old Union Road	+825	
Sequatchie River	Just downstream of U.S. Highway 127	+690	Unincorporated Areas of Sequatchie County.
	Approximately 651 feet upstream of the confluence with Big Brush Creek.	+702	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

Unincorporated Areas of Sequatchie County

Maps are available for inspection at the County Courthouse, 307 Cherry Street East, Dunlap, TN 37327.

Potter County, Texas, and Incorporated Areas
Docket Nos.: FEMA–B–1014 and FEMA–B–7725

Dry Creek	Approximately 500 feet upstream of Cliffside Road	+3400	City of Amarillo, Unincorporated Areas of Potter County.
	Approximately 500 feet upstream of West 335 North Loop	+3428	
Dry Creek Overflow	Approximately 500 feet downstream from the confluence with Dry Creek.	+3416	City of Amarillo, Unincorporated Areas of Potter County.
	Approximately 120 feet north of West 335 North Loop	+3437	
Playa 21 (T–Anchor Lake)	Approximately 570 feet east of Willow Street and Southeast 15th Avenue.	+3616	City of Amarillo.
Playa Lake 22	Approximately 3,500 feet north of the intersection of Southeast 3rd Avenue and South Whitaker Road.	+3593	City of Amarillo.
Playa Lake 23	Approximately 1,500 feet northwest of the intersection of South Adams Street and Southwest 1st Avenue.	+3619	City of Amarillo.
Playa Lake 24 (Martin Lake)	Approximately 650 feet north of the intersection of Dale Street and Martin Road.	+3631	City of Amarillo.
Playa Lake 26	Approximately 4,600 feet southwest of the intersection of I–40 and Juett Attebury Road.	+3573	City of Amarillo, Unincorporated Areas of Potter County.
Playa Lake 27	Approximately 2,000 feet east of the intersection of Northeast 18th Avenue and Hacienda Drive.	+3548	City of Amarillo.
Playa Lake 28 (Airport Lake)	Approximately 1,350 feet northwest of Amarillo International Airport runway.	+3590	City of Amarillo.
Playa Lake 34	Approximately 4,600 feet southwest of the intersection of Highway 287 and South Parsley Road.	+3553	City of Amarillo, Unincorporated Areas of Potter County.
Playa Lake 6	Approximately 1,000 feet south of the intersection of Pecos Street and I–40.	+3624	City of Amarillo.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL) Modified	Communities affected
Playa Lake 60	Approximately 2,000 feet east of Spur 228	+3558	Unincorporated Areas of Potter County.
Playa Lake 61	Approximately 1,100 feet northeast of the intersection of Parsley Road and railroad.	+3596	City of Amarillo, Unincorporated Areas of Potter County.
Tributary B	At the confluence with Dry Creek	+3468	City of Amarillo.
	Approximately 100 feet from North Western Street	+3530	
Tributary C	At the confluence with Dry Creek	+3468	City of Amarillo.
	Approximately 100 feet upstream of Fairway Drive	+3506	
Tributary D	At the confluence with Tributary B	+3505	City of Amarillo.
	Approximately 500 feet upstream of West Amarillo Boulevard.	+3582	
Tributary D Tributary	Approximately 50 feet downstream of the confluence with Tributary D.	+3532	City of Amarillo.
	Approximately 1,000 feet upstream of Northwest 10th Avenue.	+3579	
West Amarillo Creek	Approximately 1,000 feet west of the intersection of Helium Road and West 9th Avenue.	+3616	Unincorporated Areas of Potter County.
	Approximately 100 feet upstream of the intersection with Indian Hill Road.	+3708	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Amarillo

Maps are available for inspection at 509 Southeast 7th Avenue, Amarillo, TX 79101.

Unincorporated Areas of Potter County

Maps are available for inspection at 500 South Fillmore Street, Amarillo, TX 79101.

Randall County, Texas, and Incorporated Areas
Docket Nos.: FEMA–B–1014 and FEMA–B–7758

Palo Duro Creek	At the confluence with Prairie Dog Town Fork of Red River.	+3484	Unincorporated Areas of Randall County.
	At West Country Club Road	+3562	
Playa Lake 11	Approximately 500 feet south of the intersection of Bell Street and Attebury Drive.	+3646	City of Amarillo, Unincorporated Areas of Randall County.
Playa Lake 13	Approximately 2,500 feet southeast of the intersection of West 335 SouthLoop and Valleyview Drive.	+3626	City of Amarillo, Unincorporated Areas of Randall County.
Playa Lake 14 (Diamond Horseshoe Lake).	Approximately 100 feet south of Winners Circle	+3658	City of Amarillo.
Playa Lake 16	Approximately 350 feet south of the intersection of South Hayden and Southwest 48th Avenue.	+3633	City of Amarillo.
Playa Lake 18	Approximately 1,000 feet south of the intersection of Farmers Avenue and Tradewind Street.	+3583	Unincorporated Areas of Randall County.
Playa Lake 19	Approximately 1,200 feet east of the intersection of Southwest 42nd Avenue and South Harrison Street.	+3638	City of Amarillo.
Playa 20 (Gooch Lake)	Approximately 5,000 feet south of the intersection of Southeast 34th Avenue and South Manhattan Street.	+3579	City of Amarillo.
Playa Lake 3	Approximately 1,000 feet north of Ascension Parkway	+3710	Unincorporated Areas of Randall County.
Playa Lake 34	Approximately 4,600 feet southwest of the intersection of Highway 287 and South Parsley Road.	+3553	Unincorporated Areas of Randall County.
Playa Lake 4	At the intersection of West CR 58 and Helium Road	+3699	City of Amarillo, Unincorporated Areas of Randall County.
Playa Lake 5 (McDonald Lake)	Approximately 1,100 feet southeast of the intersection of South Coulter Street and Southwest 45th Street.	+3687	City of Amarillo.
Playa Lake 7	Approximately 100 feet north of the intersection of West 77th Avenue and Cody Drive.	+3675	City of Amarillo, Unincorporated Areas of Randall County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL) Modified	Communities affected
Playa Lake 8	Approximately 100 feet south of FM 2186 and 335 South Loop.	+3681	City of Amarillo, Unincorporated Areas of Randall County.
Playa Lake 9	Approximately 480 feet north of the intersection of West Sundown Street and Elaine Street.	+3683	Unincorporated Areas of Randall County.
Prairie Dog Town Fork of Red River.	Approximately 100 feet downstream of the intersection of Exmoor Road and Canyon Creek Road.	+3395	Unincorporated Areas of Randall County, Village of Lake Tanglewood, Village of Palisades.
Tierra Blanca Creek	At the confluence with Tierra Blanca Creek	+3484	City of Canyon, Unincorporated Areas of Randall County.
	At the confluence with Palo Duro Creek	+3484	
	Approximately 1,500 feet downstream of Gordon Cummings Road.	+3547	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

ADDRESSES

City of Amarillo
Maps are available for inspection at 509 Southeast 7th Avenue, Amarillo, TX 79101.

City of Canyon
Maps are available for inspection at 301 16th Street, Canyon, TX 79015.

Unincorporated Areas of Randall County
Maps are available for inspection at 301 Highway 60, Canyon, TX 79015.

Village of Lake Tanglewood
Maps are available for inspection at 1000 Tanglewood Drive, Amarillo, TX 79118.

Village of Palisades
Maps are available for inspection at 115 Brentwood Road, Amarillo, TX 79118.

(Catalog of Federal Domestic Assistance No. 97.022, "Flood Insurance.")

Dated: April 27, 2010.

Sandra K. Knight,

Deputy Federal Insurance and Mitigation Administrator, Mitigation, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. 2010–10387 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[Docket No. 0809121213–9221–02]

RIN 0648–AY82

Magnuson-Stevens Act Provisions; Fisheries off West Coast States; Pacific Coast Groundfish Fishery; Biennial Specifications and Management Measures; Inseason Adjustments; Pacific Halibut Fisheries

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule; inseason adjustments to management measures; announcement of elimination of incidental Pacific halibut retention allowance; request for comments.

SUMMARY: This final rule announces two actions: an inseason change to the regulations regarding the retention of Pacific halibut landed incidentally in the limited entry fixed gear primary sablefish fishery north of Pt. Chehalis, Washington (46°53.30′ N. lat.); and an inseason change to the cumulative limit for minor slope rockfish and darkblotched rockfish north of 40°10.00′ N. lat. in the commercial Pacific Coast groundfish limited entry trawl fishery. These actions, which are authorized by the Pacific Coast Groundfish Fishery Management Plan (FMP), are intended to prevent exceeding the 2010 Area 2A Pacific halibut quota and to prevent exceeding the 2010 OY for darkblotched rockfish, an overfished species.

DATES: Effective 0001 hours (local time) May 1, 2010. Comments on this final rule must be received no later than 5 p.m., local time on June 3, 2010.

ADDRESSES: You may submit comments, identified by RIN 0648–AY82 by any one of the following methods:

- *Electronic Submissions:* Submit all electronic public comments via the Federal eRulemaking Portal *http://www.regulations.gov.*

• *Fax:* 206–526–6736, Attn: Gretchen Hanshew.

• *Mail:* Barry A. Thom, Acting Regional Administrator, Northwest Region, NMFS, 7600 Sand Point Way NE., Seattle, WA 98115–0070, Attn: Gretchen Hanshew.

Instructions: No comments will be posted for public viewing until after the comment period has closed. All comments received are a part of the public record and will generally be posted to *http://www.regulations.gov* without change. All Personal Identifying Information (for example, name, address, *etc.*) voluntarily submitted by the commenter may be publicly accessible. Do not submit Confidential Business Information or otherwise sensitive or protected information.

NMFS will accept anonymous comments (enter N/A in the required fields, if you wish to remain anonymous). You may submit attachments to electronic comments in Microsoft Word, Excel, WordPerfect, or Adobe PDF file formats only.

FOR FURTHER INFORMATION CONTACT: Gretchen Hanshew (Northwest Region, NMFS), phone: 206–526–6147, fax: 206–526–6736 and e-mail *gretchen.hanshew@noaa.gov.*

SUPPLEMENTARY INFORMATION:

Electronic Access

This final rule is accessible via the Internet at the Office of the **Federal Register**'s Web site at *http://www.gpoaccess.gov/fr/index.html.* Background information and documents are available at the Pacific Fishery Management Council's Web site at *http://www.pcouncil.org/.*

Background

The Pacific Coast Groundfish FMP and its implementing regulations at title 50 in the Code of Federal Regulations (CFR), part 660, subpart G, regulate fishing for over 90 species of groundfish off the coasts of Washington, Oregon, and California. Groundfish specifications and management measures are developed by the Pacific Fishery Management Council (Council), and are implemented by NMFS. A proposed rule to implement the 2009–2010 groundfish harvest specifications and management measures was published on December 31, 2008, (73 FR 80516). The final rule to implement the 2009–2010 specifications and management measures for the Pacific Coast Groundfish Fishery was published on March 6, 2009 (74 FR 9874). This final rule was subsequently amended by inseason actions on April 27, 2009 (74 FR 19011), July 6, 2009 (74 FR 31874), October 28, 2009 (74 FR 55468), and February 26, 2010 (75 FR 8820). Additional changes to the 2009–2010 specifications and management measures for petrale sole were made in two final rules: On November 4, 2009 (74 FR 57117), and December 10, 2009 (74 FR 65480). These specifications and management measures are at 50 CFR part 660, subpart G.

The reduction to the bimonthly cumulative limit for minor slope rockfish and darkblotched rockfish in the limited entry bottom trawl fishery implemented by this action was recommended by the Council, in consultation with Pacific Coast Treaty Indian Tribes and the States of Washington, Oregon, and California, at its April 9 through April 15, 2010, meeting in Portland, Oregon. The elimination of incidental Pacific halibut (halibut) retention in the limited entry fixed gear primary sablefish fishery north of Point Chehalis, Washington (46°53.30′ N. lat.) is implemented in order to achieve consistency with the 2010 halibut rule and Catch Sharing Plan published on March 18, 2010 (75 FR 13024). These changes must be effective on May 1, 2010.

On April 23, 2010, NMFS received a decision in the case of *Natural Resources Defense Council* v. *Locke,* Case No. C 01–0421 JL (N.D. Cal.) in which the court has ruled against NMFS on an issue relating to darkblotched rockfish. The court has not yet issued the Order on Remedy, and NMFS is in the process of determining the full implications of this decision. NMFS is publishing this rule as scheduled for the reasons described below. Upon further review of the court decision NMFS will determine whether additional measures may be needed with respect to darkblotched rockfish and will implement any such measures in a subsequent rule.

Limited Entry Fixed Gear Sablefish Primary Fishery

The International Pacific Halibut Commission (IPHC) sets the halibut total allowable catch (TAC) on an annual basis. A portion of the TAC is available to fisheries in Area 2A (waters off the U.S. West Coast). The Council's Catch Sharing Plan (CSP) guides allocation of the Area 2A portion of the TAC to the various commercial and recreational fisheries in Area 2A. It provides that if the Area 2A TAC is greater than 900,000 lb, the portion of the Washington sport allocation that is in excess of 214,110 lb is available to the primary directed sablefish fishery north of Point Chehalis. NMFS published the 2010 halibut final rule and CSP on March 18, 2010 (75 FR 13024). The final Area 2A halibut TAC for 2010 was adopted by the IPHC at their January 26 through January 29, 2010 meeting, and is below 900,000-lbs (408–mt). Therefore, based on the CSP, no halibut quota is assigned to the limited entry fixed gear sablefish primary fishery. Since there is no halibut available for this fishery in 2010, no retention of halibut will be allowed in the limited entry fixed gear sablefish primary fishery north of Point Chehalis, Washington.

The Council was notified of this issue at its March 6 through March 11, 2010 meeting. Through this inseason rule, NMFS is eliminating the halibut retention allowance for the limited entry fixed gear sablefish fishery north of Point Chehalis, Washington (46°53.30′ N. lat.) to change the 2010 Pacific halibut possession and landing limits in this area from "100-lb (45-kg) dressed weight, head-on of halibut per fishing trip" to "no retention of halibut."

Limited Entry Trawl Fishery North of 40°10.00′ N. lat.

Catches of darkblotched rockfish in the limited entry trawl fishery north of 40°10.00′ N. lat. are tracking ahead of projections. If no action were taken, and darkblotched rockfish catch rates remain higher than previously expected throughout the year, total coastwide catch of darkblotched rockfish through the end of the year is projected to be 369 mt, exceeding the 2010 coastwide darkblotched rockfish OY of 291 mt by 78 mt. Therefore, to slow catch of darkblotched rockfish and stay below the 2010 darkblotched rockfish OY, the Council at its April 9 through April 15, 2010 meeting considered an inseason adjustment reducing "minor slope rockfish and darkblotched rockfish" cumulative limits in the area north of 40°10.00′ N. lat. beginning on May 1, 2010. The Groundfish Management Team (GMT), an advisory body to the Council, recommended reducing the bimonthly cumulative limit from 6,000 lb (2722 kg) per two months to 2,000 lb (907 kg) per two months. With this change, if the species composition is unchanged under this lower limit, total coastwide catch of darkblotched rockfish through the end of the year is projected to be 285 mt, 6 mt below the 2010 OY.

Based on rationale described above, the Council recommended and NMFS is implementing a decrease in the limited entry trawl fishery cumulative limit for minor slope rockfish and darkblotched rockfish north of 40°10.00′ N. lat. from "6,000 lb (2722 kg) per two months" to "2,000 lb (907 kg) per two months" from May 1 through December 31.

Classification

These actions are taken under the authority of 50 CFR 660.370(c) and are exempt from review under Executive Order 12866.

This inseason adjustment is taken under the authority of: (1) The Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act), and is in accordance with 50 CFR part 660, the regulations implementing the FMP; and (2) the Halibut Act and its implementing regulations. This action is based on the most recent data available. The aggregate data upon which this action is based are available for public inspection at the Office of the Administrator, Northwest Region, NMFS, (*see* **ADDRESSES**) during business hours.

For the following reasons, NMFS finds good cause to waive prior public notice and comment on the revision to groundfish management measures under 5 U.S.C. 553(b) because notice and comment would be impracticable and contrary to the public interest. Also, for the same reasons, NMFS finds good cause to waive the 30-day delay in effectiveness pursuant to 5 U.S.C. 553(d)(3), so that this final rule may become effective by May 1, 2010.

The 2010 Pacific halibut TAC was adopted by the IPHC at its January 2010 meeting and was presented to the Council at its March 5 through March 11, 2010, meeting in Sacramento, California. The change for the limited entry fixed gear sablefish fishery described in this rule is based on the 2010 TAC in conjunction with the 2010 CSP. The fishery data upon which the change in the limited entry bottom trawl fishery was based was provided to the Council at its April 10 through April 15, 2010, meeting in Portland, Oregon, the first Council meeting at which this data was available. These changes must be implemented by May 1, 2010 in order to avoid fisheries exceeding the 2010 halibut TAC and the 2010 darkblotched rockfish OY. There was not sufficient time after the March and April Council meetings to conduct proposed and final rulemaking before these actions need to be in effect. For the actions to be implemented in this final rule, affording the time necessary for prior notice and opportunity for public comment would prevent the Agency from managing fisheries using the best available science to approach, without exceeding, the OYs or TACs for Federally managed species in accordance with the FMP, the CSP, and applicable laws. The adjustments to management measures in this document affect commercial fisheries off Washington, Oregon and northern California.

These adjustments to management measures must be implemented in a timely manner to prevent the Area 2A portion of the 2010 halibut TAC from being exceeded. The elimination of halibut retention in the limited entry fixed gear sablefish primary fishery is intended to prevent exceeding the Area 2A portion of the 2010 Pacific halibut TAC. These changes must be implemented in a timely manner, by May 1, 2010 which is when the incidental halibut retention allowance is currently scheduled to begin.

These adjustments to management measures must be implemented in a timely manner to prevent the 2010 darkblotched rockfish OY from being exceeded. The decrease to the "minor slope rockfish and darkblotched rockfish" trip limit in the limited entry non-whiting bottom trawl fishery is intended to prevent exceeding the 2010 darkblotched rockfish OY, and prevent premature closure of fisheries that impact darkblotched rockfish, an overfished species. These changes must be implemented in a timely manner, by May 1, 2010, which is the start of the cumulative period. Even a short delay in implementation could allow fisheries to take the entire two month limit for this period.

Delaying the implementation of this rule would impair achievement of the Pacific halibut Catch Sharing Plan objective to manage fisheries to remain within the TAC for Area 2A, while also allowing each commercial, recreational (sport), and Tribal fishery to target halibut in the manner that is appropriate to meet both the conservation requirements for species that co-occur with Pacific halibut and the needs of fishery participants in particular fisheries and fishing areas. Such delay would also impair achievement of the Pacific Coast Groundfish FMP objectives of providing for year-round harvest opportunities, extending fishing opportunities as long as practicable during the fishing year, and staying within the OY for darkblotched rockfish.

List of Subjects in 50 CFR Part 660

Fisheries, Fishing, Indian fisheries.

Dated: April 29, 2010.

Emily H. Menashes,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

■ For the reasons set out in the preamble, 50 CFR part 660 is amended as follows:

PART 660—FISHERIES OFF WEST COAST STATES

■ 1. The authority citation for part 660 is amended to read as follows:

Authority: 16 U.S.C. 1801 *et seq.* and 16 U.S.C. 773 *et seq.*

■ 2. In § 660.372, paragraph (b)(3)(iv) is revised to read as follows:

§ 660.372 Fixed gear sablefish fishery management.

* * * * *

(b) * * *

(3) * * *

(iv) *Incidental halibut retention north of Pt. Chehalis, WA (46°53.30′ N. lat.).* No halibut retention is allowed during the primary sablefish fishery in 2010.

* * * * *

■ 3. Table 3 (North) to part 660, subpart G is revised to read as follows:

BILLING CODE 3510–22–P

Table 3 (North) to Part 660, Subpart G -- 2010 Trip Limits for Limited Entry Trawl Gear North of 40°10' N. Lat.

Other Limits and Requirements Apply – Read § 660.301 - § 660.399 before using this table 05012010

		JAN-FEB	MAR-APR	MAY-JUN	JUL-AUG	SEP-OCT	NOV-DEC
	Rockfish Conservation Area (RCA)[6/]:						
1	North of 48°10' N. lat.	shore - modified[7/] 200 fm line[6/]	shore - 200 fm line[6/]	shore - 150 fm line[6/]		shore - 200 fm line[6/]	shore - modified[7/] 200 fm line[6/]
2	48°10' N. lat. - 45°46' N. lat.	75 fm line[6/] - modified[7/] 200 fm line[6/]	75 fm line[6/] - 200 fm line[6/]	75 fm line[6/] - 150 fm line[6/]	100 fm line[6/] - 150 fm line[6/]	75 fm line[6/] - 200 fm line[6/]	75 fm line[6/] - modified[7/] 200 fm line[6/]
3	45°46' N. lat. - 40°10' N. lat.			75 fm line[6/] - 200 fm line[6/]	100 fm line[6/] - 200 fm line[6/]		

Selective flatfish trawl gear is required shoreward of the RCA; all trawl gear (large footrope, selective flatfish trawl, and small footrope trawl gear) is permitted seaward of the RCA. Large footrope and small footrope trawl gears (except for selective flatfish trawl gear) are prohibited shoreward of the RCA. Midwater trawl gear is permitted only for vessels participating in the primary whiting season.

See § 660.370 and § 660.381 for Additional Gear, Trip Limit, and Conservation Area Requirements and Restrictions. See §§ 660.390-660.394 and §§ 660.396-660.399 for Conservation Area Descriptions and Coordinates (including RCAs, YRCA, CCAs, Farallon Islands, Cordell Banks, and EFHCAs).

State trip limits and seasons may be more restrictive than federal trip limits, particularly in waters off Oregon and California.

4	**Minor slope rockfish[2/] & Darkblotched rockfish**	6,000 lb/ 2 months		2,000 lb/ 2 months			
5	**Pacific ocean perch**	1,500 lb/ 2 months					
6	**DTS complex**						
7	Sablefish						
8	large & small footrope gear	20,000 lb/ 2 months		24,000 lb/ 2 months			20,000 lb/ 2 months
9	selective flatfish trawl gear	9,000 lb/ 2 months					
10	multiple bottom trawl gear[8/]	9,000 lb/ 2 months					
11	Longspine thornyhead						
12	large & small footrope gear	24,000 lb/ 2 months					
13	selective flatfish trawl gear	5,000 lb/ 2 months					
14	multiple bottom trawl gear[8/]	5,000 lb/ 2 months					
15	Shortspine thornyhead						
16	large & small footrope gear	18,000 lb/2 months					
17	selective flatfish trawl gear	5,000 lb/ 2 months					
18	multiple bottom trawl gear[8/]	5,000 lb/ 2 months					
19	Dover sole						
20	large & small footrope gear	110,000 lb/ 2 months					
21	selective flatfish trawl gear	65,000 lb/ 2 months					
22	multiple bottom trawl gear[8/]	65,000 lb/ 2 months					

TABLE 3 (North)

Table 3 (North). Continued

		JAN-FEB	MAR-APR	MAY-JUN	JUL-AUG	SEP-OCT	NOV-DEC
23	**Whiting**						
24	midwater trawl	Before the primary whiting season: CLOSED. -- During the primary season: mid-water trawl permitted in the RCA. See §660.373 for season and trip limit details. -- After the primary whiting season: CLOSED.					
25	large & small footrope gear	Before the primary whiting season: 20,000 lb/trip. -- During the primary season: 10,000 lb/trip. -- After the primary whiting season: 10,000 lb/trip.					
26	**Flatfish** (except Dover sole)						
27	Arrowtooth flounder						
28	large & small footrope gear	150,000 lb/ 2 months					
29	selective flatfish trawl gear	90,000 lb/ 2 months					
30	multiple bottom trawl gear [8/]	90,000 lb/ 2 months					
31	Other flatfish [3/], English sole, starry flounder, & Petrale sole						
32	large & small footrope gear for Other flatfish [3/], English sole, & starry flounder	110,000 lb/ 2 months	110,000 lb/ 2 months, no more than 9,500 lb/ 2 months of which may be petrale sole.				110,000 lb/ 2 months
33	large & small footrope gear for Petrale sole	9,500 lb/ 2 months					9,500 lb/ 2 months
34	selective flatfish trawl gear for Other flatfish [3/], English sole, & starry flounder	90,000 lb/ 2 months, no more than 9,500 lb/ 2 months of which may be petrale sole.	60,000 lb/ 2 months, no more than 9,500 lb/ 2 months of which may be petrale sole.				
35	selective flatfish trawl gear for Petrale sole						
36	multiple bottom trawl gear [8/]	90,000 lb/ 2 months, no more than 9,500 lb/ 2 months of which may be petrale sole.	60,000 lb/ 2 months, no more than 9,500 lb/ 2 months of which may be petrale sole.				
37	**Minor shelf rockfish [1/], Shortbelly, Widow & Yelloweye rockfish**						
38	midwater trawl for Widow rockfish	Before the primary whiting season: CLOSED. -- During primary whiting season: In trips of at least 10,000 lb of whiting, combined widow and yellowtail limit of 500 lb/ trip, cumulative widow limit of 1,500 lb/ month. Mid-water trawl permitted in the RCA. See §660.373 for primary whiting season and trip limit details. -- After the primary whiting season: CLOSED.					
39	large & small footrope gear	300 lb/ 2 months					
40	selective flatfish trawl gear	300 lb/ month		1,000 lb/ month, no more than 200 lb/ month of which may be yelloweye rockfish			300 lb/ month
41	multiple bottom trawl gear [8/]	300 lb/ month		300 lb/ 2 months, no more than 200 lb/ month of which may be yelloweye rockfish			300 lb/ month

TABLE 3 (North) con't

Table 3 (North). Continued

		JAN-FEB	MAR-APR	MAY-JUN	JUL-AUG	SEP-OCT	NOV-DEC
42	**Canary rockfish**						
43	large & small footrope gear	CLOSED					
44	selective flatfish trawl gear	100 lb/ month		300 lb/ month		100 lb/ month	
45	multiple bottom trawl gear 8/	CLOSED					
46	**Yellowtail**						
47	midwater trawl	Before the primary whiting season: CLOSED. -- During primary whiting season: In trips of at least 10,000 lb of whiting: combined widow and yellowtail limit of 500 lb/ trip, cumulative yellowtail limit of 2,000 lb/ month. Mid-water trawl permitted in the RCA. See §660.373 for primary whiting season and trip limit details. -- After the primary whiting season: CLOSED.					
48	large & small footrope gear	300 lb/ 2 months					
49	selective flatfish trawl gear	2,000 lb/ 2 months					
50	multiple bottom trawl gear 8/	300 lb/ 2 months					
51	**Minor nearshore rockfish & Black rockfish**						
52	large & small footrope gear	CLOSED					
53	selective flatfish trawl gear	300 lb/ month					
54	multiple bottom trawl gear 8/	CLOSED					
55	**Lingcod** 4/						
56	large & small footrope gear	1,200 lb/ 2 months		4,000 lb/ 2 months			
57	selective flatfish trawl gear			1,200 lb/2 months			
58	multiple bottom trawl gear 8/						
59	**Pacific cod**	30,000 lb/ 2 months		70,000 lb/ 2 months			30,000 lb/ 2 months
60	**Spiny dogfish**	200,000 lb/ 2 months		150,000 lb/ 2 months	100,000 lb/ 2 months		
61	**Other Fish** 5/	Not limited					

TABLE 3 (North) con't

1/ Bocaccio, chilipepper and cowcod are included in the trip limits for minor shelf rockfish.
2/ Splitnose rockfish is included in the trip limits for minor slope rockfish.
3/ "Other flatfish" are defined at § 660.302 and include butter sole, curlfin sole, flathead sole, Pacific sanddab, rex sole, rock sole, and sand sole.
4/ The minimum size limit for lingcod is 22 inches (56 cm) total length North of 42° N. lat. and 24 inches (61 cm) total length South of 42° N. lat.
5/ "Other fish" are defined at § 660.302 and include sharks, skates (including longnose skate), ratfish, morids, grenadiers, and kelp greenling. Cabezon is included in the trip limits for "other fish."
6/ The Rockfish Conservation Area is an area closed to fishing by particular gear types, bounded by lines specifically defined by latitude and longitude coordinates set out at §§ 660.391-660.394. This RCA is not defined by depth contours, and the boundary lines that define the RCA may close areas that are deeper or shallower than the depth contour. Vessels that are subject to the RCA restrictions may not fish in the RCA, or operate in the RCA for any purpose other than transiting.
7/ The "modified" fathom lines are modified to exclude certain petrale sole areas from the RCA.
8/ If a vessel has both selective flatfish gear and large or small footrope gear on board during a cumulative limit period (either simultaneously or successively), the most restrictive cumulative limit for any gear on board during the cumulative limit period applies for the entire cumulative limit period.

To convert pounds to kilograms, divide by 2.20462, the number of pounds in one kilogram.

[FR Doc. 2010–10400 Filed 4–29–10; 4:15 pm]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[Docket No. 100421192–0193–01]

RIN 0648–AY78 and 0648–AY59

Magnuson-Stevens Act Provisions; Fisheries Off West Coast States; Pacific Coast Groundfish Fishery; Biennial Specifications and Management Measures

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule; inseason adjustments to groundfish management measures; Pacific whiting harvest specifications and tribal allocation; request for comments.

SUMMARY: This final rule establishes the 2010 fishery specifications for Pacific whiting in the U.S. exclusive economic zone (EEZ) and state waters off the coasts of Washington, Oregon, and California, as authorized by the Pacific Coast Groundfish Fishery Management Plan (FMP). These specifications include the level of the acceptable biological catch (ABC), optimum yield (OY), and allocations for the non-tribal commercial sectors. This final rule also announces the tribal allocation of Pacific whiting for the 2010 season and inseason adjustments of bycatch limits for the 2010 Pacific whiting fishery.

DATES: Effective April 29, 2010. Comments on the revisions to bycatch limits must be received no later than 5 p.m., local time on May 19, 2010.

ADDRESSES: You may submit comments, identified by RIN 0648–AY78 by any of the following methods:

- *Electronic Submissions:* Submit all electronic public comments via the Federal eRulemaking Portal *http://www.regulations.gov.*
- *Fax:* 206–526–6736, Attn: Kevin C. Duffy.
- *Mail:* Barry A. Thom, Acting Regional Administrator, Northwest Region, NMFS, Attn: Kevin C. Duffy, 7600 Sand Point Way NE., Seattle, WA 98115–0070.

Instructions: No comments will be posted for public viewing until after the comment period has closed. All comments received are a part of the public record and will generally be posted to *http://www.regulations.gov* without change. All Personal Identifying Information (for example, name, address, etc.) voluntarily submitted by the commenter may be publicly accessible. Do not submit Confidential Business Information or otherwise sensitive or protected information.

NMFS will accept anonymous comments (enter N/A in the required fields if you wish to remain anonymous). You may submit attachments to electronic comments in Microsoft Word, Excel, WordPerfect, or Adobe PDF file formats only.

FOR FURTHER INFORMATION CONTACT: Kevin C. Duffy (Northwest Region, NMFS), phone: 206–526–4743, fax: 206–

526–6736 and e-mail: *kevin.duffy@noaa.gov.*

SUPPLEMENTARY INFORMATION:

Electronic Access

This final rule is accessible via the Internet at the Office of the Federal Register's Web site at *http://www.gpoaccess.gov/fr/index.html.* Background information and documents are available at the Pacific Fishery Management Council's Web site at *http://www.pcouncil.org/.* Background information and documents are also available at the NMFS Northwest Region Web site at *http://www.nwr.noaa.gov/Groundfish-Halibut/Groundfish-Fishery-Management/index.cfm.*

Copies of the final environmental impact statement (FEIS) for the 2009–2010 Groundfish Specifications and Management Measures are available from Donald McIsaac, Executive Director, Pacific Fishery Management Council (Council), 7700 NE Ambassador Place, Portland, OR 97220, phone: 503–820–2280.

Copies of additional reports referred to in this document may also be obtained from the Council. Copies of the Record of Decision (ROD), final regulatory flexibility analysis (FRFA), and the Small Entity Compliance Guide are available from Barry A. Thom, Acting Administrator, Northwest Region (Regional Administrator), NMFS, 7600 Sand Point Way, NE., Seattle, WA 98115–0070.

Background

On December 31, 2008, NMFS published a proposed rule to implement the 2009–2010 specifications and management measures for the Pacific Coast groundfish fishery (73 FR 80516). A final rule was published on March 6, 2009 (74 FR 9874), which codified the specifications and management measures in the CFR (50 CFR part 660, subpart G), except for the Pacific whiting harvest specifications. This final rule establishes the 2010 harvest specifications for Pacific whiting. The proposed rule announced a range of Pacific whiting harvest specifications that were being considered for 2009 and 2010, and also announced the intent to adopt final specifications after the Council's March 2009 and 2010 meetings. As explained below, the information necessary for the annual updated stock assessment is not available until January or February, which necessarily delays the preparation of the stock assessment until February.

Delaying the adoption of Pacific whiting specifications until March is also consistent with the U.S.-Canada agreement for Pacific whiting. The U.S.-Canada agreement for Pacific whiting was signed in November 2003. This agreement addresses the conservation, research, and catch sharing of Pacific whiting. Presently, both countries are taking steps to fully implement the agreement. Until this occurs, the negotiators recommended that each country apply the agreed-upon provisions to their respective fisheries. In addition to the time frame in which stock assessments are to be considered and harvest specifications established, the U.S.-Canada agreement specifies how the catch is to be shared between the two countries. The Pacific whiting catch sharing arrangement provides 73.88 percent of the total catch Optimum Yield (OY) [a] to the U.S. fisheries, and 26.12 percent to the Canadian fisheries. This action accounts for this division of catch share allocation between the U.S. and Canada.

On April 23, 2010, NMFS received a decision in the case of *Natural Resources Defense Council* v. *Locke,* Case No. C 01–0421 JL (N.D. Cal.), in which the court has ruled against NMFS on an issue related to darkblotched rockfish. The court has not yet issued the Order on Remedy, and NMFS is in the process of determining the full implications of this decision. NMFS is publishing this rule as scheduled so that it will be in place for the start of the Pacific whiting season. Upon further review of the court decision, NMFS will determine whether additional measures may be needed with respect to darkblotched rockfish, and will implement any such measures through an emergency rule.

Comments and Responses

In addition to the December 2008 proposed rule, on March 12, 2010 NMFS issued a proposed rule for the allocation and management of the 2010 tribal Pacific whiting fishery (75 FR 11829). The comment period on this proposed rule closed on April 2, 2010. During the comment period, NMFS received four letters of comment. The Makah Tribe and the Quileute Tribe each submitted letters of comment concerning the tribal allocation for Pacific whiting. The Pacific Whiting Conservation Cooperative and the West Coast Seafood Processors Association also submitted letters of comment. As discussed further below, this final rule takes the tribal allocation figures into account in its final allocation of Pacific whiting.

Makah Tribe

Comment 1: The Makah Tribe requested that NMFS establish interim individual tribal set-asides for Makah and Quileute in 2010, as it did in 2009. They requested a 2010 Makah Pacific whiting set aside of 17.5 percent of the 2010 Pacific whiting U.S. OY, the amount reflected in the proposed rule. They commented on the Quileute's request for a 16,000 mt set aside in 2010, stating the Quileute have provided no indication that they have two boats that will participate. Further, they pointed out that when Makah entered the fishery in 1996, the tribal allocation was 5,000 mt per boat, and in the following two years, the allocation increased to 6,000 mt per boat. They said that during this time period, there were fewer serious bycatch constraints on the fishery than there are today. They also pointed out that the set aside for Makah in 2009 averaged less than 5,000 mt per boat.

The Makah also expressed support for NMFS's position regarding reapportionment of the tribal Pacific whiting allocation stated in the proposed rule. They stated their belief that the Quileute's usual and accustomed grounds are much less extensive than those currently designated by NMFS, and the Makah noted that they have initiated a sub-proceeding in *United States* v. *Washington* to determine the actual boundaries of those areas. Finally, the Makah clarified that there are five boats, rather than four, in their Pacific whiting fishery.

Response: NMFS supports the Makah request for 17.5 percent of the 2010 Pacific whiting U.S. OY, as stated in the proposed rule, and is using that amount in its calculation of the overall tribal allocation for 2010. However, NMFS supports this request as a component of the total tribal allocation for 2010 as opposed to an individual tribal set aside. On March 6, 2009, NMFS adopted a Pacific whiting tribal allocation of 50,000 mt for the 2009 fishing season (74 FR 9874). This allocation was codified at 50 CFR 660.385. In the rule, individual set asides for the Makah Tribe (42,000 mt) and Quileute Tribe (8,000 mt) were established for 2009. In a May, 2009 rule (74 FR 20620), NMFS reapportioned 18,211 mt of the tribal allocation to the non-tribal sector. This action was based on the low OY of

[a] OY is the amount of fish that will provide the greatest overall benefit to the Nation, taking into account the protection of marine ecosystems. It is defined on the basis of maximum sustained yield from the fishery, as reduced by any relevant economic, social, or ecological factors. For overfished species, OY provides for rebuilding to a level consistent with producing maximum sustained yield.

Pacific whiting for 2009, the Makah Tribe's intent to harvest only 23,789 mt of their 42,000 mt set aside, and their request that the 18,211 mt be reapportioned to the non-tribal sectors of the fishery.

Based on the separate requests by the Makah and Quileute Tribes, NMFS set the individual tribal set asides for 2009 at 42,000 mt and 8,000 mt, respectively. At the June 2008 Council meeting, where the specific motion to create tribal set asides was discussed, NMFS met with the Makah Tribe, the Quileute Tribe, and the State of Washington. For 2010, NMFS has decided to issue an overall tribal allocation, without individual set asides, primarily for two reasons. First, although the Makah Tribe made a request for a specific allocation, the Quileute Tribe did not. Second, NMFS has received comments from the Quileute Tribe (addressed below), disputing that they agreed to a set aside for the 2009 season, and specifically requesting that no such set aside be created this year.

NMFS acknowledges the Makah Tribes' comments on the Quileute Tribal request of 8,000 mt per boat for economic viability, but does not agree that this requested amount for 2010 is unreasonable. Further, as the Makah Tribe notes, the resulting tribal allocation appears to be within the total treaty right, based on the existing scientific information. NMFS is aware of the current litigation over the boundaries of the Quileute and Quinault usual and accustomed fishing grounds, and will make adjustments to the boundaries as described in its regulations if any are needed to achieve consistency with any court orders that result from that litigation. NMFS acknowledges the Makah's clarification on the number of boats in their Pacific whiting fishery.

Quileute Tribe

Comment 2: The Quileute Tribe stated that they never requested or agreed to specific set asides for their proposed Pacific whiting fishery in 2009, and feel NMFS lacks the authority to establish intertribal allocations. They did not object to the total amount of the tribal Pacific whiting allocation that would be derived under the formula stated in the proposed rule (17.5 percent of U.S. OY + 16,000 mt), but requested that the final rule simply provide for a total tribal allocation, as opposed to individual set asides. Regarding reapportionment, the Quileute Tribe feels a mechanism does not exist for reapportionment between these separately managed tribal and non-tribal fisheries, and stated their desire to develop a process where reapportionment may be desirable, consistent with consultation required by Executive Order 13175 and with unanimous tribal consensus. The Quileute Tribe also indicated that they will likely have no more than one vessel participating in the fishery in 2010, and reiterated their belief that at least 8,000 mt per boat is necessary for economic feasibility. Finally, they stated that the total tribal Pacific whiting allocation should not be changed based on this information, because it is within the range of tribal treaty rights to Pacific whiting.

Response: NMFS notes that the Pacific whiting set asides established for the Makah and Quileute Tribes in 2009 were based on individual tribal requests, and did not set any precedent regarding future allocations of Pacific whiting to the tribes. The final rule for 2010 establishes a total tribal allocation, as opposed to individual tribal set asides. NMFS does not agree that no mechanism exists to reapportion unused Pacific whiting from the tribal to the non-tribal fishery. NMFS currently has the authority to reapportion Pacific whiting from the tribal to the non-tribal fishery under 50 CFR 660.323(c). NMFS will coordinate and consult with the affected tribes, and will attempt to reach consensus before any reapportionment decisions are made in 2010. However, absent consensus, the NMFS Regional Administrator will make reapportionment decisions. NMFS acknowledges the Quileute Tribe's comments that they will probably have no more than one vessel participating in the fishery in 2010, and that they believe the total tribal allocation should not be changed, given this information.

Pacific Whiting Conservation Cooperative

Comment 3: The Pacific Whiting Conservation Cooperative (PWCC) strongly supports NMFS' authority to reapportion unharvested whiting from the tribal fishery to the non-tribal fishery, consistent with 50 CFR 660.323(c), stating that current regulations and past practice provide the necessary authority. PWCC stated their support for the Makah tribal request of 17.5 percent of the U.S. OY. Finally, PWCC expressed concern that NMFS is not requiring greater certainty from the Quileute Tribe regarding their fishing operation's capacity to harvest 16,000 mt of Pacific whiting in 2010, and that NMFS is not requesting greater clarity from the Quileute Tribe about its plans to manage bycatch of overfished rockfish and salmonids in a manner consistent with the Pacific Fishery Management Council's groundfish conservation goals and objectives.

Response 3: NMFS acknowledges and agrees with the PWCC comments supporting our authority to reapportion Pacific whiting. NMFS concurs with PWCC's support of the Makah request for 17.5 percent of the Pacific whiting U.S. OY in 2010, but acknowledges that this is only a portion of the total tribal allocation, and not an individual tribal set aside. NMFS is working with all tribes participating in the Pacific whiting fishery, encouraging them to share information about their fisheries plans and harvests before and during the fishing season. NMFS will make this reasonable request a priority for tribal participation in Pacific whiting fisheries in 2011 and beyond.

West Coast Seafood Processors Association

Comment 4: The West Coast Seafood Processors Association (WCSPA) did not object to the Makah Tribes' request for 17.5 percent of the U.S. OY to the extent that it falls within the range of tribal treaty rights. They also stated their belief that the allocation of 16,000 mt to the Quileute Tribe in the first year of their fishery is excessive. They state that 2 inexperienced vessels harvesting that amount of fish in the relatively short time that market-grade Pacific whiting are available in the Quileute Tribe's usual and accustomed fishing area, without exceeding bycatch limits, is exceedingly far-fetched, and that a lesser amount should be allocated. They also stated their support for NMFS' assertion of its authority to reapportion potentially unharvested whiting among all sectors, tribal and non-tribal, in accordance with regulations governing the Pacific groundfish fishery. They stated that they expect NMFS to exercise this authority "with due diligence" in 2010, and in consultation with all sectors of the fishery.

Response 4: NMFS agrees with WCSPA's lack of objection to the Makah Tribes' request for 17.5 percent of the Pacific whiting U.S. OY in 2010, and reflects that support in this final rule. NMFS acknowledges the WCSPA perspective that 16,000 mt to the Quileute Tribe in their first year of operation is excessive. NMFS has considered these comments, as well as others, in making a final determination of the tribal allocation for 2010. NMFS will take under advisement the WCSPA comment that NMFS assert its authority to reapportion potentially unharvested whiting among all sectors, tribal and non-tribal, in accordance with regulations governing the Pacific groundfish fishery. NMFS believes it

currently has the regulatory authority to reapportion Pacific whiting, through 50 CFR 660.323(c). NMFS will consult with all sectors of the fishery in determining whether and when to reapportion, consistent with WCSPA comment.

Pacific Whiting Stock Status

The joint U.S.-Canada Stock Assessment Review (STAR) panel met February 8–10, 2010 in Seattle, Washington, to review two draft stock assessment documents: one had been prepared by Stewart & Hamel (Stock Synthesis III model, 2010) and the second had been prepared by Martell (TINSS, 2010). The Stock Synthesis III model is an age-structured stock assessment model. Age-structured assessment models of various forms have been used to assess Pacific whiting since the early 1980s. The Stock Synthesis III model uses data on total fishery landings, fishery length and age compositions and survey abundance indices. The TINSS model provides an age-structured assessment that directly estimates management variables C^* (the maximum sustained yield) and F^* (the fishing mortality rate that produces C^*).

During its deliberations, the 2010 STAR panel identified major issues with both assessments, namely whether: (a) The age and length data from the acoustic survey are an accurate representation of Pacific whiting; (b) the commercial length and conditional catch-at-age data are inconsistent with the assumptions of the models; and (c) the 1986 acoustic survey estimate is biased because the pre- and post-survey calibrations are substantially different. These issues had been raised by past STAR panels, and have also been reflected in past research recommendations. Additionally, the 2010 Pacific whiting STAR panel expressed concern about the reliability of the acoustic signal because of the presence of Humboldt squid, which has an acoustic signal similar to Pacific whiting.

The STAR Panel responded to these concerns by identifying a simpler model that did not use data it considered questionable. This led to two new model formulations. The panel considered both of these as equally acceptable, but adopted the modified TINSS model as its base model because it had the capacity to provide immediate results that quantified uncertainty.

At the March 2010 Council meeting, the Council's Scientific and Statistical Committee (SSC) reviewed and discussed both the revised TINSS and the original Stock Synthesis III models in detail. The SSC was unable to reach consensus regarding which model formulation reflected the best available science for Pacific whiting in 2010, and put forth both models as the best available science, without assigning weights to either.

In general, Pacific whiting is a very productive species with highly variable recruitment and a relatively short life span when compared to most other groundfish species. The base model indicates that the Pacific whiting female spawning biomass declined rapidly after a peak in 1984. The decline continued until 2000, and was followed by a brief increase to a peak in 2003 as the large 1999 year class matured (fish spawned during a particular year are referred to as a year class).

Acceptable Biological Catch (ABC)/OY Recommendations

From these stock assessments, the U.S. OYs analyzed in the FEIS for 2009 and 2010 specifications and management measures varied between a low OY of 134,773 mt and a high OY of 404,318 mt (a U.S.-Canada OY range of 182,421 mt—547,263 mt). This range represents 50 to 150 percent of the 2008 U.S. OY of 269,545. These broad ranges in Pacific whiting harvest levels were analyzed in order to assess the potential range of the effects of the harvest of Pacific whiting on incidentally-caught overfished species, and the economic effects to coastal communities.

The final Acceptable Biological Catch (ABC) [b] and OY values recommended by the Council for 2010 are based on the new stock assessments, and are consistent with the U.S.-Canada agreement and the impacts considered in the FEIS for the 2009 and 2010 management measures. For this rule, ABC is used as defined in the current Pacific Coast Groundfish FMP.[c]

Based on the SSC advice that both models be put forward as the best available science, and additional input from Council advisory bodies and public comment, the Council adopted both the Pacific whiting stock assessments to decide harvest specifications for 2010 Pacific whiting fisheries.

Ultimately, for the 2010 Pacific whiting fisheries, the Council adopted a coastwide (U.S. plus Canada) ABC of 455,550 mt, which is the average of the ABCs estimated in each of the two stock assessments adopted by the Council. The U.S. share of the ABC is 336,560 mt (or 73.88 percent of the coastwide ABC). Due to the considerable uncertainty in the scientific advice, the Council used a more precautionary approach in choosing the OY and did not choose the average of the two model OYs. The OY values from the two models ranged from 186,000 mt (SS model) to 550,000 mt (TINSS model), and the average OY between the two models is 368,000 mt. Instead of choosing the average, the Council started with an OY value of 339,000 mt from the modified TINSS model. The TINSS model estimated the harvest rate that produces maximum sustained yield of F53%, which is more conservative than the proxy F_{MSY} harvest rate of F40%. The OY estimated in that assessment, using the F53% harvest rate, is 339,000 mt, and projects the stock depletion level to be 31 percent in 2011, which will maintain the stock well above the overfished threshold. Next, the Council selected the OY value of 186,000 mt from the Stock Synthesis III model under an F40% harvest rate, which is projected to result in a depletion of 25 percent in 2011. The Council then averaged these two OY values, and adopted a coastwide OY of 262,500 mt for 2010, which is considerably closer to the OY value of the more conservative Stock Synthesis III model. Under the terms of the U.S.-Canada agreement on Pacific whiting, the U.S. allocation of the coastwide OY is 73.88 percent, which equates to a U.S. OY of 193,935 mt.

Allocations

Since 1996, NMFS has been allocating a portion of the U.S. OY of Pacific whiting to the tribal fishery, following the process established in 50 CFR 660.324(d). The tribal allocation is subtracted from the total U.S. Pacific whiting OY before it is allocated to the non-tribal sectors. The tribal Pacific whiting fishery is a separate fishery, and is not governed by the limited entry or open access regulations or allocations. To date, only the Makah Tribe has prosecuted a tribal fishery for Pacific whiting.

For 2010, both the Makah and Quileute have stated their intent to participate in the Pacific whiting fishery. The Quinault Nation has indicated that they plan to participate in the 2011 fishery, but not the 2010 fishery.

The final rule for the tribal allocation in 2010 is not intended to establish any precedent for future Pacific whiting seasons, or for the long-term tribal allocation of whiting. Based on the formula for the tribal allocation used in

[b] Defined in the FMP as the Maximum Sustainable Yield, or the largest average catch that can be taken continuously from a stock under average environmental conditions while maintaining current stock abundance.

[c] The term ABC is not used here in the same sense as it is in the Magnuson-Stevens Act's National Standard 1 Guidelines, which will be implemented in the groundfish harvest specifications and management measures for 2011–12.

the proposed rule, and taking into account public comments received on the proposed rule, the tribal allocation of Pacific whiting in 2010 is [17.5 percent * (U.S. OY)] + 16,000 mt. With a U.S. OY of 193,935 mt, the tribal allocation for the 2010 tribal Pacific whiting fishery is 49,939 mt.

The 2010 commercial (non-tribal) OY for Pacific whiting is 140,996 mt. This amount was determined by deducting from the total U.S. OY of 193,935 mt, the 49,939 mt tribal allocation, along with 3,000 mt for research catch and bycatch in non-groundfish fisheries. Regulations at 50 CFR 660.323(a)(2) allocate the commercial OY among the non-tribal catcher/processor, mothership, and shore-based sectors of the Pacific whiting fishery.

The catcher/processor sector is comprised of vessels that harvest and process Pacific whiting. The mothership sector is comprised of motherships and catcher vessels that harvest Pacific whiting for delivery to motherships. Motherships are vessels that process, but do not harvest, Pacific whiting. The shoreside sector is comprised of vessels that harvest Pacific whiting for delivery to shoreside processors. Each sector receives a portion of the commercial OY, with the catcher/processors getting 34 percent (or 47,939 mt for 2010), motherships getting 24 percent (or 33,839 mt for 2010), and the shore-based sector getting 42 percent (or 59,218 mt for 2010). The fishery south of 42°N. lat. may not take more than 2,961 mt (5 percent of the shore-based allocation) prior to the start of the primary Pacific whiting season North of 42°N. lat.

Bycatch Limit Adjustments

Bycatch limits have been used to restrict the catch of overfished species, particularly canary, darkblotched and widow rockfish, in the non-tribal Pacific whiting fisheries. With bycatch limits, the industry has the opportunity to harvest a larger Pacific whiting OY, provided the incidental catch of these overfished species does not exceed the adopted bycatch limits.

Since 2005, a single bycatch limit for darkblotched, canary and widow rockfish species has been used for all commercial sectors of the fishery. However, beginning in 2009, concern that bycatch in one sector would result in the closure of a different sector of the fishery led to the implementation of sector-specific bycatch limits, rather than a single bycatch limit, for all commercial sectors (74 FR 9874, March 6, 2009). This practice is continued in 2010.

If a sector-specific bycatch limit is reached, or is projected to be reached, the Pacific whiting fishery for that sector will be closed, regardless of whether the Pacific whiting allocation has been achieved. When a sector is closed because a bycatch limit has been reached or was projected to be reached, unused amounts of the other bycatch limit species will be rolled-over to the remaining sectors of the non-tribal Pacific whiting fishery. If a sector reaches its Pacific whiting allocation, unused amounts of bycatch limit species will be shifted to those sectors of the non-tribal Pacific whiting fishery that remain open. Sector-specific bycatch limits are apportioned in the same percentages used to calculate the original sector Pacific whiting allocations.

During the development of the 2009–2010 specifications and management measures, the non-tribal Pacific whiting fishery bycatch limits were preliminarily set at 18 mt for canary rockfish, 25 mt for darkblotched rockfish, and 450 mt for widow rockfish (74 FR 9874, March 6, 2009). The final 2009 widow rockfish bycatch limit for the non-tribal Pacific whiting fishery was reduced to 250 mt, due to higher projected catch of widow rockfish in the non-Pacific whiting fisheries and the need to keep the total projected widow rockfish catch below the 2009 OY of 522 mt. The best available data at the March 2010 Council meeting indicated that there is an increasing trend in the bycatch rate for widow rockfish in the non-tribal Pacific whiting fishery and, given the higher 2010 Pacific whiting OY, the Council recommended increasing the widow rockfish bycatch limit for 2010. The 279 mt widow rockfish bycatch limit for 2010 is based on a linear interpolation of the bycatch rates for widow rockfish from 2006–2009. From the overall bycatch limit of 279 mt, the following sector-specific bycatch limits are established for widow rockfish: The catcher/processors bycatch limit is increased from 85.0 mt to 95.0 mt; the mothership bycatch limit is increased from 60.0 mt to 67.0 mt; and the shorebased bycatch limit is increased from 105.0 mt to 117.0 mt.

The 2009 canary rockfish bycatch limit was 18.0 mt. The 2009 canary bycatch limit was approximately 12 mt higher than it had been in the previous four years. The bycatch limit was increased for 2009–2010, based on the much higher canary rockfish harvest specifications for that period. The best available data at the March 2010 Council meeting indicated that there is an increasing trend in the bycatch rate for canary rockfish in the non-tribal whiting fishery. However, based on (1) The latest understanding of canary biomass from the most recent assessment (biomass is lower than previously thought), (2) that only 17 percent of the 2009 bycatch limit was caught, and (3) that the non-Pacific whiting fisheries would need to be further limited to keep the projected impacts to canary rockfish below the 2010 OY of 105 mt if the 18 mt bycatch limit was not reduced, the Council recommended decreasing the canary rockfish bycatch limit for 2010. The 2010 canary rockfish bycatch limit of 14 mt is based on the need to balance an increasing canary rockfish bycatch rate in the non-tribal Pacific whiting fishery with the needs of the non-Pacific whiting sectors. From the overall bycatch limit of 14 mt, the following sector-specific bycatch limits are established for canary rockfish: The catcher/processors bycatch limit is decreased from 6.1 mt to 4.8 mt; the mothership bycatch limit is decreased from 4.3 mt to 3.3 mt; and the shore-based bycatch limit is decreased from 7.6 mt to 5.9 mt.

At their March 2010 meeting, the Council also considered revising the darkblotched rockfish bycatch limits, but found no reason to revise them before the start of the 2010 season.

Classification

The final Pacific whiting specifications and management measures for 2010 are issued under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act), and the Pacific Whiting Act of 2006, and are in accordance with 50 CFR part 660, subpart G, the regulations implementing the FMP. The Administrator, Northwest Region, NMFS, has determined that this rule is consistent with the national standards of the Magnuson-Stevens Act and other applicable laws.

Pursuant to the Administrative Procedure Act, 5 U.S.C. 553(b)(B), NMFS finds good cause to waive prior public notice and comment on the 2010 Pacific whiting specifications. NMFS also finds good cause to waive the 30-day delay in effectiveness pursuant to 5 U.S.C. 553(d)(3), so that this final rule may become effective as soon as possible after April 1, 2010, the typical fishery start date.

These waivers are necessary and in the public interest. The FMP requires that fishery specifications be evaluated periodically using the best scientific information available. Every year, NMFS conducts a Pacific whiting stock assessment in which U.S. and Canadian scientists cooperate. The 2010 stock assessment for Pacific whiting was prepared in early 2010, which is the

optimal time of year to conduct stock assessments for this species. New 2009 data used in this assessment that were not available until January, 2010 include: updated total catch; length and age data from the U.S. and Canadian fisheries; and biomass indices from the Joint US–Canadian acoustic/midwater trawl surveys. Pacific whiting differs from other groundfish species in that it has a shorter life span and the population fluctuates more swiftly. Thus, it is important to use the most recent stock assessment for Pacific whiting when determining ABC and OY. Because of the timing of obtaining the data and conducting the assessment, the results of Pacific whiting stock assessments are not available for use in developing the new ABC and OY until just before the Council's annual March meeting. The new Pacific whiting season begins in April 2010. Thus, if the actions in this final rule are to be implemented early in this fishing season, affording the time necessary for prior notice and opportunity for public comment would prevent the agency from managing the Pacific whiting and related fisheries using the best available science.

Moreover, delaying this rule would leave in place the harvest specifications and bycatch limits from the 2009 fishery. Through setting lower bycatch limits, this rule is intended to ensure that the rebuilding OYs for darkblotched, canary and widow rockfish are not exceeded. Without these lower limits, these rebuilding OY levels could be exceeded, contrary to the requirements of the Magnuson-Stevens Act and the Groundfish FMP. This would be contrary to not only the interest of the fishing communities, but to the public at large. Additionally, failing to implement the higher Pacific whiting harvest specifications as early as possible in 2010 could prevent the tribal and non-tribal fisheries from attaining their higher allocations, and thus would result in unnecessary short-term adverse economic effects for the Pacific whiting fishing vessels and the associated fishing communities.

The environmental impacts associated with the Pacific whiting harvest levels being adopted by this action are consistent with the impacts in the FEIS for the 2009–2010 specification and management measures. In approving the 2009–2010 groundfish harvest specifications and management measures, NMFS issued a Record of Decision (ROD). The ROD was signed on February 23, 2009. Copies of the FEIS and the ROD are available from the Council (*see* **ADDRESSES**).

Pursuant to the Regulatory Flexibility Act (RFA), 5 U.S.C. 601 *et seq.,* NMFS prepared an Initial Regulatory Flexibility Analysis (IRFA) and FRFA for the 2009–2010 harvest specifications and management measures. These analyses included the regulatory impacts of this action on small entities. The IRFA was summarized in the proposed rule published on December 31, 2008 (73 FR 80516). A summary of the FRFA analysis, which covers the entire groundfish regulatory scheme of which this is a part, was published in the final rule on March 6, 2009 (74 FR 9874). An IRFA was also prepared for the proposed rule on the tribal fishery for Pacific whiting in 2010. This proposed rule was published on March 12, 2010 (75 FR 11829). A FRFA for that rule was also prepared, and a summary of that FRFA is contained below. A copy of this analysis is available from NMFS (*see* **ADDRESSES**). The need for and objectives of this final rule are contained in the **SUMMARY** and in the Background section under **SUPPLEMENTARY INFORMATION.**

The final 2009–2010 specifications and management measures were intended to allow West Coast commercial and recreational fisheries participants to fish the harvestable surplus of more abundant stocks, while also ensuring that those fisheries do not exceed the allowable catch levels intended to rebuild and protect overfished stocks. The ABCs and OYS follow the guidance of the Magnuson-Stevens Act, the national standard guidelines, and the FMP for protecting and conserving fish stocks. Fishery management measures include trip and bag limits, size limits, time/area closures, gear restrictions, and others intended to allow year-round West Coast groundfish landings, without compromising overfished species rebuilding measures.

In recent years the number of participants engaged in the Pacific whiting fishery has varied with changes in the Pacific whiting OY and economic conditions. Pacific whiting shoreside vessels (26 to 29), mothership processors (4 to 6), mothership catcher vessels (11–20), catcher/processors (5 to 9), Pacific whiting shoreside first receivers (8–16), and five tribal trawlers are the major units of this fishery. For 2010, an additional one to two tribal trawlers may enter the fishery. NMFS records suggest the gross annual revenue for each of the catcher/processor and mothership operations on the Pacific coast exceeds $4,000,000. Therefore, they are not considered small businesses. NMFS records also show that 10–43 catcher vessels have taken part in the mothership fishery yearly since 1994. These companies are all assumed to be small businesses as defined by the RFA (although some of these vessels may be affiliated with larger processing companies). Since 1994, 26–31 catcher vessels participated in the shoreside fishery annually. These companies are all assumed to be small businesses (although some of these vessels may be affiliated to larger processing companies). Tribal trawlers are presumed to be small entities, whereas the Tribes are presumed to be small government jurisdictions.

In 2008, these participants harvested about 248,000 tons of Pacific whiting, worth about $63 million in ex-vessel value, based on shoreside ex-vessel prices of $254 per ton—the highest ex-vessel revenues and prices on record. In comparison, the 2007 fishery harvested about 224,000 tons, worth $36 million at an average ex-vessel price of about $160 per ton. From 2003–2007, estimated Pacific whiting ex-vessel values averaged about $29 million.

Seafood processors convert Pacific whiting into surimi, fillets, fish meal, and headed gutted products. Besides recent high OY levels, ex-vessel revenues have been increasing due to increased prices for headed and gutted Pacific whiting. From 2004–2007, wholesale prices for headed and gutted Pacific whiting product increased from about $1,200 per ton, to $1,600 per ton. In 2008, wholesale prices averaged $1,980 per ton according to U.S. Export Trade statistics. Fuel prices, a major expense for Pacific whiting vessels, also increased dramatically. For example, at the start of the primary fishery in June 2008 fuel prices were about $4.30 per gallon, compared to June 2007 levels of $2.70 per gallon.

In 2009, wholesale headed gutted prices fell slightly to $1,950 per ton. Fuel prices, a major expense for Pacific whiting vessels, continued to fluctuate. However, by 2009, these prices fell from their June, 2008 high to about $2.32 per gallon.

The fisheries' ability to harvest the entire 2010 Pacific whiting OY will depend on how well the industry stays within the overfished species bycatch limits. For example, in 2008 the Pacific whiting shoreside fishery was closed prematurely because of overfished species bycatch issues, leaving a major portion its allocation unharvested. Although NMFS transferred the unharvested allocations to the other nontribal fleets, by year's end, 7 percent of the 2008 Pacific whiting OY remained unharvested. In 2009, the ex-vessel price of Pacific whiting averaged about $115 per ton. Based on this price,

if the total amount of Pacific whiting available to the tribal and non-tribal commercial fisheries is harvested in 2010, the revenues generated would approach $22 million—a potential increase over the $14 million generated in 2009.

Pursuant to Executive Order 13175, this action was developed after meaningful consultation and collaboration with tribal officials from the area covered by the FMP. Under the Magnuson-Stevens Act, 16 U.S.C. 1852(b)(5), one of the voting members of the Council must be a representative of an Indian tribe with federally recognized fishing rights from the area of the Council's jurisdiction. In addition, regulations implementing the FMP establish a procedure by which the tribes with treaty fishing rights in the area covered by the FMP request, in writing, new allocations or regulations specific to the tribes before the first of the two meetings at which the Council considers groundfish management measures. Both the Makah and Quileute Tribes requested a Pacific whiting allocation for 2009. The regulations at 50 CFR 660.324(d) further state that, "the Secretary will develop tribal allocations and regulations under this paragraph in consultation with the affected tribe(s) and, insofar as possible, with tribal consensus."

This final rule has been determined to be not significant for purposes of Executive Order 12866.

List of Subjects in 50 CFR Part 660

Fisheries, Fishing, and Indian fisheries.

Dated: April 29, 2010.

Eric C. Schwaab,

Assistant Administrator for Fisheries, National Marine Fisheries Service.

■ For the reasons set out in the preamble, 50 CFR part 660 is amended as follows:

PART 660—FISHERIES OFF WEST COAST STATES

■ 1. The authority citation for part 660 is amended to read as follows:

Authority: 16 U.S.C. 1801 *et seq.* and 16 U.S.C. 7001 *et seq.*

■ 2. In § 660.373 paragraph (b)(4)(i) is revised to read as follows:

§ 660.373 Pacific whiting (whiting) fishery management.

* * * * *

(b) * * *

(4) * * *

(i) The whiting fishery bycatch limit is apportioned among the sectors identified in paragraph (a) of this section based on the same percentages used to allocate whiting among the sectors, established in § 660.323(a). The sector specific bycatch limits are: for catcher/processors 4.8 mt of canary rockfish, 95 mt of widow rockfish, and 8.5 mt of darkblotched rockfish; for motherships 3.3 mt of canary rockfish, 67 mt of widow rockfish, and 6.0 mt of darkblotched rockfish; and for shore-based 5.9 mt of canary rockfish, 117 mt of widow rockfish, and 10.5 mt of darkblotched rockfish.

* * * * *

■ 3. In § 660.385 paragraph (e) is revised to read as follows:

§ 660.385 Washington coastal tribal fisheries management measures.

* * * * *

(e) *Pacific whiting*—The tribal allocation for 2010 is 49,939 mt.

* * * * *

■ 4. Revise Table 2a to Part 660, Subpart G, and footnotes "/f" and "/q" following Tables 2a through 2c to Part 660, Subpart G to read as follows:

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Table 2a. To Part 660, Subpart G-2010, Specifications of ABCs, OYs, and HGs, by Management Area (weights in metric tons).

Species	ABC Specifications						OY	HG b/	
	ABC Contributions by Area					ABC			
	Vancouver a/	Columbia	Eureka	Monterey	Concepti on			Commerci al	Recreation al
ROUNDFISH:									
Lingcod c/ N of 42 N. lat.	4,058		771			4,829	4,829		
S of 42 N. lat.									
Pacific Cod e/	3,200		d/			3,200	1,600		
Pacific Whiting f/	336,560					336,560	193,935		
Sablefish g/ N of 36 N. lat.	9,217					9,217	6,471		
S of 36 N. lat.							1,258		
Cabezon h/ S of 42 N. lat.	d/		86		25	111	79		
FLATFISH:									
Dover sole	28,582					28,582	16,500		
English sole j/	9,745					9,745	9,745	-	
Petrale sole k/	1,514		1,237			2,751	1,200	-	
Arrowtooth flounder l/	10,112					10,112	10,112	-	
Starry Flounder m/	1,578					1,578	1,077		
Other flatfish n/	6,731					6,731	4,884	-	
ROCKFISH:									
Pacific Ocean Perch o/	1,173					1,173	200	198	

Species	ABC Specifications						OY	HG b/	
	ABC Contributions by Area					ABC		Commercial	Recreational
	Vancouver a/	Columbia	Eureka	Monterey	Conception				
Shortbelly p/	6,950					6,950	6,950		
Widow q/	6,937					6,937	509	447.4	7.2
Canary r/	940					940	44 - 105		
Chilipepper s/	d/			2,576		2,576	2,447	2,447	
Bocaccio t/	d/			793		793	288	206.4	67.3
Splitnose u/	d/			615		615	461		
Yellowtail v/	4,562			d/		4,562	4,562		
Shortspine thornyhead w/ N of 34 27' N. lat.	2,411					2,411	1,591	1,591	
S of 34 27' N. lat.							410		
Longspine thornyhead x/ N of 34 27' N. lat.	3,671					3,671	2,175		
S of 34 27' N. lat.							385		
Cowcod y/	d/			14		14	4		
Darkblotched z/	440					440	291	288.05	
Yelloweye aa/						32	17	3.1	8.0
California Scorpionfish bb/					155	155	155		
Black cc/ N of 46 16' N. lat.	464					464	464		
S of 46 16' N. lat.			1,317			1,317	1,000		

Species	ABC Specifications						OY	HG b/	
	ABC Contributions by Area					ABC		Commercial	Recreational
	Vancouver a/	Columbia	Eureka	Monterey	Conception				
Minor Rockfish dd/ N of 40 10' N. lat.	3,678			--		3,678	2,283		
Minor Rockfish ee/ S of 40 10' N. lat.	--			3,382		3,382	1,990		
Remaining	1,640			1,318					
bank ff/	d/			350					
blackgill gg/	d/			292					
blue	28			211					
bocaccio north	318			--					
chilipepper north	32			--					
redstripe	576			d/					
sharpchin	307			45					
silvergrey	38			d/					
splitnose north	242			--					
yellowmouth	99			d/					
yellowtail	--			116					
gopher	d/			302					
Other rockfish hh/	2,038			2,066					
SHARKS/SKATES/RATFISH/MORIDS/GRENADIERS/KELP GREENLING:									
Longnose Skate ii/	3,269					3,269	1,349		
Other fish jj/	11,200					11,200	5,600		

* * * * *

[f]Pacific whiting—The most recent stock assessment was prepared in January 2010. The stock assessment base model estimated the Pacific whiting biomass to be at 31 percent (50th percentile estimate of depletion) of its unfished biomass in 2010. The U.S.-Canada coastwide ABC is 455,550 mt, the U.S. share of the ABC is 336,560 mt (73.88 percent of the coastwide ABC). The U.S.-Canada coastwide Pacific whiting OY is 262,500 mt, with a corresponding U.S. OY of 193,935 mt. The tribal allocation is 49,939 mt. The amount estimated to be taken as research catch and in non-groundfish fisheries is 3,000 mt. The commercial OY is 140,996 mt. Each sector receives a portion of the commercial OY, with the catcher/processors getting 34 percent (47,939 mt), motherships getting 24 percent (33,839 mt), and the shore-based sector getting 42 percent (59,218 mt). No more than 2,961 mt (5 percent of the shore-based allocation) may be taken in the fishery south of 42° N. lat. prior to the start of the primary season for the shorebased fishery north of 42° N. lat.

* * * * *

[q]Widow rockfish was assessed in 2005, and an update was prepared in 2007. The stock assessment update estimated the stock

to be at 36.2 percent of its unfished biomass in 2006. The ABC of 6,937 mt is based on the stock assessment update with an F50% FMSY proxy. The OY of 509 mt is based on a rebuilding plan with a target year to rebuild of 2015 and an SPR harvest rate or 95 percent. To derive the commercial harvest guideline of 447.4 mt, the OY is reduced by 1.1 mt for the amount anticipated to be taken during research activity, 45.5 mt for the tribal set-aside, 7.2 mt the amount estimated to be taken in the recreational fisheries, 0.4 mt for the amount expected to be taken incidentally in non-groundfish fisheries, and 7.4 mt for EFP fishing activities.

* * * * *

[FR Doc. 2010–10403 Filed 4–29–10; 4:15 pm]

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Proposed Rules

Federal Register
Vol. 75, No. 85
Tuesday, May 4, 2010

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Foreign Agricultural Service

7 CFR Part 1530

Sugar Re-Export Program, the Sugar-Containing Products Re-Export Program, and the Polyhydric Alcohol Program

AGENCY: Foreign Agricultural Service, USDA.

ACTION: Proposed rule; withdrawal.

SUMMARY: The Foreign Agricultural Service (FAS) is withdrawing the proposed rule published at 70 FR 3150 on January 21, 2005, to implement Chapter 17 of the Harmonized Tariff Schedule of the United States (HTS), Additional U.S. Note 6, which authorizes entry of raw cane sugar under subheading 1701.11.20 of the HTS for the production of polyhydric alcohols, except polyhydric alcohols for use as a substitute for sugar in human food consumption, or to be refined and re-exported in refined form or in sugar-containing products, or to be substituted for domestically produced raw cane sugar that has been or will be exported. The proposed rule would have revised the current regulation at 7 CFR part 1530.

DATES: Effective date: May 4, 2010.

FOR FURTHER INFORMATION CONTACT: Ronald C. Lord, Chief, Sugar and Dairy Branch, Import Programs and Export Reporting Division, Foreign Agricultural Service, U.S. Department of Agriculture or by phone (202) 720–2916; or by fax (202) 720–0876; or by e-mail: *Ronald.Lord@fas.usda.gov.*

SUPPLEMENTARY INFORMATION:

Background

The U.S. and Mexican sugar markets have become increasingly integrated since duty-free, quota-free trade in sugar was fully implemented on January 1, 2008 under the North American Free Trade Agreement (NAFTA). FAS is withdrawing this proposed rule because market conditions have changed. FAS intends to publish an advance notice of proposed rulemaking concerning trade under the Sugar Re-Export Program with Mexico, requesting comments on revisions to the regulation, in particular with respect to issues not fully addressed in previous comments on the proposed rule that is being withdrawn by this action.

Signed at Washington, DC on the 26th of April, 2010.

John D. Brewer,

Administrator, Foreign Agricultural Service.

[FR Doc. 2010–10425 Filed 5–3–10; 8:45 am]

BILLING CODE P

FEDERAL HOUSING FINANCE BOARD

12 CFR Part 956

FEDERAL HOUSING FINANCE AGENCY

12 CFR Part 1267

RIN 2590–AA32

Federal Home Loan Bank Investments

AGENCY: Federal Housing Finance Agency, Federal Housing Finance Board.

ACTION: Notice of proposed rulemaking; request for comment.

SUMMARY: The Federal Housing Finance Agency (FHFA) is proposing to re-organize and re-adopt existing investment regulations that apply to the Federal Home Loan Banks (Banks) and that were previously adopted by the Federal Housing Finance Board (Finance Board) as new part 1267 of the FHFA's regulations. FHFA is also proposing to incorporate into the new part 1267 limits on the Banks' investment in mortgage-backed securities (MBS) and certain asset-backed securities (ABS) that are now set forth in the Financial Management Policy (FMP) that had been issued by the Finance Board. If the proposed rule is adopted in its current form, FHFA expects to terminate the FMP as of the effective date of the new rule.

DATES: Comments on the proposed rule must be received on or before July 6, 2010. For additional information, *see* **SUPPLEMENTARY INFORMATION.**

ADDRESSES: You may submit your comments on the proposed rule, identified by regulatory information number (RIN) 2590–AA32 by any of the following methods:

- *E-mail:* Comments to Alfred M. Pollard, General Counsel, may be sent by e-mail to *RegComments@FHFA.gov.* Please include "RIN 2590–AA32" in the subject line of the message.
- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments. If you submit your comments to the Federal eRulemaking Portal, please also send it by e-mail to FHFA at *RegComments@FHFA.gov* to ensure timely receipt by the agency. Please include "RIN 2590–AA32" in the subject line of the message.
- *Hand Delivery/Courier:* The hand delivery address is: Alfred M. Pollard, General Counsel, Attention: Comments/RIN 2590–AA32, Federal Housing Finance Agency, Fourth Floor, 1700 G Street, NW., Washington, DC 20552. The package should be logged at the Guard Desk, First Floor, on business days between 9 a.m. and 5 p.m.
- *U.S. Mail, United Parcel Service, Federal Express, or Other Mail Service:* The mailing address for comments is: Alfred M. Pollard, General Counsel, Attention: Comments/RIN 2590–AA32, Federal Housing Finance Agency, Fourth Floor, 1700 G Street, NW., Washington, DC 20552.

FOR FURTHER INFORMATION CONTACT: Louis Scalza, Associate Director, 202–408–2953, Division of Federal Home Loan Bank Regulation, Federal Housing Finance Agency, 1625 Eye Street, NW., Washington, DC 20006; or Thomas E. Joseph, Senior Attorney-Advisor, 202–414–3095, Office of General Counsel, Federal Housing Finance Agency, Fourth Floor, 1700 G Street, NW., Washington, DC 20552. The telephone number for the Telecommunications Device for the Deaf is (800) 877–8339.

SUPPLEMENTARY INFORMATION:

I. Comments

FHFA invites comments on all aspects of the proposed rule, and will adopt a final regulation with appropriate changes after taking all comments into consideration. Copies of all comments will be posted on the Internet Web site at *https://www.fhfa.gov.* In addition, copies of all comments received will be available for examination by the public on business days between the hours of 10 a.m. and 3 p.m., at the Federal

Housing Finance Agency, Fourth Floor, 1700 G Street, NW., Washington, DC 20552. To make an appointment to inspect comments, please call the Office of General Counsel at (202) 414–6924.

II. Background

A. Creation of the Federal Housing Finance Agency and Recent Legislation

Effective July 30, 2008, the Housing and Economic Recovery Act of 2008 (HERA), Public Law 110–289, 122 Stat. 2654, created FHFA as a new independent agency of the Federal Government, and transferred to FHFA the supervisory and oversight responsibilities of the Office of Federal Housing Enterprise Oversight (OFHEO) over the Federal National Mortgage Association (Fannie Mae), and the Federal Home Loan Mortgage Corporation (Freddie Mac) (collectively, the Enterprises), the oversight responsibilities of the Finance Board over the Banks and the Office of Finance (OF) (which acts as the Banks' fiscal agent) and certain functions of the Department of Housing and Urban Development. *See id.* at section 1101, 122 Stat. 2661–62. FHFA is responsible for ensuring that the Enterprises and the Banks operate in a safe and sound manner, including that they maintain adequate capital and internal controls, that their activities foster liquid, efficient, competitive and resilient national housing finance markets, and that they carry out their public policy missions through authorized activities. *See id.* at section 1102, 122 Stat. 2663–64. OFHEO and the Finance Board were abolished July 30, 2009, one year after the enactment of HERA, however, the Enterprises, the Banks, and the OF continue to operate under regulations promulgated by OFHEO and the Finance Board until such regulations are superseded by regulations issued by FHFA. *See id.* at sections 1301, 1302, 1311, 1312, 122 Stat. 2794–95, 2797–98.

B. The Bank System Generally

The twelve Banks are instrumentalities of the United States organized under the Federal Home Loan Bank Act (Bank Act).[1] *See* 12 U.S.C. 1423, 1432(a). The Banks are cooperatives; only members of a Bank may purchase the capital stock of a Bank, and only members or certain eligible housing associates (such as state housing finance agencies) may obtain access to secured loans, known as advances, or other products provided by a Bank. *See* 12 U.S.C. 1426(a)(4), 1430(a), 1430b. Each Bank is managed by its own board of directors and serves the public interest by enhancing the availability of residential mortgage and community lending credit through its member institutions. *See* 12 U.S.C. 1427. Any eligible institution (generally a federally insured depository institution or state-regulated insurance company) may become a member of a Bank if it satisfies certain criteria and purchases a specified amount of the Bank's capital stock. *See* 12 U.S.C. 1424; 12 CFR part 1263.

As government-sponsored enterprises (GSEs), the Banks are granted certain privileges under federal law. In light of those privileges and their status as GSEs, the Banks typically can borrow funds at spreads over the rates on U.S. Treasury securities of comparable maturity lower than most other entities. The Banks pass along a portion of their GSE funding advantage to their members—and ultimately to consumers—by providing advances and other financial services at rates that would not otherwise be available to their members.

C. Investment Requirements and the FMP

Under sections 11(g), 11(h) and 16(a) of the Bank Act, 12 U.S.C. 1431(g), 1431(h), 1436(a), a Bank is specifically authorized, subject to the rules of FHFA, to invest in: (1) Obligations of the United States; (2) deposits in banks and trust companies; (3) obligations, participations or other instruments of, or issued by, Fannie Mae or Government National Mortgage Association (Ginnie Mae); (4) mortgages, obligations or other securities that are or ever have been sold by Freddie Mac; (5) stock of Fannie Mae; (6) stock, obligations or other securities of any small business investment company (SBIC) formed pursuant to 15 U.S.C. 681, to the extent the investment is made for purposes of aiding a Bank member; and (7) instruments that a Bank has determined are permissible investments for fiduciary and trust funds under the laws of the state in which the Bank is located. Part 956 of the Finance Board regulations authorizes the Banks to invest in all the instruments specifically identified in the statute, except for stock in Fannie Mae, subject to certain safety and soundness limitations that are also set forth in the regulation. *See* 12 CFR 956.2, 956.3. The part 956 regulations also allow the Banks to enter into derivative transactions, standby letters of credit which conform to other regulations, and commitments to make advances or commitments to make or purchase other loans. *See* 12 CFR 956.5. The Banks may, however, enter into derivative contracts only for hedging or other documented, non-speculative purposes, such as intermediating derivative transactions for members, and the Banks are subject to prudential and safety and soundness requirements with regard to derivative transactions. *See* 12 CFR 956.6.

The FMP evolved from a series of policies and guidelines initially adopted by the former Federal Home Loan Bank Board, predecessor agency to the Finance Board, in the 1970s and revised a number of times thereafter. The Finance Board adopted the FMP in 1991, consolidating into one document the previously separate policies on funds management, hedging and interest-rate swaps, and adding new guidelines on the management of unsecured credit and interest-rate risks.[2] Prior to the adoption of the part 956 regulations in 2000, the FMP governed how the Banks implemented their financial management strategies by specifying the types of investments the Banks could purchase. *See* Proposed Rule: *Federal Home Loan Bank Acquired Member Assets, Core Mission Activities, Investments and Advances,* 65 FR 25676, 25686 (May 3, 2000). The FMP also established mandatory guidelines relating to the funding and hedging practices of the Banks, the management of their credit, interest-rate, and liquidity risks, and the liquidity requirements for the Banks in addition to those required by statute.

Beginning in 2000, many of the provisions contained in the FMP were superseded by regulations adopted by the Finance Board including regulations that implemented the new capital structure for the Banks that had been mandated by the Gramm-Leach-Bliley Act of 1999, Public Law 106–102, 113 Stat. 1338 (Nov. 12, 1999) (GLB Act). Among other things, the new capital structure incorporated risk-based capital requirements to support the risks in the Banks' activities, and therefore eliminated the need for most of the FMP restrictions on investments. *See* 12 CFR part 932. In approving the capital plans that each Bank was required to adopt under provisions of the GLB Act, the Finance Board issued separate orders providing that upon a Bank's implementation of its capital plan and its full coverage by the capital regime in part 932 of the regulations, the Bank would be exempted from future

[1] The twelve Banks are located in: Boston, New York, Pittsburgh, Atlanta, Cincinnati, Indianapolis, Chicago, Des Moines, Dallas, Topeka, San Francisco, and Seattle.

[2] *See* Fin. Bd. Res. No. 96–45 (July 3, 1996), as amended by Fin. Bd. Res. No. 96–90 (Dec. 6, 1996), Fin. Bd. Res. No. 97–05 (Jan. 14, 1997), and Fin. Bd. Res. No. 97–86 (Dec. 17, 1997). *See also* 62 FR 13146 (Mar. 19, 1997)).

compliance with all provisions of the FMP except for a few specific restrictions related to the Bank's investment in mortgage-backed and certain asset-backed securities along with some related restrictions on entering into some derivative transactions.[3] *See, e.g.,* Fin. Bd. Res. No. 2002–11 (Mar. 13, 2002). Currently, all the Banks but the Federal Home Loan Bank of Chicago (Chicago Bank) have implemented their capital plans and are fully subject to the part 932 capital provisions. Thus, only a few of the provisions of the FMP remain applicable to all the Banks.

In addition to the FMP provisions already discussed and applicable to all the Banks, the Chicago Bank remains subject to FMP provisions related to prudential limits on investments (other than MBS or ABS)[4] and interest rate risk guidelines. The latter have been subsumed into the risk management and hedging guidelines that the Chicago Bank was required to submit for review and approval (and update as necessary) under Article III of the *Consent Order To Cease and Desist* entered into with the Finance Board on October 10, 2007 and which remains in effect. *See* 2007–SUP–01.

D. Considerations of Differences Between the Banks and the Enterprises

Section 1201 of HERA requires the Director, when promulgating regulations relating to the Banks, to consider the following differences between the Banks and the Enterprises: Cooperative ownership structure; mission of providing liquidity to members; affordable housing and community development mission; capital structure; and joint and several liability. *See* section 1201 Public Law 110–289, 122 Stat. 2782–83 (*amending* 12 U.S.C. 4513). The Director also may consider any other differences that are deemed appropriate. In preparing this proposed rule, FHFA considered the differences between the Banks and the Enterprises as they relate to the above factors. FHFA requests comments from the public about whether differences related to these factors should result in any revisions to the proposal. FHFA also requests comment on whether differences related to these factors are relevant to the issues and questions raised in section III.B. below.

III. The Proposed Rule

The proposed rule would re-organize current part 956 of the Finance Board's regulations and re-adopt it as part 1267 of the FHFA's regulations. More significantly, it would also incorporate into the regulation restrictions that are now applicable to the Banks and are contained in the FMP. Adopting these restrictions in a regulation would consolidate all the investment requirements in one place and allow FHFA to terminate the FMP. In addition, the proposed rule would make other conforming changes to the part 956 regulations related to the transfer of the regulations to chapter XII, 12 CFR part 1267 and to the incorporation of the FMP restrictions into the rule.

A. Highlights of the Proposed Rule

The proposed rule would re-organize the current 956 rules by combining § 956.2 and § 956.5, which respectively provide a list of authorized investments and authorization for derivative and other transactions, into new § 1267.2. This would consolidate all authority for investments and other transactions into a single section but does not otherwise substantially alter the part 956 provisions. The proposed rule would carry over current § 956.3, which sets forth a list of prohibited investments and other prudential requirements as new § 1267.3. The proposed rule would incorporate as new § 1267.3(a)(5) through (7) restrictions found in section II.C.3. through C.5. of the FMP related to investment in MBS and ABS, including the prohibition on investment in residual interest and interest accrual classes of securities and interest-only and principal-only stripped MBS and ABS.

New § 1267.3(c) would incorporate the limits now in section II.C.2. of the FMP that limit a Bank's level of investment in MBS and eligible ABS to 300 percent of its total capital. The proposed provision also states that a Bank's purchase of MBS and ABS in any calendar quarter cannot cause its total holdings of such securities to increase by more than 50 percent of its total capital as of the beginning of such quarter. Both these limits are carried over directly from the Finance Board's FMP without change. The proposed provision also clarifies that a Bank would not be required to divest securities solely to bring the level of its holdings into compliance with the limits in new § 1267.3(c), provided that the original purchase of the securities complied with these limits.

The proposed rule also would re-adopt the limitations and prudential requirement on use of derivative instruments now found in § 956.6 as new § 1267.4. FHFA is also proposing to add to this section new paragraph (b) which would incorporate the remaining applicable limitations on derivative transaction found in section V.C.5. of the FMP. These FMP restrictions are meant to prevent the Banks from using derivatives to create exposures or investments similar to residual interest and interest accrual classes of securities, interest-only and principal-only stripped MBS and ABS, or other investments that are currently prohibited by section II.C. of the FMP (and would continue to be prohibited by new § 1267.3(a)(5) through (7)).

B. Potential Additional Limitations and Specific Requests for Information

The FMP limits on total investment in MBS and ABS that FHFA is proposing to incorporate into new § 1267.3 address both mission and safety and soundness concerns. FHFA acknowledges that some of the Banks' investments in private-label MBS have resulted in accounting charges for other-than-temporary impairment (OTTI) but is proposing transferring the existing limits on MBS and ABS contained in the FMP as an administrative reorganization. FHFA is specifically requesting comments on whether more restrictive limits or other modifications to the MBS investment requirements are needed.

Some of the Banks' OTTI charges were on private-label MBS that were backed by subprime and nontraditional residential mortgage loans. To address certain issues associated with subprime and nontraditional loans, the Finance Board's Office of Supervision issued two advisory bulletins that remain

[3] The restrictions in question are found in sections II.C.2.,3.,4. and 5. and Section V.C.5. of the FMP. These limits, among other things, prohibit investment in residual interest and interest accrual classes of securities and in interest-only and principal-only stripped securities, and limit a Bank's investment in MBS and ABS to 300 percent of a Bank's total capital. The provisions also limit an increase in a Bank's holdings of MBS and ABS to no more than 50 percent of its total capital in any calendar quarter. The restrictions also prohibit the Bank from entering into swap transactions that would amortize similar to residual interest or interest accrual classes of securities or to interest-only and principal-only stripped securities.

In March 2008, the Finance Board temporarily expanded the Banks' authority to invest in MBS guaranteed by the Enterprises by an additional three times total capital, subject to certain conditions. *See* Fin. Brd. Res. No. 2008–08 (Mar. 24, 2008). The temporary authority expired on March 31, 2010. The Finance Board believed that the temporary increase in the Banks' investment authority would help address severe liquidity and other constraints that were affecting the housing finance markets in early 2008.

[4] Even if the FMP were terminated so that these FMP prudential limits were no longer applicable to the Chicago Bank, the Bank would be subject to the new business activity requirements under part 980 of current regulations. Therefore, the Bank would require FHFA's approval before it could make investments beyond what it is currently allowed, and FHFA could impose any prudent limits, as appropriate, as part of the approval process. *See* 12 CFR part 980.

applicable to the Banks and contain guidance designed to promote better risk management of private-label MBS with these types of underlying loans. On April 12, 2007, the Office of Supervision issued Advisory Bulletin 2007–AB–01 that established expectations for the Banks' pre-purchase analysis and periodic reviews of MBS investments. The Bulletin also advised the Banks' boards of directors to establish: (1) Limits on the level of MBS with underlying nontraditional or subprime mortgage collateral; (2) requirements for the level of credit protection for particular credit tranches when purchased at the time of original issuance of the security, and (3) limits on concentrations by geographic area, issuer, servicer, and size. On July 1, 2008, the Office of Supervision issued Advisory Bulletin 2008–AB–02 that expressed the expectation that the Banks' purchases of private-label MBS will be limited to securities in which the underlying mortgage loans comply with all aspects of the federal banking agencies' *Interagency Guidance on Nontraditional Mortgage Product Risks,* issued on October 4, 2006 (71 FR 58609), and *Statement on Subprime Mortgage Lending,* issued on July 10, 2007 (72 FR 37569), (collectively "interagency guidance"). The interagency guidance emphasizes underwriting standards intended to ensure a borrower's ability to repay a mortgage loan at the fully indexed rate and assuming an amortizing repayment schedule. FHFA believes that future investments in private-label MBS backed by mortgage loans that conform to the interagency guidance and are purchased in line with the guidelines set forth in the April 2007 Advisory Bulletin may offer some protection against OTTI losses.

The Banks' OTTI charges are problematic. In the third quarter of 2009, the Banks' OTTI charges on private-label MBS totaled $2.2 billion. Cumulative OTTI on such investments through the third quarter of 2009 was $12.4 billion. These charges raise questions as to the Banks' ability to: (1) Properly manage the risks associated with investments in private-label MBS, and (2) adopt and implement prudent private-label MBS investment and credit risk policies.

In particular, in the FHFA's 2008 Annual Report to Congress, the agency expressed concern regarding the financial condition of some Banks and the negative performance of their private-label MBS. FHFA examination comments were that, to varying degrees, the Banks' investment policies and risk mitigation measures were deficient in terms of post-purchase monitoring, overreliance on NRSRO ratings, and limited risk reporting. Considering these factors, several Banks were found to have significant weaknesses in their private-label MBS credit risk management systems.

Thus, FHFA is considering whether it should adopt additional restrictions, or lower the overall limit, on the Banks' investment in MBS generally, and in private-label MBS, in particular, as part of the final rule. In this regard, FHFA is seeking specific comments and information on the following:

1. Although the proposed rule would retain the FMP provision limiting MBS holdings to 300 percent of a Bank's capital, FHFA also requests comment on what other measures might offer a prudent limit on MBS holdings that also would mitigate potential future losses from the Banks' MBS portfolios. Comments on this issue may address both the magnitude of the limit (*i.e.,* 300 percent of capital) and its basis (*i.e.,* capital). For example, because retained earnings can absorb losses without compromising the par value of Bank capital stock, a limit based on a Bank's retained earnings may offer a more prudent basis for limiting private-label MBS investments.

2. In addition to the overall limit on MBS investments, FHFA requests comments on whether there should be a separate limit or additional restrictions on the purchase of private-label MBS (*e.g.,* a limit of one or two times capital, or a separate limit linked to retained earnings or some other basis). If such provisions are appropriate, FHFA seeks comments on the appropriate magnitude of the limit and its basis, as well as whether the rule should prohibit the purchase of private-label MBS.

3. In addition to the types of limits contemplated by the questions immediately above, FHFA seeks comments on whether it should restrict purchases of private-label MBS based on collateral characteristics (*e.g.,* restrictions based on whether the underlying mortgages are commercial or residential real estate loans, adjustable-rate loans, interest-only loans, or credit scores below certain levels). If such limits are appropriate, FHFA also would request comments on the types of characteristics and restrictions that should be implemented. For example, FHFA has considered proposing a limit on a Bank's private-label MBS purchases that decreases as the amount of relatively risky collateral in the Bank's mortgage pools and portfolio increases. Such restrictions could serve to limit the Bank's exposure to credit losses by reducing purchases of private-label MBS with relatively risky collateral.

4. At one time, the FMP limited the purchase of private-label MBS to only those instruments rated in the highest investment grade category.[5] FHFA requests comments on whether it should re-introduce that type of limit as a means to limit the potential risks to the Banks from their MBS portfolios, and whether it would suffice to adopt a ratings requirement only for private-label MBS backed by certain types of collateral (*e.g.,* subprime or Alt-A loans).

If the proposed rule is adopted in its current form, FHFA anticipates that it would rescind the FMP as of the effective date of the new rule.

IV. Paperwork Reduction Act

The proposed rule does not contain any collections of information pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*). Therefore, FHFA has not submitted any information to the Office of Management and Budget for review.

V. Regulatory Flexibility Act

The proposed rule applies only to the Banks, which do not come within the meaning of small entities as defined in the Regulatory Flexibility Act (RFA). *See* 5 U.S.C. 601(6). Therefore in accordance with section 605(b) of the RFA, FHFA certifies that this proposed rule, if promulgated as a final rule, will not have significant economic impact on a substantial number of small entities.

List of Subjects in 12 CFR Parts 956 and 1267

Community development, Credit, Federal home loan bank, Housing, Reporting and recordkeeping requirements.

Accordingly, for reasons stated in the preamble and under the authority of 12 U.S.C. 1429, 1430, 1430b, 1431, 1436, 4511, 4513, 4526, FHFA proposes to amend subchapter G of chapter IX and subchapter D of chapter XII of title 12 of the Code of Federal Regulations as follows:

CHAPTER IX—FEDERAL HOUSING FINANCE BOARD

SUBCHAPTER G—FEDERAL HOME LOAN BANK ASSETS AND OFF-BALANCE SHEET ITEMS

PART 956—[REMOVED]

1. Remove part 956.

[5] This provision was in section II.B. of the FMP, and no longer applies to the Banks that have converted to the GLB Act capital structure.

CHAPTER XII—FEDERAL HOUSING FINANCE AGENCY

SUBCHAPTER D—FEDERAL HOME LOAN BANKS

2. Add part 1267 to subchapter D to read as follows:

PART 1267—FEDERAL HOME LOAN BANK INVESTMENTS

Sec.
1267.1 Definitions.
1267.2 Authorized investments and transactions.
1267.3 Prohibited investments and prudential rules.
1267.4 Limitations and prudential requirements on use of derivative instruments.
1267.5 Risk-based capital requirements for investments.

Authority: 12 U.S.C. 1429, 1430, 1430b, 1431, 1436, 4511, 4513, 4526.

§ 1267.1 Definitions.

As used in this part:

Asset-backed security or ABS means a debt instrument backed by loans, but does not include debt instruments that meet the definition of a mortgage-backed security.

Bank, written in title case, means a Federal Home Loan Bank established under section 12 of the Bank Act, as amended (12 U.S.C. 1432).

Bank Act means the Federal Home Loan Bank Act, as amended (12 U.S.C. 1421 through 1449).

Consolidated obligation means any bond, debenture or note on which the Banks are jointly and severally liable and which was issued under section 11 of the Bank Act (12 U.S.C. 1431) and in accordance with any implementing regulations, whether or not such instrument was originally issued jointly by the Banks or by the Federal Housing Finance Board on behalf of the Banks.

Deposits in banks or trust companies means:

(1) A deposit in another Bank;

(2) A demand account in a Federal Reserve Bank;

(3) A deposit in or sale of federal funds to:

(i) An insured depository institution, as defined in section 2(9) of the Bank Act, that is designated by the Bank's board of directors;

(ii) A trust company that is a member of the Federal Reserve System or insured by the Federal Deposit Insurance Corporation and is designated by the Bank's board of directors; or

(iii) A U.S. branch or agency of a foreign Bank as defined in the International Banking Act of 1978, as amended, (12 U.S.C. 3101 *et seq.*) that is subject to supervision of the Board of Governors of the Federal Reserve System and is designated by the Bank's board of directors.

Derivative contract means generally a financial contract the value of which is derived from the values of one or more referenced assets, rates, or indices of asset values, or credit-related events. Derivative contracts include interest rate derivative contracts, foreign exchange rate derivative contracts, equity derivative contracts, precious metals derivative contracts, commodity derivative contracts and credit derivatives, and any other instruments that pose similar risks.

GAAP means the United States generally accepted accounting principles.

Indexed principal swap means an interest rate swap agreement in which the notional principal balance amortizes based upon the prepayment experience of a specified group of MBS or ABS or the behavior of an interest rate index.

Interest-only stripped security or *IO* means a class of mortgage-backed or asset-backed security that is allocated only the interest payments made on the underlying mortgages or loans and receives no principal payments.

Investment grade means:

(1) A credit quality rating in one of the four highest credit rating categories by an NRSRO and not below the fourth highest credit rating category by any NRSRO; or

(2) If there is no credit quality rating by an NRSRO, a determination by a Bank that the issuer, asset or instrument is the credit equivalent of investment grade using credit rating standards available from an NRSRO or similar standards.

Mortgage-backed security or MBS means a security or instrument, including collateralized mortgage obligations (CMOs), and Real Estate Mortgage Investment Trusts (REMICS), that represents an interest in, or is secured by, one or more pools of mortgages loans.

NRSRO means a credit rating organization registered with the Securities and Exchange Commission as a nationally recognized statistical rating organization.

Principal-only stripped security or *PO* means a class of mortgage-backed or asset-backed security that is allocated only the principal payments made on the underlying mortgages, or loans and receives no interest payments.

Total capital shall have the meaning set forth in § 1229.1 of this title.

§ 1267.2 Authorized investments and transactions.

(a) In addition to assets enumerated in parts 950 and 955 of this title and subject to the applicable limitations set forth in this part, and in part 980 of this title, each Bank may invest in:

(1) Obligations of the United States;

(2) Deposits in banks or trust companies;

(3) Obligations, participations or other instruments of, or issued by, the Federal National Mortgage Association or the Government National Mortgage Association;

(4) Mortgages, obligations, or other securities that are, or ever have been, sold by the Federal Home Loan Mortgage Corporation pursuant to section 305 or 306 of the Federal Home Loan Mortgage Corporation Act (12 U.S.C. 1454 or 1455);

(5) Stock, obligations, or other securities of any small business investment company formed pursuant to 15 U.S.C. 681, to the extent such investment is made for purposes of aiding members of the Bank; and

(6) Instruments that the Bank has determined are permissible investments for fiduciary or trust funds under the laws of the state in which the Bank is located.

(b) Subject to any applicable limitations set forth in this part and in part 980 of this title, a Bank also may enter into the following types of transactions:

(1) Derivative contracts;

(2) Standby letters of credit, pursuant to the requirements of part 1269 of this title;

(3) Forward asset purchases and sales;

(4) Commitments to make advances; and

(5) Commitments to make or purchase other loans.

§ 1267.3 Prohibited investments and prudential rules.

(a) *Prohibited investments.* A Bank may not invest in:

(1) Instruments that provide an ownership interest in an entity, except for investments described in § 1265.3(e) and (f) of this title;

(2) Instruments issued by non-United States entities, except United States branches and agency offices of foreign commercial banks;

(3) Debt instruments that are not rated as investment grade, except:

(i) Investments described in § 1265.3(e) of this title; and

(ii) Debt instruments that were downgraded to a below investment grade rating after acquisition by the Bank;

(4) Whole mortgages or other whole loans, or interests in mortgages or loans, except:

(i) Acquired member assets;

(ii) Investments described in § 1265.3(e) of this title;

(iii) Marketable direct obligations of state, local, or tribal government units or agencies, having at least the second highest credit rating from an NRSRO, where the purchase of such obligations by the Bank provides to the issuer the customized terms, necessary liquidity, or favorable pricing required to generate needed funding for housing or community lending;

(iv) Mortgage-backed securities, or asset-backed securities collateralized by manufactured housing loans or home equity loans, that meet the definition of the term "securities" under 15 U.S.C. 77b(a)(1) and are not otherwise prohibited under paragraphs (a)(5) through (a)(7) of this section; and

(v) Loans held or acquired pursuant to section 12(b) of the Bank Act (12 U.S.C. 1432(b)).

(5) Residual interest and interest accrual classes of securities;

(6) Interest-only and principal-only stripped securities; and

(7) Fixed rate mortgage-backed securities or eligible asset-backed securities or floating rate mortgage-backed securities or eligible asset-backed securities that on the trade date are at rates equal to their contractual cap, with average lives that vary more than six years under an assumed instantaneous interest rate change of 300 basis points, unless the instrument qualifies as an acquired member asset under part 955 of this title.

(b) *Foreign currency or commodity positions prohibited.* A Bank may not take a position in any commodity or foreign currency. The Banks may issue consolidated obligations denominated in a currency other than U.S. Dollars or linked to equity or commodity prices, provided that the Banks meet the requirements of § 966.8(d) of this title, and all other applicable requirements related to issuing consolidated obligations.

(c) *Limits on certain investments.* (1) A purchase, otherwise authorized under this part, of mortgage-backed securities or asset-backed securities, may not cause the aggregate book value of all such securities held by the Bank to exceed 300 percent of the Bank's total capital. A Bank will not be required to divest securities solely to bring the level of its holdings into compliance with the limits of this paragraph, provided that the original purchase of the securities complied with the limits in this paragraph.

(2) A Bank's purchase of any mortgage-backed or asset-backed security may not cause its total holdings of mortgage-backed and asset-backed securities to increase in any calendar quarter by more than 50 percent of its total capital as of the beginning of such quarter.

§ 1267.4 Limitations and prudential requirements on use of derivative instruments.

(a) *Non-speculative use.* Derivative instruments that do not qualify as hedging instruments pursuant to GAAP may be used only if a non-speculative use is documented by the Bank.

(b) *Additional prohibitions.* (1) A Bank may not enter into interest rate swaps that amortize according to behavior of instruments described in § 1267.3(a)(5) or (a)(6) of this part.

(2) A Bank may not enter into indexed principal swaps that have lives that vary by more than six years under an assumed instantaneous change in interest rates of 300 basis points, unless they are entered into in conjunction with the issuance of consolidated obligations or the purchase of permissible investments or entry into a permissible transaction in which all interest rate risk is passed through to the investor or counterparty.

(c) *Documentation requirements.* (1) Derivative transactions with a single counterparty shall be governed by a single master agreement when practicable.

(2) A Bank's agreement with the counterparty for over-the-counter derivative contracts shall include:

(i) A requirement that market value determinations and subsequent adjustments of collateral be made at least on a monthly basis;

(ii) A statement that failure of a counterparty to meet a collateral call will result in an early termination event;

(iii) A description of early termination pricing and methodology, with the methodology reflecting a reasonable estimate of the market value of the over-the-counter derivative contract at termination (standard International Swaps and Derivatives Association, Inc. language relative to early termination pricing and methodology may be used to satisfy this requirement); and

(iv) A requirement that the Bank's consent be obtained prior to the transfer of an agreement or contract by a counterparty.

§ 1267.5 Risk-based capital requirements for investments.

Any Bank which is not subject to the capital requirements set forth in part 932 of this title shall hold retained earnings plus general allowance for losses as support for the credit risk of all investments that are not rated by an NRSRO, or are rated or have a putative rating below the second highest credit rating, in an amount equal to or greater than the outstanding balance of the investments multiplied by:

(a) A factor associated with the credit rating of the investments as determined by FHFA on a case-by-case basis for rated assets to be sufficient to raise the credit quality of the asset to the second highest credit rating category; and

(b) 0.08 for assets having neither a putative nor actual rating.

Dated: April 28, 2010.

Edward J. DeMarco,

Acting Director, Federal Housing Finance Agency.

[FR Doc. 2010–10426 Filed 5–3–10; 8:45 am]

BILLING CODE 8070–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2010–0403; Airspace Docket No. 10–ACE–4]

Proposed Amendment of Class E Airspace; Perryville, MO

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This action proposes to amend Class E airspace at Perryville, MO. Additional controlled airspace is necessary to accommodate new Standard Instrument Approach Procedures (SIAPs) at Perryville Municipal Airport, Perryville, MO. The FAA is taking this action to enhance the safety and management of Instrument Flight Rules (IFR) operations at the airport.

DATES: 0901 UTC. Comments must be received on or before June 18, 2010.

ADDRESSES: Send comments on this proposal to the U.S. Department of Transportation, Docket Operations, 1200 New Jersey Avenue, SE., West Building Ground Floor, Room W12–140, Washington, DC 20590–0001. You must identify the docket number FAA–2010–0403/Airspace Docket No. 10–ACE–4, at the beginning of your comments. You may also submit comments through the Internet at *http://www.regulations.gov.* You may review the public docket containing the proposal, any comments received, and any final disposition in person in the Dockets Office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Office (telephone 1–800–647–5527), is on the ground floor of the building at the above address.

FOR FURTHER INFORMATION CONTACT: Scott Enander, Central Service Center, Operations Support Group, Federal Aviation Administration, Southwest Region, 2601 Meacham Blvd, Fort Worth, TX 76137; telephone: 817–321–7716.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments, as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify both docket numbers and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: "Comments to Docket No. FAA–2010–0403/Airspace Docket No. 10–ACE–4." The postcard will be date/time stamped and returned to the commenter.

Availability of NPRMs

An electronic copy of this document may be downloaded through the Internet at *http://www.regulations.gov.* Recently published rulemaking documents can also be accessed through the FAA's Web page at *http://www.faa.gov/airports_airtraffic/air_traffic/publications/airspace_amendments/.*

You may review the public docket containing the proposal, any comments received and any final disposition in person in the Dockets Office (*see* **ADDRESSES** section for address and phone number) between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. An informal docket may also be examined during normal business hours at the office of the Central Service Center, 2601 Meacham Blvd, Fort Worth, TX 76137.

Persons interested in being placed on a mailing list for future NPRM's should contact the FAA's Office of Rulemaking 202–267–9677, to request a copy of Advisory Circular No. 11–2A, Notice of Proposed Rulemaking Distribution System, which describes the application procedure.

The Proposal

This action proposes to amend Title 14, Code of Federal Regulations (14 CFR), part 71 by adding additional Class E airspace extending upward from 700 feet above the surface for SIAPs at Perryville Municipal Airport, Perryville, MO. Controlled airspace is needed for the safety and management of IFR operations at the airport.

Class E airspace areas are published in Paragraph 6005 of FAA Order 7400.9T, dated August 27, 2009, and effective September 15, 2009, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designation listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore, (1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the U.S. Code. Subtitle 1, section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, part A, subpart I, section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it would add additional controlled airspace at Perryville Municipal Airport, Perryville, MO.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

1. The authority citation for part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of FAA Order 7400.9T, Airspace Designations and Reporting Points, signed August 27, 2009, and effective September 15, 2009, is amended as follows:

Paragraph 6005 Class E Airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

ACE MO E5 Perryville, MO [Amended]

Perryville Municipal Airport, MO
(Lat. 37°52′07″ N., long. 89°51′44″ W.)

Farmington VORTAC, MO
(Lat. 37°40′24″ N., long. 90°14′03″ W.)

That airspace extending upward from 700 feet above the surface within a 6.6-mile radius of Perryville Municipal Airport and within 1.8 miles each side of the 057° radial of the Farmington VORTAC extending from the 6.6-mile radius to 8.2 miles southwest of the airport, and within 3.9 miles each side of the 197° bearing from the airport extending from the 6.6-mile radius to 11 miles south of the airport.

Issued in Fort Worth, TX on April 23, 2010.

Anthony D. Roetzel,

Manager, Operations Support Group, ATO Central Service Center.

[FR Doc. 2010–10323 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Part 1910

Injury and Illness Prevention Program

AGENCY: Occupational Safety and Health Administration (OSHA), Labor.

ACTION: Notice of stakeholder meetings.

SUMMARY: OSHA invites interested parties to participate in informal stakeholder meetings on Injury and Illness Prevention Programs, referred to as "I2P2." OSHA plans to use the information gathered at these meetings in developing an Injury and Illness Prevention Program proposed rule. The discussions will be informal and will provide the Agency with the necessary

information to develop a rule that will help employers reduce workplace injuries and illnesses through a systematic process that proactively addresses workplace safety and health hazards.

DATES: Dates and locations for the stakeholder meetings are:

- June 3, 2010, 8:30 a.m. to 4:30 p.m., in East Brunswick, NJ.
- June 10, 2010, 8:30 a.m. to 4:30 p.m., in Dallas, TX.
- June 29, 2010, 8:30 a.m. to 4:30 p.m., in Washington, DC.

The deadlines for confirmed registration at each meeting are May 20, May 27, and June 15, 2010 respectively.

ADDRESSES:

I. Registration

Submit your notice of intent to participate in one of the scheduled meetings by one of the following:

- *Electronic.* Register at *https://www2.ergweb.com/projects/conferences/osha/register-osha-I2P2.htm* (follow the instructions online).
- *Facsimile.* Fax your request to: (781) 674–2906, and label it "Attention: OSHA I2P2 Stakeholder Meeting Registration."
- *Regular mail, express delivery, hand (courier) delivery, and messenger service.*

Send your request to: Eastern Research Group, Inc., 110 Hartwell Avenue, Lexington, MA 02421; Attention: OSHA I2P2 Stakeholder Meeting Registration.

II. Meetings

Specific information on the location of each meeting can be found on the I2P2 Web site at *https://www2.ergweb.com/projects/conferences/osha/register-osha-I2P2.htm.*

FOR FURTHER INFORMATION CONTACT: Information regarding this notice is available from the following sources:

- *Press inquiries.* Contact Jennifer Ashley, Director, OSHA Office of Communications, Room N–3647, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210; telephone: (202) 693–1999.
- *General and technical information.* Contact Michael Seymour, OSHA Directorate of Standards and Guidance, Room N–3718, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210, telephone: (202) 693–1950.
- *Copies of this Federal Register notice.* Electronic copies are available at *http://www.regulations.gov.* This **Federal Register** notice, as well as news releases and other relevant information, also are available on the OSHA Web page at *http://www.osha.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Over the past 30 years, the occupational safety and health community has used various names to describe systematic approaches to reducing injuries and illnesses in the workplace. OSHA has voluntary Safety and Health Management Program guidelines, consensus and international standards use the term "Safety and Health Management Systems," and OSHA's state plan states use terms such as "Injury and Illness Prevention Programs" and "Accident Prevention Programs." In this notice, OSHA uses the term "Injury and Illness Prevention Programs." Regardless of the title, the common goal of these approaches is to help employers reduce workplace injuries and illnesses through a systematic process that proactively addresses workplace safety and health hazards.

OSHA's History With Safety and Health Programs

The Occupational Safety and Health Act (29 U.S.C. 651 *et seq.*) (the Act) in Section 17, paragraph (j), provides the Occupational Safety and Health Review Commission (OSHRC) the authority to assess civil penalties giving due consideration to the good faith of the employer. Based on this paragraph of the Act, OSHA has also had a policy of reducing penalties for employers who have violated OSHA standards but who have demonstrated a good faith effort to provide a safe and healthy workplace to their employees. The Agency has long recognized the implementation of a safety and health program as a way of demonstrating good faith. Similarly, in its first decision, the OSHRC held that good faith compliance efforts are gauged primarily by the presence of effective safety and health programs (*Nacirema Operating Co.,* 1 O.S.H. Cas. (BNA) 1001 (Rev. Comm'n 1972)).

Over the years, OSHA has established a number of initiatives to encourage employers to develop and implement employee safety and health programs. OSHA's Small Business Consultation Program, which offers small businesses with exemplary safety and health programs an opportunity for recognition under their Safety and Health Achievement Recognition Program (SHARP) and the Agency's Voluntary Protection Program (VPP) are two examples of such initiatives. The Agency established the VPP to recognize companies in the private sector with outstanding records in the area of employee safety and health. It became apparent that many of these worksites, which had higher levels of compliance, fewer serious hazards, and injury and illness rates markedly below industry averages, were relying on safety and health programs to produce these results.

Based on the growing support for safety and health programs, OSHA issued the Safety and Health Program Management Guidelines in 1989 (54 FR 3908). These guidelines reflect the best management practices of successful companies and encourage employers to institute and maintain a program which provides systematic policies, procedures, and practices that are adequate to recognize and protect their employees from occupational safety and health hazards. The guidelines identify four major elements of an effective program: Management commitment and employee involvement; worksite analysis; hazard prevention and controls; and safety and health training.

OSHA's Previous Rulemaking Effort

In October of 1995, OSHA held the first series of stakeholder meetings to discuss preliminary ideas for a safety and health program rule and the significant issues that would be raised by such a rule. Many small businesses and organizations representing small businesses attended the stakeholder meetings. Staff members from the Office of Advocacy of the Small Business Administration (SBA) were also present at the stakeholder meetings.

In all, OSHA interacted with hundreds of stakeholders, including employers, employees, employee representatives, trade associations, State and local government personnel, safety and health professionals, Advisory Committees, and other interested parties.

In 1998, OSHA developed a draft proposed rule that would have required employers in general industry and maritime workplaces to establish safety and health programs. The program in the draft proposed rule had five core elements, including: Management leadership and employee participation; hazard identification and assessment; hazard prevention and control; information and training; and evaluation of the program's effectiveness. In developing the draft proposed rule, OSHA worked extensively with stakeholders from labor, industry, safety and health organizations, State governments, trade associations, insurance companies, and small businesses.

On October 20, 1998, OSHA convened a Small Business Regulatory

Enforcement Fairness Act (SBREFA) Panel for the draft Safety and Health Programs proposed rule. The Panel provided small entity representatives (SERs) with initial drafts of the rule, a summary of the rule, the Initial Regulatory Flexibility Analysis, a summary of the benefits and costs of the rule as it affected firms in the small entity representative's industry, OSHA's draft enforcement policy for the rule, and a list of issues of interest to panel members.

The SBREFA Panel held teleconferences and received written comments from the SERs. The comments, and the Panel's responses to them, formed the principal basis for the Panel's report. The Panel's report provided background information on the draft proposed rule and the types of small entities that would be subject to the proposed rule, described the Panel's efforts to obtain the advice and recommendations of representatives of those small entities, summarized the comments that had been received from those representatives, and presented the findings and recommendations of the Panel.

A proposed Safety and Health Program rule was never published, and the rulemaking effort was removed from the Regulatory Agenda on August 15, 2002. However, the effort in the 1990s showed the interest of OSHA, the States, employers, employees, OSHA's advisory committees, and others in a systematic process that proactively addresses workplace safety and health hazards. It demonstrated that OSHA was not alone in believing that these processes work to save lives and to prevent injuries and illnesses in the workplace.

Safety and Health Management System Consensus Standards

Recently, consensus standards have been developed that address safety and health management systems. The American Industrial Hygiene Association published a voluntary consensus standard, *ANSI/AIHA Z10—2005 Occupational Safety and Health Management Systems,* based on the "Plan-Do-Check-Act" cycle. The Z10 standard places an emphasis on continual improvement and systematically eliminating the underlying root cause of hazards. In addition, the Occupational Health and Safety Assessment Series (OHSAS) Project Group, which is an international association of government agencies, private industries, and consulting organizations, developed *OHSAS 18001—2007 Occupational Health and Safety Management Systems* in response to customer demand for a recognized occupational health and safety management system standard against which their management systems could be assessed and certified. The OHSAS 18001 is published by the British Standards Institute.

II. Stakeholder Meetings

Stakeholder meetings will provide OSHA with current information and appreciation of the views of a wide range of interests. The meetings will be conducted as a group discussion. To facilitate as much group interaction as possible, formal presentations will not be permitted. OSHA believes the stakeholder meeting discussion should center on major issues such as:

- Possible regulatory approaches.
- Scope and application of a rule.

—Covered industries.
—Covered employers (size, high/low injury rates).
—Covered hazards.
—Relationship to existing OSHA requirements.

- Organization of a rule.

—Regulatory text.
—Mandatory or voluntary appendices.
—Other standards incorporated by reference.

- The role of consensus standards.
- Economic impacts.
- Any additional topics as time permits.

In addition, OSHA is interested in receiving feedback on the following specific questions:

- In light of the ANSI Z10 standard, the OHSAS 18001 standard, and OSHA's 1989 guidelines, what are the advantages and disadvantages of addressing through rulemaking a systematic process that proactively addresses workplace safety and health hazards?
- Based on OSHA's experience, the agency believes that an I2P2 rule would include the following elements:

1. Management duties (including items such as establishing a policy, setting goals, planning and allocating resources, and assigning and communicating roles and responsibilities);
2. Employee participation (including items such as involving employees in establishing, maintaining and evaluating the program, employee access to safety and health information, and employee role in incident investigations);
3. Hazard identification and assessment (including items such as what hazards must be identified, information gathering, workplace inspections, incident investigations, hazards associated with changes in the workplace, emergency hazards, hazard assessment and prioritization, and hazard identification tools);
4. Hazard prevention and control (including items such as what hazards must be controlled, hazard control priorities, and the effectiveness of the controls);
5. Education and training (including items such as content of training, relationship to other OSHA training requirements, and periodic training); and
6. Program evaluation and improvement (including items such as monitoring performance, correcting program deficiencies, and improving program performance).

Are these the appropriate elements? Which elements are essential for an effective approach? Should additional elements be included?

- How can OSHA ensure that small business employers are able to implement and maintain an effective I2P2?
- Should an OSHA I2P2 rule apply to every business or should it be limited in some way based on an employer's size, industry, incident rates, and/or hazard indices?
- To what extent should OSHA rely on existing consensus standards in developing a rule?
- How can OSHA use state experience with injury and illness prevention in developing a rule?
- What mechanisms have been found to be effective for enabling employees to participate in safety and health in the workplace?
- Given the variety of names used to describe processes to reduce injuries and illnesses in the workplace, what is the most appropriate name for OSHA to describe this topic?

III. Public Participation

Approximately 50 participants will be accommodated in each meeting, and eight hours will be allotted for each meeting. Members of the general public may observe, but not participate in, the meetings on a first-come, first-served basis as space permits. OSHA staff will be present to take part in the discussions. Logistics for the meetings are being managed by Eastern Research Group (ERG), which will provide a facilitator and compile notes summarizing the discussion; these notes will not identify individual speakers. ERG also will make an audio recording of each session to ensure that the summary notes are accurate; these recordings will not be transcribed. The summary notes will be available on OSHA's Web page at *http://www.osha.gov.*

Specific information on the location of each meeting can be found on the I2P2 Web site at *https://www2.ergweb.com/projects/conferences/osha/register-osha-I2P2.htm.*

To participate in one of the stakeholder meetings, or be a nonparticipating observer, you may submit notice of intent electronically, by facsimile, or by hard copy. In order to encourage as wide a range of viewpoints as possible, OSHA will confirm participants as necessary to ensure a fair representation of interests and to facilitate gathering diverse viewpoints. To receive a confirmation of your participation 1 week before the meeting, register by the date listed in the **DATES** section of this notice. However, registration will remain open until the meetings are full. Additional nonparticipating observers that do not register for the meeting will be accommodated as space permits. See the **ADDRESSES** section of this notice for the registration Web site, facsimile number, and address. To register electronically, follow the instructions provided on the Web site. To register by mail or facsimile, please indicate the following:

- Name, address, phone, fax, and e-mail.
- Meeting location you would like to attend.
- Organization for which you work.
- Organization you represent (if different).
- Stakeholder category: Government, industry, standards-developing organization, research or testing agency, union, trade association, insurance, consultant, or other (if other, please specify).
- Industry sector (if applicable).

Electronic copies of this **Federal Register** notice, as well as news releases and other relevant documents, are available on the OSHA Web page at: *http://www.osha.gov.*

IV. Authority and Signature

This document was prepared under the direction of David Michaels, PhD, MPH, Assistant Secretary of Labor for Occupational Safety and Health, U.S. Department of Labor, pursuant to sections 4, 6, and 8 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 653, 655, 657), 29 CFR part 1911, and Secretary's Order 5–2007 (72 FR 31160).

Signed at Washington, DC, on April 12, 2010.

David Michaels,

Assistant Secretary of Labor for Occupational Safety and Health.

[FR Doc. 2010–10138 Filed 5–3–10; 8:45 am]

BILLING CODE 4510–26–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R02–OAR–2009–0462, FRL–9144–6]

Approval and Promulgation of Implementation Plans; New York Reasonably Available Control Technology and Reasonably Available Control Measures

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: On August 25, 2009, the EPA proposed to disapprove portions of a proposed revision to the New York State Implementation Plan, submitted on February 8, 2008, that was intended to meet specific Clean Air Act requirements for attaining the 0.08 parts per million 8-hour ozone national ambient air quality standards. Specifically, EPA proposed to disapprove New York's reasonably available control measure analysis and New York's efforts to meet the reasonably available control technology requirements. Subsequent to that action, New York passed two additional rules and submitted them for review and inclusion in the State Implementation Plan and made additional commitments to meet the remaining reasonably available control technology and reasonably available control measure requirements. Therefore, in this action EPA is proposing a conditional approval of the reasonably available control technology requirement which applies to the entire State of New York, including the New York portion of the New York-Northern New Jersey-Long Island, NY–NJ–CT and the Poughkeepsie 8-hour ozone moderate nonattainment areas. In addition, EPA is proposing a conditional approval of the reasonably available control measure analysis which applies to the New York portion of the New York-Northern New Jersey-Long Island, NY–NJ–CT 8-hour ozone moderate nonattainment area.

DATES: Comments must be received on or before June 3, 2010.

ADDRESSES: Submit your comments, identified by Docket Number EPA–R02–OAR–2009–0462, by one of the following methods:

- *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.
- *E-mail: Werner.Raymond@epa.gov.*
- *Fax:* 212–637–3901.
- *Mail:* Raymond Werner, Chief, Air Programs Branch, Environmental Protection Agency, Region 2 Office, 290 Broadway, 25th Floor, New York, New York 10007–1866.
- *Hand Delivery:* Raymond Werner, Chief, Air Programs Branch, Environmental Protection Agency, Region 2 Office, 290 Broadway, 25th Floor, New York, New York 10007–1866. Such deliveries are only accepted during the Regional Office's normal hours of operation. The Regional Office's official hours of business are Monday through Friday, 8:30 to 4:30 excluding Federal holidays.

Instructions: Direct your comments to Docket No. EPA–R02–OAR–2009–0462. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters or any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.*

Docket: All documents in the docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *http://*

www.regulations.gov or in hard copy at the Environmental Protection Agency, Region 2 Office, Air Programs Branch, 290 Broadway, 25th Floor, New York, New York 10007–1866. EPA requests, if at all possible, that you contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section to view the hard copy of the docket. You may view the hard copy of the docket Monday through Friday, 8 a.m. to 4 p.m., excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: Kirk Wieber (*wieber.kirk@epa.gov*), Air Programs Branch, Environmental Protection Agency, 290 Broadway, 25th Floor, New York, New York 10007–1866, (212) 637–4249.

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I. What action is EPA proposing?

The Environmental Protection Agency (EPA) has reviewed elements of New York's comprehensive proposed State Implementation Plan (SIP) revisions for the 0.08 parts per million (ppm) 8-hour ozone national ambient air quality standards (NAAQS or standard) [1] along with other related Clean Air Act (Act) requirements necessary to ensure attainment of the standard. On August 25, 2009 (74 FR 42813), EPA proposed to disapprove New York's reasonably available control measure (RACM) analysis and New York's efforts to meet the reasonably available control technology (RACT) requirement. The reader is referred to that rulemaking action and its accompanying technical support document for a more detailed discussion of New York's RACT and RACM plans. New York submitted a letter committing to adopt the necessary control measures that will satisfy the RACT and RACM requirement by August 31, 2010, which is no more than one year from our anticipated final action on the SIP submittals. Therefore, in this action, EPA is proposing a conditional approval of New York's RACT and RACM plans.

[1] Unless otherwise specifically noted in this action, references to the 8-hour ozone standard are to the 0.08 ppm ozone standard promulgated in 1997.

II. What was included in New York's SIP submittals?

After completing the appropriate public notice and comment procedures, New York made a series of submittals in order to address the Act's 8-hour ozone attainment requirements. On September 1, 2006, New York submitted its state-wide 8-hour ozone RACT SIP, which included a determination that many of the RACT rules currently contained in its SIP meet the RACT obligation for the 8-hour standard. On February 8, 2008, New York submitted two comprehensive 8-hour ozone SIPs—one for the New York portion of the New York-Northern New Jersey-Long Island, NY–NJ–CT nonattainment area, entitled, "New York SIP for Ozone—Attainment Demonstration for New York Metro Area" and one for the Poughkeepsie nonattainment area, entitled, "New York SIP for Ozone—Attainment Demonstration for Poughkeepsie, NY Area." The submittals included the 2002 base year emissions inventory, projection year emissions, attainment demonstrations, Reasonable Further Progress (RFP) plans, RACT analysis, RACM analysis, contingency measures, new source review and on-road motor vehicle emission budgets. These proposed SIP revisions were subject to notice and comment by the public and the State addressed the comments received on the proposed SIP revisions before adopting the plans and submitting them for EPA review and rulemaking action.

Included in New York's February 8, 2008 8-hour Ozone SIP submittal was a list of additional control measures identified by the State as RACT and RACM. The State committed to adopt additional control measures applicable to the following source categories: Adhesives and Sealants, Consumer Products, Portable Fuel Containers, Graphic Arts, Asphalt Formulation, Asphalt Paving Production, Portland Cement Plants, Glass Manufacturing, and NOx RACT.

Of the source categories identified by New York, on July 15, 2009 and September 30, 2009, the State adopted rules for Portable Fuel Containers and Consumer Products, respectively. New York submitted the Consumer Products rule (on October 21, 2009) and the Portable Fuel Container rule (on November 23, 2009) to EPA, for review and approval into the SIP. On March 2, 2010 (75 FR 9373), EPA proposed to approve New York's Consumer Products and Portable Fuel Container rules and will take final action in the near future.

On December 28, 2009, New York provided supplemental information intended to clarify the RFP and 2002 base year emissions inventory, projection year emissions and conformity budgets that were included in the February 8, 2008 ozone SIP submittals. EPA is reviewing this information and will make a decision in the near future as to whether these submissions satisfy the requirements of the Act.

III. What is the rationale for this proposed rulemaking action?

On August 25, 2009 (74 FR 42813), EPA proposed to disapprove New York's RACT and RACM plans. In that proposed rulemaking action, EPA made suggestions for how New York could correct the identified deficiencies and strengthen the 8-hour ozone SIP (see 74 FR 42819). As discussed in Section II, New York adopted and submitted for inclusion in the SIP two of the control measures it had adopted. On December 23, 2009, New York proposed adoption of all but one of the remaining additional control measures that it committed to adopt as satisfying the RACT and RACM requirement. Based on this recent progress and on New York's commitment to submit adopted RACT/RACM rules by August 31, 2010, EPA is proposing a conditional approval of the RACT and RACM SIPs for the 8-hour ozone NAAQS. EPA has determined that New York will be able to meet this commitment because the State has already adopted rules for two of the source categories and recently proposed, and concluded public comment on, RACT/RACM provisions for all but one of the remaining source categories.

IV. What are EPA's conclusions?

EPA is proposing a conditional approval of the moderate area RACM analysis for the New York portion of the New York-Northern New Jersey-Long Island, NY–NJ–CT 8-hour ozone moderate nonattainment area as presented in the February 8, 2008 "New York SIP for Ozone—Attainment Demonstration for New York Metro Area" SIP submittal.

EPA is also proposing a conditional approval of the September 1, 2006 New York RACT assessment SIP submittal, supplemented on February 8, 2008 and September 16, 2008, which applies to the entire State and to the New York portion of the New York-Northern New Jersey-Long Island, NY–NJ–CT and the Poughkeepsie 8-hour ozone moderate nonattainment areas.

EPA is proposing a conditional approval of the RACT and RACM analyses for the 8-hour ozone NAAQS based on New York's letter committing

to submit adopted RACT/RACM rules for several source categories by August 31, 2010. EPA has determined that New York will be able to meet this commitment because the State has already adopted rules for two of the source categories and recently proposed, and concluded public comment on, RACT/RACM provisions for all but one of the remaining source categories.

Under section 110(k)(4) of the Act, EPA may conditionally approve a plan based on a commitment from the State to adopt specific enforceable measures by a date certain, but not later than 1 year from the date of approval. If EPA conditionally approves the commitment in a final rulemaking action, the State must meet its commitment to adopt the identified regulations. If the State fails to do so, this action will become a disapproval upon the State's failure to meet its commitment. EPA will notify the State by letter that this action has occurred. If the conditional approval converts to a disapproval, the commitment will no longer be a part of the approved New York SIP. Upon notification to the State that the conditional approval has converted to a disapproval, EPA will publish a notice in the **Federal Register** notifying the public that the conditional approval automatically converted to a disapproval. If EPA disapproves the RACT and RACM SIP submittals, such action will start a sanctions and FIP clock (see section V). If the State meets its commitment, within the applicable time frame, the conditionally approved submission will remain a part of the SIP until EPA takes final action approving or disapproving the RACT and RACM submittals. If EPA approves the submittals, the RACT and RACM analyses will be fully approved into the SIP in their entirety.

V. What are the consequences if a final conditional approval is converted to a disapproval?

The Act provides for the imposition of sanctions and the promulgation of a federal implementation plan (FIP) if states fail to correct any deficiencies identified by EPA in a final disapproval action within certain timeframes.

A. What are the Act's provisions for sanctions?

If EPA disapproves a required SIP submittal or component of a SIP submittal, section 179(a) provides for the imposition of sanctions unless the deficiency is corrected within 18 months of the final rulemaking of disapproval. The first sanction would apply 18 months after EPA disapproves the SIP submittal if a state fails to make the required submittal that EPA proposes to fully or conditionally approve within that time. Under EPA's sanctions regulations, 40 CFR 52.31, the first sanction would be 2:1 offsets for sources subject to the new source review requirements under section 173 of the Act. If the state has still failed to submit a SIP for which EPA proposes full or conditional approval 6 months after the first sanction is imposed, the second sanction will apply. The second sanction is a limitation on the receipt of federal highway funds. EPA also has authority under section 110(m) to sanction a broader area.

B. What federal implementation plan provisions apply if a state fails to submit an approvable plan?

In addition to sanctions, if EPA finds that a state failed to submit the required SIP revision or disapproves the required SIP revision, or a portion thereof, EPA must promulgate a FIP no later than 2 years from the date of the finding if the deficiency has not been corrected.

VI. Statutory and Executive Order Reviews

Under the Act, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Act. Accordingly, this proposed action merely approves state law as meeting federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this proposed action:

- Is not a "significant regulatory action" subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Act; and
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the state, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Hydrocarbons, Incorporation by reference, Intergovernmental relations, Oxides of nitrogen, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: April 23, 2010.

Judith A. Enck,

Regional Administrator, Region 2.

[FR Doc. 2010–10416 Filed 5–3–10; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket ID FEMA–2010–0003; Internal Agency Docket No. FEMA–B–1093]

Proposed Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Proposed rule.

SUMMARY: Comments are requested on the proposed Base (1% annual-chance) Flood Elevations (BFEs) and proposed BFE modifications for the communities listed in the table below. The purpose of this notice is to seek general information and comment regarding the proposed regulatory flood elevations for

the reach described by the downstream and upstream locations in the table below. The BFEs and modified BFEs are a part of the floodplain management measures that the community is required either to adopt or to show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP). In addition, these elevations, once finalized, will be used by insurance agents and others to calculate appropriate flood insurance premium rates for new buildings and the contents in those buildings.

DATES: Comments are to be submitted on or before August 2, 2010.

ADDRESSES: The corresponding preliminary Flood Insurance Rate Map (FIRM) for the proposed BFEs for each community is available for inspection at the community's map repository. The respective addresses are listed in the table below.

You may submit comments, identified by Docket No. FEMA–B–1093, to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) proposes to make determinations of BFEs and modified BFEs for each community listed below, in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed BFEs and modified BFEs, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities. These proposed elevations are used to meet the floodplain management requirements of the NFIP and also are used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in those buildings.

Comments on any aspect of the Flood Insurance Study and FIRM, other than the proposed BFEs, will be considered. A letter acknowledging receipt of any comments will not be sent.

National Environmental Policy Act. This proposed rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Executive Order 12866, Regulatory Planning and Review. This proposed rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866, as amended.

Executive Order 13132, Federalism. This proposed rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This proposed rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

Accordingly, 44 CFR part 67 is proposed to be amended as follows:

PART 67—[AMENDED]

1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.4 [Amended]

2. The tables published under the authority of § 67.4 are proposed to be amended as follows:

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Douglas County, Illinois, and Incorporated Areas				
Bourbon No. 3	Approximately 0.4 mile downstream of Vine Street	None	+654	Unincorporated Areas of Douglas County.
	At Vine Street	None	+658	
Embarras River	Approximately 0.7 mile upstream of U.S. Route 36	None	+641	Village of Camargo.
	Approximately 0.5 mile upstream of Main Street	None	+644	
Lake Fork	Approximately 900 feet downstream of U.S. Route 36	None	+657	Village of Atwood.
	Approximately 100 feet downstream of U.S. Route 36	None	+657	
West Ditch	Approximately 50 feet downstream of Sycamore Street.	+649	+650	City of Villa Grove, Unincorporated Areas of Douglas County.
	Approximately 0.41 mile upstream of Harrison Street	None	+651	
West Fork Kaskaskia River	At the railroad	None	+653	Unincorporated Areas of Douglas County.
	Approximately 300 feet upstream of County Road 500 North.	None	+655	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Villa Grove

Maps are available for inspection at City Hall, 612 East Front Street, Villa Grove, IL 61956.

Unincorporated Areas of Douglas County

Maps are available for inspection at the Douglas County Courthouse, 401 South Center Street, Tuscola, IL 61953.

Village of Atwood

Maps are available for inspection at the Atwood Municipal Building, 110 West Central Avenue, Atwood, IL 61913.

Village of Camargo

Maps are available for inspection at the Douglas County Courthouse, 401 South Center Street, Tuscola, IL 61953.

Mason County, Illinois, and Incorporated Areas

Ponding	North boundary: Private drive approximately 230 feet north of north entrance to Linwood Lake Estates Road/East boundary: Abandoned road approximately 660 feet west of Highway 78/South boundary: Private drive approximately 665 feet north of beginning of North Elm Street/West boundary: Highway 78.	None	+466	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 2,470 feet north of County Highway 1/East boundary: Approximately 0.86 mile east of Olive Street along County Highway 1/South boundary: 385 feet south of County Highway 1/West boundary: Approximately 0.49 mile east of Olive Street along County Highway 1.	None	+471	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 1,300 feet south of County Highway 1/East boundary: Approximately 0.54 mile east of southeastern tip of East Main Street/South boundary: Approximately 0.72 mile south of County Highway 1/West boundary: Approximately 300 feet east of southeastern tip of East Main Street.	None	+472	Unincorporated Areas of Mason County.
Ponding	North boundary: 330 feet south of B Street along Highway 78/East boundary: At Highway 78/South boundary: Approximately 810 feet south of B Street along Highway 78/West boundary: 425 feet west of Highway 78.	None	+465	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 1,030 feet north of East 800 North Road along North 1100 East Road/East boundary: Approximately 930 feet east of North 1100 East Road/South boundary: Approximately 1,580 feet south of intersection of East 800 North Road and North 1100 East Road/West boundary: Approximately 1,950 feet east of Highway 78.	None	+465	Unincorporated Areas of Mason County.
Ponding	North boundary: At East 800 North Road/East boundary: Approximately 1,380 feet east of Highway 78/South boundary: Approximately 275 feet north of East 750 North Road/West boundary: At Highway 78.	None	+462	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 830 feet north of Hurst Street/East boundary: Approximately 1,200 feet east of Promenade Street along railroad/South boundary: Approximately 760 feet north of Hurst Street/West boundary: Approximately 770 feet west of Promenade Street along railroad.	None	+460	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 430 feet north of Mason Street/East boundary: Approximately 310 feet west of William Boulevard/South boundary: At Mason Street/West boundary: At Mason Street and railroad crossing.	None	+468	Unincorporated Areas of Mason County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Ponding	North boundary: Approximately 240 feet north of Mason Street/East boundary: Approximately 0.59 mile west of North 1800 East Road/South boundary: Approximately 1,090 feet north of U.S. Route 136/West boundary: Approximately 1,050 feet east of William Boulevard.	None	+472	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 1,230 feet south of intersection of Maywood Street and Oakwood Avenue/East boundary: Approximately 75 feet east of railroad/South boundary: Approximately 1,290 feet south of intersection of Maywood Street and Oakwood Avenue/West boundary: Approximately 25 feet east of railroad.	None	+468	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 125 feet south of Hillcrest Court extended/East boundary: At railroad/South boundary: Approximately 500 feet south of Hillcrest Court extended/West boundary: Approximately 75 feet west of railroad.	None	+476	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 970 feet south of Highway 97 railroad crossing/East boundary: Approximately 480 feet from end of Hillcrest Court/South boundary approximately 1,550 feet south of Highway 97 railroad crossing/West boundary: At railroad.	None	+476	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 0.51 mile north of East 1500 North Road/East boundary: Approximately 140 feet west of Highway 97/South boundary: Approximately 0.47 mile north of East 1500 North Road/West boundary: Approximately 465 feet west of Highway 97.	None	+476	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 1,470 feet north of East 1500 North Road/East boundary: Approximately 0.6 mile west of North 1800 East Road/South boundary: Approximately 940 feet south of intersection of Highway 97 and East 1500 North Road/West boundary: Approximately 625 feet west of intersection of Highway 97 and East 1500 North Road.	None	+480	Unincorporated Areas of Mason County.
Ponding	North boundary: Approximately 0.68 mile north of East 1500 North Road/East boundary: Approximately 0.41 mile west of North 1800 East Road/South boundary: Approximately 250 feet south of East 1500 North Road/West boundary: Approximately 1,460 feet west of Highway 97.	None	+480	Unincorporated Areas of Mason County.
Ponding	North boundary: Private drive approximately 665 feet north of beginning of North Elm Street/East boundary: Approximately 1,000 feet east of Vine Street/South boundary: Approximately 315 feet north of East 800 North Road/West boundary: Approximately at Highway 78.	None	+463	Village of Bath.
Ponding	North boundary: Approximately 250 feet south of County Highway 1/East boundary: Approximately 1,950 feet east of intersection of Olive Street and Cedar Street/South boundary: Approximately 2,000 feet south of intersection of Hickory Street and Main Street/West boundary: 980 feet east of southern tip of Locust Street.	None	#1	Village of Bath.
Ponding	North boundary: At Lincoln Street/East boundary: 50 feet west of Highway 78/South boundary: At northernmost entrance to Bath Cemetery/West boundary: Approximately 400 feet west of Highway 78 along 1st Street.	None	#3	Village of Bath.
Ponding	North boundary: 225 feet south of 4th Street/East boundary: Approximately 140 feet east of Highway 78/South boundary: Approximately 200 feet north of B Street/West boundary: At Highway 78.	None	+463	Village of Bath.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Ponding	North boundary: Approximately 600 feet north of Hurst Street/East boundary: Approximately 125 feet west of Promenade Street/South boundary: Approximately 420 feet north of Hurst Street/West boundary: Approximately 330 feet east of Pearl Street extended.	None	+460	City of Havana.
Ponding	North boundary: Approximately 415 feet north of Hurst Street/East boundary: At Promenade Street/South boundary: Approximately 500 feet north of Mound Street/West boundary: Approximately 365 feet east of intersection of Pearl Street and Hurst Street.	None	+460	City of Havana.
Ponding	North boundary: Approximately 100 feet south of Mound Street/East boundary: At Promenade Street/South boundary: Approximately 220 feet south of Mound Street/West boundary: Approximately 240 feet east of High Street.	None	+460	City of Havana.
Ponding	North boundary: Approximately 60 feet north of Mason Street/East boundary: At Teal Drive/South boundary: At Mason Street/West boundary: Approximately 175 feet west of Teal Drive.	None	+468	City of Havana.
Ponding	North boundary: Approximately 20 feet north of Mason Street/East boundary: At Mason Street railroad crossing/South boundary: At Mason Street/West boundary: Approximately 125 feet west of Teal Drive.	None	+468	City of Havana.
Ponding	North boundary: Approximately 470 feet north of Mason Street/East boundary: Approximately 1,030 feet east of William Boulevard along Mason Street/South boundary: Approximately 1,300 feet north of Laurel Street/West boundary: At railroad (560 feet east of Teal Drive).	None	+468	City of Havana.
Ponding	North boundary: At Mason Street/East boundary: At railroad (560 feet east of Teal Drive)/South boundary: At Adams Street/West boundary: Approximately 230 feet west of Promenade Street along Main Street.	None	+468	City of Havana.
Ponding	North boundary: Approximately 915 feet south of Laurel Street/East boundary: Approximately 250 feet west of railroad (560 feet east of Teal Drive)/South boundary: Approximately 410 feet north of East 1600 North Road/West boundary: At Highway 97.	None	+472	City of Havana.
Ponding	North boundary: At Windsor Street/East boundary: At Highway 97/South boundary: Approximately 800 feet north of East 1600 North Road along Highway 97/West boundary: Approximately 50 feet west of Highway 97.	None	+472	City of Havana.
Ponding	North boundary: Approximately 350 feet north of East 1600 North Road/East boundary: Approximately 375 feet west of Highway 97/South boundary: Approximately 275 feet north of East 1600 North Road/West boundary: Approximately 415 feet east of McKinley Street.	None	+472	City of Havana.
Ponding	North boundary: Approximately 140 feet south of East 1600 North Road/East boundary: Approximately 330 feet west of Highway 97/South boundary: Approximately 740 feet south of East 1600 North Road/West boundary: Approximately 500 feet west of Highway 97.	None	+472	City of Havana.
Ponding	North boundary: Approximately 80 feet south of intersection of Tinkham Street and Lincoln Street/East boundary: Approximately 535 feet west of Promenade Street/South boundary: Approximately 375 feet south of intersection of Tinkham Street and Lincoln Street/West boundary: Approximately 610 feet west of Promenade Street.	None	+472	City of Havana.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Ponding	North boundary: Approximately 75 feet south of intersection of Schrader Street and 1st Street/East boundary: Approximately 40 feet west of 1st Street/South boundary: Approximately 110 feet north of Oakwood Avenue/West boundary: Approximately 105 feet east of Highway 78.	None	+467	City of Havana.
Ponding	North boundary: Approximately 230 feet south of intersection of Dearborn Street and Water Street/East boundary: Approximately 75 feet east of Highway 78/South boundary: At intersection of Tinkham Street and Water Street/West boundary: Approximately 55 feet west of Highway 78.	None	+467	City of Havana.
Ponding	North boundary: At intersection of Water Street and 10th Street/East boundary: Approximately 160 feet east of railroad that runs parallel to Maywood Street/South boundary: Approximately 230 feet south of Water Street railroad crossing/West boundary: At Water Street.	None	#3	City of Havana.
Ponding	North boundary: Approximately 810 feet south of Wagner Avenue/East boundary: Approximately 580 feet east of Pear Street/South boundary: Approximately 1,460 feet south of Wagner Avenue/West boundary: Approximately at Pear Street.	None	+469	City of Havana.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Havana

Maps are available for inspection at City Hall, 227 West Main Street, Havana, IL 62644.

Unincorporated Areas of Mason County

Maps are available for inspection at the Mason County Courthouse, County Zoning Office, 125 North Plum Street, Havana, IL 62644.

Village of Bath

Maps are available for inspection at the Village Hall, 205 East 1st Street, Bath, IL 62617.

Des Moines County, Iowa, and Incorporated Areas

Mississippi River	Approximately 6.6 miles downstream of Burlington Northern Railroad.	+531	+532	City of Burlington, Unincorporated Areas of Des Moines County.
	Approximately 13.7 miles upstream of Lock and Dam No. 18.	+542	+543	
Spring Creek	Approximately 0.6 mile downstream of Summer Street	None	+533	Unincorporated Areas of Des Moines County.
	Approximately 0.5 mile downstream of Summer Street	None	+534	
Unnamed Tributary (Backwater from Long Creek).	Approximately 1,100 feet upstream of the confluence with Long Creek.	None	+700	Town of Danville.
	Approximately 1,400 feet upstream of the confluence with Long Creek.	None	+700	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

ADDRESSES

City of Burlington

Maps are available for inspection at City Hall, 400 Washington Street, Burlington, IA 52601.

Unincorporated Areas of Des Moines County

Maps are available for inspection at 200 North Front Street, Suite 400, Burlington, IA 52601.

Town of Danville

Maps are available for inspection at City Hall, 105 West Shepherd Street, Danville, IA 52623.

Dubuque County, Iowa, and Incorporated Areas				
Mississippi River	Approximately 11.1 miles downstream of the confluence with Catfish Creek.	+605	+606	City of Dubuque, Unincorporated Areas of Dubuque County.
	Approximately 17.5 miles upstream of Lock and Dam 11.	+615	+616	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Dubuque

Maps are available for inspection at City Hall, 50 West 13th Street, Dubuque, IA 52001.

Unincorporated Areas of Dubuque County

Maps are available for inspection at 720 Central Avenue, Dubuque, IA 52001.

Louisa County, Iowa, and Unincorporated Areas				
Mississippi River	Approximately 8.3 miles downstream of the confluence with the Iowa River.	+543	+544	Unincorporated Areas of Louisa County.
	Approximately 1.4 miles upstream of the confluence with Michaels Creek.	+553	+552	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Louisa County

Maps are available for inspection at the Louisa County Courthouse, 117 South Main Street, Wapello, IA 52653.

Nelson County, Kentucky, and Incorporated Areas				
Beech Fork Tributary 27 (Backwater effects from Beech Fork).	From the confluence with Beech Fork to just downstream of Martha Layne Collins Bluegrass Parkway.	None	+480	Unincorporated Areas of Nelson County.
Beech Fork Tributary 29 (Backwater effects from Beech Fork).	From the confluence with Beech Fork to approximately 0.8 mile upstream of the confluence with Beech Fork.	None	+478	Unincorporated Areas of Nelson County.
Buffalo Creek (Backwater effects from Beech Fork).	From the confluence with Beech Fork to just downstream of Boston Road.	None	+482	Unincorporated Areas of Nelson County.
Cedar Creek (Backwater effects from Beech Fork).	From the confluence with Beech Fork to approximately 1,710 feet upstream of the confluence with Cedar Creek Tributary 12.	None	+475	Unincorporated Areas of Nelson County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
David Run (Backwater effects from Rolling Fork).	From the confluence with Rolling Fork to approximately 0.7 mile upstream of the confluence with Rolling Fork.	None	+467	Unincorporated Areas of Nelson County.
Price Creek (Backwater effects from Rolling Fork).	From the confluence with Rolling Fork to approximately 0.6 mile upstream of the confluence with Price Creek Tributary 7.	None	+465	Unincorporated Areas of Nelson County.
Price Creek Tributary 7 (Backwater effects from Rolling Fork).	From the confluence with Price Creek to approximately 0.5 mile upstream of the confluence with Price Creek.	None	+465	Unincorporated Areas of Nelson County.
Rowan Creek (Backwater effects from Beech Fork).	From the confluence with Beech Fork to approximately 1,140 feet upstream of the confluence with Town Creek.	+487	+486	City of Bardstown, Unincorporated Areas of Nelson County.
Taylorsville Lake	Entire shoreline of Taylorsville Lake	None	+592	Unincorporated Areas of Nelson County.
Timber Creek (Backwater effects from Taylorsville Lake).	From the confluence with Taylorsville Lake to approximately 0.7 mile downstream of Highview Church Road.	None	+592	Unincorporated Areas of Nelson County.
Town Creek (Backwater effects from Beech Fork).	From the confluence with Rowan Creek to approximately 585 feet upstream of the confluence with Rowan Creek.	+487	+486	City of Bardstown, Unincorporated Areas of Nelson County.
Vittow Creek (Backwater effects from Rolling Fork).	From the confluence with Rolling Fork to approximately 0.6 mile upstream of the confluence with Rolling Fork.	None	+463	Unincorporated Areas of Nelson County.

* National Geodetic Vertical Datum.

+ North American Vertical Datum.

Depth in feet above ground.

∧ Mean Sea Level, rounded to the nearest 0.1 meter.

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Bardstown

Maps are available for inspection at City Hall, 220 North 5th Street, Morgantown, KY 42261.

Unincorporated Areas of Nelson County

Maps are available for inspection at the Nelson County Courthouse, 113 East Stephen Foster Avenue, Morgantown, KY 42261.

Taylor County, Kentucky, and Incorporated Areas

Brushy Fork (Backwater effects from Green River Lake).	From the confluence with Long Branch to approximately 0.4 mile upstream of the confluence with Long Branch.	None	+713	Unincorporated Areas of Taylor County.
Green River Lake	Entire shoreline	None	+713	Unincorporated Areas of Taylor County.
Green River Tributary 24.2 (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 1,300 feet upstream of the confluence with Green River Lake.	None	+713	Unincorporated Areas of Taylor County.
Long Branch (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 1,022 feet upstream of the confluence with Brushy Fork.	None	+713	Unincorporated Areas of Taylor County.
Opossum Branch (Backwater effects from Green River Lake).	From the confluence with Robinson Creek to approximately 1,716 feet upstream of the confluence with Robinson Creek.	None	+713	Unincorporated Areas of Taylor County.
Robinson Creek (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 730 feet downstream of the confluence with Duton Creek.	None	+713	Unincorporated Areas of Taylor County.
Robinson Creek Tributary 1 (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 0.6 mile upstream of the confluence with Green River Lake.	None	+713	Unincorporated Areas of Taylor County.
Robinson Creek Tributary 10 (Backwater effects from Robinson Creek).	From the confluence with Robinson Creek to approximately 88 feet upstream of Bradfordsville Road.	None	+741	Unincorporated Areas of Taylor County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Robinson Creek Tributary 12 (Backwater effects from Robinson Creek).	From the confluence with Robinson Creek to approximately 1,166 feet upstream of the confluence with Robinson Creek.	None	+732	Unincorporated Areas of Taylor County.
Robinson Creek Tributary 7 (Backwater effects from Robinson Creek).	From the confluence with Robinson Creek to approximately 1,855 feet upstream of the confluence with Robinson Creek.	None	+750	Unincorporated Areas of Taylor County.
Robinson Creek Tributary 8 (Backwater effects from Robinson Creek).	From the confluence with Robinson Creek to approximately 1,041 feet upstream of the confluence with Robinson Creek.	None	+744	Unincorporated Areas of Taylor County.
Robinson Creek Tributary 9 (Backwater effects from Robinson Creek).	From the confluence with Robinson Creek to approximately 55 feet upstream of Bradfordsville Road.	None	+743	Unincorporated Areas of Taylor County.
Sprat Branch (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 0.7 mile upstream of Elkhorn Road.	None	+713	Unincorporated Areas of Taylor County.
Stone Quarry Creek (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 1,010 feet upstream of the confluence with Stone Quarry Creek Tributary 5.	None	+713	Unincorporated Areas of Taylor County.
Stone Quarry Creek Tributary 5 (Backwater effects from Green River Lake).	From the confluence with Stone Quarry Creek to approximately 845 feet upstream of the confluence with Stone Quarry Creek.	None	+713	Unincorporated Areas of Taylor County.
Stoner Creek (Backwater effects from Green River Lake).	From the confluence with Robinson Creek to approximately 1.2 miles upstream of the confluence with Robinson Creek.	None	+713	Unincorporated Areas of Taylor County.
Tallow Creek Tributary 4 (Backwater effects from Tallow Creek).	From the confluence with Tallow Creek to approximately 920 feet upstream of Bradfordsville Road.	None	+831	Unincorporated Areas of Taylor County.
Wilson Creek (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 1,630 feet upstream of the confluence with Wilson Creek Tributary 14.	None	+713	Unincorporated Areas of Taylor County.
Wilson Creek Tributary 14 (Backwater effects from Green River Lake).	From the confluence with Wilson Creek to approximately 670 feet upstream of the confluence with Wilson Creek.	None	+713	Unincorporated Areas of Taylor County.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Taylor County

Maps are available for inspection at the Taylor County Judicial Center, 300 East Main Street, Campbellsville, KY 42718.

Clay County, Mississippi, and Incorporated Areas

Tombigbee River	Approximately 1.7 mile upstream of the confluence with Tibbee Creek.	+176	+177	Unincorporated Areas of Clay County.
	Approximately 4.2 miles upstream of the confluence with Town Creek East.	+187	+188	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

ADDRESSES

Unincorporated Areas of Clay County

Maps are available for inspection at the Clay County Courthouse, 205 Court Street, West Point, MS 39773.

Grenada County, Mississippi, and Incorporated Areas

Grenada Lake	Entire shoreline within Grenada County	None	+237	City of Grenada, Unincorporated Areas of Grenada County.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Grenada

Maps are available for inspection at City Hall, 108 South Main Street, Grenada, MS 38901.

Unincorporated Areas of Grenada County

Maps are available for inspection at the Grenada County Courthouse, 59 Green Street, Room 1, Grenada, MS 38901.

Lawrence County, Mississippi, and Incorporated Areas

Runnels Creek	Approximately 0.5 mile downstream of Robinwood Road.	+192	+193	Town of Monticello, Unincorporated Areas of Lawrence County.
	Approximately 100 feet downstream of Robinwood Road.	+192	+193	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Town of Monticello

Maps are available for inspection at 202 Jefferson Street South, Monticello, MS 39654.

Unincorporated Areas of Lawrence County

Maps are available for inspection at 435 Brinson Street, Monticello, MS 39564.

Dade County, Missouri, and Incorporated Areas

Stockton Lake	Entire shoreline	None	+887	Unincorporated Areas of Dade County.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
ADDRESSES				
Unincorporated Areas of Dade County				
Maps are available for inspection at 300 West Water Street, Greenfield, MO 65661.				
St. Francois County, Missouri, and Incorporated Areas				
Flat River	Approximately 375 feet downstream of the confluence with Walker Branch.	None	+683	City of Desloge, City of Park Hills, Unincorporated Areas of St. Francois County.
	At St. Joe Drive	None	+701	
	Approximately 875 feet downstream of East Elvins Boulevard.	None	+750	
	Approximately 3,000 feet upstream of State Highway 32.	None	+784	
Kennedy Branch	Approximately 425 feet downstream of County Highway F.	None	+837	City of Farmington, Unincorporated Areas of St. Francois County.
	Approximately 1,400 feet upstream of Middle Street	+894	+893	
Koen Creek	Approximately 100 feet upstream of the City of Park Hills and City of Desloge corporate limits.	None	+695	City of Desloge, City of Park Hills, Unincorporated Areas of St. Francois County.
	Approximately 2,350 feet upstream of Hurryville Road	None	+846	
Koen Creek Tributary	Approximately 325 feet upstream of the confluence with Koen Creek.	None	+718	City of Park Hills, Unincorporated Areas of St. Francois County.
	Approximately 100 feet upstream of 5th Street	None	+792	
Shaw Creek	Approximately 700 feet upstream of the confluence with Flat Creek.	None	+732	City of Park Hills, Unincorporated Areas of St. Francois County.
	Approximately 2,000 feet upstream of City of Park Hills corporate limits.	None	+767	
St. Francois River	Approximately 150 feet upstream of the City of Farmington corporate limits.	None	+844	City of Farmington, Unincorporated Areas of St. Francois County.
	Approximately 50 feet upstream of County Highway W.	None	+859	
St. Francois Tributary	Approximately 750 feet upstream of the confluence with the St. Francois River.	None	+846	City of Farmington, Unincorporated Areas of St. Francois County.
	Approximately 75 feet upstream of County Highway W.	+878	+881	
	Approximately 925 feet downstream of Liberty Street	None	+896	
	Approximately 200 feet upstream of the City of Farmington corporate limits.	None	+910	
Walker Branch	Approximately 600 feet upstream of the confluence with the Flat River.	None	+685	Unincorporated Areas of St. Francois County.
	Approximately 7,000 feet upstream of Halter Road	None	+783	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

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Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Desloge

Maps are available for inspection at 300 North Lincoln, Desloge, MO 63601.

City of Farmington

Maps are available for inspection at 110 West Columbia Street, Farmington, MO 63640.

City of Park Hills

Maps are available for inspection at 9 Bennet Street, Park Hills, MO 63601.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ∧ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Unincorporated Areas of St. Francois County				
Maps are available for inspection at 1 West Liberty Street, 2nd Floor, Farmington, MO 63640.				
Wayne County, Missouri, and Incorporated Areas				
Clearwater Lake	Entire shoreline in Wayne County	None	+572	Unincorporated Areas of Wayne County.
Lake Wappapello	Entire shoreline in Wayne County	None	+403	Unincorporated Areas of Wayne County.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Wayne County

Maps are available for inspection at 109 Walnut Street, Greenville, MO 63944.

Greenwood County, South Carolina, and Incorporated Areas				
Lake Greenwood	Entire shoreline within Greenwood County	None	+442	Unincorporated Areas of Greenwood County.
Ninety-Six Creek	Approximately 1.0 mile downstream of U.S. Route 702.	None	+399	Unincorporated Areas of Greenwood County.
	Approximately 1,655 feet upstream of U.S. Route 702	None	+403	
Rocky Creek Tributary	Approximately 516 feet downstream of Bypass 72	None	+575	City of Greenwood.
	Approximately 2,177 feet upstream of Bypass 72	None	+590	
Saluda River	Approximately 3.9 miles downstream of U.S. Route 25.	None	+448	Town of Ware Shoals, Unincorporated Areas of Greenwood County.
	Approximately 200 feet upstream of Saluda Avenue	None	+531	
Sample Branch	Approximately 1,206 feet upstream of the confluence with Rocky Creek.	None	+527	Unincorporated Areas of Greenwood County, City of Greenwood.
	Approximately 130 feet upstream of Dry Branch Court	None	+563	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
∧ Mean Sea Level, rounded to the nearest 0.1 meter.

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Greenwood

Maps are available for inspection at City Hall, 520 Monument Street, Greenwood, SC 29648.

Town of Ware Shoals

Maps are available for inspection at the Town Hall, 8 Mill Street, Ware Shoals, SC 29692.

Unincorporated Areas of Greenwood County

Maps are available for inspection at the Greenwood County Courthouse, 600 Monument Street, Greenwood, SC 29646.

(Catalog of Federal Domestic Assistance No. 97.022, "Flood Insurance.")

Dated: April 15, 2010.

Sandra K. Knight,

Deputy Federal Insurance and Mitigation Administrator, Mitigation, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. 2010–10342 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

[Docket No. FWS-R8-ES-2010-0031]
[MO 92210-0-0008-B2]

Endangered and Threatened Wildlife and Plants; 90-Day Finding on a Petition to List Hermes Copper Butterfly as Threatened or Endangered

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of petition finding and initiation of status review.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), announce a 90–day finding on a petition to list Hermes copper butterfly (*Hermelycaena* [*Lycaena] hermes*) as a threatened or endangered species under the Endangered Species Act of 1973, as amended (Act) and to designate critical habitat. We find the petition presents substantial scientific or commercial information indicating that listing the Hermes copper butterfly may be warranted. Therefore, with the publication of this notice, we are initiating a status review to determine if the petitioned action is warranted. To ensure that the status review is comprehensive, we are soliciting scientific and commercial data and other information regarding this species. Based on the status review, we will issue a 12–month finding on the petition, which will address whether the petitioned action is warranted, as provided in section 4(b)(3)(B) of the Act.

DATES: To allow us adequate time to conduct this review, we request that we receive information on or before July 6, 2010. Please note that if you are using the *Federal eRulemaking Portal* (see **ADDRESSES** section, below), the deadline for submitting an electronic comment is 11:59 p.m. Eastern Time on this date. After July 6, 2010, you must submit information directly to the Field Office (see **FOR FURTHER INFORMATION CONTACT** section below). Please note that we might not be able to address or incorporate information that we receive after the above requested date.

ADDRESSES: You may submit comments by one of the following methods:

- Federal eRulemaking Portal: *http://www.regulations.gov*. Search for docket FWS-R8-ES-2010-0031 and then follow the instructions for submitting comments.
- U.S. mail or hand-delivery: Public Comments Processing, Attn: FWS-R8-ES-2010-0031; Division of Policy and Directives Management; U.S. Fish and Wildlife Service; 4401 N. Fairfax Drive, Suite 222; Arlington, VA 22203.

We will post all comments on *http://www.regulations.gov*. This generally means that we will post any personal information you provide us (see the Request for Information section below for more details).

FOR FURTHER INFORMATION CONTACT: Jim Bartel, Field Supervisor, Carlsbad Fish and Wildlife Office, Carlsbad Fish and Wildlife Office, U.S. Fish and Wildlife Service, 6010 Hidden Valley Road, Suite 101, Carlsbad, CA 92011, by telephone at 760–431–9440, or by facsimile to 760–431–9624. Persons who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 800–877–8339.

SUPPLEMENTARY INFORMATION:

Request for Information

When we make a finding that a petition presents substantial information indicating that listing a species may be warranted, we are required to promptly review the status of the species (status review). For the status review to be complete and based on the best available scientific and commercial information, we request information on the Hermes copper butterfly from governmental agencies, Native American Tribes, the scientific community, industry, and any other interested parties. We seek information on:

(1) The species' biology, range, and population trends, including:

(a) Habitat requirements for feeding, breeding, and sheltering;

(b) Genetics and taxonomy;

(c) Historical and current range, including distribution patterns;

(d) Historical and current population levels, and current and projected trends; and

(e) Past and ongoing conservation measures for the species and its habitat in the United States and Mexico.

(2) The factors that are the basis for making a listing determination for a species under section 4(a) of the Endangered Species Act of 1973, as amended (Act) (16 U.S.C. 1531 *et seq.*), which are:

(a) The present or threatened destruction, modification, or curtailment of its habitat or range;

(b) Overutilization for commercial, recreational, scientific, or educational purposes;

(c) Disease or predation;

(d) The inadequacy of existing regulatory mechanisms; or

(e) Other natural or manmade factors affecting its continued existence.

(3) Information on management programs for the conservation of Hermes copper butterfly.

(4) The potential effects of climate change on this species and its habitat, what regional climate change models are available, and whether they are reliable and credible to use as step-down models for assessing the effects of climate change on this species and its habitat.

(5) Additional information on the following locations in San Diego County, California, United States of America (U.S.A.) where the status of the species or level of the threat (such as fire), is unknown (petitioner location names used for the first time are in quotation marks if we added a location description):

- approximately 3 miles (mi) (5 kilometers (km)) south of the City of El Cajon ("El Cajon (3 miles South)");
- the neighborhood of Flinn Springs in the City of El Cajon ("Flinn Springs (El Cajon)");
- Fairmont Canyon in the City of San Diego ("Fairmont Canyon");
- the community of Kearny Mesa ("Kearny Mesa");
- City of San Diego urban core area;
- the Crosby property in the City of Rancho Santa Fe ("The Crosby");
- City of Spring Valley ("Spring Valley");
- community of Harmony Grove in the City of Escondido ("Harmony Grove");
- Steel Canyon near the community of Jamul ("Steel Canyon");
- Mission Valley in the City of San Diego ("Mission Valley");
- City of Poway near the intersection of Poway Road and State Route 395 ("Poway Road/Highway 395");
- community of Dulzura ("Dulzura");
-- Deerhorn Valley near the community of Jamul ("Deerhorn Valley");
- area near Mt. Miguel; the community of Pine Valley ("Pine Valley");
- Big Rock Road in the city of Santee ("Santee's Big Rock Road;");
- community of Alpine ("Alpine");
- community of Miramar ("Miramar");
- Sycamore Canyon and Gooden Ranch in the City of Santee ("Sycamore Canyon and Gooden Ranch");
- Otay Mountain foothills ("Otay-Foothill area");

- 1 mi (1.6 km) west of Lake Hodges ("Lake Hodges (1 mile West)");
- Boulder Creek Road near the community of Descanso ("Boulder Creek Road");
- Harbison Canyon near the community of Crest ("Harbison Canyon");
- Little Cedar Creek near Otay Mountain ("Little Cedar Creek");
- San Marcos Creek in the City of San Marcos ("San Marcos Creek");
- Spring Canyon near the City of Santee ("Spring Canyon"); and
- Sycuan Peak in the community of Jamul ("Sycuan Peak").

We would also like information for the following locations in Baja California, Mexico:

- 12 mi (19 km) north of the city of Ensenada ("Ensenada (12 mi north)");
- 18 mi (29 km) south of Santo Tomas Valley ("Santo Tomas (18 mi south)");
- the community of Bajamar ("Bajamar"); and the community of Salsipuedes ("Salsi Puedes")..

(6) Information on U.S. Forest Service Land and Resource Management Plan revisions and the status of the species on U.S. Forest Service lands.

Please include sufficient information with your submission (such as full references) to allow us to verify any scientific or commercial information you include.

If, after the status review, we determine that listing Hermes copper butterfly is warranted, we intend to propose critical habitat (see definition in section 3(5)(A) of the Act), as per section 4 of the Act, to the maximum extent prudent and determinable at the time we propose to list the species. Therefore, within the geographical range currently occupied by Hermes copper butterfly, we request data and information on:

(1) What may constitute "physical or biological features essential to the conservation of the species,"

(2) Where these features are currently found, and

(3) Whether any of these features may require special management considerations or protection.

In addition, we request data and information on "specific areas outside the geographical area occupied by the species" that are "essential to the conservation of the species." Please provide specific comments and information as to what, if any, critical habitat you think we should propose for designation if the species is proposed for listing, and why such habitat meets the requirements of section 4 of the Act.

Submissions merely stating support for or opposition to the action under consideration without providing supporting information, although noted, will not be considered in making a determination. Section 4(b)(1)(A) of the Act directs that determinations as to whether any species is an endangered or threatened species must be made "solely on the basis of the best scientific and commercial data available."

You may submit your information concerning this status review by one of the methods listed in the **ADDRESSES** section. If you submit information via *http://www.regulations.gov*, your entire submission—including any personal identifying information—will be posted on the website. If you submit a hardcopy that includes personal identifying information, you may request at the top of your document that we withhold this personal identifying information from public review. However, we cannot guarantee that we will be able to do so. We will post all hardcopy submissions on *http://www.regulations.gov*.

Information and supporting documentation that we received and used in preparing this finding, will be available for you to review at *http://www.regulations.gov*, or you may make an appointment during normal business hours at the U.S. Fish and Wildlife Service, Carlsbad Fish and Wildlife Office (see **FOR FURTHER INFORMATION CONTACT**).

Background

Section 4(b)(3)(A) of the Act requires that we make a finding on whether a petition to list, delist, or reclassify a species presents substantial scientific or commercial information indicating that the petitioned action may be warranted. We are to base this finding on information provided in the petition, supporting information submitted with the petition, and information otherwise available in our files. To the maximum extent practicable, we are to make this finding within 90 days of our receipt of the petition and publish our notice of the finding promptly in the **Federal Register**.

Our standard for substantial scientific or commercial information within the Code of Federal Regulations (CFR) with regard to a 90–day petition finding is "that amount of information that would lead a reasonable person to believe that the measure proposed in the petition may be warranted" (50 CFR 424.14(b)). If we find that substantial scientific or commercial information was presented, we are required to promptly review the status of the species, which is subsequently summarized in our 12–month finding.

New species information received since the our previous 90–day finding (71 FR 44966, August 8, 2006) is limited to Marschalek and Deutschman's (2008) study of the effect of habitat edges on Hermes copper butterfly, new species observation locations, and fire data (see *Species Information* sections below). We received additional information from the petitioners in an email on March 5, 2010 (Evans 2010). We reviewed and evaluated the information they submitted, and did not find that it provided any new data relative to the status of the species or threats to it or its habitat. The petitioners submitted one piece of anecdotal species information that we did not already have in our files, a personal communication (cited "D. Faulkner, V. Marquez-Waller pers. comm. on 4/16/08") that a "Ladybird beetle" is a potential Hermes copper butterfly predator (Evans 2010 attachment, p. 8).

For biological and other scientific information on Hermes copper butterfly, please refer to our previous 90–day finding published in the **Federal Register** on August 8, 2006 (71 FR 44966).

Previous Federal Actions

On August 8, 2006, we published 90–day findings for both Hermes copper butterfly and Thorne's hairstreak butterfly in the **Federal Register**. The findings concluded that the petitions and information in our files did not present substantial scientific or commercial information indicating that listing Hermes copper (71 FR 44966) or Thorne's hairstreak butterflies (71 FR 44980) was warranted. (For a detailed history of Federal actions involving Hermes copper butterfly prior to the 2006 90–day finding, please see the August 8, 2006, **Federal Register** Notice (71 FR 44966)). On March 17, 2009, CBD and David Hogan filed a complaint for declaratory and injunctive relief challenging the Service's decision not to list Hermes copper butterfly and Thorne's hairstreak butterfly as threatened or endangered under the Act. In a settlement agreement dated October 23, 2009 (Case No. 09-0533 S.D. Cal.), the Service agreed to submit new 90–day petition findings to the **Federal Register** by April 2, 2010, for Thorne's hairstreak butterfly, and by May 13, 2010, for Hermes copper butterfly. As a part of the settlement agreement, we agreed to evaluate the October 25, 2004, petition filed by David Hogan and CBD, supporting information submitted with the petition, and information available in the Service's files, including information that has become available since the publication of the negative 90–day findings on August 8, 2006. If the 90–day findings determine that listing

may be warranted, we agreed to submit a 12–month finding to the **Federal Register** by March 4, 2011, for Thorne's hairstreak butterfly, and by April 15, 2011, for Hermes copper butterfly. We published a 90–day finding in the **Federal Register** on April 5, 2010 (75 FR 17062) concluding that listing Thorne's hairstreak butterfly may be warranted. This notice constitutes our 90–day finding on the petition to list Hermes copper butterfly under section 4(b)(1)(A) of the Act.

Species Information

Hermes copper butterfly is endemic to the southern California region, primarily occurring in San Diego County, California, and a few records of the species have been documented in Baja California, Mexico (Faulkner and Klein 2005, p. 23). The species inhabits coastal sage scrub and southern mixed chaparral (Marschalek and Deutschman 2008, p. 98) and is dependent on its larval host plant, *Rhamnus crocea* (spiny redberry), to complete its lifecycle. Adult Hermes copper butterflies lay single eggs on *R. crocea* stems where they hatch and feed until pupation occurs at the base of the plant. Hermes copper butterflies have one flight period (termed univoltine) occurring in mid-May to early-July, depending on weather conditions and elevation (Faulkner and Klein 2005, pp. 23–24).

Adult Hermes copper butterflies have been known to nectar (feed) in coastal sage scrub and chaparral ecosystems on *Adenostema fasciculatum* (chamise), *Eriogonum fasciculatum* (California buckwheat), *Helianthus gracilentus* (slender sunflower), *Toxicodendron diversilobum* (poison oak), and *Hirshfeldia incana* (short-podded mustard) and are rarely seen far from their nectar source or host plant (Faulkner and Klein 2005, pp. 24–25; Marschalek and Deutschman 2008, p. 102). Marschalek and Deutschman (2008) documented densities of Hermes copper butterflies on paired transects along edges and within the interior of host plant stands in rural areas. Their study results indicate Hermes copper butterfly densities are significantly higher near host plant stand edges than in the interior (Marschalek and Deutschman 2008, p. 102), suggesting that this single factor in natural areas may have a positive effect on species' density.

Historical data indicate Hermes copper butterflies ranged from Fallbrook, California, in northern San Diego County to 18 mi (29 km) south of Santo Tomas in Baja California, Mexico, and from Pine Valley in eastern San Diego County to Lopez Canyon in western San Diego County. Range-wide species surveys have not been completed; therefore, it is difficult to assess the extent of occupation throughout the historical range.

Habitat

According to Thorne (1963, pp. 143–144), Hermes copper butterflies are dependent on *Rhamnus crocea* (spiny redberry), a wide-ranging perennial coastal sage scrub and chaparral-associated species, as its larval host and for completion of its lifecycle. The range of *R. crocea* extends throughout coastal northern California, central western California, southwestern California, and into Baja California, Mexico, to an elevation of 3,280 feet (ft) (1000 meters (m)). The coastal sage scrub and chaparral ecosystems in San Diego County have been subject to multiple fires of various levels of severity (Keeley and Fotheringham 2003, pp. 242–243; Faulkner and Klein 2005, p. 25). *Rhamnus crocea* and other coastal sage scrub or chaparral-associated species are adapted to intermittent fire, but researchers postulate that increased fire frequency may result in altered vegetation structure or type conversion throughout the range (Keeley and Fotheringham 2003, pp. 243–244; Keeley 2004, pp. 2–3) and lead to a significant decline in Hermes copper butterfly habitat availability and suitability. Anecdotal evidence indicates Hermes copper butterflies require mature *R. crocea* to complete their lifecycle; therefore, increased fire frequency may reduce suitable host plant availability. However, no quantitative studies have occurred to test this hypothesis.

For additional detailed species information on Hermes copper butterfly, please refer to our previous 90–day finding, which published in the **Federal Register** on August 8, 2006 (71 FR 44966).

Evaluation of Information for this Finding

Section 4 of the Act (16 U.S.C. 1533), and its implementing regulations in the Code of Federal Regulations (CFR) at 50 CFR 424, set forth the procedures for adding species to the Federal Lists of Endangered and Threatened Wildlife and Plants. A species may be determined to be an endangered or threatened species due to one or more of the five factors described in section 4(a)(1) of the Act: (A) The present or threatened destruction, modification, or curtailment of its habitat or range; (B) overutilization for commercial, recreational, scientific, or educational purposes; (C) disease or predation; (D) the inadequacy of existing regulatory mechanisms; or (E) other natural or manmade factors affecting its continued existence.

In making this 90–day finding, we evaluated whether information on threats to Hermes copper butterfly, as presented in the 2004 petition and other information available in our files, is substantial, thereby indicating that the petitioned action may be warranted. In the sections that follow, we summarize information included in the 2004 petition and evaluate any new information in our files. For additional information regarding Hermes copper butterfly please refer to the previous 90–day finding published in the **Federal Register** on August 8, 2006 (71 FR 44966).

A. The Present or Threatened Destruction, Modification, or Curtailment of the Species' Habitat or Range

The petition, its appendices, and referenced documents discuss the following threats that are grouped under Factor A: development, wildfire, fire management techniques, and habitat fragmentation.

The petition includes a table that lists Hermes copper butterfly populations and their presumed status at 56 occurrences throughout San Diego County and into Mexico. The table identifies 22 occurrences that were presumed lost in the 2003 Otay, Cedar, and Paradise fires; 6 occurrences that were presumed lost to urban development; 8 occurrences that were known to be occupied and were mentioned in various environmental review documents; 2 occurrences with unknown locations and occupancy status; and 18 occurrences of unknown occupancy status (which include 4 in Baja California, Mexico).

Development

Information Provided in the Petition

The petitioner stated that Hermes copper butterfly is vulnerable to extinction due to loss of populations and habitat loss as a result of urban development. The petitioner's table lists 6 locations that are presumed lost to development and 8 locations discovered as a result of surveys and environmental reviews for development projects. There are 14 Hermes copper butterfly locations in the petitioner's table that do not include any indication of current occupancy status and an additional 2 occurrences with unknown locations and status.

Evaluation of Information Provided in the Petition and Available in Service Files

At one of the 6 locations presumed lost to development ("Scripps Gateway" at the southwest corner of Interstate 15 and Scripps Poway Parkway), the last Hermes copper butterfly observation was in 1996, and information in our files indicates that development has not impacted this area. Further investigation is needed to accurately determine the species' status at this location. The remaining 5 locations identified by the petitioner as lost to development were observed 45 or more years ago. We do not have more recent data on these specific locations and further investigation is needed to determine their status. However, information in our files indicates that some of the historical occurrences referenced by the petitioner (Kearny Mesa, Mission Valley, San Diego State College, and "Suncrest" in the community of Crest) have probably been impacted by urban development.

Information in our files indicates that the status of Hermes copper butterfly at 4 (the Crosby property in Rancho Santa Fe, Spring Valley, Harmony Grove, and Steel Canyon) of the 8 locations discovered as a result of surveys and environmental reviews for development projects is currently unknown, and the butterfly is currently extant at the other 4 locations (Skyline Truck Trail, Lyons Valley, Lawson Valley, and Jamul Highlands Road in the community of Jamul). Further investigation is needed to determine the status of Hermes copper butterfly at the Crosby property in Rancho Santa Fe, Spring Valley, Harmony Grove, and Steel Canyon.

Our files do not contain more recent data for the Mexico occurrences cited in the petition, or data on the 2 unknown locations listed in the petition that are of unknown status (Mission Valley and Poway Road/Highway 395). Further investigation is needed to accurately determine the status of Hermes copper butterfly at those locations.

Of the locations in the petitioner's table, information in our files indicates that the current status of 5 (Dulzura, Deerhorn Valley, Mt. Miguel, Pine Valley, and Santee's Big Rock Road) of the 14 locations is unknown, and that 9 of the occurrences (Lyons Peak, Black Mountain, the community of "Guatay," McGinty Mountain, Poway, "Robert's Ranch" near the intersection of State Route 79 and Interstate 8, San Diego National Wildlife Refuge, Sycuan Peak, and "Wright's Field" in the community of Alpine) are extant. Further investigation of Hermes copper butterfly occupancy at the Dulzura, Deerhorn Valley, Mt. Miguel, Pine Valley, and Santee's Big Rock Road locations is needed to determine the species' status at these locations.

Information in our files indicates the Service is currently evaluating habitat conservation plans (HCPs) for the San Diego County Water Authority, Joint Water Agencies, North San Diego County, East San Diego County, and the City of Santee where Hermes copper butterfly may be included as a "covered species" in order to avoid conflict with planned future development. These HCPs are seeking coverage for take of Hermes copper butterfly throughout their plan areas, but the plans are not yet finalized (see "*D. The Inadequacy of Existing Regulatory Mechanisms*" section below for further discussion of approved HCPs). Additionally, the population of San Diego County is predicted to grow 25.2 percent from 2000 to 2020 (California Department of Finance 2007), suggesting that urbanization pressure will continue to pose an increasing threat to remaining populations within the range of Hermes copper butterfly. Development on U.S. Forest Service lands may also pose a threat to Hermes copper butterflies. The species is considered an animal species-at-risk by the U.S. Forest Service; defined specifically, as an uncommon, narrow endemic, disjunct, or peripheral in the Cleveland National Forest (CNF) Land Resource Management Plan (LRMP)) area, with substantial threats to species persistence or distribution from Forest Service activities (USFS 2005a, p. 119). Information in our files indicates that one specific project is currently in the permitting and implementation phase (Sunrise Powerlink) and there are existing energy projects within the CNF (Winter 2010, pers. comm.) that may pose a threat to Hermes copper butterfly habitat. These projects may impact Hermes copper butterfly through direct loss or fragmentation of available habitat. Although no roads or facility development has been planned for the CNF within Hermes copper butterfly habitat that we are aware of at this time, future development or the maintenance of existing facilities may potentially be a threat to Hermes copper butterfly through fragmentation of habitat. Information in our files indicates that the existing electrical energy lines that pass through the CNF may pose a potential threat of wildfire through accidental ignition (see "*Wildfire*" section below).

In summary, we have evaluated information in our files and the petition and find there has been some loss of Hermes copper butterfly habitat due to development, and we conclude there is substantial information indicating Hermes copper butterfly listing may be warranted due to the threat of urban development.

Wildfire

Information Provided in the Petition

The petitioner claims that Hermes copper butterfly is highly vulnerable to extinction due to the threat of fire. The petitioner claims that excessive human-induced fires threaten the species' survival, even on lands protected from development. The petitioner lists 22 locations that are presumed lost to fire (see analysis below for location descriptions).

Evaluation of Information Provided in the Petition and Available in Service Files

Information in our files indicates that wildfire regimes throughout southern California have been changing for some time, and much of this change is attributed to human demography and population density. Specifically, fire frequency and season have increased throughout chaparral and coastal sage scrub ecosystems (Keeley and Fotheringham 2003, pp. 239–242). Information in our files indicates that the 2003 Otay, Cedar, and Paradise fires and the 2007 Harris, Poomacha, and Witch fires did impact some of the areas with documented Hermes copper butterfly occurrences (Alpine, Crestridge Ecological Reserve, the community of Descanso, Spring Valley, Miramar, Mission Trails Regional Park, Santee, Sycamore Canyon, Otay-Foothill area, and Rancho Jamul Ecological Reserve). However, the extent to which the habitat (chaparral and coastal sage scrub and, more specifically, the host plant *Rhamnus crocea*) was impacted is unknown and requires further investigation to accurately assess the impact to Hermes copper butterfly. Of the 22 locations identified in the petition as presumed lost to fire, 12 of these locations cited observation data dating back 20 or more years. We do not have more recent data on Hermes copper butterfly at those locations, and their current status is unknown. Of the remaining 10 locations, we have data in our files indicating that Hermes copper butterfly is extant at 5 locations: Mission Trails Regional Park, Crestridge Ecological Reserve, Descanso, Rancho Jamul, and Santee (Fanita Ranch). The remaining 5 locations noted in the petitioner's table that potentially harbor Hermes copper butterfly would require further investigation to determine the species' status.

Information in our files indicates that occurrences at 5 of the 22 locations identified in the petition as lost to wildfire are currently extant. Further investigation is needed to determine the status of the species at the remaining 17 locations; however, with the expected increased frequency of fires, the species may not be able to recolonize habitat patches where they have been extirpated by fire. Additionally, information in our files indicates that approximately 80 percent of the Hermes copper butterfly habitat (*Rhamnus crocea* and other coastal sage scrub or associated-chaparral species) on CNF lands burned in the 2003 and 2007 fires and only few of the historical locations on CNF are currently persisting (Winter 2010, pers. comm.)

After reviewing the petition and information in our files, we find substantial information exists indicating that listing Hermes copper butterfly may be warranted due to the threat to Hermes copper butterfly habitat as the result of increased fire frequency or excessive wildfire relative to historic conditions.

Fire Management Techniques

Information Provided in the Petition

The petitioner claims that prescribed burns used as fire management techniques are likely to impact the Hermes copper butterfly in a number of locations throughout the County of San Diego, including the Cleveland National Forest (CNF). The petitioner asserts that the County has relied on excessive brush clearing around homes and communities for fire protection and that the CNF has aggressively pursued prescribed burning as a vegetation management tool. The petitioner claims that prescribed burns are likely to reduce the survival of Hermes copper butterflies.

Evaluation of Information Provided in the Petition and Available in Service Files

The County of San Diego's Zoning and Ordinance regulations and recommendations indicate that lands within the County of San Diego are required to have a defensible space around homes and structures, which may impact Hermes copper butterfly habitat; however, emphasis is placed on replacing flammable roofing material with fire-resistant shingles, planting fire-resistant landscape vegetation, using fire-resistant native plant species, avoiding invasive nonnative species in landscaping, and implementing other effective conservation-oriented fire management techniques (County of San Diego 2006, p. 2; The Fire Safe Council of San Diego County 2009, p. 1). Information available to us at this time does not support the petitioner's claim that the County of San Diego is rejecting conservation-oriented rural planning or emphasizing prescribed burns. Although prescribed burning is conducted in potential Hermes copper butterfly habitat on Marine Corps Air Station Miramar, neither the petition nor information in our files indicates that prescribed burning is being conducted in occupied Hermes copper butterfly habitat.

According to the U.S. Forest Service's 2005 final environmental impact statement for land management plans in the Angeles, Cleveland, Los Padres and San Bernardino National Forests, Hermes copper butterfly is an animal species-at-risk due to prescribed burns or fuel reduction projects in the CNF (USFS 2005(a), p. 175). The CNF's conservation strategy for the next 3 to 5 years states their intention to monitor Hermes copper butterfly in burned areas and to prevent and suppress fires throughout the habitat of Hermes copper butterflies (USFS 2005(b), pp. 88-89). To further fire prevention efforts, the CNF is creating fuel breaks adjacent to homes and other developed areas to prevent spread of wildfire from developed areas onto CNF lands. Information in our files also indicates that CNF is not conducting large scale prescribed burns, but is actively engaged in fuel reduction throughout the forest (Winter 2010, pers. comm.).

After reviewing information in our files and in the petition, we do not find substantial information to indicate that listing of Hermes copper butterfly may be warranted due to the use of prescribed fire as a fire management technique either in the County of San Diego or on the CNF. However, we will further investigate the potential threat of prescribed fires in our status review for this species.

Habitat Fragmentation

Information Provided in the Petition

The petitioner claims habitat (chaparral and coastal sage scrub) for Hermes copper butterfly is being fragmented through various mechanisms (i.e., urban development, fire, type-conversion, and roads) and that this threatens the species' survival. The petitioner's claims include the following:

(1) Habitat fragmentation is reducing the overall area of habitat available for the Hermes copper butterfly;

(2) Host plant, *Rhamnus crocea*, population distributions have been fragmented throughout the range of Hermes copper butterfly by urban development, fire, vegetation type-conversion, road construction, and other factors; and

(3) Fragmentation leads to expansion of edge habitat that stresses Hermes copper butterfly populations.

Evaluation of Information Provided in the Petition and Available in Service Files

Habitat fragmentation increases the ratio of edge to interior habitat area, creating a boundary around existing suitable habitat where the surrounding area is unsuitable for the particular organism. This process isolates the habitat patch from other surrounding suitable habitat patches and, depending on the movement dynamics of a particular organism, this habitat separation (or fragmentation) and isolation may result in increased extirpation risk (Bell *et al.* 1991, pp. 1–438).

Information in our files and in the petition indicates that habitat for Hermes copper butterfly has been fragmented by wildfire and urban development. Comparison of Hermes copper butterfly and host plant distribution data with satellite imagery indicates wildfire causes short-term fragmentation of habitat, and much historical habitat has been fragmented by development. Additionally, the extent of habitat fragmentation on USFS lands has not been quantified, but information available at this time indicates that there has been significant loss and possible patchy distribution of the habitat that is remaining (Winter 2010, pers. comm.). Specific impacts of habitat fragmentation on Hermes copper butterfly have not been documented and require further investigation. The smaller and more isolated butterfly populations are, the less likely its habitat patches will be recolonized following extirpation due to wildfire or another catastrophic event. Given that some locations that historically harbored Hermes copper butterflies have been impacted and the existence of a possibility of habitat fragmentation, further investigation is necessary to determine the implications of these findings to Hermes copper butterfly's persistence.

In summary, we evaluated the petition and information in our files and find substantial information has been presented in the petition or is available in our files to indicate listing Hermes copper butterfly may be warranted due to the present or threatened destruction, modification, or curtailment of the species' habitat or range. In particular,

we find that fires that have occurred in the north and south of the species' range and development (including urban development and activities on CNF lands) through the center of its distribution may have impacted the habitat (host plant and nectar sources) through loss or fragmentation and, in turn, may threaten the species' existence.

B. Overutilization for Commercial, Recreational, Scientific, or Educational Purposes

Information Provided in the Petition

The petitioner claims at least one commercial operation may impact Hermes copper butterfly. According to the petition, a company called "Morningstar Flower and Vibrational Essences" markets a Hermes copper "butterfly essence" through their website. The petitioner states it is unclear how these essences are manufactured or obtained; however, the petition states that flower essences are produced by soaking the material in water, alcohol, or vinegar. Additionally, the petition states that over-collection may impact the Hermes copper butterfly. The petitioner claims that a female Hermes copper butterfly was worth up to $20.00 in 1986.

Evaluation of Information Provided in the Petition and Available in Service Files

Neither the petition nor information available in our files indicates that commercial use threatens the existence of Hermes copper butterfly. Information in our files indicates that no Hermes copper butterflies, whole or physical parts, are used in the process of making these butterfly essences (Morning Star Essences, pers. comm., 2006). We are unaware of any other business that markets and sells "butterfly essences," and we have no information to indicate this activity threatens Hermes copper butterfly.

Additionally, there is no information in our files or the petition to indicate over-collection is a threat to Hermes copper butterfly. We have information in our files that on June 26, 2004, two different advertisements on the Internet offered specimens of Hermes copper butterfly for sale for approximately $152.00 (Martin, pers. comm., 2004). However, there is no evidence that trade or collection directly contributes, or is a substantial threat, to the species.

After a review of information in our files and in the petition, we do not find substantial information to indicate that listing Hermes copper butterfly may be warranted due to overutilization for commercial, recreational, scientific, or educational purposes. However, we will further investigate the potential threat of overutilization for commercial, recreational, scientific, or education purposes in our status review for this species.

C. Disease or Predation

Disease

There was no information provided in the petition nor do we have any information in our files to indicate that disease is a threat to the Hermes copper butterfly.

Predation

Information Provided in the Petition

The petitioner states that species experts suspect predatory insects, and parasitic insects, spiders, and possibly birds, prey upon Hermes copper butterfly. Additionally, the petitioner asserts that the harmful effects of otherwise normal predation or parasitism might be exacerbated by population reduction from excessive fires. We received additional information from the petitioner in an email on March 5, 2010 (Evans 2010). The petitioner submitted one piece of anecdotal species information we did not already have in our files, a personal communication (cited "D. Faulkner, V. Marquez-Waller pers. comm. on 4/16/08") that a "Ladybird beetle" is a potential Hermes copper butterfly predator (Evans 2010 attachment, p. 8).

Evaluation of Information Provided in the Petition and Available in Service Files

Faulkner and Klein (2005, p. 26) state that no documentation exists of parasitism or predation on Hermes copper butterfly, and we have no information in our files that suggests parasitism or predation is a threat to the species' existence. The petitioner did not provide information to support the hypothesis that predation or parasitism may exacerbate population reduction as result of fire or any specific information that "Ladybird beetles" may be a significant predator, and we have no information in our files to support either of these claims.

After a review of information in our files and in the petition, we do not find substantial information to indicate that listing Hermes copper butterfly may be warranted due to disease or predation. However, we will further investigate the potential threat of disease and predation in our status review for this species.

D. The Inadequacy of Existing Regulatory Mechanisms

The petition states very few regulatory mechanisms are in place that afford Hermes copper butterfly conservation; however, the petitioner states the following mechanisms may provide some conservation:

(1) The California Environmental Quality Act (CEQA);

(2) National Environmental Policy Act (NEPA) (42 U.S.C. 4321 *et seq.*);

(3) U.S. Forest Service management;

(4) San Diego Multiple Species Conservation Plan (MSCP);

(5) Biological Mitigation Ordinance (BMO);

(6) County of San Diego Resource Protection Ordinance (RPO); and

(7) City and County of San Diego open space parks.

The petitioner states that although the measures listed above exist, they have not proven effective in reducing what the petitioner believes are the primary threats to Hermes copper butterfly survival (urban development, wildfire, and habitat degradation).

California Environmental Quality (CEQA) and National Environmental Policy Acts (NEPA)

Information Provided in the Petition

The petitioner claims the Service has previously provided extensive discussion of the inadequacy of CEQA to protect imperiled species, identifying several listings in the **Federal Register** (62 FR 2318, January 16, 1997; 62 FR 4935, February 3, 1997; 61 FR 25829, May 23, 1996; 69 FR 47236, August 4, 2004). The petitioner did not provide information regarding NEPA.

Evaluation of Information Provided in the Petition and Available in Service Files

CEQA and NEPA provide some protection for Hermes copper butterfly. CEQA (Public Resources Code, Sections 21000-21178, and Title 14 CCR, Section 753, and Sections 15000-15387) requires public agencies to disclose environmental impacts of a project on native species and natural communities during the land use planning process and to identify and impose mitigation measures to reduce project impacts to a less than significant level unless the agency makes a finding of overriding consideration. Through this process, CEQA ensures that proposed project effects on Hermes copper butterflies will be considered and, generally, reduced or mitigated. NEPA requires Federal agencies to disclose the significant impacts of a proposed action but does not require that such impacts be

reduced to a level of insignificance. These statutes provide some protection for Hermes copper butterfly and its habitat.

U.S. Forest Service (USFS) Management

Information Provided in the Petition

The petitioner claims U.S. Forest Service regulations and management activities appear to provide few protections to Hermes copper butterfly. The petitioner states that, aside from monitoring survey results by others, there is no indication that the Cleveland National Forest (CNF) is engaged in the conservation of Hermes copper butterfly. Additionally, the petitioner states that Hermes copper butterfly is not recognized as a "sensitive species" by the U.S. Forest Service, which would provide monitoring efforts to track the species' status and some protection from harmful projects. However, the petitioner states that even if the U.S. Forest Service recognized Hermes copper butterfly as a "sensitive species," proactive conservation activities would not be implemented until the species receives protection from the Act.

Evaluation of Information Provided in the Petition and Available in Service Files

Information in our files does support the petitioner's claim that inadequacy of U.S. Forest Service management may be a contributing factor impacting the survival of the Hermes copper butterfly. According to the 2005 LRMP currently in place for CNF, Hermes copper butterfly is considered an animal species-at-risk by U.S. Forest Service but is not currently recognized as a "sensitive species" by the U.S. Forest Service. Because the butterfly is not currently identified as a "sensitive species," preventative measures by the U.S. Forest Service to avoid impacts from development, excessive wildfire often as a result of development projects, and habitat fragmentation (see Factor A discussion) to Hermes copper butterflies or their habitat are not required. However, information in our files indicates that the U.S. Forest Service is taking some management actions to protect and conserve this species. The following management efforts are being implemented or are planned on U.S. Forest Service lands leading to the conservation and protection of Hermes copper butterfly:

(1) All historical locations have been surveyed;

(2) Re-vegetation of *Eriogonum fasciculatum* (California buckwheat), an important nectar source, is planned for the Barber Mountain area where most of this nectar source was burned in the 2007 fire; and

(3) The Sunrise Powerlink project was modified to protect remaining Hermes copper butterfly habitat on Barber Mountain (Winter 2009, pers. comm.).

The "sensitive species" list is currently being updated by U.S. Forest Service and will likely include Hermes copper butterfly (Winter 2009, pers. comm.); however, this is a future action that is not certain.

In summary, although U.S. Forest Service has undertaken or is planning some preventative measures to avoid impacts to Hermes copper butterfly and its habitat, the failure of the CNF to identify Hermes copper butterfly as a sensitive species under its LRMP suggests that current regulation may not be adequate to protect the species and its habitat from future development, related impacts, such as habitat loss, (fragmentation and excessive wildfire), and similar impacts resulting for the maintenance of existing facilities and roads on U.S. Forest Service lands. The conservation measures and preventative actions listed above that the U.S. Forest Service has implemented or is planning to implement on the CNF are not required and do not prohibit activities that may impact Hermes copper butterfly or its habitat.

San Diego Multiple Species Conservation Plan (MSCP), the Biological Mitigation Ordinance, and the County of San Diego Resource Protection Ordinance

Information Provided in the Petition

The petitioner states that:

(1) Hermes copper butterfly is not recognized as a "covered species" under the County of San Diego's Subarea Plan under the MSCP (MSCP 1998);

(2) The MSCP cannot provide the necessary management to benefit the species because no species-specific management is planned, described, or required; and

(3) The MSCP can benefit Hermes copper butterfly only in the event of collaterally beneficial conservation activities for other species and habitats.

The petitioner claims the informal treatment of Hermes copper butterfly by the MSCP provides few conservation benefits. The petitioner also states that the MSCP identifies only three sites where the butterfly occurs in the Metro-Lakeside-Jamul Segment of the County of San Diego Subarea Plan. The petitioner claims that conservation under the County of San Diego Subarea Plan is presumably provided under the Biological Mitigation Ordinance (BMO) that applies to more species than those covered under MSCP, and establishes mitigation ratios and conditions for impacted species within the County. However, the petitioner states that the BMO only protects those "non-covered" species if they are inside the County of San Diego Subarea Plan's Biological Resources Core Areas, and even then, the County of San Diego Subarea Plan does not require avoidance of important Hermes copper butterfly populations, habitat, or dispersal corridors. Moreover, the BMO would not improve the species' status. The petitioners also claim the County of San Diego Resource Protection Ordinance (RPO), which imposes controls on development of wetlands, floodplains, steep slopes, sensitive biological habitats, and historical sites outside the boundaries of the County of San Diego Subarea Plan, does not directly protect species or impose any species-specific management efforts. Rather, the RPO attempts to minimize the impacts of urban development on habitat. The petition states that the County of San Diego asserts these regulatory measures will still contribute to conservation of the Hermes copper butterfly; however, the petitioner noted that the County of San Diego Subarea Plan provides only inadvertent protection to the species, which the petitioner believes is insufficient.

Evaluation of Information Provided in the Petition and Available in Service Files

Information in our files indicates that Hermes copper butterfly is not a "covered species" under the County of San Diego Subarea Plan (Service 1998, p. 2). Although not a "covered species" under the plan, the Hermes copper butterfly and its habitat receive some indirect protection through land use restrictions applicable to lands within the County of San Diego under the BMO (in effect since 2004) and the RPO. The BMO, which applies to areas in the county covered by the County's approved MSCP Subarea Plan, implements preserve design criteria for urban development and provides for conservation of sensitive biological habitats, such as chaparral, coastal sage scrub, and woodland, by establishing mitigation ratios and project development conditions. Therefore, the BMO may provide some protection and mitigation for larval and adult habitat for the Hermes copper butterfly within the County of San Diego MSCP Subarea Plan to the extent that habitat occurs within sensitive biological habitats regulated by the BML. The RPO, which applies to the entire County of San Diego (and not solely outside the

boundaries of the MSCP as stated in the petition), provides protection and requires mitigation for impacts to Hermes copper butterfly habitat that is deemed sensitive habitat land or occurs on steep slopes. The County of San Diego Guidelines for Determining Significance and Report Format and Content Requirements for Biological Resources (County of San Diego 2009, p. 7) includes guidance that habitat occupied by Hermes copper butterfly should be considered sensitive, thus triggering species-based mitigation and avoidance to the maximum extent possible under the RPO. Hermes copper butterfly is included on the County's Group 1 Sensitive Animals List because it is considered a rare endemic species and is on the State of California's special animal taxa list (County of San Diego 2009, p. 50; CDFG 2009). Therefore, the MSCP, BMO, and RPO provide variable protection to the Hermes copper butterfly habitat depending on the specific regulatory mechanism and habitat location.

City of San Diego and County of San Diego Open Space Parks

Information Provided in the Petition

The petition states that remaining Hermes copper butterfly populations are not necessarily protected from edge effects, wildfire, or potential park development by the nature of their location on the following open space park lands managed by the City or County of San Diego: Mission Trails Regional Park, McGinty Mountain, and Black Mountain. The petitioner claims Hermes copper butterfly cannot directly benefit from these open spaces without formal protection.

Evaluation of Information Provided in the Petition and Available in Service Files

Information in our files does not support the petitioner's claim that lack of specific management plans or area-specific management directives for open space parks threatens the persistence of Hermes copper butterfly. Furthermore, McGinty Mountain is part of the San Diego National Wildlife Refuge and is not managed by the City or County of San Diego. Although there are no formal management plans in our files written by the City or County of San Diego for these specific parks, it appears Hermes copper butterfly is persisting at all three locations listed in the petition. Information in our files indicates that:

(1) Hermes copper butterfly has been observed historically at Mission Trails Regional Park since the late 1950s through current surveys in 2009;

(2) Observations at McGinty Mountain were first reported in the 1980s and the butterfly has been repeatedly observed since; and

(3) The City of San Diego's website on the Black Mountain Open Space Park states that all plants and animals found within the park are protected and must not be harmed or removed (City of San Diego 2009); Hermes copper butterflies were observed on Black Mountain in 2004.

There are few known occurrences of Hermes copper butterflies in City or County open space parks. Although there is no formal regulation or management specifically for Hermes copper butterflies on these lands, we are not aware of any evidence to suggest that the absence of such regulation and management poses a threat to the Hermes copper butterfly or its habitat.

In summary, we have evaluated the petition and information in our files and find substantial information exists to indicate that listing the Hermes butterfly may be warranted because existing regulatory mechanisms may not adequately address the threats of habitat loss and fragmentation posed by development related impacts, including human-induced, excessive wildfire (see Factor A discussion). The regulatory mechanisms discussed above provide a patchwork of protection for Hermes copper butterfly and its habitat; however, the cumulative protection provided by these mechanisms may not adequately remove the threat of habitat loss and fragmentation resulting from development. We do not believe that the observed increase in frequency of natural wildfires recently observed in Hermes butterfly habitat is a threat amenable to reduction or elimination by regulatory mechanisms. However, we will further investigate the effectiveness of existing regulatory mechanisms to protect the Hermes copper butterfly and its habitat from wildfire and other potential threats in our status review of the species.

E. Other Natural or Manmade Factors Affecting the Species' Continued Existence

The petition, its appendices, and referenced documents discuss the following threats that are grouped under Factor E: wildfire, vulnerability of small and isolated populations, and global climate change.

Mortality Due to Wildfire

Information Provided in the Petition

The petitioner states that the Hermes copper butterfly cannot escape fire. The petitioner states that: (1) Pupae and larvae are likely killed when fire burns *Rhamnus crocea* and other nearby coastal sage scrub or chaparral vegetation; (2) adults are likely killed by fire due to their habit of remaining close to their host plant; and (3) adults are likely outpaced by an approaching fire. The petition claims excessive fires over the last several decades have reduced Hermes copper butterfly population numbers and disrupted metapopulation dynamics and stability.

Evaluation of Information Provided in the Petition and Available in Service Files

Fire causes direct mortality of Hermes copper butterflies, and is reported to have extirpated a population in habitat where they were not observed again until 18 years after the fire (Faulkner and Klein 2005, pp. 24–26). The persistence of Hermes copper butterfly after the 2003 fires was at first questioned because much of the fire footprint appeared to cover known locations occupied by the species (Betzler *et al.* 2003, p. 12). However, information in our files indicates Hermes copper butterfly persisted in reduced numbers at sites within the 2003 and 2007 fire footprints (such as Mission Trails Regional Park, Wildwood Glen Lane in CNF, Barber Mountain, and Potrero Road). Given the described negative impacts of fire on Hermes copper butterfly populations (Faulkner and Klein 2005, pp. 24–26), it is likely the species' existence is threatened by wildfires. Additional surveys and monitoring are needed to determine the survival and recolonization rate following fire to address the petitioner's claim of a direct mortality extinction threat due to high fire frequency. After reviewing the petition and information in our files, we find substantial information exists indicating that listing the Hermes copper butterfly may be warranted due to the threat of mortality from wildfire.

Vulnerability of Small and Isolated Populations

Information Provided in the Petition

The petitioner asserts that endemic taxa such as Hermes copper butterfly are considered more prone to extinction than widespread species due to their restricted geographical range and that population isolation is exacerbated by habitat fragmentation (see Factor A above for discussion of habitat fragmentation). According to the petition, the common factors that increase the vulnerability of small and isolated populations to extinction are demographic fluctuations,

environmental stochasticity (random events), and reduced genetic diversity.

Evaluation of Information Provided in the Petition and Available in Service Files

Small population size, a low number of populations, or population isolation are not necessarily factors that may threaten a species independently. Typically, it is the combination of small size and number and isolation of populations in conjunction with other threats (such as the present or threatened destruction, modification, or curtailment of the species' habitat or range) that may significantly increase the probability of species' extinction.

Information in our files indicates large annual fluctuations in observed abundance of adult butterflies are common throughout this butterfly's range. Adult butterfly abundance may fluctuate approximately two orders of magnitude from one year to the next and may be correlated with rainfall levels (Klein and Faulkner 2003, p. 96); however, it is not clear how adult observations correlate with abundance of all life stages, including diapausing (quiescent) stages. Also, much uncertainty exists regarding the species' distribution because the range of its host plant, *Rhamnus crocea*, extends well beyond the known range of the butterfly and surveys have not been conducted throughout the host plant's range (especially inland San Diego County and northwestern Baja California, Mexico).

Population isolation and fragmentation may render smaller populations more vulnerable to stochastic extirpation. Small populations and isolation could also subject the butterfly to genetic drift and restricted gene flow that may decrease genetic variability over time and could adversely affect species' viability (Allee 1931, pp. 12-37; Stephens *et al.* 1999, pp. 185-190; Dennis 2002, pp. 389-401). Information in our files indicates that reduced adult Hermes copper butterfly densities are present in burned areas (see Factor A discussion on *Wildfire*) and new occurrences (such as at Potrero Road, north Lyons Valley, and west Japatul Valley) have been documented after the 2003 and 2007 fires. Sufficient distribution, population structure, genetic, or demographic information about the species to determine the effect of isolation and small population size is currently unavailable. However, information in our files indicates that the habitat area and range that the species inhabits have been reduced and fragmented and the status of some historical occurrences remains unknown after recent fires; therefore, stochastic extinction as a result of restricted geographical range or population isolation may pose a significant threat to the species.

Global Climate Change

Information Provided in the Petition

The petitioner asserts that butterflies (in general) are threatened by global climate change and are specifically sensitive to small changes in microclimate, such as fluctuations in moisture, temperature, or sunlight. According to the petition, studies of Edith's checkerspot butterfly (*Euphydryas editha*) have shown that whole ecosystems may move northward or shift in elevation as the Earth's climate warms (Parmesan and Galbraith 2004, p. 9).

Evaluation of Information Provided in the Petition and Available in Service Files

We recognize recent evaluations by Parmesan and Galbraith (2004, pp. 1–2, 29–33) that indicate that whole ecosystems may be shifting northward and upward in elevation, or are otherwise being altered by differing climate tolerance among species within a community. Additionally, we recognize that climate change is likely to cause changes in the arrangement and community composition of occupied habitat patches. Current climate change predictions for terrestrial areas in the Northern Hemisphere indicate warmer air temperatures, more intense precipitation events, and increased summer continental drying (Field *et al.* 1999, pp. 1–3; Hayhoe *et al.* 2004, p. 12422; Cayan *et al.* 2005, p. 6; Intergovernmental Panel on Climate Change (IPCC) 2007, p. 11). However, predictions of climatic conditions for smaller subregions, such as California, remain less certain. Thus, the information currently available in our files on the effects of global climate change, such as increasing temperatures or moisture, require further analysis and comparison with local climate models and other literature to make sufficiently certain estimates of the likely magnitude of predicted effects on Hermes copper butterfly. Given the current uncertainty, we find that information in our files does not provide substantial information suggesting that global climate change may be a factor that threatens Hermes copper butterfly. We will further investigate this potential threat to Hermes copper butterfly in our status review of the species.

In summary, we find the petition and information in our files provide substantial information indicating that listing Hermes copper butterfly may be warranted due to other natural or manmade factors affecting the species' continued existence. Specifically, we find that mortality due to wildfire and restricted geographical range or population isolation may pose significant threats to the species.

Finding

On the basis of our determination under section 4(b)(3)(A) of the Act, we determine that the petition presents substantial scientific or commercial information indicating that listing the Hermes copper butterfly may be warranted. This finding is based on information provided under Factor A (present or threatened destruction, modification, or curtailment of the species' habitat or range), Factor D (the inadequacy of existing regulatory mechanisms), and Factor E (other natural or manmade factors affecting the species' continued existence). Because we find that the petition presents substantial information indicating that listing the Hermes copper butterfly may be warranted, we are initiating a status review to determine whether listing the Hermes copper butterfly under the Act is warranted.

The "substantial information" standard for a 90–day finding differs from the Act's "best scientific and commercial data" standard that applies to a status review to determine whether a petitioned action is warranted. A 90–day finding does not constitute a status review under the Act. In a 12–month finding, we will determine whether a petitioned action is warranted after we have completed a thorough status review of the species, which is conducted following a substantial 90–day finding. Because the Act's standards for 90–day and 12–month findings are different, as described above, a substantial 90–day finding does not mean that the 12–month finding will result in a warranted finding.

The petitioner requested that critical habitat be designated for this species. If we determine in our 12–month finding that listing Hermes copper butterfly is warranted, we will address the designation of critical habitat at the time of the proposed rulemaking. The proposed rulemaking may be published concurrently with the 12–month finding or at a later date.

References Cited

A complete list of references cited is available on the Internet at *http://www.regulations.gov* and upon request from the Carlsbad Fish and Wildlife

Office (see **FOR FURTHER INFORMATION CONTACT**).

Author

The primary authors of this notice are staff members of the Carlsbad Fish and Wildlife Office (see **FOR FURTHER INFORMATION CONTACT**).

Authority

The authority for this action is the Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*).

Dated: April 19, 2010.

Daniel M. Ashe,

Acting Director, Fish and Wildlife Service.

[FR Doc. 2010–10317 Filed 5–3–10; 8:45 am]

BILLING CODE 4310–55–S

Notices

Federal Register

Vol. 75, No. 85

Tuesday, May 4, 2010

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Submission for OMB Review; Comment Request

April 29, 2010.

The Department of Agriculture has submitted the following information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Comments regarding (a) whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of burden including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology should be addressed to: Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), *Pamela_Beverly_OIRA_Submission@OMB.EOP.GOV* or fax (202) 395–5806 and to Departmental Clearance Office, USDA, OCIO, Mail Stop 7602, Washington, DC 20250–7602. Comments regarding these information collections are best assured of having their full effect if received within 30 days of this notification. Copies of the submission(s) may be obtained by calling (202) 720–8958.

An agency may not conduct or sponsor a collection of information unless the collection of information displays a currently valid OMB control number and the agency informs potential persons who are to respond to the collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

Cooperative State Research, Education, and Extension Service

Title: Veterinary Medicine Loan Repayment Program (VMLRP) Shortage Situation.

OMB Control Number: 0524–0046.

Summary of Collection: In January 2003, the National Veterinary Medical Service Act (NVMSA) was passed into law adding section 1415A to the National Agricultural Research, Extension, and Teaching Policy Act of 1997. This law established a new Veterinary Medicine Loan Repayment Program (VMLRP) (7 U.S.C. 3151a) authorizing the Secretary of Agriculture to carry out a program of entering into agreements with veterinarians under which they agree to provide veterinary services in veterinarian shortage situations. The purpose of the program is to assure an adequate supply of trained food animal veterinarians in shortage situations and provide USDA with a pool of veterinary specialists to assist in the control and eradication of animal disease outbreaks.

Need and Use of the Information: The National Institute of Food and Agriculture (NIFA) will collect information using the Veterinarian Shortage Situation Nomination form. Applications for the VMLRP will be accepted from eligible veterinarians who agree to serve in one of the designated shortage situations in exchange for the repayment of the veterinarian's qualifying educational loans. The nomination form includes a series of questions that will need to be answered before the nomination can be submitted to the peer panelists for their review and recommendations.

Description of Respondents: State, Local or Tribal Government.

Number of Respondents: 60.

Frequency of Responses: Reporting: Biennially.

Total Burden Hours: 480.

Ruth Brown,

Departmental Information Collection Clearance Officer.

[FR Doc. 2010–10427 Filed 5–3–10; 8:45 am]

BILLING CODE 3410–09–P

DEPARTMENT OF AGRICULTURE

Submission for OMB Review; Comment Request

April 29, 2010.

The Department of Agriculture has submitted the following information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Comments regarding (a) whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of burden including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology should be addressed to: Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), *OIRA_Submission@OMB.EOP.GOV* or fax (202) 395–5806 and to Departmental Clearance Office, USDA, OCIO, Mail Stop 7602, Washington, DC 20250–7602. Comments regarding these information collections are best assured of having their full effect if received within 30 days of this notification. Copies of the submission(s) may be obtained by calling (202) 720–8958.

An agency may not conduct or sponsor a collection of information unless the collection of information displays a currently valid OMB control number and the agency informs potential persons who are to respond to the collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

Animal and Plant Health Inspection Service

Title: Untreated Oranges, Tangerines, and Grapefruit from Mexico Transiting the United States to Foreign Countries.

OMB Control Number: 0579–0303.

Summary of Collection: Under the Plant Protection Act (7 U.S.C. 7701–7772), the Secretary of Agriculture is authorized to prohibit or restrict the importation, entry, or movement of plants and plant pests to prevent the introduction of plant pests into the United States or their dissemination within the United States. The Code of Federal Regulations, § 352.30 addresses the movement into or through the United States of untreated oranges, tangerines, and grapefruit from Mexico that transit the United States en route to foreign countries.

Need and Use of the Information: The Animal and Plant Health Inspection Service (APHIS) is taking action to provide additional protection against the possible introduction of fruit flies via untreated oranges, tangerines, and grapefruit from Mexico that transit the United States. Untreated oranges, tangerines, and grapefruit from Mexico transiting the United States for export to another country must be shipped in sealed, refrigerated container and insect-proof packaging. A transportation and exportation permit must be issued by an inspector for shipments of untreated oranges, tangerines, and grapefruit from Mexico. Without the information, APHIS would not be able to allow the movement of untreated citrus to transit the United States to foreign countries.

Description of Respondents: Business or other for-profit; Individual or households.

Number of Respondents: 25.

Frequency of Responses: Reporting: On occasion.

Total Burden Hours: 13.

Ruth Brown,

Departmental Information Collection Clearance Officer.

[FR Doc. 2010–10429 Filed 5–3–10; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

Agency Information Collection Activities: Proposed Collection; Comment Request—Supplemental Nutrition Assistance Program State Agency Options

AGENCY: Food and Nutrition Service, USDA.

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice invites the general public and other public agencies to comment on the proposed collection. This collection is an extension without change for the State Agency Options, Standard Utility Allowance and Self Employment Costs, burden calculations for the Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program.

DATES: Written comments must be received on or before July 6, 2010.

ADDRESSES: Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on those who respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Comments may be sent to Angela Kline, Chief, Certification Policy Branch, Program Development Division, FNS, U.S. Department of Agriculture, 3101 Park Center Drive, Room 812, Alexandria, VA 22302. Comments may also be faxed to the attention of Ms. Kline at (703) 305–2486. The Internet address is: *Angela.Kline@FNS.USDA.GOV.*

Comments will also be accepted through the Federal eRulemaking Portal. Go to *http://www.regulations.gov* and follow the online instructions for submitting comments electronically.

All written comments will be open for public inspection at the office of the FNS during regular business hours (8:30 a.m. to 5 p.m., Monday through Friday) at 3101 Park Center Drive, Alexandria, Virginia, 22302, Room 800.

All responses to this notice will be summarized and included in the request for OMB approval. All comments will be a matter of public record.

FOR FURTHER INFORMATION CONTACT: Requests for additional information should be directed to Ms. Kline at (703) 305–2495.

SUPPLEMENTARY INFORMATION:

Title: Supplemental Nutrition Assistance Program: State Agency Options.

OMB Number: 0584–0496.

Form Number: None.

Expiration Date: 10/31/2010.

Type of Request: Extension without change of a currently approved information collection.

Abstract: This collection is an extension without change for the State Agency Options, Standard Utility Allowance and Self Employment Costs, burden calculations for SNAP, formerly known as the Food Stamp Program. The program's name was changed by the Food, Conservation, and Energy Act of 2008 (Pub. L. 110–246) (FCEA) on October 1, 2008, to reflect the fact that participants no longer receive stamps or coupons to make food purchases and to emphasize the nutritional aspect of the program. To comply with current law, FNS is using the new program name SNAP in this extension of information collection for OMB No. 0584–0496. It should be noted, however, that the program regulations at 7 CFR parts 271–285 have not yet been revised to reflect the new name.

The SNAP regulations at 7 CFR part 273 contain the requirements for the application, certification and continued eligibility for SNAP benefits. On January 29, 2010, FNS published a final rule in the **Federal Register** (75 FR 4912), which codified the eligibility and certification provisions of the Farm Security and Rural Investment Act of 2002 (FSRIA). This notice extends the collection burden, which was recently revised and approved by OMB on March 26, 2010, to account for changes required by the final FSRIA rule.

Establishing and reviewing standard utility allowances. The regulations at 7 CFR 273.9(d)(6)(iii) allow State agencies to establish standard utility allowances (SUA) in place of the actual utility costs incurred by a household. Once SUAs are established, State agencies are required to review and adjust SUAs annually to reflect changes in the costs of utilities. Many State agencies already have one or more approved standards, which they update annually. State agencies may use information already available from case files, quality control reviews or other sources and from utility companies. State agencies may make adjustments based on cost-of-living increases. The information will be used to establish standards to be used in place of actual utility costs in the computation of the excess shelter deduction. State agencies are required to submit the amounts of these standards and methodologies used in developing and updating the standards to FNS when they are developed or changed.

Estimates of burden: Currently 52 State agencies have a standard that includes heating or cooling costs and 41 have a standard for utility costs other than heating or cooling. In addition, 51 State agencies have a telephone allowance standard. We estimate a minimum of 2.5 hours annually to make this review and adjustment (2.5 hours × 52 State agencies = 130 hours). Total

burden for this provision is estimated to be 130 hours per year.

Self-employment costs. The regulations at 7 CFR 273.11(b) allow self-employment gross income to be reduced by the cost of producing such income. The regulations allow the State agencies, with approval from FNS, to establish the methodology for offsetting the costs of producing self-employment income, as long as the procedure does not increase program costs. State agencies may submit a request to FNS to use a method of producing a reasonable estimate of the costs of producing self-employment income in lieu of calculating the actual costs for each household with such income. Different methods may be proposed for different types of self-employment. The proposal shall include a description of the proposed method, the number and type of households and percent of the caseload affected, and documentation indicating that the proposed procedure will not increase program costs. State agencies may collect this data from household case records or other sources that may be available.

Estimates of burden: We estimate that 10 State agencies will submit a request of this type each year for the next three years. It is estimated that these States will incur a one-time burden of at least 10 working hours gathering and analyzing data, developing the methodology, determining the cost implication, and submitting a request to FNS for a total burden of 100 hours annually (10 State agencies × 10 working hours = 100 burden hours). State agencies are not required to periodically review their approved methodologies. We do not anticipate that State agencies will voluntarily review their methodologies for change on a regular basis, thus burden is not being assessed for this purpose.

Recordkeeping burden only: Each State agency would be required to keep a record of the information gathered and submitted to FNS for the SUA and self-employment costs. We estimate this to be 7 minutes or .1169 hours per year for the 53 State agencies to equal a total of 6 burden hours annually (53 State agencies × .1169 hours = 6 hours annual burden).

Summary of burden hours:

Affected Public: State agencies and local governments administering the SNAP.

Estimated Number of Respondents: 53.

Estimated Number of Responses Per Respondent: 1.

Estimated Number of Responses: 115.

Estimated Hours per Response: 12.6.

Estimated Total Annual Burden on Respondents: 236.

OMB # 0584–0496	Requirement	Estimated number of respondents	Response annually per respondent	Total annual responses	Hours per response	Annual burden hours
Affected Public						
State Agency						
Reporting Burden	Standard Utility Allowance	52	1	52	2.5	130
	Self-employment costs	10	1	10	10	100
	Reporting Totals	52		62		230
Recordkeeping Burden	Recordkeeping	53	1	53	.1169	6
	Recordkeeping Totals	53		53		6
	Total Recordkeeping and Reporting Burden.	53		115		236
	Total Number of Record Keepers.	53				

Dated: April 27, 2010.

Julia Paradis,

Administrator, Food and Nutrition Service.

[FR Doc. 2010–10390 Filed 5–3–10; 8:45 am]

BILLING CODE 3410–30–P

DEPARTMENT OF AGRICULTURE

Forest Service

Huron-Manistee National Forests, White Pines Wind Farm Project, Mason County, MI

AGENCY: Forest Service, USDA.

ACTION: Cancellation Notice of notice of intent to prepare an environmental impact statement.

SUMMARY: The Forest Service proposed to prepare an environmental impact statement for the White Pines Wind Farm Project on National Forest System (NFS) lands managed by the Huron-Manistee National Forests. This project has been cancelled. This cancellation notice terminates the environmental analysis process for the White Pines Wind Farm Project.

DATES: The Notice of Intent to prepare the White Pines Wind Farm Project environmental impact statement was published in the **Federal Register** on September 12, 2008, Vol. 73, No. 178, page 52945. The draft environmental impact statement was expected May 2009 and the final environmental impact statement was expected December 2009. This project has been cancelled.

FOR FURTHER INFORMATION CONTACT: Patricia O'Connell, Cadillac-Manistee Ranger District, Huron-Manistee National Forests; Manistee Ranger Stations, 412 Red Apple Road, Manistee, MI 49660; telephone: 231–723–2211, ext. 3119; fax: 231–723–8642; e-mail: *poconnell@fs.fed.us.* Information updating the status of this project can be found on the Forest's Web site at: *http://fs.usda.gov/Internet/FSE_DOCUMENTS/stelprdb5150088.pdf.*

Responsible Official

Barry Paulson, Forest Supervisor, Huron-Manistee National Forests, 1755 S. Mitchell Street, Cadillac, MI 49601.

Dated: April 26, 2010.

Barry Paulson,

Forest Supervisor.

[FR Doc. 2010–10397 Filed 5–3–10; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Foreign Agricultural Service

Trade Adjustment Assistance for Farmers

AGENCY: Foreign Agricultural Service, USDA.

ACTION: Notice of public hearings.

The Administrator today accepted a petition, and began a review of a petition, for trade adjustment assistance by the Michigan Agricultural Cooperative Marketing Association on behalf of apple producers in Michigan. A public hearing to review the merits of the petition will be held in Room 411–P of Suite 400, Portals Office Building, 1250 Maryland Ave., SW., Washington, DC 20024 on May 5, 2010, at 11 a.m. Eastern Time to receive written and oral comments associated with this petition.

SUPPLEMENTARY INFORMATION: The Administrator will determine within 40 days whether or not increasing imports of apple juice contributed to a greater than 15 percent decrease in the national average price of apples compared to the average of the 3 preceding marketing years. The petition maintains that Michigan apple producers have suffered primarily due to increased imports of apple juice concentrate. Over 81 percent of the apple juice consumed in the U.S. is from imported concentrate. If a determination is affirmative, producers who produce and market apples in Michigan will be eligible to apply to the Farm Service Agency for technical assistance and cash benefits. Persons who wish to speak at the hearing must register with the TAA Coordinator at (202) 720–0638 or (202) 690–0633, at least 24 hours before the hearing. Presenters will be allotted time to speak and should submit a written summary of their remarks for the record.

FOR FURTHER INFORMATION CONTACT: Trade Adjustment Assistance Staff, Office of Trade Programs, Foreign Agricultural Service, U.S. Department Agriculture at (202) 720–0638, or by e-mail at: *tradeadjustment@fas.usda.gov.* Additional program information can be obtained at the Web site for the Trade Adjustment Assistance for Farmers program. The URL is *http://www.fas.usda.gov/itp/taa.*

Dated: April 28, 2010.

John D. Brewer,

Administrator, Foreign Agricultural Service.

[FR Doc. 2010–10431 Filed 5–3–10; 8:45 am]

BILLING CODE 3410–10–P

DEPARTMENT OF AGRICULTURE

Foreign Agricultural Service

Trade Adjustment Assistance for Farmers

AGENCY: Foreign Agricultural Service, USDA.

ACTION: Notice of public hearing.

The Administrator today accepted a petition, and began review of a petition, for trade adjustment assistance by the Prune Bargaining Association on behalf of prune producers in California. A public hearing to review the merits of the petition will be held via teleconference on May 6, 2010, at 3 p.m. Eastern Time to receive oral comments associated with this petition.

SUPPLEMENTARY INFORMATION: The Administrator will determine within 40 days whether or not increasing imports of prune juice contributed importantly to a greater than 15 percent decrease in the national average price of prunes compared to the average of the three preceding marketing years. The petition maintains that California prune producers have suffered a greater than 15 percent decrease in the national average price due primarily to U.S. imports of prune juice (primarily in the form of prune juice concentrate) and, to a smaller degree, dried prunes. If a determination is affirmative, producers who produce and market prunes in California will be eligible to apply to the Farm Service Agency for cash benefits and technical assistance at no cost. Persons who wish to listen or speak at the hearing must register with the TAA Coordinator at (202) 720–0638 or (202) 690–0633, at least 24 hours before the hearing. Presenters will be allotted time to speak via telephone and must dial 1 (800) 867–6144. When prompted for your conference code, please enter 4843 on your telephone keypad. Speakers should also submit a written summary of their remarks for the record by faxing them to (202) 720–0876.

FOR FURTHER INFORMATION CONTACT: Trade Adjustment Assistance Staff, FAS, USDA, at (202) 720–0638, or by e-mail at: *tradeadjustment@fas.usda.gov.* Additional program information can be obtained at the Web site for the Trade Adjustment Assistance for Farmers program. The URL is *http://www.fas.usda.gov/itp/taa.*

Dated: April 28, 2010.

John D. Brewer,

Administrator, Foreign Agricultural Service.

[FR Doc. 2010–10439 Filed 5–3–10; 8:45 am]

BILLING CODE 3410–10–P

DEPARTMENT OF COMMERCE

International Trade Administration

A–560–822, A–583–843, A–552–806

Antidumping Duty Orders: Polyethylene Retail Carrier Bags from Indonesia, Taiwan, and the Socialist Republic of Vietnam

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: Based on affirmative final determinations by the Department of Commerce (the Department) and the International Trade Commission (ITC), the Department is issuing antidumping duty orders on polyethylene retail carrier bags (PRCBs) from Indonesia, Taiwan, and the Socialist Republic of Vietnam (Vietnam). On April 26, 2010, the ITC notified the Department of its affirmative determination of the threat of material injury to a U.S. industry. Pursuant to section 736(a) of the Tariff Act of 1930, as amended (the Act), the Department of Commerce is issuing the antidumping duty orders on PRCBs from Indonesia, Taiwan, and Vietnam.

EFFECTIVE DATE: May 4, 2010

FOR FURTHER INFORMATION CONTACT: Yang Jin Chun (Indonesia) at (202) 482–5760 and Dmitry Vladimirov (Taiwan) at (202) 482–0665, AD/CVD Operations, Office 5, and Shawn Higgins (Vietnam) at (202) 482–0679, AD/CVD Operations, Office 4, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230.

SUPPLEMENTARY INFORMATION:

Background

On March 26, 2010, the Department published its affirmative final determination of sales at less than fair value in the antidumping duty investigation of PRCBs from Taiwan. *See Polyethylene Retail Carrier Bags from Taiwan: Final Determination of Sales at Less Than Fair Value*, 75 FR 14569 (March 26, 2010). On April 1, 2010, the Department published its affirmative final determinations of sales at less than fair value in the antidumping duty investigations of PRCBs from Indonesia and Vietnam. *See Polyethylene Retail Carrier Bags From Indonesia: Final Determination of Sales at Less Than Fair Value*, 75 FR 16431 (April 1, 2010), and *Polyethylene Retail Carrier Bags From the Socialist Republic of Vietnam: Final Determination of Sales at Less Than Fair Value*, 75 FR 16434 (April 1, 2010).

On April 26, 2010, the ITC notified the Department of its final

determination, pursuant to section 735(d) of the Act, that an industry in the United States is threatened with material injury by reason of less–than-fair–value imports of PRCBs from Indonesia, Taiwan, and Vietnam. See section 735(b)(1)(A)(i) of the Act and *Polyethylene Retail Carrier Bags from Indonesia, Taiwan, and Vietnam*, Investigation Nos. 701–TA–462 and 731–TA–1156–1158 (Final), USITC Publication 4144 (April 2010).

Scope of the Orders

The merchandise subject to these antidumping duty orders are PRCBs, which also may be referred to as t–shirt sacks, merchandise bags, grocery bags, or checkout bags. The subject merchandise is defined as non–sealable sacks and bags with handles (including drawstrings), without zippers or integral extruded closures, with or without gussets, with or without printing, of polyethylene film having a thickness no greater than 0.035 inch (0.889 mm) and no less than 0.00035 inch (0.00889 mm), and with no length or width shorter than 6 inches (15.24 cm) or longer than 40 inches (101.6 cm). The depth of the bag may be shorter than 6 inches (15.24 cm) but not longer than 40 inches (101.6 cm).

PRCBs are typically provided without any consumer packaging and free of charge by retail establishments, *e.g.*, grocery, drug, convenience, department, specialty retail, discount stores, and restaurants to their customers to package and carry their purchased products. The scope of these antidumping duty orders exclude (1) polyethylene bags that are not printed with logos or store names and that are closeable with drawstrings made of polyethylene film and (2) polyethylene bags that are packed in consumer packaging with printing that refers to specific end–uses other than packaging and carrying merchandise from retail establishments, *e.g.*, garbage bags, lawn bags, trash–can liners.

Imports of merchandise included within the scope of these antidumping duty orders are currently classifiable under statistical category 3923.21.0085 of the Harmonized Tariff Schedule of the United States (HTSUS). This subheading may also cover products that are outside the scope of these antidumping duty orders. Although the HTSUS subheading is provided for convenience and customs purposes, the written description of the scope of these antidumping duty orders is dispositive.

Antidumping Duty Orders

On April 26, 2010, in accordance with section 735(d) of the Act, the ITC notified the Department of its final determination that an industry in the United States is threatened with material injury within the meaning of section 735(b)(1)(A)(ii) of the Act by reason of less–than-fair–value imports of PRCBs from Indonesia, Taiwan, and Vietnam.

In accordance with section 736(a)(1) of the Act, the Department will direct U.S. Customs and Border Protection (CBP) to assess, upon further instruction by the Department, antidumping duties equal to the amount by which the normal value of the merchandise exceeds U.S. price of the merchandise for all relevant entries of PRCBs from Indonesia, Taiwan, and Vietnam.

Pursuant to section 736(b)(2) of the Act, duties shall be assessed on subject merchandise entered, or withdrawn from warehouse, for consumption on or after the date of publication of the ITC's notice of final determination if that determination is based on the threat of material injury, other than threat of material injury described in section 736(b)(1) of the Act. Section 736(b)(1) states that, "{i}f the Commission, in its final determination under section 735(b), finds material injury or threat of material injury which, but for the suspension of liquidation under section 733(d)(2) would have led to a finding of material injury, then entries of the subject merchandise, the liquidation of which has been suspended under section 733(d)(2), shall be subject to the imposition of antidumping duties under section 731." In addition, section 736(b)(2) of the Act requires CBP to release any bond or other security and refund any cash deposit made of estimated antidumping duties posted since the Department's preliminary antidumping duty determinations.

Because the ITC's final determination is based on the threat of material injury and is not accompanied by a finding that injury would have resulted but for the imposition of suspension of liquidation of entries since the Department's preliminary determinations, section 736(b)(2) of the Act is applicable. According to section 736(b)(2) of the Act, where the ITC finds threat of material injury, duties shall only be assessed on subject merchandise entered, or withdrawn from warehouse, for consumption on or after the date of publication of the ITC's notice of final determination. In addition, section 736(b)(2) of the Act requires CBP to refund any cash deposits or bonds of estimated antidumping duties posted since the preliminary antidumping determinations and prior to the ITC's notice of final determination.

Therefore, on or after the date of publication of the ITC's notice of final determination in the **Federal Register**, CBP will require, pursuant to section 736(a)(3) of the Act, at the same time as importers would normally deposit estimated duties on this merchandise, a cash deposit equal to the estimated dumping margins listed below. The all–others rates for Indonesia and Taiwan apply to all Indonesian and Taiwanese producers or exporters not specifically listed. The Vietnam–wide rate applies to all Vietnamese exporters of subject merchandise not specifically listed.

The antidumping duty margins and cash–deposit rates are as follows:

INDONESIA

Producer or Exporter	Antidumping Duty Percent Margin
P.T. Sido Bangun Indonesia	85.17
P.T. Super Exim Sari Ltd. and P.T. Super Makmur	69.64
All Others	69.64

TAIWAN

Producer or Exporter	Antidumping Duty Percent Margin
Ipsido Corporation	95.81
TCI Plastic Co., Ltd.	36.54
All Others	36.54

SOCIALIST REPUBLIC OF VIETNAM[1]

Manufacturer	Exporter	Antidumping–Duty Percent Margin
Alpha Plastics (Vietnam) Co., Ltd.∧	Alpha Plastics (Vietnam) Co., Ltd.∧	52.30
Alta Company°	Alta Company°	52.30
Ampac Packaging Vietnam Ltd.∧	Ampac Packaging Vietnam Ltd. ∧	52.30
BITAHACO*	BITAHACO*	52.30
Chin Sheng Co., Ltd.*	Chin Sheng Co., Ltd.*	52.30
Chung Va (Vietnam) Plastic Packaging Co., Ltd.∧	Chung Va Century Macao Commercial Offshore Limited∧	52.30
Hanoi 27–7 Packaging Company Limited, aka Hanoi 27–7 Packaging Company Limited, aka HAPACK Co. Ltd, aka HAPACK°	Hanoi 27–7 Packing Company Limited, aka Hanoi 27–7 Packing Company Limited,aka HAPACK Co. Ltd, aka HAPACK°	52.30
Hoi Hung Company Limited∧	Kong Wai Polybag Printing Company∧	52.30
Kinsplastic Vietnam Ltd. Co.∧	Kinsplastic Vietnam Ltd. Co.∧	52.30
Loc Cuong Trading Producing Company Limited, aka Loc Cuong Trading Producing Company, aka Loc Cuong Trading Producing Co. Ltd.*	Loc Cuong Trading Producing Company Limited, aka Loc Cuong Trading Producing Company, aka Loc Cuong Trading Producing Co. Ltd.*	52.30
Ontrue Plastics Co., Ltd. (Vietnam)∧	Ontrue Plastics Co., Ltd. (Vietnam)∧	52.30
Richway Plastics Vietnam Co., Ltd.∧	Richway Plastics Vietnam Co., Ltd.∧	52.30
RKW Lotus Limited Co., Ltd., aka RKW Lotus Limited, aka RKW Lotus Ltd.∧	RKW Lotus Limited Co., Ltd., aka RKW Lotus Limited, aka RKW Lotus Ltd.∧	52.30
VINAPACKINK Co., Ltd.*	VINAPACKINK Co., Ltd.*	52.30
VN K's International Polybags Joint Stock Company *	K's International Polybags MFG Ltd *	52.30
VN Plastic Industries Co. Ltd.∧	VN Plastic Industries Co. Ltd.∧	52.30
Vietnam–Wide Entity[2]		76.11

[1] The symbol "∧"designates companies as foreign-owned separate-rate recipients, "*" designates companies as Vietnamese separate-rate recipients, and "°" designates companies as state-owned separate-rate recipients.

[2] Advance Polybag Co., Ltd., Fotai Vietnam Enterprise Corp., Green Care Packaging Industrial (Vietnam) Co., An Phat Plastic and Packing Joint Stock Co., Genius Development Ltd., J.K.C. Vina Co., Ltd., are all part of the Vietnam-wide entity.

In accordance with section 736(b)(2) of the Act and 19 CFR 351.211(b), the Department will instruct CBP to terminate the suspension of liquidation for entries of PRCBs from Indonesia, Taiwan, and Vietnam entered, or withdrawn from warehouse, for consumption and refund any cash deposits made and release any bonds posted for estimated antidumping duties between the dates of publication of the Department's preliminary determinations on October 27, 2009,[3] for Taiwan and November 3, 2009,[4] for Indonesia and Vietnam and the day before publication of the ITC's final determination in the **Federal Register**.

This notice constitutes the antidumping duty orders with respect to PRCBs from Indonesia, Taiwan, and Vietnam pursuant to section 736(a) of the Act. Interested parties may contact the Central Records Unit of the main Department of Commerce building, Room 1117, for copies of an updated list of antidumping duty orders currently in effect.

These orders are published in accordance with section 736(a) of the Act and 19 CFR 351.211(b).

Dated: April 27, 2010.

Ronald K. Lorentzen,

Deputy Assistant Secretary for Import Administration.

[FR Doc. 2010–10254 Filed 5–3–10; 8:45 am]

BILLING CODE 3510–DS–S

[3] See *Polyethylene Retail Carrier Bags From Taiwan: Preliminary Determination of Sales at Less Than Fair Value and Postponement of Final Determination*, 74 FR 55183 (October 27, 2009).

[4] See *Polyethylene Retail Carrier Bags from Indonesia: Preliminary Determination of Sales at Less Than Fair Value and Postponement of Final Determination, 74 FR 56807 (November 3, 2009), and Polyethylene Retail Carrier Bags From the Socialist Republic of Vietnam: Preliminary Determination of Sales at Less Than Fair Value and Postponement of Final Determination*, 74 FR 56813 (November 3, 2009).

DEPARTMENT OF COMMERCE

International Trade Administration

Application(s) for Duty–Free Entry of Scientific Instruments

Pursuant to Section 6(c) of the Educational, Scientific and Cultural Materials Importation Act of 1966 (Pub. L. 89–651, as amended by Pub. L. 106–36; 80 Stat. 897; 15 CFR part 301), we invite comments on the question of whether instruments of equivalent scientific value, for the purposes for which the instruments shown below are intended to be used, are being manufactured in the United States. Comments must comply with 15 CFR 301.5(a)(3) and (4) of the regulations and be postmarked on or before May 24, 2010. Address written comments to Statutory Import Programs Staff, Room 3720, U.S. Department of Commerce, Washington, D.C. 20230. Applications may be examined between 8:30 A.M. and 5:00 P.M. at the U.S. Department of Commerce in Room 3720.

Docket Number: 10–008. Applicant: Colorado State University, Department of Biomedical Sciences 200 Westlake St., Campus Delivery 1617, Fort Collins, CO 80523. Instrument: Electron Microscope. Manufacturer: JEOL, Ltd., Japan. Intended Use: This instrument will be used for the tomographic analysis of viruses. Justification for Duty–Free Entry: There are no instruments of the same general category as this instrument being produced in the United States. Application accepted by Commissioner of Customs: April 15, 2010.

Docket Number: 10–009. Applicant: University of Oregon, Purchasing & Contracting Services, 720 E. 13th Ave., Suite 302, Eugene, OR 97401–3753. Instrument: Electron Microscope Manufacturer: FEI Company, Czech

Republic. Intended Use: This instrument will be used to study the size, shape and elemental compositions of nanoparticles to determine the effect on biological interactions at the nano scale. Justification for Duty–Free Entry: There are no instruments of the same general category as this instrument being produced in the United States. Application accepted by Commissioner of Customs: April 15, 2010.

Dated: April 28, 2010.

Gregory W. Campbell,

Acting Director, IA Subsidies Enforcement Office.

[FR Doc. 2010–10487 Filed 5–3–10; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

(C–552–805)

Polyethylene Retail Carrier Bags from the Socialist Republic of Vietnam: Countervailing Duty Order

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: Based on affirmative final determinations by the Department of Commerce (the Department) and the U.S. International Trade Commission (ITC), the Department is issuing a countervailing duty order on polyethylene retail carrier bags (PRCBs) from the Socialist Republic of Vietnam (Vietnam).

EFFECTIVE DATE: May 4, 2010.

FOR FURTHER INFORMATION CONTACT: Gene Calvert or Jun Jack Zhao, AD/CVD Operations, Office 6, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482–3586 and (202) 482–1396, respectively.

SUPPLEMENTARY INFORMATION:

Background

In accordance with section 705(d) of the Tariff Act of 1930, as amended (the Act), on April 1, 2010, the Department published its final determination in the countervailing duty investigation of PRCBs from Vietnam. *See Polyethylene Retail Carrier Bags from the Socialist Republic of Vietnam: Final Affirmative Countervailing Duty Determination*, 75 FR 16428 (April 1, 2010).

On April 26, 2010, the ITC notified the Department of its final determination, pursuant to sections 705(b)(1)(A)(ii) and 705(d) of the Act, that a U.S. industry is threatened with material injury by reason of subsidized imports of subject merchandise from Vietnam. *See Polyethylene Retail Carrier Bags from Indonesia, Taiwan, and Vietnam*, USITC Publication 4144, Investigation Nos. 701–TA–462 and 731–TA–1156–1158 (Final) (April 2010). Pursuant to section 706(a) of the Act, the Department is publishing a countervailing duty order on the subject merchandise.

Scope of the Order

The scope of this order covers polyethylene retail carrier bags, which also may be referred to as t–shirt sacks, merchandise bags, grocery bags, or checkout bags. The subject merchandise is defined as non–sealable sacks and bags with handles (including drawstrings), without zippers or integral extruded closures, with or without gussets, with or without printing, of polyethylene film having a thickness no greater than 0.035 inch (0.889 mm) and no less than 0.00035 inch (0.00889 mm), and with no length or width shorter than 6 inches (15.24 cm) or longer than 40 inches (101.6 cm). The depth of the bag may be shorter than 6 inches but not longer than 40 inches (101.6 cm).

PRCBs are typically provided without any consumer packaging and free of charge by retail establishments, *e.g.*, grocery, drug, convenience, department, specialty retail, discount stores, and restaurants to their customers to package and carry their purchased products. The scope of this order excludes (1) polyethylene bags that are not printed with logos or store names and that are closeable with drawstrings made of polyethylene film and (2) polyethylene bags that are packed in consumer packaging with printing that refers to specific end–uses other than packaging and carrying merchandise from retail establishments, *e.g.*, garbage bags, lawn bags, trash–can liners.

Imports of merchandise included within the scope of this order are currently classifiable under statistical category 3923.21.0085 of the Harmonized Tariff Schedule of the United States (HTSUS). This subheading may also cover products that are outside the scope of this order. Furthermore, although the HTSUS subheading is provided for convenience and customs purposes, the written description of the scope of this order is dispositive.

Countervailing Duty Order

In accordance with section 706(a)(1) of the Act, the Department will direct U.S. Customs and Border Protection (CBP) to assess, upon further instruction by the Department, countervailing duties equal to the amount of the net countervailable subsidy for all relevant entries of PRCBs from Vietnam.

According to section 706(b)(2) of the Act, duties shall be assessed on subject merchandise entered, or withdrawn from warehouse, for consumption on or after the date of the ITC's notice of final determination if that determination is based upon threat of material injury. Section 706(b)(1) of the Act states, "If the Commission, in its final determination under section 705(b), finds material injury or threat of material injury which, but for the suspension of liquidation under section 703(d)(2), would have led to a finding of material injury, then entries of the merchandise subject to the countervailing duty order, the liquidation of which has been suspended under section 703(d)(2), shall be subject to the imposition of countervailing duties under section 701(a)." In addition, section 706(b)(2) of the Act requires CBP to refund any cash deposits or bonds of estimated countervailing duties posted since the Department's preliminary countervailing duty determination, if the ITC's final determination is threat–based. Because the ITC's final determination in this case is based on the threat of material injury and is not accompanied by a finding that injury would have resulted but for the imposition of suspension of liquidation of entries since the Department's *Preliminary Determination*[1] was published in the **Federal Register**, section 706(b)(2) of the Act is applicable.

Therefore, the Department will direct CBP to reinstitute suspension of liquidation,[2] and to assess, upon further instruction from the Department, countervailing duties on all unliquidated entries of PRCBs from Vietnam entered, or withdrawn from warehouse, for consumption on or after the date of publication of the ITC's

[1] *See Polyethylene Retail Carrier Bags from the Socialist Republic of Vietnam: Preliminary Affirmative Countervailing Duty Determination and Alignment of Final Countervailing Duty Determination with Final Antidumping Duty Determination*, 74 FR 45811 (September 4, 2009) (*Preliminary Determination*).

[2] The Department instructed CBP to discontinue the suspension of liquidation on January 2, 2010, in accordance with section 703(d) of the Act. Section 703(d) states that suspension of liquidation pursuant to a preliminary determination may not remain in effect for more than four months. Entries of PRCBs from Vietnam made on or after January 2, 2010, and prior to the date of publication of the ITC's final determination in the **Federal Register**, are not liable for the assessment of countervailing duties because of the Department's discontinuation of the suspension of liquidation, effective January 2, 2010.

notice of final determination of threat of material injury in the **Federal Register**.

Cash Deposit Requirements

Pursuant to section 706(a)(3) of the Act, effective on the date of publication of the ITC's notice of final determination in the **Federal Register**, CBP will require, at the same time as importers would normally deposit estimated duties, cash deposits for the subject merchandise equal to the net subsidy rates listed below, except for subject merchandise entered by Chin Sheng Company, Ltd., whose net subsidy rate is *de minimis* and, hence, is excluded from this order. This exclusion applies only to subject merchandise both produced and exported by Chin Sheng Company, Ltd. The all–others rate applies to all producers and exporters of subject merchandise not specifically listed.

Producer/Exporter	Net Subsidy Rate
Advance Polybag Co., Ltd. ...	52.56%
Chin Sheng Company, Ltd. ..	0.44% (*de minimis*)
Fotai Vietnam Enterprise Corp. And Fotai Enterprise Corporation	5.28%
All Others	5.28%

Termination of the Suspension of Liquidation

Pursuant to the ITC's determination of threat of injury to a U.S. industry, the Department will instruct CBP to terminate the suspension of liquidation for entries of PRCBs from Vietnam entered, or withdrawn from warehouse, for consumption prior to the publication of the ITC's notice of final determination. The Department will also instruct CBP to refund any cash deposits made, and to release any bonds posted between September 4, 2009 (*i.e.*, the date of publication of the Department's *Preliminary Determination*) and on or before January 2, 2010, the date on which the Department discontinued the suspension of liquidation pursuant to section 703(d) of the Act.

This notice constitutes the countervailing duty order with respect to PRCBs from Vietnam, pursuant to section 706(a) of the Act. Interested parties may contact the Department's Central Records Unit, Room 1117 of the main Commerce Building, for copies of an updated list of countervailing duty orders currently in effect.

This order is issued and published in accordance with section 706(a) of the Act, and 19 CFR 351.211(b).

Dated: April 27, 2010.

Ronald K. Lorentzen,

Deputy Assistant Secretary for Import Administration.

[FR Doc. 2010–10245 Filed 5–3–10; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XW23

Endangered and Threatened Species; Take of Anadromous Fish; Research Permit Applications

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Applications for three new scientific research permits, one permit modification, and one permit renewal.

SUMMARY: Notice is hereby given that NMFS has received five scientific research permit application requests relating to Pacific salmon. The proposed research is intended to increase knowledge of species listed under the Endangered Species Act (ESA) and to help guide management and conservation efforts. The applications may be viewed online at: *https://apps.nmfs.noaa.gov/preview/preview__open__for__comment.cfm*

DATES: Comments or requests for a public hearing on the applications must be received at the appropriate address or fax number (see ADDRESSES) no later than 5 p.m. Pacific standard time on June 3, 2010.

ADDRESSES: Written comments on the applications should be sent to the Protected Resources Division, NMFS, 1201 NE Lloyd Blvd., Suite 1100, Portland, OR 97232–1274. Comments may also be sent via fax to 503–230–5441 or by e-mail to *nmfs.nwr.apps@noaa.gov*.

FOR FURTHER INFORMATION CONTACT: Garth Griffin, Portland, OR (ph.: 503–231–2005, Fax: 503–230–5441, e-mail: *garth.griffin@noaa.gov*. Permit application instructions are available from the address above, or online at *apps.nmfs.noaa.gov*.

SUPPLEMENTARY INFORMATION:

Species Covered in This Notice

The following listed species are covered in this notice:

Chinook salmon (*Oncorhynchus tshawytscha*): threatened lower Columbia River (LCR), threatened upper Willamette River (UWR), endangered upper Columbia River (UCR), threatened Snake River (SR) spring/summer (spr/sum), threatened SR fall, threatened Puget Sound (PS).

Chum salmon (*O. keta*): threatened Columbia River (CR).

Steelhead (*O. mykiss*): threatened LCR, threatened UWR, threatened middle Columbia River (MCR), threatened SR, threatened UCR, threatened PS.

Coho salmon (*O. kisutch*): threatened LCR, threatened Oregon Coast (OC).

Sockeye salmon (*O. nerka*): endangered SR.

Green Sturgeon (*Acipenser medirostris*)

Eulachon: Southern Distinct Population Segment (DPS) (*Thaleichthys pacificus*)

Authority

Scientific research permits are issued in accordance with section 10(a)(1)(A) of the ESA (16 U.S.C. 1531 *et seq.*) and regulations governing listed fish and wildlife permits (50 CFR 222–226). NMFS issues permits based on findings that such permits: (1) are applied for in good faith; (2) if granted and exercised, would not operate to the disadvantage of the listed species that are the subject of the permit; and (3) are consistent with the purposes and policy of section 2 of the ESA. The authority to take listed species is subject to conditions set forth in the permits.

Anyone requesting a hearing on an application listed in this notice should set out the specific reasons why a hearing on that application would be appropriate (see **ADDRESSES**). Such hearings are held at the discretion of the Assistant Administrator for Fisheries, NMFS.

Applications Received

Permit 1548 - 2R

The Yakima Training Center - US Army (YTC) is seeking to renew its permit to annually take listed salmonids while conducting research designed to determine fish abundance and distribution on the YTC lands and describe habitat conditions throughout the 500–square mile reservation. The research will also give regional fish managers previously unavailable data on fish presence. The YTC researchers would capture the fish using backpack electrofishing gear, seines, and minnow traps. Once captured, the fish would be measured, allowed to recover, and released. Some of the steelhead may have scale samples taken. The YTC does not intend to kill any of the fish being taken, but some may die as an unintended result of the activities.

Permit 14457 - 2M

The Columbia River Estuary Study Taskforce (CREST) is seeking to modify its current research permit to add some collection locations and increase the numbers of listed fish that may be taken. Under the modified permit, they would annually capture, handle, and release juvenile fish from all the species covered by this notice. They would also capture, mark, tag, and release adult LCR coho, Chinook, and steelhead and CR chum. The purpose of the research is to evaluate estuarine habitat restoration efforts. Specific objectives are to (1) determine species composition, relative abundance, and residence time of various listed fish by using pre-restored and restoration project habitats and adjacent references sites; (2) determine prey use by juvenile salmon; and (3) determine prey availability. The research would benefit listed salmonids by determining how effectively currently altered habitats support salmonids and using that information to guide future habitat modifications.

The CREST would capture the fish using fyke nets, trap nets, and beach seines. Salmonids would be anesthetized, identified, counted, measured, weighed, checked for tags and hatchery marks, and released. Some of the fish may be tagged with passive integrated transponders, or injected with dye or visible implant elastomers. Fin or scale samples for genetic or age analysis would be taken from a portion of the captured juvenile Chinook salmon. Some of the captured juvenile salmonid would be sampled for stomach contents. The CREST does not propose to kill any of the fish being captured, but a small number may die as an unintended result of the activities.

Permit 15207

The Oregon State University (OSU) is seeking a permit to annually take all the listed fish covered by this notice while conducting research designed to help managers assess the condition of rivers and streams in the 12 conterminous western states and evaluate and develop scientifically and statistically rigorous field protocols for assessing large rivers and their tributaries. The study was previously conducted under Permit 1559 - 4A and will benefit listed species by providing baseline information about water quality in the study areas and helping managers enforce the Clean Water Act in those river systems where listed fish are present. The OSU researchers would capture fish (using raft-mounted electrofishing equipment), sample them for biological information, and release them. The researchers will try to avoid adult salmonids, but some may be handled. The researchers do not intend to kill any fish being captured but some may die as an unintentional result of the research activities.

Permit 15162

The University of Idaho (UI) is seeking a three-year permit to take listed salmonids (UCR Chinook and steelhead, SR spr/sum and fall Chinook, SR steelhead, SR sockeye, and MCR steelhead) while conducting research on pacific lamprey passage at McNary And John Day Dams on the Columbia River. The UI researchers would capture pacific lamprey at temporary traps installed near the bottoms of the fishways at the dams. They would also look for lamprey in the fishways and use dipnets to capture them. If listed fish are captured during the dipnetting, they would be released immediately. If they are caught in the lamprey traps, they may be held for up to 11 hours (from 8:00 p.m. when the traps are lowered into place, to 7:00 a.m. when they are pulled and checked), but any captured fish will be released at the moment the trap is checked. The researchers do not expect to kill any listed fish but a small number may die as an unintended result of the research activities.

Permit 15461

The U.S. Fish and Wildlife Service (FWS) is seeking a five-year permit to annually take juvenile threatened SR steelhead during the course of research on Pacific lamprey in the Snake River basin. The research is designed to assess lamprey numbers and habitat in the basin and gauge the effectiveness of a lamprey translocation program. The research will benefit steelhead by generating information that will be used when conducting habitat restoration activities in the basin. The listed fish would be affected by the use of a low-power electrofishing unit designed to bring lamprey young up out of a stream's substrate. Any affected steelhead would simply be allowed to escape; they would not be collected or sampled in any manner. The FWS does not expect to kill any listed fish, but a small number may die as an unintended result of the activities.

This notice is provided pursuant to section 10(c) of the ESA. NMFS will evaluate the applications, associated documents, and comments submitted to determine whether the applications meet the requirements of section 10(a) of the ESA and Federal regulations. The final permit decisions will not be made until after the end of the 30–day comment period. NMFS will publish notice of its final action in the **Federal Register**.

Dated: April 28, 2010.

Angela Somma,

Chief, Endangered Species Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 2010–10489 Filed 5–3–10; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

International Trade Administration

A–533–502

Certain Welded Carbon Steel Standard Pipes and Tubes from India: Extension of Time Limit for Preliminary Results of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

EFFECTIVE DATE: May 4, 2010.

FOR FURTHER INFORMATION CONTACT: Michael A. Romani, AD/CVD Operations, Office 5, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482–0198.

SUPPLEMENTARY INFORMATION:

Background

The Department of Commerce (the Department) published an antidumping duty order on certain welded carbon steel standard pipes and tubes from India on May 12, 1986. *See Antidumping Duty Order; Certain Welded Carbon Steel Standard Pipes and Tubes from India*, 51 FR 17384 (May 12, 1986). On June 24, 2009, the Department published a notice of initiation of an administrative review of the antidumping duty order on certain welded carbon steel standard pipes and tubes from India for the period May 1, 2008, through April 30, 2009. *See Initiation of Antidumping and Countervailing Duty Administrative Reviews and Requests for Revocation in Part*, 74 FR 30052 (June 24, 2009). The period of review is May 1, 2008, through April 30, 2009.

On December 28, 2009, the Department published an extension of the due date for the preliminary results. *See Extension of Time Limit for Certain Welded Carbon Steel Standard Pipes and Tubes from India: Preliminary Results of Antidumping Duty Administrative Review*, 74 FR 68586 (December 28, 2009). In accordance

with section 751(a)(3)(A) of the Tariff Act of 1930, as amended (the Act), the Department extended the due date for issuing the preliminary results by 92 days, from the original date of January 31, 2010, to May 3, 2010.

As explained in the February 12, 2010, memorandum from the Deputy Assistant Secretary for Import Administration, the Department has exercised its discretion to toll Import Administration deadlines for the duration of the closure of the Federal Government from February 5 through February 12, 2010. Thus, all deadlines in this segment of the proceeding have been extended by seven days. The revised deadline for the preliminary results of this review is currently May 10, 2010. See Memorandum to the Record from Ronald Lorentzen, DAS for Import Administration, regarding "Tolling of Administrative Deadlines As a Result of the Government Closure During the Recent Snowstorm," dated February 12, 2010.

Extension of Time Limit for Preliminary Results

Section 751(a)(3)(A) of the Act requires the Department to make a preliminary determination within 245 days after the last day of the anniversary month of an order for which a review is requested and a final determination within 120 days after the date on which the preliminary determination is published in the **Federal Register**. If it is not practicable to complete the review within these time periods, section 751(a)(3)(A) of the Act allows the Department to extend the time limit for the preliminary determination to a maximum of 365 days after the last day of the anniversary month.

We determine that it is not practicable to complete the preliminary results of this review by the current deadline of May 10, 2010, because before issuing the preliminary results of review we intend to verify the sales of a respondent to this review. Also, we have granted several extensions requested by the respondent to respond to our requests for information in this administrative review and, as a result, need additional time to analyze the respondent's submissions. Therefore, in accordance with section 751(a)(3)(A) of the Act and 19 CFR 351.213(h)(2), we are extending the time period for issuing the preliminary results of this review by 28 days from May 10, 2010, to June 7, 2010.

This notice is published in accordance with sections 751(a)(3)(A) and 777(i)(1) of the Act.

Dated: April 27, 2010.

Edward C. Yang,

Acting Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

[FR Doc. 2010–10482 Filed 5–3–10; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

A–549–821

Polyethylene Retail Carrier Bags from Thailand: Extension of Time Limit for Preliminary Results of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

EFFECTIVE DATE: May 4, 2010.

FOR FURTHER INFORMATION CONTACT: Thomas Schauer or Michael A. Romani, AD/CVD Operations, Office 5, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482–0410 or (202) 482–0198, respectively.

SUPPLEMENTARY INFORMATION:

Background

On August 9, 2004, the Department of Commerce published in the **Federal Register** the antidumping duty order on polyethylene retail carrier bags from Thailand. *See Antidumping Duty Order: Polyethylene Retail Carrier Bags From Thailand*, 69 FR 48204 (August 9, 2004). On September 22, 2009, we published a notice of initiation of an administrative review of six companies. *See Initiation of Antidumping and Countervailing Duty Administrative Reviews and Requests for Revocation in Part*, 74 FR 48224, 48226 (September 22, 2009).[1] The period of review is August 1, 2008 through July 31, 2009.

As explained in the February 12, 2010, memorandum from the Deputy Assistant Secretary for Import Administration, the Department has exercised its discretion to toll Import Administration deadlines for the duration of the closure of the Federal Government from February 5 through February 12, 2010. Thus, the deadline in this segment of the proceeding has been extended by seven days. This revised deadline for the preliminary results of this administrative review is now May 10, 2010. See Memorandum to the Record from Ronald Lorentzen, DAS for Import Administration, regarding "Tolling of Administrative Deadlines As a Result of the Government Closure During the Recent Snowstorm," dated February 12, 2010.

Extension of Time Limit for Preliminary Results

Section 751(a)(3)(A) of the Tariff Act of 1930, as amended (the Act), requires the Department to make a preliminary determination within 245 days after the last day of the anniversary month of an order for which a review is requested and a final determination within 120 days after the date on which the preliminary determination is published in the **Federal Register**. If it is not practicable to complete the review within these time periods, section 751(a)(3)(A) of the Act allows the Department to extend the time limit for the preliminary determination to a maximum of 365 days after the last day of the anniversary month.

We determine that it is not practicable to complete the preliminary results of this review by the current deadline of May 10, 2010, because we require additional time to analyze a number of complex cost–accounting and corporate–affiliation issues relating to this administrative review that have been raised by parties to the proceeding. Therefore, in accordance with section 751(a)(3)(A) of the Act and 19 CFR 351.213(h)(2), we are extending the time period for issuing the preliminary results of this review by 50 days to June 29, 2010.

This notice is published in accordance with sections 751(a)(3)(A) and 777(i)(1) of the Act.

Dated: April 27, 2010.

Edward C. Yang,

Acting Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

[FR Doc. 2010–10485 Filed 5–3–10; 8:45 am]

BILLING CODE 3510–DS–S

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[1] The review covers the following companies: C.P. Packaging Co., Ltd., Giant Pack Co., Ltd., Landblue (Thailand) Co., Ltd., Sahachit Watana Plastics Ind. Co., Ltd., Thai Plastic Bags Industries Co., Ltd., and Thantawan Industry Public Co., Ltd. *Id.* The Department has determined previously that Thai Plastic Bags Industries Co., Ltd., APEC Film Ltd., and Winner's Pack Co., Ltd., comprise the Thai Plastic Bags Group (TPBG). *See Notice of Final Determination of Sales at Less than Fair Value: Polyethylene Retail Carrier Bags From Thailand*, 69 FR 34122, 34123 (June 18, 2004).

DEPARTMENT OF COMMERCE

International Trade Administration

A–357–812

Honey from Argentina: Final Results of Antidumping Duty Administrative Review and Determination to Revoke Order in Part

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: On December 28, 2009, the Department of Commerce (the Department) published its preliminary results of the 2007–2008 administrative review of the antidumping duty order on honey from Argentina. *See Honey from Argentina: Preliminary Results of Antidumping Duty Administrative Review and Intent to Revoke Order in Part*, 74 FR 68570 (December 28, 2009) (*Preliminary Results*). This review covers one exporter, Asociacion de Cooperativas Argentinas (ACA). The period of review (POR) is December 1, 2007, through November 30, 2008. We invited interested parties to comment on the *Preliminary Results*, and received no comments. Therefore, our final results remain unchanged from our *Preliminary Results*, and we are revoking the order with respect to ACA.

EFFECTIVE DATE: May 4, 2010.

FOR FURTHER INFORMATION CONTACT: John Drury or Dena Crossland, Office 7, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482–0195 or (202) 482–3362, respectively.

SUPPLEMENTARY INFORMATION:

Background

On December 28, 2009, the Department published in the **Federal Register** the preliminary results of the administrative review of the antidumping duty order on honey from Argentina for the period December 1, 2007, through November 30, 2008. *See Preliminary Results*. We invited parties to comment on the *Preliminary Results*. We received no comments or a request for a hearing.

As explained in the memorandum from the Deputy Assistant Secretary (DAS) for Import Administration, the Department exercised its discretion to toll Import Administration deadlines for the duration of the closure of the Federal Government from February 5, through February 12, 2010. Thus, all deadlines in this segment of the proceeding were extended by seven days. Therefore, the revised deadline for the final results of this review became May 4, 2010. *See* Memorandum to the Record from Ronald Lorentzen, DAS for Import Administration, regarding "Tolling of Administrative Deadlines As a Result of the Government Closure During the Recent Snowstorm," dated February 12, 2010.

Period of Review

The POR is December 1, 2007, through November 30, 2008.

Scope of the Order

The merchandise covered by the order is honey from Argentina. The products covered are natural honey, artificial honey containing more than 50 percent natural honey by weight, preparations of natural honey containing more than 50 percent natural honey by weight, and flavored honey. The subject merchandise includes all grades and colors of honey whether in liquid, creamed, comb, cut comb, or chunk form, and whether packaged for retail or in bulk form. The merchandise is currently classifiable under subheadings 0409.00.00, 1702.90.90, and 2106.90.99 of the *Harmonized Tariff Schedule of the United States (HTSUS)*. Although the HTSUS subheadings are provided for convenience and Customs purposes, the Department's written description of the merchandise under this order is dispositive.

Determination to Revoke Order, in Part

The Department may revoke, in whole or in part, an antidumping duty order upon completion of a review under section 751 of the Tariff Act of 1930, as amended (the Act). While Congress has not specified the procedures that the Department must follow in revoking an order, in whole or in part, the Department has developed a procedure for revocation that is described in 19 CFR 351.222. For exporters or producers requesting revocation from an antidumping duty order, this regulation requires, *inter alia*, that the company submit the following: (1) a certification that the company has sold the subject merchandise at not less than normal value (NV) in the current review period and that the company will not sell subject merchandise at less than NV in the future; (2) a certification that the company sold commercial quantities of the subject merchandise to the United States in each of the three years forming the basis of the request; and (3) an agreement to immediate reinstatement in the order if the Department concludes that the company, subsequent to the revocation, sold subject merchandise at less than NV. *See* 19 CFR 351.222(e)(1). Upon receipt of such a request, the Department will consider: (1) whether the company in question has sold subject merchandise at not less than NV for a period of at least three consecutive years and is not likely to sell the subject merchandise at less than NV in the future; and (2) whether the company has agreed in writing to its immediate reinstatement in the order, as long as any exporter or producer is subject to the order, if the Department concludes that the company, subsequent to the revocation, sold the subject merchandise at less than NV. *See* 19 CFR 351.222(b)(2).

On December 30, 2008, pursuant to section 751(d) of the Act and 19 CFR 351.222(b)(2), ACA requested revocation of the antidumping duty order with respect to its sales of subject merchandise. ACA's request was accompanied by certification that it: (1) sold subject merchandise at not less than NV in the current review period and will not sell subject merchandise at less than NV in the future; (2) sold subject merchandise in commercial quantities during each of the consecutive three years forming the basis for its request for revocation; and (3) agreed to immediate reinstatement of the antidumping duty order if the Department concludes ACA has sold subject merchandise at less than NV subsequent to revocation. *See* 19 CFR 351.222(e)(1).

In the *Preliminary Results*, we determined that ACA's request meets all of the criteria under 19 CFR 351.222(e)(1) and that revocation is warranted pursuant to 19 CFR 351.222(b)(2). *See Preliminary Results*, 74 FR at 68572 and Memorandum to John M. Andersen, Acting Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations, "Request by Asociacion de Cooperativas Argentinas (ACA) for Revocation in the Antidumping Duty Administrative Review of Honey from Argentina," dated December 18, 2009. We have not received any comments or evidence to alter our findings for these final results. Therefore, we find that ACA qualifies for revocation of the antidumping duty order on honey from Argentina under 19 CFR 351.222(b)(2) and, accordingly, we are revoking the order with respect to subject merchandise exported by ACA.[1]

Effective Date of Revocation

The revocation of ACA applies to all entries of subject merchandise that are exported by ACA, and are entered, or withdrawn from warehouse, for

[1] Only exports by ACA in which ACA is the first party with knowledge of the U.S. destination of the merchandise are covered by this revocation.

consumption on or after December 1, 2008. The Department will order the suspension of liquidation ended for all such entries and will instruct U.S. Customs and Border Protection (CBP) to release any cash deposits or bonds. The Department also will instruct CBP to refund with interest any cash deposits on entries made on or after December 1, 2008.

Final Results of Review

We determine that the following dumping margin exists for the period December 1, 2007, through November 30, 2008:

Exporter	Weighted–Average Margin (percentage)
Asociacion de Cooperativas Argentinas	0.00

Assessment Rates

The Department shall determine, and CBP shall assess, antidumping duties on all appropriate entries, in accordance with 19 CFR 351.212(b). Since the importer–specific assessment rate calculated in the final results of this review is 0.00 percent, we will instruct CBP to liquidate without regard to antidumping duties for these entries. *See* 19 CFR 351.106(c)(2). The Department intends to issue appropriate assessment instructions directly to CBP 15 days after publication of these final results of review.

The Department clarified its automatic assessment regulation on May 6, 2003 (68 FR 23954). This clarification will apply to entries of subject merchandise during the POR produced by the company(ies) included in these final results of review for which the reviewed company(ies) did not know their merchandise was destined for the United States. In such instances, we will instruct CBP to liquidate un–reviewed entries at the all–others rate if there is no rate for the intermediate company(ies) involved in the transaction. For a full discussion of this clarification, *see Antidumping and Countervailing Duty Proceedings: Assessment of Antidumping Duties*, 68 FR 23954 (May 6, 2003).

Cash Deposit Requirements

The following cash deposit requirements will be effective upon publication of the final results of this administrative review for all shipments of the subject merchandise entered, or withdrawn from warehouse, for consumption on or after the publication date of these final results, consistent with section 751(a)(1) of the Act: (1) for ACA, which is revoked from the order, no cash deposit will be required; (2) if the exporter is not a firm covered in this review, but was covered in a previous review or the original less than fair value (LTFV) investigation, the cash deposit rate will continue to be the company–specific rate published for the most recent period; (3) if the exporter is not a firm covered in this review, a prior review, or the original LTFV investigation, but the manufacturer is, the cash deposit rate will be the rate established for the most recent period for the manufacturer of the merchandise; and (4) if neither the exporter nor the manufacturer is a firm covered in this or any previous review conducted by the Department, the cash deposit rate will continue to be 30.24 percent, which is the all–others rate established in the LTFV investigation. *See Notice of Antidumping Duty Order; Honey From Argentina*, 66 FR 63672 (December 10, 2001). These deposit requirements, when imposed, shall remain in effect until publication of the final results of the next administrative review.

Notifications to Interested Parties

This notice also serves as a final reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of doubled antidumping duties.

This notice also serves as a reminder to parties subject to administrative protective orders (APO) of their responsibility concerning the return or destruction of proprietary information disclosed under APO in accordance with 19 CFR 351.305, which continues to govern business proprietary information in this segment of the proceeding. Timely written notification of the return/destruction of APO materials or conversion to judicial protective order is hereby requested. Failure to comply with the regulations and terms of an APO is a violation, which is subject to sanction.

We are issuing and publishing this notice in accordance with sections 751(a)(1) and 777(i)(1) of the Act.

Dated: April 22, 2010.

Ronald K. Lorentzen,

Deputy Assistant Secretary for Import Administration.

[FR Doc. 2010–10479 Filed 5–3–10; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN: 0648–XW24

Pacific Fishery Management Council; Public Meeting

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of a public meeting.

SUMMARY: The Pacific Fishery Management Council (Council) will hold a meeting of its Ad Hoc Regulatory Deeming Workgroup (Workgroup). The meeting is open to the public.

DATES: The Workgroup meeting will be held Thursday, May 20, 2010, from 8 a.m. until business for the day is completed and Friday, May 21, 2010 from 8 a.m. until business for the day is completed.

ADDRESSES: The Workgroup meeting will be held at a Seattle, WA, location to be determined.

Council address: Pacific Fishery Management Council, 7700 NE Ambassador Place, Suite 101, Portland, OR 97220–1384.

FOR FURTHER INFORMATION CONTACT: Mr. Jim Seger, Staff Officer; telephone: (503) 820–2280.

SUPPLEMENTARY INFORMATION: The purpose of the Workgroup meeting is to review the draft regulations that would implement Amendment 20 (Trawl Rationalization) to the groundfish fishery management plan, if it is approved.

Although non-emergency issues not contained in the meeting agenda may come before the Workgroup for discussion, those issues may not be the subject of formal Workgroup action during this meeting. Workgroup action will be restricted to those issues specifically listed in this notice and any issues arising after publication of this notice that require emergency action under Section 305(a) of the Magnuson-Stevens Fishery Conservation and Management Act, provided the public has been notified of the Workgroup intent to take final action to address the emergency.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Ms. Carolyn Porter at (503) 820–2280 at least 5 days prior to the meeting date.

Dated: April 28, 2010.

William D. Chappell,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2010–10292 Filed 5–3–10; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN: 0648–XW25

Fisheries of the Gulf of Mexico and South Atlantic; Southeast Data, Assessment, and Review (SEDAR); Public Meeting

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of SEDAR Data Workshop for HMS sandbar, dusky, and blacknose sharks.

SUMMARY: The SEDAR assessments of the HMS stocks of sandbar, dusky, and blacknose sharks will consist of a series of workshops and webinars: a Data Workshop, a series of Assessment webinars, and a Review Workshop. See **SUPPLEMENTARY INFORMATION**.

DATES: The Data Workshop will take place June 21–25, 2010. See **SUPPLEMENTARY INFORMATION**.

ADDRESSES: The Data Workshop will be held at Embassy Suites Historic Charleston, 337 Meeting Street, Charleston, SC 29403; telephone: (843) 723–6900

FOR FURTHER INFORMATION CONTACT: Julie Neer, SEDAR Coordinator, 4055 Faber Place Drive, Suite 201, North Charleston, SC 29405; telephone: (843) 571–4366; e-mail: *Julie.neer@safmc.net*

SUPPLEMENTARY INFORMATION: The Gulf of Mexico, South Atlantic, and Caribbean Fishery Management Councils, in conjunction with NOAA Fisheries and the Atlantic and Gulf States Marine Fisheries Commissions have implemented the Southeast Data, Assessment and Review (SEDAR) process, a multi-step method for determining the status of fish stocks in the Southeast Region. SEDAR is a three-step process including: (1) Data Workshop, (2) Assessment Process utilizing webinars and (3) Review Workshop. The product of the Data Workshop is a data report which compiles and evaluates potential datasets and recommends which datasets are appropriate for assessment analyses. The product of the Assessment Process is a stock assessment report which describes the fisheries, evaluates the status of the stock, estimates biological benchmarks, projects future population conditions, and recommends research and monitoring needs. The assessment is independently peer reviewed at the Review Workshop. The product of the Review Workshop is a Summary documenting Panel opinions regarding the strengths and weaknesses of the stock assessment and input data. Participants for SEDAR Workshops are appointed by the Gulf of Mexico, South Atlantic, and Caribbean Fishery Management Councils and NOAA Fisheries Southeast Regional Office and Southeast Fisheries Science Center. Participants include data collectors and database managers; stock assessment scientists, biologists, and researchers; constituency representatives including fishermen, environmentalists, and NGO's; International experts; and staff of Councils, Commissions, and state and federal agencies.

SEDAR 21 Data Workshop Schedule

June 21–25, 2010; SEDAR 21 Data Workshop

June 21, 2010: 1 p.m. - 8 p.m.; June 21–24, 2010: 8 a.m. - 8 p.m.; June 25, 2010: 8 a.m. - 12 p.m.

An assessment data set and associated documentation will be developed during the Data Workshop. Participants will evaluate all available data and select appropriate sources for providing information on life history characteristics, catch statistics, discard estimates, length and age composition, and fishery dependent and fishery independent measures of stock abundance.

Although non-emergency issues not contained in this agenda may come before this group for discussion, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically listed in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Fishery Conservation and Management Act, provided the public has been notified of the Council's intent to take final action to address the emergency.

Special Accommodations

These meetings are physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to the Council office (see **ADDRESSES**) at least 10 business days prior to each workshop.

Dated: April 28, 2010.

William D. Chappell,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2010–10293 Filed 5–3–10; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

Economic Development Administration

[Docket No.: 100429201–0201–01]

Solicitation of Applications for the i6 Challenge Under EDA's Economic Adjustment Assistance Program

AGENCY: Economic Development Administration (EDA), Department of Commerce.

ACTION: Notice and request for applications.

SUMMARY: The i6 Challenge is a new, multi-agency innovation competition led by the U.S. Department of Commerce (DOC) and its Economic Development Administration (EDA). EDA intends to fund implementation grants for technical assistance through its Economic Adjustment Assistance Program under the i6 Challenge. The DOC and EDA will coordinate this funding opportunity with the National Institutes of Health (NIH), the National Science Foundation (NSF), and the U.S. Patent and Trademark Office (USPTO) to leverage federal resources and maximize available funding to i6 Challenge winners. The i6 Challenge is designed to encourage and reward innovative, ground-breaking ideas that will accelerate technology commercialization and new venture formation across the United States, for the ultimate purpose of helping to drive economic growth and job creation. To accomplish this, the i6 Challenge targets sections of the research-to-deployment continuum that are in need of additional support, in order to strengthen regional innovation ecosystems. Applicants to the i6 Challenge are expected to propose mechanisms to fill in existing gaps in the continuum or leverage existing infrastructure and institutions, such as economic development organizations, academic institutions, or other non-profit organizations, in new and

innovative ways to achieve the i6 objectives.

DATES: Applicants (defined below) must submit their applications no later than 11:59 p.m. EDT on July 15, 2010 in order to be considered for funding. Letters of intent to participate are strongly encouraged and must be sent to *i6@doc.gov* no later than 11:59 p.m. EDT on June 15, 2010. Winning Applicants should expect to receive grant awards by fall of 2010. EDA will hold an online information session at 2:00 p.m. Eastern time on May 17, 2010 to answer questions about the i6 Challenge. More details on the session will be posted at the i6 Challenge website at *http://www.eda.gov/i6.*

Application Submission Requirements: Applicants are advised to read carefully the instructions contained in section IV of the Federal Funding Opportunity (FFO) announcement for this request for applications. To access the FFO announcement, please see the websites listed below under "Electronic Access."

Applications may be submitted only in electronic form, either (i) in accordance with the procedures provided on *http://www.grants.gov;* or (ii) if Grants.gov produces an error message as an Applicant tries to apply via the Web site, then in PDF format via e-mail to *i6@doc.gov.* EDA will not accept facsimile transmissions of applications. Applicants applying electronically through *http://www.grants.gov* may access the application package by following the instructions provided on *http://www.grants.gov*. See the FFO for more details on how to apply via *http://www.grants.gov.*

The preferred file format for electronic attachments (*e.g.,* the Project Narrative and attachments to Form ED–900) is portable document format (PDF); however, EDA will accept electronic files in Microsoft Word, WordPerfect, or Excel formats.

Applicants should access the following link for assistance in navigating *http://www.grants.gov* and for a list of useful resources: *http://www.grants.gov/help/help.jsp*. If you do not find an answer to your question under "Applicant FAQs," try consulting the "Applicant User Guide." If you still cannot find an answer to your question, contact *http://www.grants.gov* via e-mail at *support@grants.gov* or telephone at 1–800–518–4726.

FOR FURTHER INFORMATION CONTACT: For additional information please send questions via e-mail to *i6@doc.gov.* EDA's Web site at *http://www.eda.gov/i6* also has information on EDA and the i6 Challenge.

SUPPLEMENTARY INFORMATION:

Program Information: EDA's mission is to lead the federal economic development agenda by promoting innovation and competitiveness, preparing American regions for growth and success in the worldwide economy. Under the i6 Challenge, EDA solicits competitive applications to increase and accelerate technology commercialization in regions across the United States. Applicants are expected to leverage regional strengths, capabilities, and competitive advantages. Furthermore, they are expected to identify a real or persistent problem or an unaddressed opportunity with a sense of urgency, cultivate strong public-private partnerships, provide a credible plan to access resources, demonstrate how the effort will be sustained, and bring together a well-qualified team and partners.

EDA encourages the submission of applications that will significantly benefit regions with distressed economies. Distress may exist in a variety of forms, including high levels of unemployment, low income levels, large concentrations of low-income families, and significant declines in per capita income because of large numbers (or high rates) of business failures, sudden major layoffs or plant closures, military base closures, natural or other major disasters, depletion of natural resources or reduced tax bases, and substantial loss of population because of the lack of employment opportunities.

Electronic Access: The FFO announcement for the i6 Challenge is available at *http://www.grants.gov* and at *http://www.eda.gov/InvestmentsGrants/FFON.xml*.

Statutory Authority: EDA's authorizing statute is the Public Works and Economic Development Act of 1965, as amended (42 U.S.C. 3121 *et seq.*) (PWEDA). The specific authority for the Economic Adjustment Assistance Program is section 209 of PWEDA (42 U.S.C. 3149), which authorizes EDA to make grants for economic adjustment assistance. EDA's regulations at 13 CFR parts 300–302 and subpart A of 13 CFR part 307 set out the general and specific regulatory requirements applicable to the Economic Adjustment Assistance Program.

EDA's regulations are codified at 13 CFR chapter III. The regulations and PWEDA are accessible on EDA's Web site at *http://www.eda.gov/InvestmentsGrants/Lawsreg.xml*.

Funding Availability: Funding appropriated under the Consolidated Appropriations Act, 2010 (Pub. L. No. 111–117, 123 Stat. 3034 at 3114 (2009)) is available for the economic development assistance programs authorized by PWEDA and for the Trade Adjustment Assistance for Firms Program under the Trade Act of 1974, as amended (19 U.S.C. 2341 *et seq.*). Funds in the amount of $255,000,000 have been appropriated for FY 2010 and shall remain available until expended. For FY 2010, EDA will allocate a total of $6,000,000 for this competitive solicitation. EDA will make at least six awards of up to $1,000,000, one in each of its six regions. The i6 Challenge awards will be made pursuant to grant agreements. The project period of each award is not to exceed two years. These award funds are anticipated to be available until expended.

The funding periods and funding amounts referenced in this competitive solicitation are subject to the availability of funds at the time of award, as well as to Department of Commerce and EDA priorities at the time of award. The Department of Commerce and EDA will not be held responsible for application preparation costs if the i6 Challenge fails to receive funding or is cancelled because of agency priorities. Publication of this competitive solicitation does not obligate the Department of Commerce or EDA to award any specific grant or cooperative agreement or to obligate all or any part of available funds.

EDA hopes to be able to fund at least one winning Applicant in each EDA region. Subject to the availability of funding at the time of award, the funds allocated to the i6 Challenge are anticipated to be available until expended.

Catalog of Federal Domestic Assistance (CFDA) Number: 11.307, Economic Adjustment Assistance.

Definitions: For purposes of this FFO, the following terms shall have the following meanings:

1. *Applicant* means the party(ies) submitting the application to EDA for funding, who is/are either a (i) non-profit organization formed by a team of more than one individual or entity, or (ii) combination of entities that satisfy the eligibility requirements described in section 3 of PWEDA (42 U.S.C. 3122) and 13 CFR 300.3 and that apply jointly as co-applicants to EDA for a single award.

2. *Matching Share* means the monetary value of the Applicant's committed cash matching funds or in-kind contributions, all of which must be from non-federal sources.

3. *SBIR Grantee* means a recipient of a Small Business Innovation Research grant from the National Institutes of

Health or the National Science Foundation.

4. *Partner* means any individual or entity, working with an Applicant, who has provided a letter of commitment to contribute to the accomplishment of that Applicant's proposed objectives.

Applicant Eligibility: Pursuant to PWEDA, only the following types of entities are eligible to receive funding assistance from EDA:

1. District Organization (as defined in 13 CFR 304.2);
2. Indian Tribe or a consortium of Indian Tribes;
3. State, city, or other political subdivision of a State, including a special purpose unit of a State or local government engaged in economic or infrastructure development activities, or a consortium of political subdivisions;
4. Institution of higher education or a consortium of institutions of higher education; or
5. Public or private non-profit organization or association acting in cooperation with officials of a political subdivision of a State.[1]

See section 3 of PWEDA (42 U.S.C. 3122) and 13 CFR 300.3.

In addition to satisfying these statutory requirements, in order to be eligible for the i6 Challenge (and as stated in the Definitions section), an Applicant must be either:

(i) A non-profit organization that is formed by a team of more than one individual or entity, including, but not limited to, entrepreneurs, universities, SBIR Grantees, foundations, or other private or non-profit organizations, or

(ii) A combination of otherwise eligible entities that apply jointly as co-applicants to EDA for a single award. Applicants (including eligible entities that form part of an Applicant) may submit more than one proposal to EDA in response to this competitive solicitation.

EDA is not authorized to provide grants directly to individuals or to for-profit entities. However, individuals or for-profit entities may form an Applicant or be Partners with Applicants.

Project Period: The project period shall not exceed two years.

Matching Share Requirement: Applicants must demonstrate a Matching Share of at least $500,000, which must be available and committed to the project from non-federal sources. EDA will give preference to applications with higher Matching Shares and to applications with higher levels of cash contributions in their Matching Share. Generally, the amount of an EDA grant may not exceed 50 percent of the total cost of the project. Projects may receive up to 80 percent of total cost, based on the relative needs of the region in which the project will be located, as determined by EDA. *See* section 204(a) of PWEDA (42 U.S.C. 3144) and 13 CFR 301.4(b)(1). In-kind contributions, in the form of space, equipment, or services, or forgiveness or assumptions of debt, may provide the required matching requirement. *See* section 204(b) of PWEDA (42 U.S.C. 3144), 13 CFR 301.4(b)(1), and 15 CFR 14.23 and 24.24. EDA will fairly evaluate all in-kind contributions, which must be used for eligible project costs that meet applicable federal cost principles and uniform administrative requirements. Applicants must provide letters of commitment to demonstrate that the Matching Share is committed to the project for the project period, will be available as needed, and is not conditioned or encumbered in any way that precludes its use consistent with the requirements of EDA investment assistance. *See* 13 CFR 301.5.

Intergovernmental Review: Applications for funding under the i6 Challenge are subject to the State review requirements imposed by Executive Order 12372, "*Intergovernmental Review of Federal Programs,*" where applicable.

Evaluation and Selection Procedures: Throughout the review and selection process, EDA reserves the right to seek clarification in writing from Applicants whose applications are being reviewed and considered.

1. Responsiveness Review

EDA will review all applications for responsiveness. Applications that are ineligible for EDA funding or that do not contain all forms and narratives listed in Section IV of the FFO announcement will be deemed non-responsive and excluded from further consideration.

2. Merit Review by EDA Review Panels

EDA will convene a panel of federal employees in each of its six regions to review the merits of each application submitted within that region. Using the evaluation criteria listed in Section V.A. of the FFO announcement, the panels will identify the top five applications in each region.

3. Merit Review by NSF Peer Review Panels

Each region's top five applications will be subject to external peer review by NSF. NSF will convene panels of external peer reviewers to discuss the merits and shortcomings of each application, using the evaluation criteria in this notice and further detailed in Section V.A of the FFO announcement. Applications will be reviewed in a fair, competitive, and in-depth manner pursuant to NSF peer review policies and guidelines set forth at *http://www.nsf.gov/bfa/dias/policy/meritreview.* The peer review panels will summarize and make recommendations to be presented to the Selection Committee (defined below) for discussion and consideration.

4. Joint Selection Committee Review

Upon completion of the NSF peer review, a selection committee ("Selection Committee"), which will be composed of senior officials from the Department of Commerce, NIH, and NSF, will review the findings and recommendations of the EDA review panels and NSF peer review panels. Then it will either (i) rank the top five applications in each region and forward this ranked list to the Selecting Official (defined below), or (ii) identify any deficiencies in the review process and convene a new EDA review panel in the applicable region(s) to restart the selection process in those region(s). If directed by the Selection Committee to re-evaluate the applications in a particular region, a new EDA review panel will perform a merit review and submit the top five applications in the region with new findings and recommendations to a NSF peer review panel and subsequent referral to the Selection Committee.

Selecting Official and Policy factors: EDA expects to fund the highest ranking applications. The Regional Director in each EDA region will be the Selecting Official for the award to be made within his region. The Selecting Official may follow the recommendations of the Selection Committee; however, the Selecting Official retains the discretion not to make a selection in any region, or to select an application out of order in any region for any of the following reasons:

1. Availability of program funding;
2. A determination that the application better meets the overall objectives of section 2 and 209 of PWEDA (42 U.S.C. 3121 and 3149); or
3. The Applicant's performance under previous federal financial assistance awards.

If the Selecting Official makes a selection out of order, he will document the rationale for the decision in writing. Each Selecting Official will submit his decision to EDA headquarters for review before making the final selection.

[1] For projects of significant regional or national scope, EDA may waive the requirement that a non-profit organization demonstrate it is acting in cooperation with officials of a political subdivision of a State. *See* 13 CFR 301.2(b) and 307.5(b).

Evaluation Criteria: Review Panels, convened pursuant to Section V of the FFO announcement, will evaluate applications based on the following criteria, which will be weighted equally:

1. Merit

The extent to which Applicants demonstrate:

- A clear understanding of a real or persistent problem or an unaddressed opportunity and its urgency;
- Creative or even potentially transformative models or solutions and how the proposal is different from those that are funded by other government agencies;
- A clear understanding of the challenges facing the region's entrepreneurs and innovators;
- A "roadmap" for filling the gaps in the research-to-commercialization continuum and eliminating obstacles to commercialization; and
- Alignment with EDA investment priorities, as described at *http://www.eda.gov/InvestmentsGrants/InvestmentPriorities.xml.*

2. Feasibility

The extent to which Applicants demonstrate:

- A coherent plan to leverage regional strengths, mitigate regional weaknesses, and capitalize on strategic opportunities while minimizing short- and long-term threats;
- A sound strategy to support entrepreneurs and innovators at appropriate phase(s) of the process, that could include assessments for commercialization potential, patenting, licensing, venture formation, financing, and marketing;
- Adequate financial resources to ensure robust institutional capacity, as well as access to capital for high-growth firms;
- Strong potential to become self-sustaining, even without significant future federal funding;
- Long-term, broad, and deep commitment from private and public sector leaders throughout the region, and strong participation and buy-in from stakeholders; and
- Qualified personnel that, as a group, demonstrate project management expertise, as well as demonstrated success in protecting, licensing, and commercializing intellectual property.

3. Impact

The extent to which Applicants demonstrate:

- Quantifiable benefits that go beyond the Applicant and benefit the regional economy;
- The extent to which infrastructure for commercialization and enterprise formation will be enhanced; and
- A clear understanding of how the model or solution could be replicated elsewhere.

Information Session: Please be advised that the informational teleconferences may be audio-taped and the actual recordings or a transcript of the actual recording may be made available online or otherwise for the benefit of prospective applicants unable to participate. Prospective applicants who participate on the teleconferences are deemed to consent to the taping.

The Department of Commerce Pre-Award Notification Requirements for Grants and Cooperative Agreements: Administrative and national policy requirements for all Department of Commerce awards are applicable to this competitive solicitation. These requirements may be found in the *Department of Commerce Pre-Award Notification Requirements for Grants and Cooperative Agreements,* which was published in the **Federal Register** on February 11, 2008 (73 FR 7696). This notice may be accessed by entering the **Federal Register** volume and page number provided in the previous sentence at the following Web site: *http://www.gpoaccess.gov/fr/index.html.*

Paperwork Reduction Act: This document contains the following collections of information subject to the Paperwork Reduction Act (PRA) and approved by the Office of Management and Budget (OMB): (i) Form ED–900 (OMB Control No. 0610–0094); (ii) Form SF–424 (OMB Control No. 4040–0004); (iii) Form SF–424A (OMB Control No. 4040–0006); (iv) Form SF–424B (OMB Control No. 4040–0007); (v) Form SF–LLL (OMB Control No. 0348–0046). This document contains the following collections of information subject to the Paperwork Reduction Act (PRA) and approved by the Office of Management and Budget (OMB): (i) Form ED–900 (OMB Control No. 0610–0094); (ii) Form SF–424 (OMB Control No. 4040–0004); (iii) Form SF–424A (OMB Control No. 4040–0006); (iv) Form SF–424B (OMB Control No. 4040–0007); (v) Form SF–LLL (OMB Control No. 0348–0046). The documents that are listed in section IV.B of the FFO announcement have been approved by OMB under the following respective forms/control numbers. Specifically, the Project Narrative, Biographies of Key Individuals and Letter(s) of commitment from any Partner(s) are supplemental information requested by Form SF–424 and approved under OMB Control No. 4040–0004. The Letter(s) of commitment for Matching Share; Budget Narrative; Facilities and Administrative Cost Rate Agreement; and Staffing Plan are supplemental information requested by Form SF–424A and approved under OMB Control No. 4040–0006. The collection of a Comprehensive Economic Development Strategy is requested by ED–900 and approved under OMB Control No. 0610–0094. Notwithstanding any other provision of law, no person is required to respond to, nor shall any person be subject to a penalty for failure to comply with, a collection of information subject to the requirements of the PRA unless that collection of information displays a currently valid OMB control number.

Executive Order 12866: This notice has been determined to be not significant for purposes of Executive Order 12866.

Executive Order 13132 (Federalism): It has been determined that this notice does not contain policies with Federalism implications as that term is defined in Executive Order 13132.

Administrative Procedure Act/Regulatory Flexibility Act: Prior notice and an opportunity for public comments are not required by the Administrative Procedure Act or any other law for rules concerning grants, benefits, and contracts (5 U.S.C. 553(a)(2)). Because notice and opportunity for comment are not required pursuant to 5 U.S.C. 553 or any other law, the analytical requirements of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) are inapplicable. Therefore, a regulatory flexibility analysis has not been prepared.

Dated: April 29, 2010.

John R. Fernandez,

Assistant Secretary of Commerce for Economic Development, Economic Development Administration.

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COMMODITY FUTURES TRADING COMMISSION

Order Finding That the ICE Malin Financial Basis Contract Traded on the IntercontinentalExchange, Inc., Does Not Perform a Significant Price Discovery Function

AGENCY: Commodity Futures Trading Commission.

ACTION: Final orders.

SUMMARY: On October 9, 2009, the Commodity Futures Trading Commission ("CFTC" or "Commission") published for comment in the **Federal**

Register [1] a notice of its intent to undertake a determination whether the Malin Financial Basis ("MLN") contract, traded on the IntercontinentalExchange, Inc. ("ICE"), an exempt commercial market ("ECM") under sections 2(h)(3)–(5) of the Commodity Exchange Act ("CEA" or the "Act"), performs a significant price discovery function pursuant to section 2(h)(7) of the CEA. The Commission undertook this review based upon an initial evaluation of information and data provided by ICE as well as other available information. The Commission has reviewed the entire record in this matter, including all comments received, and has determined to issue orders finding that the MLN contract does not perform a significant price discovery function. Authority for this action is found in section 2(h)(7) of the CEA and Commission rule 36.3(c) promulgated thereunder.

DATES: *Effective date:* April 28, 2010.

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SUPPLEMENTARY INFORMATION:

I. Introduction

The CFTC Reauthorization Act of 2008 ("Reauthorization Act") [2] significantly broadened the CFTC's regulatory authority with respect to ECMs by creating, in section 2(h)(7) of the CEA, a new regulatory category—ECMs on which significant price discovery contracts ("SPDCs") are traded—and treating ECMs in that category as registered entities under the CEA.[3] The legislation authorizes the CFTC to designate an agreement, contract or transaction as a SPDC if the Commission determines, under criteria established in section 2(h)(7), that it performs a significant price discovery function. When the Commission makes such a determination, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the Act and Commission regulations, and must comply with nine core principles established by new section 2(h)(7)(C).

On March 16, 2009, the CFTC promulgated final rules implementing the provisions of the Reauthorization Act.[4] As relevant here, rule 36.3 imposes increased information reporting requirements on ECMs to assist the Commission in making prompt assessments whether particular ECM contracts may be SPDCs. In addition to filing quarterly reports of its contracts, an ECM must notify the Commission promptly concerning any contract traded in reliance on the exemption in section 2(h)(3) of the CEA that averaged five trades per day or more over the most recent calendar quarter, and for which the exchange sells its price information regarding the contract to market participants or industry publications, or whose daily closing or settlement prices on 95 percent or more of the days in the most recent quarter were within 2.5 percent of the contemporaneously determined closing, settlement or other daily price of another contract.

Commission rule 36.3(c)(3) established the procedures by which the Commission makes and announces its determination whether a particular ECM contract serves a significant price discovery function. Under those procedures, the Commission will publish notice in the **Federal Register** that it intends to undertake an evaluation whether the specified agreement, contract or transaction performs a significant price discovery function and to receive written views, data and arguments relevant to its determination from the ECM and other interested persons. Upon the close of the comment period, the Commission will consider, among other things, all relevant information regarding the subject contract and issue an order announcing and explaining its determination whether or not the contract is a SPDC. The issuance of an affirmative order signals the effectiveness of the Commission's regulatory authorities over an ECM with respect to a SPDC; at that time such an ECM becomes subject to all provisions of the CEA applicable to registered entities.[5] The issuance of such an order also triggers the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4).[6]

II. Notice of Intent To Undertake SPDC Determination

On October 9, 2009, the Commission published in the **Federal Register** notice of its intent to undertake a determination whether the MLN contract performs a significant price discovery function and requested comment from interested parties.[7] Comments were received from the Industrial Energy Consumers of America ("IECA"), Working Group of Commercial Energy Firms ("WGCEF"), ICE, Economists Incorporated ("EI"), Natural Gas Suppliers Association ("NGSA"), Federal Energy Regulatory Commission ("FERC"), and Financial Institutions Energy Group ("FIEG").[8] The comment letter from FERC [9] did not directly

[1] 74 FR 52192 (October 9, 2009).

[2] Incorporated as Title XIII of the Food, Conservation and Energy Act of 2008, Public Law 110–246, 122 Stat. 1624 (June 18, 2008).

[3] 7 U.S.C. 1a(29).

[4] 74 FR 12178 (Mar. 23, 2009); these rules became effective on April 22, 2009.

[5] Public Law 110–246 at 13203; *Joint Explanatory Statement of the Committee of Conference,* H.R. Rep. No. 110–627, 110 Cong., 2d Sess. 978, 986 (Conference Committee Report). See also 73 FR 75888, 75894 (Dec. 12, 2008).

[6] For an initial SPDC, ECMs have a grace period of 90 calendar days from the issuance of a SPDC determination order to submit a written demonstration of compliance with the applicable core principles. For subsequent SPDCs, ECMs have a grace period of 30 calendar days to demonstrate core principle compliance.

[7] The Commission's Part 36 rules establish, among other things, procedures by which the Commission makes and announces its determination whether a specific ECM contract serves a significant price discovery function. Under those procedures, the Commission publishes a notice in the **Federal Register** that it intends to undertake a determination whether a specified agreement, contract or transaction performs a significant price discovery function and to receive written data, views and arguments relevant to its determination from the ECM and other interested persons.

[8] IECA describes itself as an "association of leading manufacturing companies" whose membership "represents a diverse set of industries including: plastics, cement, paper, food processing, brick, chemicals, fertilizer, insulation, steel, glass, industrial gases, pharmaceutical, aluminum and brewing." WGCEF describes itself as "a diverse group of commercial firms in the domestic energy industry whose primary business activity is the physical delivery of one or more energy commodities to customers, including industrial, commercial and residential consumers" and whose membership consists of "energy producers, marketers and utilities." ICE is an ECM, as noted above. EI is an economic consulting firm with offices located in Washington, DC, and San Francisco, CA. NGSA is an industry association comprised of natural gas producers and marketers. FERC is an independent federal regulatory agency that, among other things, regulates the interstate transmission of natural gas, oil and electricity. FIEG describes itself as an association of investment and commercial banks who are active participants in various sectors of the natural gas markets, "including acting as marketers, lenders, underwriters of debt and equity securities, and proprietary investors." The comment letters are available on the Commission's Web site: *http://www.cftc.gov/lawandregulation/federalregister/federalregistercomments/2009/09–020.html.*

[9] FERC stated that the MLN contract is cash settled and does not contemplate actual physical delivery of natural gas. Accordingly, FERC expressed the opinion that a determination by the Commission that a contract performs a significant price discovery function "would not appear to conflict with FERC's exclusive jurisdiction under

address the issue of whether or not the MLN contract is a SPDC; IECA concluded that the MLN contract is a SPDC, but did not provide a basis for its conclusion.[10] The other parties' comments raised substantive issues with respect to the applicability of section 2(h)(7) to the MLN contract, generally asserting that the MLN contract is not a SPDC as it does not meet the material liquidity, material price reference and price linkage criteria for SPDC determination. Those comments are more extensively discussed below, as applicable.

III. Section 2(h)(7) of the CEA

The Commission is directed by section 2(h)(7) of the CEA to consider the following criteria in determining a contract's significant price discovery function:

- *Price Linkage*—the extent to which the agreement, contract or transaction uses or otherwise relies on a daily or final settlement price, or other major price parameter, of a contract or contracts listed for trading on or subject to the rules of a designated contract market ("DCM") or derivatives transaction execution facility ("DTEF"), or a SPDC traded on an electronic trading facility, to value a position, transfer or convert a position, cash or financially settle a position, or close out a position.
- *Arbitrage*—the extent to which the price for the agreement, contract or transaction is sufficiently related to the price of a contract or contracts listed for trading on or subject to the rules of a DCM or DTEF, or a SPDC traded on or subject to the rules of an electronic trading facility, so as to permit market participants to effectively arbitrage between the markets by simultaneously maintaining positions or executing trades in the contracts on a frequent and recurring basis.
- *Material price reference*—the extent to which, on a frequent and recurring basis, bids, offers or transactions in a commodity are directly based on, or are determined by referencing or consulting, the prices generated by agreements, contracts or transactions being traded or executed on the electronic trading facility.
- *Material liquidity*—the extent to which the volume of agreements, contracts or transactions in a commodity being traded on the electronic trading facility is sufficient to have a material effect on other agreements, contracts or transactions listed for trading on or subject to the rules of a DCM, DTEF or electronic trading facility operating in reliance on the exemption in section 2(h)(3).

Not all criteria must be present to support a determination that a particular contract performs a significant price discovery function, and one or more criteria may be inapplicable to a particular contract.[11] Moreover, the statutory language neither prioritizes the criteria nor specifies the degree to which a SPDC must conform to the various criteria. In Guidance issued in connection with the Part 36 rules governing ECMs with SPDCs, the Commission observed that these criteria do not lend themselves to a mechanical checklist or formulaic analysis. Accordingly, the Commission has indicated that in making its determinations it will consider the circumstances under which the presence of a particular criterion, or combination of criteria, would be sufficient to support a SPDC determination.[12] For example, for contracts that are linked to other contracts or that may be arbitraged with other contracts, the Commission will consider whether the price of the potential SPDC moves in such harmony with the other contract that the two markets essentially become interchangeable. This co-movement of prices would be an indication that activity in the contract had reached a level sufficient for the contract to perform a significant price discovery function. In evaluating a contract's price discovery role as a price reference, the Commission will consider the extent to which, on a frequent and recurring basis, bids, offers or transactions are directly based on, or are determined by referencing, the prices established for the contract.

IV. Findings and Conclusions

a. The Malin Financial Basis (MLN) Contract and the SPDC Indicia

The ICE MLN contract is cash settled based on the difference between the bidweek price index of natural gas at the Malin hub for the contract-specified month of delivery, as published in Intelligence Press Inc.'s ("IPI") *Natural Gas Bidweek Survey,* and the final settlement price for New York Mercantile Exchange's ("NYMEX's") Henry Hub physically-delivered natural gas futures contract for the same specified calendar month. The IPI bidweek price, which is published monthly, is based on a survey of cash market traders who voluntarily report to IPI data on their fixed-price transactions for physical delivery of natural gas at the Malin hub conducted during the last five business days of the month; such bidweek transactions specify the delivery of natural gas on a uniform basis throughout the following calendar month at the agreed upon rate. The IPI bidweek index is published on the first business day of the calendar month in which the natural gas is to be delivered. The size of the MLN contract is 2,500 million British thermal units ("mmBtu"), and the unit of trading is any multiple of 2,500 mmBtu. The MLN contract is listed for up to 72 calendar months commencing with the next calendar month.

The Henry Hub,[13] which is located in Erath, Louisiana, is the primary cash market trading and distribution center for natural gas in the United States. It also is the delivery point and pricing basis for the NYMEX's actively traded Henry Hub physically-delivered natural gas futures contract, which is the most important pricing reference for natural gas in the United States. The Henry Hub, which is operated by Sabine Pipe Line, LLC, serves as a juncture for 13 different pipelines. These pipelines bring in natural gas from fields in the Gulf Coast region and move it to major consumption centers along the East Coast and Midwest. The throughput shipping capacity of the Henry Hub is 1.8 trillion mmBtu per day.

In addition to the Henry Hub, there are a number of other locations where natural gas is traded. In 2008, there were 33 natural gas market centers in North America.[14] Some of the major trading centers include Alberta, Northwest Rockies, Southern California border and

the Natural Gas Act (NGA) over certain sales of natural gas in interstate commerce for resale or with its other regulatory responsibilities under the NGA" and further that, "the FERC staff will continue to monitor for any such conflict * * * [and] advise the CFTC" should any such potential conflict arise. CL 06.

[10] IECA stated that the subject ICE contract should "be required to come into compliance with core principles mandated by Section 2(h)(7) of the Act and with other statutory provisions applicable to registered entities. [This contract] should be subject to the Commission's position limit authority, emergency authority and large trader reporting requirements, among others." CL 01.

[11] In its October 9, 2009, **Federal Register** release, the Commission identified material price reference, price linkage and material liquidity as the possible criteria for SPDC determination of the MLN contract. Arbitrage was not identified as a possible criterion. As a result, arbitrage will not be discussed further in this document and the associated Order.

[12] 17 CFR 36, Appendix A.

[13] The term "hub" refers to a juncture where two or more natural gas pipelines are connected. Hubs also serve as pricing points for natural gas.

[14] See *http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

the Houston Ship Channel. For locations that are directly connected to the Henry Hub by one or more pipelines and where there typically is adequate shipping capacity, the price at the other locations usually directly tracks the price at the Henry Hub, adjusted for transportation costs. However, at other locations that are not directly connected to the Henry Hub or where shipping capacity is limited, the prices at those locations often diverge from the Henry Hub price. Furthermore, one local price may be significantly different than the price at another location even though the two markets' respective distances from the Henry Hub are the same. The reason for such pricing disparities is that a given location may experience supply and demand factors that are specific to that region, such as differences in pipeline shipping capacity, unusually high or low demand for heating or cooling or supply disruptions caused by severe weather. As a consequence, local natural gas prices can differ from the Henry Hub price by more than the cost of shipping and such price differences can vary in an unpredictable manner.

The Malin hub is the entry point along the California-Oregon border at which natural gas reaches the California market. This trading center connects with the Gas Transmission Northwest interstate pipeline, which carries gas from the Canada/Idaho border through Washington State and Oregon. A connection with the California Gas Transmission Company also exists at the Malin hub. The Malin hub is considered by traders to be an important trading center for natural gas.

The Malin hub is part of the Golden Gate Market Center, which is located in Northern California. The Golden Gate Market Center offers seven different transaction points, which are Malin, Citygate, Kern River Station, High Desert Lateral, Daggett, Southern Trails and Topock. The Golden Gate Market Center had an estimated throughput capacity of two billion cubic feet per day in 2008. Moreover, the number of pipeline interconnections at the Golden Gate Market Center was nine in 2008, up from eight in 2003. Lastly, the pipeline interconnection capacity of the Golden Gate Market Center in 2008 was 6 billion cubic feet per day, which constituted a 32 percent increase over the pipeline interconnection capacity in 2003.[15] The Malin hub is far removed from the Henry Hub and is not directly connected to the Henry Hub by an existing pipeline.

The local price at the Malin hub typically differs from the price at the Henry Hub. Thus, the price of the Henry Hub physically-delivered futures contract is an imperfect proxy for the Malin price. Moreover, exogenous factors, such as adverse weather, can cause the Malin gas price to differ from the Henry Hub price by an amount that is more or less than the cost of shipping, making the NYMEX Henry Hub futures contract even less precise as a hedging tool than desired by market participants. Basis contracts[16] allow traders to more accurately discover prices at alternative locations and hedge price risk that is associated with natural gas at such locations. In this regard, a position at a local price for an alternative location can be established by adding the appropriate basis swap position to a position taken in the NYMEX physically-delivered Henry Hub contract (or in the NYMEX or ICE Henry Hub look-alike contract, which cash settle based on the NYMEX physically-delivered natural gas contract's final settlement price).

In its October 9, 2009, **Federal Register** notice, the Commission identified material price reference, price linkage and material liquidity as the potential SPDC criteria applicable to the MLN contract. Each of these criteria is discussed below.[17]

1. Material Price Reference Criterion

The Commission's October 9, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission considered the fact that ICE maintains exclusive rights over IPI's bidweek price indices. As a result, no other exchange can offer such a basis contract based on IPI's Malin bidweek index. While other third-party price providers produce natural gas price indices for this and other trading centers, market participants indicate that the IPI Malin bidweek index is highly regarded for this particular location and should market participants wish to establish a hedged position based on this index, they would need to do so by taking a position in the ICE MLN swap since ICE has the right to the IPI index for cash settlement purposes. In addition, ICE sells its price data to market participants in a number of different packages which vary in terms of the hubs covered, time periods, and whether the data are daily only or historical. For example, ICE offers the "West Gas End of Day" and "OTC Gas End of Day"[18] packages with access to all price data or just current prices plus a selected number of months (*i.e.,* 12, 24, 36 or 48 months) of historical data. These two packages include price data for the MLN contract.

The Commission will rely on one of two sources of evidence—direct or indirect—to determine that the price of a contract was being used as a material price reference and therefore, serving a significant price discovery function.[19] With respect to direct evidence, the Commission will consider the extent to which, on a frequent and recurring basis, cash market bids, offers or transactions are directly based on or quoted at a differential to, the prices generated on the ECM in question. Direct evidence may be established when cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract in question. Cash market prices are set explicitly at a differential to the section 2(h)(3) contract when, for instance, they are quoted in dollars and cents above or below the reference contract's price. Cash market prices are set implicitly at a differential to a section 2(h)(3) contract when, for instance, they are arrived at after adding to, or subtracting from the section 2(h)(3) contract, but then quoted or reported at a flat price. With respect to indirect evidence, the Commission will consider the extent to which the price of the contract in question is being routinely disseminated in widely distributed industry publications—or offered by the ECM itself for some form of remuneration—and consulted on a frequent and recurring basis by industry participants in pricing cash market transactions.

Following the issuance of the **Federal Register** release, the Commission further evaluated the ICE's data offerings and their use by industry participants. The Malin hub is a significant trading center for natural gas but is not as important as other hubs, such as the PG&E Citygate, for pricing natural gas in the western half of the U.S. marketplace.

[15] See *http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[16] Basis contracts denote the difference in the price of natural gas at a specified location minus the price of natural gas at the Henry Hub. The differential can be either a positive or negative value.

[17] As noted above, the Commission did not find an indication of arbitrage in connection with this contract; accordingly, that criterion is not discussed in reference to the MLN contract.

[18] The OTC Gas End of Day dataset includes daily settlement prices for natural gas contracts listed for all points in North America.

[19] 17 CFR part 36, Appendix A.

Although the Malin hub is a major trading center for natural gas in the United States and, as noted, ICE sells price information for the MLN contract, the Commission has found upon further evaluation that the cash market transactions are not being directly based or quoted as a differential to the MLN contract nor is that contract routinely consulted by industry participants in pricing cash market transactions and thus does not meet the Commission's Guidance for the material price reference criterion. Thus, the MLN contract does not satisfy the direct price reference test for existence of material price reference. Furthermore, the Commission notes that publication of the MLN contract's prices is not indirect evidence material price reference. The MLN contract's prices are published with those of numerous other contracts, which are of more interest to market participants. Due to the less importance of the Malin hub, the Commission has concluded that traders likely do not specifically purchase the ICE data packages for the MLN contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions.

i. Federal Register Comments

As noted above, WGCEF,[20] ICE,[21] EI,[22] NGSA [23] and FIEG [24] addressed the question of whether the MLN contract met the material price reference criterion for a SPDC.[25] The commenters argued that because the MLN contract is cash-settled, it cannot truly serve as an independent "reference price" for transactions in natural gas at this location. Rather, the commenters argue, the underlying cash price series against which the ICE MLN contract is settled (in this case, the IPI bidweek price for natural gas at this location) is the authentic reference price and not the ICE contract itself. The Commission believes that this interpretation of price reference is too limiting in that it only considers the final index value on which the contract is cash settled after trading ceases. Instead, the Commission believes that a cash-settled derivatives contract could meet the price reference criterion if market participants "consult on a frequent and recurring basis" the derivatives contract when pricing forward, fixed-price commitments or other cash-settled derivatives that seek to "lock in" a fixed price for some future point in time to hedge against adverse price movements. As noted above, the Malin hub is a significant trading center for natural gas in North America. However, traders do not consider the Malin hub to be as important as other natural gas trading points, particularly the nearby PG&E Citygate.

ICE argued that the Commission appeared to base the case that the MLN contract is potentially a SPDC on two disputable assertions. First, in issuing its notice of intent to determine whether the MLN contract is a SPDC, the CFTC cited a general conclusion in its ECM Study "that certain market participants referred to ICE as a price discovery market for certain natural gas contracts." [26] ICE states that CFTC's reason is "hard to quantify as the ECM report does not mention" this contract as a potential SPDC. "It is unknown which market participants made this statement in 2007 or the contracts that were referenced." [27] In response to the above comment, the Commission notes that it cited the ECM study's general finding that some ICE natural gas contracts appear to be regarded as price discovery markets merely as an indicia that an investigation of certain ICE contracts may be warranted, and was not intended to serve as the sole basis for determining whether or not a particular contract meets the material price reference criterion.

Second, ICE argued that the Commission should not base a determination that the MLN contract is a SPDC on the fact that this contract has the exclusive right to base its settlement on the IPI Malin Index price. While the Commission acknowledges that there are other firms that produce price indices for the Malin hub, as it notes above, market participants indicate that the IPI Index is very highly regarded. However, since the Malin hub is not considered the predominant pricing point for natural gas in the upper Northwest, it is likely that cash market participants do not consult the MLN contract's prices on a frequent and recurring basis in pricing cash market transactions.

Both EI [28] and WGCEF [29] stated that publication of price data in a package format is a weak justification for material price reference. These commenters argue that market participants generally do not purchase ICE data sets for one contract's prices, such as those for the MLN contract. Instead, traders are interested in the settlement prices, so the fact that ICE sells the MLN prices as part of a broad package is not conclusive evidence that market participants are buying the ICE data sets because they find the MLN prices have substantial value to them. As mentioned above, the Commission notes that publication of the MLN contract's prices is not indirect evidence of routine dissemination. The MLN contract's prices are published with those of numerous other contracts, which are of more interest to market participants. Due to the lack of importance of the Malin hub, the Commission has concluded that traders likely do not specifically purchase the ICE data packages for the MLN contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions.

ii. Conclusion Regarding Material Price Reference

Based on the above, the Commission finds that the MLN contract does not meet the material price reference criterion because cash market transactions are not priced on a frequent and recurring basis at a differential to the MLN contract's price (direct evidence). Moreover, while the ECM sells the MLN contract's price data to market participants, market participants likely do not specifically purchase the ICE data packages for the MLN contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions (indirect evidence).

2. Price Linkage Criterion

In its October 9, 2009, **Federal Register** notice, the Commission identified price linkage as a potential basis for a SPDC determination with respect to the MLN contract. In this regard, the final settlement of the MLN contract is based, in part, on the final settlement price of the NYMEX's Henry Hub physically-delivered natural gas futures contract, where the NYMEX is registered with the Commission as a DCM.

The Commission's Guidance on Significant Price Discovery Contracts [30] notes that a "price-linked contract is a contract that relies on a contract traded on another trading facility to settle, value or otherwise offset the price-linked contract." Furthermore, the Guidance notes that "[f]or a linked contract, the mere fact that a contract is linked to another contract will not be sufficient to support a determination

[20] CL 02.

[21] CL 04.

[22] CL 05.

[23] CL 06.

[24] CL 08.

[25] As noted above, IECA expressed the opinion that the MLN contract met the criteria for SPDC determination but did not provide its reasoning.

[26] CL 03.

[27] CL 03.

[28] CL 05.

[29] CL 02.

[30] Appendix A to the Part 36 rules.

that a contract performs a significant price discovery function. To assess whether such a determination is warranted, the Commission will examine the relationship between transaction prices of the linked contract and the prices of the referenced contract. The Commission believes that where material liquidity exists, prices for the linked contract would be observed to be substantially the same as, or move substantially in conjunction with, the prices of the referenced contract." The Guidance proposes a threshold price relationship such that prices of the ECM linked contract will fall within a 2.5 percent price range for 95 percent of contemporaneously determined closing, settlement or other daily prices over the most recent quarter. Finally, the Commission also stated in the Guidance that it would consider a linked contract that has a trading volume equivalent to 5 percent of the volume of trading in the contract to which it is linked to have sufficient volume potentially to be deemed a SPDC ("minimum threshold").

To assess whether the MLN contract meets the Price Linkage criterion, Commission staff obtained price data from ICE and performed the statistical tests cited above. Staff found that, while the Malin price is determined, in part, by the final settlement price of the NYMEX physically-delivered natural gas futures contract (a DCM contract), the Malin price is not within 2.5 percent of the settlement price of the corresponding NYMEX Henry Hub natural gas futures contract on 95 percent or more of the days. Specifically, during the third quarter of 2009, 10 percent of the Malin hub natural gas prices derived from the ICE basis values were within 2.5 percent of the daily settlement price of the NYMEX Henry Hub futures contract. In addition, staff finds that the MLN contract fails to meet the volume threshold requirement. In particular, the total trading volume in the NYMEX Natural Gas contract during the third quarter of 2009 was 14,022,963 contracts, with 5 percent of that number being 701,148 contracts. The number of trades on the ICE centralized market in the MLN contract during the same period was 54,759 contracts (equivalent to 13,690 NYMEX contracts, given the size difference).[31] Thus, centralized-market trades in the MLN contract amounted to less than the minimum threshold.

i. Federal Register Comments

WGCEF, ICE, EI, NGSA and FIEG addressed the question of whether the MLN contract met the price linkage criterion for a SPDC.[32] Each of the commenters expressed the opinion that the MLN contract did not appear to meet the above-discussed Commission guidance regarding the price relationship and/or the minimum volume threshold relative to the DCM contract to which the MLN is linked. Based on its analysis discussed above, the Commission agrees with this assessment.

ii. Conclusion Regarding the Price Linkage Criterion

The Commission finds that the MLN contract does not meet the price linkage criterion because it fails the volume and price linkage tests provided for in the Commission's Guidance.

3. Material Liquidity Factor

As noted above, in its October 9, 2009, **Federal Register** notice, the Commission identified material price reference, price linkage and material liquidity as potential criteria for SPDC determination of the MLN contract. To assess whether a contract meets the material liquidity criterion, the Commission first examines trading activity as a general measurement of the contract's size and potential importance. If the Commission finds that the contract in question meets a threshold of trading activity that would render it of potential importance, the Commission will then perform a statistical analysis to measure the effect that the prices of the subject contract potentially may have on prices for other contracts listed on an ECM or a DCM.

Based upon on a required quarterly filing made by ICE on July 27, 2009, the total number of MLN trades executed on ICE's electronic trading platform was 664 in the second quarter of 2009, resulting in a daily average of 10.4 trades. During the same period, the MLN contract had a total trading volume on ICE's electronic trading platform of 59,564 contracts and an average daily trading volume of 930.7 contracts. The open interest as of June 30, 2009, was 65,804 contracts, which includes trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing.

In a subsequent filing dated November 13, 2009, ICE reported that 686 separate trades occurred on its electronic platform in the third quarter of 2009, resulting in a daily average of 10.4 trades. During the same period, the MLN contract had a total trading volume on its electronic platform of 54,759 contracts (which was an average of 830 contracts per day). As of September 30, 2009, open interest in the MLN contract was 57,332 contracts. Reported open interest included positions resulting from trades that were executed on ICE's electronic platform, as well as trades that were executed off of ICE's electronic platform and brought to ICE for clearing.

As indicated above, the average number trades per day in the second and third quarters of 2009 was only slightly above the minimum reporting level (5 trades per day). Moreover, trading activity in the MLN contract, as characterized by total quarterly volume, indicates that the MLN contract experiences trading activity similar to that of other thinly-traded contracts.[33] Thus, the MLN contract does not meets a threshold of trading activity that would render it of potential importance and no additional statistical analysis is warranted.[34]

i. Federal Register Comments

As noted above, WGCEF, ICE, EI, NGSA and FIEG addressed the question of whether the MLN contract met the material liquidity criterion for a SPDC.[35] These commenters stated that the MLN contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

WGCEF,[36] ICE[37] and EI[38] noted that the Commission's Guidance had posited

[31] The MLN contract is one-quarter the size of the NYMEX Henry Hub physically-delivered futures contract.

[32] As noted above, IECA expressed the opinion that the MLN contract met the criteria for SPDC determination but did not provide its reasoning.

[33] Staff has advised the Commission that in its experience, a thinly-traded contract is, generally, one that has a quarterly trading volume of 100,000 contracts or less. In this regard, in the third quarter of 2009, physical commodity futures contracts with trading volume of 100,000 contracts or fewer constituted less than one percent of total trading volume of all physical commodity futures contracts.

[34] In establishing guidance to illustrate how it will evaluate the various criteria, or combinations of criteria, when determining whether a contract is a SPDC, the Commission made clear that "material liquidity itself would not be sufficient to make a determination that a contract is a [SPDC], * * * but combined with other factors it can serve as a guidepost indicating which contracts are functioning as [SPDCs]." For the reasons discussed above, the Commission has found that the MLN contract does not meet either the price linkage or material price reference criterion. In light of this finding and the Commission's Guidance cited above, there is no need to evaluate further the material liquidity criteria since it cannot be used alone as a basis for a SPDC determination.

[35] As noted above, IECA expressed the opinion that the MLN contract met the criteria for SPDC determination but did not provide its reasoning.

[36] CL 02.

[37] CL 04.

[38] CL 05.

concepts of liquidity that generally assumed a fairly constant stream of prices throughout the trading day, and noted that the relatively low number of trades per day in the MLN contract did not meet this standard of liquidity. The Commission observes that a continuous stream of prices would indeed be an indication of liquidity for certain markets but the Guidance also notes that "quantifying the levels of immediacy and price concession that would define material liquidity may differ from one market or commodity to another."

WGCEF, FIEG [39] and NGSA [40] noted that the MLN contract represents a differential, which does not affect other contracts, including the NYMEX Henry Hub contract and physical gas contracts. FIEG and WGCEF also noted that the MLN contract's trading volume represents only a fraction of natural gas trading.

ICE opined that the Commission "seems to have adopted a five trade-per-day test to determine whether a contract is materially liquid. It is worth noting that ICE originally suggested that the CFTC use a five trades-per-day threshold as the basis for an ECM to *report* trade data to the CFTC." Furthermore, FIEG cautioned the Commission in using a reporting threshold as a measure of liquidity. In this regard, the Commission adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs" [41] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC but this does not mean that the contract will be found to be a SPDC merely because it met the reporting threshold.

ICE and EI proposed that the statistics provided by ICE were misinterpreted and misapplied by the Commission. In particular, ICE stated that the volume figures used in the Commission's analysis (cited above) "include trades made in *all months of each contract*" as well as in strips of contract months, and a "more appropriate method of determining liquidity is to examine the activity in a *single* traded month or strip of a given contract." [42] A similar argument was made by EI, which observed that the five-trades-per-day number "is highly misleading * * * because the contracts can be offered for as long as 120 months, [thus] the average per day for an individual contract may be less than 1 per day."

It is the Commission's opinion that liquidity, as it pertains to the MLN contract, is typically a function of trading activity in particular lead months and, given sufficient liquidity in such months, the ICE MLN contract itself would be considered liquid. In any event, in light of the fact that the Commission has found that the MLN contract does not meet the material price reference or price linkage criteria, according to the Commission's Guidance, it would be unnecessary to evaluate whether the MLN contract meets the material liquidity criterion since it cannot be used alone for SPDC determination.

ii. Conclusion Regarding Material Liquidity

For the reasons discussed above, the Commission does not find evidence that the MLN contract meets the material liquidity criterion.

4. Overall Conclusion Regarding the MLN Contract

After considering the entire record in this matter, including the comments received, the Commission has determined that the MLN contract does not perform a significant price discovery function under the criteria established in section 2(h)(7) of the CEA. Specifically, the Commission has determined that the MLN contract does not meet the material price reference, price linkage and material liquidity criteria at this time. Accordingly, the Commission will issue the attached Order declaring that the MLN contract is not a SPDC. Issuance of this Order indicates that the Commission does not at this time regard ICE as a registered entity in connection with its MLN contract.[43] Accordingly, with respect to its MLN contract, ICE is not required to comply with the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) for ECMs with SPDCs. However, ICE must continue to comply with the applicable reporting requirements.

V. Related Matters

a. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 ("PRA") [44] imposes certain requirements on Federal agencies, including the Commission, in connection with their conducting or sponsoring any collection of information as defined by the PRA. Certain provisions of Commission rule 36.3 impose new regulatory and reporting requirements on ECMs, resulting in information collection requirements within the meaning of the PRA. OMB previously has approved and assigned OMB control number 3038–0060 to this collection of information.

b. Cost-Benefit Analysis

Section 15(a) of the CEA [45] requires the Commission to consider the costs and benefits of its actions before issuing an order under the Act. By its terms, section 15(a) does not require the Commission to quantify the costs and benefits of an order or to determine whether the benefits of the order outweigh its costs; rather, it requires that the Commission "consider" the costs and benefits of its actions. Section 15(a) further specifies that the costs and benefits shall be evaluated in light of five broad areas of market and public concern: (1) Protection of market participants and the public; (2) efficiency, competitiveness and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. The Commission may in its discretion give greater weight to any one of the five enumerated areas and could in its discretion determine that, notwithstanding its costs, a particular order is necessary or appropriate to protect the public interest or to effectuate any of the provisions or accomplish any of the purposes of the Act.

When a futures contract begins to serve a significant price discovery function, that contract, and the ECM on which it is traded, warrants increased oversight to deter and prevent price manipulation or other disruptions to

[39] CL 08.

[40] CL 06.

[41] 73 FR 75892 (December 12, 2008).

[42] In addition, both EI and ICE stated that the trades-per-day statistics that it provided to the Commission in its quarterly filing and which were cited in the Commission's October 9, 2009, **Federal Register** notice includes 2(h)(1) transactions, which were not completed on the electronic trading platform and should not be considered in the SPDC determination process. The Commission staff asked ICE to review the data it sent in its quarterly filings; ICE confirmed that the volume data it provided and which the Commission cited includes only transaction data executed on ICE's electronic trading platform. As noted above, supplemental data supplied by ICE confirmed that block trades are in addition to the trades that were conducted on the electronic platform; block trades comprise about 55 percent of all transactions in the MLN contract. The Commission acknowledges that the open interest information it provided in its October 9, 2009, **Federal Register** notice includes transactions made off the ICE platform. However, once open interest is created, there is no way for ICE to differentiate between "on-exchange" versus "off-exchange" created positions, and all such positions are fungible with one another and may be offset in any way agreeable to the position holder regardless of how the position was initially created.

[43] See 73 FR 75888, 75893 (Dec. 12, 2008).

[44] 44 U.S.C. 3507(d).

[45] 7 U.S.C. 19(a).

market integrity, both on the ECM itself and in any related futures contracts trading on DCMs. An Order finding that a particular contract is a SPDC triggers this increased oversight and imposes obligations on the ECM calculated to accomplish this goal. The increased oversight engendered by the issue of a SPDC Order increases transparency and helps to ensure fair competition among ECMs and DCMs trading similar products and competing for the same business. Moreover, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the CEA and Commission regulations. Additionally, the ECM must comply with nine core principles established by section 2(h)(7) of the Act—including the obligation to establish position limits and/or accountability standards for the SPDC. Section 4(i) of the CEA authorize the Commission to require reports for SPDCs listed on ECMs. These increased responsibilities, along with the CFTC's increased regulatory authority, subject the ECM's risk management practices to the Commission's supervision and oversight and generally enhance the financial integrity of the markets.

The Commission has concluded that ICE's MLN contract, which is the subject of the attached Order, is not a SPDC; accordingly, the Commission's Order imposes no additional costs and no additional statutorily or regulatory mandated responsibilities on the ECM.

c. Regulatory Flexibility Act

The Regulatory Flexibility Act ("RFA") [46] requires that agencies consider the impact of their rules on small businesses. The requirements of CEA section 2(h)(7) and the Part 36 rules affect ECMs. The Commission previously has determined that ECMs are not small entities for purposes of the RFA.[47] Accordingly, the Chairman, on behalf of the Commission, hereby certifies pursuant to 5 U.S.C. 605(b) that these Orders, taken in connection with section 2(h)(7) of the Act and the Part 36 rules, will not have a significant impact on a substantial number of small entities.

VI. Order

a. Order Relating to the Malin Financial Basis Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following Order:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the Malin Financial Basis contract, traded on the IntercontinentalExchange, Inc., does not at this time satisfy the material price reference, price linkage or material liquidity criteria for significant price discovery contracts. Consistent with this determination, the IntercontinentalExchange, Inc., is not considered a registered entity [48] with respect to the Malin Financial Basis contract and is not subject to the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the IntercontinentalExchange, Inc., are not applicable to the Malin Financial Basis contract with the issuance of this Order.

This Order is based on the representations made to the Commission by the IntercontinentalExchange, Inc., dated July 27, 2009, and November 13, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the Malin Financial Basis contract is not a significant price discovery contract. Additionally, to the extent that it continues to rely upon the exemption in Section 2(h)(3) of the Act, the IntercontinentalExchange, Inc., must continue to comply with all of the applicable requirements of Section 2(h)(3) and Commission Regulation 36.3.

Issued in Washington, DC on April 28, 2010, by the Commission.

David A. Stawick,

Secretary of the Commission.

[FR Doc. 2010–10306 Filed 5–3–10; 8:45 am]

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[46] 5 U.S.C. 601 *et seq.*

[47] 66 FR 42256, 42268 (Aug. 10, 2001).

[48] 7 U.S.C. 1a(29).

COMMODITY FUTURES TRADING COMMISSION

Order Finding That the Carbon Financial Instrument Contract Offered for Trading on the Chicago Climate Exchange, Inc. Does Not Perform a Significant Price Discovery Function

AGENCY: Commodity Futures Trading Commission.

ACTION: Final order.

SUMMARY: On August 20, 2009, the Commodity Futures Trading Commission ("CFTC" or "Commission") published for comment in the **Federal Register** [1] a notice of its intent to undertake a determination whether the Carbon Financial Instrument ("CFI") contract offered for trading on the Chicago Climate Exchange, Inc. ("CCX"), an exempt commercial market ("ECM") under Section 2(h)(3)–(5) of the Commodity Exchange Act ("CEA" or the "Act"), performs a significant price discovery function pursuant to section 2(h)(7) of the CEA. The Commission undertook this review based upon an initial evaluation of information and data provided by CCX. The Commission has reviewed public comments and the entire record in this matter and has determined to issue an order finding that the CCX CFI contract, at this time, does not perform a significant price discovery function. Authority for this action is found in section 2(h)(7) of the CEA and Commission rule 36.3(c) promulgated thereunder.

DATES: *Effective date:* April 28, 2010.

FOR FURTHER INFORMATION CONTACT: Irina Leonova, Financial Economist, Division of Market Oversight, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW., Washington, DC 20581. Telephone: (202) 418–5646. Email: *ileonova@cftc.gov,* or Gregory K. Price, Industry Economist, Division of Market Oversight, same address. Telephone: (202) 418–5515. E-mail: *gprice@cftc.gov,* or Susan Nathan, Senior Special Counsel, Division of Market Oversight, same address. Telephone: (202) 418–5133. E-mail: *snathan@cftc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The CFTC Reauthorization Act of 2008 ("Reauthorization Act") [2] significantly broadened the CFTC's regulatory authority with respect to ECMs by creating, in section 2(h)(7) of the CEA, a new regulatory category—ECMs on which significant price discovery contracts ("SPDCs") are traded—and treating ECMs in that category as registered entities under the CEA. The legislation authorizes the CFTC to designate an agreement, contract or transaction traded on an ECM as a SPDC if the Commission determines, under criteria established in section 2(h)(7), that it performs a significant price discovery function. When the Commission makes such a

[1] 74 FR 42052 (August 20, 2009).

[2] Incorporated as Title XIII of the Food, Conservation and Energy Act of 2008, Public Law 110–246, 122 Stat. 1624 (June 18, 2008).

determination, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the Act and Commission regulations, and must comply with nine core principles established by new section 2(h)(7)(C).

On March 16, 2009, the CFTC promulgated final rules implementing the provisions of the Reauthorization Act.[3] As relevant here, Rule 36.3 imposes increased information reporting requirements on ECMs to assist the Commission in making prompt assessments whether particular ECM contracts may be SPDCs. In addition to filing quarterly reports regarding its contracts, an ECM must notify the Commission promptly concerning any contract traded in reliance on the exemption in section 2(h)(3) of the CEA that averaged five trades per day or more over the most recent calendar quarter, and that either: (1) had its price information sold by the exchange to market participants or industry publications or (2) had daily closing or settlement prices which were within 2.5% of the contemporaneously determined closing, settlement or other daily price of another contract on 95 percent or more of the days in the most recent quarter.

Commission Rule 36.3(c)(3) established the procedures by which the Commission makes and announces its determination whether a particular ECM contract serves a significant price discovery function. Under those procedures, the Commission publishes notice in the **Federal Register** that it intends to undertake a determination whether the specified agreement, contract or transaction performs a significant price discovery function and receives written views, data and arguments relevant to its determination from the ECM and other interested persons. The Commission, within a reasonable period of time after the close of the comment period, considers all relevant information and issues an order announcing and explaining its determination. The issuance of an affirmative order subjects an ECM with a SPDC to the full application of the Commission's regulatory authorities; at that time, such an ECM becomes subject to all provisions of the CEA applicable to registered entities.[4] The issuance of such an order also triggers the obligations, requirements and timetables prescribed in Commission Rule 36.3(c)(4).[5]

II. Notice of Intent To Undertake SPDC Determination

On August 20, 2009, the Commission published in the **Federal Register** a notice of its intent to undertake a determination whether the CCX's CFI contract performs a significant price discovery function, and requested comment from interested parties.[6] Comments were received from the IntercontinentalExchange, Inc. ("ICE"); Jeremy D. Weinstein, Esq. ("Weinstein"); the California Forestry Association ("CFA"); and Scott DeMonte ("DeMonte").[7] The comments are more extensively discussed below in the Analysis Section.

III. Section 2(h)(7) of the CEA

The Commission is directed by section 2(h)(7) of the CEA to consider, as appropriate, the following factors in determining whether a contract performs a significant price discovery function:

- *Price Linkage*—the extent to which the agreement, contract or transaction uses or otherwise relies on a daily or final settlement price, or other major price parameter, of a contract or contracts listed for trading on or subject to the rules of a designated contract market ("DCM") or derivatives transaction execution facility ("DTEF"), or a SPDC traded on an electronic trading facility, to value a position, transfer or convert a position, cash or financially settle a position, or close out a position.
- *Arbitrage*—the extent to which the price for the agreement, contract or transaction is sufficiently related to the price of a contract or contracts listed for trading on or subject to the rules of a DCM or DTEF, or a SPDC traded on or subject to the rules of an electronic trading facility, so as to permit market participants to effectively arbitrage between the markets by simultaneously maintaining positions or executing trades in the contracts on a frequent and recurring basis.
- *Material price reference*—the extent to which, on a frequent and recurring basis, bids, offers or transactions in a commodity are directly based on, or are determined by referencing, the prices generated by agreements, contracts or transactions being traded or executed on the electronic trading facility.
- *Material liquidity*—the extent to which the volume of agreements, contracts or transactions in the commodity being traded on the electronic trading facility is sufficient to have a material effect on other agreements, contracts or transactions listed for trading on or subject to the rules of a DCM, DTEF or electronic trading facility operating in reliance on the exemption in section 2(h)(3).

Not all factors must be present to support a determination that a particular contract performs a significant price discovery function. Moreover, the statutory language neither prioritizes the factors nor specifies the degrees to which a SPDC must conform to the various factors. In Guidance issued in connection with the Part 36 rules governing ECMs with SPDCs, the Commission observed that these factors do not lend themselves to a mechanical checklist or formulaic analysis.[8]

Accordingly, the Commission has indicated that in making its determination it will consider the circumstances under which the presence of a particular factor, or combination of factors, would be sufficient to support a SPDC determination.[9] For example, for contracts that are linked to other contracts or that may be arbitraged with other contracts, the Commission will consider whether the price of the potential SPDC moves in such harmony with the other contract that the two markets essentially become interchangeable.[10] This co-movement of prices would be an indication that activity in the contract had reached a level sufficient for the contract to perform a significant price discovery function.

IV. The CCX CFI Contract

CCX, launched in 2003, operates the only North American voluntary, legally

[3] 74 FR 12178 (Mar. 23, 2009); these rules became effective on April 22, 2009.

[4] Public Law 110–246 at 13203; *Joint Explanatory Statement of the Committee of Conference,* H.R. Rep. No. 110–627, 110 Cong., 2d Sess. 978, 986 (Conference Committee Report). *See also* 73 FR 75888, 75894 (Dec. 12, 2008).

[5] For an initial SPDC determination, ECMs have a grace period of 90 calendar days from the issuance of a SPDC determination order to submit a written demonstration of compliance with the applicable core principles. For subsequent SPDC determinations, ECMs have a grace period of 30 calendar days to demonstrate core principle compliance.

[6] The Commission's Part 36 Rules establish, among other things, procedures by which the Commission makes and announces its determination whether a specific ECM contract serves a significant price discovery function. Under those procedures, the Commission publishes a notice in the **Federal Register** that it intends to undertake a determination whether a specified agreement, contract or transaction performs a significant price discovery function and to receive written data, views and arguments relevant to its determination from the ECM and other interested persons.

[7] The comment letters are available on the Commission's Web site: *http://www.cftc.gov/lawandregulation/federalregister/federalregistercomments/2009/09-010.html.*

[8] Appendix A to Part 36, 17 CFR part 36 (2009).

[9] 17 CFR part 36, appendix A.

[10] Appendix A to Part 36, 17 CFR 36 (2009).

binding integrated trading system to reduce emissions of six major greenhouse gases, with offset projects worldwide. CCX offers a cap and trade system whose members [11] make a legally binding emission reduction commitment. Members are allocated annual emission allowances in accordance with their emissions baseline and the CCX emission reduction schedule. Members who reduce beyond their targets have surplus allowances to sell or bank; those who do not meet the targets must comply by purchasing CCX CFIs. The CCX CFI contract is a cash market instrument and not a derivatives contract. The Chicago Climate Futures Exchange (CCFE), a subsidiary of CCX that operates as a DCM, lists derivatives (futures and option contracts) on CCX CFIs.

The size of the CCX CFI contract is 100 metric tons (MT) of CO_2-equivalent emissions. A CCX CFI contract involves the immediate delivery of, and payment for, vintage specific CCX carbon dioxide (CO_2) emission allowances called CFIs. Earlier dated vintages may be delivered against later vintage trades. Transactions (with exception of bilateral agreements) are cleared on trade day. Full contract value settlement occurs on the next business day. CCX substitutes as a counterparty to all transactions and guarantees performance until settlement is completed.

Based upon a required quarterly notification filed on October 15, 2009, (mandatory under Rule 36.3(c)(2)), the CCX reported that, with respect to its CFI contract, an average of 8 trades per day occurred in the third quarter of 2009. During the same period, the CFI had an average daily trading volume of 1,141 contracts. In the second quarter of 2009, market participants traded the CFI contract on average 15 times per day with an average daily trading volume of 1,235 contracts. Because the CCX CFI is a cash market instrument, open interest figures are not applicable.

V. Analysis

A. The Statutory Criteria

In its notice of intent to undertake a determination whether the CCX CFI contract performs a significant price discovery function, the Commission indicated that the CCX CFI contract might satisfy the material price reference and material liquidity criteria for SPDC determination.[12] Further analysis reveals that the CCX CFI contract does not meet either criterion.

Material Price Reference Criterion

The Commission has concluded that the CCX CFI contract does not meet the material price reference criterion for SPDC determination. As noted in the original **Federal Register** notice, the CFI market is solely a CCX-created entity.[13] The CCX designed all of the parameters of this carbon emission reduction program, and it established the rules for membership in the ECM, allowance trading, and the creation of offsets. Based on these attributes, staff considered whether traders look to the CCX as a source of price information and price discovery for the CFI or the U.S. carbon market in general that would either be a direct or an indirect source of evidence of the material price reference. Staff concluded that it appears that CCX CFI prices are not used as a price reference to the U.S. carbon market due to the relatively small market share of the CCX CFI program in the overall U.S. carbon market, the limited potential for the CFI program to be folded into a national carbon reduction program, and significant price volatility of the CCX CFI instrument. As part of its material price reference analysis, Commission staff considered comments filed pursuant to the request for comment and all other relevant information.[14]

Material Liquidity Criterion

The Commission's decision to undertake a review to determine whether the CCX CFI contract performs a significant price discovery function was based on CCX's required initial quarterly notification filed on July 1, 2009. At that time, CCX reported that, with respect to all CFI trades combined (aggregate of vintages 2003–2010), an average of 15 separate trades per day occurred in the second quarter of 2009. Subsequent to the publication of the Commission's **Federal Register** notice announcing its intent to undertake a SPDC review, however, CCX amended its filing to show the number of trades per day for each vintage, and clarified that the exchange lists and trades CFI contract vintages individually and provides a vintage-specific closing price for each CFI vintage contract. In these circumstances, the Commission recognizes that the CCX CFI vintage-specific contracts should not be aggregated, but rather should be treated individually for the purpose of a SPDC analysis. Accordingly, the Commission has analyzed each individual vintage of the CCX CFIs to determine whether any of them are SPDCs.[15]

The Commission's evaluation of the supplemental data indicates that the CCX CFI vintage specific contracts (2003–2010 vintages) do not meet the material liquidity criterion for a SPDC; the average number of trades per day per vintage was only one contract, well below the five trades per day reporting threshold established by the Commission.

B. Comments Received

The Commission received four responses to its request for comments. Two of the comment letters addressed issues beyond the scope of the instant matter;[16] two raised substantive issues

[11] CCX membership categories:

Members: Entities with direct greenhouse gas (GHG) emissions. Members make a legally binding commitment to the CCX Emission Reduction Schedule and are subject to annual emissions verification by FINRA. Indirect emissions are an opt-in.

Registry Participant Members: Entities with direct GHG emissions that establish a CCX Registry account of their emissions and undergo data verification. Standardized independent third-party data verification is provided by FINRA on an annual or multi-annual basis.

Associate Members: Office-based businesses or institutions with negligible direct GHG emissions. Associate Members commit to report and fully offset 100 percent of indirect emissions associated with energy purchases and business travel from year of entry through 2010 and emissions data are verified by FINRA.

Offset Providers: Owners of title to qualifying offset projects that sequester, destroy or reduce GHG emissions. Offset Providers register and sell offsets directly on the CCX.

Offset Aggregators: Entities that serve as the administrative representative, on behalf of offset project owners, of multiple offset-generating projects. Offset projects involving less than 10,000 metric tons of carbon dioxide equivalent per year should be registered and sold through an Offset Aggregator.

Liquidity Providers: Entities or individuals who trade on CCX for purposes other than complying with the CCX Emission Reduction Schedule, such as market makers and proprietary trading groups.

Exchange Participants: Entities or individuals who purchase CFI contracts and retire them to offset emissions associated with special events or other specified activities.

[12] 74 FR 42054 (Aug. 20, 2009).The Commission did not identify either price linkage or arbitrage as the possible criteria for the CCX CFI contact to be a SPDC. Accordingly, those criteria will not be discussed further in this Order.

[13] 74 FR 42054 (Aug. 20, 2009).

[14] The Commission will rely on one of two sources of evidence—direct or indirect—to determine a SPDC. Direct evidence can be cash market transactions that are frequently based on or quoted as a differential to the potential SPDC. Indirect evidence includes contracts whose price series are routinely disseminated in industry publications or are sold to market participants by the ECM.

[15] Because this shift in focus did not alter either the analysis or conclusion or otherwise suggest the need for further comment, the Commission did not republish its original notice of intent to make a SPDC determination with respect to the CCX CFI contract.

[16] *See* supra note 7. Specifically, the California Forestry Association offered the opinion that all the over-the-counter voluntary carbon trading occurring now serves a significant price discovery function. CL 02. Scott DeMonte advises the Commission to "fix the manipulation" in [its] exchanges" and

with respect to the applicability of section 2(h)(7) to the CFI contract.[17]

Weinstein opines that the CCX offset project protocols "do not conform to the stringent additionality [18] and leakage standards [19] that are in the carbon offset contracts * * * accepted by the broader market." Consequently, Mr. Weinstein asserts that "the absence from the CCX CFI contract of the most essential requirements for commonality with other carbon offset contract prevents market participants from using the CFI contracts for material price reference, arbitrage, and settlement and execution of transactions." The environmental requirements of the CCX offset protocols are beyond the scope of the Commission authority, and this inquiry was limited to an evaluation whether the CCX CFI contract might satisfy the material liquidity and material price reference statutory criterion for a SPDC determination.

ICE expressed an opinion that "the CFI does not serve a significant price discovery function and the Commission may exceed its jurisdiction if it determines that the CFI serves as a significant price discovery contract." ICE observed that the CCX CFI contract fails the threshold for material liquidity because "each [CCX CFI contract] vintage may trade less than twice a day." Consequently, ICE concluded that "a trade every couple of hours does not equate to the "ability to transact immediately" or "a more or less continuous stream of prices." As noted above, after a thorough review of supplemental data provided for the CCX CFI contract, Commission staff concluded that different CCX CFI vintages should be considered as separate CCX contracts. When analyzed in this manner, the CCX CFI contracts do not meet the material liquidity criterion for SPDC determination.

When analyzing the material price reference factor for a CCX CFI SPDC determination, ICE commented that "under the Commission's theory, any spot contract automatically serves as a material price reference, simply because the *contract references itself*" (emphasis in original). Additionally, ICE expresses an opinion that "by making this determination [the CCX CFI contract is a SPDC], the Commission is broadly asserting jurisdiction over the spot market if the spot contract is electronically traded." In response, the Commission notes that Section 2(h)(7), refers to "any agreement, contract or transaction conducted in reliance on the exemption" in Section 2(h)(3) and does not require that the Commission find that a potential SPDC contract is a commodity futures or options contract. The determination to list particular instruments in reliance on the Section 2(h)(3) exemption is made by the ECM, not the Commission, when the ECM files notice with the Commission, under Section 2(h)(5), of its reliance on such exemption. Section 2(i) of the CEA reinforces the view that instruments traded on 2(h)(3) markets may include non-futures products; that section states that there is no presumption that an agreement, contract or transaction exempted under section 2(h)(3) "is or would otherwise be subject to this chapter."

VI. Findings and Conclusion

In consideration of the initial and supplemental information provided by CCX, the comments received in connection with the **Federal Register** notice and all other relevant information, the Commission has determined that the CCX CFI contract does not, at this time, perform a significant price discovery function. Accordingly, as set forth in the Commission's Order, CCX is not required to comply with Commission Rule 36.3(c)(4) applicable to ECMs with SPDCs, or otherwise to assume the statutory and regulatory responsibilities of a registered entity with respect to the CFI contract. The Reauthorization Act amended the CEA to require that the Commission evaluate not less than annually all agreements, contracts and transactions conducted on an ECM in reliance on the exemption in section 2(h)(3) to determine whether they serve a significant price discovery function.[20] In addition, the Commission routinely monitors contracts traded or executed in reliance on section 2(h)(3) and reviews all ECM submissions on an ongoing basis for the presence of SPDCs. Accordingly, like all ECMs, CCX remains responsible for compliance with the reporting requirements described in Rule 36.3(a) and (b).

VII. Related Matters

A. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 ("PRA") [21] imposes certain requirements on federal agencies, including the Commission, in connection with their conducting or sponsoring any collection of information, as defined by the PRA. Certain provisions of final Commission Rule 36.3 impose new regulatory and reporting requirements on ECMs, resulting in information collection requirements within the meaning of the PRA; OMB previously has approved and assigned OMB control number 3038–0060 to this collection of information.

B. Cost-Benefit Analysis

Section 15(a) of the CEA [22] requires the Commission to consider the costs and benefits of its actions before issuing an order under the Act. By its terms, section 15(a) does not require the Commission to quantify the costs and benefits of an order or to determine whether the benefits of the order outweigh its costs; rather, it requires that the Commission "consider" the costs and benefits of its action. Section 15(a) further specifies that the costs and benefits shall be evaluated in light of five broad areas of market and public concern: (1) Protection of market participants and the public; (2) efficiency, competitiveness, and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. The Commission may in its discretion give greater weight to any of the five enumerated areas and could in its discretion determine that, notwithstanding its costs, a particular order is necessary or appropriate to protect the public interest or to effectuate any provisions or accomplish any of the purposes of the Act.

When a futures contract begins to serve a significant price discovery function, that contract, and the ECM on which it is traded, warrants increased oversight to deter and prevent price manipulation and other disruptions to market integrity, both on the ECM itself and in any related futures contracts trading on DCMs. An Order finding that a particular contract is a SPDC triggers

requests that firms be required to have collateral in excess of two times their average end of daily trade value in order to participate in this market. CL 01.

[17] *See* supra note 7. The commenters who raised substantive issues with respect to the applicability of section 2(h)(7) to the CFI contract are Jeremy D. Weinstein, Esq., owner of the law offices of Jeremy D. Weinstein, a professional corporation located in Walnut Creek, California and IntercontinentalExchange, Inc., operator of regulated exchanges, trading platforms and clearing houses serving the global markets for agricultural, credit, currency, emissions, energy and equity index markets headquartered in Atlanta, Georgia, U.S.

[18] There are a number of interpretations of the additionality concept in application to the environmental offset projects. The most popular interpretations are "environmental additionality" where a project is additional if the emissions from the project are lower than the baseline, and "project additionality" where the project must not have happened without the Clean Development Mechanism (CDM).

[19] Leakage generally refers to the increase in emissions outside the project boundary that occurs as a consequence of the project activity's implementation.

[20] Section 2(h)(7)(D)(ii), 7 U.S.C. 2(h)(7)(D)(ii).

[21] 44 U.S.C. 3507(d).

[22] 7 U.S.C.19(a).

this increased oversight and imposes obligations on the ECM calculated to accomplish this goal. The increased oversight engendered by the issuance of a SPDC Order increases transparency and helps to ensure fair competition among ECMs and DCMs trading similar products and competing for the same business. Moreover, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the CEA and Commission regulations. Additionally, the ECM must comply with nine core principles established by section 2(h)(7) of the Act—including the obligation to establish position limits and/or accountability standards for the SPDC. Amendments to section 4(i) of the CEA authorize the Commission to require large trader reports for SPDCs listed on ECMs. These increased ECM responsibilities, along with the CFTC's increased regulatory authority, subject the ECM's risk management practices to the Commission's supervision and oversight and generally enhance the financial integrity of the markets.

The Commission has concluded that the Chicago Climate Exchange's Carbon Financial Instrument contract that is the subject of the attached Order is not a SPDC; accordingly, the Commission's Order impose no additional costs and no additional statutorily or regulatory mandated responsibilities on the ECM.

VIII. Order

Order Relating to the CCX CFI Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the Chicago Climate Exchange's Carbon Financial Instrument contract that was submitted to the Commission by the Chicago Climate Exchange for review on July 1, 2009 and October 15, 2009 does not, at this time, satisfy the statutory or regulatory requirements of a significant price discovery contract. Consistent with this determination, the Chicago Climate Exchange is not required at this time to comply with section 2(h)(7)(C) in connection with the Carbon Financial Instrument contract or the Part 36 regulations applicable to exempt commercial markets with significant price discovery contracts, and is not required to assume the statutory or regulatory responsibilities required of registered entities with respect to the Carbon Financial Instrument contract.

This order is based upon the representations made to the Commission by the Chicago Climate Exchange in filings dated July 1, 2009 and October 15, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the Carbon Financial Instrument contract is not a significant price discovery contract.

The Commission may, based upon information regarding the Carbon Financial Instrument contract reviewed under this Order that is submitted in required reports and filings, issue another notice of intent to undertake a significant price discovery contract determination for these contracts. Further, issuance of this Order does not affect the Chicago Climate Exchange's continuing obligation to comply with all statutory and regulatory requirements applicable to 2(h)(3) markets, including all reporting requirements found in Commission Regulation 36.3.

Issued in Washington, DC on April 28, 2010 by the Commission.

David A. Stawick,

Secretary of the Commission.

[FR Doc. 2010–10311 Filed 5–3–10; 8:45 am]

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COMMODITY FUTURES TRADING COMMISSION

Order Finding That the NGPL TxOk Financial Basis Contract Traded on the IntercontinentalExchange, Inc., Does Not Perform a Significant Price Discovery Function

AGENCY: Commodity Futures Trading Commission

ACTION: Final Order.

SUMMARY: On October 9, 2009, the Commodity Futures Trading Commission ("CFTC" or "Commission") published for comment in the **Federal Register** [1] a notice of its intent to undertake a determination whether the NGPL TxOk Financial Basis ("NTO") contract traded on the IntercontinentalExchange, Inc. ("ICE"), an exempt commercial market ("ECM") under sections 2(h)(3)–(5) of the Commodity Exchange Act ("CEA" or the "Act"), performs a significant price discovery function pursuant to section 2(h)(7) of the CEA. The Commission undertook this review based upon an initial evaluation of information and data provided by ICE as well as other available information. The Commission has reviewed the entire record in this matter, including all comments received, and has determined to issue an order finding that the NTO contract does not perform a significant price discovery function. Authority for this action is found in section 2(h)(7) of the CEA and Commission rule 36.3(c) promulgated thereunder.

DATES: *Effective date:* April 28, 2010.

FOR FURTHER INFORMATION CONTACT: Gregory K. Price, Industry Economist, Division of Market Oversight, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW., Washington, DC 20581. Telephone: (202) 418–5515. E-mail: *gprice@cftc.gov*; or Susan Nathan, Senior Special Counsel, Division of Market Oversight, same address. Telephone: (202) 418–5133. E-mail: *snathan@cftc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The CFTC Reauthorization Act of 2008 ("Reauthorization Act") [2] significantly broadened the CFTC's regulatory authority with respect to ECMs by creating, in section 2(h)(7) of the CEA, a new regulatory category—ECMs on which significant price discovery contracts ("SPDCs") are traded—and treating ECMs in that category as registered entities under the CEA.[3] The legislation authorizes the CFTC to designate an agreement, contract or transaction as a SPDC if the Commission determines, under criteria established in section 2(h)(7), that it performs a significant price discovery function. When the Commission makes such a determination, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the Act and Commission regulations, and must comply with nine core principles established by new section 2(h)(7)(C).

On March 16, 2009, the CFTC promulgated final rules implementing the provisions of the Reauthorization Act.[4] As relevant here, rule 36.3 imposes increased information reporting requirements on ECMs to assist the Commission in making prompt assessments whether particular ECM contracts may be SPDCs. In addition to filing quarterly reports of its contracts, an ECM must notify the Commission

[1] 74 FR 52208 (October 9, 2009).

[2] Incorporated as Title XIII of the Food, Conservation and Energy Act of 2008, Public Law 110–246, 122 Stat. 1624 (June 18, 2008).

[3] 7 U.S.C. 1a(29).

[4] 74 FR 12178 (Mar. 23, 2009); these rules became effective on April 22, 2009.

promptly concerning any contract traded in reliance on the exemption in section 2(h)(3) of the CEA that averaged five trades per day or more over the most recent calendar quarter, and for which the exchange sells its price information regarding the contract to market participants or industry publications, or whose daily closing or settlement prices on 95 percent or more of the days in the most recent quarter were within 2.5 percent of the contemporaneously determined closing, settlement or other daily price of another contract.

Commission rule 36.3(c)(3) established the procedures by which the Commission makes and announces its determination whether a particular ECM contract serves a significant price discovery function. Under those procedures, the Commission will publish notice in the **Federal Register** that it intends to undertake an evaluation whether the specified agreement, contract or transaction performs a significant price discovery function and to receive written views, data and arguments relevant to its determination from the ECM and other interested persons. Upon the close of the comment period, the Commission will consider, among other things, all relevant information regarding the subject contract and issue an order announcing and explaining its determination whether or not the contract is a SPDC. The issuance of an affirmative order signals the effectiveness of the Commission's regulatory authorities over an ECM with respect to a SPDC; at that time such an ECM becomes subject to all provisions of the CEA applicable to registered entities.[5] The issuance of such an order also triggers the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4).[6]

II. Notice of Intent To Undertake SPDC Determination

On October 9, 2009, the Commission published in the **Federal Register** notice of its intent to undertake a determination whether the NTO contract performs a significant price discovery function and requested comment from interested parties.[7] Comments were received from Industrial Energy Consumers of America ("IECA"), Working Group of Commercial Energy Firms ("WGCEF"), Platts, ICE, Economists Incorporated ("EI"), Natural Gas Supply Association ("NGSA"), Federal Energy Regulatory Commission ("FERC") and Financial Institutions Energy Group ("FIEG").[8] The comment letters from FERC[9] and Platts did not directly address the issue of whether or not the NTO contract is a SPDC; IECA expressed the opinion that the NTO contract did perform a significant price discovery function; and thus, should be subject to the requirements of the core principles enumerated in Section 2(h)(7) of the Act, but did not elaborate on its reasons for saying so or directly address any of the criteria. The remaining comment letters raised substantive issues with respect to the applicability of section 2(h)(7) to the NTO contract and generally expressed the opinion that the NTO contract is not a SPDC because it does not meet the material price reference, price reference and material liquidity criteria for SPDC determination. These comments are more extensively discussed below, as applicable.

III. Section 2(h)(7) of the CEA

The Commission is directed by section 2(h)(7) of the CEA to consider the following criteria in determining a contract's significant price discovery function:

- *Price Linkage*—the extent to which the agreement, contract or transaction uses or otherwise relies on a daily or final settlement price, or other major price parameter, of a contract or contracts listed for trading on or subject to the rules of a designated contract market ("DCM") or derivatives transaction execution facility ("DTEF"), or a SPDC traded on an electronic trading facility, to value a position, transfer or convert a position, cash or financially settle a position, or close out a position.
- *Arbitrage*—the extent to which the price for the agreement, contract or transaction is sufficiently related to the price of a contract or contracts listed for trading on or subject to the rules of a designated DCM or DTEF, or a SPDC traded on or subject to the rules of an electronic trading facility, so as to permit market participants to effectively arbitrage between the markets by simultaneously maintaining positions or executing trades in the contracts on a frequent and recurring basis.
- *Material price reference*—the extent to which, on a frequent and recurring basis, bids, offers or transactions in a commodity are directly based on, or are determined by referencing or consulting, the prices generated by agreements, contracts or transactions being traded or executed on the electronic trading facility.
- *Material liquidity*—the extent to which the volume of agreements, contracts or transactions in a commodity being traded on the electronic trading facility is sufficient to have a material effect on other agreements, contracts or transactions listed for trading on or subject to the rules of a DCM, DTEF or electronic trading facility operating in reliance on the exemption in section 2(h)(3).

[5] Public Law 110–246 at 13203; *Joint Explanatory Statement of the Committee of Conference*, H.R. Rep. No. 110–627, 110 Cong., 2d Sess. 978, 986 (Conference Committee Report). See also 73 FR 75888, 75894 (Dec. 12, 2008).

[6] For an initial SPDC, ECMs have a grace period of 90 calendar days from the issuance of a SPDC determination order to submit a written demonstration of compliance with the applicable core principles. For subsequent SPDCs, ECMs have a grace period of 30 calendar days to demonstrate core principle compliance.

[7] The Commission's Part 36 rules establish, among other things, procedures by which the Commission makes and announces its determination whether a specific ECM contract serves a significant price discovery function. Under those procedures, the Commission publishes a notice in the **Federal Register** that it intends to undertake a determination whether a specified agreement, contract or transaction performs a significant price discovery function and to receive written data, views and arguments relevant to its determination from the ECM and other interested persons.

[8] IECA describes itself as an "association of leading manufacturing companies" whose membership "represents a diverse set of industries including: plastics, cement, paper, food processing, brick, chemicals, fertilizer, insulation, steel, glass, industrial gases, pharmaceutical, aluminum and brewing." WGCEF describes itself as "a diverse group of commercial firms in the domestic energy industry whose primary business activity is the physical delivery of one or more energy commodities to customers, including industrial, commercial and residential consumers" and whose membership consists of "energy producers, marketers and utilities." McGraw-Hill, through its division Platts, compiles and calculates monthly natural gas price indices from natural gas trade data submitted to Platts by energy marketers. Platts includes those price indices in its monthly *Inside FERC's Gas Market Report* ("Inside FERC"). ICE is an exempt commercial market, as noted above. EI is an economic consulting firm with offices located in Washington, DC, and San Francisco, CA. NGSA is an industry association comprised of natural gas producers and marketers. FERC is an independent federal regulatory agency that, among other things, regulates the interstate transmission of natural gas, oil and electricity. FIEG describes itself as an association of investment and commercial banks who are active participants in various sectors of the natural gas markets, "including acting as marketers, lenders, underwriters of debt and equity securities, and proprietary investors." The comment letters are available on the Commission's Web site: *http://www.cftc.gov/lawandregulation/federalregister/federalregistercomments/2009/09-021.html.*

[9] FERC stated that the NTO contract is cash settled and does not contemplate the actual physical delivery of natural gas. Accordingly, FERC expressed the opinion that a determination by the Commission that a contract performs a significant price discovery function "would not appear to conflict with FERC's exclusive jurisdiction under the Natural Gas Act (NGA) over certain sales of natural gas in interstate commerce for resale or with its other regulatory responsibilities under the NGA" and further that, "FERC staff will continue to monitor for any such conflict * * * [and] advise the CFTC" should any such potential conflict arise. CL 07.

Not all criteria must be present to support a determination that a particular contract performs a significant price discovery function, and one or more criteria may be inapplicable to a particular contract.[10] Moreover, the statutory language neither prioritizes the criteria nor specifies the degree to which a SPDC must conform to the various criteria. In Guidance issued in connection with the Part 36 rules governing ECMs with SPDCs, the Commission observed that these criteria do not lend themselves to a mechanical checklist or formulaic analysis. Accordingly, the Commission has indicated that in making its determinations it will consider the circumstances under which the presence of a particular criterion, or combination of criteria, would be sufficient to support a SPDC determination.[11] For example, for contracts that are linked to other contracts or that may be arbitraged with other contracts, the Commission will consider whether the price of the potential SPDC moves in such harmony with the other contract that the two markets essentially become interchangeable. This co-movement of prices would be an indication that activity in the contract had reached a level sufficient for the contract to perform a significant price discovery function. In evaluating a contract's price discovery role as a price reference, the Commission will consider the extent to which, on a frequent and recurring basis, bids, offers or transactions are directly based on, or are determined by referencing, the prices established for the contract.

IV. Findings and Conclusions

The NGPL TxOk Financial Basis (NTO) Contract and the SPDC Indicia

The NTO contract is cash settled based on the difference between the bidweek price index for a particular calendar month at the Natural Gas Pipeline Co. of America's ("NGPL's") TxOk [12] hub, as published in Platts' *Inside FERC's Gas Market Report*, and the final settlement price of the New York Mercantile Exchange's ("NYMEX's") physically-delivered Henry Hub natural gas futures contract for the same calendar month. The Platts bidweek price, which is published monthly, is based on a survey of cash market traders who voluntarily report to Platts data on their fixed-price transactions conducted during the last five business days of the month for physical delivery of natural gas at the TxOk hub; such bidweek transactions specify the delivery of natural gas on a uniform basis throughout the following calendar month at the agreed upon rate. The Platts bidweek index is published on the first business day of the calendar month in which the natural gas is to be delivered. The size of the TxOk contract is 2,500 million British thermal units ("mmBtu"), and the unit of trading is any multiple of 2,500 mmBtu. The TxOk contract is listed for up to 72 consecutive calendar months.

The Henry Hub,[13] which is located in Erath, Louisiana, is the primary cash market trading and distribution center for natural gas in the United States. It also is the delivery point and pricing basis for the NYMEX's actively traded, physically-delivered natural gas futures contract, which is the most important pricing reference for natural gas in the United States. The Henry Hub, which is operated by Sabine Pipe Line, LLC, serves as a juncture for 13 different pipelines. These pipelines bring in natural gas from fields in the Gulf Coast region and ship it to major consumption centers along the East Coast and Midwest. The throughput shipping capacity of the Henry Hub is 1.8 trillion mmBtu per day.

In addition to the Henry Hub, there are a number of other locations where natural gas is traded. In 2008, there were 33 natural gas market centers in North America.[14] Some of the major trading centers include Alberta, Northwest Rockies, Southern California border and the Houston Ship Channel. For locations that are directly connected to the Henry Hub by one or more pipelines and where there typically is adequate shipping capacity, the price at the other locations usually directly tracks the price at the Henry Hub, adjusted for transportation costs. However, at other locations that are not directly connected to the Henry Hub or where shipping capacity is limited, the prices at those locations often diverge from the Henry Hub price. Furthermore, one local price may be significantly different than the price at another location even though the two markets' respective distances from the Henry Hub are the same. The reason for such pricing disparities is that a given location may experience supply and demand factors that are specific to that region, such as differences in pipeline shipping capacity, unusually high or low demand for heating or cooling or supply disruptions caused by severe weather. As a consequence, local natural gas prices can differ from the Henry Hub price by more than the cost of shipping and such price differences can vary in an unpredictable manner.

NGPL transports natural gas from production areas in the Permian Basin in Texas and the Gulf of Mexico to various demand points northward through the Midwest up to Chicago. NGPL is one of the largest natural gas transportation systems in the United States, with over 9,800 miles of pipeline. Moreover, NGPL is the largest provider of natural gas to the Chicago market.[15] The TxOk section of the NGPL pipeline network is located in Sayre, Oklahoma (on the border with Texas), and has a large underground natural gas storage facility. The NGPL TxOk hub is a major natural gas trading center in the Gulf region of the U.S.

As noted, the NTO contract prices trading activity at the NGPL TxOk hub. The Carthage hub, a natural gas market center located in east Texas includes the NGPL TxOk hub. The Carthage natural gas market center had an estimated throughput capacity of 600 million cubic feet per day in 2008. Additionally, the number of pipeline interconnection capacity at the Carthage hub was 11 in 2008, up from 9 in 2003. The interconnection capacity of these pipelines in 2008 was 1.7 billion cubic feet per day, an increase of 12 percent from 2003.[16] Finally, as noted, the NGPL has an extensive network of about 9,800 miles of interstate pipelines. The NTO hub is far removed from the Henry Hub but is directly connected to the Henry Hub through interstate pipeline connections.

The local price at the TxOk hub typically differs from the price at the Henry Hub. Thus, the price of the Henry Hub physically-delivered futures contract is an imperfect proxy for the NTO price. Moreover, exogenous factors, such as adverse weather, can cause the NTO gas price to differ from the Henry Hub price by an amount that is more or less than the cost of shipping, making the NYMEX Henry Hub futures

[10] In its October 9, 2009, **Federal Register** release, the Commission identified material price reference, price linkage and material liquidity as the possible criteria for SPDC determination of the NTO contract. Arbitrage was not identified as a possible criterion. As a result, arbitrage will not be discussed further in this document and the associated Order.

[11] 17 CFR part 36, Appendix A.

[12] Refers to Texas/Oklahoma.

[13] The term "hub" refers to a juncture where two or more natural gas pipelines are connected. Hubs also serve as pricing points for natural gas at the particular locations.

[14] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[15] Kinder Morgan, Inc., is the operator and co-owner (20 percent) of NGPL. (Myria Holdings, Inc., owns 80 percent of NGPL). *See http://www.kne.com/business/gas_pipelines/NGPL//.*

[16] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

contract even less precise as a hedging tool than desired by market participants. Basis contracts [17] allow traders to more accurately discover prices at alternative locations and hedge price risk that is associated with natural gas at such locations. In this regard, a position at a local price for an alternative location can be established by adding the appropriate basis swap position to a position taken in the NYMEX physically-delivered Henry Hub contract (or in the NYMEX or ICE Henry Hub look-alike contract, which cash settle based on the NYMEX physically-delivered natural gas contract's final settlement price).

In its October 9, 2009, **Federal Register** notice, the Commission identified material price reference, price linkage and material liquidity as the potential SPDC criteria applicable to the NTO contract. Each of these criteria is discussed below.[18]

1. Material Price Reference Criterion

The Commission's October 9, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission considered the fact that ICE sells its price data to market participants in a number of different packages which vary in terms of the hubs covered, time periods, and whether the data are daily only or historical. For example, ICE offers the "Micontient Gas End of Day" and "OTC Gas End of Day" [19] packages with access to all price data or just current prices plus a selected number of months (i.e., 12, 24, 36 or 48 months) of historical data. These two packages include price data for the NTO contract.

The Commission also noted that its October 2007 *Report on the Oversight of Trading on Regulated Futures Exchanges and Exempt Commercial Markets* ("ECM Study") [20] found that in general, market participants view the ICE as a price discovery market for certain natural gas contracts. The study did not specify which markets performed this function; nevertheless, the Commission determined that the NTO contract, while not mentioned by name in the ECM Study, might warrant further analysis.

The Commission will rely on one of two sources of evidence—direct or indirect—to determine that the price of a contract was being used as a material price reference and therefore, serving a significant price discovery function.[21] With respect to direct evidence, the Commission will consider the extent to which, on a frequent and recurring basis, cash market bids, offers or transactions are directly based on or quoted at a differential to, the prices generated on the ECM in question. Direct evidence may be established when cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract in question. Cash market prices are set explicitly at a differential to the section 2(h)(3) contract when, for instance, they are quoted in dollars and cents above or below the reference contract's price. Cash market prices are set implicitly at a differential to a section 2(h)(3) contract when, for instance, they are arrived at after adding to, or subtracting from the section 2(h)(3) contract, but then quoted or reported at a flat price. With respect to indirect evidence, the Commission will consider the extent to which the price of the contract in question is being routinely disseminated in widely distributed industry publications—or offered by the ECM itself for some form of remuneration—and consulted on a frequent and recurring basis by industry participants in pricing cash market transactions.

Following the issuance of the **Federal Register** release, the Commission further evaluated the ICE's data offerings and their use by industry participants. Although the TxOk hub is a major trading center for natural gas in the United States and, as noted, ICE sells price information for the NTO contract, the Commission has found upon further evaluation that cash market transactions are not being directly based on or quoted as a differential to the NTO contract nor is that contract routinely consulted by industry participants in pricing cash market transactions and thus does not meet the Commission's Guidance for the material price reference criterion. In this regard, the NYMEX Henry Hub physically delivered natural gas futures contract is routinely consulted by industry participants in pricing cash market transactions at this location. Because the TxOk hub is directly connected to the Henry Hub, it is not necessary for market participants to independently refer to the NTO contract for pricing natural gas at this location. Thus, the NTO contract does not satisfy the direct price reference test for existence of material price reference. Furthermore, the Commission notes that publication of the NTO contract's prices is not indirect evidence material price reference. The NTO contract's prices are published with those of numerous other contracts, which are of more interest to market participants. Due to the lack of importance of the TxOk hub, the Commission has concluded that traders likely do not specifically purchase the ICE data packages for the NTO contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions.

i. Federal Register Comments

As noted above, WGCEF, ICE, EI, NGSA and FIEG addressed the question of whether the NTO contract met the material price reference criterion for a SPDC.[22] The commenters argued that because the NTO contract is cash-settled, it cannot truly serve as an independent "reference price" for transactions in natural gas at this location. Rather, the commenters argue, the underlying cash price series against which the ICE NTO contract is settled (in this case, the differential between the NYMEX last settlement price for a particular month and the NGPL's price for the same month for natural gas at this location) is the authentic reference price and not the ICE contract itself. The Commission believes that this interpretation of price reference is too limiting and believes that a cash-settled derivatives contract could meet the price reference criterion if market participants "consult on a frequent and recurring basis" the derivatives contract when pricing forward, fixed-price commitments or other cash-settled derivatives that seek to "lock in" a fixed price for some future point in time to hedge against adverse price movements.

ICE also argued that the Commission appeared to base the case that the NTO contract is potentially a SPDC on a disputable assertion. In issuing its notice of intent to determine whether the NTO contract is a SPDC, the CFTC cited a general conclusion in its ECM Study "that certain market participants referred to ICE as a price discovery market for certain natural gas contracts."

[17] Basis contracts denote the difference in the price of natural gas at a specified location minus the price of natural gas at the Henry Hub. The differential can be either a positive or negative value.

[18] As noted above, the Commission did not find an indication of arbitrage in connection with this contract; accordingly, that criterion was not discussed in reference to the NTO contract.

[19] The OTC Gas End of Day dataset includes daily settlement prices for natural gas contracts listed for all points in North America.

[20] *http://www.cftc.gov/ucm/groups/public/@newsroom/documents/file/pr5403-07_ecmreport.pdf.*

[21] 17 CFR part 36, Appendix A.

[22] As noted above, IECA expressed the opinion that the PER contract met the criteria for SPDC determination but did not provide its reasoning.

ICE states that CFTC's conclusion is "hard to quantify as the ECM report does not mention" this contract as a potential SPDC. "It is unknown which market participants made this statement in 2007 or the contracts that were referenced." In response to the above comment, the Commission notes that it cited the ECM study's general finding that some ICE natural gas contracts appear to be regarded as price discovery markets merely as indicia that an investigation of certain ICE contracts may be warranted. The ECM Study was not intended to serve as the sole basis for determining whether or not a particular contract meets the material price reference criterion.

Both EI [23] and WGCEF [24] stated that publication of price data in a package format is a weak justification for material price reference. These commenters argue that market participants generally do not purchase ICE data sets for one contract's prices, such as those for the NTO contract. Instead, traders are interested in the settlement prices, so the fact that ICE sells the NTO prices as part of a broad package is not conclusive evidence that market participants are buying the ICE data sets because they find the NTO prices have substantial value to them. As noted above, the Commission notes that publication of the NTO contract's prices is not indirect evidence of routine dissemination. The NTO contract's prices are published with those of numerous other contracts, which are of more interest to market participants. Due to the lack of importance of the TxOk hub, the Commission has concluded that traders likely do not specifically purchase the ICE data packages for the NTO contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions.

ii. Conclusion Regarding Material Price Reference

Based on the above, the Commission finds that the NTO contract does not meet the material price reference criterion because cash market transactions are not priced either explicitly or implicitly on a frequent and recurring basis at a differential to the NTO contract's price (direct evidence). Moreover, while the ECM sells the NTO contract's price data to market participants, market participants likely do not specifically purchase the ICE data packages for the NTO contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions (indirect evidence).

2. Price Linkage Criterion

In its October 9, 2009, **Federal Register** notice, the Commission identified price linkage as a potential basis for a SPDC determination with respect to the NTO contract. In this regard, the final settlement of the NTO contract is based, in part, on the final settlement price of the NYMEX's physically-delivered natural gas futures contract, where the NYMEX is registered with the Commission as a DCM.

The Commission's Guidance on Significant Price Discovery Contracts [25] notes that a "price-linked contract is a contract that relies on a contract traded on another trading facility to settle, value or otherwise offset the price-linked contract." Furthermore, the Guidance notes that, "[f]or a linked contract, the mere fact that a contract is linked to another contract will not be sufficient to support a determination that a contract performs a significant price discovery function. To assess whether such a determination is warranted, the Commission will examine the relationship between transaction prices of the linked contract and the prices of the referenced contract. The Commission believes that where material liquidity exists, prices for the linked contract would be observed to be substantially the same as or move substantially in conjunction with the prices of the referenced contract." Furthermore, the Guidance proposes a threshold price relationship such that prices of the ECM linked contract will fall within a 2.5 percent price range for 95 percent of contemporaneously determined closing, settlement or other daily prices over the most recent quarter. Finally, in Guidance the Commission stated that it would consider a linked contract that has a trading volume equivalent to 5 percent of the volume of trading in the contract to which it is linked to have sufficient volume to be deemed a SPDC ("minimum threshold").

To assess whether the NTO contract meets the price linkage criterion, Commission staff obtained price data from ICE and performed the statistical tests cited above. Staff found that, while the NTO contract price is determined, in part, by the final settlement price of the NYMEX physically-delivered natural gas futures contract (a DCM contract), the imputed TxOk location price (derived by adding the NYMEX Henry Hub Natural Gas price to the ICE NTO basis price) is not within 2.5 percent of the settlement price of the corresponding NYMEX Henry Hub natural gas futures contract on 95 percent or more of the days. Specifically, during the third quarter of 2009, only 3.3 percent of the NTO natural gas prices derived from the ICE basis values were within 2.5 percent of the daily settlement price of the NYMEX Henry Hub futures contract. In addition, staff found that the NTO contract fails to meet the volume threshold requirement. In particular, the total trading volume in the NYMEX Natural Gas contract during the third quarter of 2009 was 14,022,963 contracts, with 5 percent of that number being 701,148 contracts. Trades on the ICE centralized market in the NTO contract during the same period were 68,792 contracts (equivalent to 17,198 NYMEX contracts, given the size difference).[26] Thus, centralized-market trades in the NTO contract amounted to less than the minimum volume threshold.[27]

i. Federal Register Comments

As noted above, WGCEF, ICE, EI, NGSA and FIEG addressed the question of whether the NTO contract met the price linkage criterion for a SPDC.[28] Each of the commenters expressed the opinion that the NTO contract did not appear to meet the above-discussed Commission guidance regarding the price relationship and/or the minimum volume threshold relative to the DCM contract to which the NTO is linked. Based on its analysis discussed above, the Commission agrees with this assessment.

ii. Conclusion Regarding the Price Linkage Criterion

Based on the above, the Commission finds that the NTO contract does not meet the price linkage criterion because it fails the price relationship and volume tests provided for in the Commission's Guidance.

3. Material Liquidity Criterion

As noted above, in its October 9, 2009, **Federal Register** notice, the Commission identified price linkage, material price reference, and material liquidity as potential criteria for SPDC

[23] CL 05.

[24] CL 02.

[25] Appendix A to the Part 36 rules.

[26] The size of the NYMEX Henry Hub physically-delivered natural gas futures contract is 10,000 mmBtu. The NTO contract has a trading unit of 2,500 mmBtu, which is one-quarter the size of the NYMEX Henry Hub contract.

[27] Supplemental data subsequently submitted by the ICE indicated that block trades are included in the on-exchange trades; block trades comprise 59 percent of all transactions in the NTO contract.

[28] As noted above, IECA expressed the opinion that the NTO contract met the criteria for SPDC determination but did not provide its reasoning.

determination of the NTO contract. To assess whether a contract meets the material liquidity criterion, the Commission first examines trading activity as a general measurement of the contract's size and potential importance. If the Commission finds that the contract in question meets a threshold of trading activity that would render it of potential importance, the Commission will then perform a statistical analysis to measure the effect that the prices of the subject contract potentially may have on prices for other contracts listed on an ECM or a DCM.

The total number of transactions executed on ICE's electronic platform in the NTO contract was 1,083 in the second quarter of 2009, resulting in a daily average of 16.9 trades. During the same period, the NTO contract had a total trading volume of 84,432 contracts and an average daily trading volume of 1,319.3 contracts. Moreover, open interest as of June 30, 2009, was 70,557 contracts, which included trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing. In this regard, ICE does not differentiate between open interest created by a transaction executed on its trading platform and that created by a transaction executed off its trading platform.[29]

In a subsequent filing dated November 13, 2009, ICE reported that total trading volume in the third quarter of 2009 was 68,792 contracts (or 1,042 contracts on a daily basis). In terms of number of transactions, 688 trades occurred in the third quarter of 2009 (10.4 trades per day). As of September 30, 2009, open interest in the NTO contract was 97,786 contracts, which included trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing.

As indicated above, the average number of trades per day in the second and third quarters of 2009 was only marginally above the minimum reporting level (5 trades per day). Moreover, trading activity in the NTO contract, as characterized by total quarterly volume, indicates that the NTO contract experiences trading activity similar to that of other thinly-traded contracts.[30] Thus, the NTO contract does not meet a threshold of trading activity that would render it of potential importance and no additional statistical analysis is warranted.[31]

i. Federal Register Comments

As noted above, WGCEF, ICE, EI, NGSA and FIEG addressed the question of whether the NTO contract met the material liquidity criterion for a SPDC.[32] These commenters stated that the NTO contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

WGCEF,[33] ICE[34] and EI[35] noted that the Commission's Guidance had posited concepts of liquidity that generally assumed a fairly constant stream of prices throughout the trading day, and noted that the relatively low number of trades per day in the NTO contract did not meet this standard of liquidity. The Commission observes that a continuous stream of prices would indeed be an indication of liquidity for certain markets, but the Guidance also notes that "quantifying the levels of immediacy and price concession that would define material liquidity may differ from one market or commodity to another."[36]

WGCEF, FIEG[37] and NGSA[38] noted that the NTO contract represents a differential, which does not affect other contracts, including the NYMEX Henry Hub contract and physical gas contracts. FIEG and WGCEF also noted that the NTO contract's trading volume represents only a fraction of natural gas trading.

ICE opined that the Commission "seems to have adopted a five trade-per-day test to determine whether a contract is materially liquid. It is worth noting that ICE originally suggested that the CFTC use a five trades-per-day threshold as the basis for an ECM to *report* trade data to the CFTC." Furthermore, FIEG cautioned the Commission in using a reporting threshold as a measure of liquidity. In this regard, the Commission adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs"[39] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC but this does not mean that the contract will be found to be a SPDC merely because it met the reporting threshold.

ICE and EI proposed that the statistics provided by ICE were misinterpreted and misapplied by the Commission. In particular, ICE stated that the volume figures used in the Commission's analysis (cited above) "include trades made in *all months of each contract*" as well as in strips of contract months, and a "more appropriate method of determining liquidity is to examine the activity in a single traded month or strip of a given contract."[40] A similar argument was made by EI, which observed that the five-trades-per-day number "is highly misleading * * * because the contracts can be offered for as long as 120 months, [thus] the average per day for an individual contract may be less than 1 per day."

It is the Commission's opinion that liquidity, as it pertains to the NTO contract, is typically a function of trading activity in particular lead months and, given sufficient liquidity in such months, the ICE NTO contract

[29] 74 FR 52208 (October 9, 2009).

[30] Staff has advised the Commission that in its experience, a thinly-traded contract is, generally, one that has a quarterly trading volume of 100,000 contracts or less. In this regard, in the third quarter of 2009, physical commodity futures contracts with trading volume of 100,000 contracts or fewer constituted less than one percent of total trading volume of all physical commodity futures contracts.

[31] In establishing guidance to illustrate how it will evaluate the various criteria, or combinations of criteria, when determining whether a contract is a SPDC, the Commission made clear that "material liquidity itself would not be sufficient to make a determination that a contract is a [SPDC], * * * but combined with other factors it can serve as a guidepost indicating which contracts are functioning as [SPDCs]." For the reasons discussed above, the Commission has found that the NTO contract does not meet either the price linkage or material price reference criterion. In light of this finding and the Commission's Guidance cited above, there is no need to evaluate further the material liquidity criteria since it cannot be used alone as a basis for a SPDC determination.

[32] As noted above, IECA expressed the opinion that the NTO contract met the criteria for SPDC determination but did not provide its reasoning.

[33] CL 02.

[34] CL 04.

[35] CL 05.

[36] 17 CFR 36, Appendix A.

[37] CL 08.

[38] CL 06.

[39] 73 FR 75892 (December 12, 2008).

[40] In addition, both EI and ICE stated that the trades-per-day statistics that it provided to the Commission in its quarterly filing and which were cited in the Commission's October 9, 2009, **Federal Register** notice includes 2(h)(1) transactions, which were not completed on the electronic trading platform and should not be considered in the SPDC determination process. The Commission staff asked ICE to review the data it sent in its quarterly filings; ICE confirmed that the volume data it provided and which the Commission cited includes only transaction data executed on ICE's electronic trading platform. As noted above, supplemental data supplied by ICE confirmed that block trades are in addition to the trades that were conducted on the electronic platform; block trades comprise 59 percent of all transactions in the NTO contract. The Commission acknowledges that the open interest information it provided in its October 9, 2009, **Federal Register** notice includes transactions made off the ICE platform. However, once open interest is created, there is no way for ICE to differentiate between "on-exchange" versus "off-exchange" created positions, and all such positions are fungible with one another and may be offset in any way agreeable to the position holder regardless of how the position was initially created.

itself would be considered liquid. In any event, in light of the fact that the Commission has found that the NTO contract does not meet the material price reference or price linkage criteria, according to the Commission's Guidance, it would be unnecessary to evaluate whether the NTO contract meets the material liquidity criterion since it cannot be used alone for SPDC determination.

ii. Conclusion Regarding Material Liquidity

For the reasons discussed above, the Commission has found that the NTO contract does not meet the material liquidity criterion.

4. Overall Conclusion

After considering the entire record in this matter, including the comments received, the Commission has determined that the NTO contract does not meet the material price criterion, price linkage and material liquidity criteria. Thus, the NTO contract does not perform a significant price discovery function under the criteria established in section 2(h)(7) of the CEA. Accordingly, the Commission will issue the attached Order declaring that the NTO contract is not a SPDC.

Issuance of this Order indicates that the Commission does not at this time regard ICE as a registered entity in connection with its NTO contract.[41] Accordingly, with respect to its NTO contract, ICE is not required to comply with the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) for ECMs with SPDCs. However, ICE must continue to comply with the applicable reporting requirements.

IV. Related Matters

a. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 ("PRA")[42] imposes certain requirements on Federal agencies, including the Commission, in connection with their conducting or sponsoring any collection of information as defined by the PRA. Certain provisions of Commission rule 36.3 impose new regulatory and reporting requirements on ECMs, resulting in information collection requirements within the meaning of the PRA. OMB previously has approved and assigned OMB control number 3038–0060 to this collection of information.

b. Cost-Benefit Analysis

Section 15(a) of the CEA[43] requires the Commission to consider the costs and benefits of its actions before issuing an order under the Act. By its terms, section 15(a) does not require the Commission to quantify the costs and benefits of an order or to determine whether the benefits of the order outweigh its costs; rather, it requires that the Commission "consider" the costs and benefits of its actions. Section 15(a) further specifies that the costs and benefits shall be evaluated in light of five broad areas of market and public concern: (1) Protection of market participants and the public; (2) efficiency, competitiveness and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. The Commission may in its discretion give greater weight to any one of the five enumerated areas and could in its discretion determine that, notwithstanding its costs, a particular order is necessary or appropriate to protect the public interest or to effectuate any of the provisions or accomplish any of the purposes of the Act. The Commission has considered the costs and benefits in light of the specific provisions of section 15(a) of the Act and has concluded that the Order, required by Congress to strengthen federal oversight of exempt commercial markets and to prevent market manipulation, is necessary and appropriate to accomplish the purposes of section 2(h)(7) of the Act.

When a futures contract begins to serve a significant price discovery function, that contract, and the ECM on which it is traded, warrants increased oversight to deter and prevent price manipulation or other disruptions to market integrity, both on the ECM itself and in any related futures contracts trading on DCMs. An Order fining that a particular contract is a SPDC triggers this increased oversight and imposes obligations on the ECM calculated to accomplish this goal. The increased oversight engendered by the issue of a SPDC Order increases transparency and helps to ensure fair competition among ECMs and DCMs trading similar products and competing for the same business. Moreover, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the CEA and Commission regulations. Additionally, the ECM must comply with nine core principles established by section 2(h)(7) of the Act—including the obligation to establish position limits and/or accountability standards for the SPDC. Amendments to section 4(i) of the CEA authorize the Commission to require reports for SPDCs listed on ECMs. These increased responsibilities, along with the CFTC's increased regulatory authority, subject the ECM's risk management practices to the Commission's supervision and oversight and generally enhance the financial integrity of the markets.

The Commission has concluded that ICE's NTO contract, which is the subject of the attached Order, is not a SPDC; accordingly, the Commission's Order imposes no additional costs and no additional statutorily or regulatory mandated responsibilities on the ECM.

c. Regulatory Flexibility Act

The Regulatory Flexibility Act ("RFA")[44] requires that agencies consider the impact of their rules on small businesses. The requirements of CEA section 2(h)(7) and the Part 36 rules affect exempt commercial markets. The Commission previously has determined that exempt commercial markets are not small entities for purposes of the RFA.[45] Accordingly, the Chairman, on behalf of the Commission, hereby certifies pursuant to 5 U.S.C. 605(b) that this Order, taken in connection with section 2(h)(7) of the Act and the Part 36 rules, will not have a significant impact on a substantial number of small entities.

V. Order

Order Relating to the NGPL TxOk Financial Basis Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following Order:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the NGPL TxOk Financial Basis contract, traded on the IntercontinentalExchange, Inc., does not at this time satisfy the material price reference, price linkage and material liquidity criteria for significant price discovery contracts. Consistent with this determination, the IntercontinentalExchange, Inc., is not considered a registered entity[46] with respect to the NTO Financial Basis contract and is not subject to the provisions of the Commodity Exchange

[41] *See* 73 FR 75888, 75893 (Dec. 12, 2008).

[42] 44 U.S.C. 3507(d).

[43] 7 U.S.C. 19(a).

[44] 5 U.S.C. 601 *et seq.*

[45] 66 FR 42256, 42268 (Aug. 10, 2001).

[46] 7 U.S.C. 1a(29).

Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the IntercontinentalExchange, Inc., are not applicable to the NGPL TxOk Financial Basis contract with the issuance of this Order.

This Order is based on the representations made to the Commission by the IntercontinentalExchange, Inc., dated July 27, 2009, and November 13, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the NGPL TxOk Financial Basis contract is not a significant price discovery contract. Additionally, to the extent that it continues to rely upon the exemption in Section 2(h)(3) of the Act, the IntercontinentalExchange, Inc., must continue to comply with all of the applicable requirements of Section 2(h)(3) and Commission Regulation 36.3.

Issued in Washington, DC on April 28, 2010, by the Commission.

David A. Stawick,

Secretary of the Commission.

[FR Doc. 2010–10308 Filed 5–3–10; 8:45 am]

BILLING CODE P

COMMODITY FUTURES TRADING COMMISSION

Order Finding That the AECO Financial Basis Contract Traded on the IntercontinentalExchange, Inc., Performs a Significant Price Discovery Function

AGENCY: Commodity Futures Trading Commission.

ACTION: Final order.

SUMMARY: On October 9, 2009, the Commodity Futures Trading Commission ("CFTC" or "Commission") published for comment in the **Federal Register** [1] a notice of its intent to undertake a determination whether the AECO Financial Basis ("AEC") contract traded on the IntercontinentalExchange, Inc. ("ICE"), an exempt commercial market ("ECM") under sections 2(h)(3)–(5) of the Commodity Exchange Act ("CEA" or the "Act"), performs a significant price discovery function pursuant to section 2(h)(7) of the CEA. The Commission undertook this review based upon an initial evaluation of information and data provided by ICE as well as other available information. The Commission has reviewed the entire record in this matter, including all comments received, and has determined to issue an order finding that the AEC contract performs a significant price discovery function. Authority for this action is found in section 2(h)(7) of the CEA and Commission rule 36.3(c) promulgated thereunder.

DATES: *Effective date:* April 28, 2010.

FOR FURTHER INFORMATION CONTACT: Gregory K. Price, Industry Economist, Division of Market Oversight, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW., Washington, DC 20581. Telephone: (202) 418–5515. E-mail: *gprice@cftc.gov;* or Susan Nathan, Senior Special Counsel, Division of Market Oversight, same address. Telephone: (202) 418–5133. E-mail: *snathan@cftc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The CFTC Reauthorization Act of 2008 ("Reauthorization Act") [2] significantly broadened the CFTC's regulatory authority with respect to ECMs by creating, in section 2(h)(7) of the CEA, a new regulatory category—ECMs on which significant price discovery contracts ("SPDCs") are traded—and treating ECMs in that category as registered entities under the CEA.[3] The legislation authorizes the CFTC to designate an agreement, contract or transaction as a SPDC if the Commission determines, under criteria established in section 2(h)(7), that it performs a significant price discovery function. When the Commission makes such a determination, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the Act and Commission regulations, and must comply with nine core principles established by new section 2(h)(7)(C).

On March 16, 2009, the CFTC promulgated final rules implementing the provisions of the Reauthorization Act.[4] As relevant here, rule 36.3 imposes increased information reporting requirements on ECMs to assist the Commission in making prompt assessments whether particular ECM contracts may be SPDCs. In addition to filing quarterly reports of its contracts, an ECM must notify the Commission promptly concerning any contract traded in reliance on the exemption in section 2(h)(3) of the CEA that averaged five trades per day or more over the most recent calendar quarter, and for which the exchange sells its price information regarding the contract to market participants or industry publications, or whose daily closing or settlement prices on 95 percent or more of the days in the most recent quarter were within 2.5 percent of the contemporaneously determined closing, settlement or other daily prices of another contract.

Commission rule 36.3(c)(3) established the procedures by which the Commission makes and announces its determination whether a particular ECM contract serves a significant price discovery function. Under those procedures, the Commission will publish notice in the **Federal Register** that it intends to undertake an evaluation whether the specified agreement, contract or transaction performs a significant price discovery function and to receive written views, data and arguments relevant to its determination from the ECM and other interested persons. Upon the close of the comment period, the Commission will consider, among other things, all relevant information regarding the subject contract and issue an order announcing and explaining its determination whether or not the contract is a SPDC. The issuance of an affirmative order signals the effectiveness of the Commission's regulatory authorities over an ECM with respect to a SPDC; at that time such an ECM becomes subject to all provisions of the CEA applicable to registered entities.[5] The issuance of such an order also triggers the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4).[6]

II. Notice of Intent To Undertake SPDC Determination

On October 9, 2009, the Commission published in the **Federal Register** notice of its intent to undertake a determination whether the AEC contract performs a significant price discovery function and requested comment from

[1] 74 FR 52196 (October 9, 2009).

[2] Incorporated as Title XIII of the Food, Conservation and Energy Act of 2008, Public Law 110–246, 122 Stat. 1624 (June 18, 2008).

[3] 7 U.S.C. 1a(29).

[4] 74 FR 12178 (Mar. 23, 2009); these rules became effective on April 22, 2009.

[5] Public Law 110–246 at 13203; *Joint Explanatory Statement of the Committee of Conference,* H.R. Rep. No. 110–627, 110 Cong., 2d Sess. 978, 986 (Conference Committee Report). See also 73 FR 75888, 75894 (Dec. 12, 2008).

[6] For an initial SPDC, ECMs have a grace period of 90 calendar days from the issuance of a SPDC determination order to submit a written demonstration of compliance with the applicable core principles. For subsequent SPDCs, ECMs have a grace period of 30 calendar days to demonstrate core principle compliance.

interested parties.[7] Comments were received from the Industrial Energy Consumers of America ("IECA"), Working Group of Commercial Energy Firms ("WGCEF"), ICE, Economists Incorporated ("EI"), Natural Gas Supply Association ("NGSA"), Federal Energy Regulatory Commission ("FERC"), Financial Institutions Energy Group ("FIEG") and an anonymous individual.[8] The comment letter from FERC[9] did not directly address the issue of whether or not the AEC contract is a SPDC; IECA[10] and the anonymous commenter[11] concluded that the AEC contract is a SPDC, but did not provide a basis for their conclusions.[12] The other parties' comments raised substantive issues with respect to the applicability of section 2(h)(7) to the AEC contract, generally asserting that the AEC contract is not a SPDC as it does not meet the material liquidity, material price reference and price linkage criteria for SPDC determination. Those comments are more extensively discussed below, as applicable.

III. Section 2(h)(7) of the CEA

The Commission is directed by section 2(h)(7) of the CEA to consider the following criteria in determining a contract's significant price discovery function:

- *Price Linkage*—the extent to which the agreement, contract or transaction uses or otherwise relies on a daily or final settlement price, or other major price parameter, of a contract or contracts listed for trading on or subject to the rules of a designated contract market ("DCM") or derivatives transaction execution facility ("DTEF"), or a SPDC traded on an electronic trading facility, to value a position, transfer or convert a position, cash or financially settle a position, or close out a position.
- *Arbitrage*—the extent to which the price for the agreement, contract or transaction is sufficiently related to the price of a contract or contracts listed for trading on or subject to the rules of a DCM or DTEF, or a SPDC traded on or subject to the rules of an electronic trading facility, so as to permit market participants to effectively arbitrage between the markets by simultaneously maintaining positions or executing trades in the contracts on a frequent and recurring basis.
- *Material price reference*—the extent to which, on a frequent and recurring basis, bids, offers or transactions in a commodity are directly based on, or are determined by referencing, the prices generated by agreements, contracts or transactions being traded or executed on the electronic trading facility.
- *Material liquidity*—the extent to which the volume of agreements, contracts or transactions in a commodity being traded on the electronic trading facility is sufficient to have a material effect on other agreements, contracts or transactions listed for trading on or subject to the rules of a DCM, DTEF or electronic trading facility operating in reliance on the exemption in section 2(h)(3).

Not all criteria must be present to support a determination that a particular contract performs a significant price discovery function, and one or more criteria may be inapplicable to a particular contract.[13] Moreover, the statutory language neither prioritizes the criteria nor specifies the degree to which a SPDC must conform to the various criteria. In Guidance issued in connection with the Part 36 rules governing ECMs with SPDCs, the Commission observed that these criteria do not lend themselves to a mechanical checklist or formulaic analysis. Accordingly, the Commission has indicated that in making its determinations it will consider the circumstances under which the presence of a particular criterion, or combination of criteria, would be sufficient to support a SPDC determination.[14] For example, for contracts that are linked to other contracts or that may be arbitraged with other contracts, the Commission will consider whether the price of the potential SPDC moves in such harmony with the other contract that the two markets essentially become interchangeable. This co-movement of prices would be an indication that activity in the contract had reached a level sufficient for the contract to perform a significant price discovery function. In evaluating a contract's price discovery role as a price reference, the Commission will consider whether cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract.

IV. Findings and Conclusions

a. The AECO Financial Basis (AEC) Contract and the SPDC Indicia

The AEC contract is cash settled based on the difference between the AECO–C & Nova Inventory Transfer (Alberta) price index for natural gas in the month of production, as reported in the first publication of the month of Canadian Enerdata, Ltd.'s *Canadian Gas Price Reporter* ("CGPR") and the final settlement price for the New York Mercantile Exchange's ("NYMEX's") Henry Hub physically-delivered natural gas futures contract for the same specified calendar month. The transactions used to calculate the

[7] The Commission's Part 36 rules establish, among other things, procedures by which the Commission makes and announces its determination whether a specific ECM contract serves a significant price discovery function. Under those procedures, the Commission publishes a notice in the **Federal Register** that it intends to undertake a determination whether a specified agreement, contract or transaction performs a significant price discovery function and to receive written data, views and arguments relevant to its determination from the ECM and other interested persons.

[8] IECA describes itself as an "association of leading manufacturing companies" whose membership "represents a diverse set of industries including: plastics, cement, paper, food processing, brick, chemicals, fertilizer, insulation, steel, glass, industrial gases, pharmaceutical, aluminum and brewing." WGCEF describes itself as "a diverse group of commercial firms in the domestic energy industry whose primary business activity is the physical delivery of one or more energy commodities to customers, including industrial, commercial and residential consumers" and whose membership consists of "energy producers, marketers and utilities." ICE is an ECM, as noted above. EI is an economic consulting firm with offices located in Washington, DC, and San Francisco, CA. NGSA is an industry association comprised of natural gas producers and marketers. FERC is an independent federal regulatory agency that, among other things, regulates the interstate transmission of natural gas, oil and electricity. FIEG describes itself as an association of investment and commercial banks who are active participants in various sectors of the natural gas markets, "including acting as marketers, lenders, underwriters of debt and equity securities, and proprietary investors." The comment letters are available on the Commission's Web site: *http://www.cftc.gov/lawandregulation/federalregister/federalregistercomments/2009/09-016.html.*

[9] FERC stated that the AEC contract is cash settled and does not contemplate actual physical delivery of natural gas. Accordingly, FERC expressed the opinion that a determination by the Commission that a contract performs a significant price discovery function "would not appear to conflict with FERC's exclusive jurisdiction under the Natural Gas Act (NGA) over certain sales of natural gas in interstate commerce for resale or with its other regulatory responsibilities under the NGA" and further that "FERC staff will continue to monitor for any such conflict . . . [and] advise the CFTC" should any such potential conflict arise. CL 06.

[10] CL 01.

[11] CL 08.

[12] IECA stated that the subject ICE contract should "be required to come into compliance with core principles mandated by Section 2(h)(7) of the Act and with other statutory provisions applicable to registered entities. [This contract] should be subject to the Commission's position limit authority, emergency authority and large trader reporting requirements, among others." CL 01.

[13] In its October 9, 2009, **Federal Register** release, the Commission identified material price reference, price linkage and material liquidity as the possible criteria for SPDC determination of the AEC contract. Arbitrage was not identified as a possible criterion and will not be discussed further in this document or the associated Order.

[14] 17 CFR part 36, appendix A.

monthly Alberta price index are those that are conducted on the Natural Gas Exchange ("NGX") in a given month and specify the delivery of natural gas at the Alberta hub in the following month. The Alberta price index is computed as the volume-weighted average of the applicable natural gas transactions. The size of the AEC contract is 2,500 million British thermal units ("mmBtu"), and the unit of trading is any multiple of 2,500 mmBtu. The AEC contract is listed for up to 120 calendar months commencing with the next calendar month.

The Henry Hub,[15] which is located in Erath, Louisiana, is the primary cash market trading and distribution center for natural gas in the United States. It also is the delivery point and pricing basis for the NYMEX's actively traded, physically-delivered natural gas futures contract, which is the most important pricing reference for natural gas in the United States. The Henry Hub, which is operated by Sabine Pipe Line, LLC, serves as a juncture for 13 different pipelines. These pipelines bring in natural gas from fields in the Gulf Coast region and ship it to major consumption centers along the East Coast and Midwest. The throughput shipping capacity of the Henry Hub is 1.8 trillion mmBtu per day.

In addition to the Henry Hub, there are a number of other locations where natural gas is traded. In 2008, there were 33 natural gas market centers in North America.[16] Some of the major trading centers include Alberta, Northwest Rockies, Southern California border and the Houston Ship Channel. For locations that are directly connected to the Henry Hub by one or more pipelines and where there typically is adequate shipping capacity, the price at the other locations usually directly tracks the price at the Henry Hub, adjusted for transportation costs. However, at other locations that are not directly connected to the Henry Hub or where shipping capacity is limited, the prices at those locations often diverge from the Henry Hub price. Furthermore, one local price may be significantly different than the price at another location even though the two markets' respective distances from the Henry Hub are the same. The reason for such pricing disparities is that a given location may experience supply and demand factors that are specific to that region, such as differences in pipeline shipping capacity, unusually high or low demand for heating or cooling or supply disruptions caused by severe weather. As a consequence, local natural gas prices can differ from the Henry Hub price by more than the cost of shipping and such price differences can vary in an unpredictable manner.

The Alberta hub is far removed from the Henry Hub and is not directly connected to the Henry Hub by an existing pipeline. Located in the Canadian province of Alberta, the Alberta natural gas market is a major connection point for long-distance transmission systems that ship natural gas to points throughout Canada and the United States. The Alberta province is Canada's dominant natural gas producing region; six of the nine Canadian market centers are located in the Alberta province. The throughput capacity at the AECO–C hub is ten billion cubic feet per day. Moreover, the number of pipeline interconnections at that hub was four in 2008. Lastly, the AECO–C hub's capacity is 20.4 billion cubic feet per day.[17]

The local price at the Alberta hub typically differs from the price at the Henry Hub. Thus, the price of the Henry Hub physically-delivered futures contract is an imperfect proxy for the Alberta price. Moreover, exogenous factors, such as adverse weather, can cause the Alberta gas price to differ from the Henry Hub price by an amount that is more or less than the cost of shipping, making the NYMEX Henry Hub futures contract even less precise as a hedging tool than desired by market participants. Basis contracts[18] allow traders to more accurately discover prices at alternative locations and hedge price risk that is associated with natural gas at such locations. In this regard, a position at a local price for an alternative location can be established by adding the appropriate basis swap position to a position taken in the NYMEX physically-delivered Henry Hub contract (or in the NYMEX or ICE Henry Hub look-alike contract, which cash settle based on the NYMEX contract's final settlement price).

In its October 9, 2009, **Federal Register** notice, the Commission identified material price reference, price linkage and material liquidity as the potential SPDC criteria applicable to the AEC contract. Each of these criteria is discussed below.[19]

1. Material Price Reference Criterion.

The Commission's October 9, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission considered the fact that ICE maintains exclusive rights over using CGPR's Alberta price index for cash settlement purposes. As a result, no other exchange can offer such a basis contract based on CGPR's Alberta price index. While other third-party price providers produce natural gas price indices for this and other trading centers, market participants indicate that the CGPR price index is highly regarded for this particular location and should market participants wish to establish a hedged position based on this index, they would need to do so by taking a position in the ICE AEC contract since ICE has the right to the CGPR index for cash settlement purposes. In addition, ICE sells its price data to market participants in a number of different packages which vary in terms of the hubs covered, time periods, and whether the data are daily only or historical. For example, ICE offers the "West Gas End of Day" and OTC Gas End of Day"[20] packages with access to all price data or just current prices plus a selected number of months (i.e., 12, 24, 36 or 48 months) of historical data. These two packages include price data for the AEC contract.

The Alberta hub is a major trading center for natural gas in North America. Traders, including producers, keep abreast of the prices of the AEC contract when conducting cash deals. These traders look to a competitively determined price as an indication of expected values of natural gas at the Alberta hub when entering into cash market transactions for natural gas, especially those trades providing for physical delivery in the future. Traders use the ICE AEC contract, as well as other ICE basis swap contracts, to hedge cash market positions and transactions—activities which enhance the AEC contract's price discovery utility. The substantial volume of trading and open interest in the AEC contract appears to attest to its use for this purpose. While the AEC contract's settlement prices may not be the only

[15] The term "hub" refers to a juncture where two or more natural gas pipelines are connected. Hubs also serve as pricing points for natural gas at the particular locations.

[16] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[17] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[18] Basis contracts denote the difference in the price of natural gas at a specified location minus the price of natural gas at the Henry Hub. The differential can be either a positive or negative value.

[19] As noted above, the Commission did not find an indication of arbitrage in connection with this contract; accordingly, that criterion is not discussed in reference to the AEC contract.

[20] The OTC Gas End of Day dataset includes daily settlement prices for natural gas contracts listed for all points in North America.

factor influencing spot and forward transactions, natural gas traders consider the ICE price to be a critical factor in conducting OTC transactions.[21]

Lastly, the fact that the AEC contract does not meet the price linkage criterion (discussed below) bolsters the argument for material price reference. As noted above, the Henry Hub is the pricing reference for natural gas in the United States. However, regional market conditions may cause the price of natural gas in another area of the country to diverge by more than the cost of transportation, thus making the Henry Hub price an imperfect proxy for the local gas price. The more variable the local natural gas price is, the more traders need to accurately hedge their price risk. Basis swap contracts provide a means of more accurately pricing natural gas at a location other than the Henry Hub. An analysis of Alberta natural gas prices showed that 98 percent of the observations were more than 2.5 percent different than the contemporaneous Henry Hub prices. Specifically, the average Alberta basis value between January 2008 and September 2009 was −$0.87 per mmBtu with a variance of $0.21 per mmBtu.

i. Federal Register Comments

ICE stated in its comment letter that the AEC contract does not meet the material price reference criterion for SPDC determination. ICE argued that the Commission appeared to base the case that the AEC contract is potentially a SPDC on two disputable assertions. First, in issuing its notice of intent to determine whether the AEC contract is a SPDC, the CFTC cited a general conclusion in its ECM study "that certain market participants referred to ICE as a price discovery market for certain natural gas contracts." ICE states that CFTC's reason is "hard to quantify as the ECM report does not mention" this contract as a potential SPDC. "It is unknown which market participants made this statement *in 2007* or the contracts that were referenced." In response to the above comment, the Commission notes that it cited the ECM study's general finding that some ICE natural gas contracts appear to be regarded as price discovery markets merely as an indicia that an investigation of certain ICE contracts may be warranted, and was not intended to serve as the sole basis for determining whether or not a particular contract meets the material price reference criterion.

Second, ICE argued that the Commission should not base a determination that the AEC contract is a SPDC merely because this contract has the exclusive right to base its settlement on the CGPR Alberta price index. While the Commission acknowledges that there are other firms that produce price indices for the Alberta hub, market participants indicate that the CGPR index is very highly regarded and should they wish to establish a hedged position based on this index, they would need to do so by taking a position in the ICE AEC swap since ICE has the exclusive right to use the CGPR index.[22]

WGCEF, NGSA, EI and FIEG all stated that the AEC contract does not satisfy the material price reference criterion. The commenters argued that other contracts (physical or financial) are not indexed basis the ICE AEC contract price, but rather are indexed based on the underlying cash price series against which the ICE AEC contract is settled. Thus, they contend that the underlying cash price series is the authentic reference price and not the ICE contract itself. The Commission believes that this interpretation of price reference is too limiting in that it only considers the final index value on which the contract is cash settled after trading ceases. Instead, the Commission believes that a cash-settled derivatives contract could meet the price reference criteria if market participants "consult on a frequent and recurring basis" the derivatives contract when pricing forward, fixed-price commitments or other cash-settled derivatives that seek to "lock in" a fixed price for some future point in time to hedge against adverse price movements.

As noted above, the Alberta hub is a major trading center for natural gas in North America. Traders, including producers, keep abreast of the prices of the AEC contract when conducting cash deals. These traders look to a competitively determined price as an indication of expected values of natural gas at the Alberta hub when entering into cash market transaction for natural gas, especially those trades that provide for physical delivery in the future. Traders use the ICE AEC contract to hedge cash market positions and transactions, which enhances the AEC contract's price discovery utility. While the AEC contract's settlement prices may not be the only factor influencing spot and forward transactions, natural gas traders consider the ICE price to be a crucial factor in conducting OTC transactions.

Both EI and WGCEF stated that publication of price data in a package format is a weak justification for material price reference. These commenters argue that market participants generally do not purchase ICE data sets for one contract's prices, such as those for the AEC contract. Instead, traders are interested in the settlement prices, so the fact that ICE sells the AEC prices as part of a broad package is not conclusive evidence that market participants are buying the ICE data sets because they find the AEC prices have substantial value to them. The Commission notes that the Alberta hub is a major natural gas trading point, and the AEC contract's prices are well regarded in the industry as indicative of the value of natural gas at the Alberta hub. Accordingly, the Commission believes that it is reasonable to conclude that market participants are purchasing the data packages that include the AEC contract's prices in substantial part because the AEC contract prices have particular value to them.

ii. Conclusion Regarding Material Price Reference

Based on the above, the Commission finds that the AEC contract meets the material price reference criterion because it is referenced on a frequent and recurring basis by cash market participants when pricing transactions (direct evidence). Moreover, the ECM sells the AEC contract's price data to market participants (indirect evidence).

2. Price Linkage Criterion

In its October 9, 2009 **Federal Register** notice, the Commission identified price linkage as a potential basis for a SPDC determination with respect to the AEC contract. In this regard, the final settlement of the AEC contract is based, in part, on the final settlement price of the NYMEX's physically-delivered natural gas futures contract, where the NYMEX is registered with the Commission as a DCM.

The Commission's Guidance on Significant Price Discovery Contracts[23] notes that a "price-linked contract is a

[21] In addition to referencing ICE prices, natural gas market firms participating in the Alberta market may rely on other cash market quotes as well as industry publications and price indices that are published by third-party price reporting firms when entering into natural gas transactions.

[22] Futures and swaps based on other Alberta indices have not met with the same market acceptance as the ICE AEC contract. For example, NYMEX previously listed a basis swap contract that was comparable to the AEC contract. However, ICE's exclusive agreement with Enerdata forced NYMEX to delist its contract because NYMEX could not find a suitable alternative price index. Up until the point of being delisted, there was no centralized-market trading in the NYMEX version of the AEC contract, so it never served as a source of price discovery for cash market traders with natural gas at the Alberta hub.

[23] Appendix A to the Part 36 rules.

contract that relies on a contract traded on another trading facility to settle, value or otherwise offset the price-linked contract." Furthermore, the Guidance notes that, "[f]or a linked contract, the mere fact that a contract is linked to another contract will not be sufficient to support a determination that a contract performs a significant price discovery function. To assess whether such a determination is warranted, the Commission will examine the relationship between transaction prices of the linked contract and the prices of the referenced contract. The Commission believes that where material liquidity exists, prices for the linked contract would be observed to be substantially the same as or move substantially in conjunction with the prices of the referenced contract." Furthermore, the Guidance proposes a threshold price relationship such that prices of the ECM linked contract will fall within a 2.5 percent price range for 95 percent of contemporaneously determined closing, settlement or other daily prices over the most recent quarter. Finally, the Commission also stated in the Guidance that it would consider a linked contract which has a trading volume equivalent to 5 percent of the volume of trading in the contract to which it is linked to have sufficient volume potentially to be deemed a SPDC ("minimum threshold").

To assess whether the AEC contract meets the price linkage criterion, Commission staff obtained price data from ICE and performed the statistical tests cited above. Staff found that, while the Alberta price is determined, in part, by the final settlement price of the NYMEX physically-delivered natural gas futures contract (a DCM contract), the Alberta hub price is not within 2.5 percent of the settlement price of the corresponding NYMEX Henry Hub natural gas futures contract on 95 percent or more of the days. Specifically, during the third quarter of 2009, only 2.4 percent of the Alberta natural gas prices derived from the ICE basis values were within 2.5 percent of the daily settlement price of the NYMEX Henry Hub futures contract. In addition, staff found that the AEC contract fails to meet the volume threshold requirement. In particular, the total trading volume in the NYMEX physically delivered natural gas contract during the third quarter of 2009 was 14,022,963 contracts, with 5 percent of that number being 701,148 contracts. Trades on the ICE centralized market in the AEC contract during the same period was 736,412 contracts (equivalent to 184,103 NYMEX contracts, given the size difference).[24] Thus, centralized-market trades in the AEC contract amounted to less than the minimum threshold.

Due to the specific criteria that a given ECM contract must meet to fulfill the price linkage criterion, the requirements, for all intents and purposes, exclude ECM contracts that are not near facsimiles of DCM contracts even though the ECM contract may specifically use the settlement price to value a position, which is the case of the AEC contract. In this regard, an ECM contract that is priced and traded as if it is a functional equivalent of a DCM contract likely will have a price series that mirrors that of the corresponding DCM contract. In contrast, for contracts that are not look-alikes of DCM contracts, it is reasonable to expect that the two price series would be divergent. The Alberta hub and the Henry Hub are located in two different areas of North America. Moreover, both hubs are supply centers, where the Alberta hub handles a throughput volume that is ten times that of the Henry Hub. These differences contribute to the divergence between the two price series and, as discussed above, increase the likelihood that the "basis" contract is used for material price reference.

i. Federal Register Comments

NGSA stated that the AEC contract does not meet the price linkage criterion because basis contracts, including the AEC contract, are not equivalent to the NYMEX physically-delivered Henry Hub contract. EI also noted that the AEC and NYMEX natural gas contracts are not economically equivalent and that the AEC contract's volume is too low to affect the NYMEX natural gas futures contract. WGCEF stated that the Alberta price is determined, in part, by the final settlement price of the NYMEX Henry Hub futures contract. However, WCEF goes on to state that the AEC contract "(a) is not substantially the same as the NYMEX [natural gas futures contract] * * * nor (b) does it move substantially in conjunction" with the NYMEX natural gas futures contract. ICE opined that the AEC contract's trading volume is too low to affect the price discovery process for the NYMEX natural gas futures contract. In addition, ICE states that the AEC contract simply reflects a price differential between Alberta and the Henry Hub; "there is no price linkage as contemplated by Congress or the CFTC in its rulemaking." FIEG acknowledged that the AEC contract is a locational spread that is based in part on the NYMEX natural gas futures price, but also questioned the significance of this fact relative to the price linkage criterion since the key component of the spread is the price at the Alberta location and not the NYMEX physically-delivered natural gas futures price.

ii. Conclusion Regarding the Price Linkage Criterion

Based on the above, the Commission finds that the AEC contract does not meet the price linkage criterion because it fails the price relationship and volume tests provided for in the Commission's Guidance.

3. Material Liquidity Criterion

To assess whether the AEC contract meets the material liquidity criterion, the Commission first examined volume and open interest data provided to it by ICE as a general measurement of the AEC market's size and potential importance, and second performed a statistical analysis to measure the effect that changes to AEC prices potentially may have on prices for the NYMEX Henry Hub Natural Gas (a DCM contract), the ICE Socal Border Financial Basis ("SCL") contract (an ECM contract) and the ICE HSC[25] Financial Basis contract (an ECM contract).[26]

The Commission's Guidance (Appendix A to Part 36) notes that "[t]raditionally, objective measures of trading such as volume or open interest have been used as measures of liquidity." In this regard, the Commission in its October 9, 2009, **Federal Register** notice referred to second quarter 2009 trading statistics that ICE had submitted for its AEC contract. Based upon on a required quarterly filing made by ICE on July 27, 2009, the total number of AEC trades executed on ICE's electronic trading platform was 7,263 in the second quarter of 2009, resulting in a daily average of 113.5 trades. During the same period, the AEC contract had a total trading volume on ICE's electronic trading platform of 806,438 contracts and an average daily trading volume of 12,601 contracts. Moreover, the open interest as of June 30, 2009, was 443,402 contracts, which includes trades executed on ICE's electronic trading platform, as well as trades executed off

[24] The AEC contract is one-quarter the size of the NYMEX Henry Hub physically-delivered futures contract.

[25] The acronym stands for Houston Ship Channel.

[26] As noted above, the material liquidity criterion speaks to the effect that transactions in the potential SPDC may have on trading in "agreements, contracts and transactions listed for trading on or subject to the rules of a designated contract market, a derivatives transaction execution facility, or an electronic trading facility operating in reliance on the exemption in section 2(h)(3) of the Act.

of ICE's electronic trading platform and then brought to ICE for clearing.[27]

Subsequent to the October 9, 2009, **Federal Register** notice, ICE submitted another quarterly notification filed on November 13, 2009,[28] with updated trading statistics. Specifically, with respect to its AEC contract, 6,320 separate trades occurred on its electronic platform in the third quarter of 2009, resulting in a daily average of 95.8 trades. During the same period, the AEC contract had a total trading volume on its electronic platform of 736,412 contracts (which was an average of 11,158 contracts per day).[29] As of September 30, 2009, open interest in the AEC contract was 483,561 [30] contracts. Reported open interest included positions resulting from trades that were executed on ICE's electronic platform, as well as trades that were executed off of ICE's electronic platform and brought to ICE for clearing.

In Appendix A to Part 36, the material liquidity criterion for SPDC determination specifies that an ECM contract should have a material effect on another contract. To measure the effect that the AEC contract has on a DCM contract, or on another ECM contract, Commission staff performed a statistical analysis [31] of ICE and NYMEX price data using daily settlement prices (between January 2, 2008, and September 30, 2009) for the NYMEX Henry Hub natural gas contract (a DCM contract) and the ICE Socal Border Financial Basis and HSC Financial Basis contracts (ECM contracts).[32] The simulation results suggest that, on average over the sample period, a one percent rise in the AEC contract's price elicited a 0.8 percent to 0.9 percent increase in each of the NYMEX Henry Hub, ICE SCL and ICE HSC contracts' prices.

i. Federal Register Comments

As noted above, comments were received from eight individuals and organizations, with five comments being directly applicable to the SPDC determination of the ICE AEC contract. WGCEF, EI, FIEG, ICE and NGSA generally agreed that the AEC contract does not meet the material liquidity criterion.

WGCEF [33] and NGSA [34] both stated that the AEC contract does not materially affect other contracts that are listed for trading on DCMs or ECMs, as well as other over-the-counter contracts. Instead, the AEC contract is influenced by the underlying Alberta cash price index and the final settlement price of the NYMEX Henry Hub natural gas futures contract, not vice versa. FIEG [35] stated that the AEC contract cannot have a material effect on NYMEX contract because the AEC contract trades on a differential and represents "one leg (and not the relevant leg) of the locational spread." The Commission's statistical analysis shows that changes in the ICE AEC contract's price significantly influences the prices of other contracts that are traded on DCMs and ECMs.

ICE [36] opined that the Commission "seems to have adopted a five trade-per-day test to determine whether a contract is materially liquid. It is worth noting that ICE originally suggested that the CFTC use a five trades-per-day threshold as the basis for an ECM to report trade data to the CFTC." In this regard, the Commission adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs" [37] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC; the threshold is not intended to define liquidity in a broader sense. As noted above, the Division is basing a finding of material liquidity for the ICE AEC contract in part on the fact that there have been around 100 trades per day on average in the AEC contract during the second and third quarters of 2009, which is far more than the five trades-per-day that is cited in the ICE comment.

ICE implied that the statistics provided by ICE were misinterpreted and misapplied by the Commission. In particular, ICE stated that the volume figures used in the Commission's analysis (cited above) "include trades made in *all months of each contract*" as well as in strips of contract months, and the "more appropriate method of determining liquidity is to examine the activity in a *single* traded month or strip of a given contract." Furthermore, ICE noted that for the AEC contract (and other basis swap contracts), "about 25–40% of the trades * * * occurred in the single most liquid, usually prompt, month of * * * [the] contract." EI,[38] and FIEG also noted that contract months should be considered separately rather than on an aggregated basis. When done so, none of the contract months meet the material liquidity criterion.

It is the Commission's opinion that liquidity, as it pertains to the AEC contract, is typically a function of trading activity in particular lead months and, given sufficient liquidity in such months, the AEC contract itself would be considered liquid. ICE's analysis of its own trade data confirms this to be the case for the AEC contract, and thus, the Commission believes that it applied the statistical data cited above in an appropriate manner for gauging material liquidity.

In addition, EI and ICE stated that the trades-per-day statistics that it provided to the Commission in its quarterly filing and which are cited above includes 2(h)(1) transactions, which were not completed on the electronic trading platform and should not be considered in the SPDC determination process. The Commission staff asked ICE to review the data it sent in its quarterly filings. In response, ICE confirmed that the volume data it provided and which the Commission cited in its October 9, 2009, **Federal Register** notice, as well as the additional volume information it cites above, includes only transaction data

[27] ICE does not differentiate between open interest created by a transaction executed on its trading platform versus that created by a transaction executed off its trading platform. 74 FR 52196 (October 9, 2009).

[28] See Commission Rule 36.3(c)(2), 17 CFR 36.3(c)(2).

[29] By way of comparison, the number of contracts traded in the AEC contract is similar to that exhibited on a liquid futures market and is roughly equivalent to the volume of trading for the ICE US Coffee "C" and Cocoa contracts during this period.

[30] By way of comparison, open interest in the AEC contract is similar to that exhibited on a liquid futures market and is roughly equivalent to that in the Commodity Exchange's Gold contract and the Chicago Board of Trade's soybean contract.

[31] Specifically, Commission staff econometrically estimated a vector autoregression model using daily natural gas price levels. A vector autoregression model is an econometric model used to capture the dependencies and interrelationships among multiple time series, generalizing the univariate autoregression model. The estimated model displays strong diagnostic evidence of statistical adequacy. In particular, the model's impulse response function was shocked with a one-time rise in Alberta price. The simulation results suggest that, on average over the sample period, a one percent rise in the Alberta natural gas price elicited a 0.9 percent increase in the NYMEX Henry Hub price and the Southern California border gas price, as well as a 0.8 percent increase in HSC gas prices. These multipliers of response emerge with noticeable statistical strength or significance. Based on such long run sample patterns, if the Alberta price rises by 10 percent, then the price of NYMEX Henry Hub natural gas futures contract and the Sothern California gas price each would rise by about 9 percent; a 10 percent rise in the Alberta gas price would lead to a rise in the HSC contract's price by about 9 percent.

[32] Natural gas prices at the Alberta, HSC, and Socal trading centers were obtained by adding the daily settlement prices of ICE's AECO Financial Basis, HSC Financial Basis and Socal Border Financial Basis contracts, respectively, to the contemporaneous daily settlement prices of the NYMEX Henry Hub physically-delivered natural gas futures contract.

[33] CL 02.

[34] CL 05.

[35] CL 07.

[36] CL 03.

[37] 73 FR 75892 (December 12, 2008).

[38] CL 04.

executed on ICE's electronic trading platform.[39] The Commission acknowledges that the open interest information it cites above includes transactions made off the ICE platform. However, once open interest is created, there is no way for ICE to differentiate between "on-exchange" versus "off-exchange" created positions, and all such positions are fungible with one another and may be offset in any way agreeable to the position holder regardless of how the position was initially created.

ii. Conclusion Regarding Material Liquidity

Based on the above, the Commission concludes that the AEC contract meets the material liquidity criterion in that there is sufficient trading activity in the AEC contract to have a material effect on "other agreements, contracts or transactions listed for trading on or subject to the rules of a designated contract market * * * or an electronic trading facility operating in reliance on the exemption in section 2(h)(3) of the Act" (that is, an ECM).

4. Overall Conclusion

After considering the entire record in this matter, including the comments received, the Commission has determined that the AEC contract performs a significant price discovery function under two of the four criteria established in section 2(h)(7) of the CEA. Although the Commission has determined that the AEC contract does not meet the price linkage criterion at this time, the Commission has determined that the AEC contract does meet both the material liquidity and material price reference criteria. Accordingly, the Commission will issue the attached Order declaring that the AEC contract is a SPDC.

Issuance of this Order signals the immediate effectiveness of the Commission's authorities with respect to ICE as a registered entity in connection with its AEC contract,[40] and triggers the obligations, requirements—both procedural and substantive—and timetables prescribed in Commission rule 36.3(c)(4) for ECMs.

IV. Related Matters

a. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 ("PRA")[41] imposes certain requirements on Federal agencies, including the Commission, in connection with their conducting or sponsoring any collection of information as defined by the PRA. Certain provisions of Commission rule 36.3 impose new regulatory and reporting requirements on ECMs, resulting in information collection requirements within the meaning of the PRA. OMB previously has approved and assigned OMB control number 3038–0060 to this collection of information.

b. Cost-Benefit Analysis

Section 15(a) of the CEA[42] requires the Commission to consider the costs and benefits of its actions before issuing an order under the Act. By its terms, section 15(a) does not require the Commission to quantify the costs and benefits of an order or to determine whether the benefits of the order outweigh its costs; rather, it requires that the Commission "consider" the costs and benefits of its actions. Section 15(a) further specifies that the costs and benefits shall be evaluated in light of five broad areas of market and public concern: (1) Protection of market participants and the public; (2) efficiency, competitiveness and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. The Commission may in its discretion give greater weight to any one of the five enumerated areas and could in its discretion determine that, notwithstanding its costs, a particular order is necessary or appropriate to protect the public interest or to effectuate any of the provisions or accomplish any of the purposes of the Act. The Commission has considered the costs and benefits in light of the specific provisions of section 15(a) of the Act and has concluded that the Order, required by Congress to strengthen Federal oversight of exempt commercial markets and to prevent market manipulation, is necessary and appropriate to accomplish the purposes of section 2(h)(7) of the Act.

When a futures contract begins to serve a significant price discovery function, that contract, and the ECM on which it is traded, warrants increased oversight to deter and prevent price manipulation or other disruptions to market integrity, both on the ECM itself and in any related futures contracts trading on DCMs. An Order finding that a particular contract is a SPDC triggers this increased oversight and imposes obligations on the ECM calculated to accomplish this goal. The increased oversight engendered by the issue of a SPDC Order increases transparency and helps to ensure fair competition among ECMs and DCMs trading similar products and competing for the same business. Moreover, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the CEA and Commission regulations. Additionally, the ECM must comply with nine core principles established by section 2(h)(7) of the Act—including the obligation to establish position limits and/or accountability standards for the SPDC. Section 4(i) of the CEA authorizes the Commission to require reports for SPDCs listed on ECMs. These increased responsibilities, along with the CFTC's increased regulatory authority, subject the ECM's risk management practices to the Commission's supervision and oversight and generally enhance the financial integrity of the markets.

c. Regulatory Flexibility Act

The Regulatory Flexibility Act ("RFA")[43] requires that agencies consider the impact of their rules on small businesses. The requirements of CEA section 2(h)(7) and the Part 36 rules affect ECMs. The Commission previously has determined that ECMs are not small entities for purposes of the RFA.[44] Accordingly, the Chairman, on behalf of the Commission, hereby certifies pursuant to 5 U.S.C. 605(b) that this Order, taken in connection with section 2(h)(7) of the Act and the Part 36 rules, will not have a significant impact on a substantial number of small entities.

V. Order

a. Order Relating to the ICE AECO Financial Basis Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the AECO Financial Basis contract, traded on the IntercontinentalExchange, Inc., must comply with, with respect to the AECO Financial Basis contract, the nine core principles established by new section

[39] Supplemental data supplied by the ICE confirmed that block trades in the third quarter of 2009 were in addition to the trades that were conducted on the electronic platform; block trades comprised 32.4 percent of all transactions in the AEC contract.

[40] See 73 FR 75888, 75893 (Dec. 12, 2008).

[41] 44 U.S.C. 3507(d).

[42] 7 U.S.C. 19(a).

[43] 5 U.S.C. 601 *et seq.*

[44] 66 FR 42256, 42268 (Aug. 10, 2001).

2(h)(7)(C). Additionally, the IntercontinentalExchange, Inc., satisfies the statutory material liquidity and material price reference criteria for significant price discovery contracts. Consistent with this determination, and effective immediately, the IntercontinentalExchange, Inc., shall be and is considered a registered entity [45] with respect to the AECO Financial Basis contract and is subject to all the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the IntercontinentalExchange, Inc. commence with the issuance of this Order.[46]

Issued in Washington, DC on April 28, 2010, by the Commission.

David A. Stawick,

Secretary of the Commission.

[FR Doc. 2010–10299 Filed 5–3–10; 8:45 am]

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[45] 7 U.S.C. 1a(29).

[46] Because ICE already lists for trading a contract (i.e., the Henry Financial LD1 Fixed Price contract) that was previously declared by the Commission to be a SPDC, ICE must submit a written demonstration of compliance with the Core Principles within 30 calendar days of the date of this Order. 17 CFR 36.3(c)(4).

COMMODITY FUTURES TRADING COMMISSION

Order Finding That the NWP Rockies Financial Basis Contract Traded on the IntercontinentalExchange, Inc., Performs a Significant Price Discovery Function

AGENCY: Commodity Futures Trading Commission.

ACTION: Final order.

SUMMARY: On October 22, 2009, the Commodity Futures Trading Commission ("CFTC" or "Commission") published for comment in the **Federal Register** [1] a notice of its intent to undertake a determination whether the NWP [2] Rockies Financial Basis ("NWR") contract traded on the IntercontinentalExchange, Inc. ("ICE"), an exempt commercial market ("ECM") under sections 2(h)(3)–(5) of the Commodity Exchange Act ("CEA" or the "Act"), performs a significant price discovery function pursuant to section 2(h)(7) of the CEA. The Commission undertook this review based upon an initial evaluation of information and data provided by ICE as well as other available information. The Commission has reviewed the entire record in this matter, including all comments received, and has determined to issue an order finding that the NWR contract performs a significant price discovery function. Authority for this action is found in section 2(h)(7) of the CEA and Commission rule 36.3(c) promulgated thereunder.

DATES: *Effective date:* April 28, 2010.

FOR FURTHER INFORMATION CONTACT: Gregory K. Price, Industry Economist, Division of Market Oversight, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW., Washington, DC 20581. Telephone: (202) 418–5515. E-mail: *gprice@cftc.gov;* Christa Lachenmayr, Economist, Division of Market Oversight, same address. Telephone: (202) 418–5252. E-mail: *clachenmayr@cftc.gov;* or Susan Nathan, Senior Special Counsel, Division of Market Oversight, same address. Telephone: (202) 418–5133. E-mail: *snathan@cftc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The CFTC Reauthorization Act of 2008 ("Reauthorization Act") [3] significantly broadened the CFTC's regulatory authority with respect to ECMs by creating, in section 2(h)(7) of the CEA, a new regulatory category—ECMs on which significant price discovery contracts ("SPDCs") are traded—and treating ECMs in that category as registered entities under the CEA.[4] The legislation authorizes the CFTC to designate an agreement, contract or transaction as a SPDC if the Commission determines, under criteria established in section 2(h)(7), that it performs a significant price discovery function. When the Commission makes such a determination, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the Act and Commission regulations, and must comply with nine core principles established by new section 2(h)(7)(C).

On March 16, 2009, the CFTC promulgated final rules implementing the provisions of the Reauthorization Act.[5] As relevant here, rule 36.3 imposes increased information reporting requirements on ECMs to assist the Commission in making prompt assessments whether particular ECM contracts may be SPDCs. In addition to filing quarterly reports of its contracts, an ECM must notify the Commission promptly concerning any contract traded in reliance on the exemption in section 2(h)(3) of the CEA that averaged five trades per day or more over the most recent calendar quarter, and for which the exchange sells its price information regarding the contract to market participants or industry publications, or whose daily closing or settlement prices on 95 percent or more of the days in the most recent quarter were within 2.5 percent of the contemporaneously determined closing, settlement or other daily prices of another contract.

Commission rule 36.3(c)(3) established the procedures by which the Commission makes and announces its determination whether a particular ECM contract serves a significant price discovery function. Under those procedures, the Commission will publish notice in the **Federal Register** that it intends to undertake an evaluation whether the specified agreement, contract or transaction performs a significant price discovery function and to receive written views, data and arguments relevant to its determination from the ECM and other interested persons. Upon the close of the comment period, the Commission will consider, among other things, all relevant information regarding the subject contract and issue an order announcing and explaining its determination whether or not the contract is a SPDC. The issuance of an affirmative order signals the effectiveness of the Commission's regulatory authorities over an ECM with respect to a SPDC; at that time such an ECM becomes subject to all provisions of the CEA applicable to registered entities.[6] The issuance of such an order also triggers the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4).[7]

II. Notice of Intent To Undertake SPDC Determination

On October 22, 2009, the Commission published in the **Federal Register** notice of its intent to undertake a

[1] 74 FR 54550 (October 22, 2009).

[2] The acronym "NWP" indicates the Northwest Pipeline.

[3] Incorporated as Title XIII of the Food, Conservation and Energy Act of 2008, Public Law 110–246, 122 Stat. 1624 (June 18, 2008).

[4] 7 U.S.C. 1a(29).

[5] 74 FR 12178 (Mar. 23, 2009); these rules became effective on April 22, 2009.

[6] Pub. L. 110–246 at 13203; *Joint Explanatory Statement of the Committee of Conference,* H.R. Rep. No. 110–627, 110 Cong., 2d Sess. 978, 986 (Conference Committee Report). See also 73 FR 75888, 75894 (Dec. 12, 2008).

[7] For an initial SPDC, ECMs have a grace period of 90 calendar days from the issuance of a SPDC determination order to submit a written demonstration of compliance with the applicable core principles. For subsequent SPDCs, ECMs have a grace period of 30 calendar days to demonstrate core principle compliance.

determination whether the NWR contract performs a significant price discovery function and requested comment from interested parties.[8] Comments were received from the Federal Energy Regulatory Commission ("FERC"), Platts, Economists Incorporated ("EI") and ICE.[9] The comment letters from FERC [10] and Platts did not directly address the issue of whether or not the NWR contract is a SPDC; ICE's and EI's comments raised substantive issues with respect to the applicability of section 2(h)(7) the NWR contract, generally asserting that the NWR contract is not a SPDC as it does not meet the material liquidity, material price reference and price linkage criteria for SPDC determination. ICE's and EI's comments are more extensively discussed below, as applicable.

III. Section 2(h)(7) of the CEA

The Commission is directed by section 2(h)(7) of the CEA to consider the following criteria in determining a contract's significant price discovery function:

- *Price Linkage*—the extent to which the agreement, contract or transaction uses or otherwise relies on a daily or final settlement price, or other major price parameter, of a contract or contracts listed for trading on or subject to the rules of a designated contract market ("DCM") or derivatives transaction execution facility ("DTEF"), or a SPDC traded on an electronic trading facility, to value a position, transfer or convert a position, cash or financially settle a position, or close out a position.
- *Arbitrage*—the extent to which the price for the agreement, contract or transaction is sufficiently related to the price of a contract or contracts listed for trading on or subject to the rules of a DCM or DTEF, or a SPDC traded on or subject to the rules of an electronic trading facility, so as to permit market participants to effectively arbitrage between the markets by simultaneously maintaining positions or executing trades in the contracts on a frequent and recurring basis.
- *Material price reference*—the extent to which, on a frequent and recurring basis, bids, offers or transactions in a commodity are directly based on, or are determined by referencing or consulting, the prices generated by agreements, contracts or transactions being traded or executed on the electronic trading facility.
- *Material liquidity*—the extent to which the volume of agreements, contracts or transactions in a commodity being traded on the electronic trading facility is sufficient to have a material effect on other agreements, contracts or transactions listed for trading on or subject to the rules of a DCM, DTEF or electronic trading facility operating in reliance on the exemption in section 2(h)(3).

Not all criteria must be present to support a determination that a particular contract performs a significant price discovery function, and one or more criteria may be inapplicable to a particular contract.[11] Moreover, the statutory language neither prioritizes the criteria nor specifies the degree to which a SPDC must conform to the various criteria. In Guidance issued in connection with the Part 36 rules governing ECMs with SPDCs, the Commission observed that these criteria do not lend themselves to a mechanical checklist or formulaic analysis. Accordingly, the Commission has indicated that in making its determinations it will consider the circumstances under which the presence of a particular criterion, or combination of criteria, would be sufficient to support a SPDC determination.[12] For example, for contracts that are linked to other contracts or that may be arbitraged with other contracts, the Commission will consider whether the price of the potential SPDC moves in such harmony with the other contract that the two markets essentially become interchangeable. This co-movement of prices would be an indication that activity in the contract had reached a level sufficient for the contract to perform a significant price discovery function. In evaluating a contract's price discovery role as a price reference, the Commission will consider whether cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract.

IV. Findings and Conclusions

a. The NWP Rockies Financial Basis (NWR) Contract and the SPDC Indicia

The ICE NWR contract is cash settled based on the difference between the bidweek price of natural gas at the Northwest Pipeline's Rockies hub for the month of delivery, as published in Platts' *Inside FERC's Gas Market Report,* and the final settlement price for the New York Mercantile Exchange's ("NYMEX's") Henry Hub physically-delivered natural gas futures contract for the same specified calendar month. The Platts bidweek price, which is published monthly, is based on a survey of cash market traders who voluntarily report to Platts data on fixed-price transactions for physical delivery of natural gas at the Rockies hub conducted during the last five business days of the month; such bidweek transactions specify the delivery of natural gas on a uniform basis throughout the following calendar month at the agreed upon rate. The Platts bidweek index is published on the first business day of the calendar month in which the natural gas is to be delivered. The size of the NWR contract is 2,500 million British thermal units ("mmBtu"), and the unit of trading is any multiple of 2,500 mmBtu. The NWR contract is listed for up to 120 calendar months commencing with the next calendar month.

The Henry Hub,[13] which is located in Erath, Louisiana, is the primary cash market trading and distribution center for natural gas in the United States. It

[8] The Commission's Part 36 rules establish, among other things, procedures by which the Commission makes and announces its determination whether a specific ECM contract serves a significant price discovery function. Under those procedures, the Commission publishes a notice in the **Federal Register** that it intends to undertake a determination whether a specified agreement, contract or transaction performs a significant price discovery function and to receive written data, views and arguments relevant to its determination from the ECM and other interested persons.

[9] FERC is an independent Federal regulatory agency that, among other things, regulates the interstate transmission of natural gas, oil and electricity. McGraw-Hill, through its division Platts, compiles and calculates monthly natural gas price indices from natural gas trade data submitted to Platts by energy marketers. Platts includes those price indices in its monthly *Inside FERC's Gas Market Report* ("Inside FERC"). ICE is an ECM, as noted above. EI is an economic consulting firm with offices located in Washington, DC, and San Francisco, CA. The comment letters are available on the Commission's Web site: *http://www.cftc.gov/lawandregulation/federalregister/federalregistercomments/2009/09-031.html.*

[10] FERC stated that the NWR contract is cash settled and does not contemplate the actual physical delivery of natural gas. Acccordingly, FERC expressed the opinion that a determination by the Commission that a contract performs a significant price discovery function "would not appear to conflict with FERC's exclusive jurisdiction under the Natural Gas Act (NGA) over certain sales of natural gas in interstate commerce for resale or with its other regulatory responsibilities under the NGA" and further that "FERC staff will continue to monitor for any such conflict * * * [and] advise the CFTC" should any such potential conflict arise. CL 01.

[11] In its October 22, 2009, **Federal Register** release, the Commission identified material price reference, price linkage and material liquidity as the possible criteria for SPDC determination of the NWR contract. Arbitrage was not identified as a possible criterion and will not be discussed further in this document or the associated Order.

[12] 17 CFR Part 36, Appendix A.

[13] The term "hub" refers to a juncture where two or more natural gas pipelines are connected. Hubs also serve as pricing points for natural gas at the particular locations.

also is the delivery point and pricing basis for the NYMEX's actively traded, physically-delivered natural gas futures contract, which is the most important pricing reference for natural gas in the United States. The Henry Hub, which is operated by Sabine Pipe Line, LLC, serves as a juncture for 13 different pipelines. These pipelines bring in natural gas from fields in the Gulf Coast region and ship it to major consumption centers along the East Coast and Midwest. The throughput shipping capacity of the Henry Hub is 1.8 trillion mmBtu per day.

In addition to the Henry Hub, there are a number of other locations where natural gas is traded. In 2008, there were 33 natural gas market centers in North America.[14] Some of the major trading centers include Alberta, Northwest Rockies, Southern California border region and the Houston Ship Channel. For locations that are directly connected to the Henry Hub by one or more pipelines and where there typically is adequate shipping capacity, the price at the other locations usually directly tracks the price at the Henry Hub, adjusted for transportation costs. However, at other locations that are not directly connected to the Henry Hub or where shipping capacity is limited, the prices at those locations often diverge from the Henry Hub price. Furthermore, one local price may be significantly different than the price at another location even though the two markets' respective distances from the Henry Hub are the same. The reason for such pricing disparities is that a given location may experience supply and demand factors that are specific to that region, such as differences in pipeline shipping capacity, unusually high or low demand for heating or cooling or supply disruptions caused by severe weather. As a consequence, local natural gas prices can differ from the Henry Hub price by more than the cost of shipping and such price differences can vary in an unpredictable manner.

The Northwest Pipeline's Rockies hub is located in Wyoming, Utah and Colorado.[15] The Northwest Pipeline draws natural gas supplies from the Rocky Mountain region and ships it along a 3,900-mile, bi-directional transmission system to markets throughout the Rockies and Pacific Northwest. The Opal market center, a trading region that includes the Rockies hub, had an estimated throughput capacity of 1.5 billion cubic feet per day in 2008. Moreover, the number of pipeline interconnections at the Opal market center was eight in 2008, up from four interconnections in 2003. Lastly, the pipeline interconnection capacity of the Opal market center in 2008 was six billion cubic feet per day, which constituted an 86 percent increase over the pipeline interconnection capacity in 2003.[16] The Rockies hub is far removed from the Henry Hub and is not directly connected to the Henry Hub by an existing pipeline.

The local price at the Rockies hub typically differs from the price at the Henry Hub. Thus, the price of the Henry Hub physically-delivered futures contract is an imperfect proxy for the Rockies price. Moreover, exogenous factors, such as adverse weather, can cause the Rockies gas price to differ from the Henry Hub price by an amount that is more or less than the cost of shipping, making the NYMEX Henry Hub futures contract even less precise as a hedging tool than desired by market participants. Basis contracts[17] allow traders to more accurately discover prices at alternative locations and hedge price risk that is associated with natural gas at such locations.[18] In this regard, a position at a local price for an alternative location can be established by adding the appropriate basis swap position to a position taken in the NYMEX physically-delivered Henry Hub contract (or in the NYMEX or ICE Henry Hub look-alike contract, which cash settle based on the NYMEX physically-delivered natural gas contract's final settlement price).

In its October 22, 2009, **Federal Register** notice, the Commission identified material price reference, price linkage and material liquidity as the potential SPDC criteria applicable to the NWR contract. Each of these criteria is discussed below.[19]

1. Material Price Reference Criterion

The Commission's October 22, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission considered the fact that ICE sells its price data to market participants in a number of different packages which vary in terms of the hubs covered, time periods, and whether the data are daily only or historical. For example, ICE offers the "West Gas End of Day" and "OTC Gas End of Day"[20] packages with access to all price data or just current prices plus a selected number of months (i.e., 12, 24, 36 or 48 months) of historical data. These two packages include price data for the NWR contract.

The Rockies hub is a major trading center for natural gas in the United States. Traders, including producers, keep abreast of the prices of the NWR contract when conducting cash deals. These traders look to a competitively determined price as an indication of expected values of natural gas at the Rockies hub when entering into cash market transactions for natural gas, especially those trades that provide for physical delivery in the future. Traders use the ICE NWR contract, as well as other ICE basis swap contracts, to hedge cash market positions and transactions—activities which enhance the NWR contract's price discovery utility. The substantial volume of trading and open interest in the NWR contract appears to attest to its use for this purpose. While the NWR contract's settlement prices may not be the only factor influencing spot and forward transactions, natural gas traders consider the ICE price to be a critical factor in conducting OTC transactions.[21]

NYMEX lists a futures contract that is comparable to the ICE NWR contract on its ClearPort platform. However, unlike the ICE contract, none of the trades in the NYMEX Rockies Basis Swap (Platts IFERC) futures contract are executed in NYMEX's centralized marketplace; instead, all of the transactions originate as bilateral swaps that are submitted to

[14] See *http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[15] The Rockies hub includes fixed-price gas delivered into Northwest Pipeline's mainline in Wyoming, Utah and Colorado between the Kemmerer and Moab stations. Deliveries at Ignacio, CO, and elsewhere in zone MO (the area South of Moab, UT, into the San Juan Mountains) are excluded. Transactions done at Opal, WY, and the Muddy Creek compressor station (where the Northwest Pipeline connects with Kern River Gas Transmission, Questar Pipeline and Colorado Interstate Gas) are used because gas traded at those two points often is not nominated into a specific pipeline.

[16] See *http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[17] Basis contracts denote the difference in the price of natural gas at a specified location minus the price of natural gas at the Henry Hub. The differential can be either a positive or negative value.

[18] Commercial activity in natural gas basis swap contracts is evidenced by large positions held by energy trading firms in the comparable NYMEX ClearPort basis swap contract for the Rockies hub.

[19] As noted above, the Commission did not find an indication of arbitrage in connection with this contract; accordingly, that criterion was not discussed in reference to the NWR contract.

[20] The OTC Gas End of Day dataset includes daily settlement prices for natural gas contracts listed for all points in North America.

[21] In addition to referencing ICE prices, natural gas market firms participating in the Rockies market may rely on other cash market quotes as well as industry publications and price indices that are published by third-party price reporting firms when entering into natural gas transactions.

NYMEX for clearing. The daily settlement prices of the NYMEX Rockies Basis Swap contract are influenced, in part, by the daily settlement prices of the ICE NWR contract. This is because NYMEX determines the daily settlement prices for its natural gas basis swap contracts through a survey of cash market voice brokers. Voice brokers, in turn, refer to the ICE NWR price, among other information, as an important indicator as to where the market is trading. Therefore, the ICE NWR price influences the settlement price for the NYMEX Rockies Basis Swap contract. This is supported by an analysis of the daily settlement prices for the NYMEX and ICE Rockies basis swap contracts. In this regard, 98 percent of the daily settlement prices for the NYMEX Rockies Basis Swap contract are within one standard deviation of the NWR contract's settlement prices.

Lastly, the fact that the NWR contract does not meet the price linkage criterion (discussed below) bolsters the argument for material price reference. As noted above, the Henry Hub is the pricing reference for natural gas in the United States. However, regional market conditions may cause the price of natural gas in another area of the country to diverge by more than the cost of transportation, thus making the Henry Hub price an imperfect proxy for the local gas price. The more variable the local natural gas price is, the more traders need to accurately hedge their price risk. Basis swap contracts provide a means of more accurately pricing natural gas at a location other than the Henry Hub. An analysis of Rockies natural gas prices showed that all of the observations were more than 2.5 percent different than the contemporaneous Henry Hub prices. Specifically, the average Rockies basis value between January 2008 and September 2009 was −$1.94 per mmBtu with a variance of $1.88 per mmBtu.

i. Federal Register Comments

Both EI and ICE stated in their comment letters that the NWR contract does not meet the material price reference criterion for SPDC determination. ICE argued that the Commission appeared to base the case that the NWR contract is potentially a SPDC on a disputable assertion. In issuing its notice of intent to determine whether the NWR contract is a SPDC, the CFTC cited a general conclusion in its ECM study "that certain market participants referred to ICE as a price discovery market for certain natural gas contracts." ICE stated that, "Basing a material price reference determination on general statements made in a two year old study does not seem to meet Congress' intent that the CFTC use its considerable expertise to study the OTC markets." In response to the above comment, the Commission notes that it cited the ECM study's general finding that some ICE natural gas contracts appear to be regarded as price discovery markets merely as an indicia that an investigation of certain ICE contracts may be warranted, and was not intended to serve as the sole basis for determining whether or not a particular contract meets the material price reference criterion.

EI also stated that the NWR contract does not satisfy the material price reference criterion. The commenter argued that other contracts (physical or financial) are not indexed based on the ICE NWR contract price, but rather are indexed based on the underlying cash price series against which the NWR contract is settled. Thus, EI contends that the underlying cash price series is the authentic reference price and not the ICE contract itself. The Commission believes that this interpretation of price reference is too limiting in that it only considers the final index value on which the contract is cash settled after trading ceases. Instead, the Commission believes that a cash-settled derivatives contract could meet the price reference criteria if market participants "consult on a frequent and recurring basis" the derivatives contract when pricing forward, fixed-price commitments or other cash-settled derivatives that seek to "lock in" a fixed price for some future point in time to hedge against adverse price movements.

EI also argued that publication of price data in a package format is a weak justification for material price reference. According to the commenter, market participants generally do not purchase ICE data sets for one contract's prices, so the fact that ICE sells the NWR prices as part of a broad package is not conclusive evidence that market participants are buying the ICE data sets because they find the NWR prices have substantial value to them. The Commission notes that the Rockies hub is a major natural gas trading point, and the NWR contract's prices are well regarded in the industry as indicative of the value of natural gas at the Rockies hub. Accordingly, the Commission believes that it is reasonable to conclude that market participants are purchasing the data packages that include the NWR contract's prices in substantial part because the NWR contract prices have particular value to them.

ii. Conclusion Regarding Material Price Reference

Based on the above, the Commission finds that the NWR contract meets the material price reference criterion because it is referenced and consulted on a frequent and recurring basis by cash market participants when pricing transactions (direct evidence). Moreover, the ECM sells the NWR contract's price data to market participants (indirect evidence).

2. Price Linkage Criterion

In its October 22, 2009, **Federal Register** notice, the Commission identified price linkage as a potential basis for a SPDC determination with respect to the NWR contract. In this regard, the final settlement of the NWR contract is based, in part, on the final settlement price of the NYMEX's physically-delivered natural gas futures contract, where the NYMEX is registered with the Commission as a DCM.

The Commission's Guidance on Significant Price Discovery Contracts [22] notes that a "price-linked contract is a contract that relies on a contract traded on another trading facility to settle, value or otherwise offset the price-linked contract." Furthermore, the Guidance notes that, "[f]or a linked contract, the mere fact that a contract is linked to another contract will not be sufficient to support a determination that a contract performs a significant price discovery function. To assess whether such a determination is warranted, the Commission will examine the relationship between transaction prices of the linked contract and the prices of the referenced contract. The Commission believes that where material liquidity exists, prices for the linked contract would be observed to be substantially the same as or move substantially in conjunction with the prices of the referenced contract." Furthermore, the Guidance proposes a threshold price relationship such that prices of the ECM linked contract will fall within a 2.5 percent price range for 95 percent of contemporaneously determined closing, settlement or other daily prices over the most recent quarter. Finally, the Commission also stated in the Guidance that it would consider a linked contract that has a trading volume equivalent to 5 percent of the volume of trading in the contract to which it is linked to have sufficient volume potentially to be deemed a SPDC ("minimum threshold").

[22] Appendix A to the Part 36 rules.

To assess whether the NWR contract meets the price linkage criterion, Commission staff obtained price data from ICE and performed the statistical tests cited above. Staff found that, while the Rockies price is determined, in part, by the final settlement price of the NYMEX physically-delivered natural gas futures contract (a DCM contract), the Rockies hub price is not within 2.5 percent of the settlement price of the corresponding NYMEX Henry Hub natural gas futures contract on 95 percent or more of the days. Specifically, during the third quarter of 2009, only 2.4 percent of the Rockies natural gas prices derived from the ICE basis values were within 2.5 percent of the daily settlement price of the NYMEX Henry Hub futures contract. In addition, staff found that the NWR contract fails to meet the volume threshold requirement. In particular, the total trading volume in the NYMEX physically-delivered natural gas contract during the third quarter of 2009 was 14,022,963 contracts, with 5 percent of that number being 701,148 contracts. The number of trades on the ICE centralized market in the NWR contract during the same period was 279,905 contracts (equivalent to 69,976 NYMEX contracts, given the size difference).[23] Thus, centralized-market trades in the NWR contract amounted to less than the minimum threshold.

Due to the specific criteria that a given ECM contract must meet to fulfill the price linkage criterion, the requirements, for all intents and purposes, exclude ECM contracts that are not near facsimiles of DCM contracts even though the ECM contract may specifically use the settlement price to value a position, which is the case of the NWR contract. In this regard, an ECM contract that is priced and traded as if it is a functional equivalent of a DCM contract likely will have a price series that mirrors that of the corresponding DCM contract. In contrast, for contracts that are not look-alikes of DCM contracts, it is reasonable to expect that the two price series would be divergent. While the Rockies hub and the Henry Hub are both supply centers, they are located in two different areas of the United States. Moreover, the Rockies hub is somewhat isolated and the two hubs are not directly connected to each other. These differences contribute to the divergence between the two price series and, as discussed above, increase the likelihood that the "basis" contract is used for material price reference.

i. Federal Register Comments

As noted above, ICE and EI addressed the question of whether the NWR contract is a SPDC. EI noted that the NWR and NYMEX natural gas contracts are not economically equivalent and that the NWR contract's volume is too low to affect the NYMEX natural gas futures contract. ICE opined that the NWR contract's trading volume is too low to affect the price discovery process for the NYMEX natural gas futures contract. In addition, ICE states that the NWR contract simply reflects a price differential between the Rockies and the Henry Hub; "there is no price linkage as contemplated by Congress or the CFTC in its rulemaking."

ii. Conclusion Regarding the Price Linkage Criterion

Based on the above, the Commission finds that the NWR contract does not meet the price linkage criterion because it fails the price relationship and volume tests provided for in the Commission's Guidance.

3. Material Liquidity Criterion

To assess whether the NWR contract meets the material liquidity criterion, the Commission first examined volume and open interest data provided to it by ICE as a general measurement of the NWR market's size and potential importance, and second performed a statistical analysis to measure the effect that changes to NWR prices potentially may have on prices for the NYMEX Henry Hub Natural Gas (a DCM contract), the ICE PG&E Citygate Financial Basis contract (an ECM contract) and the Malin Financial Basis contract (an ECM contract).[24]

The Commission's Guidance (Appendix A to Part 36) notes that "[t]raditionally, objective measures of trading such as volume or open interest have been used as measures of liquidity." In this regard, the Commission in its October 22, 2009, **Federal Register** notice referred to second quarter 2009 trading statistics that ICE had submitted for its NWR contract. Based upon on a required quarterly filing made by ICE on July 27, 2009, the total number of NWR trades executed on ICE's electronic trading platform was 3,013 in the second quarter of 2009, resulting in a daily average of 47.1 trades. During the same period, the NWR contract had a total trading volume on ICE's electronic trading platform of 276,187 contracts and an average daily trading volume of 4,315 contracts. Moreover, the open interest as of June 30, 2009, was 349,931 contracts, which included trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing.[25]

Subsequent to the October 22, 2009, **Federal Register** notice, ICE submitted another quarterly notification filed on November 13, 2009,[26] with updated trading statistics. Specifically, with respect to its NWR contract, 2,950 separate trades occurred on its electronic platform in the third quarter of 2009, resulting in a daily average of 44.7 trades. During the same period, the NWR contract had a total trading volume on its electronic platform of 279,905 contracts (which was an average of 4,241 contracts per day).[27] As of September 30, 2009, open interest in the NWR contract was 345,683 contracts.[28] Reported open interest included positions resulting from trades that were executed on ICE's electronic platform, as well as trades that were executed off of ICE's electronic platform and brought to ICE for clearing.

In Appendix A to Part 36, the material liquidity criterion for SPDC determination specifies that an ECM contract should have a material effect on another contract. To measure the effect that the NWR contract potentially could have on a DCM contract, or on another ECM contract, Commission staff performed a statistical analysis[29] using

[23] The NWR contract is one-quarter the size of the NYMEX Henry Hub physically-delivered futures contract.

[24] As noted above, the material liquidity criterion speaks to the effect that transactions in the potential SPDC may have on trading in "agreements, contracts and transactions listed for trading on or subject to the rules of a designated contract market, a derivatives transaction execution facility, or an electronic trading facility operating in reliance on the exemption in section 2(h)(3) of the Act."

[25] ICE does not differentiate between open interest created by a transaction executed on its trading platform versus that created by a transaction executed off its trading platform. 74 FR 54550 (October 22, 2009).

[26] See Commission Rule 36.3(c)(2), 17 CFR 36.3(c)(2).

[27] By way of comparison, the number of contracts traded in the NWR contract is similar to that exhibited on a liquid futures market and is roughly equivalent to the volume of trading for the Chicago Mercantile Exchange Feeder Cattle futures contract during this period.

[28] By way of comparison, open interest in the NWR contract is roughly equivalent to that in the Chicago Board of Trade's wheat contract.

[29] Specifically, Commission staff econometrically estimated a vector autoregression model using daily natural gas price levels. A vector autoregression model is an econometric model used to capture the dependencies and interrelationships among multiple time series, generalizing the univariate autoregression model. The estimated model displays strong diagnostic evidence of statistical adequacy. In particular, the model's impulse response function was shocked with a one-time rise in Rockies price. The simulation results suggest that, on average over the sample period, a one percent rise in the Rockies natural gas price elicited a 0.176 percent increase in the NYMEX Henry Hub price, as well as a 0.254 percent to 0.276 percent

daily settlement prices (between January 2, 2008, and September 30, 2009) for the NYMEX Henry Hub natural gas contract (a DCM contract) and price levels for the Rockies, PG&E Citygate and Malin market centers.[30] The simulation results suggest that, on average over the sample period, a one percent rise in the Rockies natural gas price elicited a 0.254 percent to 0.276 percent increase in the PG&E Citygate and Malin hub natural gas prices, and a 0.176 percent increase in the NYMEX Henry Hub natural gas price.

i. Federal Register Comments

As noted above, ICE and EI addressed the question of whether the NWR contract is a SPDC. ICE stated in its comment letter that the NWR contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

First, ICE opined that the Commission "seems to have adopted a five trade-per-day test to determine whether a contract is materially liquid. It is worth noting that ICE originally suggested that the CFTC use a five trades-per-day threshold as the basis for an ECM to report trade data to the CFTC." In this regard, the Commission adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs" [31] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC; the threshold is not intended to define liquidity in a broader sense. As noted above, the Commission is basing a finding of material liquidity for the ICE NWR contract, in part, on the fact that there were nearly 45 trades per day on average in the NWR contract during the third quarter of 2009, which was far more than the five trades-per-day threshold that is cited in the ICE comment. In addition, the Commission notes that the number of contracts per transaction in the NWR contract is high (approximately 95 contracts per transaction) and thus, as noted, trading volume (measured in contract units) is substantial. The NWR contract also has substantial open interest.

ICE also stated that "the statistics [provided by ICE] have been misinterpreted and misapplied." In particular, ICE stated that the volume figures used in the Commission's analysis (cited above) "include trades made in all 120 months of each contract" as well as in strips of contract months, and a "more appropriate method of determining liquidity is to examine the activity in a single traded month or strip of a given contract." Furthermore, ICE noted that for the NWR contract, "28% of the trades actually executed in the ICE platform occurred in the single most liquid, usually prompt, month of the contract." EI also expressed its belief that the contract months should be evaluated individually.

It is the Commission's opinion that liquidity, as it pertains to the NWR contract, is typically a function of trading activity in particular lead months and, given sufficient liquidity in such months, the NWR contract itself would be considered liquid. ICE's analysis of its own trade data confirms this to be the case for the NWR contract, and thus, the Commission believes that it applied the statistical data cited above in an appropriate manner for gauging material liquidity.

In addition, ICE and EI both stated that the trades-per-day statistics that it provided to the Commission in its quarterly filing and which are cited above includes 2(h)(1) transactions, which were not completed on the electronic trading platform and should not be considered in the SPDC determination process. The Commission staff asked ICE to review the data it sent in its quarterly filings. In response, ICE confirmed that the volume data it provided and which the Commission cited in its October 22, 2009, **Federal Register** notice, as well as the additional volume information it cites above, includes only transaction data executed on ICE's electronic trading platform.[32] The Commission acknowledges that the open interest information it cites above includes transactions made off the ICE platform. However, once open interest is created, there is no way for ICE to differentiate between "on-exchange" versus "off-exchange" created positions, and all such positions are fungible with one another and may be offset in any way agreeable to the position holder regardless of how the position was initially created.

ii. Conclusion Regarding Material Liquidity

Based on the above, the Commission concludes that the NWR contract meets the material liquidity criterion in that there is sufficient trading activity in the NWR contract to have a material effect on "other agreements, contracts or transactions listed for trading on or subject to the rules of a designated contract market * * * or an electronic trading facility operating in reliance on the exemption in section 2(h)(3) of the Act" (that is, an ECM).

4. Overall Conclusion

After considering the entire record in this matter, including the comments received, the Commission has determined that the NWR contract performs a significant price discovery function under two of the four criteria established in section 2(h)(7) of the CEA. Although the Commission has determined that the NWR contract does not meet the price linkage criterion at this time, the Commission has determined that the NWR contract does meet both the material liquidity and material price reference criteria. Accordingly, the Commission will issue the attached Order declaring that the NWR contract is a SPDC.

Issuance of this Order signals the immediate effectiveness of the Commission's authorities with respect to ICE as a registered entity in connection with its NWR contract,[33] and triggers the obligations, requirements—both procedural and substantive—and timetables prescribed in Commission rule 36.3(c)(4) for ECMs.

V. Related Matters

a. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 ("PRA") [34] imposes certain requirements on Federal agencies, including the Commission, in connection with their conducting or sponsoring any collection of information as defined by the PRA. Certain provisions of Commission rule 36.3 impose new regulatory and reporting requirements on ECMs, resulting in information collection requirements within the meaning of the PRA. OMB previously has approved and

increase in the other two modeled natural gas prices. These multipliers of response emerge with noticeable statistical strength or significance. Based on such long run sample patterns, if the Rockies price rises by 10 percent, then the price of NYMEX Henry Hub natural gas futures contract, as well as those for the Alberta and HSC hubs, each would rise by about 1.5 percent to 2.5 percent. The relatively small magnitude of the multipliers likely reflects the fact that the Rockies hub is isolated and not directly connected to the Henry Hub.

[30] Natural gas prices at the Rockies, PG&E Citygate and Malin trading centers were obtained by adding the daily settlement prices of ICE's NWP Rockies Financial Basis, PG&E Citygate Financial Basis and Malin Financial Basis contracts, respectively, to the contemporaneous daily settlement prices of the NYMEX Henry Hub physically-delivered natural gas futures contract.

[31] 73 FR 75892 (December 12, 2008).

[32] Supplemental data supplied by ICE confirmed that block trades in the third quarter of 2009 were in addition to the trades that were conducted on the electronic platform; block trades comprised 44.4 percent of all transactions in the NWR contract.

[33] See 73 FR 75888, 75893 (Dec. 12, 2008).

[34] 44 U.S.C. 3507(d).

assigned OMB control number 3038–0060 to this collection of information.

b. Cost-Benefit Analysis

Section 15(a) of the CEA [35] requires the Commission to consider the costs and benefits of its actions before issuing an order under the Act. By its terms, section 15(a) does not require the Commission to quantify the costs and benefits of an order or to determine whether the benefits of the order outweigh its costs; rather, it requires that the Commission "consider" the costs and benefits of its actions. Section 15(a) further specifies that the costs and benefits shall be evaluated in light of five broad areas of market and public concern: (1) Protection of market participants and the public; (2) efficiency, competitiveness and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. The Commission may in its discretion give greater weight to any one of the five enumerated areas and could in its discretion determine that, notwithstanding its costs, a particular order is necessary or appropriate to protect the public interest or to effectuate any of the provisions or accomplish any of the purposes of the Act. The Commission has considered the costs and benefits in light of the specific provisions of section 15(a) of the Act and has concluded that the Order, required by Congress to strengthen federal oversight of exempt commercial markets and to prevent market manipulation, is necessary and appropriate to accomplish the purposes of section 2(h)(7) of the Act.

When a futures contract begins to serve a significant price discovery function, that contract, and the ECM on which it is traded, warrants increased oversight to deter and prevent price manipulation or other disruptions to market integrity, both on the ECM itself and in any related futures contracts trading on DCMs. An Order finding that a particular contract is a SPDC triggers this increased oversight and imposes obligations on the ECM calculated to accomplish this goal. The increased oversight engendered by the issue of a SPDC Order increases transparency and helps to ensure fair competition among ECMs and DCMs trading similar products and competing for the same business. Moreover, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the CEA and Commission regulations. Additionally, the ECM must comply with nine core principles established by section 2(h)(7) of the Act—including the obligation to establish position limits and/or accountability standards for the SPDC. Section 4(i) of the CEA authorizes the Commission to require reports for SPDCs listed on ECMs. These increased responsibilities, along with the CFTC's increased regulatory authority, subject the ECM's risk management practices to the Commission's supervision and oversight and generally enhance the financial integrity of the markets.

c. Regulatory Flexibility Act

The Regulatory Flexibility Act ("RFA") [36] requires that agencies consider the impact of their rules on small businesses. The requirements of CEA section 2(h)(7) and the Part 36 rules affect ECMs. The Commission previously has determined that ECMs are not small entities for purposes of the RFA.[37] Accordingly, the Chairman, on behalf of the Commission, hereby certifies pursuant to 5 U.S.C. 605(b) that this Order, taken in connection with section 2(h)(7) of the Act and the Part 36 rules, will not have a significant impact on a substantial number of small entities.

VI. Order

a. Order Relating to the ICE NWP Rockies Financial Basis Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the NWP Rockies Financial Basis contract, traded on the IntercontinentalExchange, Inc., satisfies the statutory material liquidity and material price reference criteria for significant price discovery contracts. Consistent with this determination, and effective immediately, the IntercontinentalExchange, Inc., must comply with, with respect to the NWP Rockies Financial Basis contract, the nine core principles established by new section 2(h)(7)(C). Additionally, the IntercontinentalExchange, Inc., shall be and is considered a registered entity [38] with respect to the NWP Rockies Financial Basis contract and is subject to all the provisions of the Commodity Exchange Act applicable to registered entities.

Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the IntercontinentalExchange, Inc., commence with the issuance of this Order.[39]

Issued in Washington, DC on April 28, 2010, by the Commission.

David A. Stawick,

Secretary of the Commission.

[FR Doc. 2010–10304 Filed 5–3–10; 8:45 am]

BILLING CODE P

[35] 7 U.S.C. 19(a).

[36] 5 U.S.C. 601 *et seq.*

[37] 66 FR 42256, 42268 (Aug. 10, 2001).

[38] 7 U.S.C. 1a(29).

[39] Because ICE already lists for trading a contract (i.e., the Henry Financial LD1 Fixed Price contract) that was previously declared by the Commission to be a SPDC, ICE must submit a written demonstration of compliance with the Core Principles within 30 calendar days of the date of this Order. 17 CFR 36.3(c)(4).

COMMODITY FUTURES TRADING COMMISSION

Order Finding That the ICE PG&E Citygate Financial Basis Contract Traded on the IntercontinentalExchange, Inc., Performs a Significant Price Discovery Function

AGENCY: Commodity Futures Trading Commission.

ACTION: Final order.

SUMMARY: On October 9, 2009, the Commodity Futures Trading Commission ("CFTC" or "Commission") published for comment in the **Federal Register** [1] a notice of its intent to undertake a determination whether the PG&E Citygate Financial Basis ("PGE") contract, traded on the IntercontinentalExchange, Inc. ("ICE"), an exempt commercial market ("ECM") under sections 2(h)(3)–(5) of the Commodity Exchange Act ("CEA" or the "Act"), performs a significant price discovery function pursuant to section 2(h)(7) of the CEA. The Commission undertook this review based upon an initial evaluation of information and data provided by ICE as well as other available information. The Commission has reviewed the entire record in this matter, including all comments received, and has determined to issue an order finding that the PGE contract performs a significant price discovery function. Authority for this action is found in section 2(h)(7) of the CEA and Commission rule 36.3(c) promulgated thereunder.

DATES: *Effective date:* April 28, 2010.

FOR FURTHER INFORMATION CONTACT: Gregory K. Price, Industry Economist, Division of Market Oversight,

[1] 74 FR 52210 (October 9, 2009).

Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW., Washington, DC 20581. Telephone: (202) 418–5515. E-mail: *gprice@cftc.gov*; or Susan Nathan, Senior Special Counsel, Division of Market Oversight, same address. Telephone: (202) 418–5133. E-mail: *snathan@cftc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The CFTC Reauthorization Act of 2008 ("Reauthorization Act") [2] significantly broadened the CFTC's regulatory authority with respect to ECMs by creating, in section 2(h)(7) of the CEA, a new regulatory category—ECMs on which significant price discovery contracts ("SPDCs") are traded—and treating ECMs in that category as registered entities under the CEA.[3] The legislation authorizes the CFTC to designate an agreement, contract or transaction as a SPDC if the Commission determines, under criteria established in section 2(h)(7), that it performs a significant price discovery function. When the Commission makes such a determination, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the Act and Commission regulations, and must comply with nine core principles established by new section 2(h)(7)(C).

On March 16, 2009, the CFTC promulgated final rules implementing the provisions of the Reauthorization Act.[4] As relevant here, rule 36.3 imposes increased information reporting requirements on ECMs to assist the Commission in making prompt assessments whether particular ECM contracts may be SPDCs. In addition to filing quarterly reports of its contracts, an ECM must notify the Commission promptly concerning any contract traded in reliance on the exemption in section 2(h)(3) of the CEA that averaged five trades per day or more over the most recent calendar quarter, and for which the exchange sells its price information regarding the contract to market participants or industry publications, or whose daily closing or settlement prices on 95 percent or more of the days in the most recent quarter were within 2.5 percent of the contemporaneously determined closing, settlement or other daily prices of another contract.

Commission rule 36.3(c)(3) established the procedures by which the Commission makes and announces its determination whether a particular ECM contract serves a significant price discovery function. Under those procedures, the Commission will publish notice in the **Federal Register** that it intends to undertake an evaluation whether the specified agreement, contract or transaction performs a significant price discovery function and to receive written views, data and arguments relevant to its determination from the ECM and other interested persons. Upon the close of the comment period, the Commission will consider, among other things, all relevant information regarding the subject contract and issue an order announcing and explaining its determination whether or not the contract is a SPDC. The issuance of an affirmative order signals the effectiveness of the Commission's regulatory authorities over an ECM with respect to a SPDC; at that time such an ECM becomes subject to all provisions of the CEA applicable to registered entities.[5] The issuance of such an order also triggers the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4).[6]

II. Notice of Intent To Undertake SPDC Determination

On October 9, 2009, the Commission published in the **Federal Register** notice of its intent to undertake a determination whether the PGE contract performs a significant price discovery function, and requested comment from interested parties.[7] Comments were received from the Industrial Energy Consumers of America ("IECA"), Working Group of Commercial Energy Firms ("WGCEF"), ICE, Economists Incorporated ("EI"), Natural Gas Supply Association ("NGSA"), Federal Energy Regulatory Commission ("FERC"), and Financial Institutions Energy Group ("FIEG").[8] The comment letter from FERC [9] did not directly address the issue of whether or not the PGE contract is a SPDC; IECA concluded that the PGE contract is a SPDC, but did not provide a basis for its conclusion.[10] The other parties' comments raised substantive issues with respect to the applicability of section 2(h)(7) to the PGE contract, generally asserting that the PGE contract is not a SPDC as it does not meet the material liquidity, material price reference and price linkage criteria for SPDC determination. Those comments are more extensively discussed below, as applicable.

III. Section 2(h)(7) of the CEA

The Commission is directed by section 2(h)(7) of the CEA to consider

[2] Incorporated as Title XIII of the Food, Conservation and Energy Act of 2008, Pub. L. 110–246, 122 Stat. 1624 (June 18, 2008).

[3] 7 U.S.C. 1a(29).

[4] 74 FR 12178 (Mar. 23, 2009); these rules became effective on April 22, 2009.

[5] Public Law 110–246 at 13203; *Joint Explanatory Statement of the Committee of Conference*, H.R. Rep. No. 110–627, 110 Cong., 2d Sess. 978, 986 (Conference Committee Report). See also 73 FR 75888, 75894 (Dec. 12, 2008).

[6] For an initial SPDC, ECMs have a grace period of 90 calendar days from the issuance of a SPDC determination order to submit a written demonstration of compliance with the applicable core principles. For subsequent SPDCs, ECMs have a grace period of 30 calendar days to demonstrate core principle compliance.

[7] The Commission's Part 36 rules establish, among other things, procedures by which the Commission makes and announces its determination whether a specific ECM contract serves a significant price discovery function. Under those procedures, the Commission publishes a notice in the **Federal Register** that it intends to undertake a determination whether a specified agreement, contract or transaction performs a significant price discovery function and to receive written data, views and arguments relevant to its determination from the ECM and other interested persons.

[8] IECA describes itself as an "association of leading manufacturing companies" whose membership "represents a diverse set of industries including: plastics, cement, paper, food processing, brick, chemicals, fertilizer, insulation, steel, glass, industrial gases, pharmaceutical, aluminum and brewing." WGCEF describes itself as "a diverse group of commercial firms in the domestic energy industry whose primary business activity is the physical delivery of one or more energy commodities to customers, including industrial, commercial and residential consumers" and whose membership consists of "energy producers, marketers and utilities." ICE is an ECM, as noted above. EI is an economic consulting firm with offices located in Washington, DC, and San Francisco, CA. NGSA is an industry association comprised of natural gas producers and marketers. FERC is an independent federal regulatory agency that, among other things, regulates the interstate transmission of natural gas, oil and electricity. FIEG describes itself as an association of investment and commercial banks who are active participants in various sectors of the natural gas markets, "including acting as marketers, lenders, underwriters of debt and equity securities, and proprietary investors." The comment letters are available on the Commission's Web site: *http://www.cftc.gov/lawandregulation/federalregister/federalregistercomments/2009/09-023.html.*

[9] FERC stated that the PGE contract is cash settled and does not contemplate actual physical delivery of natural gas. Accordingly, FERC expressed the opinion that a determination by the Commission that a contract performs a significant price discovery function "would not appear to conflict with FERC's exclusive jurisdiction under the Natural Gas Act (NGA) over certain sales of natural gas in interstate commerce for resale or with its other regulatory responsibilities under the NGA" and further that, "the FERC staff will continue to monitor for any such conflict * * * [and] advise the CFTC" should any such potential conflict arise. CL 06 (references the number of the comment letter ("CL") in the public record).

[10] IECA stated that the subject ICE contract should "be required to come into compliance with core principles mandated by Section 2(h)(7) of the Act and with other statutory provisions applicable to registered entities. [This contract] should be subject to the Commission's position limit authority, emergency authority and large trader reporting requirements, among others." CL 01.

the following criteria in determining a contract's significant price discovery function:

• *Price Linkage*—the extent to which the agreement, contract or transaction uses or otherwise relies on a daily or final settlement price, or other major price parameter, of a contract or contracts listed for trading on or subject to the rules of a designated contract market ("DCM") or derivatives transaction execution facility ("DTEF"), or a SPDC traded on an electronic trading facility, to value a position, transfer or convert a position, cash or financially settle a position, or close out a position.

• *Arbitrage*—the extent to which the price for the agreement, contract or transaction is sufficiently related to the price of a contract or contracts listed for trading on or subject to the rules of a DCM or DTEF, or a SPDC traded on or subject to the rules of an electronic trading facility, so as to permit market participants to effectively arbitrage between the markets by simultaneously maintaining positions or executing trades in the contracts on a frequent and recurring basis.

• *Material price reference*—the extent to which, on a frequent and recurring basis, bids, offers or transactions in a commodity are directly based on, or are determined by referencing or consulting, the prices generated by agreements, contracts or transactions being traded or executed on the electronic trading facility.

• *Material liquidity*—the extent to which the volume of agreements, contracts or transactions in a commodity being traded on the electronic trading facility is sufficient to have a material effect on other agreements, contracts or transactions listed for trading on or subject to the rules of a DCM, DTEF or electronic trading facility operating in reliance on the exemption in section 2(h)(3).

Not all criteria must be present to support a determination that a particular contract performs a significant price discovery function, and one or more criteria may be inapplicable to a particular contract.[11] Moreover, the statutory language neither prioritizes the criteria nor specifies the degree to which a SPDC must conform to the various criteria. In Guidance issued in connection with the Part 36 rules governing ECMs with SPDCs, the Commission observed that these criteria do not lend themselves to a mechanical checklist or formulaic analysis. Accordingly, the Commission has indicated that in making its determinations it will consider the circumstances under which the presence of a particular criterion, or combination of criteria, would be sufficient to support a SPDC determination.[12] For example, for contracts that are linked to other contracts or that may be arbitraged with other contracts, the Commission will consider whether the price of the potential SPDC moves in such harmony with the other contract that the two markets essentially become interchangeable. This co-movement of prices would be an indication that activity in the contract had reached a level sufficient for the contract to perform a significant price discovery function. In evaluating a contract's price discovery role as a price reference, the Commission will consider the extent to which, on a frequent and recurring basis, bids, offers or transactions are directly based on, or are determined by referencing, the prices established for the contract.

IV. Findings and Conclusions

a. The PG&E Citygate (PGE) Financial Basis Contract and the SPDC Indicia

The PGE contract is cash settled based on the difference between the bidweek price index for the price of natural gas at the PG&E Citygate for the month of delivery, as published in Intelligence Press Inc.'s ("IPI's") *Natural Gas Bidweek Survey*, and the final settlement price of the New York Mercantile Exchange's ("NYMEX's") physically-delivered Henry Hub natural gas futures contract for the same calendar month. The IPI bidweek price, which is published monthly, is based on a survey of cash market traders who voluntarily report to IPI data on fixed-price transactions for physical delivery of natural gas at the PG&E Citygate conducted during the last five business days of the month; such bidweek transactions specify the delivery of natural gas on a uniform basis throughout the following calendar month at the agreed upon rate. The IPI bidweek index is published on the first business day of the calendar month in which the natural gas is to be delivered. The size of the PGE contract is 2,500 million British thermal units ("mmBtu"), and the unit of trading is any multiple of 2,500 mmBtu. The PGE contract is listed for up to 72 calendar months commencing with the next calendar month.

The Henry Hub,[13] which is located in Erath, Louisiana, is the primary cash market trading and distribution center for natural gas in the United States. It also is the delivery point and pricing basis for the NYMEX's actively traded, physically-delivered natural gas futures contract, which is the most important pricing reference for natural gas in the United States. The Henry Hub, which is operated by Sabine Pipe Line, LLC, serves as a juncture for 13 different pipelines. These pipelines bring in natural gas from fields in the Gulf Coast region and ship it to major consumption centers along the East Coast and Midwest. The throughput shipping capacity of the Henry Hub is 1.8 trillion mmBtu per day.

In addition to the Henry Hub, there are a number of other locations where natural gas is traded. In 2008, there were 33 natural gas market centers in North America.[14] Some of the major trading centers include Alberta, Northwest Rockies, Southern California border and the Houston Ship Channel. For locations that are directly connected to the Henry Hub by one or more pipelines and where there typically is adequate shipping capacity, the price at the other locations usually directly tracks the price at the Henry Hub, adjusted for transportation costs. However, at other locations that are not directly connected to the Henry Hub or where shipping capacity is limited, the prices at those locations often diverge from the Henry Hub price. Furthermore, one local price may be significantly different than the price at another location even though the two markets' respective distances from the Henry Hub are the same. The reason for such pricing disparities is that a given location may experience supply and demand factors that are specific to that region, such as differences in pipeline shipping capacity, unusually high or low demand for heating or cooling or supply disruptions caused by severe weather. As a consequence, local natural gas prices can differ from the Henry Hub price by more than the cost of shipping and such price differences can vary in an unpredictable manner.

The PG&E Citygate is part of the Golden Gate Market Center, which is located in Northern California. The Golden Gate Market Center offers seven

[11] In its October 9, 2009, **Federal Register** release, the Commission identified material price reference, price linkage and material liquidity as the possible criteria for SPDC determination of the PGE contract. Arbitrage was not identified as a possible criterion and will not be discussed further in this document or the associated Order.

[12] 17 CFR 36, Appendix A.

[13] The term "hub" refers to a juncture where two or more natural gas pipelines are connected. Hubs also serve as pricing points for natural gas at the particular locations.

[14] See *http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

different transaction points, which are Malin, Citygate, Kern River Station, High Desert Lateral, Daggett, Southern Trails and Topock. Citygate serves as interconnection between the backbone pipeline system and the local transmission and distribution lines.[15] The Golden Gate Market Center had an estimated throughput capacity of two billion cubic feet per day in 2008. Moreover, the number of pipeline interconnections at the Golden Gate Market Center was nine in 2008, up from eight in 2003. Lastly, the pipeline interconnection capacity of the Golden Gate Market Center in 2008 was 6 billion cubic feet per day, which constituted a 32 percent increase over the pipeline interconnection capacity in 2003.[16] The PG&E Citygate is far removed from the Henry Hub and is not directly connected to the Henry Hub by an existing pipeline.

The local price at the PG&E Citygate typically differs from the price at the Henry Hub. Thus, the price of the Henry Hub physically-delivered futures contract is an imperfect proxy for the PG&E Citygate price. Moreover, exogenous factors, such as adverse weather, can cause the PG&E Citygate gas price to differ from the Henry Hub price by an amount that is more or less than the cost of shipping, making the NYMEX Henry Hub futures contract even less precise as a hedging tool than desired by market participants. Basis contracts[17] allow traders to more accurately discover prices at alternative locations and hedge price risk that is associated with natural gas at such locations. In this regard, a position at a local price for an alternative location can be established by adding the appropriate basis swap position to a position taken in the NYMEX physically-delivered Henry Hub contract (or in the NYMEX or ICE Henry Hub look-alike contract, which cash settle based on the NYMEX physically-delivered natural gas contract's final settlement price).

In its October 9, 2009, **Federal Register** notice, the Commission identified material price reference, price linkage and material liquidity as the potential SPDC criteria applicable to the PGE contract. Each of these criteria is discussed below.[18]

1. Material Price Reference Criterion

The Commission's October 9, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission considered the fact that ICE maintains exclusive rights over IPI's bidweek price indices. As a result, no other exchange can offer such a basis contract based on IPI's PG&E Citygate bidweek index. While other third-party price providers produce natural gas price indices for this and other trading centers, market participants indicate that the IPI PG&E Citygate bidweek index is highly regarded for this particular location and should market participants wish to establish a hedged position based on this index, they would need to do so by taking a position in the ICE PGE swap since ICE has the right to the IPI index for cash settlement purposes. In addition, ICE sells its price data to market participants in a number of different packages which vary in terms of the hubs covered, time periods, and whether the data are daily only or historical. For example, ICE offers "West Gas End of Day" and "OTC Gas End of Day"[19] with access to all price data or just current prices plus a selected number of months (i.e., 12, 24, 36 or 48 months) of historical data. These two packages include price data for the PGE contract.

The Commission will rely on one of two sources of evidence—direct or indirect—to determine that the price of a contract was being used as a material price reference and therefore, serving a significant price discovery function.[20] With respect to direct evidence, the Commission will consider the extent to which, on a frequent and recurring basis, cash market bids, offers or transactions are directly based on or quoted at a differential to, the prices generated on the ECM in question. Direct evidence may be established when cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract in question. Cash market prices are set explicitly at a differential to the section 2(h)(3) contract when, for instance, they are quoted in dollars and cents above or below the reference contract's price. Cash market prices are set implicitly at a differential to a section 2(h)(3) contract when, for instance, they are arrived at after adding to, or subtracting from the section 2(h)(3) contract, but then quoted or reported at a flat price. With respect to indirect evidence, the Commission will consider the extent to which the price of the contract in question is being routinely disseminated in widely distributed industry publications—or offered by the ECM itself for some form of remuneration—and consulted on a frequent and recurring basis by industry participants in pricing cash market transactions.

The PG&E Citygate is a major trading center for natural gas in the United States. Traders, including producers, keep abreast of the prices of the PGE contract when conducting cash deals. These traders look to a competitively determined price as an indication of expected values of natural gas at the PG&E Citygate when entering into cash market transaction for natural gas, especially those trades providing for physical delivery in the future. Traders use the ICE PGE contract, as well as other ICE basis swap contracts, to hedge cash market positions and transactions—activities which enhance the PGE contract's price discovery utility. The substantial volume of trading and open interest in the PGE contract appears to attest to its use for this purpose. While the PGE contract's settlement prices may not be the only factor influencing spot and forward transactions, natural gas traders consider the ICE price to be a critical factor in conducting OTC transactions.[21] As a result, the PGE contract satisfies the direct price reference test.

In terms of indirect price reference, ICE sells the PGE contract's prices as part of a broad package. The Commission notes that the PG&E Citygate is a major natural gas trading point, and the PGE contract's prices are well regarded in the industry as indicative of the value of natural gas at the PG&E Citygate. Accordingly, the Commission believes that it is reasonable to conclude that market participants are purchasing the data packages that include the PGE contract's prices in substantial part because the PGE contract prices have particular value to them. Moreover, such prices are

[15] The cash market transactions included in the comparable Platts index are those fixed-price gas deliveries from Pacific Gas and Electric's intrastate transmission system to citygates on PG&E's local distribution system in Northern California.

[16] See *http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf*

[17] Basis contracts denote the difference in the price of natural gas at a specified location minus the price of natural gas at the Henry Hub. The differential can be either a positive or negative value.

[18] As noted above, the Commission did not find an indication of arbitrage in connection with this contract; accordingly, that criterion was not discussed in reference to the PGE contract.

[19] The OTC Gas End of Day dataset includes daily settlement prices for natural gas contracts listed for all points in North America.

[20] 17 CFR part 36, appendix A.

[21] In addition to referencing ICE prices, natural gas market firms participating in the PG&E Citygate market may rely on other cash market quotes as well as industry publications and price indices that are published by third-party price reporting firms when entering into natural gas transactions.

consulted on a frequent and reoccurring basis by industry participants in pricing cash market transactions. In light of the above, the PGE contract meets the indirect price reference test.

NYMEX lists a futures contract that is comparable to the ICE PGE contract on its ClearPort platform. However, unlike the ICE contract, none of the trades in the NYMEX, PG&E Citygate Basis Swap (Platts IFERC) futures contract are executed in NYMEX's centralized marketplace; instead, all of the transactions originate as bilateral swaps that are submitted to NYMEX for clearing. The daily settlement prices of the NYMEX PG&E Citygate Basis Swap futures contract are influenced, in part, by the daily settlement prices of the ICE PGE contract. This is because NYMEX determines the daily settlement prices for its natural gas basis swap contracts through a survey of cash market voice brokers. Voice brokers, in turn, refer to the ICE PGE price, among other information, as an important indicator as to where the market is trading. Therefore, the ICE PGE price influences the settlement price for the NYMEX PG&E Citygate Basis Swap futures contract. This is supported by an analysis of the daily settlement prices for the NYMEX and ICE PG&E Citygate contracts. In this regard, 97 percent of the daily settlement prices for the NYMEX PG&E Citygate Basis Swap futures contract are within one standard deviation of the PGE contract's price settlement prices.

Lastly, the fact that the PGE contract does not meet the price linkage criterion (discussed below) bolsters the argument for material price reference. As noted above, the Henry Hub is the pricing reference for natural gas in the United States. However, regional market conditions may cause the price of natural gas in another area of the country to diverge by more than the cost of transportation, thus making the Henry Hub price an imperfect proxy for the local gas price. The more variable the local natural gas price is, the more traders need to accurately hedge their price risk. Basis swap contracts provide a means of more accurately pricing natural gas at a location other than the Henry Hub. An analysis of PG&E Citygate natural gas prices showed that 55 percent of the observations were more than 2.5 percent different than the contemporaneous Henry Hub prices. The average PG&E Citygate basis value between January 2008 and September 2009 was −$0.16 per mmBtu with a variance of $0.10 per mmBtu.

i. Federal Register Comments

ICE stated in its comment letter that the PGE contract does not meet the material price reference criterion for SPDC determination. ICE argued that the Commission appeared to base the case that the PGE contract is potentially a SPDC on two disputable assertions. First, in issuing its notice of intent to determine whether the PGE contract is a SPDC, the CFTC cited a general conclusion in its ECM study "that certain market participants referred to ICE as a price discovery market for certain natural gas contracts." [22] ICE states that CFTC's reason is "hard to quantify as the ECM report does not mention" this contract as a potential SPDC. "It is unknown which market participants made this statement in 2007 or the contracts that were referenced." [23] In response to the above comment, the Commission notes that it cited the ECM study's general finding that some ICE natural gas contracts appear to be regarded as price discovery markets merely as an indicia that an investigation of certain ICE contracts may be warranted, and was not intended to serve as the sole basis for determining whether or not a particular contract meets the material price reference criterion.

Second, ICE argued that the Commission should not base a determination that the PGE contract is a SPDC on the fact that this contract has the exclusive right to base its settlement on the IPI PG&E Citygate Index price. While the Commission acknowledges that there are other firms that produce price indices for the PG&E Citygate, as it notes above, market participants indicate that the IPI Index is very highly regarded and should they wish to establish a hedged position based on this index, they would need to do so by taking a position in the ICE PGE swap since ICE has the exclusive right to use the IPI index.[24]

WGCEF, NGSA, EI and FIEG all stated that the PGE contract does not satisfy the material price reference criterion. The commenters argued that other contracts (physical or financial) are not indexed based on the ICE PGE contract price, but rather are indexed based on the underlying cash price series against which the ICE PGE contract is settled. Thus, they contend that the underlying cash price series is the authentic reference price and not the ICE contract itself. The Commission believes that this interpretation of price reference is too limiting in that it only considers the final index value on which the contract is cash settled after trading ceases. Instead, the Commission believes that a cash-settled derivatives contract could meet the price reference criteria if market participants "consult on a frequent and recurring basis" the derivatives contract when pricing forward, fixed-price commitments or other cash-settled derivatives that seek to "lock in" a fixed price for some future point in time to hedge against adverse price movements.

As noted above, the PG&E Citygate is a major trading center for natural gas in North America. Traders, including producers, keep abreast of the prices of the PGE contract when conducting cash deals. These traders look to a competitively determined price as an indication of expected values of natural gas at the PG&E Citygate when entering into cash market transaction for natural gas, especially those trades that provide for physical delivery in the future. Traders use the ICE PGE contract to hedge cash market positions and transactions, which enhances the PGE contract's price discovery utility. While the PGE contract's settlement prices may not be the only factor influencing spot and forward transactions, natural gas traders consider the ICE price to be a crucial factor in conducting OTC transactions.

Both EI and WGCEF stated that publication of price data in a package format is a weak justification for material price reference. These commenters argue that market participants generally do not purchase ICE data sets for one contract's prices, such as those for the PGE contract. Instead, traders are interested in the settlement prices, so the fact that ICE sells the PGE prices as part of a broad package is not conclusive evidence that market participants are buying the ICE data sets because they find the PGE prices have substantial value to them. The Commission notes that the PG&E Citygate is a major natural gas trading point, and the PGE contract's prices are well regarded in the industry as indicative of the value of natural gas at the PG&E Citygate. Accordingly, the Commission believes that it is

[22] CL 03.

[23] CL 03.

[24] Futures and swaps based on other PG&E Citygate indices have not met with the same market acceptance as the PGE contract. For example, NYMEX lists a basis swap contract that is comparable to the PGE contract with the exception that it uses a different price index for cash settlement. Open interest as of September 30, 2009, was approximately 19,000 contracts in the NYMEX PG&E Citygate Basis Swap contract versus about 167,000 contracts in ICE's PGE contract. Moreover, there has been no centralized-market trading in the NYMEX PG&E Citygate Basis Swap contract, so that contract does not serve as a source of price discovery for cash market traders with natural gas at that location.

reasonable to conclude that market participants are purchasing the data packages that include the PGE contract's prices in substantial part because the PGE contract prices have particular value to them.

ii. Conclusion Regarding Material Price Reference

Based on the above, the Commission finds that the PGE contract meets the material price reference criterion because cash market transactions are being priced on a frequent and recurring basis at a differential to the PGE contract's price (direct evidence). Moreover, the ECM sells the PGE contract's price data to market participants and it is reasonable to conclude that market participants are purchasing the data packages that include the PGE contract's prices in substantial part because the PGE contract prices have particular value to them. Furthermore, such prices are consulted on a frequent and reoccurring basis by industry participants in pricing cash market transactions (indirect evidence).

2. Price Linkage Criterion

In its October 9, 2009, **Federal Register** notice, the Commission identified price linkage as a potential basis for a SPDC determination with respect to the PGE contract. In this regard, the final settlement of the PGE contract is based, in part, on the final settlement price of the NYMEX's physically-delivered natural gas futures contract, where the NYMEX is registered with the Commission as a DCM.

The Commission's Guidance on Significant Price Discovery Contracts [25] notes that a "price-linked contract is a contract that relies on a contract traded on another trading facility to settle, value or otherwise offset the price-linked contract." Furthermore, the Guidance notes that, "[f]or a linked contract, the mere fact that a contract is linked to another contract will not be sufficient to support a determination that a contract performs a significant price discovery function. To assess whether such a determination is warranted, the Commission will examine the relationship between transaction prices of the linked contract and the prices of the referenced contract. The Commission believes that where material liquidity exists, prices for the linked contract would be observed to be substantially the same as or move substantially in conjunction with the prices of the referenced contract." Furthermore, the Guidance proposes a threshold price relationship such that prices of the ECM linked contract will fall within a 2.5 percent price range for 95 percent of contemporaneously determined closing, settlement or other daily prices over the most recent quarter. Finally, the Commission also stated in the Guidance that it would consider a linked contract that has a trading volume equivalent to 5 percent of the volume of trading in the contract to which it is linked to have sufficient volume potentially to be deemed a SPDC ("minimum threshold").

To assess whether the PGE contract meets the price linkage criterion, Commission staff obtained price data from ICE and performed the statistical tests cited above. Staff found that while the PG&E Citygate price is determined, in part, by the final settlement price of the NYMEX physically-delivered natural gas futures contract (a DCM contract), the PG&E Citygate price is not within 2.5 percent of the settlement price of the corresponding NYMEX Henry Hub natural gas futures contract on 95 percent of the days. Specifically, during the third quarter of 2009, 45 percent of the PG&E Citygate natural gas prices derived from the ICE basis values were within 2.5 percent of the daily settlement price of the NYMEX Henry Hub futures contract. In addition, staff finds that the PGE contract fails to meet the volume threshold requirement. In particular, the total trading volume in the NYMEX Natural Gas contract during the third quarter of 2009 was 14,022,963 contracts, with 5 percent of that number being 701,148 contracts. The number of trades on the ICE centralized market in the PGE contract during the same period was 108,468 contracts (equivalent to 27,117 NYMEX contracts, given the size difference).[26] Thus, centralized-market trades in the PGE contract amounted to less than the minimum threshold.

Due to the specific criteria that a given ECM contract must meet to fulfill the price linkage criterion, the requirements, for all intents and purposes, exclude ECM contracts that are not near facsimiles of DCM contracts. That is, even though an ECM contract may specifically use a DCM contract's settlement price to value a position, which is the case of the PGE contract, a substantive difference between the two price series would rule out the presence of price linkage. In this regard, an ECM contract that is priced and traded as if it is a functional equivalent of a DCM contract likely will have a price series that mirrors that of the corresponding DCM contract. In contrast, for contracts that are not look-alikes of DCM contracts, it is reasonable to expect that the two price series would be divergent. The PG&E Citygate and the Henry Hub are located in two different areas of the United States. The Henry Hub primarily is a supply center while the PG&E Citygate primarily is a demand center. These differences contribute to the divergence between the two price series and, as discussed below, increase the likelihood that the "basis" contract is used for material price reference.

i. Federal Register Comments

NGSA [27] stated that the PGE contract does not meet the price linkage criterion because basis contracts, including the PGE contract, are not equivalent to the NYMEX physically-delivered Henry Hub contract. EI [28] also noted that the PGE and NYMEX natural gas contracts are not economically equivalent and that the PGE contract's volume is too low to affect the NYMEX natural gas futures contract. WGCEF [29] stated that the PG&E Citygate price is determined, in part, by the final settlement price of the NYMEX Henry Hub futures contract. However, WGCEF goes on to state that the PGE contract "(a) is not substantially the same as the NYMEX [natural gas futures contract] * * * nor (b) does it move substantially in conjunction" with the NYMEX natural gas futures contract. ICE [30] opined that the PGE contract's trading volume is too low to affect the price discovery process for the NYMEX natural gas futures contract. In addition, ICE states that the PGE contract simply reflects a price differential between PG&E Citygate and the Henry Hub; "there is no price linkage as contemplated by Congress or the CFTC in its rulemaking." FIEG [31] acknowledged that the PGE contract is a locational spread that is based in part on the NYMEX natural gas futures price, but also questioned the significance of this fact relative to the price linkage criterion since the key component of the spread is the price at the PG&E Citygate location and not the NYMEX physically-delivered natural gas futures price.

ii. Conclusion Regarding the Price Linkage Criterion

Based on the above, the Commission finds that the PGE contract does not meet the price linkage criterion because

[25] Appendix A to the Part 36 rules.

[26] The PGE contract is one-quarter the size of the NYMEX Henry Hub physically-delivered futures contract.

[27] CL 05.

[28] CL 04.

[29] CL 02.

[30] CL 03.

[31] CL 07.

it fails the price relationship and volume tests provided for in the Commission's Guidance.

3. Material Liquidity Criterion

To assess whether the PGE contract meets the material liquidity criterion, the Commission first examined volume and open interest data provided to it by ICE as a general measurement of the PGE market's size and potential importance, and second performed a statistical analysis to measure the effect that changes to PGE prices potentially may have on prices for the NYMEX Henry Hub Natural Gas (a DCM contract), the ICE NWP Financial Basis contract (an ECM contract) and the ICE Malin Financial Basis contract (an ECM contract).[32]

The Commission's Guidance (Appendix A to Part 36) notes that "[t]raditionally, objective measures of trading such as volume or open interest have been used as measures of liquidity." In this regard, the Commission in its October 9, 2009, **Federal Register** notice referred to second quarter 2009 trading statistics that ICE had submitted for its PGE contract. Based upon on a required quarterly filing made by ICE on July 27, 2009, the total number of PGE trades executed on ICE's electronic trading platform was 1,142 in the second quarter of 2009, resulting in a daily average of 17.8 trades. During the same period, the PGE contract had a total trading volume on ICE's electronic trading platform of 99,418 contracts and an average daily trading volume of 1,553.4 contracts. Moreover, the open interest as of June 30, 2009, was 150,299 contracts, which includes trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing.[33]

Subsequent to the October 9, 2009, **Federal Register** notice, ICE submitted another quarterly notification filed on November 13, 2009,[34] with updated trading statistics. Specifically, with respect to its PGE contract, 1,514 separate trades occurred on its electronic platform in the third quarter of 2009, resulting in a daily average of 22.9 trades. During the same period, the PGE contract had a total trading volume on its electronic platform of 108,468 contracts (which was an average of 1,643 contracts per day).[35] As of September 30, 2009, open interest in the PGE contract was 166,981[36] contracts. Reported open interest included positions resulting from trades that were executed on ICE's electronic platform, as well as trades that were executed off of ICE's electronic platform and brought to ICE for clearing.

In the Guidance, the Commission stated that material liquidity can be identified by the impact liquidity exhibits through observed prices. Thus, to make a determination whether the PGE contract has such material impact, the Commission reviewed the relevant trading statistics (noted above). In this regard, the average number trades per day in the second and third quarters of 2009 were above the minimum reporting level (5 trades per day). Moreover, trading activity in the PGE contract, as characterized by total quarterly volume, indicates that the PGE contract experiences trading activity that generally exceeds that found in thinly-traded markets.[37] Thus, it is reasonable to infer that the PGE contract could have a material effect on other ECM contracts or on DCM contracts.

To measure the effect that the PGE contract potentially could have on a DCM contract, or on another ECM contract, Commission staff performed a statistical analysis[38] using daily settlement prices (between January 2, 2008, and September 30, 2009) for the PGE contract, as well as for the NYMEX Henry Hub natural gas contract (a DCM contract) and the ICE NWP Rockies Financial Basis and ICE Malin Financial Basis contracts (ECM contracts). The simulation results suggest that, on average over the sample period, a one percent rise in the PGE contract's price elicited a 1.1 percent increase in each of the NYMEX Henry Hub and ICE Malin prices, as well as a 1 percent increase in the Rockies price.

i. Federal Register Comments

As noted above, comments were received from seven individuals and organizations, with five comments being directly applicable to the SPDC determination of the ICE PGE contract. WGCEF, EI, FIEG, ICE and NGSA generally agreed that the PGE contract does not meet the material liquidity criterion.

WGCEF[39] and NGSA[40] both stated that the PGE contract does not materially affect other contracts that are listed for trading on DCMs or ECMs, as well as other over-the-counter contracts. Instead, the PGE contract is influenced by the underlying PG&E Citygate cash price index and the final settlement price of the NYMEX Henry Hub natural gas futures contract, not vice versa. FIEG[41] stated that the PGE contract cannot have a material effect on NYMEX contract because the PGE contract trades on a differential and represents "one leg (and not the relevant leg) of the locational spread." The Commission's statistical analysis shows that changes in the ICE PGE contract's price significantly influences the prices of other contracts that are traded on DCMs and ECMs.

First, ICE opined that the Commission "seems to have adopted a five trade-per-day test to determine whether a contract is materially liquid. It is worth noting that ICE originally suggested that the CFTC use a five trades-per-day threshold as the basis for an ECM to report trade data to the CFTC." In this regard, the Commission adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs"

[32] As noted above, the material liquidity criterion speaks to the effect that transactions in the potential SPDC may have on trading in "agreements, contracts and transactions listed for trading on or subject to the rules of a designated contract market, a derivatives transaction execution facility, or an electronic trading facility operating in reliance on the exemption in section 2(h)(3) of the Act."

[33] ICE does not differentiate between open interest created by a transaction executed on its trading platform versus that created by a transaction executed off its trading platform.

[34] See Commission Rule 36.3(c)(2), 17 CFR 36.3(c)(2).

[35] By way of comparison, the number of contracts traded in the PGE contract is similar to that exhibited on a liquid futures market and is roughly equivalent to the volume of trading for the NYMEX Palladium futures contract during this period.

[36] By way of comparison, open interest in the PGE contract is similar to that exhibited on a liquid futures market and is roughly equivalent to that in the Chicago Board of Trade's soybean meal futures contract.

[37] Staff has advised the Commission that in its experience, a thinly-traded contract is, generally, one that has a quarterly trading volume of 100,000 contracts or less. In this regard, in the third quarter of 2009, physical commodity futures contracts with trading volume of 100,000 contracts or fewer constituted less than one percent of total trading volume of all physical commodity futures contracts.

[38] Specifically, Commission staff econometrically estimated a vector autoregression (VAR) model using daily settlement prices. A vector autoregression model is an econometric model used to capture the evolution and the interdependencies between multiple time series, generalizing the univariate autoregression models. The estimated model displays strong diagnostic evidence of statistical adequacy. In particular, the model's impulse response function was shocked with a one-time rise in PGE contract's price. The simulation results suggest that, on average over the sample period, a one-percent rise in the PGE contract's price elicited a 1.1 percent increase in the NYMEX Henry Hub and Malin prices, as well as a one percent increase in the Rockies contract's price. These multipliers of response emerge with noticeable statistical strength or significance. Based on such long run sample patterns, if the PGE contract's price rises by 10 percent, then the price of NYMEX Henry Hub natural gas futures contract, as well as those for the ICE basis swap contracts based on the Rockies and Malin hubs, each would rise by about 10 percent to 11 percent.

[39] CL 02.

[40] CL 05.

[41] CL 07.

rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC. As noted above, the Commission is basing a finding of material liquidity for the ICE PGE contract, in part, on the fact that there have been more than 20 trades per day on average in the PGE contract during the third quarter of 2009, which is quadruple the five trades-per-day that is cited in the ICE comment. In addition, the Commission notes that the number of contracts per transaction in the PGE contract is high (approximately 72 contracts per transaction) and thus, as noted, trading volume (measured in contract units) is substantial. The PGE contract also has significant open interest.

ICE implied that the statistics provided by ICE were misinterpreted and misapplied by the Commission. In particular, ICE stated that the volume figures used in the Commission's analysis (cited above) "include trades made in all [72] months of * * * [the] contract" as well as in strips of contract months, and a "more appropriate method of determining liquidity is to examine the activity in a single traded month or strip of a given contract." ICE stated that only about 25 to 40 percent of the trades occurred in the single most liquid, usually prompt, month of the contract.

It is the Commission's opinion that liquidity, as it pertains to the PGE contract, is typically a function of trading activity in particular lead months and, given sufficient liquidity in such months, the PGE contract itself would be considered liquid. ICE's analysis of its own trade data confirms this to be the case for the PGE contract, and thus, the Commission believes that it applied the statistical data cited above in an appropriate manner for gauging material liquidity.

In addition, EI and ICE stated that the trades-per-day statistics that it provided to the Commission in its quarterly filing and which are cited above includes 2(h)(1) transactions, which were not completed on the electronic trading platform and should not be considered in the SPDC determination process. Commission staff asked ICE to review the data it sent in its quarterly filings. In response, ICE confirmed that the volume data it provided and which the Commission cited in its October 9, 2009, **Federal Register** notice, as well as the additional volume information it cites above, includes only transaction data executed on ICE's electronic trading platform. The Commission acknowledges that the open interest information it cites above includes transactions made off the ICE platform.[42] However, once open interest is created, there is no way for ICE to differentiate between "on-exchange" versus "off-exchange" created positions, and all such positions are fungible with one another and may be offset in any way agreeable to the position holder regardless of how the position was initially created.

ii. Conclusion Regarding Material Liquidity

Based on the above, the Commission concludes that the PGE contract meets the material liquidity criterion in that there is sufficient trading activity in the PGE contract to have a material effect on "other agreements, contracts or transactions listed for trading on or subject to the rules of a designated contract market * * * or an electronic trading facility operating in reliance on the exemption in section 2(h)(3) of the Act" (that is, an ECM).

4. Overall Conclusion

After considering the entire record in this matter, including the comments received, the Commission has determined that the PGE contract performs a significant price discovery function under two of the four criteria established in section 2(h)(7) of the CEA. Although the Commission has determined that the PGE contract does not meet the price linkage criterion at this time, the Commission has concluded that the PGE contract does meet both the material liquidity and material price reference criteria. Accordingly, the Commission is issuing the attached Order declaring that the PGE contract is a SPDC.

Issuance of this Order signals the immediate effectiveness of the Commission's authorities with respect to ICE as a registered entity in connection with its PGE contract,[43] and triggers the obligations, requirements—both procedural and substantive—and timetables prescribed in Commission rule 36.3(c)(4) for ECMs.

V. Related Matters

a. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 ("PRA")[44] imposes certain requirements on Federal agencies, including the Commission, in connection with their conducting or sponsoring any collection of information as defined by the PRA. Certain provisions of Commission rule 36.3 impose new regulatory and reporting requirements on ECMs, resulting in information collection requirements within the meaning of the PRA. OMB previously has approved and assigned OMB control number 3038–0060 to this collection of information.

b. Cost-Benefit Analysis

Section 15(a) of the CEA[45] requires the Commission to consider the costs and benefits of its actions before issuing an order under the Act. By its terms, section 15(a) does not require the Commission to quantify the costs and benefits of an order or to determine whether the benefits of the order outweigh its costs; rather, it requires that the Commission "consider" the costs and benefits of its actions. Section 15(a) further specifies that the costs and benefits shall be evaluated in light of five broad areas of market and public concern: (1) Protection of market participants and the public; (2) efficiency, competitiveness and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. The Commission may in its discretion give greater weight to any one of the five enumerated areas and could in its discretion determine that, notwithstanding its costs, a particular order is necessary or appropriate to protect the public interest or to effectuate any of the provisions or accomplish any of the purposes of the Act. The Commission has considered the costs and benefits in light of the specific provisions of section 15(a) of the Act and has concluded that the Order, required by Congress to strengthen federal oversight of exempt commercial markets and to prevent market manipulation, is necessary and appropriate to accomplish the purposes of section 2(h)(7) of the Act.

When a futures contract begins to serve a significant price discovery function, that contract, and the ECM on which it is traded, warrants increased oversight to deter and prevent price manipulation or other disruptions to market integrity, both on the ECM itself and in any related futures contracts trading on DCMs. An Order finding that a particular contract is a SPDC triggers this increased oversight and imposes obligations on the ECM calculated to accomplish this goal. The increased oversight engendered by the issue of a SPDC Order increases transparency and

[42] Supplemental data supplied by the ICE confirmed that block trades in the third quarter of 2009 were in addition to the trades that were conducted on the electronic platform; block trades comprised 63.4 percent of all transactions in the PGE contract.

[43] See 73 FR 75888, 75893 (Dec. 12, 2008).

[44] 44 U.S.C. 3507(d).

[45] 7 U.S.C. 19(a).

helps to ensure fair competition among ECMs and DCMs trading similar products and competing for the same business. Moreover, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the CEA and Commission regulations. Additionally, the ECM must comply with nine core principles established by section 2(h)(7) of the Act—including the obligation to establish position limits and/or accountability standards for the SPDC. Section 4(i) of the CEA authorizes the Commission to require reports for SPDCs listed on ECMs. These increased responsibilities, along with the CFTC's increased regulatory authority, subject the ECM's risk management practices to the Commission's supervision and oversight and generally enhance the financial integrity of the markets.

c. Regulatory Flexibility Act

The Regulatory Flexibility Act ("RFA") [46] requires that agencies consider the impact of their rules on small businesses. The requirements of CEA section 2(h)(7) and the Part 36 rules affect ECMs. The Commission previously has determined that ECMs are not small entities for purposes of the RFA.[47] Accordingly, the Chairman, on behalf of the Commission, hereby certifies pursuant to 5 U.S.C. 605(b) that this Order, taken in connection with section 2(h)(7) of the Act and the Part 36 rules, will not have a significant impact on a substantial number of small entities.

VI. Order

a. Order Relating to the ICE PG&E Citygate Financial Basis Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following Order:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the PG&E Citygate Financial Basis contract, traded on the IntercontinentalExchange, Inc., satisfies the statutory material liquidity and material price reference criteria for significant price discovery contracts. Consistent with this determination, and effective immediately, the IntercontinentalExchange, Inc., must comply with, with respect to the PG&E Citygate Financial Basis contract, the nine core principles established by new section 2(h)(7)(C). Additionally, the IntercontinentalExchange, Inc., shall be and is considered a registered entity [48] with respect to the PG&E Citygate Financial Basis contract and is subject to all the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the IntercontinentalExchange, Inc., commence with the issuance of this Order.[49]

Issued in Washington, DC on April 28, 2010, by the Commission.

David A. Stawick,

Secretary of the Commission.

[FR Doc. 2010–10305 Filed 5–3–10; 8:45 am]

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[46] 5 U.S.C. 601 *et seq.*

[47] 66 FR 42256, 42268 (Aug. 10, 2001).

[48] 7 U.S.C. 1a(29).

[49] Because ICE already lists for trading a contract (i.e., the Henry Financial LD1 Fixed Price contract) that was previously declared by the Commission to be a SPDC, ICE must submit a written demonstration of compliance with the Core Principles within 30 calendar days of the date of this Order. 17 CFR 36.3(c)(4).

COMMODITY FUTURES TRADING COMMISSION

Orders Finding That the Henry Financial Basis Contract, Henry Financial Index Contract and Henry Financial Swing Contract Traded on the IntercontinentalExchange, Inc., Do Not Perform a Significant Price Discovery Function

AGENCY: Commodity Futures Trading Commission.

ACTION: Final orders.

SUMMARY: On October 20, 2009, the Commodity Futures Trading Commission ("CFTC" or "Commission") published for comment in the **Federal Register** [1] a notice of its intent to undertake a determination whether the Henry Financial Basis ("HEN") contract, Henry Financial Index ("HIS") contract and Henry Financial Swing ("HHD") contract traded on the IntercontinentalExchange, Inc. ("ICE"), an exempt commercial market ("ECM") under sections 2(h)(3)–(5) of the Commodity Exchange Act ("CEA" or the "Act"), perform a significant price discovery function pursuant to section 2(h)(7) of the CEA. The Commission undertook this review based upon an initial evaluation of information and data provided by ICE as well as other available information. The Commission has reviewed the entire record in this matter, including all comments received, and has determined to issue orders finding that the HEN, HIS and HHD contracts do not perform a significant price discovery function. Authority for this action is found in section 2(h)(7) of the CEA and Commission rule 36.3(c) promulgated thereunder.

DATES: *Effective date:* April 28, 2010.

FOR FURTHER INFORMATION CONTACT: Gregory K. Price, Industry Economist, Division of Market Oversight, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW., Washington, DC 20581. Telephone: (202) 418–5515. E-mail: *gprice@cftc.gov*; or Susan Nathan, Senior Special Counsel, Division of Market Oversight, same address. Telephone: (202) 418–5133. E-mail: *snathan@cftc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The CFTC Reauthorization Act of 2008 ("Reauthorization Act") [2] significantly broadened the CFTC's regulatory authority with respect to ECMs by creating, in section 2(h)(7) of the CEA, a new regulatory category—ECMs on which significant price discovery contracts ("SPDCs") are traded—and treating ECMs in that category as registered entities under the CEA.[3] The legislation authorizes the CFTC to designate an agreement, contract or transaction as a SPDC if the Commission determines, under criteria established in section 2(h)(7), that it performs a significant price discovery function. When the Commission makes such a determination, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the Act and Commission regulations, and must comply with nine core principles established by new section 2(h)(7)(C).

On March 16, 2009, the CFTC promulgated final rules implementing the provisions of the Reauthorization Act.[4] As relevant here, rule 36.3 imposes increased information reporting requirements on ECMs to assist the Commission in making prompt assessments whether particular ECM contracts may be SPDCs. In addition to filing quarterly reports of its contracts, an ECM must notify the Commission promptly concerning any contract traded in reliance on the exemption in section 2(h)(3) of the CEA that averaged

[1] 74 FR 53720 (October 20, 2009).

[2] Incorporated as Title XIII of the Food, Conservation and Energy Act of 2008, Pub. L. 110–246, 122 Stat. 1624 (June 18, 2008).

[3] 7 U.S.C. 1a(29).

[4] 74 FR 12178 (Mar. 23, 2009); these rules became effective on April 22, 2009.

five trades per day or more over the most recent calendar quarter, and for which the exchange sells its price information regarding the contract to market participants or industry publications, or whose daily closing or settlement prices on 95 percent or more of the days in the most recent quarter were within 2.5 percent of the contemporaneously determined closing, settlement or other daily price of another contract.

Commission rule 36.3(c)(3) established the procedures by which the Commission makes and announces its determination whether a particular ECM contract serves a significant price discovery function. Under those procedures, the Commission will publish notice in the **Federal Register** that it intends to undertake an evaluation whether the specified agreement, contract or transaction performs a significant price discovery function and to receive written views, data and arguments relevant to its determination from the ECM and other interested persons. Upon the close of the comment period, the Commission will consider, among other things, all relevant information regarding the subject contract and issue an order announcing and explaining its determination whether or not the contract is a SPDC. The issuance of an affirmative order signals the effectiveness of the Commission's regulatory authorities over an ECM with respect to a SPDC; at that time such an ECM becomes subject to all provisions of the CEA applicable to registered entities.[5] The issuance of such an order also triggers the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4).[6]

II. Notice of Intent To Undertake SPDC Determination

On October 20, 2009, the Commission published in the **Federal Register** notice of its intent to undertake a determination whether the HEN, HIS and HHD contracts performs a significant price discovery function and requested comment from interested parties.[7] Comments [8] were received from the Federal Energy Regulatory Commission ("FERC"), Platts,[9] Public Utility Commission of Texas ("PUCT") and ICE. The comment letters from FERC,[10] Platts and PUCT [11] did not directly address the issue of whether or not the HEN, HIS and HHD contracts are SPDCs; ICE's comments raised substantive issues with respect to the applicability of section 2(h)(7) to the subject contracts. Generally, ICE asserted that its HEN, HIS and HHD contracts are not SPDCs as they do not meet any of the criteria for SPDC determination (CL 03). ICE's comments are more extensively discussed below, as applicable.

III. Section 2(h)(7) of the CEA

The Commission is directed by section 2(h)(7) of the CEA to consider the following criteria in determining a contract's significant price discovery function:

- *Price Linkage*—the extent to which the agreement, contract or transaction uses or otherwise relies on a daily or final settlement price, or other major price parameter, of a contract or contracts listed for trading on or subject to the rules of a designated contract market ("DCM") or derivatives transaction execution facility ("DTEF"), or a SPDC traded on an electronic trading facility, to value a position, transfer or convert a position, cash or financially settle a position, or close out a position.
- *Arbitrage*—the extent to which the price for the agreement, contract or transaction is sufficiently related to the price of a contract or contracts listed for trading on or subject to the rules of a DCM or DTEF, or a SPDC traded on or subject to the rules of an electronic trading facility, so as to permit market participants to effectively arbitrage between the markets by simultaneously maintaining positions or executing trades in the contracts on a frequent and recurring basis.
- *Material price reference*—the extent to which, on a frequent and recurring basis, bids, offers or transactions in a commodity are directly based on, or are determined by referencing or consulting, the prices generated by agreements, contracts or transactions being traded or executed on the electronic trading facility.
- *Material liquidity*—the extent to which the volume of agreements, contracts or transactions in a commodity being traded on the electronic trading facility is sufficient to have a material effect on other agreements, contracts or transactions listed for trading on or subject to the rules of a DCM, DTEF or electronic trading facility operating in reliance on the exemption in section 2(h)(3).

Not all criteria must be present to support a determination that a particular contract performs a significant price discovery function, and one or more criteria may be inapplicable to a particular contract.[12] Moreover, the statutory language neither prioritizes the criteria nor specifies the degree to which a SPDC must conform to the various criteria. In Guidance issued in connection with the Part 36 rules governing ECMs with SPDCs, the

[5] Public Law 110–246 at 13203; *Joint Explanatory Statement of the Committee of Conference*, H.R. Rep. No. 110–627, 110 Cong., 2d Sess. 978, 986 (Conference Committee Report). See also 73 FR 75888, 75894 (Dec. 12, 2008).

[6] For an initial SPDC, ECMs have a grace period of 90 calendar days from the issuance of a SPDC determination order to submit a written demonstration of compliance with the applicable core principles. For subsequent SPDCs, ECMs have a grace period of 30 calendar days to demonstrate core principle compliance.

[7] The Commission's Part 36 rules establish, among other things, procedures by which the Commission makes and announces its determination whether a specific ECM contract serves a significant price discovery function. Under those procedures, the Commission publishes a notice in the **Federal Register** that it intends to undertake a determination whether a specified agreement, contract or transaction performs a significant price discovery function and to receive written data, views and arguments relevant to its determination from the ECM and other interested persons.

[8] The comment letters are available on the Commission's Web site: *http://www.cftc.gov/lawandregulation/federalregister/federalregistercomments/2009/09-027.html.*

[9] McGraw-Hill, through its division Platts, compiles and calculates monthly natural gas price indices from natural gas trade data submitted to Platts by energy marketers. Platts includes those price indices in its monthly *Inside FERC's Gas Market Report* ("Inside FERC").

[10] FERC stated that the HEN, HIS and HHD contracts are cash-settled and that none of them contemplates the actual physical delivery of natural gas. Accordingly, FERC expressed the opinion that a determination by the Commission that a contract performs a significant price discovery function "would not appear to conflict with FERC's exclusive jurisdiction under the Natural Gas Act (NGA) over certain sales of natural gas in interstate commerce for resale or with its other regulatory responsibilities under the NGA" and further that "FERC staff will continue to monitor for any such conflict * * * [and] advise the CFTC" should any such potential conflict arise. CL 01.

[11] PUCT noted that it oversees the Electric Reliability Council of Texas, much like FERC oversees independent system operators. The mission of PUCT is "to ensure nondiscriminatory access to the [electricity] transmission and distribution systems, to ensure the reliability and adequacy of the regional electrical network and to perform other essential market functions." CL 04.

[12] In its October 20, 2009, **Federal Register** release, the Commission identified material liquidity, material price reference and price linkage as the possible criteria for SPDC determination of the HEN contract (arbitrage was not identified as a possible criterion). With respect to the HIS contract, the **Federal Register** release identified material liquidity and material price reference as possible criteria for SPDC determination (price linkage and arbitrage were not identified as possible criteria). With respect to the HHD contract, the **Federal Register** release identified material liquidity, arbitrage and material price reference as possible criteria for SPDC determination (price linkage was not identified as a possible criterion). The criteria not indentified in the initial release will not be discussed further in this document or the associated Orders.

Commission observed that these criteria do not lend themselves to a mechanical checklist or formulaic analysis. Accordingly, the Commission has indicated that in making its determinations it will consider the circumstances under which the presence of a particular criterion, or combination of criteria, would be sufficient to support a SPDC determination.[13] For example, for contracts that are linked to other contracts or that may be arbitraged with other contracts, the Commission will consider whether the price of the potential SPDC moves in such harmony with the other contract that the two markets essentially become interchangeable. This co-movement of prices would be an indication that activity in the contract had reached a level sufficient for the contract to perform a significant price discovery function. In evaluating a contract's price discovery role as a price reference, the Commission will consider whether cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract.

IV. Findings and Conclusions

The Commission's findings and conclusions with respect to the Henry Financial Basis (HEN) contract, the Henry Financial Index (HIS) contract and the Henry Financial Swing (HHD) contract are discussed separately below.

a. The Henry Financial Basis (HEN) Contract and the SPDC Indicia

The ICE HEN contract is cash settled based on the difference between the bidweek price of natural gas at the Henry Hub for the contract-specified month of delivery, as reported in Platts' *Inside FERC's Gas Market Report*, and the final settlement price for New York Mercantile Exchange's ("NYMEX's") Henry Hub physically-delivered natural gas futures contract for the same specified calendar month. The Platts bidweek price, which is published monthly, is based on a survey of cash market traders who voluntarily report to Platts data on their fixed-price transactions conducted during the last five business days of the month for physical delivery of natural gas at the Henry Hub; such bidweek transactions specify the delivery of natural gas on a uniform basis throughout the following calendar month at the agreed upon rate. The Platts bidweek index is published on the first business day of the calendar month in which the natural gas is to be delivered. The size of the HEN contract is 2,500 million British thermal units ("mmBtu"), and the unit of trading is any multiple of 2,500 mmBtu. The HEN contract is listed for up to 72 calendar months commencing with the next calendar month.

The Henry Hub,[14] which is located in Erath, Louisiana, is the primary cash market trading and distribution center for natural gas in the United States. It also is the delivery point and pricing basis for the NYMEX's actively traded Henry Hub physically-delivered natural gas futures contract, which is the most important pricing reference for natural gas in the United States. The Henry Hub, which is operated by Sabine Pipe Line, LLC, serves as a juncture for 13 different pipelines. These pipelines bring in natural gas from fields in the Gulf Coast region and move it to major consumption centers along the East Coast and Midwest. The throughput shipping capacity of the Henry Hub is 1.8 trillion mmBtu per day.

The HEN contract price measures the discrepancy between two Henry Hub-related prices, where one price is a futures price and the other is a forward cash price. Traders may make commitments to buy or sell natural gas at the Henry Hub using the NYMEX Henry Hub natural gas futures contract, which specifies physical delivery. Because the NYMEX futures contract is listed for at least twelve years, market participants can make such decisions a long time before delivery actually occurs, since they can have an effective hedge in place to offset price risk associated with long-dated cash market commitments. While the futures price and the bidweek price both reflect the price of natural gas during the following month, the two values may not be equal. This is because the NYMEX futures contract stops trading three business days prior to first business day of the delivery month. In contrast, the bidweek price is derived from cash market deals consummated during the last five business days of the month that specify physical delivery during the following calendar month. Thus, it is possible that the bidweek price could include two additional days of market information, which could result in a price that is significantly higher or lower than the futures price. The ICE HEN contract can be used to more accurately price natural gas in the delivery month. For example, a firm may lock in its November 2009 needs by taking a long position in the November 2009 contract. Assume that the futures position is established at $4.00 per mmBtu. This means that the gas was purchased at $4, which may be higher or lower than the spot price during the delivery month. During the final few days in October, the November 2009 natural gas contract stops trading and the November bidweek price is determined. Assume that the weather forecast calls for warmer than normal temperatures in the area, causing the futures price to fall and settle on October 27 at $3.90 per mmBtu, resulting in a loss of $0.10 per mmBtu on the futures side. Market sentiment of a strong downward pressure on gas prices may persist, leading spot transactions for next-month delivery to be priced even lower than the futures settlement price. In this regard, the bidweek price is determined as a volume weighted average of fixed-price transactions for November 2009 delivery that were conducted between October 25, 2009, and October 29, 2009. If the bidweek price ends up being at $3.75 per mmBtu, the firm will incur an additional loss of $0.15 per mmBtu because of falling spot prices. By taking a position in the ICE HEN contract, the firm can mitigate some of the losses by accounting for the difference between the final settlement price and the bidweek price.[15]

In its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity, price linkage and material price reference as the potential SPDC criteria applicable to the HEN contract. Each of these criteria is discussed below.[16]

1. Material Price Reference Criterion

The Commission's October 20, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission noted that ICE sells its price data to market participants in a number of different packages which vary in terms of the hubs covered, time periods and whether the data are daily only or historical. For example, ICE offers the "Gulf Gas End of Day" and "OTC Gas End of Day"[17] packages with access to all price data or just current prices plus a selected number of months (i.e., 12, 24, 36 or 48 months) of

[13] 17 CFR part 36, Appendix A.

[14] The term "hub" refers to a juncture where two or more natural gas pipelines are connected. Hubs also serve as pricing points for natural gas.

[15] If the firm simultaneously takes positions involving the NYMEX futures contract and the ICE HEN basis contract, the firm will be able to price the natural gas at the bidweek price.

[16] As noted above, the Commission did not find an indication of arbitrage in connection with this contract; accordingly, that criterion is not discussed in reference to the HEN contract.

[17] The OTC Gas End of Day dataset includes daily settlement prices for natural gas contracts listed for all points in North America.

historical data. These two packages include price data for the HEN contract.

Although the Henry Hub is a major trading center for natural gas in the United States and, as noted, ICE sells price information for the HEN contract, the Commission has found upon further evaluation that the HEN contract is not routinely consulted by industry participants in pricing cash market transactions and thus does not meet the Commission's Guidance for the material price reference criterion. In this regard, the NYMEX Henry Hub physically delivered natural gas futures contract is routinely consulted by industry participants in pricing cash market transactions at this location. Because both the HEN and the NYMEX contracts basically price the same commodity at the same location and time and the NYMEX contract has significantly higher trading volume and open interest,[18] it is not necessary for market participants to independently refer to the HEN contract for pricing natural gas at this location. Furthermore, the Commission notes that publication of the HEN contract's prices is not indirect evidence of routine dissemination. The HEN contract's prices are published with those of numerous other contracts, which are of more interest to market participants.[19] The Commission cannot surmise whether or not traders specifically purchase the ICE data packages for the HEN contract's prices.

i. Federal Register Comments

As noted above, ICE was the sole respondent which addressed the question of whether the HEN contract is a SPDC. ICE stated in its comment letter that the HEN contract does not meet the material price reference criterion for SPDC determination. ICE stated that the Commission appeared to base the case that the HEN contract is potentially a SPDC on a disputable assertion. In issuing its notice of intent to determine whether the HEN contract is a SPDC, the CFTC cited a general conclusion in its ECM study "that certain market participants referred to ICE as a price discovery market for certain natural gas contracts." ICE states that "[b]asing a material price reference determination on general statements made in a two year old study does not seem to meet Congress' intent that the CFTC use its considerable expertise to study the OTC markets." The Commission cited the ECM study's general finding that some ICE natural gas contracts appear to be regarded as price discovery markets as an indication that an investigation of certain ICE contracts may be warranted; the ECM study was not intended to serve as the sole basis for determining whether or not a particular contract meets the material price reference criterion.

ii. Conclusion Regarding Material Price Reference

The Commission finds that the HEN contract does not meet the material price reference criterion because it is not routinely consulted by cash market participants when pricing transactions at the Henry Hub (direct evidence is not supported). Moreover, the ECM sells the HEN contract's price data along with those of other contracts, which are of more interest to market participants (indirect evidence is not supported).

2. Price Linkage Criterion

In its October 20, 2009, **Federal Register** notice, the Commission identified price linkage as a potential basis for a SPDC determination with respect to the HEN contract. In this regard, the final settlement of the HEN contract is based, in part, on the final settlement price of the NYMEX's Henry Hub physically-delivered natural gas futures contract, where the NYMEX is registered with the Commission as a DCM.

The Commission's Guidance on Significant Price Discovery Contracts[20] notes that a "price-linked contract is a contract that relies on a contract traded on another trading facility to settle, value or otherwise offset the price-linked contract." Furthermore, the Guidance notes that "[f]or a linked contract, the mere fact that a contract is linked to another contract will not be sufficient to support a determination that a contract performs a significant price discovery function. To assess whether such a determination is warranted, the Commission will examine the relationship between transaction prices of the linked contract and the prices of the referenced contract. The Commission believes that where material liquidity exists, prices for the linked contract would be observed to be substantially the same as, or move substantially in conjunction with, the prices of the referenced contract." The Guidance proposes a threshold price relationship such that prices of the ECM linked contract will fall within a 2.5 percent price range for 95 percent of contemporaneously determined closing, settlement or other daily prices over the most recent quarter. Finally, the Commission also stated in the Guidance that it would consider a linked contract that has a trading volume equivalent to 5 percent of the volume of trading in the contract to which it is linked to have sufficient volume potentially to be deemed a SPDC ("minimum threshold").

To assess whether the HEN contract meets the price linkage criterion, Commission staff obtained price data from ICE and performed the statistical tests cited above. Staff found that the Henry Hub futures/cash price differential is determined in part by the final settlement price of the NYMEX Henry Hub physically-delivered natural gas futures contract (a DCM contract) and that the derived Henry Hub prices (using the NYMEX Henry Hub natural gas futures contract's settlement prices and the Henry Hub cash price differentials) are within 2.5 percent of the settlement prices of the corresponding NYMEX Henry Hub natural gas futures contract on 95 percent or more of the days. Specifically, during the third quarter of 2009, 100 percent of the Henry Hub natural gas prices derived from the HEN values were within 2.5 percent of the daily settlement price of NYMEX Henry Hub natural gas futures contract. However, staff found that the HEN contract fails to meet the volume threshold requirement. In particular, the total trading volume in the NYMEX Henry Hub natural gas futures contract during the third quarter of 2009 was 14,022,963 contracts, with 5 percent of that number being 701,148 contracts. The number of trades on the ICE centralized market in the HEN contract during the same period totaled 173,973 contracts (equivalent to 43,493 NYMEX futures contracts, given the size difference).[21] Thus, total amount of centralized-market trades in the HEN contract was significantly below the minimum threshold.

i. Federal Register Comments

ICE was the sole respondent which addressed the question of whether the HEN contract is a SPDC. ICE stated in its comment letter that the HEN contract does not meet the price linkage criterion for SPDC determination because it fails the volume test provided in the Commission's Guidance.

[18] Trading data was obtained by the Commission using the Integrated Surveillance System.

[19] The Commission will rely on one of two sources of evidence—direct or indirect—to determine a SPDC. Direct evidence can be cash market transactions that are frequently based on or quoted as a differential to the potential SPDC. Indirect evidence includes contracts whose price series are routinely disseminated in industry publications or are sold to market participants by the ECM.

[20] Appendix A to the Part 36 rules.

[21] The HEN contract is one-quarter the size of the NYMEX Henry Hub physically-delivered futures contract.

ii. Conclusion Regarding the Price Linkage Criterion

The Commission finds that the HEN contract does not meet the price linkage criterion because it fails the volume test provided for in the Commission's Guidance.

3. Material Liquidity Criterion

As noted above, in its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity, price linkage and material price reference as potential criteria for SPDC determination of the HEN contract. With respect to the material liquidity criterion, the Commission noted that the total number of transactions executed on ICE's electronic platform in the HEN contract was 538 in the second quarter of 2009, resulting in a daily average of 8.4 trades. During the same period, the HEN contract had a total trading volume of 78,780 contracts and an average daily trading volume of 1,232 contracts. Moreover, open interest as of June 30, 2009, was 128,504 contracts, which included trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing. In this regard, ICE does not differentiate between open interest created by a transaction executed on its trading platform and that created by a transaction executed off its trading platform.[22] In a subsequent filing dated November 13, 2009, ICE reported that total trading volume in the third quarter of 2009 was 173,973 contracts (or 2,636 contracts on a daily basis). In term of number of transactions, 1,174 trades occurred in the third quarter of 2009 (17.8 trades per day). As of September 30, 2009, open interest in the HEN contract was 160,804 contracts, which included trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing.

The Commission notes that trading activity in the HEN contract increased between the second and third quarters of 2009. However, the number of trades per day remained relatively low and only slightly more than the reporting level of five trades per day. Moreover, the Commission notes that the number of contracts traded is comparable to that experienced in a relatively small futures market, such as the NYMEX Platinum and ICE US Frozen Concentrated Orange Juice contracts. Accordingly, the data at best provides weak evidence that the HEN contract meets the material liquidity criterion.[23]

i. Federal Register Comments

As noted above, ICE was the sole respondent which addressed the question of whether the HEN contract is a SPDC. ICE stated in its comment letter that the HEN contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

First, ICE opined that the Commission "seems to have adopted a five trade-per-day test to determine whether a contract is materially liquid. It is worth noting that ICE originally suggested that the CFTC use a five trades-per-day threshold as the basis for an ECM to report trade data to the CFTC." On the contrary, the Commission adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs"[24] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. While a contract that meets this threshold may be subject to scrutiny as a potential SPDC, the threshold is not a test for material liquidity. As noted above, the Commission has not reached a decision regarding material liquidity because, regardless of the relatively large quarterly trading volume in the HEN contract, material liquidity alone is not sufficient to support a SPDC determination.

ICE also stated that "the statistics [provided by ICE] have been misinterpreted and misapplied." In particular, ICE stated that the volume figures used in the Commission's analysis (cited above) "include trades made in all 120 months of each contract" as well as in strips of contract months, and a "more appropriate method of determining liquidity is to examine the activity in a single traded month or strip of a given contract." Furthermore, ICE noted that for the HEN contract, "98% of the trades and volume actually executed on the ICE platform occurred in the single most liquid, usually prompt, month of the contract."

It is the Commission's opinion that liquidity, as it relates to the HEN contract, is typically a function of trading activity in particular lead months and, given sufficient liquidity in such months, the HEN contract itself would be considered liquid. ICE's analysis of its own trade data confirms this to be the case for the HEN contract, and thus, the Commission believes that it applied the statistical data cited above in an appropriate manner for gauging material liquidity.

In addition, ICE stated that the trades-per-day statistics that it provided to the Commission in its quarterly filing and which are cited above includes 2(h)(1) transactions, which were not completed on the electronic trading platform and should not be considered in the SPDC determination process. Commission staff asked ICE to review the data it sent in its quarterly filings. In response, ICE confirmed that the volume data it provided and which the Commission cited in its October 20, 2009, **Federal Register** notice, as well as the additional volume information it cites above, includes only transaction data executed on ICE's electronic trading platform.[25] The Commission acknowledges that the open interest information it cites above includes transactions made off the ICE platform. However, once open interest is created, there is no way for ICE to differentiate between "on-exchange" versus "off-exchange" created positions, and all such positions are fungible with one another and may be offset in any way agreeable to the position holder regardless of how the position was initially created.

ii. Conclusion Regarding Material Liquidity

For the reasons discussed above, the Commission finds at best weak evidence that the HEN contract meets the material liquidity criterion. However, because the HEN contract does not meet either the price linkage or material price reference criterion, it is not possible to declare the HEN contract a SPDC since material liquidity cannot be used alone as a basis for a SPDC determination.

4. Overall Conclusion the HEN Contract

After considering the entire record in this matter, including the comments received, the Commission has determined that the HEN contract does not perform a significant price discovery

[22] 74 FR 53720 (October 20, 2009).

[23] In establishing guidance to illustrate how it will evaluate the various criteria, or combinations of criteria, when determining whether a contract is a SPDC, the Commission made clear that "material liquidity itself would not be sufficient to make a determination that a contract is a [SPDC], * * * but combined with other factors it can serve as a guidepost indicating which contracts are functioning as [SPDCs]." For the reasons discussed above, the Commission has found that the HEN contract does not meet either the price linkage or material price reference criterion. In light of this finding and the Commission's Guidance cited above, there is no need to evaluate further the material liquidity criteria since it cannot be used alone as a basis for a SPDC determination.

[24] 73 FR 75892 (December 12, 2008).

[25] Supplemental data supplied by ICE confirmed that block trades in the third quarter of 2009 were in addition to the trades that were conducted on the electronic platform; block trades comprised 62.2 percent of all transactions in the HEN contract.

function under the criteria established in section 2(h)(7) of the CEA. Specifically, the Commission has determined that the HEN contract does not meet the material price reference and price linkage criteria at this time, and there is at best weak evidence that it meets the material liquidity criterion, which is not sufficient by itself to support a SPDC determination. Accordingly, the Commission will issue the attached Order declaring that the HEN contract is not a SPDC.

Issuance of this Order indicates that the Commission does not at this time regard ICE as a registered entity in connection with its HEN contract.[26] Accordingly, with respect to its HEN contract, ICE is not required to comply with the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) for ECMs with SPDCs.

b. The Henry Financial Index (HIS) Contract and the SPDC Indicia

The ICE HIS contract is cash settled based on the arithmetic average of the daily natural gas prices at the Henry Hub, as quoted in the "Daily Price Survey" table of Platts' *Gas Daily* during the specified month, less the Platts bidweek price that is reported in the first issue of *Inside FERC's Gas Market Report* in which the natural gas is delivered. The Platts prices are based on the fixed-price cash market transactions that are voluntarily reported by traders. As noted above, the Platts bidweek price is based on a survey of cash market traders who voluntarily report data on their fixed-price transactions conducted during the last five business days of the month for physical delivery of natural gas at the Henry Hub on a uniform basis throughout the following calendar month. The Platts bidweek index is published on the first business day of the calendar month in which the natural gas is to be delivered. The Gas Daily price is for next-day delivery of natural gas at the Henry Hub. The size of the HIS contract is 2,500 mmBtu, and the unit of trading is any multiple of 2,500 mmBtu. The HIS contract is listed for 36 calendar months.

The index used to settle the HIS contract measures the discrepancy between two cash market prices for natural gas, where one (the Platts bidweek price) is a fixed forward price that locks in the price paid for gas deliveries made on each calendar day of the following month. The other price (the Platts Daily Price Survey) is a calendar month average of the daily spot price for gas deliveries made during the same month. The forward and average spot prices may differ from each other as new market conditions unfold during the month in which deliveries are made.

For example, assume that a firm prices natural gas that is going to be delivered at the Henry Hub in November 2009 at the bidweek price. The NYMEX Henry Hub futures can be used to procure the physical gas, and HEN contract can be overlayed in order to achieve the bidweek price. If there is a potential that the average daily price during the delivery month may differ from the bidweek price, the firm can add the HIS contract to the NYMEX futures/ICE HEN combination to achieve a price that is based on actual daily prices rather than a forward spot price that applies to all business days in the delivery month. As a result, the HIS contract allows commercial participants to price natural gas more accurately during the delivery period.

In its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity and material price reference as the potential SPDC criteria applicable to the HIS contract. Each of these factors is discussed below.[27]

1. Material Price Reference Criterion

The Commission's October 20, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission noted that ICE sells its price data to market participants in a number of different packages which vary in terms of the hubs covered, time periods, and whether the data are daily only or historical. For example, ICE offers "Gulf Gas End of Day" and "OTC Gas End of Day"[28] with access to all price data or just current prices plus a selected number of months (i.e., 12, 24, 36 or 48 months) of historical data. These two packages include price data for the HIS contract.

Although the Henry Hub is a major trading center for natural gas in the United States, and as noted ICE does sell price information for the HIS contract, the Commission has found upon further evaluation that the HIS contract is not "routinely consulted by industry participants in pricing cash market transactions" and thus does not meet the Commission's guidance for the material price reference criterion. In this regard, the NYMEX Henry Hub natural gas futures contract is routinely consulted by industry participants in pricing cash market transactions at this location. Because both the HIS and the NYMEX contracts basically price the same commodity at the same location and time and the NYMEX futures contract has significantly higher trading volume and open interest, it is not necessary for market participants to independently refer to the HIS contract for pricing natural gas at this location. Furthermore, the Commission notes that publication of the HIS contract's prices is not indirect evidence of routine dissemination. The HIS contract's prices are published with those of numerous other contracts, which are of more interest to market participants.[29] The Commission cannot surmise whether or not traders specifically purchase the ICE data packages for the HIS contract's prices.

i. Federal Register Comments

As noted above, ICE was the sole respondent which addressed the question of whether the HIS contract is a SPDC. ICE stated in its comment letter that the HIS contract does not meet the material price reference criterion for SPDC determination and, further, that the Commission's identification of the HIS contract as a potential SPDC is based on a disputable assertion. In issuing its notice of intent to determine whether the HIS contract is a SPDC, the CFTC cited a general conclusion in its ECM study "that certain market participants referred to ICE as a price discovery market for certain natural gas contracts." ICE states that "[b]asing a material price reference determination on general statements made in a two year old study does not seem to meet Congress' intent that the CFTC use its considerable expertise to study the OTC markets." The Commission cited the ECM study's general finding that some ICE natural gas contracts appear to be regarded as price discovery markets as an indication that an investigation of certain ICE contracts may be warranted; the ECM study was not intended to serve as the sole basis for determining whether or not a particular contract meets the material price reference criterion.

[26] *See* 73 FR 75888, 75893 (Dec. 12, 2008).

[27] As noted above, the Commission did not find an indication of arbitrage and price linkage in connection with this contract; accordingly, those criteria are not discussed in reference to the HIS contract.

[28] The OTC Gas End of Day dataset includes daily settlement prices for natural gas contracts listed for all points in North America.

[29] The Commission will rely on one of two sources of evidence—direct or indirect—to determine a SPDC. Direct evidence can be cash market transactions that are frequently based on or quoted as a differential to the potential SPDC. Indirect evidence includes contracts whose price series are routinely disseminated in industry publications or are sold to market participants by the ECM.

ii. Conclusion Regarding Material Price Reference

The Commission finds that the HIS contract does not meet the material price reference criterion because it is not routinely consulted by cash market participants when pricing transactions at the Henry Hub (direct evidence is not supported). Moreover, the ECM sells the HIS contract's price data along with those of other contracts, which are of more interest to market participants (indirect evidence is not supported).

2. Material Liquidity Criterion

As noted above, in its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity and material price reference as potential criteria for SPDC determination of the HIS contract. With respect to the material liquidity criterion, the Commission noted that the total number of transactions executed on ICE's electronic platform in the HIS contract was 550 in the second quarter of 2009, resulting in a daily average of 8.6 trades. During the same period, the HIS contract had a total trading volume of 79,330 contracts and an average daily trading volume of 1,239 contracts. Moreover, open interest as of June 30, 2009, was 127,346 contracts, which included trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing. In this regard, ICE does not differentiate between open interest created by a transaction executed on its trading platform and that created by a transaction executed off its trading platform.[30] In a subsequent filing dated November 13, 2009, ICE reported that total trading volume in the third quarter of 2009 was 178,649 contracts (or 2,707 contracts on a daily basis). In term of number of transactions, 1,250 trades occurred in the third quarter of 2009 (18.9 trades per day). As of September 30, 2009, open interest in the HIS contract was 255,496 contracts, which included trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing.

The Commission notes that trading activity in the HIS contract increased between the second and third quarters of 2009. However, the number of trades per day remained relatively low and only slightly more than the reporting level of five trades per day. Moreover, the Commission notes that the number of contracts traded is comparable to that experienced in a relatively small futures market, such as the NYMEX Platinum and ICE U.S. Frozen Concentrated Orange Juice contracts. Accordingly, the data at best provides weak evidence that the HIS contract meets the material liquidity criterion.[31]

i. Federal Register Comments

As noted above, ICE was the sole respondent which addressed the question of whether the HIS contract is a SPDC. ICE stated in its comment letter that the HIS contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

First, ICE opined that the Commission "seems to have adopted a five trade-per-day test to determine whether a contract is materially liquid. It is worth noting that ICE originally suggested that the CFTC use a five trades-per-day threshold as the basis for an ECM to report trade data to the CFTC." On the contrary, the Commission adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs"[32] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. While a contract that meets this threshold may be subject to scrutiny as a potential SPDC, the threshold is not a test for material liquidity. As noted above, the Commission has not reached a decision regarding material liquidity because, regardless of the relatively large quarterly trading volume in the HIS contract, material liquidity alone is not sufficient to support a SPDC determination.

ICE also stated that "the statistics [provided by ICE] have been misinterpreted and misapplied." In particular, ICE stated that the volume figures used in the Commission's analysis (cited above) "include trades made in all 120 months of each contract" as well as in strips of contract months, and a "more appropriate method of determining liquidity is to examine the activity in a single traded month or strip of a given contract." Furthermore, ICE noted that for the HIS contract, "98% of the trades and volume actually executed on the ICE platform occurred in the single most liquid, usually prompt, month of the contract."

It is the Commission's opinion that liquidity, with regard to the HIS contract, is typically a function of trading activity in particular lead months and, given sufficient liquidity in such months, the HIS contract itself would be considered liquid. ICE's analysis of its own trade data confirms this to be the case for the HIS contract, and thus, the Commission believes that it applied the statistical data cited above in an appropriate manner for gauging material liquidity.

In addition, ICE stated that the trades-per-day statistics that it provided to the Commission in its quarterly filing and which are cited above includes 2(h)(1) transactions, which were not completed on the electronic trading platform and should not be considered in the SPDC determination process. Commission staff asked ICE to review the data it sent in its quarterly filings. In response, ICE confirmed that the volume data it provided and which the Commission cited in its October 20, 2009, **Federal Register** notice as well as the additional volume information it cites above includes only transaction data executed on ICE's electronic trading platform.[33] The Commission acknowledges that the open interest information it cites above includes transactions made off the ICE platform. However, once open interest is created, there is no way for ICE to differentiate between "on-exchange" versus "off-exchange" created positions, and all such positions are fungible with one another and may be offset in any way agreeable to the position holder regardless of how the position was initially created.

ii. Conclusion Regarding Material Liquidity

For the reasons discussed above, the Commission finds weak evidence at best that the HIS contract meets the material liquidity criterion. However, because the HIS contract does not meet the material price reference criterion, it is not possible to declare the HIS contract a SPDC since material liquidity cannot be used alone as a basis for a SPDC determination.

[30] 74 FR 53720 (October 20, 2009).

[31] In establishing guidance to illustrate how it will evaluate the various criteria, or combinations of criteria, when determining whether a contract is a SPDC, the Commission made clear that "material liquidity itself would not be sufficient to make a determination that a contract is a [SPDC], * * * but combined with other factors it can serve as a guidepost indicating which contracts are functioning as [SPDCs]." For the reasons discussed above, the Commission has found that the HIS contract does not meet either the price linkage or material price reference criterion. In light of this finding and the Commission's Guidance cited above, there is no need to evaluate further the material liquidity criteria since it cannot be used alone as a basis for a SPDC determination.

[32] 73 FR 75892 (December 12, 2008).

[33] Supplemental data supplied by ICE confirmed that block trades in the third quarter of 2009 were in addition to the trades that were conducted on the electronic platform; block trades comprised 59.7 percent of all transactions in the HIS contract.

3. Overall Conclusion

After considering the entire record in this matter, including the comments received, the Commission has determined that the HIS contract does not perform a significant price discovery function under the criteria established in section 2(h)(7) of the CEA. Specifically, the Commission has determined that the HIS contract does not meet the material price reference criterion at this time, and there is weak evidence at best that it meets the material liquidity criterion, which is not sufficient by itself to support a SPDC determination. Accordingly, the Commission will issue the attached Order declaring that the HIS contract is not a SPDC.

Issuance of this Order indicates that the Commission does not at this time regard ICE as a registered entity in connection with its HIS contract.[34] Accordingly, with respect to its HIS contract ICE is not required to comply with the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) for ECMs with SPDCs.

c. The Henry Financial Swing (HHD) Contract and the SPDC Indicia

The ICE HHD contract is cash settled based on the spot index price for natural gas at the Henry Hub on a specified day, as reported in the "Daily Price Survey" table of Platts' *Gas Daily.* The Platts index price is based on fixed-price cash market transactions that are voluntarily reported by traders. The size of the HHD contract is 2,500 mmBtu, and the unit of trading is any multiple of 2,500 mmBtu. The HHD contract is listed for 65 consecutive calendar days.

Swing contracts are cash-settled natural gas contracts that specify 2,500 mmBtu of gas at a particular location on a specific day and is settled using a price index published by a third-party price reporter. The ICE HHD swing contract represents the spot price of natural gas at the Henry Hub on a particular day. Swing contracts allow traders to refine or lift hedges during the delivery month that were previously established using the NYMEX Henry Hub natural gas futures contract. Swing contracts are most useful after the NYMEX futures contract has stopped trading, which is just prior to the beginning of the delivery month. Physically-delivered and cash-settled transactions based on the NYMEX Henry Hub price involves natural gas that is delivered over the entire delivery month. If, for example, a firm's needs change and it no longer needs all of the natural gas for which it hedged (say it now requires only half of the originally hedged natural gas in the final week of the delivery month), then the HHD contract can be used to offset the part of the original hedge even though NYMEX futures contract has ceased trading.

In its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity, arbitrage and material price reference as the potential SPDC criteria applicable to the HHD contract. Each of these criteria is discussed below.[35]

1. Material Price Reference Criterion

The Commission's October 20, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission noted that ICE sells its price data to market participants in a number of different packages which vary in terms of the hubs covered, time periods, and whether the data are daily only or historical. For example, ICE offers "Gulf Gas End of Day" and "OTC Gas End of Day"[36] with access to all price data or just current prices plus a selected number of months (*i.e.,* 12, 24, 36 or 48 months) of historical data. These two packages include price data for the HHD contract.

Although the Henry Hub is a major trading center for natural gas in the United States and, as noted, ICE sells price information for the HHD contract, the Commission has found upon further evaluation that the HHD contract is not "routinely consulted by industry participants in pricing cash market transactions" and thus does not meet the Commission's guidance for the Material Price Reference criteria. In this regard, the NYMEX Henry Hub futures contract is routinely consulted by industry participants in pricing cash market transactions at this location, because both the HHD and the NYMEX contracts basically price the same commodity at the same location and the NYMEX contract has significantly higher trading volume and open interest, it is not necessary for market participants to independently refer to the HHD contract for pricing natural gas at this location. Furthermore, the Commission notes that publication of the HHD contract's prices is not indirect evidence of routine dissemination. The HHD contract's prices are published with those of numerous other contracts, which are of more interest to market participants.[37] The Commission cannot surmise whether or not traders specifically purchase the ICE data packages for the HHD contract's prices.

i. Federal Register Comments

As noted above, ICE was the sole respondent which addressed the question of whether the HHD contract is a SPDC. ICE stated in its comment letter that the HHD contract does not meet the material price reference criterion for SPDC determination. ICE stated that the Commission appeared to base the case that the HHD contract is potentially a SPDC on a disputable assertion. First, in issuing its notice of intent to determine whether the HHD contract is a SPDC, the CFTC cited a general conclusion in its ECM study "that certain market participants referred to ICE as a price discovery market for certain natural gas contracts." ICE states that "[b]asing a material price reference determination on general statements made in a two year old study does not seem to meet Congress' intent that the CFTC use its considerable expertise to study the OTC markets." The Commission cited the ECM study's general finding that some ICE natural gas contracts appear to be regarded as price discovery markets as an indication that an investigation of certain ICE contracts may be warranted; the ECM study was not intended to serve as the sole basis for determining whether or not a particular contract meets the material price reference criterion.

ii. Conclusion Regarding Material Price Reference

The Commission finds that the HHD contract does not meet the material price reference criterion because it is not routinely consulted by cash market participants when pricing transactions at the Henry Hub (direct evidence is not supported). Moreover, the ECM sells the HHD contract's price data along with those of other contracts, which are of more interest to market participants (indirect evidence is not supported).

2. Arbitrage Criterion

In its October 20, 2009, **Federal Register** notice, the Commission identified arbitrage as a potential basis

[34] See 73 FR 75888, 75893 (Dec. 12, 2008).

[35] As noted above, the Commission did not find an indication of price linkage in connection with this contract; accordingly, that criterion is not discussed in reference to the HHD contract.

[36] The OTC Gas End of Day dataset includes daily settlement prices for natural gas contracts listed for all points in North America.

[37] The Commission will rely on one of two sources of evidence—direct or indirect—to determine a SPDC. Direct evidence can be cash market transactions that are frequently based on or quoted as a differential to the potential SPDC. Indirect evidence includes contracts whose price series are routinely disseminated in industry publications or are sold to market participants by the ECM.

for a SPDC determination with respect to the HHD contract.

The Commission's Guidance (Appendix A to Part 36) notes that "the Commission will consider an arbitrage contract potentially to be a [SPDC] * * * if, over the most recent quarter, greater than 95 percent of the closing or settlement prices of the contract, which have been calculated using transaction prices, fall within 2.5 percent of the closing or settlement price of the contract or contracts which it could be arbitraged." As noted above, the HHD contract is a daily contract that reflects the spot price of natural gas at the Henry Hub and is listed for 65 calendar days. In contrast, the NYMEX Henry Hub natural gas futures contract is a pricing mechanism for natural gas in the future. The NYMEX Henry Hub natural gas futures contract is available for trading many months prior to the delivery period.

Arbitrage between the ICE HHD and NYMEX Henry Hub physically-delivered natural gas futures contract potentially is possible. However, the ability to arbitrage likely would be limited based on a number of factors. First, the HHD contract prices the value of natural gas on a single day while the NYMEX futures contract prices the value of gas over a calendar month. Second, the futures contract and the HHD contract are not always trading simultaneously. For example, the NYMEX futures contract trades many years before delivery while the HHD contract is listed out only 65 consecutive calendar days. Moreover, the HHD contract trades into the delivery month while the NYMEX futures contract stops trading three business days before the first business day of the delivery month. Even during the times where the two contracts are simultaneously traded, arbitrage between the two contracts likely would involve multiple HHD contract to cover a period of several days or weeks against a single NYMEX position, which would be rather cumbersome and probably not practicable. Due to the heterogeneous attributes of the two contracts, the test noted above to determine the similarity of the two price series was not performed.

i. Federal Register Comments

As noted above, ICE was the sole respondent which addressed the question of whether the HHD contract is a SPDC. ICE stated in its comment letter that the HHD contract does not meet the arbitrage criterion because it is a "'decaying' product that expires daily throughout its contract term. The HHD [contract] typically trades 'balance of month' therefore using multiple daily settlement prices. In fact, the majority of HHD trades are intra-month after the * * * [NYMEX Henry Hub natural gas futures contract] has already been priced."

ii. Conclusion Regarding the Arbitrage Criterion

The HHD contract does not meet the arbitrage criterion because it prices natural gas on a daily basis while the NYMEX futures contract prices gas on a monthly basis. Moreover, the futures contract is used to discover prices while the HHD contract is used to modify or lift preexisting hedges.

3. Material Liquidity Criterion

As noted above, in its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity, arbitrage and material price reference as potential criteria for SPDC determination of the HHD contract. With respect to the material liquidity criterion, the Commission noted that the total number of transactions executed on ICE's electronic platform in the HHD contract was 5,246 in the second quarter of 2009, resulting in a daily average of 82 trades. During the same period, the HHD contract had a total trading volume of 242,968 contracts and an average daily trading volume of 3,796 contracts. Moreover, open interest as of June 30, 2009, was 20,173 contracts, which included trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing. In this regard, ICE does not differentiate between open interest created by a transaction executed on its trading platform and that created by a transaction executed off its trading platform.[38] In a subsequent filing dated November 13, 2009, ICE reported that total trading volume in the third quarter of 2009 was 407,037 contracts (or 6,167 contracts on a daily basis). In term of number of transactions, 10,376 trades occurred in the third quarter of 2009 (157.2 trades per day). As of September 30, 2009, open interest in the HHD contract was 25,418 contracts, which included trades executed on ICE's electronic trading platform, as well as trades executed off of ICE's electronic trading platform and then brought to ICE for clearing.

The Commission notes that trading activity in the HHD contract increased between the second and third quarters of 2009. Moreover, the number of trades per day was quite large and was significantly greater than the reporting level of five trades per day. Furthermore, the number of contracts traded is comparable to the levels experienced in a moderately active futures market, such as the ICE US Cotton No. 2 contract. Accordingly, the transaction data provide evidence that the HHD contract may meet the material liquidity criterion.[39]

i. Federal Register Comments

As noted above, ICE was the sole respondent which addressed the question of whether the HHD contract is a SPDC. ICE stated in its comment letter that the HHD contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

First, ICE opined that the Commission "seems to have adopted a five trade-per-day test to determine whether a contract is materially liquid. It is worth noting that ICE originally suggested that the CFTC use a five trades-per-day threshold as the basis for an ECM to report trade data to the CFTC." On the contrary, the Commission adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs"[40] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. While a contract that meets this threshold may be subject to scrutiny as a potential SPDC, the threshold is not a test for material liquidity. As noted above, the Commission has not reached a decision regarding material liquidity because, regardless of the relatively large number of trades per day and the large quarterly trading volume in the HHD contract, material liquidity alone is not sufficient to support a SPDC determination.

ICE also stated that "the statistics [provided by ICE] have been misinterpreted and misapplied." In particular, ICE stated that the volume figures used in the Commission's analysis (cited above) "include trades made in all 120 months of each contract" as well as in strips of contract

[38] 74 FR 53720 (October 20, 2009).

[39] In establishing guidance to illustrate how it will evaluate the various criteria, or combinations of criteria, when determining whether a contract is a SPDC, the Commission made clear that "material liquidity itself would not be sufficient to make a determination that a contract is a [SPDC], * * * but combined with other factors it can serve as a guidepost indicating which contracts are functioning as [SPDCs]." For the reasons discussed above, the Commission has found that the HEN contract does not meet either the price linkage or material price reference criterion. In light of this finding and the Commission's Guidance cited above, there is no need to evaluate further the material liquidity criteria since it cannot be used alone as a basis for a SPDC determination.

[40] 73 FR 75892 (December 12, 2008).

months, and a "more appropriate method of determining liquidity is to examine the activity in a single traded month or strip of a given contract." Furthermore, ICE noted that for the HHD contract, "78% of the total volume was actually executed on the ICE platform in the single most liquid, usually prompt, month of the contract."

It is the Commission's opinion that liquidity, with regard to the HHD contract, is typically a function of trading activity in particular lead months and, given sufficient liquidity in such months, the HHD contract itself would be considered liquid. ICE's analysis of its own trade data confirms this to be the case for the HHD contract, and thus, the Commission believes that it applied the statistical data cited above in an appropriate manner for gauging material liquidity.

In addition, ICE stated that the trades-per-day statistics that it provided to the Commission in its quarterly filing and which are cited above includes 2(h)(1) transactions, which were not completed on the electronic trading platform and should not be considered in the SPDC determination process. Commission staff asked ICE to review the data it sent in its quarterly filings and ICE confirmed that the volume data it provided and which the Commission cited in its October 20, 2009, **Federal Register** notice as well as the additional volume information it cites above includes only transaction data executed on ICE's electronic trading platform.[41] The Commission acknowledges that the open interest information it cites above includes transactions made off the ICE platform. However, once open interest is created, there is no way for ICE to differentiate between "on-exchange" versus "off-exchange" created positions, and all such positions are fungible with one another and may be offset in any way agreeable to the position holder regardless of how the position was initially created.

ii. Conclusion Regarding Material Liquidity

For the reasons discussed above, the Commission finds that the HHD contract may meet the material liquidity criterion. However, because the HHD contract does not meet the material price reference or the arbitrage criterion, it is not possible to declare the HHD contract a SPDC since material liquidity cannot be used alone as a basis for SPDC determination.

4. Overall Conclusion

After considering the entire record in this matter, including the comments received, the Commission has determined that the HHD contract does not perform a significant price discovery function under the criteria established in section 2(h)(7) of the CEA. Specifically, the Commission has determined that the HHD contract does not meet the material price reference and arbitrage criteria at this time nor is material liquidity sufficient by itself to support a SPDC determination. Accordingly, the Commission will issue the attached Order declaring that the HHD contract is not a SPDC.

Issuance of this Order indicates that the Commission does not at this time regard ICE as a registered entity in connection with its HHD contract.[42] Accordingly, with respect to its HHD contract ICE is not required to comply with the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) for ECMs with SPDCs.

V. Related Matters

a. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 ("PRA")[43] imposes certain requirements on Federal agencies, including the Commission, in connection with their conducting or sponsoring any collection of information as defined by the PRA. Certain provisions of Commission rule 36.3 impose new regulatory and reporting requirements on ECMs, resulting in information collection requirements within the meaning of the PRA. OMB previously has approved and assigned OMB control number 3038–0060 to this collection of information.

b. Cost-Benefit Analysis

Section 15(a) of the CEA[44] requires the Commission to consider the costs and benefits of its actions before issuing an order under the Act. By its terms, section 15(a) does not require the Commission to quantify the costs and benefits of an order or to determine whether the benefits of the order outweigh its costs; rather, it requires that the Commission "consider" the costs and benefits of its actions. Section 15(a) further specifies that the costs and benefits shall be evaluated in light of five broad areas of market and public concern: (1) Protection of market participants and the public; (2) efficiency, competitiveness and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. The Commission may in its discretion give greater weight to any one of the five enumerated areas and could in its discretion determine that, notwithstanding its costs, a particular order is necessary or appropriate to protect the public interest or to effectuate any of the provisions or accomplish any of the purposes of the Act.

When a futures contract begins to serve a significant price discovery function, that contract, and the ECM on which it is traded, warrants increased oversight to deter and prevent price manipulation or other disruptions to market integrity, both on the ECM itself and in any related futures contracts trading on DCMs. An Order finding that a particular contract is a SPDC triggers this increased oversight and imposes obligations on the ECM calculated to accomplish this goal. The increased oversight engendered by the issue of a SPDC Order increases transparency and helps to ensure fair competition among ECMs and DCMs trading similar products and competing for the same business. Moreover, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the CEA and Commission regulations. Additionally, the ECM must comply with nine core principles established by section 2(h)(7) of the Act—including the obligation to establish position limits and/or accountability standards for the SPDC. Section 4(i) of the CEA authorize the Commission to require reports for SPDCs listed on ECMs. These increased responsibilities, along with the CFTC's increased regulatory authority, subject the ECM's risk management practices to the Commission's supervision and oversight and generally enhance the financial integrity of the markets.

The Commission has concluded that ICE's HEN, HIS and HHD contracts that are the subject of the attached Orders are not SPDCs; accordingly, the Commission's Orders impose no additional costs and no additional statutorily or regulatory mandated responsibilities on the ECM.

c. Regulatory Flexibility Act

The Regulatory Flexibility Act ("RFA")[45] requires that agencies consider the impact of their rules on small businesses. The requirements of CEA section 2(h)(7) and the Part 36 rules affect ECMs. The Commission previously has determined that ECMs

[41] Supplemental data supplied by ICE confirmed that block trades in the third quarter of 2009 were in addition to the trades that were conducted on the electronic platform; block trades comprised 1.2 percent of all transactions in the HHD contract.

[42] *See* 73 FR 75888, 75893 (Dec. 12, 2008).

[43] 44 U.S.C. 3507(d).

[44] 7 U.S.C. 19(a).

[45] 5 U.S.C. 601 *et seq.*

are not small entities for purposes of the RFA.[46] Accordingly, the Chairman, on behalf of the Commission, hereby certifies pursuant to 5 U.S.C. 605(b) that these Orders, taken in connection with section 2(h)(7) of the Act and the Part 36 rules, will not have a significant impact on a substantial number of small entities.

VI. Orders

a. Order Relating to the ICE Henry Financial Basis Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the Henry Financial Basis contract, traded on the IntercontinentalExchange, Inc., does not at this time satisfy the material price reference and price linkage criteria for significant price discovery contracts. Moreover, under Commission Guidance material liquidity alone cannot support a significant price discovery finding for the Henry Financial Basis contract. Consistent with this determination, the IntercontinentalExchange, Inc., is not considered a registered entity[47] with respect to the Henry Financial Basis contract and is not subject to the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the IntercontinentalExchange, Inc., are not applicable to the Henry Financial Basis contract with the issuance of this Order.

This Order is based on the representations made to the Commission by the IntercontinentalExchange, Inc., dated July 27, 2009, and November 13, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the Henry Financial Basis contract is not a significant price discovery contract. Additionally, to the extent that it continues to rely upon the exemption in Section 2(h)(3) of the Act, the IntercontinentalExchange, Inc., must continue to comply with all of the applicable requirements of Section 2(h)(3) and Commission Regulation 36.3.

b. Order Relating to the ICE Henry Financial Index Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the Henry Financial Index contract, traded on the IntercontinentalExchange, Inc., does not at this time satisfy the material price reference criterion for significant price discovery contracts. Moreover, under Commission Guidance material liquidity alone cannot support a significant price discovery finding for the Henry Financial Index contract. Consistent with this determination, the IntercontinentalExchange, Inc., is not considered a registered entity[48] with respect to the Henry Financial Index contract and is not subject to the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the IntercontinentalExchange, Inc., are not applicable to the Henry Financial Index contract with the issuance of this Order.

This Order is based on the representations made to the Commission by the IntercontinentalExchange, Inc., dated July 27, 2009, and November 13, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the Henry Financial Index contract is not a significant price discovery contract. Additionally, to the extent that it continues to rely upon the exemption in Section 2(h)(3) of the Act, the IntercontinentalExchange, Inc., must continue to comply with all of the applicable requirements of Section 2(h)(3) and Commission Regulation 36.3.

c. Order Relating to the ICE Henry Financial Swing Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the Henry Financial Swing contract, traded on the IntercontinentalExchange, Inc., does not at this time satisfy the material price reference and arbitrage criteria for significant price discovery contracts. Moreover, under Commission Guidance material liquidity alone cannot support a significant price discovery finding for the Henry Financial Swing contract. Consistent with this determination, the IntercontinentalExchange, Inc., is not considered a registered entity[49] with respect to the Henry Financial Swing contract and is not subject to the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the IntercontinentalExchange, Inc., are not applicable to the Henry Financial Swing contract with the issuance of this Order.

This Order is based on the representations made to the Commission by the IntercontinentalExchange, Inc., dated July 27, 2009, and November 13, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the Henry Financial Swing contract is not a significant price discovery contract. Additionally, to the extent that it continues to rely upon the exemption in Section 2(h)(3) of the Act, the IntercontinentalExchange, Inc., must continue to comply with all of the applicable requirements of Section 2(h)(3) and Commission Regulation 36.3.

Issued in Washington, DC on April 28, 2010, by the Commission.

David A. Stawick,

Secretary of the Commission.

[FR Doc. 2010–10313 Filed 5–3–10; 8:45 am]

BILLING CODE P

[46] 66 FR 42256, 42268 (Aug. 10, 2001).

[47] 7 U.S.C. 1a(29).

[48] 7 U.S.C. 1a(29).

[49] 7 U.S.C. 1a(29).

COMMODITY FUTURES TRADING COMMISSION

Orders Finding that the (1) Phys,[1] BS,[2] LD1 [3] (US/MM), AB–NIT;[4] (2) Phys, BS, LD1 (US/MM), Union-Dawn; [5] (3) Phys, FP,[6] (CA/GJ),[7] AB–NIT; (4) Phys, FP, (US/MM), Union-Dawn; and (5) Phys, ID,[8] 7a [9] (CA/GJ), AB–NIT Contracts, Offered for Trading on the Natural Gas Exchange, Inc., Do Not Perform a Significant Price Discovery Function

AGENCY: Commodity Futures Trading Commission.

ACTION: Final orders.

SUMMARY: On October 20, 2009, the Commodity Futures Trading Commission ("CFTC" or "Commission") published for comment in the **Federal Register** [10] a notice of its intent to undertake a determination whether the (1) Phys, BS, LD1 (US/MM), AB–NIT ("Alberta Basis"); (2) Phys, BS, LD1 (US/MM), Union-Dawn ("Union-Dawn Basis"); (3) Phys, FP, (CA/GJ), AB–NIT ("Alberta Fixed-Price"); (4) Phys, FP, (US/MM), Union-Dawn ("Union-Dawn Fixed-Price"); and (5) Phys, ID, 7a (CA/GJ), AB–NIT ("7a Index") contracts, which are listed for trading on the Natural Gas Exchange, Inc. ("NGX"), an exempt commercial market ("ECM") under sections 2(h)(3)–(5) of the Commodity Exchange Act ("CEA" or the "Act"), perform a significant price discovery function pursuant to section 2(h)(7) of the CEA. The Commission undertook this review based upon an initial evaluation of information and data provided by NGX as well as other available information. The Commission has reviewed the entire record in this matter, including all comments received, and has determined to issue orders finding that the Alberta Basis, Union-Dawn Basis, Alberta Fixed-Price, Union-Dawn Fixed-Price and 7a Index contracts do not perform a significant price discovery function. Authority for this action is found in section 2(h)(7) of the CEA and Commission rule 36.3(c) promulgated thereunder.

DATES: *Effective Date:* April 28, 2010.

FOR FURTHER INFORMATION CONTACT: Gregory K. Price, Industry Economist, Division of Market Oversight, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street, NW., Washington, DC 20581. Telephone: (202) 418–5515. E-mail: *gprice@cftc.gov*; or Susan Nathan, Senior Special Counsel, Division of Market Oversight, same address. Telephone: (202) 418–5133. E-mail: *snathan@cftc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The CFTC Reauthorization Act of 2008 ("Reauthorization Act") [11] significantly broadened the CFTC's regulatory authority with respect to ECMs by creating, in section 2(h)(7) of the CEA, a new regulatory category—ECMs on which significant price discovery contracts ("SPDCs") are traded—and treating ECMs in that category as registered entities under the CEA.[12] The legislation authorizes the CFTC to designate an agreement, contract or transaction as a SPDC if the Commission determines, under criteria established in section 2(h)(7), that it performs a significant price discovery function. When the Commission makes such a determination, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the Act and Commission regulations, and must comply with nine core principles established by new section 2(h)(7)(C).

On March 16, 2009, the CFTC promulgated final rules implementing the provisions of the Reauthorization Act.[13] As relevant here, rule 36.3 imposes increased information reporting requirements on ECMs to assist the Commission in making prompt assessments whether particular ECM contracts may be SPDCs. In addition to filing quarterly reports of its contracts, an ECM must notify the Commission promptly concerning any contract traded in reliance on the exemption in section 2(h)(3) of the CEA that averaged five trades per day or more over the most recent calendar quarter, and for which the exchange sells its price information regarding the contract to market participants or industry publications, or whose daily closing or settlement prices on 95 percent or more of the days in the most recent quarter were within 2.5 percent of the contemporaneously determined closing, settlement or other daily price of another contract.

Commission rule 36.3(c)(3) established the procedures by which the Commission makes and announces its determination whether a particular ECM contract serves a significant price discovery function. Under those procedures, the Commission will publish notice in the **Federal Register** that it intends to undertake an evaluation whether the specified agreement, contract or transaction performs a significant price discovery function and to receive written views, data and arguments relevant to its determination from the ECM and other interested persons. Upon the close of the comment period, the Commission will consider, among other things, all relevant information regarding the subject contract and issue an order announcing and explaining its determination whether or not the contract is a SPDC. The issuance of an affirmative order signals the effectiveness of the Commission's regulatory authorities over an ECM with respect to a SPDC; at that time such an ECM becomes subject to all provisions of the CEA applicable to registered entities.[14] The issuance of such an order also triggers the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4).[15]

II. Notice of Intent To Undertake SPDC Determination

On October 20, 2009, the Commission published in the **Federal Register** notice of its intent to undertake a determination whether the Alberta Basis, Union-Dawn Basis, Alberta Fixed-

[1] The acronym "Phys" indicates physical delivery of natural gas.

[2] The acronym "BS" indicates that the contract is a cash-settled basis swap.

[3] The acronym "LD1" indicates the final settlement price of the New York Mercantile Exchange's ("NYMEX's") physically-delivered Henry Hub Natural Gas futures contract for the corresponding contract month, which is expressed in U.S. dollars and cents per million British thermal units (mmBtu).

[4] The acronym "AB–NIT" refers to the Alberta, Canada, market center and Nova Inventory Transfer hub.

[5] "Union-Dawn" refers to the Union Gas, Ltd.'s, Dawn hub, which is located in Canada across the U.S. border from Detroit, Michigan.

[6] The acronym "FP" refers to a fixed-price contract.

[7] The abbreviation CA/GJ refers the Canadian dollars per gigajoule, which is a unit of measure for energy. One GJ is equal to 0.9478 mmBtu.

[8] The acronym "ID" refers to an index contract.

[9] The term "7a" refers to a price index that is computed as a volume-weighted average of transactions that occur on the Natural Gas Exchange's trading platform during a particular calendar month. Such transactions specify the physical delivery of natural gas at the AB–NIT hub in the following calendar month.

[10] 74 FR 53724 (October 20, 2009).

[11] Incorporated as Title XIII of the Food, Conservation and Energy Act of 2008, Public Law 110–246, 122 Stat. 1624 (June 18, 2008).

[12] 7 U.S.C. 1a(29).

[13] 74 FR 12178 (Mar. 23, 2009); these rules became effective on April 22, 2009.

[14] Public Law 110–246 at 13203; *Joint Explanatory Statement of the Committee of Conference,* H.R. Rep. No. 110–627, 110 Cong., 2d Sess. 978, 986 (Conference Committee Report). *See* also 73 FR 75888, 75894 (Dec. 12, 2008).

[15] For an initial SPDC, ECMs have a grace period of 90 calendar days from the issuance of a SPDC determination order to submit a written demonstration of compliance with the applicable core principles. For subsequent SPDCs, ECMs have a grace period of 30 calendar days to demonstrate core principle compliance.

Price, Union-Dawn Fixed Price and 7a Index contracts perform a significant price discovery function and requested comment from interested parties.[16] Comments were received from the Federal Energy Regulatory Commission ("FERC"), NGX and Working Group of Commercial Energy Firms ("WGCEF").[17] The comment letter from FERC[18] did not directly address the issue of whether or not the subject contracts are SPDCs. NGX stated that the subject contracts lack sufficient liquidity to perform a significant price discovery function. WGCEF argued that the Alberta Basis and Union-Dawn Basis contracts fail to meet the material price reference, price linkage and material liquidity criteria for SPDC determination. Similarly, the 7a Index contracts lack sufficient liquidity to perform a significant price discovery function.[19] NGX's and the Working Group's comments are more extensively discussed below, as applicable.

III. Section 2(h)(7) of the CEA

The Commission is directed by section 2(h)(7) of the CEA to consider the following criteria in determining a contract's significant price discovery function:

- *Price Linkage*—the extent to which the agreement, contract or transaction uses or otherwise relies on a daily or final settlement price, or other major price parameter, of a contract or contracts listed for trading on or subject to the rules of a designated contract market ("DCM") or derivatives transaction execution facility ("DTEF"), or a SPDC traded on an electronic trading facility, to value a position, transfer or convert a position, cash or financially settle a position, or close out a position.
- *Arbitrage*—the extent to which the price for the agreement, contract or transaction is sufficiently related to the price of a contract or contracts listed for trading on or subject to the rules of a DCM or DTEF, or a SPDC traded on or subject to the rules of an electronic trading facility, so as to permit market participants to effectively arbitrage between the markets by simultaneously maintaining positions or executing trades in the contracts on a frequent and recurring basis.
- *Material price reference*—the extent to which, on a frequent and recurring basis, bids, offers or transactions in a commodity are directly based on, or are determined by referencing or consulting, the prices generated by agreements, contracts or transactions being traded or executed on the electronic trading facility.
- *Material liquidity*—the extent to which the volume of agreements, contracts or transactions in a commodity being traded on the electronic trading facility is sufficient to have a material effect on other agreements, contracts or transactions listed for trading on or subject to the rules of a DCM, DTEF or electronic trading facility operating in reliance on the exemption in section 2(h)(3).

Not all criteria must be present to support a determination that a particular contract performs a significant price discovery function, and one or more criteria may be inapplicable to a particular contract.[20] Moreover, the statutory language neither prioritizes the criteria nor specifies the degree to which a SPDC must conform to the various criteria. In Guidance issued in connection with the Part 36 rules governing ECMs with SPDCs, the Commission observed that these criteria do not lend themselves to a mechanical checklist or formulaic analysis. Accordingly, the Commission has indicated that in making its determinations it will consider the circumstances under which the presence of a particular criterion, or combination of criteria, would be sufficient to support a SPDC determination.[21] For example, for contracts that are linked to other contracts or that may be arbitraged with other contracts, the Commission will consider whether the price of the potential SPDC moves in such harmony with the other contract that the two markets essentially become interchangeable. This co-movement of prices would be an indication that activity in the contract had reached a level sufficient for the contract to perform a significant price discovery function. In evaluating a contract's price discovery role as a price reference, the Commission the extent to which, on a frequent and recurring basis, bids, offers or transactions are directly based on, or are determined by referencing, the prices established for the contract.

IV. Findings and Conclusions

The Commission's findings and conclusions with respect to the Alberta Basis, Union-Dawn Basis, Alberta Fixed-Price, Union-Dawn Fixed-Price and 7a Index contracts are discussed separately below.

a. The Phys, BS, LD1 (US/MM), AB–NIT (Alberta Basis Contract) and the SPDC Indicia

The Alberta Basis contract calls for the physical delivery of natural gas based on the final settlement price for New York Mercantile Exchange's ("NYMEX's") Henry Hub physically-delivered Natural Gas ("NG") futures contract for the specified calendar month, plus or minus the price differential (basis) between the Alberta delivery point and the Henry Hub. There is no standard size for the Alberta Basis contract, although a minimum

[16] The Commission's Part 36 rules establish, among other things, procedures by which the Commission makes and announces its determination whether a specific ECM contract serves a significant price discovery function. Under those procedures, the Commission publishes a notice in the **Federal Register** that it intends to undertake a determination whether a specified agreement, contract or transaction performs a significant price discovery function and to receive written data, views and arguments relevant to its determination from the ECM and other interested persons.

[17] FERC is an independent Federal regulatory agency that, among other things, regulates the interstate transmission of natural gas, oil and electricity. NGX is Canada's leading energy exchange and North America's largest physical clearing and settlement facility; NGX is wholly owned by the TMX Group, Inc. WGCEF describes itself as "a diverse group of commercial firms in the domestic energy industry whose primary business activity is the physical delivery of one or more energy commodities to customers, including industrial, commercial and residential consumers" and whose membership consists of "energy producers, marketers and utilities." FIEG describes itself as an association of investment and commercial banks who are active participants in various sectors of the natural gas markets, "including acting as marketers, lenders, underwriters of debt and equity securities, and proprietary investors." The comment letters are available on the Commission's website: comment letters are available on the Commission's Web site: *http://www.cftc.gov/lawandregulation/federalregister/federalregistercomments/2009/09-029.html.*

[18] FERC stated that the subject contracts call for physical delivery of natural gas in Canada, and thus do not appear to be interstate commerce under the Natural Gas Act ("NGA"). Accordingly, FERC expressed the opinion that a determination by the Commission that any of the contracts performs a significant price discovery function "would not appear to conflict with FERC's exclusive jurisdiction under NGA over certain sales of natural gas in interstate commerce for resale or with its other regulatory responsibilities under the NGA" and further that "FERC staff will continue to monitor for any such conflict * * * [and] advise the CFTC" should any such potential conflict arise. CL01.

[19] WGCEF did not address whether the Alberta Fixed Price or Union-Dawn Fixed Price contracts are SPDCs.

[20] In its October 20, 2009, **Federal Register** release, the Commission identified material price reference, price linkage and material liquidity as the possible criteria for SPDC determination of the Alberta Basis and Union-Dawn Basis contracts (arbitrage was not identified as a possible criterion). With respect to the Alberta Fixed-Price, Union-Dawn Fixed-Price and 7a Index contracts, the **Federal Register** release identified material price reference and material liquidity as the possible criteria for SPDC determination (price linkage and arbitrage were not identified as possible criteria). The criteria not indentified in the initial release will not be discussed further in this document or the associated Orders.

[21] 17 CFR part 36, Appendix A.

volume of 100 million British thermal units ("mmBtu") is required in increments of 100 units per day. The Alberta Basis contract is listed for 60 consecutive calendar months.

The Henry Hub,[22] which is located in Erath, Louisiana, is the primary cash market trading and distribution center for natural gas in the United States. It also is the delivery point and pricing basis for the NYMEX's actively traded, physically-delivered natural gas futures contract, which is the most important pricing reference for natural gas in the United States. The Henry Hub, which is operated by Sabine Pipe Line, LLC, serves as a juncture for 13 different pipelines. These pipelines bring in natural gas from fields in the Gulf Coast region and ship it to major consumption centers along the East Coast and Midwest. The throughput shipping capacity of the Henry Hub is 1.8 trillion mmBtu per day.

In addition to the Henry Hub, there are a number of other locations where natural gas is traded. In 2008, there were 33 natural gas market centers in North America.[23] Some of the major trading centers include Alberta, Northwest Rockies, Southern California border and the Houston Ship Channel. For locations that are directly connected to the Henry Hub by one or more pipelines and where there typically is adequate shipping capacity, the price at the other locations usually directly tracks the price at the Henry Hub, adjusted for transportation costs. However, at other locations that are not directly connected to the Henry Hub or where shipping capacity is limited, the prices at those locations often diverge from the Henry Hub price. Furthermore, one local price may be significantly different than the price at another location even though the two markets' respective distances from the Henry Hub are the same. The reason for such pricing disparities is that a given location may experience supply and demand factors that are specific to that region, such as differences in pipeline shipping capacity, unusually high or low demand for heating or cooling or supply disruptions caused by severe weather. As a consequence, local natural gas prices can differ from the Henry Hub price by more than the cost of shipping and such price differences can vary in an unpredictable manner.

The Alberta hub is far removed from the Henry Hub and is not directly connected to the Henry Hub by an existing pipeline. Located in the Canadian province of Alberta, the Alberta natural gas market is a major connection point for long-distance transmission systems that ship natural gas to points throughout Canada and the United States. The Alberta province is Canada's dominant natural gas producing region; six of the nine Canadian market centers are located in the Alberta province. The throughput capacity at the AECO–C hub is ten billion cubic feet per day. Moreover, the number of pipeline interconnections at that hub was four in 2008. Lastly, the AECO–C hub's capacity is 20.4 billion cubic feet per day.[24]

The local price at the Alberta hub typically differs from the price at the Henry Hub. Thus, the price of the Henry Hub physically-delivered futures contract is an imperfect proxy for the Alberta price. Moreover, exogenous factors, such as adverse weather, can cause the Alberta gas price to differ from the Henry Hub price by an amount that is more or less than the cost of shipping, making the NYMEX Henry Hub futures contract even less precise as a hedging tool than desired by market participants. Basis contracts[25] allow traders to more accurately discover prices at alternative locations and hedge price risk that is associated with natural gas at such locations. In this regard, a position at a local price for an alternative location can be established by adding the appropriate basis swap position to a position taken in the NYMEX physically-delivered Henry Hub contract (or in the NYMEX or ICE Henry Hub look-alike contract, which cash settle based on the NYMEX physically-delivered NG contract's final settlement price).

In its October 20, 2009, **Federal Register** notice, the Commission identified material price reference, price linkage and material liquidity as the potential SPDC criteria applicable to the Alberta Basis contract.[26] Each of these criteria is discussed below.

1. Material Price Reference Criterion

The Commission's October 20, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to the Alberta Basis contract. The Commission noted that NGX forged an alliance with the IntercontinentalExchange, Inc., ("ICE") to use the ICE's matching engine to complete transactions in physical natural gas contracts traded on NGX. In return, NGX agreed to provide clearing services for such transactions. As part of the agreement, NGX provides ICE with transaction data, which are then made available to market participants on a paid basis. ICE offers NGX's price data in several packages, which vary in terms of the amount of available historical data. For example, the ICE offers the "OTC Gas End of Day" data package with access to all price data, or just current prices plus a selected number of months (i.e., 12, 24, 36, or 48 months) of historical data.

The Commission will rely on one of two sources of evidence—direct or indirect—to determine that the price of a contract was being used as a material price reference and therefore, serving a significant price discovery function.[27] With respect to direct evidence, the Commission will consider the extent to which, on a frequent and recurring basis, cash market bids, offers or transactions are directly based on or quoted at a differential to, the prices generated on the ECM in question. Direct evidence may be established when cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract in question. Cash market prices are set explicitly at a differential to the section 2(h)(3) contract when, for instance, they are quoted in dollars and cents above or below the reference contract's price. Cash market prices are set implicitly at a differential to a section 2(h)(3) contract when, for instance, they are arrived at after adding to, or subtracting from the section 2(h)(3) contract, but then quoted or reported at a flat price. With respect to indirect evidence, the Commission will consider the extent to which the price of the contract in question is being routinely disseminated in widely distributed industry publications—or offered by the ECM itself for some form of remuneration—and consulted on a frequent and recurring basis by industry

[22] The term "hub" refers to a juncture where two or more natural gas pipelines are connected. Hubs also serve as pricing points for natural gas at the particular locations.

[23] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[24] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf*

[25] Basis contracts denote the difference in the price of natural gas at a specified location minus the price of natural gas at the Henry Hub. The differential can be either a positive or negative value.

[26] As noted above, the Commission did not find an indication of arbitrage in connection with this contract; accordingly, that criterion is not discussed in reference to the Alberta Basis contract.

[27] 17 CFR part 36, Appendix A.

participants in pricing cash market transactions.

The Alberta hub is a major trading center for natural gas in North America. Traders, including producers, keep abreast of the prices of the Alberta market center when conducting cash deals. However, ICE's cash-settled AECO Financial Basis contract is used more widely as a price reference than the NGX Alberta Basis contract. Traders look to ICE contract's competitively determined price as an indication of expected values of natural gas at the Alberta hub when entering into cash market transactions for natural gas, especially those trades providing for physical delivery in the future. Moreover, traders use ICE's AECO Financial Basis contract, as well as other basis contracts, to hedge cash market positions and transactions. The substantial volume of trading and open interest in the ICE contract attests to its use for this purpose.[28] In contrast, trading volume in the NGX Alberta Basis contract is much smaller than in ICE's cash-settled version of the contract. In this regard, total trading volume in the NGX Alberta Basis contract in the third quarter of 2009 was equivalent to 52,158 NYMEX physically-delivered natural gas contracts, which has a size of 10,000 mmBtu.

Accordingly, although the Alberta Hub is a major trading center for natural gas and, as noted, NGX provides price information for the Alberta Basis contract to ICE which sells it, the Commission has found upon further evaluation that the Alberta Basis contract is not routinely consulted by industry participants in pricing cash market transactions and thus does not meet the Commission's Guidance for the material price reference criterion. In this regard, the ICE AECO natural gas futures contract is routinely consulted by industry participants in pricing cash market transactions at this location. Because both the NGX and the ICE contracts basically price the same commodity at the same location and time and the ICE contract has significantly higher trading volume and open interest, it is not necessary for market participants to independently refer to the NGX Alberta Basis contract for pricing natural gas at this location. Thus, the Alberta Basis contract does not satisfy the direct price reference test for existence of material price reference. Furthermore, the Commission notes that publication of the Alberta Basis contract's prices is not indirect evidence of material price reference. The Alberta Basis contract's prices are published with those of numerous other contracts, including ICE's AECO Financial Basis contract, which are of more interest to market participants. Thus, the Commission has concluded that traders likely do not specifically purchase ICE data packages for the NGX Alberta Basis contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions.

i. **Federal Register** Comments

NGX states its opinion that the Alberta Basis contract does not satisfy the material price reference criteria because the contract lacks sufficient liquidity, and "the consideration of liquidity is implicitly understood to be a relevant, if not fundamental factor, where material price reference is being considered."[29] Furthermore, NGX opined that the Commission purported "to adopt a threshold as low as 5, 10 or 20 trades per day as sufficiently material to attract a SPDC designation."[30] In this regard, the Commission adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs"[31] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC. However, this does not mean that the contract will be found to be a SPDC merely because it met the reporting threshold. WGCEF states that there is no direct evidence that any contracts on any market settle to or reference the NGX Alberta Basis price. Moreover, WGCEF "does not believe the fact that ICE publishes the settlement prices of NGX physical transactions constitutes sufficient evidence of a Material Price Reference necessary to satisfy the requirements of CEA Section 2(h)(7)(B)(iii)." It notes that the publication of NGX price data by ICE is the result of a unique arrangement between ICE and NGX, whereby ICE serves as the exclusive trading platform for NGX contracts and NGX does not publish any trade data on its own website. "Given this unique arrangement," WGCEF asserts, "it is only logical that ICE publishes transaction data regarding the NGX physical deals in its "OTC Gas End of Day" publication." As noted above, the Commission believes that publication of the Alberta Basis contract's prices is not indirect evidence of material price reference. The Alberta Basis contract's prices are published with those of numerous other contracts, including ICE's AECO Financial Basis contract, which are of more interest to market participants. As a result, the Commission has concluded that traders likely do not specifically purchase ICE data packages for the NGX Alberta Basis contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions.

ii. Conclusion Regarding Material Price Reference

Based on the above, the Commission finds that the NGX Alberta Basis contract does not meet the material price reference criterion because cash market transactions are not priced either explicitly or implicitly on a frequent and recurring basis at a differential to the Alberta Basis contract's price (direct evidence). Moreover, while the Alberta Basis contract's price data is sold to market participants, market participants likely do not specifically purchase the ICE data packages for the Alberta contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions (indirect evidence).

2. Price Linkage Criterion

In its October 20, 2009, **Federal Register** notice, the Commission identified price linkage as a potential basis for a SPDC determination with respect to the Alberta Basis contract. In this regard, the final settlement of the Alberta Basis contract is based, in part, on the final settlement price of NYMEX's Henry Hub physically delivered NG futures contract, where NYMEX is registered with the Commission as a DCM.

The Commission's Guidance on Significant Price Discovery Contracts notes that a "price-linked contract is a contract that relies on a contract traded on another trading facility to settle, value or otherwise offset the price-linked contract."[32] Furthermore, the Guidance notes that "[f]or a linked contract, the mere fact that a contract is linked to another contract will not be sufficient to support a determination that a contract performs a significant

[28] In the third quarter of 2009, 6,320 separate trades occurred on ICE's electronic platform in its AECO Financial Basis contract, resulting in a daily average of 95.8 trades. During the same period, the ICE contract had a total trading volume on its electronic platform of 736,412 contracts (which was an average of 11,158 contracts per day). As of September 30, 2009, open interest in the ICE AECO Financial Basis contract was 483,561 contracts.

[29] CL 02.

[30] *Id.*

[31] 73 FR 75892 (December 12, 2008)

[32] Appendix A to the Part 36 rules.

price discovery function. To assess whether such a determination is warranted, the Commission will examine the relationship between transaction prices of the linked contract and the prices of the referenced contract. The Commission believes that where material liquidity exists, prices for the linked contract would be observed to be substantially the same as, or move substantially in conjunction with, the prices of the referenced contract." The Guidance proposes a threshold price relationship such that prices of the ECM linked contract will fall within a 2.5 percent price range for 95 percent of contemporaneously determined closing, settlement or other daily prices over the most recent quarter. Finally, the Commission also stated in the Guidance that it would consider a linked contract that has a trading volume equivalent to 5 percent of the volume of trading in the contract to which it is linked to have sufficient volume potentially to be deemed SPDC ("minimum threshold").

To assess whether the Alberta Basis contract meets the price linkage criterion, Commission staff obtained price data from NGX and performed the statistical tests cited above. Staff found that, while the Alberta Basis contract price is determined, in part, by the final settlement price of the NYMEX physically delivered natural gas futures contract (a DCM contract), the imputed Alberta price (derived by adding the NYMEX Henry Hub Natural Gas price to the Alberta Basis price) is not within 2.5 percent of the settlement price of the corresponding NYMEX Henry Hub natural gas futures contract on 95 percent or more of the days. Specifically, during the third quarter of 2009, none of the Alberta Basis natural gas prices derived from the NGX basis values were within 2.5 percent of the daily settlement price of the NYMEX Henry Hub futures contract. In addition, staff found that the Alberta Basis contract fails to meet the volume threshold requirement. In particular, the total trading volume in the NYMEX NG contract during the third quarter of 2009 was 14,022,963 contracts, with 5 percent of that number being 701,148 contracts. Trades on the NGX centralized market in the Alberta Basis contract during the same period was 52,168 NYMEX-equivalent contracts. Thus, centralized-market trades in the Alberta Basis contract amounted to less than the minimum threshold.

i. Federal Register Comments

NGX states its belief that the Alberta Basis contract does not meet the price linkage factor because there is insufficient trading activity in this contract.

WGCEF acknowledges that the Alberta Basis contract is technically linked to the NYMEX Henry Hub NG contract. However, WGCEF contends that a comparison of the Alberta Basis contract price with NYMEX NG settlement prices from July 21, 2009 through November 2, 2009 clearly establishes that prices for these contracts are not substantially the same and do not move substantially in conjunction with one another.

ii. Conclusion Regarding the Price Linkage Criterion

The Commission finds that the NGX Alberta Basis contract does not meet the price linkage criterion because it fails the price relationship and volume test provided for in the Commission's Guidance.

3. Material Liquidity Criterion

As noted above, in its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity, price linkage and material price reference as potential criteria for SPDC determination of the AB contract. To assess whether a contract meets the material liquidity criterion, the Commission first examines trading activity as a general measurement of the contract's size and potential importance. If the Commission finds that the contract in question meets a threshold of trading activity that would render it of potential importance, the Commission will then perform a statistical analysis to measure the effect that changes to the subject-contract's prices potentially may have on prices for other contracts listed on an ECM or a DCM.

With respect to the material liquidity criterion, the Commission noted that the average number of transactions in the Alberta Basis nearby month contract was 23.2 trades per day in the second quarter of 2009. During the same period, the Alberta Basis contract had an average daily trading volume of 5,869,000 mmBtu (or 587 NYMEX-equivalent contracts of 10,000 mmBtu size). Moreover, open interest as of June 30, 2009, was 150,213,600 mmBtu in the nearby month (15,021 NYMEX equivalents) and 10,112,200 mmBtu (1,011 NYMEX equivalents) for delivery two months out.[33]

In a subsequent filing, NGX reported that in the third quarter of 2009 the total number of transactions was 2,640 trades (an average of 40 trades per day). Trading volume in the third quarter of 2009 was 521,580,000 mmBtu (52,158 NYMEX-equivalent contracts) or an average of 7,900,000 mmBtu (790 NYMEX-equivalent contracts) on a daily basis. As of September 30, 2009, open interest in the Alberta Basis contract was 6,440,000 mmBtu (644 NYMEX-equivalent contracts).

The number of trades per day remained relatively low from the second to third quarters of 2009, and averaged only slightly more than the reporting level of five trades per day. Moreover, trading activity in the Alberta Basis contract, as characterized by total quarterly volume, indicates that the Alberta Basis contract experiences trading activity that is similar to that of minor futures markets.[34] Thus, the Alberta Basis contract does not meet a threshold of trading activity that would render it of potential importance and no additional statistical analysis is warranted.[35]

i. **Federal Register** Comments

NGX stated in its comment letter that the Alberta Basis contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

First, NGX opined that the Commission "seems to have applied a threshold for 'material liquidity' that is extremely low, and in general insufficient to support a determination that these contracts are no longer emerging markets but in fact serve a significant price discovery function." NGX also noted that the Commission's Guidance states that material liquidity was intended to be a "broad concept that captures the ability to transact immediately with little or no price concession." The Guidance also states that where "material liquidity exists, a more or less continuous stream of prices can be observed and the prices should be similar," such as "where trades occur multiple times per minute." NGX then opined that "[t]he levels of liquidity

[33] Second quarter 2009 data was submitted to the Commission in a different format than in later filings. In this regard total trading volume and total number of trades per quarter were not identified.

[34] Based on the Commission's experience, a minor futures contract is, generally, one that has a quarterly trading volume of 100,000 contracts or less.

[35] In establishing guidance to illustrate how it will evaluate the various criteria, or combinations of criteria, when determining whether a contract is an SPDC, the Commission made clear that "material liquidity itself would not be sufficient to make a determination that a contract is a [SPDC], * * * but combined with other factors it can serve as a guidepost indicating which contracts are functioning as [SPDCs]." For the reasons discussed above, the Commission has found that the Union-Dawn Basis contract does not meet either the price linkage or material price reference criterion. In light of this finding and the Commission's Guidance cited above, there is no need to evaluate further the material liquidity criteria since it cannot be used alone as a basis for an SPDC determination.

outlined above for the Proposed Contracts cannot be what Congress intended in establishing the dividing line between contracts ripe for regulation and those still emerging and in need of further incubation."

WGCEF used arguments similar to those of NGX in opining that the Alberta Basis contract does not meet the material liquidity criterion. For example, WGCEF stated that the Alberta Basis contract does not have an effect on other contracts that are listed for trading, particularly the NYMEX NG contract. WGCEF pointed out the Commission's Guidance which states that a "continuous stream of prices" should be observed in markets with material liquidity. In addition, WGCEF indicated that in liquid markets observed prices should be similar to each other and that transactions should occur multiple times per minute; "the trade frequency of the Alberta Basis Contract in terms of multiple trades per minute is very low." In this regard, the Commission notes that it adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs" [36] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC but this does not mean that the contract will be found to be a SPDC merely because it met the reporting threshold. Furthermore, the Commission observes that a continuous stream of prices would indeed be an indication of liquidity for certain markets but the Guidance also notes that "quantifying the levels of immediacy and price concession that would define material liquidity may differ from one market or commodity to another."

ii. Conclusion Regarding Material Liquidity

For the reasons discussed above, the Commission finds that the Alberta Basis contract does not meet the material liquidity criterion.

4. Overall Conclusion Regarding the Alberta Basis Contract

After considering the entire record in this matter, including the comments received, the Commission has determined that the NGX Alberta Basis contract does not perform a significant price discovery function under the criteria established in section 2(h)(7) of the CEA. Specifically, the Commission has determined that the NGX Alberta Basis contract does not meet the material price reference, price linkage, or material liquidity criteria at this time. Accordingly, the Commission is issuing the attached Order declaring that the Alberta Basis contract is not a SPDC.

Issuance of this Order indicates that the Commission does not at this time regard NGX as a registered entity in connection with its Alberta Basis contract.[37] Accordingly, with respect to its Alberta Basis contract, NGX is not required to comply with the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) for ECMs with SPDCs. However, NGX must continue to comply with the applicable reporting requirements for ECMs.

b. The Phys, BS, LD1 (US/MM), Union-Dawn (Union-Dawn Basis) Contract and the SPDC Indicia

The NGX Union-Dawn Basis contract is a monthly contract that calls for physical delivery of natural gas based on the final settlement price for NYMEX's Henry Hub physically-delivered natural gas futures contract for the specified calendar month, plus or minus the price differential (basis) between the Dawn delivery point and the Henry Hub. There is no standard size for the Union-Dawn Basis contract, although a minimum volume of 100 mmBtu is required in increments of 100 units per day. The Union-Dawn Basis contract is listed for 60 consecutive calendar months.

The Henry Hub,[38] which is located in Erath, Louisiana, is the primary cash market trading and distribution center for natural gas in the United States. It also is the delivery point and pricing basis for the NYMEX's actively traded, physically-delivered natural gas futures contract, which is the most important pricing reference for natural gas in the United States. The Henry Hub, which is operated by Sabine Pipe Line, LLC, serves as a juncture for 13 different pipelines. These pipelines bring in natural gas from fields in the Gulf Coast region and ship it to major consumption centers along the East Coast and Midwest. The throughput shipping capacity of the Henry Hub is 1.8 trillion mmBtu per day.

In addition to the Henry Hub, there are a number of other locations where natural gas is traded. In 2008, there were 33 natural gas market centers in North America.[39] Some of the major trading centers include Alberta, Northwest Rockies, Southern California border and the Houston Ship Channel. For locations that are directly connected to the Henry Hub by one or more pipelines and where there typically is adequate shipping capacity, the price at the other locations usually directly tracks the price at the Henry Hub, adjusted for transportation costs. However, at other locations that are not directly connected to the Henry Hub or where shipping capacity is limited, the prices at those locations often diverge from the Henry Hub price. Furthermore, one local price may be significantly different than the price at another location even though the two markets' respective distances from the Henry Hub are the same. The reason for such pricing disparities is that a given location may experience supply and demand factors that are specific to that region, such as differences in pipeline shipping capacity, unusually high or low demand for heating or cooling or supply disruptions caused by severe weather. As a consequence, local natural gas prices can differ from the Henry Hub price by more than the cost of shipping and such price differences can vary in an unpredictable manner.

Union Gas, Ltd., is a major Canadian natural gas storage, transmission, and distribution company based in Ontario, Canada. Union Gas offers premium storage and transportation services to customers at the Dawn hub, which is the largest underground storage facility in Canada and one of the largest in North America. The Dawn hub offers customers an important link for natural gas moving from Western Canadian and U.S. supply basins to markets in central Canada and the northeast United States. The throughput capacity at the Dawn hub is 9.3 billion cubic feet per day. Moreover, the number of pipeline interconnections at that hub was ten in 2008. Lastly, the Dawn hub's capacity is 12.8 billion cubic feet per day.[40]

The local price at the Dawn hub typically differs from the price at the Henry Hub. Thus, the price of the Henry Hub physically-delivered futures contract is an imperfect proxy for the Dawn price. Moreover, exogenous factors, such as adverse weather, can cause the Dawn gas price to differ from the Henry Hub price by an amount that is more or less than the cost of shipping, making the NYMEX Henry Hub futures

[36] 73 FR 75892 (December 12, 2008).

[37] *See* 73 FR 75888, 75893 (Dec. 12, 2008).

[38] The term "hub" refers to a juncture where two or more natural gas pipelines are connected. Hubs also serve as pricing points for natural gas at the particular locations.

[39] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[40] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

contract even less precise as a hedging tool than desired by market participants. Basis contracts [41] allow traders to more accurately discover prices at alternative locations and hedge price risk that is associated with natural gas at such locations. In this regard, a position at a local price for an alternative location can be established by adding the appropriate basis swap position to a position taken in the NYMEX physically-delivered Henry Hub contract (or in the NYMEX or ICE Henry Hub look-alike contract, which cash settle based on the NYMEX physically-delivered natural gas contract's final settlement price).

In its October 20, 2009, **Federal Register** notice, the Commission identified material price reference, price linkage and material liquidity as the potential SPDC criteria applicable to the Union-Dawn Basis contract. Each of these criteria is discussed below.[42]

1. Material Price Reference Criterion

The Commission's October 20, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission noted that NGX forged an alliance with ICE to use ICE's matching engine to complete transactions in physical natural gas contracts traded on NGX. In return, NGX agreed to provide the clearing services for such transactions. As part of the agreement, NGX provides ICE with transaction data, which are then made available to market participants on a paid basis. ICE offers the NGX data in several packages, which vary in terms of the amount of available historical data. For example, the ICE offers the "OTC Gas End of Day" data packages with access to all price data, or just current prices plus a selected number of months (*i.e.,* 12, 24, 36, or 48 months) of historical data.

The Commission will rely on one of two sources of evidence—direct or indirect—to determine that the price of a contract was being used as a material price reference and therefore, serving a significant price discovery function.[43] With respect to direct evidence, the Commission will consider the extent to which, on a frequent and recurring basis, cash market bids, offers or transactions are directly based on or quoted at a differential to, the prices generated on the ECM in question. Direct evidence may be established when cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract in question. Cash market prices are set explicitly at a differential to the section 2(h)(3) contract when, for instance, they are quoted in dollars and cents above or below the reference contract's price. Cash market prices are set implicitly at a differential to a section 2(h)(3) contract when, for instance, they are arrived at after adding to, or subtracting from the section 2(h)(3) contract, but then quoted or reported at a flat price. With respect to indirect evidence, the Commission will consider the extent to which the price of the contract in question is being routinely disseminated in widely distributed industry publications—or offered by the ECM itself for some form of remuneration—and consulted on a frequent and recurring basis by industry participants in pricing cash market transactions.

The Union-Dawn hub is a relatively important trading center for natural gas in North America. Traders use the NGX Union-Dawn Basis contract to hedge cash market positions and transactions. Nevertheless, the relatively small volume of trading and open interest [44] in the Union-Dawn Basis contract does not support a finding that the contract is consulted on a frequent and recurring basis in establishing cash market transaction prices. Thus, the Union-Dawn Basis contract does not satisfy the direct price reference test for existence of material price reference. Furthermore, the Commission notes that publication of the Union-Dawn Basis contract's prices is not indirect evidence of material price reference. The Union-Dawn Basis contract's prices are published with those of numerous other contracts, including ICE's AECO Financial Basis contract, which are of more interest to market participants. Thus, the Commission has concluded that traders likely do not specifically purchase ICE data packages for the NGX Union-Dawn Basis contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions.

i. **Federal Register** Comments

NGX expressed the opinion that the Union Dawn Basis contract does not meet the material price reference criterion because there is insufficient trading activity in this contract.

WGCEF stated that there is no evidence that the Union-Dawn Basis contract does not directly affect the "settlement of the NYMEX NG Contract nor does it influence physical pricing at the Henry Hub." [45] Moreover, there is no evidence that a contract in any market is tied directly or indirectly to the settlement price of the Union-Dawn Basis contract. With respect to indirect evidence, WGCEF believes that ICE's publication of the NGX contract's settlement prices does not "constitute sufficient evidence" of material price reference, and is simply an extension of the "unique [business] arrangement" between ICE and NGX.

ii. Conclusion Regarding Material Price Reference

Based on the above, the Commission finds that the NGX Union-Dawn Basis contract does not meet the material price reference criterion because cash market transactions are not priced either explicitly or implicitly on a frequent and recurring basis at a differential to the Union-Dawn Basis contract's price (direct evidence). Moreover, while the Union-Dawn Basis contract's price data is sold to market participants, individuals likely do not specifically purchase the ICE data packages for the Union-Dawn Basis contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions (indirect evidence).

2. Price Linkage Criterion

In its October 20, 2009, **Federal Register** notice, the Commission identified price linkage as a potential basis for a SPDC determination with respect to the Union-Dawn Basis contract. In this regard, the final settlement of the Union-Dawn Basis contract is based, in part, on the final settlement price of the NYMEX's Henry Hub physically-delivered natural gas futures contract, where the NYMEX is registered with the Commission as a DCM.

The Commission's Guidance on Significant Price Discovery Contracts notes that a "price-linked contract is a contract that relies on a contract traded on another trading facility to settle, value or otherwise offset the price-

[41] Basis contracts denote the difference in the price of natural gas at a specified location minus the price of natural gas at the Henry Hub. The differential can be either a positive or negative value.

[42] As noted above, the Commission did not find an indication of arbitrage in connection with this contract; accordingly, that criterion is not discussed in reference to the Union-Dawn Basis contract.

[43] 17 CFR part 36, Appendix A.

[44] In the third quarter of 2009, the Union-Dawn Basis contract had a total trading volume that was equivalent to 28,090 NYMEX physically-delivered NG futures contracts (the size of one NYMEX NG contract is 10,000 mmBtu); the Union-Dawn contract also had an open interest equivalent to 2,948 NYMEX NG futures contracts.

[45] CL 03.

linked contract."[46] Furthermore, the Guidance notes that "[f]or a linked contract, the mere fact that a contract is linked to another contract will not be sufficient to support a determination that a contract performs a significant price discovery function. To assess whether such a determination is warranted, the Commission will examine the relationship between transaction prices of the linked contract and the prices of the referenced contract. The Commission believes that where material liquidity exists, prices for the linked contract would be observed to be substantially the same as, or move substantially in conjunction with, the prices of the referenced contract." The Guidance proposes a threshold price relationship such that prices of the ECM linked contract will fall within a 2.5 percent price range for 95 percent of contemporaneously determined closing, settlement or other daily prices over the most recent quarter. Finally, the Commission also stated in the Guidance that it would consider a linked contract that has a trading volume equivalent to 5 percent of the volume of trading in the contract to which it is linked to have sufficient volume potentially to be deemed a SPDC ("minimum threshold").

To assess whether the Union-Dawn contract meets the price linkage criterion, Commission staff obtained price data from NGX and performed the statistical tests cited above. Staff found that, while the Union-Dawn Basis contract price is determined, in part, by the final settlement price of the NYMEX physically-delivered natural gas futures contract (a DCM contract), the imputed Union-Dawn price (derived by adding the NYMEX Henry Hub Natural Gas price to the Union-Dawn Basis price) is not within 2.5 percent of the settlement price of the corresponding NYMEX Henry Hub natural gas futures contract on 95 percent or more of the days. Specifically, during the third quarter of 2009, 27.4 percent of the Union-Dawn Basis natural gas prices derived from the NGX basis values were within 2.5 percent of the daily settlement price of the NYMEX Henry Hub futures contract. In addition, staff found that the Union-Dawn Basis contract fails to meet the volume threshold requirement. In particular, the total trading volume in the NYMEX NG contract during the third quarter of 2009 was 14,022,963 contracts, with 5 percent of that number being 701,148 contracts. Trades on the NGX centralized market in the Union-Dawn Basis contract during the same period was 28,090 NYMEX-equivalent contracts. Thus, centralized-market trades in the Union-Dawn Basis contract amounted to less than the minimum threshold.

i. **Federal Register** Comments

NGX states its belief that the Union Dawn Basis contract does not meet the price linkage factor because there is insufficient trading activity in this contract. WGCEF acknowledges that the Union-Dawn Basis is technically linked to the NYMEX physically-delivered NG futures contract. The Working Group notes that a comparison of the Union-Dawn Basis with NYMEX NG settlement prices from July 21, 2009, through November 2, 2009, clearly establishes that these contracts are not substantially the same and do not move substantially in conjunction with one another.

ii. Conclusion Regarding the Price Linkage Criterion

The Commission finds that the Union-Dawn Basis contract does not meet the price linkage criterion because it fails the price relationship and volume tests provided for in the Commission's Guidance.

3. Material Liquidity Criterion

As noted above, in its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity, price linkage and material price reference as potential criteria for SPDC determination of the Union-Dawn Basis contract. To assess whether a contract meets the material liquidity criterion, the Commission first examines trading activity as a general measurement of the contract's size and potential importance. If the Commission finds that the contract in question meets a threshold of trading activity that would render it of potential importance, the Commission will then perform a statistical analysis to measure the effect that changes to the subject-contract's prices potentially may have on prices for other contracts listed on an ECM or a DCM.

In its October 20, 2009, **Federal Register** release, the Commission noted that the total number of transactions executed on NGX's electronic platform in the nearby month of the Union-Dawn Basis contract was 8.3 trades per day in the second quarter of 2009. During the same period, the Union-Dawn Basis contract had an average daily trading volume of 1,332,400 mmBtu (or 133 NYMEX-equivalent contracts per day). Moreover, open interest as of June 30, 2009, was 28,203,800 mmBtu (2,820 NYMEX-equivalent contracts) in the nearby contract month and 12,908,400 mmBtu (1,291 NYMEX-equivalent contracts) for delivery two months out.[47]

In a subsequent filing, NGX reported that total trading volume in the third quarter of 2009 was 28,090 contracts (or 425 contracts on a daily basis). In term of number of transactions, 1,831 trades occurred in the third quarter of 2009 (28 trades per day). As of September 30, 2009, open interest in the Union-Dawn Basis contract was 23,289 NYMEX-equivalent contracts.

As indicated above, the average number of trades per day in the second and third quarters of 2009 was only slightly above the minimum reporting level (5 trades per day). Moreover, trading activity in the Union-Dawn Basis contract, as characterized by total quarterly volume, indicates that the Union-Dawn Basis contract experiences trading activity similar to that of minor futures markets.[48] Thus, the Union-Dawn Basis contract does not meets a threshold of trading activity that would render it of potential importance and no additional statistical analysis is warranted.[49]

i. **Federal Register** Comments

NGX stated in its comment letter that the Union-Dawn Basis contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

First, NGX opined that the Commission "seems to have applied a threshold for 'material liquidity' that is extremely low, and in general insufficient to support a determination that these contracts are no longer emerging markets but in fact serve a significant price discovery function". NGX also noted that the Commission's Guidance states that material liquidity was intended to be a "broad concept that captures the ability to transact immediately with little or no price

[46] Appendix A to the Part 36 rules.

[47] Second quarter 2009 data was submitted to the Commission is a different format than in later filings. In this regard total trading volume and total number of trades per quarter were not identified.

[48] Based on the Commission's experience, a minor futures contract is, generally, one that has a quarterly trading volume of 100,000 contracts or less.

[49] In establishing guidance to illustrate how it will evaluate the various criteria, or combinations of criteria, when determining whether a contract is a SPDC, the Commission made clear that "material liquidity itself would not be sufficient to make a determination that a contract is a [SPDC], * * * but combined with other factors it can serve as a guidepost indicating which contracts are functioning as [SPDCs]." For the reasons discussed above, the Commission has found that the Union-Dawn Basis contract does not meet either the price linkage or material price reference criterion. In light of this finding and the Commission's Guidance cited above, there is no need to evaluate further the material liquidity criteria since it cannot be used alone as a basis for a SPDC determination.

concession." The Guidance also states that where "material liquidity exists, a more or less continuous stream of prices can be observed and the prices should be similar", such as "where trades occur multiple times per minute." NGX then opined that "[t]he levels of liquidity outlined above for the Proposed Contracts cannot be what Congress intended in establishing the dividing line between contracts ripe for regulation and those still emerging and in need of further incubation.

The WGCEF used arguments similar to those of NGX in opining that the Union-Dawn Basis contract does not meet the material liquidity criterion. In addition, WGCEF noted that to be materially liquid, a contract must have "a material effect of other contracts" and have "sufficient liquidity to perform a significant price discovery function." WGCEF stated that the Union-Dawn Basis contract lacks both of those features.

In this regard, the Commission notes that it adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs" [50] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC but this does not mean that the contract will be found to be a SPDC merely because it met the reporting threshold. Furthermore, the Commission observes that a continuous stream of prices would indeed be an indication of liquidity for certain markets but the Guidance also notes that "quantifying the levels of immediacy and price concession that would define material liquidity may differ from one market or commodity to another."

ii. Conclusion Regarding Material Liquidity

For the reasons discussed above, the Commission finds that the Union-Dawn Basis contract does not meet the material liquidity criterion.

4. Overall Conclusion Regarding the Union-Dawn Basis Contract

After considering the entire record in this matter, including the comments received, the Commission has determined that the Union-Dawn Basis contract does not perform a significant price discovery function under the criteria established in section 2(h)(7) of the CEA. Specifically, the Commission has determined that the Union-Dawn Basis contract does not meet the material price reference, price linkage, or material liquidity criteria at this time. Accordingly, the Commission is issuing the attached Order declaring that the Union-Dawn Basis contract is not a SPDC.

Issuance of this Order indicates that the Commission does not at this time regard NGX as a registered entity in connection with its Union-Dawn Basis contract.[51] Accordingly, with respect to its Union-Dawn Basis contract, NGX is not required to comply with the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) for ECMs with SPDCs. However, NGX must continue to comply with the applicable reporting requirements for ECMs.

c. The Phys, FP, (CA/GJ), AB–NIT (Alberta Fixed Price) Contract and the SPDC Indicia

The Alberta Fixed-Price contract calls for physical delivery of natural gas at the Alberta hub over a number of different time periods. This contract allows delivery of natural gas during the following day, Friday plus two or three days, Saturday plus three or four days, Sunday plus two days, the remainder of the month, throughout the nearby calendar month, and during a specific future calendar month. Each delivery period is considered to be a separate contract, and market participants value each delivery period separately. However, overlapping delivery days are considered fungible, and, thus, may be offset by traders. There is no standard size for the Alberta Fixed-Priced contract, although a minimum volume of 94.78 mmBtu is required in increments of 100 units per day. The NGX lists the Alberta Fixed-Price contract for 60 calendar months.

As noted above, the primary pricing point for natural gas in North America is the Henry Hub, which is located in Erath, Louisiana. In addition to the Henry Hub, there are a number of other locations where natural gas is traded. In 2008, there were 33 natural gas market centers in North America.[52] Some of the major trading centers include Alberta, Northwest Rockies, Southern California border and the Houston Ship Channel. For locations that are directly connected to the Henry Hub by one or more pipelines and where there typically is adequate shipping capacity, the price at the other locations usually directly tracks the price at the Henry Hub, adjusted for transportation costs. However, at other locations that are not directly connected to the Henry Hub or where shipping capacity is limited, the prices at those locations often diverge from the Henry Hub price. Furthermore, one local price may be significantly different than the price at another location even though the two markets' respective distances from the Henry Hub are the same. The reason for such pricing disparities is that a given location may experience supply and demand factors that are specific to that region, such as differences in pipeline shipping capacity, unusually high or low demand for heating or cooling or supply disruptions caused by severe weather. As a consequence, local natural gas prices can differ from the Henry Hub price by more than the cost of shipping and such price differences can vary in an unpredictable manner.

The Alberta hub is far removed from the Henry Hub and is not directly connected to the Henry Hub by an existing pipeline. Located in the Canadian province of Alberta, the Alberta natural gas market is a major connection point for long-distance transmission systems that ship natural gas to points throughout Canada and the United States. The Alberta province is Canada's dominant natural gas producing region; six of the nine Canadian market centers are located in the Alberta province. The throughput capacity at the AECO–C hub is ten billion cubic feet per day. Moreover, the number of pipeline interconnections at that hub was four in 2008. Lastly, the AECO–C hub's capacity is 20.4 billion cubic feet per day.[53]

The local price at the Alberta hub typically differs from the price at the Henry Hub. Thus, the price of the Henry Hub physically-delivered futures contract is an imperfect proxy for the Alberta price. Moreover, exogenous factors, such as adverse weather, can cause the Alberta gas price to differ from the Henry Hub price by an amount that is more or less than the cost of shipping, making the NYMEX Henry Hub futures contract even less precise as a hedging tool than desired by market participants.

In its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity and material price reference as the potential SPDC criteria applicable to the Alberta Fixed-Price contract. Each of these factors is discussed below.[54]

[50] 73 FR 75892 (December 12, 2008).

[51] *See* 73 FR 75888, 75893 (Dec. 12, 2008).

[52] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[53] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf*

[54] As noted above, the Commission did not find an indication of arbitrage and price linkage in

Continued

1. Material Price Reference Criterion

The Commission's October 20, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission noted that the NGX forged an alliance with ICE to use the ICE's matching engine to complete transactions in physical gas contracts traded on NGX. In return, the NGX agreed to provide the clearing services for such transactions. As part of the agreement, NGX provides the ICE with transaction data, which are then made available to market participants on a paid basis. The ICE offers the NGX data in several packages, which vary in terms of the amount of available historical data. For example, the ICE offers the "OTC Gas End of Day" data package with access to all price data, or just current prices plus a selected number of months (*i.e.,* 12, 24, 36, or 48 months) of historical data.

The Commission will rely on one of two sources of evidence—direct or indirect—to determine that the price of a contract was being used as a material price reference and therefore, serving a significant price discovery function.[55] With respect to direct evidence, the Commission will consider the extent to which, on a frequent and recurring basis, cash market bids, offers or transactions are directly based on or quoted at a differential to, the prices generated on the ECM in question. Direct evidence may be established when cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract in question. Cash market prices are set explicitly at a differential to the section 2(h)(3) contract when, for instance, they are quoted in dollars and cents above or below the reference contract's price. Cash market prices are set implicitly at a differential to a section 2(h)(3) contract when, for instance, they are arrived at after adding to, or subtracting from the section 2(h)(3) contract, but then quoted or reported at a flat price. With respect to indirect evidence, the Commission will consider the extent to which the price of the contract in question is being routinely disseminated in widely distributed industry publications—or offered by the ECM itself for some form of remuneration—and consulted on a frequent and recurring basis by industry participants in pricing cash market transactions.

The Alberta hub is a major trading center for natural gas in North America. Traders, including producers, keep abreast of the prices of the Alberta market center when conducting cash deals. However, ICE's cash-settled AECO Financial Basis contract is used more widely as a price reference than the NGX Alberta Fixed-Price contract. Traders look to the ICE contract's competitively determined price as an indication of expected values of natural gas at the Alberta hub when entering into cash market transactions for natural gas, especially those trades providing for physical delivery in the future. Traders use ICE's AECO Financial Basis contract, as well as other basis contracts, to hedge cash market positions and transactions. The substantial volume of trading and open interest in the ICE contract attests to its use for this purpose.[56] In contrast, trading volume in the NGX Alberta Fixed-Price contract is much smaller than in ICE's AECO Financial Basis contract. In this regard, total trading volume in the NGX Alberta Fixed Price contract in the third quarter of 2009 was equivalent to 50,313 NYMEX physically-delivered NG contracts, which has a size of 10,000 mmBtu.[57]

Accordingly, although the Alberta Hub is a major trading center for natural gas and, as noted, NGX provides price information for the Alberta Fixed Price contract to ICE which sells it, the Commission has found upon further evaluation that the Alberta Fixed Price contract is not routinely consulted by industry participants in pricing cash market transactions and thus does not meet the Commission's Guidance for the material price reference criterion. In this regard, the ICE AECO Financial Basis contract is routinely consulted by industry participants in pricing cash market transactions at this location. Because both the NGX and the ICE contracts basically price the same commodity at the same location and time[58] and the ICE contract has significantly higher trading volume and open interest, it is not necessary for market participants to independently refer to the NGX Alberta Fixed-Price contract for pricing natural gas at this location. Thus, the Alberta Fixed-Price contract does not satisfy the direct price reference test for existence of material price reference. Furthermore, the Commission notes that publication of the NGX Alberta Fixed-Price contract's prices is not indirect evidence of material price reference. The NGX Alberta Fixed-Price contract's prices are published with those of numerous other contracts, which are of more interest to market participants. Thus, the Commission has concluded that traders likely do not specifically purchase the ICE data packages for the NGX Alberta Fixed-Price contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions.

i. Federal Register Comments

NGX states its belief that the Alberta Fixed Price contract does not meet the material price reference factor because there is insufficient trading activity in this contract.

ii. Conclusion Regarding Material Price Reference

Based on the above, the Commission finds that the NGX Alberta Fixed-Price contract does not meet the material price reference criterion because cash market transactions are not priced either explicitly or implicitly on a frequent and recurring basis at a differential to the Alberta Fixed Price contract's price (direct evidence). Moreover, while the Alberta Fixed-Price contract's price data is sold to market participants, market participants likely do not specifically purchase the ICE data packages for the Alberta Fixed-Price contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions (indirect evidence).

2. Material Liquidity Criterion

As noted above, in its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity and material price reference as potential criteria for SPDC determination of the Alberta Fixed-Price contract. With respect to the material liquidity criterion, the Commission noted that the total number of transactions executed in the contract on NGX's electronic platform during the second quarter of 2009 was 122.1, 36.0,

connection with this contract; accordingly, those criteria are not discussed in reference to the Alberta Fixed-Price contract.

[55] 17 CFR part 36, Appendix A.

[56] In the third quarter of 2009, 6,320 separate trades occurred on ICE's electronic platform, resulting in a daily average of 95.8 trades. During the same period, the ICE contract had a total trading volume on its electronic platform of 736,412 contracts (which was an average of 11,158 contracts per day). Open interest in ICE's AECO Financial Basis Contract was 483,561 contracts as of September 30, 2009.

[57] Trading volume in the ICE AECO Financial Basis contract during the third quarter of 2009 was equivalent to 184,103 NYMEX NG contracts.

[58] The Alberta natural gas price can be derived using the Alberta Basis contract and the NYMEX Henry Hub NG contract. In this regard, the imputed price is the Henry Hub price plus or minus the basis at Alberta, as indicated by the NGX Alberta Basis contract.

7.0, 30.1, 7.4, 68.6 and 12.8 trades for the following delivery periods—following day, Friday plus two days, Friday plus three days, Saturday plus three days, Saturday plus four days, Sunday plus two days, remainder of the month, nearby calendar month, and any single future calendar month, respectively. During the same period, the Alberta Fixed-Price contract had a total trading volume of 1,209,505 mmBtu; 821,565 mmBtu; 223,874 mmBtu; 754,175 mmBtu; 672,568 mmBtu; 6,634,030 mmBtu; and 1,233,958 mmBtu for the following delivery periods—next day, Friday plus two days, Friday plus three days, Saturday plus three days, Saturday plus four days, Sunday plus two days, remainder of the month, nearby calendar month, and any single future calendar month, respectively. Moreover, the net open interest as of June 30, 2009, was 96,003,450 mmBtu for next-month delivery. For delivery two months out, the open interest was 54,456,997 mmBtu.[59]

In a subsequent filing NGX reported that total trading volume in the third quarter of 2009 was 50,313 contracts (or 762 contracts on a daily basis). In term of number of transactions, 4,694 trades occurred in the third quarter of 2009 (73 trades per day), for those Alberta Fixed-Price contracts that specify delivery in the spot month. As of September 30, 2009, open interest in the Alberta Fixed-Price contract was 23,961 NYMEX-equivalent contracts.

The average number of trades per day in the second and third quarters of 2009 was only moderately above the minimum reporting level (5 trades per day). Moreover, trading activity in the Alberta Fixed-Price contract, as characterized by total quarterly volume, indicates that the Alberta Fixed-Price contract experiences trading activity similar to that of minor futures markets.[60] Thus, the Alberta Fixed-Price contract does not meets a threshold of trading activity that would render it of potential importance and no additional statistical analysis is warranted.[61]

i. Federal Register Comments

NGX stated in its comment letter that the Alberta Fixed-Price contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

First, NGX opined that the Commission "seems to have applied a threshold for "material liquidity" that is extremely low, and in general insufficient to support a determination that these contracts are no longer emerging markets but in fact serve a significant price discovery function." NGX also noted that the Commission's Guidance states that material liquidity was intended to be a "broad concept that captures the ability to transact immediately with little or no price concession". The Guidance also states that where "material liquidity exists, a more or less continuous stream of prices can be observed and the prices should be similar", such as "where trades occur multiple times per minutes. NGX then opined that "[t]he levels of liquidity outlined above for the Proposed Contracts cannot be what Congress intended in establishing the dividing line between contracts ripe for regulation and those still emerging and in need of further incubation.

In this regard, the Commission notes that it adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs"[62] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC but this does not mean that the contract will be found to be a SPDC merely because it met the reporting threshold. Furthermore, the Commission observes that a continuous stream of prices would indeed be an indication of liquidity for certain markets but the Guidance also notes that "quantifying the levels of immediacy and price concession that would define material liquidity may differ from one market or commodity to another."

ii. Conclusion Regarding Material Liquidity

For the reasons discussed above, the Commission finds that the Alberta Fixed-Price contract does not meet the material liquidity criterion.

3. Overall Conclusion Regarding the Alberta Fixed-Price Contract

After considering the entire record in this matter, including the comments received, the Commission has determined that the Alberta Fixed-Price contract does not perform a significant price discovery function under the criteria established in section 2(h)(7) of the CEA. Specifically, the Commission has determined that the Alberta Fixed-Price contract does not meet the material price reference or material liquidity criteria at this time. Accordingly, the Commission is issuing the attached Order declaring that the Alberta Fixed-Price contract is not a SPDC.

Issuance of this Order indicates that the Commission does not at this time regard NGX as a registered entity in connection with its Alberta Fixed-Price contract.[63] Accordingly, with respect to its Alberta Fixed-Price contract, NGX is not required to comply with the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) for ECMs with SPDCs. However, NGX must continue to comply with the applicable reporting requirements.

d. The Phys, FP, (US/MM), Union-Dawn (Union-Dawn Fixed-Price) Contract and the SPDC Indicia

The Union-Dawn Fixed-Price contract calls for physical delivery of natural gas at the Dawn hub over two different time periods: The following day and Saturday plus three days. Each delivery period is considered to be a separate contract, and the market participants value each delivery period separately. However, overlapping delivery days are considered fungible, and, thus, may be offset by traders. There is no standard size for the Union-Dawn Fixed-Priced contract, although a minimum volume of 100 mmBtu required in increments of 100 units per day. The NGX lists the Union-Dawn Fixed-Price contract for 60 calendar months.

Union Gas, Ltd., is a major Canadian natural gas storage, transmission, and distribution company based in Ontario, Canada. Union Gas offers premium storage and transportation services to customers at the Dawn hub, which the largest underground storage facility in Canada and one of the largest in North America. The Dawn hub offers customers an important link for natural gas moving from Western Canadian and U.S. supply basins to markets in central

[59] Second quarter 2009 data was submitted to the Commission is a different format than in later filings. In this regard total trading volume and total number of trades per quarter were not identified.

[60] Based on the Commission's experience, a minor futures contract is, generally, one that has a quarterly trading volume of 100,000 contracts or less.

[61] In establishing guidance to illustrate how it will evaluate the various criteria, or combinations of criteria, when determining whether a contract is a SPDC, the Commission made clear that "material liquidity itself would not be sufficient to make a determination that a contract is a [SPDC], * * * but combined with other factors it can serve as a guidepost indicating which contracts are functioning as [SPDCs]." For the reasons discussed above, the Commission has found that the Alberta Fixed-Price contract does not meet either the price linkage or material price reference criterion. In light of this finding and the Commission's Guidance cited above, there is no need to evaluate further the material liquidity criteria since it cannot be used alone as a basis for a SPDC determination.

[62] 73 FR 75892 (December 12, 2008).

[63] *See* 73 FR 75888, 75893 (Dec. 12, 2008).

Canada and the northeast United States. The throughput capacity at the Dawn hub is 9.3 billion cubic feet per day. Moreover, the number of pipeline interconnections at that hub was ten in 2008. Lastly, the Dawn hub's capacity is 12.8 billion cubic feet per day.[64]

In its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity and material price reference as the potential SPDC criteria applicable to the Union-Dawn Fixed-Price contract. Each of these factors is discussed below.[65]

1. Material Price Reference Criterion

The Commission's October 20, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission noted that NGX forged an alliance with ICE to use the ICE's matching engine to complete transactions in physical gas contracts traded on NGX. In return, the NGX agreed to provide the clearing services for such transactions. As part of the agreement, NGX provides the ICE with transaction data, which are then made available to market participants on a paid basis. The ICE offers the NGX data in several packages, which vary in terms of the amount of available historical data. For example, the ICE offers the "OTC Gas End of Day" data packages with access to all price data, or just current prices plus a selected number of months (*i.e.,* 12, 24, 36, or 48 months) of historical data.

The Commission will rely on one of two sources of evidence—direct or indirect—to determine that the price of a contract was being used as a material price reference and therefore, serving a significant price discovery function.[66] With respect to direct evidence, the Commission will consider the extent to which, on a frequent and recurring basis, cash market bids, offers or transactions are directly based on or quoted at a differential to, the prices generated on the ECM in question. Direct evidence may be established when cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract in question. Cash market prices are set explicitly at a differential to the section 2(h)(3) contract when, for instance, they are quoted in dollars and cents above or below the reference contract's price. Cash market prices are set implicitly at a differential to a section 2(h)(3) contract when, for instance, they are arrived at after adding to, or subtracting from the section 2(h)(3) contract, but then quoted or reported at a flat price. With respect to indirect evidence, the Commission will consider the extent to which the price of the contract in question is being routinely disseminated in widely distributed industry publications—or offered by the ECM itself for some form of remuneration—and consulted on a frequent and recurring basis by industry participants in pricing cash market transactions.

The Dawn hub is a major trading center for natural gas in the United States. Traders use the NGX Union-Dawn Fixed-Price contract to hedge cash market positions and transactions. Nevertheless, the relatively small volume of trading and open interest[67] in the Union-Dawn Fixed-Price contract does not support a finding that the contract is consulted on a frequent and recurring basis in establishing cash market transaction prices. Thus, the Union-Dawn Fixed-Price contract does not satisfy the direct price reference test for existence of material price reference. Furthermore, the Commission notes that publication of the Union-Dawn Fixed-Price contract's prices is not indirect evidence of material price reference. The Union-Dawn Fixed-Price contract's prices are published with those of numerous other contracts, which are of more interest to market participants. Thus, the Commission has concluded that traders likely do not specifically purchase ICE data packages for the NGX Union-Dawn Fixed-Price contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions.

i. **Federal Register** Comments

NGX states its belief that the Union Dawn Fixed Price contract does not meet the material price reference factor because there is insufficient trading activity in this contract.

ii. Conclusion Regarding Material Price Reference

Based on the above, the Commission finds that the NGX Union-Dawn Fixed-Price contract does not meet the material price reference criterion because cash market transactions are not priced either explicitly or implicitly on a frequent and recurring basis at a differential to the Union-Dawn Fixed-Price contract's price (direct evidence). Moreover, while the Union-Dawn Fixed-Price contract's price data is sold to market participants, traders likely do not specifically purchase the ICE data packages for the NGX Union-Dawn Fixed-Price contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions (indirect evidence).

2. Material Liquidity Criterion

As noted above, in its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity and material price reference as potential criteria for SPDC determination of the Union-Dawn Fixed-Price contract. With respect to the material liquidity criterion, the Commission noted that the total number of transactions executed on NGX's electronic platform in the Union-Dawn Fixed-Price contract during the second quarter of 2009 was 114.1 trades and 23.9 trades for next-day delivery and delivery Saturday plus the next three days, respectively. During the same period, the Union-Dawn Fixed-Price contract had an average daily trading volume of 812,800 mmBtu and 458,000 mmBtu for the delivery periods next day and Saturday plus three days, respectively. Moreover, the net open interest as of June 30, 2009, was 2,241,600 mmBtu for next-day delivery (equivalent to 224 NYMEX NG contracts).[68]

In a subsequent filing, NGX reported that total trading volume in the third quarter of 2009 was the equivalent of 8,333 NYMEX NG contracts (or 130 contracts on a daily basis).[69] In term of number of transactions, 7,899 trades occurred over the entire third quarter, which equates to 123 trades per day.[70] As of September 30, 2009, open interest

[64] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[65] As noted above, the Commission did not find an indication of arbitrage and price linkage in connection with this contract; accordingly, those criteria are not discussed in reference to the Union-Dawn Fixed-Price contract.

[66] 17 CFR part 36, Appendix A.

[67] In the third quarter of 2009, the Union-Dawn Fixed-Price contract had a total trading volume that was equivalent to 145 NYMEX physically-delivered NG futures contracts (the size of one NYMEX NG contract is 10,000 mmBtu); the Union-Dawn contract also had an open interest equivalent to 1,738 NYMEX NG futures contracts.

[68] Second quarter 2009 data was submitted to the Commission is a different format than in later filings. In this regard total trading volume and total number of trades per quarter were not identified.

[69] Approximately 96 percent of the contracted natural gas volume was specified for delivery on either the next day or on the weekend. The remaining volume was to be delivered over the specified month or during the remainder of the current month.

[70] Nearly all (more than 99 percent) of the trades were in contracts that specified next-day or weekend delivery of natural gas.

in the Union-Dawn Fixed-Price contract was 1,738 NYMEX NG contracts.

The Commission notes that while trading activity in the Union-Dawn Fixed-Price appears to be substantial, it is important to keep in mind that the majority of trades involve close to immediate delivery, many times on a daily basis. With deliveries occurring each day, it is reasonable that more contracts would be traded compared to those contracts that specify delivery over an entire month. Moreover, trading activity in the Union-Dawn Fixed-Price contract, as characterized by total quarterly volume, indicates that the Union-Dawn Fixed-Price contract experiences less trading activity than minor futures markets.[71] Thus, the Union-Dawn Fixed-Price contract does not meets a threshold of trading activity that would render it of potential importance and no additional statistical analysis is warranted.[72]

i. **Federal Register** Comments

NGX stated in its comment letter that the Union-Dawn Fixed-Price contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

First, NGX opined that the Commission "seems to have applied a threshold for "material liquidity" that is extremely low, and in general insufficient to support a determination that these contracts are no longer emerging markets but in fact serve a significant price discovery function". NGX also noted that the Commission's Guidance states that material liquidity was intended to be a "broad concept that captures the ability to transact immediately with little or no price concession". The Guidance also states that where "material liquidity exists, a more or less continuous stream of prices can be observed and the prices should be similar", such as "where trades occur multiple times per minutes. NGX then opined that "[t]he levels of liquidity outlined above for the Proposed Contracts cannot be what Congress intended in establishing the dividing line between contracts ripe for regulation and those still emerging and in need of further incubation.

In this regard, the Commission notes that it adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs"[73] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC but this does not mean that the contract will be found to be a SPDC merely because it met the reporting threshold. Furthermore, the Commission observes that a continuous stream of prices would indeed be an indication of liquidity for certain markets but the Guidance also notes that "quantifying the levels of immediacy and price concession that would define material liquidity may differ from one market or commodity to another."

ii. Conclusion Regarding Material Liquidity

Based on the above, the Commission finds that the NGX Union-Dawn Fixed-Price contract does not meet the material liquidity criterion.

3. Overall Conclusion Regarding the Union-Dawn Fixed-Price Contract

After considering the entire record in this matter, including the comments received, the Commission has determined that the Union-Dawn Fixed-Price contract does not perform a significant price discovery function under the criteria established in section 2(h)(7) of the CEA. Specifically, the Commission has determined that the NGX Union-Dawn Fixed-Price contract does not meet the material price reference or material liquidity criteria at this time. Accordingly, the Commission is issuing the attached Order declaring that the Union-Dawn Fixed-Price contract is not a SPDC.

Issuance of this Order indicates that the Commission does not at this time regard NGX as a registered entity in connection with its Union-Dawn Fixed-Price contract.[74] Accordingly, with respect to its Union-Dawn Fixed-Price contract, NGX is not required to comply with the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) for ECMs with SPDCs. However, NGX must continue to comply with the applicable reporting requirements for ECMs.

e. The Phys, ID, 7a (CA/GJ), AB–NIT (7a Index) Contract and the SPDC Indicia

The NGX 7a Index contract calls for physical delivery of natural gas at the Alberta, Canada, trading hub during the specified calendar month. When trading this contract, market participants price the difference between the anticipated value of natural gas at the time of delivery and the average of actual trades on the NGX system. The average of transactions on the NGX system is reported as a volume-weighted average price index in the first publication of the delivery month of Canadian Enerdata, Ltd.'s *Canadian Gas Price Reporter.* At the time of delivery, the negotiated price premium or discount is added or subtracted to the published index price. There is no standard size for the 7a Index contract, although a minimum volume of 94.78 mmBtu is required in increments of 100 units per day. The NGX lists the 7a Index contract for 60 calendar months.

Located in the Canadian province of Alberta, the Alberta natural gas market is a major connection point for long-distance transmission systems that ship natural gas to points throughout Canada and the United States. The Alberta province is Canada's dominant natural gas producing region; six of the nine Canadian market centers are located in the Alberta province. The throughput capacity at the AECO–C hub is ten billion cubic feet per day. Moreover, the number of pipeline interconnections at that hub was four in 2008. Lastly, the AECO–C hub's capacity is 20.4 billion cubic feet per day.[75]

In its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity and material price reference as the potential SPDC criteria applicable to the 7a Index contract. Each of these factors is discussed below.[76]

1. Material Price Reference Criterion

The Commission's October 20, 2009, **Federal Register** notice identified material price reference as a potential basis for a SPDC determination with respect to this contract. The Commission noted that NGX forged an alliance with ICE to use ICE's matching engine to complete transactions in

[71] Based on the Commission's experience, a minor futures contract is, generally, one that has a quarterly trading volume of 100,000 contracts or less.

[72] In establishing guidance to illustrate how it will evaluate the various criteria, or combinations of criteria, when determining whether a contract is a SPDC, the Commission made clear that "material liquidity itself would not be sufficient to make a determination that a contract is a [SPDC], * * * but combined with other factors it can serve as a guidepost indicating which contracts are functioning as [SPDCs]." For the reasons discussed above, the Commission has found that the Alberta Fixed-Price contract does not meet either the price linkage or material price reference criterion. In light of this finding and the Commission's Guidance cited above, there is no need to evaluate further the material liquidity criteria since it cannot be used alone as a basis for a SPDC determination.

[73] 73 FR 75892 (December 12, 2008).

[74] *See* 73 FR 75888, 75893 (Dec. 12, 2008).

[75] *See http://www.eia.doe.gov/pub/oil_gas/natural_gas/feature_articles/2009/ngmarketcenter/ngmarketcenter.pdf.*

[76] As noted above, the Commission did not find an indication of arbitrage and price linkage in connection with this contract; accordingly, those criteria are not discussed in reference to the 7a Index contract.

physical gas contracts traded on NGX. In return, NGX agreed to provide the clearing services for such transactions. As part of the agreement, NGX provides ICE with transaction data, which are then made available to market participants on a paid basis. ICE offers the NGX data in several packages, which vary in terms of the amount of available historical data. For example, the ICE offers the "OTC Gas End of Day" data packages with access to all price data, or just current prices plus a selected number of months (*i.e.,* 12, 24, 36, or 48 months) of historical data.

The Commission will rely on one of two sources of evidence—direct or indirect—to determine that the price of a contract was being used as a material price reference and therefore, serving a significant price discovery function.[77] With respect to direct evidence, the Commission will consider the extent to which, on a frequent and recurring basis, cash market bids, offers or transactions are directly based on or quoted at a differential to, the prices generated on the ECM in question. Direct evidence may be established when cash market participants are quoting bid or offer prices or entering into transactions at prices that are set either explicitly or implicitly at a differential to prices established for the contract in question. Cash market prices are set explicitly at a differential to the section 2(h)(3) contract when, for instance, they are quoted in dollars and cents above or below the reference contract's price. Cash market prices are set implicitly at a differential to a section 2(h)(3) contract when, for instance, they are arrived at after adding to, or subtracting from the section 2(h)(3) contract, but then quoted or reported at a flat price. With respect to indirect evidence, the Commission will consider the extent to which the price of the contract in question is being routinely disseminated in widely distributed industry publications—or offered by the ECM itself for some form of remuneration—and consulted on a frequent and recurring basis by industry participants in pricing cash market transactions.

The Alberta hub is a major trading center for natural gas in North America. Traders, including producers, keep abreast of the prices of the Alberta market center when conducting cash deals. However, ICE's cash-settled AECO Financial Basis contract is used more widely as a price reference than the NGX 7a Index contract. Traders look to the ICE contract's competitively determined price as an indication of expected values of natural gas at the Alberta hub when entering into cash market transactions for natural gas, especially those trades providing for physical delivery in the future. Traders use ICE's Alberta contract, as well as other basis contracts, to hedge cash market positions and transactions. The substantial volume of trading and open interest in the ICE contract attests to its use for this purpose.[78] In contrast, trading volume in the 7a Index contract is much smaller than in ICE's cash-settled version of the contract. In this regard, total trading volume in the NGX 7a Index contract in the third quarter of 2009 was equivalent to 1,946 NYMEX physically-delivered natural gas contracts, which has a size of 10,000 mmBtu.

Accordingly, although the Alberta Hub is a major trading center for natural gas and, as noted, NGX provides price information for the 7a Index contract to ICE which sells it, the Commission has found upon further evaluation that the 7a Index contract is not routinely consulted by industry participants in pricing cash market transactions and thus does not meet the Commission's Guidance for the material price reference criterion. In this regard, the ICE AECO Financial Basis contract is routinely consulted by industry participants in pricing cash market transactions at this location. Because both the NGX and the ICE contracts basically price the same commodity at the same location and time and the ICE contract has significantly higher trading volume and open interest, it is not necessary for market participants to independently refer to the 7a Index contract for pricing natural gas at this location. Thus, the 7a Index contract does not satisfy the direct price reference test for existence of material price reference. Furthermore, the Commission notes that publication of the 7a Index contract's prices is not indirect evidence of material price reference. The 7a Index contract's prices are published with those of numerous other contracts, which are of more interest to market participants. Thus, the Commission has concluded that traders likely do not specifically purchase the ICE data packages for the 7a Index contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions.

i. Federal Register Comments

NGX expressed the opinion that the 7a Index contract does not meet the material price reference criteria because it lacks sufficient trading activity.

ii. Conclusion Regarding Material Price Reference

Based on the above, the Commission finds that the NGX 7a Index contract does not meet the material price reference criterion because cash market transactions are not priced either explicitly or implicitly on a frequent and recurring basis at a differential to the 7a Index contract's price (direct evidence). Moreover, while the 7a Index contract's price data is sold to market participants, market participants likely do not specifically purchase the ICE data packages for the 7a Index contract's prices and do not consult such prices on a frequent and recurring basis in pricing cash market transactions (indirect evidence).

2. Material Liquidity Criterion

As noted above, in its October 20, 2009, **Federal Register** notice, the Commission identified material liquidity and material price reference as potential criteria for SPDC determination of the 7a Index contract. To assess whether a contract meets the material liquidity criterion, the Commission first examines trading activity as a general measurement of the contract's size and potential importance. If the Commission finds that the contract in question meets a threshold of trading activity that would render it of potential importance, the Commission will then perform a statistical analysis to measure the effect that changes to the subject-contract's prices potentially may have on prices for other contracts listed on an ECM or a DCM.

The Commission noted that the average number of transactions in the 7a Index contract was 10.9 in the second quarter of 2009. During the same period, the 7a Index contract had an average daily trading volume of 2,438,627 mmBtu (244 NYMEX-equivalent contracts of 10,000 mmBtu size). Moreover, the net open interest as of June 30, 2009, was 6,287,794 mmBtu (629 NYMEX-equivalent contracts of 10,000 mmBtu size) for delivery in the following month.[79]

[77] 17 CFR part 36, Appendix A.

[78] In the third quarter of 2009, 6,320 separate trades occurred on ICE's electronic platform, resulting in a daily average of 95.8 trades. During the same period, the ICE contract had a total trading volume on its electronic platform of 736,412 contracts (which was an average of 11,158 contracts per day). As of September 30, 2009, open interest in the ICE AECO Financial Basis contract was 483,561 contracts.

[79] Second quarter 2009 data was submitted to the Commission is a different format than in later filings. In this regard total trading volume and total number of trades per quarter were not identified.

In a subsequent filing dated November 13, 2009, NGX reported that total trading volume in the third quarter of 2009 was 1,964 NYMEX-equivalent contracts. In terms of number of transactions, 1,056 trades occurred in the third quarter of 2009 (an average of 17 trades per day). As of September 30, 2009, open interest in the 7a Index contract was 14,355 NYMEX-equivalent contracts.

The Commission notes that trading activity in the 7a Index contract increased between the second and third quarters of 2009. In any case, the number of trades per day was only slightly more than the minimum reporting threshold (5 trades per day). Moreover, trading activity in the 7a Index contract, as characterized by total quarterly volume, indicates that the Index contract experiences trading activity similar to that of minor futures markets.[80] Thus, the 7a Index contract does not meets a threshold of trading activity that would render it of potential importance and no additional statistical analysis is warranted.[81]

i. Federal Register Comments

NGX stated in its comment letter that the 7a Index contract does not meet the material liquidity criterion for SPDC determination for a number of reasons.

First NGX opined that the Commission "seems to have applied a threshold for "material liquidity" that is extremely low, and in general insufficient to support a determination that these contracts are no longer emerging markets but in fact serve a significant price discovery function". NGX also noted that the Commission's Guidance states that material liquidity was intended to be a "broad concept that captures the ability to transact immediately with little or no price concession." The Guidance also states that where "material liquidity exists, a more or less continuous stream of prices can be observed and the prices should be similar", such as "where trades occur multiple times per minutes. NGX then opined that "[t]he levels of liquidity outlined above for the Proposed Contracts cannot be what Congress intended in establishing the dividing line between contracts ripe for regulation and those still emerging and in need of further investigation.

WGCEF also stated that the 7a contract lacks sufficient liquidity to perform a significant price discovery function. They cite the data in the Notice of Intent as evidence that trade frequency in terms of multiple trades per day is extremely low.

In this regard, the Commission notes that it adopted a five trades-per-day threshold as a reporting requirement to enable it to "independently be aware of ECM contracts that may develop into SPDCs"[82] rather than solely relying upon an ECM on its own to identify any such potential SPDCs to the Commission. Thus, any contract that meets this threshold may be subject to scrutiny as a potential SPDC but this does not mean that the contract will be found to be a SPDC merely because it met the reporting threshold. Furthermore, the Commission observes that a continuous stream of prices would indeed be an indication of liquidity for certain markets but the Guidance also notes that "quantifying the levels of immediacy and price concession that would define material liquidity may differ from one market or commodity to another."

ii. Conclusion Regarding Material Liquidity

For the reasons discussed above, the Commission finds that the 7a Index contract does not meet the material liquidity criterion.

3. Overall Conclusion Regarding the 7a Index Contract

After considering the entire record in this matter, including the comments received, the Commission has determined that the 7a Index contract does not perform a significant price discovery function under the criteria established in section 2(h)(7) of the CEA. Specifically, the Commission has determined that the 7a Index contract does not meet the material price reference or material liquidity criteria at this time. Accordingly, the Commission will issue the attached Order declaring that the 7a Index contract is not a SPDC.

Issuance of this Order indicates that the Commission does not at this time regard NGX as a registered entity in connection with its 7a Index contract.[83] Accordingly, with respect to its 7a Index contract NGX is not required to comply with the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) for ECMs with SPDCs. However, NGX must continue to comply with the applicable reporting requirements.

V. Related Matters

a. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 ("PRA")[84] imposes certain requirements on Federal agencies, including the Commission, in connection with their conducting or sponsoring any collection of information as defined by the PRA. Certain provisions of Commission rule 36.3 impose new regulatory and reporting requirements on ECMs, resulting in information collection requirements within the meaning of the PRA. OMB previously has approved and assigned OMB control number 3038–0060 to this collection of information.

b. Cost-Benefit Analysis

Section 15(a) of the CEA[85] requires the Commission to consider the costs and benefits of its actions before issuing an order under the Act. By its terms, section 15(a) does not require the Commission to quantify the costs and benefits of an order or to determine whether the benefits of the order outweigh its costs; rather, it requires that the Commission "consider" the costs and benefits of its actions. Section 15(a) further specifies that the costs and benefits shall be evaluated in light of five broad areas of market and public concern: (1) Protection of market participants and the public; (2) efficiency, competitiveness and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. The Commission may in its discretion give greater weight to any one of the five enumerated areas and could in its discretion determine that, notwithstanding its costs, a particular order is necessary or appropriate to protect the public interest or to effectuate any of the provisions or accomplish any of the purposes of the Act.

When a futures contract begins to serve a significant price discovery function, that contract, and the ECM on which it is traded, warrants increased oversight to deter and prevent price manipulation or other disruptions to market integrity, both on the ECM itself and in any related futures contracts

[80] Based on the Commission's experience, a minor futures contract is, generally, one that has a quarterly trading volume of 100,000 contracts or less.

[81] In establishing guidance to illustrate how it will evaluate the various criteria, or combinations of criteria, when determining whether a contract is a SPDC, the Commission made clear that "material liquidity itself would not be sufficient to make a determination that a contract is a [SPDC], * * * but combined with other factors it can serve as a guidepost indicating which contracts are functioning as [SPDCs]." For the reasons discussed above, the Commission has found that the TCO contract does not meet either the price linkage or material price reference criterion. In light of this finding and the Commission's Guidance cited above, there is no need to evaluate further the material liquidity criteria since it cannot be used alone as a basis for a SPDC determination.

[82] 73 FR 75892 (December 12, 2008).

[83] See 73 FR 75888, 75893 (Dec. 12, 2008).

[84] 44 U.S.C. 3507(d).

[85] 7 U.S.C. 19(a).

trading on DCMs. An Order finding that a particular contract is a SPDC triggers this increased oversight and imposes obligations on the ECM calculated to accomplish this goal. The increased oversight engendered by the issue of a SPDC Order increases transparency and helps to ensure fair competition among ECMs and DCMs trading similar products and competing for the same business. Moreover, the ECM on which the SPDC is traded must assume, with respect to that contract, all the responsibilities and obligations of a registered entity under the CEA and Commission regulations. Additionally, the ECM must comply with nine core principles established by section 2(h)(7) of the Act—including the obligation to establish position limits and/or accountability standards for the SPDC. Section 4(i) of the CEA authorize the Commission to require reports for SPDCs listed on ECMs. These increased responsibilities, along with the CFTC's increased regulatory authority, subject the ECM's risk management practices to the Commission's supervision and oversight and generally enhance the financial integrity of the markets.

The Commission has concluded that NGX's Alberta Basis, Union-Dawn Basis, Alberta Fixed-Price, Union-Dawn Fixed-Price and 7a Index contracts that are the subject of the attached Orders are not SPDCs; accordingly, the Commission's Orders impose no additional costs and no additional statutorily or regulatory mandated responsibilities on the ECM.

c. Regulatory Flexibility Act

The Regulatory Flexibility Act ("RFA") [86] requires that agencies consider the impact of their rules on small businesses. The requirements of CEA section 2(h)(7) and the Part 36 rules affect ECMs. The Commission previously has determined that ECMs are not small entities for purposes of the RFA.[87] Accordingly, the Chairman, on behalf of the Commission, hereby certifies pursuant to 5 U.S.C. 605(b) that these Orders, taken in connection with section 2(h)(7) of the Act and the Part 36 rules, will not have a significant impact on a substantial number of small entities.

VI. Orders

a. Order Relating to the Phys, BS, LD1 (US/MM), AB–NIT Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following Order:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the Phys, BS, LD1 (US/MM), AB–NIT contract, traded on the Natural Gas Exchange, Inc., does not at this time satisfy the material price preference, price linkage or material liquidity criteria for significant price discovery contracts. Consistent with this determination, the Natural Gas Exchange, Inc., is not considered a registered entity [88] with respect to the Phys, BS, LD1 (US/MM), AB–NIT contract and is not subject to the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the Natural Gas Exchange, Inc., are not applicable to the Phys, BS, LD1 (US/MM), AB/NIT contract with the issuance of this Order.

This Order is based on the representations made to the Commission by the Natural Gas Exchange, Inc., dated August 25, 2009, and October 15, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the Phys, BS, LD1 (US/MM), AB–NIT contract is not a significant price discovery contract. Additionally, to the extent that it continues to rely upon the exemption in Section 2(h)(3) of the Act, the Natural Gas Exchange, Inc., must continue to comply with all of the applicable requirements of Section 2(h)(3) and Commission Regulation 36.3.

b. Order Relating to the Phys, BS, LD1 (US/MM), Union-Dawn Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following Order:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the Phys, BS, LD1 (US/MM), Union-Dawn contract, traded on the Natural Gas Exchange, Inc., does not at this time satisfy the material price reference, price linkage or material liquidity criteria for significant price discovery contracts. Consistent with this determination, the Natural Gas Exchange, Inc., is not considered a registered entity [89] with respect to the Phys, BS, LD1 (US/MM), Union-Dawn contract and is not subject to the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the Natural Gas Exchange, Inc., are not applicable to the Phys, BS, LD1 (US/MM), Union-Dawn contract with the issuance of this Order.

This Order is based on the representations made to the Commission by the Natural Gas Exchange, Inc., August 25, 2009, and October 15, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the Phys, BS, LD1 (US/MM), Union-Dawn contract is not a significant price discovery contract. Additionally, to the extent that it continues to rely upon the exemption in Section 2(h)(3) of the Act, the Natural Gas Exchange, Inc., must continue to comply with all of the applicable requirements of Section 2(h)(3) and Commission Regulation 36.3.

c. Order Relating to the Phys, FP, (CA/GJ), AB–NIT Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following Order:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the Phys, FP, (CA/GJ), AB–NIT contract, traded on the Natural Gas Exchange, Inc., does not at this time satisfy the material price reference or material liquidity reference criteria for significant price discovery contracts. Consistent with this determination, the Natural Gas Exchange, Inc., is not considered a registered entity [90] with respect to the Phys, FP, (CA/GJ), AB–NIT contract and is not subject to the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the Natural Gas Exchange, Inc., are not applicable to the Phys, FP, (CA/GJ), AB–NIT contract with the issuance of this Order.

[86] 5 U.S.C. 601 *et seq.*

[87] 66 FR 42256, 42268 (Aug. 10, 2001).

[88] 7 U.S.C. 1a(29).

[89] 7 U.S.C. 1a(29).

[90] 7 U.S.C. 1a(29).

This Order is based on the representations made to the Commission by the Natural Gas Exchange, Inc., dated August 25, 2009, and October 15, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the Phys, FP, (CA/GJ), AB–NIT contract is not a significant price discovery contract. Additionally, to the extent that it continues to rely upon the exemption in Section 2(h)(3) of the Act, the Natural Gas Exchange, Inc., must continue to comply with all of the applicable requirements of Section 2(h)(3) and Commission Regulation 36.3.

d. Order Relating to the Phys, FP, (US/MM), Union-Dawn Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following Order:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the Phys, FP, (US/MM), Union-Dawn contract, traded on the Natural Gas Exchange, Inc., does not at this time satisfy the material price reference or material liquidity criteria for significant price discovery contracts. Consistent with this determination, the Natural Gas Exchange, Inc., is not considered a registered entity [91] with respect to the Phys, FP, (US/MM), Union-Dawn contract and is not subject to the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the Natural Gas Exchange, Inc., are not applicable to the Phys, FP, (US/MM), Union-Dawn contract with the issuance of this Order.

This Order is based on the representations made to the Commission by the Natural Gas Exchange, Inc., dated August 25, 2009, and October, 15, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the Phys, FP, (US/MM), Union-Dawn contract is not a significant price discovery contract. Additionally, to the extent that it continues to rely upon the exemption in Section 2(h)(3) of the Act, the Natural Gas Exchange, Inc., must continue to comply with all of the applicable requirements of Section 2(h)(3) and Commission Regulation 36.3.

e. Order Relating to the Phys, ID, 7a (CA/GJ), AB–NIT Contract

After considering the complete record in this matter, including the comment letters received in response to its request for comments, the Commission has determined to issue the following Order:

The Commission, pursuant to its authority under section 2(h)(7) of the Act, hereby determines that the Phys, ID, 7a (CA/GJ), AB–NIT contract, traded on the Natural Gas Exchange, Inc., does not at this time satisfy the material price reference or material liquidity criteria for significant price discovery contracts. Consistent with this determination, the Natural Gas Exchange, Inc., is not considered a registered entity [92] with respect to the Phys, ID, 7a (CA/GJ), AB–NIT contract and is not subject to the provisions of the Commodity Exchange Act applicable to registered entities. Further, the obligations, requirements and timetables prescribed in Commission rule 36.3(c)(4) governing core principle compliance by the Natural Gas Exchange, Inc., are not applicable to the Phys, ID, 7a (CA/GJ), AB–NIT contract with the issuance of this Order.

This Order is based on the representations made to the Commission by the Natural Gas Exchange, Inc., dated August 25, 2009, and October 15, 2009, and other supporting material. Any material change or omissions in the facts and circumstances pursuant to which this order is granted might require the Commission to reconsider its current determination that the Phys, ID, 7a (CA/GJ), AB–NIT contract is not a significant price discovery contract. Additionally, to the extent that it continues to rely upon the exemption in Section 2(h)(3) of the Act, the Natural Gas Exchange, Inc., must continue to comply with all of the applicable requirements of Section 2(h)(3) and Commission Regulation 36.3.

Issued in Washington, DC on April 28, 2010, by the Commission.

David A. Stawick,

Secretary of the Commission.

[FR Doc. 2010–10314 Filed 5–3–10; 8:45 am]

BILLING CODE P

[91] 7 U.S.C. 1a(29).

[92] 7 U.S.C. 1a(29).

CONSUMER PRODUCT SAFETY COMMISSION

[CPSC Docket No. 10–C0003]

Jo-Ann Stores, Inc., Provisional Acceptance of a Settlement Agreement and Order

AGENCY: Consumer Product Safety Commission.

ACTION: Notice.

SUMMARY: It is the policy of the Commission to publish settlements which it provisionally accepts under the Consumer Product Safety Act in the **Federal Register** in accordance with the terms of 16 CFR 1118.20(e). Published below is a provisionally-accepted Settlement Agreement with Jo-Ann Stores, Inc., containing a civil penalty of $50,000.00.

DATES: Any interested person may ask the Commission not to accept this agreement or otherwise comment on its contents by filing a written request with the Office of the Secretary by May 19, 2010.

ADDRESSES: Persons wishing to comment on this Settlement Agreement should send written comments to the Comment 10–C0003, Office of the Secretary, Consumer Product Safety Commission, 4330 East West Highway, Room 820, Bethesda, Maryland 20814–4408.

FOR FURTHER INFORMATION CONTACT: Sean R. Ward, Trial Attorney, Division of Compliance, Office of the General Counsel, Consumer Product Safety Commission, 4330 East West Highway, Bethesda, Maryland 20814–4408; telephone (301) 504–7602.

SUPPLEMENTARY INFORMATION: The text of the Agreement and Order appears below.

Dated: April 28, 2010.

Todd A. Stevenson,

Secretary.

In the Matter of Jo-Ann Stores, Inc.

Settlement Agreement

1. In accordance with 16 CFR 1118.20, Jo-Ann Stores, Inc. ("*Jo-Ann*") and the staff ("*Staff*") of the United States Consumer Product Safety Commission ("*CPSC*" or the "*Commission*") enter into this Settlement Agreement ("*Agreement*"). The Agreement and the incorporated attached Order ("*Order*") settle the Staff's allegations set forth below.

Parties

2. The Commission is an independent federal regulatory agency established pursuant to the Consumer Product

Safety Act, 15 U.S.C. 2051–2089 ("*CPSA*"). The Commission is responsible for the enforcement of the CPSA.

3. Jo-Ann is a corporation organized and existing under the laws of the State of Ohio, with its principal offices located in Hudson, Ohio. At all times relevant hereto, Jo-Ann imported, offered for sale and sold various children's products.

Staff Allegations

4. Jo-Ann imported various Robbie Ducky™ children's products including the Kids Watering Cans ("Watering Cans") from February 2007 through August 2007, the children's toy rakes, hoes, brooms and spades ("Garden Tools") from January 2007 through September 2007, and Children's Water Globes ("Water Globes") in September 2007 (collectively, "Robbie Ducky products"). Jo-Ann sold the Robbie Ducky products at its retail stores nationwide during those periods for between $5 and $10 per unit.

5. The Robbie Ducky products are "consumer product(s)," and, at all times relevant hereto, Jo-Ann was a "manufacturer" and "retailer" of those consumer product(s), which were "distributed in commerce," as those terms are defined in CPSA sections 3(a)(3), (5), (8), (11) and (13), 15 U.S.C. 2052(a)(3), (5), (8), (11) and (13).

6. The Robbie Ducky products are articles intended to be entrusted to or for use by children, and, therefore, are subject to the requirements of the Commission's Ban of Lead-Containing Paint and Certain Consumer Products Bearing Lead-Containing Paint, 16 CFR part 1303 (the "Lead-Paint Ban"). Under the Lead-Paint Ban, toys and other children's articles must not bear or contain "lead-containing paint," defined as paint or other surface coating materials whose lead content is more than 0.06 percent of the weight of the total nonvolatile content of the paint or the weight of the dried paint film. 16 CFR 1303.2(b)(1).[1]

7. On August 24, 2007, Jo-Ann reported to CPSC that it had commissioned an independent laboratory to conduct testing of samples of the Watering Cans for the presence of lead in their surface coatings. The test results demonstrated that a sample Watering Can contained lead in excess of the permissible 0.06 percent limit set forth in the Lead-Paint Ban.

8. On August 28, 2007, the Commission and Jo-Ann announced a consumer-level recall of about 6,000 units of the Watering Cans because "[t]he beak of the watering can contains lead in the paint, which violates the federal law prohibiting lead paint on children's toys. Lead is toxic if ingested by young children and can cause adverse health effects."

9. On September 14, 2007, Jo-Ann reported to CPSC that it had commissioned an independent laboratory to conduct testing of samples of the Garden Tools for the presence of lead in their surface coatings. The test results demonstrated that a sample of Garden Tools contained lead in excess of the permissible 0.06 percent limit set forth in the Lead-Paint Ban.

10. On September 26, 2007, the Commission and Jo-Ann announced a consumer-level recall of about 16,000 Garden Tools because "[s]urface paint on the handle of the rake can contain excessive levels of lead paint, violating the federal lead paint standard." This recall was expanded on October 25, 2007 to include an additional 97,000 units of children's leaf rakes, hoes, brooms and spades because these Garden Tools contained excessive levels of lead in violation of the Lead-Paint Ban.

11. On November 14, 2007, Jo-Ann reported to CPSC that it had commissioned an independent laboratory to conduct testing of samples of the Water Globes for the presence of lead in their surface coatings. The test results demonstrated that a sample of Water Globes contained lead in excess of the permissible 0.06 percent limit set forth in the Lead-Paint Ban.

12. On December 13, 2007, the Commission and Jo-Ann announced a consumer-level recall of about 60 Water Globes because "[t]he painted base of the water globes contain excessive levels of lead, violating the federal lead paint standard."

13. Although Jo-Ann reported no incidents or injuries from the Robbie Ducky products, it failed to take adequate action to ensure that they did not bear or contain lead-containing paint, thereby creating a risk of lead poisoning and adverse health effects to children.

14. The Robbie Ducky products constitute "banned hazardous products" under CPSA section 8 and the Lead-Paint Ban, 15 U.S.C. 2057 and 16 CFR 1303.1(a)(1), 1303.4(b), in that they bear or contain paint or other surface coating materials whose lead content exceeds the permissible limit of 0.06 percent of the weight of the total nonvolatile content of the paint or the weight of the dried paint film.

15. From January 2007 through September 2007, Jo-Ann sold, manufactured for sale, offered for sale, distributed in commerce, or imported into the United States, with respect to the Robbie Ducky products, in violation of section 19(a)(1) of the CPSA, 15 U.S.C. 2068(a)(1). Jo-Ann committed these prohibited acts "knowingly," as that term is defined in section 20(d) of the CPSA, 15 U.S.C. 2069(d).

16. Pursuant to section 20 of the CPSA, 15 U.S.C. 2069, Jo-Ann is subject to civil penalties for the aforementioned violations.

Jo-Ann's Responsive Allegations

17. Jo-Ann denies the Staff's allegations set forth above that Jo-Ann knowingly violated the CPSA or any of its regulations. Jo-Ann believes that it reasonably relied upon its suppliers to manufacture products compliant with all applicable safety regulations.

18. Jo-Ann alleges that, to the best of its knowledge at the time when the Robbie Ducky products were imported, offered for sale and sold by the firm, they complied with the requirements of the Lead-Paint Ban. Jo-Ann notified CPSC of the lead-containing paint problems associated with the Robbie Ducky products promptly upon discovering them. After promptly investigating the facts, Jo-Ann voluntarily conducted each of the three recalls in cooperation with CPSC.

19. Jo-Ann has consistently acted in a cooperative manner with CPSC and engaged in corrective action without being so directed by either CPSC or by any third party.

Agreement of the Parties

20. Under the CPSA, the Commission has jurisdiction over this matter and over Jo-Ann.

21. The parties enter into the Agreement for settlement purposes only. The Agreement does not constitute an admission by Jo-Ann, nor does it constitute a determination by the Commission, that Jo-Ann has knowingly violated the CPSA.

22. In settlement of the Staff's allegations set forth above, Jo-Ann shall pay a civil penalty in the amount of fifty thousand dollars ($50,000.00) within twenty (20) calendar days of service of the Commission's final Order accepting the Agreement. The payment shall be by check payable to the order of the United States Treasury.

23. The Commission will not seek or initiate any enforcement action against Jo-Ann for civil penalties, based upon information known to CPSC through the

[1] At the time of the alleged violations stated in this Settlement Agreement, the permissible limit of 0.06 was in effect for the Lead-Paint Ban. As of August 14, 2009, the limit was amended to 0.009 percent pursuant to 15 U.S.C. 1278a(f)(1).

date of the final acceptance of this Agreement, for possible violations of the reporting requirements of section 15(b), 15 U.S.C. 2064(b), regarding any Robbie Ducky products. The Commission's agreement not to seek penalties as stated herein will not relieve Jo-Ann from the continuing duty to report to CPSC any new, additional or different information as required by CPSA section 15(b), 15 U.S.C. 2064(b) and the regulations at 16 CFR part 1115. Except as expressly provided herein, nothing in this Agreement is intended nor may be construed to preclude, limit, or otherwise reduce Jo-Ann's potential liabilities under any and all applicable law, statutory provisions, regulations, rules, standards, and/or bans enforced or administered by CPSC.

24. Upon the Commission's provisional acceptance of the Agreement, the Agreement shall be placed on the public record and published in the **Federal Register** in accordance with the procedures set forth in 16 CFR 1118.20(e). In accordance with 16 CFR 1118.20(f), if the Commission does not receive any written request not to accept the Agreement within fifteen (15) days, the Agreement shall be deemed finally accepted on the sixteenth (16th) day after the date it is published in the **Federal Register**.

25. Upon the Commission's final acceptance of the Agreement and issuance of the final Order, Jo-Ann knowingly, voluntarily, and completely waives any rights it may have in this matter to the following: (1) An administrative or judicial hearing; (2) judicial review or other challenge or contest of the validity of the Commission's Order or actions; (3) a determination by the Commission of whether Jo-Ann failed to comply with the CPSA and its underlying regulations; (4) a statement of findings of fact and conclusions of law; and (5) any claims under the Equal Access to Justice Act.

26. The Commission may publicize the terms of the Agreement and Order.

27. The Agreement and Order shall apply to, and be binding upon, Jo-Ann and each of its successors and assigns.

28. The Commission issues the Order under the provisions of the CPSA, and violation of the Order may subject those referenced in ¶ 27 to appropriate legal action.

29. The Agreement may be used in interpreting the Order. Understandings, agreements, representations, or interpretations apart from those contained in the Agreement and Order may not be used to vary or contradict its terms. The Agreement shall not be waived, amended, modified, or otherwise altered, except in a writing that is executed by the party against whom such waiver, amendment, modification, or alteration is sought to be enforced.

30. If after the effective date hereof, any provision of the Agreement and Order is held to be illegal, invalid, or unenforceable under present or future laws effective during the terms of the Agreement and Order, such provision shall be fully severable. The balance of the Agreement and Order shall remain in full force and effect, unless the Commission and Jo-Ann agree that severing the provision materially affects the purpose of the Agreement and Order.

Jo-Ann Stores, Inc.

Dated: 1/13/10.

By: _____

David B. Goldston,

Senior Vice President, General Counsel & Secretary, Jo-Ann Stores, Inc., 5555 Darrow Road, Hudson, Ohio.

Dated: 1/13/10.

By: _____

Joanne E. Mattiace, Esq.,

Law Offices of Joanne E. Mattiace, 58 Stroudwater Place, Westbrook, ME 04092–4044, Counsel for Jo-Ann Stores, Inc.

U.S. CONSUMER PRODUCT SAFETY COMMISSION STAFF

Cheryl A. Falvey,

General Counsel, Office of the General Counsel.

Ronald G. Yelenik,

Assistant General Counsel, Division of Compliance, Office of the General Counsel.

Dated: 1/14/10.

By: _____

Sean R. Ward,

Trial Attorney, Division of Compliance, Office of the General Counsel.

In the Matter of Jo-Ann Stores, Inc.

Order

Upon consideration of the Settlement Agreement entered into between Jo-Ann Stores, Inc. ("*Jo-Ann*") and the U.S. Consumer Product Safety Commission ("*Commission*") staff, and the Commission having jurisdiction over the subject matter and over Jo-Ann, and it appearing that the Settlement Agreement and Order are in the public interest, it is

Ordered, that the Settlement Agreement be, and hereby is, accepted; and it is

Further ordered, that Jo-Ann shall pay a civil penalty in the amount of fifty thousand dollars ($50,000.00) within twenty (20) calendar days of service of the Commission's final Order accepting the Agreement. The payment shall be made by check payable to the order of the United States Treasury. Upon the failure of Jo-Ann to make any of the foregoing payments when due, interest on the unpaid amount shall accrue and be paid by Jo-Ann at the federal legal rate of interest set forth at 28 U.S.C. 1961(a) and (b).

Provisionally accepted and provisional Order issued on the *28th* day of *April,* 2010.

By Order of the Commission.

Todd A. Stevenson,

Secretary, U.S. Consumer Product Safety Commission.

[FR Doc. 2010–10386 Filed 5–3–10; 8:45 am]

BILLING CODE 6355–01–P

DEPARTMENT OF DEFENSE

Department of the Navy

Notice of Availability (NOA) of the Draft Environmental Impact Statement for the Disposal and Reuse of Naval Air Station Brunswick, ME, and To Announce Public Hearings

AGENCY: Department of the Navy, DoD.

ACTION: Notice.

SUMMARY: Pursuant to Section 102(2)(C) of the National Environmental Policy Act (NEPA) of 1969, as implemented by the Council on Environmental Quality Regulations (40 CFR parts 1500–1508), the Department of the Navy (Navy) with the Federal Aviation Administration (FAA) acting as a cooperating agency, has prepared and filed the Draft Environmental Impact Statement (EIS) to evaluate the potential environmental consequences associated with the disposal and reuse of Naval Air Station (NAS) Brunswick, Maine. The Navy is required to close NAS Brunswick per Public Law 101–510, the Defense Base Closure and Realignment Act of 1990, as amended in 2005. Public hearings will be held to provide information and receive oral and written comments on the Draft EIS. Federal, state and local agencies, and interested individuals are invited to be present or represented at the hearings.

DATES AND ADDRESSES: Two public hearings will be held. Each scheduled public hearing will be preceded by an open information session to allow interested individuals to review information presented in the Draft EIS. Navy representatives will be available during the information session to provide clarification as necessary related to the Draft EIS. Afternoon and evening information sessions are scheduled as follows:

1. *Evening Information Session and Public Hearing:* Brunswick Junior High

School, Gymnasium, 65 Columbia Avenue, Brunswick, Maine 04011.

Wednesday, June 2, 2010

Information Session—4:30 p.m. to 6:30 p.m.
Public Hearing—7 p.m. to 9 p.m.

2. *Daytime Information Session and Public Hearing:* Town of Brunswick, Parks and Recreation Building, 30 Federal Street, Brunswick, Maine 04011.

Thursday, June 3, 2010

Information Session—10 a.m. to 12 p.m.
Public Hearing—12:30 p.m. to 2:30 p.m.

FOR FURTHER INFORMATION CONTACT: Director, BRAC Program Management Office Northeast, 4911 Broad Street, Building 679, Philadelphia, PA 19112–1303, telephone 215–897–4900, fax 215–897–4902, e-mail: *david.drozd@navy.mil.*

SUPPLEMENTARY INFORMATION: The Navy acting as a lead agency with the FAA acting as a cooperating agency, has prepared and filed, the Draft EIS for the Disposal and Reuse of NAS Brunswick, Maine in accordance with requirements of the National Environmental Policy Act (NEPA) of 1969 (42 U.S.C. 4321–4345) and its implementing regulations (40 CFR parts 1500–1508). A Notice of Intent for this Draft EIS was published in the **Federal Register** on October 24, 2008 (**Federal Register**/Vol. 73, No. 207 pgs 63451 & 63452/Friday, October 24, 2008/Notices). Navy is lead agency for the proposed action. The purpose of the proposed action is to dispose of NAS Brunswick, Maine in a manner consistent with the *Brunswick Naval Air Station Reuse Master Plan* as developed by the Brunswick Local Redevelopment Authority (BLRA) in December 2007. The Navy is required to close NAS Brunswick, Maine, in accordance with Public Law 101–510, the Defense Base Closure and Realignment Act of 1990, as amended in 2005. NAS Brunswick must be closed on or before September 15, 2011. The BRAC Law exempts the decision-making process of the Commission from the provisions of NEPA. The Law also relieves the Department of Defense (DoD) from the NEPA requirements to consider the need for closing, realigning, or transferring functions, and from looking at alternative installations to close or realign. However, in accordance with NEPA, before disposing of any real property, the Navy must analyze the environmental effects of the disposal of the NAS Brunswick property. This Draft EIS has identified and considered two alternatives for the disposal and reuse of NAS Brunswick, and the no-action alternative.

Alternative 1 includes the disposal of NAS Brunswick and its outlying properties by the Navy and its reuse in a manner consistent with the *Brunswick Naval Air Station Reuse Master Plan.* This alternative would maintain the existing airfield for private aviation purposes. It is anticipated that full build-out of the Plan would be implemented over a 20-year period. The *Brunswick Naval Air Station Reuse Master Plan* calls for the development of approximately 1,630 acres (51%) of the total base property. In addition, approximately 1,570 acres (49%) of the base would be dedicated to a variety of active and passive land uses, including recreation, open space, and natural areas. The plan reuses the existing airfield and its supporting infrastructure, provides a mix of land use types and densities, and preserves open space and natural areas. The Navy has recognized Alternative 1 as the preferred alternative.

Alternative 2 includes the disposal of NAS Brunswick and its outlying properties by the Navy and its reuse in a manner that features a higher density of residential and community mixed-use development and does not include reuse of the airfield. Similar to Alternative 1, this alternative includes a mix of land use types, preserves open space and natural areas. It is anticipated that full build-out of the high-density scenario would be implemented over a 20-year period. Under Alternative 2 there would be development of approximately 1,580 acres (49%) of the total base property. In addition, approximately 1,620 acres (51%) of the base would be dedicated to a variety of active and passive land uses, including recreation, open space, and natural areas. Although this alternative would have less developable acres than Alternative 1, the density of residential and community mixed-uses would be higher.

Alternative 3 is required by NEPA and will evaluate the impacts at NAS Brunswick in the event that the property is not disposed. Under this alternative, existing mission and support operations would be relocated; however, the installation would be retained by the U.S. government in caretaker status. No reuse or redevelopment would occur at the facility. The installation would be placed in caretaker status. The Draft EIS addresses environmental impacts of each alternative pertaining to the disposal and reuse of the NAS Brunswick property.

The Draft EIS addresses any potential environmental impacts under each alternative associated with: water resources; air quality; biological resources; soils, topography, and geology; land use; noise exposure levels; socioeconomic resources; community facilities; transportation; environmental management; infrastructure; and cultural resources. The analyses includes direct and indirect impacts, and accounts for cumulative impacts from other foreseen Federal, State, or local activities at and around NAS Brunswick. The Navy conducted the scoping process to identify community concerns and local issues that should be addressed in the EIS. Federal, State and local agencies, and interested parties provided written comments to the Navy and identified specific issues or topics of environmental concern that should be addressed in the EIS. The Navy considered these comments in determining the scope of the EIS. The Draft EIS has been distributed to various Federal, State, and local agencies, as well as other interested individuals and organizations. In addition, copies of the Draft EIS have been distributed to the following libraries and publicly accessible facilities for public review:

1. Curtis Memorial Library, 23 Pleasant Street, Brunswick, ME 04011–2261.
2. Town of Brunswick—Department of Planning and Development, 28 Federal Street, Brunswick, Maine 04011.
3. Topsham Public Library, 25 Foreside Road, Topsham, ME 04086–1832.

An electronic copy of the Draft EIS is available for public viewing at *http://www.brunswickeis.com.* Federal, State and local agencies, as well as interested parties, are invited and encouraged to be present or represented at the hearings. To ensure the accuracy of the record, all statements presented orally at the public hearings should be submitted in writing. All comments will become part of the public record and will be responded to in the Final Environmental Impact Statement (FEIS). Equal weight will be given to oral and written statements. In the interest of available time, and to ensure all who wish to give an oral statement at the public hearings have the opportunity to do so, each speaker's comments will be limited to three minutes. If a longer statement is to be presented, it should be summarized at the public hearing and the full text submitted in writing either at the hearing or mailed or e-mailed to: Director, BRAC Program Management Office (PMO) Northeast, 4911 Broad Street, Building 679, Philadelphia, PA 19112–1303, telephone 215–897–4900, fax 215–897–4902, e-mail: *david.drozd@navy.mil.*

Residents will be required to sign-in to speak. Comments can be made in the following ways: (1) Oral statements or

written comments at the public hearings; or (2) Written comments mailed to the BRAC PMO address in this notice; or (3) Written comments faxed to the BRAC PMO fax number in this notice; or (4) Comments submitted via e-mail using the BRAC PMO e-mail address in this notice. All written comments postmarked by Monday, June 28, 2010, will become a part of the official public record and will be responded to in the FEIS.

Requests for special assistance, sign language interpretation for the hearing impaired, language interpreters, or other auxiliary aids for scheduled public hearing meeting must be sent by mail or e-mail to Mr. Matthew Butwin, Ecology and Environment, Inc., 368 Pleasant View Drive, Lancaster, NY 14086, telephone: 716–684–8060, e-mail: *mbutwin@ene.com*.

Dated: April 27, 2010.

A.M. Vallandingham,

Lieutenant Commander, Judge Advocate General's Corps, U.S. Navy, Federal Register Liaison Officer.

[FR Doc. 2010–10396 Filed 5–3–10; 8:45 am]

BILLING CODE 3810–FF–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 13011–002]

Shelbyville Hydro LLC; Notice of Intent To File License Application and Approving Use of the Traditional Licensing Process

April 27, 2010.

a. *Type of Filing:* Notice of Intent to File License Application and Request to Use the Traditional Licensing Process.

b. *Project No.:* 13011–002.

c. *Dated Filed:* March 8, 2010.

d. *Submitted By:* Shelbyville Hydro LLC.

e. *Name of Project:* Lake Shelbyville Dam Hydroelectric Project.

f. *Location:* At the Corps of Engineers' Lake Shelbyville dam on the Kaskaskia River in Shelby County, Illinois.

g. *Filed Pursuant to:* 18 CFR 5.3 of the Commission's regulations.

h. *Applicant Contact:* Brent Smith, COO, Symbiotics, LLC, P.O. Box 535, Rigby, Idaho 83442 at (208) 745–0834 or e-mail at *brent.smith@symbioticsenergy.com* or Corrine Servis, at (208) 745–0834 or e-mail *corrine.servis@symbioticsenergy.com.*

i. *FERC Contact:* John Baummer, *John.Baummer@ferc.gov,* (202) 502–6837.

j. Shelbyville Hydro LLC filed its request to use the Traditional Licensing Process on March 8, 2010. In a letter dated April 23, 2010, the Director of the Division of Hydropower Licensing approved Shelbyville Hydro's request to use the Traditional Licensing Process.

k. With this notice, we are initiating informal consultation with: (a) The U.S. Fish and Wildlife Service and NOAA Fisheries under section 7 of the Endangered Species Act and the joint agency regulations thereunder at 50 CFR part 402; (b) NOAA Fisheries under section 305(b) of the Magnuson-Stevens Fishery Conservation and Management Act and implementing regulations at 50 CFR 600.920; and (c) the Illinois State Historic Preservation Officer, as required by Section 106, National Historical Preservation Act, and the implementing regulations of the Advisory Council on Historic Preservation at 36 CFR 800.2.

l. With this notice, we are designating Shelbyville Hydro as the Commission's non-Federal representative for carrying out informal consultation, pursuant to Section 7 of the Endangered Species Act, Section 305 of the Magnuson-Stevens Fishery Conservation and Management Act, and Section 106 of the National Historic Preservation Act.

m. Shelbyville Hydro filed a Pre-Application Document (PAD; including a proposed process plan and schedule) with the Commission on September 8, 2009, pursuant to 18 CFR 5.6 of the Commission's regulations.

n. A copy of the PAD is available for review at the Commission in the Public Reference Room or may be viewed on the Commission's Web site (*http://www.ferc.gov*), using the "eLibrary" link. Enter the docket number, excluding the last three digits in the docket number field to access the document. For assistance, contact FERC Online Support at *FERCONlineSupport@ferc.gov* or toll free at 1–866–208–3676, of for TTY, (202) 502–8659. A copy is also available for inspection and reproduction at the address in paragraph h.

o. Register online at *http://www.ferc.gov/docs-filing/esubscription.asp* to be notified via e-mail of new filing and issuances related to this or other pending projects. For assistance, contact FERC Online Support.

Kimberly D. Bose,

Secretary.

[FR Doc. 2010–10354 Filed 5–3–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings

April 27, 2010.

Take notice that the Commission has received the following Natural Gas Pipeline Rate and Refund Report filings:

Docket Numbers: RP10–634–000.
Applicants: Gulf South Pipeline Company, LP.
Description: Gulf South Pipeline Company, LP submits capacity release agreement containing negotiated rate provisions with Texla Energy Management, Inc.
Filed Date: 04/23/2010.
Accession Number: 20100426–0206.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 5, 2010.

Docket Numbers: RP10–635–000.
Applicants: Carolina Gas Transmission Corporation.
Description: Request for waiver of Carolina Gas Transmission Corporation.
Filed Date: 04/23/2010.
Accession Number: 20100426–0208.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 5, 2010.

Docket Numbers: RP10–636–000.
Applicants: Southern Star Central Gas Pipeline, Inc.
Description: Southern Star Central Gas Pipeline, Inc. submits First Revised Sheet 6 *et al.* to its FERC Gas Tariff, Original Volume 1, to be effective 6/1/2010.
Filed Date: 04/26/2010.
Accession Number: 20100426–0209.
Comment Date: 5 p.m. Eastern Time on Monday, May 10, 2010.

Docket Numbers: RP10–637–000.
Applicants: Texas Eastern Transmission, L.P.
Description: Texas Eastern Transmission, LP submits Second Revised Fifth Revised Sheet 645 *et al.* to FERC Gas Tariff, Seventh Revised Volume 1, to be effective 11/13/09.
Filed Date: 04/26/2010.
Accession Number: 20100426–0210.
Comment Date: 5 p.m. Eastern Time on Monday, May 10, 2010.

Docket Numbers: RP10–638–000.
Applicants: CenterPoint Energy-Mississippi River Transmission Corporation.
Description: CenterPoint Energy-Mississippi River Transmission Corporation submits an amended negotiated rate agreement between MRT and LER.
Filed Date: 04/26/2010.
Accession Number: 20100426–0211
Comment Date: 5 p.m. Eastern Time on Monday, May 10, 2010.

Docket Numbers: RP10–639–000.
Applicants: CenterPoint Energy-Mississippi River Transmission Corporation.
Description: CenterPoint Energy-Mississippi River Transmission Corporation submits an amended negotiated rate agreement between MRT and CES.
Filed Date: 04/26/2010.
Accession Number: 20100426–0212.
Comment Date: 5 p.m. Eastern Time on Monday, May 10, 2010.

Docket Numbers: RP10–640–000.
Applicants: Texas Eastern Transmission, LP.
Description: Texas Eastern Transmission, LP submits tariff filing per 154.204: Texas Eastern April 26, 2010, Clean-up Filing to be effective 4/22/2010.
Filed Date: 04/26/2010.
Accession Number: 20100426–5042.
Comment Date: 5 p.m. Eastern Time on Monday, May 10, 2010.

Docket Numbers: RP10–641–000.
Applicants: Kinder Morgan Interstate Gas Trans. LLC.
Description: Petition of Kinder Morgan Interstate Gas Transmission LLC for a Limited Waiver of Tariff Provision.
Filed Date: 04/26/2010.
Accession Number: 20100426–5054.
Comment Date: 5 p.m. Eastern Time on Monday, May 10, 2010.

Docket Numbers: RP10–642–000.
Applicants: CenterPoint Energy Gas Transmission Company.
Description: CenterPoint Energy Gas Transmission Company submits Second Revised Sheet 195 part of its FERC Gas Tariff, Sixth Revised Volume 1, to be effective 5/26/2010.
Filed Date: 04/26/2010.
Accession Number: 20100426–0224.
Comment Date: 5 p.m. Eastern Time on Monday, May 10, 2010.

Docket Numbers: RP10–643–000.
Applicants: Dominion Transmission, Inc.
Description: Dominion Transmission, Inc. submits Thirtieth Revised Sheet 39 *et al.* to its FERC Gas Tariff, Third Revised Volume 1, to effective 5/26/2010.
Filed Date: 04/26/2010.
Accession Number: 20100426–0225.
Comment Date: 5 p.m. Eastern Time on Monday, May 10, 2010.

Docket Numbers: RP10–644–000.
Applicants: Texas Eastern Transmission, LP.
Description: Texas Eastern Transmission, LP submits tariff filing per 154.204: South Jersey Negotiated Rate be effective 4/26/2010.
Filed Date: 04/27/2010.
Accession Number: 20100427–5005.
Comment Date: 5 p.m. Eastern Time on Monday, May 10, 2010.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

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Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–10346 Filed 5–3–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings # 1

April 26, 2010.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER98–411–017.
Applicants: Wolverine Power Supply Cooperative, Inc.
Description: Notification of Change in Status of Wolverine Power Supply Cooperative, Inc.
Filed Date: 04/21/2010.
Accession Number: 20100421–5149.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Docket Numbers: ER10–1045–001.
Applicants: PJM Interconnection, L.L.C.
Description: PJM Interconnection, LLC submits a substitute Interim ISA to supersede the Original Meadow Lake Interim ISA.
Filed Date: 04/23/2010.
Accession Number: 20100423–0214.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1082–000.
Applicants: MidAmerican Energy Company.
Description: MidAmerican Energy Company submits Engineering and Procurement Agreement.
Filed Date: 04/23/2010.
Accession Number: 20100423–0213.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1083–000.
Applicants: ISO New England Inc.
Description: ISO New England Inc et al submits an executed non-confirming Standard Small Generator Interconnection Agreement etc.
Filed Date: 04/23/2010.
Accession Number: 20100423–0212.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1084–000.
Applicants: PJM Interconnection, L.L.C.
Description: PJM Interconnection LLC submits an executed Transmission Agreement among ATCLLC etc.
Filed Date: 04/23/2010.
Accession Number: 20100423–0220.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1085–000.
Applicants: Midwest Independent Transmission System Operator, Inc.
Description: Midwest Independent System Operator, Inc submits an Amended and restated Facilities Construction agreement etc.

Filed Date: 04/23/2010.
Accession Number: 20100423–0211.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1086–000.
Applicants: Midwest Independent Transmission System Operator, Inc.
Description: Midwest Independent System Operator, Inc. submits an executed Transmission Interconnection agreement etc.
Filed Date: 04/23/2010.
Accession Number: 20100423–0222.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1087–000.
Applicants: Entergy Services, Inc.
Description: City of North Rock et al submits the mutual-executed Second Revised Dynamic Transfer Operating Agreement.
Filed Date: 04/23/2010.
Accession Number: 20100423–0215.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1088–000.
Applicants: ISO New England Inc., New England Power Pool.
Description: ISO New England Inc et al submits transmittal letter and revised tariff sheets that revise, remove, and add definitions of the ISO New England Transmission, Markets and Services Tariff etc.
Filed Date: 04/23/2010.
Accession Number: 20100426–0203.
Comment Date: 5 p.m. Eastern Time on Monday, May 10, 2010.

Docket Numbers: ER10–1089–000.
Applicants: EquiPower Resources Management, LLC.
Description: EquilPower Resources Management, LLC submits application requesting that FERC accept their FERC Electric Tariff, Original Volume 1 etc.
Filed Date: 04/23/2010.
Accession Number: 20100426–0202.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1090–000.
Applicants: Commercial Energy of Montana Inc.
Description: Commercial Energy of Montana Inc. submits tariff filing per 35.12: Initial Market Based Rate to be effective 5/3/2010.
Filed Date: 04/26/2010.
Accession Number: 20100426–5049.
Comment Date: 5 p.m. Eastern Time on Monday, May 17, 2010.

Docket Numbers: ER10–1093–000.
Applicants: Delaware City Refining Company LLC.
Description: Delaware City Refining Company LLC submits tariff filing per 35.12: Initial Market Based Rates to be effective 6/1/2010.
Filed Date: 04/26/2010.
Accession Number: 20100426–5085.
Comment Date: 5 p.m. Eastern Time on Monday, May 17, 2010.

Take notice that the Commission received the following open access transmission tariff filings:
Docket Numbers: OA08–42–004.
Applicants: American Transmission Company LLC.
Description: American Transmission Company, LLC et al submits compliance filing with the changes directed by the Commission to the transmission planning principles in Attachment FF–ATCLLC etc.
Filed Date: 04/23/2010.
Accession Number: 20100426–0204.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: OA08–53–003.
Applicants: Midwest Independent Transmission System.
Description: Midwest Independent Transmission System Operator, Inc submits compliance filing revising its Open Access Transmission, Energy and Operating Reserve Markets Tariff.
Filed Date: 04/23/2010.
Accession Number: 20100426–0205.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Take notice that the Commission received the following electric reliability filings:
Docket Numbers: RD10–13–000.
Applicants: North American Electric Reliability Corporation.
Description: Petition of the North American Electric Reliability Corporation for Approval of an Interpretation to Reliability Standard CIP–006–2, Requirement R1.1.
Filed Date: 04/20/2010.
Accession Number: 20100420–5159.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

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Nathaniel J. Davis, Sr.,
Deputy Secretary.

[FR Doc. 2010–10348 Filed 5–3–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

April 23, 2010.

Take notice that the Commission received the following electric rate filings:
Docket Numbers: ER10–1077–000.
Applicants: Otay Mesa Energy Center, LLC.
Description: Otay Acquisition Company, LLC submits notice of succession to OMEC.
Filed Date: 04/22/2010.
Accession Number: 20100423–0206.
Comment Date: 5 p.m. Eastern Time on Thursday, May 13, 2010.

Docket Numbers: ER10–1078–000.
Applicants: Exelon New Boston, LLC.
Description: Exelon New Boston, LLC submits tariff filing per 35.12: Exelon New Boston MBR Tariff to be effective 4/23/2010.
Filed Date: 04/23/2010.

Accession Number: 20100423–5069.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1079–000.
Applicants: Exelon New England Power Marketing, Limited Partnership.
Description: Exelon New England Power Marketing, Limited Partnership submits tariff filing per 35.12: Exelon NEPM MBR Tariff to be effective 4/23/2010.
Filed Date: 04/23/2010.
Accession Number: 20100423–5070.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1080–000.
Applicants: Exelon West Medway, LLC.
Description: Exelon West Medway, LLC submits tariff filing per 35.12: Exelon West Medway MBR Tariff to be effective 4/23/2010.
Filed Date: 04/23/2010.
Accession Number: 20100423–5071.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1081–000.
Applicants: Exelon Wyman, LLC.
Description: Exelon Wyman, LLC submits tariff filing per 35.12: Exelon Wyman MBR Tariff to be effective 4/23/2010.
Filed Date: 04/23/2010.
Accession Number: 20100423–5073.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

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Nathaniel J. Davis, Sr.,
Deputy Secretary.

[FR Doc. 2010–10347 Filed 5–3–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

April 27, 2010.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER06–560–008.
Applicants: Credit Suisse Energy LLC.
Description: Notice of Non-Material Change in Status of Credit Suisse Energy LLC.
Filed Date: 04/26/2010.
Accession Numbers: 20100426–5092.
Comment Date: 5 p.m. Eastern Time on Monday, May 17, 2010.

Docket Numbers: ER06–739–026; ER02–537–029; ER03–983–026; ER06–738–026; ER07–501–026; ER07–758–022; ER08–649–018.
Applicants: Cogen Technologies Linden Venture, L.P., Fox Energy Company LLC, Birchwood Power Partners, L.P., Shady Hills Power Company, L.L.C., East Coast Power Linden Holding, LLC, EFS Parlin Holdings LLC, Inland Empire Energy Center, LLC.
Description: Notice of Non-Material Change in Status and Request for Waiver of East Coast Power Linden Holding, LLC, *et al.*
Filed Date: 04/26/2010.
Accession Numbers: 20100426–5124.
Comment Date: 5 p.m. Eastern Time on Monday, May 17, 2010.

Docket Numbers: ER10–662–001.
Applicants: CER Generation, LLC.
Description: Amendment to Application of CER Generation, LLC.
Filed Date: 04/26/2010.
Accession Numbers: 20100426–5113.
Comment Date: 5 p.m. Eastern Time on Thursday, May 6, 2010.

Docket Numbers: ER10–1091–000.
Applicants: Northwestern Wisconsin Electric Company.
Description: Northwestern Wisconsin Electric Co submits proposed rate change to NWEC original FERC Rate Schedule 2.
Filed Date: 04/26/2010.
Accession Numbers: 20100426–0218.
Comment Date: 5 p.m. Eastern Time on Monday, May 17, 2010.

Docket Numbers: ER10–1092–000.
Applicants: Public Service Company of New Mexico.
Description: Public Service Company of New Mexico submits Second Amended and Restated Agreement for Electric Service between PNM's Wholesale Power Marketing Department and Gallup, dated 4/18/2010.
Filed Date: 04/22/2010.
Accession Numbers: 20100426–0217.
Comment Date: 5 p.m. Eastern Time on Thursday, May 13, 2010.

Docket Numbers: ER10–1094–000.
Applicants: PacifiCorp.
Description: PacifiCorp submits Revised Network Integration Transmission Service Agreement dated 4/8/2010 etc.
Filed Date: 04/26/2010.
Accession Numbers: 20100426–0216.
Comment Date: 5 p.m. Eastern Time on Monday, May 17, 2010.

Docket Numbers: ER10–1095–000.
Applicants: Public Service Company of New Mexico.
Description: Public Service Company of New Mexico submits Construction Agreement RS–09–0064, Construction of the Interconnection Association, Inc to facilitate the interconnection of the new PNM Mendoza Substations etc.
Filed Date: 04/26/2010.
Accession Numbers: 20100426–0215.
Comment Date: 5 p.m. Eastern Time on Monday, May 17, 2010.

Docket Numbers: ER10–1096–000.
Applicants: Public Service Company of New Mexico.
Description: Public Service Company of New Mexico submits First revised Service Agreement for Network Integration Transmission Service Agreement *et al.*
Filed Date: 04/26/2010.
Accession Numbers: 20100426–0214.

Comment Date: 5 p.m. Eastern Time on Monday, May 17, 2010.

Docket Numbers: ER10–1097–000.
Applicants: PBF Power Marketing LLC.
Description: PBF Power Marketing LLC submits tariff filing per 35.12: Initial Market Based Rates to be effective 6/1/2010.
Filed Date: 04/27/2010.
Accession Numbers: 20100427–5006.
Comment Date: 5 p.m. Eastern Time on Tuesday, May 18, 2010.

Docket Numbers: ER10–1098–000.
Applicants: Midwest Independent Transmission System Operator, Inc.
Description: Midwest Independent Transmission System Operator, Inc. submits an Amended and Restated Facilities Construction Agreement among the Midwest ISO etc.
Filed Date: 04/26/2010.
Accession Numbers: 20100427–0203.
Comment Date: 5 p.m. Eastern Time on Monday, May 17, 2010.

Docket Numbers: ER10–1099–000.
Applicants: Southern California Edison Company.
Description: Southern California Edison submits revisions to Exhibit C BLY of the contract with Western Area Power Administration.
Filed Date: 04/26/2010.
Accession Numbers: 20100427–0205.
Comment Date: 5 p.m. Eastern Time on Monday, May 17, 2010.

Docket Numbers: ER10–1100–000.
Applicants: Unitil Power Corporation.
Description: Unitil Power Corp. submits Amended Unitil System Agreement Annual Filing.
Filed Date: 04/23/2010.
Accession Numbers: 20100426–0241.
Comment Date: 5 p.m. Eastern Time on Friday, May 14, 2010.

Docket Numbers: ER10–1101–000.
Applicants: Mint Energy, LLC.
Description: Mint Energy, LLC submits tariff filing per 35.12: Rate Schedule FERC No. 1 to be effective 6/26/2010.
Filed Date: 04/27/2010.
Accession Numbers: 20100427–5044.
Comment Date: 5 p.m. Eastern Time on Tuesday, May 18, 2010.

Docket Numbers: ER10–1102–000.
Applicants: Madison Paper Industries.
Description: Madison Paper Industries submits tariff filing per 35.12: Baseline Filing to be effective 3/1/2009.
Filed Date: 04/27/2010.
Accession Numbers: 20100427–5091.
Comment Date: 5 p.m. Eastern Time on Tuesday, May 18, 2010.

Take notice that the Commission received the following electric securities filings:

Docket Numbers: ES10–36–000.
Applicants: Ameren Energy Generating Company.
Description: Application for Blanket Authorization Under FPA 204 and 18 CFR Part 34 of Ameren Energy Generating Company.
Filed Date: 04/27/2010.
Accession Numbers: 20100427–5039.
Comment Date: 5 p.m. Eastern Time on Tuesday, May 18, 2010.

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Nathaniel J. Davis, Sr.,
Deputy Secretary.

[FR Doc. 2010–10349 Filed 5–3–10; 8:45 am]
BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #2

April 27, 2010.

Take notice that the Commission received the following qualifying facility filings:

Docket Numbers: QF10–13–000.
Applicants: Cornell University.
Description: Self Certification of Cogeneration Facility Cornell University (NY).
Filed Date: 10/08/2009.
Accession Number: 20091008–5041.
Comment Date: None Applicable.

Docket Numbers: QF10–88–000.
Applicants: Little Sisters of the Poor, Jeanne Jugan Residence.
Description: Notice of Self Certification of Qualifying Facility Status for a proposed Cogeneration Facility at Little Sisters of the Poor, Jeanne Jugan Residence.
Filed Date: 11/05/2009.
Accession Number: 20091106–0087.
Comment Date: None Applicable.

Docket Numbers: QF10–145–000.
Applicants: Covenant Health Systems, Inc.
Description: Self Certification Notice of Covenant Health Systems.
Filed Date: 12/01/2009.
Accession Number: 20091201–5153.
Comment Date: None Applicable.

Docket Numbers: QF10–272–000.
Applicants: St. Mary's Women and Children's Center.
Description: Qualifying Facility (QF) Application for the St. Mary's Women and Children's Center Cogeneration System in Dorchester, MA.
Filed Date: 01/21/2010.
Accession Number: 20100121–5016.
Comment Date: None Applicable.

Docket Numbers: QF10–290–000.
Applicants: Growpro Inc.
Description: Self Certification Notice of Growpro Inc.
Filed Date: 01/28/2010.
Accession Number: 20100128–5053.
Comment Date: None Applicable.

Docket Numbers: QF10–327–000.
Applicants: Beaufort Regional Health System.
Description: Notice of Self-Certification of Qualifying Status of a

Cogeneration Facility of PowerSecure Inc. for Beaufort Regional Health System.

Filed Date: 02/23/2010.

Accession Number: 20100223–5132.

Comment Date: None Applicable.

Docket Numbers: QF10–338–000.

Applicants: Suburban Athletic Club.

Description: Self Certification Notice of Suburban Athletic Club.

Filed Date: 03/02/2010.

Accession Number: 20100302–5027.

Comment Date: None Applicable.

Docket Numbers: QF10–365–000; QF10–366–000.

Applicants: Roger Grimes; Belk Inc.

Description: Belk, Inc. Qualifying Facility Application or PURPA Energy Utility Filing.

Filed Date: 03/17/2010.

Accession Number: 20100317–5093.

Comment Date: None Applicable.

Docket Numbers: QF10–415–000.

Applicants: Massachusetts Department of Corrections Bridgewater Cogeneration Plant.

Description: Certification of Qualifying Facility Status for an Existing or a Proposed Small Power Production or Cogeneration Facility Commonwealth of Massachusetts Department of Corrections.

Filed Date: 04/12/2010.

Accession Number: 20100412–5035.

Comment Date: None Applicable.

Docket Numbers: QF10–418–000.

Applicants: The Trustees of Smith College.

Description: Form 556 of Smith College.

Filed Date: 04/13/2010.

Accession Number: 20100413–5115.

Comment Date: None Applicable.

Docket Numbers: QF10–422–000.

Applicants: Fisher, Dave.

Description: Notice of Certification of Qualifying Facility Status for an Existing or a Proposed Small Power Production or Cogeneration Facility for Dave Fisher.

Filed Date: 04/14/2010.

Accession Number: 20100414–5036.

Comment Date: None Applicable.

Docket Numbers: QF10–427–000.

Applicants: Rigo, Jr., Anthony.

Description: Baker Renewable Energy for 556 of Anthony Rigo Jr.

Filed Date: 04/15/2010.

Accession Number: 20100415–5069.

Comment Date: None Applicable.

Docket Numbers: QF10–429–000.

Applicants: Green, Matthew.

Description: Baker Renewable Energy Form 556 of Matthew Green.

Filed Date: 04/16/2010.

Accession Number: 20100416–5193.

Comment Date: None Applicable.

Docket Numbers: QF10–431–000.

Applicants: Oregon State University.

Description: Self-Certification of a nominal 6.5 MW cogeneration facility on the Oregon State University campus.

Filed Date: 04/19/2010.

Accession Number: 20100419–5191.

Comment Date: None Applicable.

A notice of self-certification or self-recertification does not institute a proceeding regarding qualifying facility status; a notice of self-certification or self-recertification provides notice that the entity making the filing has determined the Facility meets the applicable criteria to be a qualifying facility. Any person seeking to challenge such qualifying facility status may do so by filing a motion pursuant to 18 CFR 292.207(d)(iii).

This filing is accessible on-line at *http://www.ferc.gov*, using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–10350 Filed 5–3–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings

April 23, 2010.

Take notice that the Commission has received the following Natural Gas Pipeline Rate and Refund Report filings:

Docket Numbers: RP10–621–000.

Applicants: Williston Basin Interstate Pipeline Company.

Description: Williston Basin Interstate Pipeline Company submits Seventy-Fifth revised Sheet 15 *et al.* to Second Revised Volume 1, to be effective 5/21/2010.

Filed Date: 04/21/2010.

Accession Number: 20100421–0211.

Comment Date: 5 p.m. Eastern Time on Monday, May 3, 2010.

Docket Numbers: RP10–622–000.

Applicants: Transcontinental Gas Pipe Line Company, LLC.

Description: Transcontinental Gas Pipe Line Company, LLC submits Eighth Revised Sheet 27 to its FERC Gas Tariff, Fourth Revised Volume 1, to be effective 5/1/10.

Filed Date: 04/21/2010.

Accession Number: 20100422–0204.

Comment Date: 5 p.m. Eastern Time on Monday, May 3, 2010.

Docket Numbers: RP10–624–000.

Applicants: Gulf South Pipeline Company, LP.

Description: Gulf South Pipeline Company, LP submits capacity release agreement containing negotiated rate provisions with Texla Energy Management, Inc.

Filed Date: 04/21/2010.

Accession Number: 20100422–0203.

Comment Date: 5 p.m. Eastern Time on Monday, May 3, 2010.

Docket Numbers: RP10–625–000.

Applicants: Texas Eastern Transmission, LP.

Description: Texas Eastern Transmission, LP submits tariff filing per 154.203: Texas Eastern Baseline Filing to be effective 4/22/2010.

Filed Date: 04/22/2010.

Accession Number: 20100422–5016.

Comment Date: 5 p.m. Eastern Time on Tuesday, May 4, 2010.

Docket Numbers: RP10–626–000.

Applicants: Southern Star Central Gas Pipeline, Inc.

Description: Southern Star Central Gas Pipeline, Inc. Petition for Waiver of Index of Customer Filing Instructions.

Filed Date: 02/19/2010.

Accession Number: 20100219–5142.

Comment Date: 5 p.m. Eastern Time on Monday, May 3, 2010.

Docket Numbers: CP10–107–000.

Applicants: The East Ohio Gas Company.

Description: The East Ohio Gas Company submits an abbreviated joint application requesting approval to lease storage capacity from DEO.

Filed Date: 03/26/2010.

Accession Number: 20100329–0210.

Comment Date: 5 p.m. Eastern Time on Monday, May 3, 2010.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Anyone filing a motion to intervene or protest must serve a copy of that

document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St., NE., Washington, DC 20426.

The filings in the above proceedings are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–10351 Filed 5–3–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

April 22, 2010.

Take notice that the Commission received the following exempt wholesale generator filings:

Docket Numbers: EG10–36–000.
Applicants: Otay Acquisition Company, LLC.
Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Otay Acquisition Company, LLC.
Filed Date: 04/22/2010.
Accession Number: 20100422–5110.
Comment Date: 5 p.m. Eastern Time on Thursday, May 13, 2010.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER00–2885–029; ER01–2765–028; ER02–2102–028; ER05–1232–025; ER07–1358–015; ER09–1141–008.
Applicants: J.P. Morgan Ventures Energy Corporation, BE Louisiana LLC, Cedar Brakes I, L.L.C., Utility Contract Funding, L.L.C., Cedar Brakes II, L.L.C., J.P. Morgan Commodities Canada Corporation.
Description: J.P. Morgan submits supplement to notice of change in status.
Filed Date: 04/16/2010.
Accession Number: 20100421–0034.
Comment Date: 5 p.m. Eastern Time on Friday, May 7, 2010.

Docket Numbers: ER01–424–011; ER01–313–011.
Applicants: Pacific Gas and Electric Company; California Independent System Operator Corporation.
Description: Refund Report of the California Independent System Operator Corporation.
Filed Date: 04/21/2010.
Accession Number: 20100421–5180.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Docket Numbers: ER07–771–004.
Applicants: E.ON U.S., LLC.
Description: E.ON U.S. LLC Annual true-up filing under Open Access Transmission Tariff.
Filed Date: 04/22/2010.
Accession Number: 20100422–5159.
Comment Date: 5 p.m. Eastern Time on Thursday, May 13, 2010.

Docket Numbers: ER09–1051–003.
Applicants: ISO New England Inc., New England Power Pool
Description: ISO New England, Inc et al submits response to the compliance requirements set forth in the Jan 21 Order.
Filed Date: 04/21/2010.
Accession Number: 20100422–0202.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Docket Numbers: ER10–1071–000.
Applicants: Midwest Independent Transmission System Operator, Inc.
Description: Midwest Independent Transmission System Operator, Inc submits an executed Amended and Restated Generator Interconnection Agreement etc.
Filed Date: 04/21/2010.
Accession Number: 20100421–0203.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Docket Numbers: ER10–1072–000.
Applicants: Westar Energy, Inc.
Description: Westar Energy, Inc. submits Supplemental Generation Agreements between Westar and the Cities of Herington and Wamego, Kansas designated as Rate Schedule FERC 338 and 339.
Filed Date: 04/21/2010.
Accession Number: 20100421–0209.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Docket Numbers: ER10–1073–000.
Applicants: Electrade Corporation.
Description: Electrade Corporation submits tariff filing per 35.12: Baseline Tariff Filing to be effective 4/21/2010.
Filed Date: 04/21/2010.
Accession Number: 20100421–5112.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Docket Numbers: ER10–1074–000; ER10–1075–000; ER10–1076–000.
Applicants: Raven One, LLC; Raven Two, LLC; Raven Three, LLC
Description: Raven One, LLC et al submits notice of cancellation of the Companies' market-based rate tariffs currently on file with the Commission.
Filed Date: 04/21/2010.
Accession Number: 20100422–0201.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Take notice that the Commission received the following electric securities filings:

Docket Numbers: ES10–35–000.
Applicants: American Transmission Company LLC, ATC Management Inc.
Description: American Transmission Company LLC and ATC. Management Inc under Section 204 of the Federal Power Act for Authorization to Issue Securities.
Filed Date: 04/21/2010.
Accession Number: 20100421–5145.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Take notice that the Commission received the following electric reliability filings:

Docket Numbers: RD10–11–000.
Applicants: North American Electric Reliability Corporation.
Description: Petition of the North American Electric Reliability Corporation for Approval of Interpretation to Reliability Standard CIP–001—Cyber Security—Sabotage Reporting, Requirement R2.
Filed Date: 04/21/2010.
Accession Number: 20100421–5077.
Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Docket Numbers: RD10–12–000.
Applicants: North American Electric Reliability Corporation.
Description: Petition of the North American Electric Reliability Corporation for Approval of Interpretation to Reliability Standard

CIP–005–2, Cyber Security, Electronic Security Perimeter(s), Section 4.2.2 and Requirement R1.3.

Filed Date: 04/21/2010.

Accession Number: 20100421–5078.

Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Take notice that the Commission received the following electric reliability filings:

Docket Numbers: RR10–1–001.

Applicants: North American Electric Reliability Corporation.

Description: Compliance Filing of the North American Electric Reliability Corp in Response to January 21, 2010 Commission Order Concerning Appendix 4D to the NERC Rules of Procedure- Procedure for Requesting and Receiving Technical Feasibility Exceptions.

Filed Date: 04/21/2010.

Accession Number: 20100421–5166.

Comment Date: 5 p.m. Eastern Time on Wednesday, May 12, 2010.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

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The filings in the above proceedings are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed dockets(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–10353 Filed 5–3–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings

April 26, 2010.

Take notice that the Commission has received the following Natural Gas Pipeline Rate and Refund Report filings:

Docket Numbers: RP10–623–000.

Applicants: Texas Eastern Transmission, L.P.

Description: Texas Eastern Transmission, LP submits First Revised Eighth Revised Sheet No 529 *et al.* to FERC Gas Tariff, Seventh Revised Volume No 1, to be effective 11/16/09.

Filed Date: 04/21/2010.

Accession Number: 20100426–0201.

Comment Date: 5 p.m. Eastern Time on Monday, May 3, 2010.

Docket Numbers: RP10–627–000.

Applicants: Saltville Gas Storage Company L.L.C.

Description: Saltville Gas Storage Company, LLC submits First Revised Sheet 1 *et al.* to FERC Gas Tariff, Original Volume 1, to be effective 5/24/10.

Filed Date: 04/22/2010.

Accession Number: 20100423–0204.

Comment Date: 5 p.m. Eastern Time on Tuesday, May 4, 2010.

Docket Numbers: RP10–628–000.

Applicants: Egan Hub Storage, LLC.

Description: Egan Hub Storage, LLC submits Third Revised Sheet 2 *et al.* to FERC Gas Tariff, First Revised Volume 1, to be effective 5/24/10.

Filed Date: 04/22/2010.

Accession Number: 20100423–0203.

Comment Date: 5 p.m. Eastern Time on Tuesday, May 4, 2010.

Docket Numbers: RP10–629–000.

Applicants: Gulf South Pipeline Company, LP.

Description: Gulf South Pipeline Company, LP submits a capacity release agreement containing negotiated rate provisions with Texla Energy Management, Inc.

Filed Date: 04/22/2010.

Accession Number: 20100423–0201.

Comment Date: 5 p.m. Eastern Time on Tuesday, May 4, 2010.

Docket Numbers: RP10–630–000.

Applicants: Gulf Stream Natural Gas System, LLC.

Description: Gulfstream Natural Gas System, LLC submits Second Revised Sheet 121 *et al.* FERC Gas tariff, Original Volume 1, to be effective 5/24/2010.

Filed Date: 04/23/2010.

Accession Number: 20100423–0216.

Comment Date: 5 p.m. Eastern Time on Wednesday, May 5, 2010.

Docket Numbers: RP10–631–000.

Applicants: Horizon Pipeline Company, L.L.C.

Description: Horizon Pipeline Company, LLC submits a report of the refund of penalty revenues.

Filed Date: 04/23/2010.

Accession Number: 20100423–0217.

Comment Date: 5 p.m. Eastern Time on Wednesday, May 5, 2010.

Docket Numbers: RP10–632–000.

Applicants: Gulf South Pipeline Company, LP.

Description: Gulf South Pipeline Company, LP submits a capacity release agreement containing negotiated rate provisions.

Filed Date: 04/23/2010.

Accession Number: 20100423–0218.

Comment Date: 5 p.m. Eastern Time on Wednesday, May 5, 2010.

Docket Numbers: RP10–633–000.

Applicants: Gulf Crossing Pipeline Company LLC.

Description: Gulf Crossing Pipeline Company submits First Revised Sheet 1 of its FERC Gas Tariff, Original Volume 1, to be effective 6/1/10.

Filed Date: 04/23/2010.

Accession Number: 20100423–0219.

Comment Date: 5 p.m. Eastern Time on Wednesday, May 5, 2010.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Anyone filing a motion to intervene or

protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

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Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–10352 Filed 5–3–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP10–76–000]

Eastern Shore Natural Gas Company; Notice of Intent To Prepare an Environmental Assessment for the Proposed Mainline Extension Interconnect Project and Request for Comments on Environmental Issues

April 27, 2010.

The staff of the Federal Energy Regulatory Commission (FERC or Commission) will prepare an environmental assessment (EA) that will discuss the environmental impacts of the Mainline Extension Interconnect Project involving construction and operation of facilities by Eastern Shore Natural Gas Company (ESNG) in Lancaster and Chester Counties, Pennsylvania. This EA will be used by the Commission in its decision-making process to determine whether the project is in the public convenience and necessity.

This notice announces the opening of the scoping process the Commission will use to gather input from the public and interested agencies on the project. Your input will help the Commission staff determine what issues need to be evaluated in the EA. Please note that the scoping period will close on May 28, 2010.

This notice is being sent to the Commission's current environmental mailing list for this project. State and local government representatives are asked to notify their constituents of this planned project and encourage them to comment on their areas of concern.

If you are a landowner receiving this notice, you may be contacted by a pipeline company representative about the acquisition of an easement to construct, operate, and maintain the proposed facilities. The company would seek to negotiate a mutually acceptable agreement. However, if the project is approved by the Commission, that approval conveys with it the right of eminent domain. Therefore, if easement negotiations fail to produce an agreement, the pipeline company could initiate condemnation proceedings in accordance with State law.

A fact sheet prepared by the FERC entitled "An Interstate Natural Gas Facility On My Land? What Do I Need To Know?" was attached to the project notice ESNG provided to landowners. This fact sheet addresses a number of typically-asked questions, including the use of eminent domain and how to participate in the Commission's proceedings. It is also available for viewing on the FERC Web site (*http://www.ferc.gov*).

Summary of the Proposed Project

ESNG proposes to construct and operate approximately 8.3 miles of 16-inch-diameter natural gas pipeline and other associated facilities in Lancaster and Chester Counties, Pennsylvania. The Mainline Extension Interconnect Project would provide its shippers the opportunity to receive natural gas supplies, with a capacity of 40,000 dekatherms per day, from the Appalachian region and other areas through an interconnection with Texas Eastern Transmission, LP's pipeline system.

The Mainline Extension Interconnect Project would consist of the following facilities:

- 8.3 miles of 16-inch-diameter natural gas pipeline;
- One meter station/pig [1] launcher at the interconnect with Texas Eastern Transmission, LP, near Honey Brook, Pennsylvania;
- One mainline valve; and
- One interconnect/pig receiver at the existing ESNG meter station near Parkesburg, Pennsylvania.

The general location of the project facilities is shown in Appendix 1.[2]

Land Requirements for Construction

Construction of the proposed facilities would disturb about 76.4 acres of land for the aboveground facilities and the pipeline. Following construction, about 51.1 acres would be maintained for permanent operation of the project's facilities; the remaining acreage would be restored and allowed to revert to former uses.

The EA Process

The National Environmental Policy Act (NEPA) requires the Commission to take into account the environmental impacts that could result from an action whenever it considers the issuance of a Certificate of Public Convenience and Necessity. NEPA also requires us [3] to discover and address concerns the public may have about proposals. This process is referred to as "scoping". The main goal of the scoping process is to focus the analysis in the EA on the important environmental issues. By this notice, the Commission requests public comments on the scope of the issues to address in the EA. All comments received will be considered during the preparation of the EA.

In the EA we will discuss impacts that could occur as a result of the construction and operation of the proposed project under these general headings:

- Geology and soils;
- Land use;
- Water resources, fisheries, and wetlands;
- Cultural resources;

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[1] A "pig" is a tool that is inserted into and moves through the pipeline, and is used for cleaning the pipeline, internal inspections, or other purposes.

[2] The appendices referenced in this notice are not being printed in the **Federal Register.** Copies of appendices were sent to all those receiving this notice in the mail and are available at *http://www.ferc.gov* using the link called "eLibrary" or from the Commission's Public Reference Room, 888 First Street, NE., Washington, DC 20426, or call (202) 502–8371. For instructions on connecting to eLibrary, refer to the last page of this notice.

[3] "We", "us", and "our" refer to the environmental staff of the Commission's Office of Energy Projects.

- Vegetation and wildlife;
- Air quality and noise;
- Endangered and threatened species; and
- Public safety.

We will also evaluate reasonable alternatives to the proposed project or portions of the project, and make recommendations on how to lessen or avoid impacts on the various resource areas.

Our independent analysis of the issues will be presented in the EA. The EA will be placed in the public record and, depending on the comments received during the scoping process, may be published and distributed to the public. A comment period will be allotted if the EA is published for review. We will consider all comments on the EA before we make our recommendations to the Commission. To ensure your comments are considered, please carefully follow the instructions in the Public Participation section below.

With this notice, we are asking agencies with jurisdiction and/or special expertise with respect to environmental issues to formally cooperate with us in the preparation of the EA. These agencies may choose to participate once they have evaluated the proposal relative to their responsibilities. Agencies that would like to request cooperating agency status should follow the instructions for filing comments provided under the Public Participation section of this notice.

Consultations Under Section 106 of the National Historic Preservation Act

In accordance with the Advisory Council on Historic Preservation's implementing regulations, we are using this notice to solicit the views of the public on the project's potential effects on historic properties.[4] We will document our findings on the impacts on cultural resources and summarize the status of consultations under section 106 of the National Historic Preservation Act in our EA.

Public Participation

You can make a difference by providing us with your specific comments or concerns about the project. Your comments should focus on the potential environmental effects, reasonable alternatives, and measures to avoid or lessen environmental impacts. The more specific your comments, the more useful they will be. To ensure that your comments are timely and properly recorded, please send your comments so that they will be received in Washington, DC on or before May 28, 2010.

For your convenience, there are three methods which you can use to submit your comments to the Commission. In all instances, please reference the project docket number CP10–76–000 with your submission. The Commission encourages electronic filing of comments and has expert eFiling staff available to assist you at (202) 502–8258 or *efiling@ferc.gov.*

(1) You may file your comments electronically by using the Quick Comment feature, which is located at *http://www.ferc.gov* under the link called "*Documents and Filings*". A Quick Comment is an easy method for interested persons to submit text-only comments on a project;

(2) You may file your comments electronically by using the "eFiling" feature that is listed under the "*Documents and Filings*" link. eFiling involves preparing your submission in the same manner as you would if filing on paper, and then saving the file on your computer's hard drive. You will attach that file to your submission. New eFiling users must first create an account by clicking on the links called "*Sign up*" or "*eRegister*". You will be asked to select the type of filing you are making. A comment on a particular project is considered a "Comment on a Filing"; or

(3) You may file a paper copy of your comments at the following address: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Room 1A, Washington, DC 20426.

Environmental Mailing List

The environmental mailing list includes federal, state, and local government representatives and agencies; elected officials; Native American Tribes; other interested parties; and local libraries and newspapers. This list also includes all affected landowners (as defined in the Commission's regulations) who are potential right-of-way grantors, whose property may be used temporarily for project purposes, or who own homes within certain distances of aboveground facilities, and anyone who submits comments on the project. We will update the environmental mailing list as the analysis proceeds to ensure that we send the information related to this environmental review to all individuals, organizations, and government entities interested in and/or potentially affected by the proposed project.

If the EA is published for distribution, copies will be sent to the environmental mailing list for public review and comment.

Becoming an Intervenor

In addition to involvement in the EA scoping process, you may want to become an "intervenor" which is an official party to the Commission's proceeding. Intervenors play a more formal role in the process and are able to file briefs, appear at hearings, and be heard by the courts if they choose to appeal the Commission's final ruling. An intervenor formally participates in the proceeding by filing a request to intervene. Instructions for becoming an intervenor are included in the User's Guide under the "e-filing" link on the Commission's Web site.

Additional Information

Additional information about the project is available from the Commission's Office of External Affairs, at (866) 208–FERC, or on the FERC Web site at *http://www.ferc.gov* using the "eLibrary" link. Click on the eLibrary link, click on "General Search" and enter the docket number, excluding the last three digits in the Docket Number field (*i.e.,* CP10–76). Be sure you have selected an appropriate date range. For assistance, please contact FERC Online Support at *FercOnlineSupport@ferc.gov* or toll free at (866) 208–3676, or for TTY, contact (202) 502–8659. The eLibrary link also provides access to the texts of formal documents issued by the Commission, such as orders, notices, and rulemakings.

In addition, the Commission now offers a free service called eSubscription which allows you to keep track of all formal issuances and submittals in specific dockets. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries, and direct links to the documents. Go to *http://www.ferc.gov/esubscribenow.htm.*

Finally, public meetings or site visits will be posted on the Commission's calendar located at *http://www.ferc.gov/EventCalendar/EventsList.aspx* along with other related information.

Kimberly D. Bose,

Secretary.

FR Doc. 2010–10355 Filed 5–3–10; 8:45 am]

BILLING CODE 6717–01–P

[4] The Advisory Council on Historic Preservation's regulations are at Title 36, Code of Federal Regulations, Part 800. Historic properties are defined in those regulations as any prehistoric or historic district, site, building, structure, or object included in or eligible for inclusion in the National Register for Historic Places.

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. AD10–11–000]

Frequency Regulation Compensation in the Organized Wholesale Power Markets; Notice of Technical Conference

April 27, 2010.

Take notice that Commission staff will hold a technical conference to elicit input on issues pertaining to Frequency Regulation Compensation in the ISO/RTO Markets. The technical conference will take place on May 26, 2010, from 9 a.m. to 1 p.m. Eastern Time. The conference will be held in the Commission Meeting Room at the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. All interested persons are invited to participate in the conference.

Those interested in speaking at the conference should notify the Commission by May 3, 2010 by completing an online form describing the topics that they will address: *https://www.ferc.gov/whats-new/registration/markets-05-26-speaker-form.asp.* Due to time constraints, we may not be able to accommodate all those interested in speaking. A detailed agenda, including panel speakers, will be published at a later date.

The technical conference will be transcribed. Transcripts of the conferences will be immediately available for a fee from Ace-Federal Reporters, Inc. (202–347–3700 or 1–800–336–6646). The transcripts will be available for free on the Commission's eLibrary system and on the Calendar of Events approximately one week after the conference.

There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov,* or call 866–208–3676 (toll free). For TTY, call 202–502–8659.

Commission conferences are accessible under section 508 of the Rehabilitation Act of 1973. For accessibility accommodations, please send an e-mail to *accessibility@ferc.gov* or call toll free (866)–208–3372 (voice) or (202)–208–1659 (TTY), or send a FAX to (202)–208–2106 with the required accommodations.

For further information about the conference, please contact:

Tatyana Kramskaya (Technical Information), Office of Energy Policy and Innovation, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. (202)–502–6262. *Tatyana.Kramskaya@ferc.gov.*

Eric Winterbauer (Legal Information), Office of the General Counsel—Energy Markets, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. (202) 502–8329. *Eric.Winterbauer@ferc.gov.*

Kimberly D. Bose,

Secretary.

[FR Doc. 2010–10356 Filed 5–3–10; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPP–2010–0261; FRL–8821–8]

Pesticide Products; Registration Applications

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: EPA has received applications to register pesticide products containing an active ingredient not included in any previously registered pesticide product. Pursuant to the provisions of section 3(c)(4) of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), EPA is hereby providing notice of receipt and opportunity to comment on these applications.

DATES: Comments must be received on or before June 3, 2010.

ADDRESSES: Submit your comments, identified by docket identification (ID) number EPA–HQ–OPP–2010–0261, by one of the following methods:

• *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the on-line instructions for submitting comments.

• *Mail*: Office of Pesticide Programs (OPP) Regulatory Public Docket (7502P), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001.

• *Delivery*: OPP Regulatory Public Docket (7502P), Environmental Protection Agency, Rm. S–4400, One Potomac Yard (South Bldg.), 2777 S. Crystal Dr., Arlington, VA. Deliveries are only accepted during the Docket Facility's normal hours of operation (8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays). Special arrangements should be made for deliveries of boxed information. The Docket Facility telephone number is (703) 305–5805.

Instructions: Direct your comments to docket ID number EPA–HQ–OPP–2010–0261. EPA's policy is that all comments received will be included in the docket without change and may be made available on-line at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through regulations.gov or e-mail. The regulations.gov website is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through regulations.gov, your e-mail address will be automatically captured and included as part of the comment that is placed in the docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD-ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the docket are listed in the docket index available at *http://www.regulations.gov*. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either in the electronic docket at *http://www.regulations.gov*, or, if only available in hard copy, at the OPP Regulatory Public Docket in Rm. S–4400, One Potomac Yard (South Bldg.), 2777 S. Crystal Dr., Arlington, VA. The hours of operation of this Docket Facility are from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The Docket Facility telephone number is (703) 305–5805.

FOR FURTHER INFORMATION CONTACT: Shaunta Hill, Registration Division (7504P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (703) 347–8961; e-mail address: *hill.shaunta@epa.gov*.

SUPPLEMENTARY INFORMATION

I. General Information

A. Does this Action Apply to Me?

You may be potentially affected by this action if you are an agricultural producer, food manufacturer, or pesticide manufacturer. Potentially affected entities may include, but are not limited to:

- Crop production (NAICS code 111).
- Animal production (NAICS code 112).
- Food manufacturing (NAICS code 311).
- Pesticide manufacturing (NAICS code 32532).

This listing is not intended to be exhaustive, but rather provides a guide for readers regarding entities likely to be affected by this action. Other types of entities not listed in this unit could also be affected. The North American Industrial Classification System (NAICS) codes have been provided to assist you and others in determining whether this action might apply to certain entities. If you have any questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

B. What Should I Consider as I Prepare My Comments for EPA?

1. *Submitting CBI.* Do not submit this information to EPA through regulations.gov or e-mail. Clearly mark the part or all of the information that you claim to be CBI. For CBI information in a disk or CD-ROM that you mail to EPA, mark the outside of the disk or CD-ROM as CBI and then identify electronically within the disk or CD-ROM the specific information that is claimed as CBI. In addition to one complete version of the comment that includes information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

2. *Tips for preparing your comments.* When submitting comments, remember to:

i. Identify the document by docket ID number and other identifying information (subject heading, **Federal Register** date and page number).

ii. Follow directions. The Agency may ask you to respond to specific questions or organize comments by referencing a Code of Federal Regulations (CFR) part or section number.

iii. Explain why you agree or disagree; suggest alternatives and substitute language for your requested changes.

iv. Describe any assumptions and provide any technical information and/or data that you used.

v. If you estimate potential costs or burdens, explain how you arrived at your estimate in sufficient detail to allow for it to be reproduced.

vi. Provide specific examples to illustrate your concerns and suggest alternatives.

vii. Explain your views as clearly as possible, avoiding the use of profanity or personal threats.

viii. Make sure to submit your comments by the comment period deadline identified.

II. Registration Applications

EPA has received applications to register pesticide products containing an active ingredient not included in any previously registered pesticide product. Pursuant to the provisions of section 3(c)(4) of FIFRA, EPA is hereby providing notice of receipt and opportunity to comment on these applications. Notice of receipt of these applications does not imply a decision by the Agency on these applications.

File Symbol: 7969-GNN. *Applicant*: BASF Corporation, 26 Davis Drive, P.O. Box 13528, Research Triangle Park, NC, 27709. *Product name*: BAS 650 00F. *Active ingredient*: Ametoctradin at 19.2%. *Proposed classification/Use*: Terrestrial food use for brassica leafy vegetables, bulb vegetables, cucurbit vegetables, fruiting vegetables, leafy vegetables, tuberous and corm vegetables, grapes, and hops.

File Symbol: 7969-GNR. *Applicant*: BASF Corporation, 26 Davis Drive, P.O. Box 13528, Research Triangle Park, NC, 27709. *Product name*: Orvego. *Active ingredients*: Dimethomorph at 20.2% and Ametoctradin at 26.9%. *Proposed classification/Use*: Terrestrial nonfood, greenhouse nonfood, residential outdoor, indoor nonfood use for ornamentals, golf courses, residential and commercial landscapes, hardwood and conifer trees.

File Symbol: 7969-GNE. *Applicant*: BASF Corporation, 26 Davis Drive, P.O. Box 13528, Research Triangle Park, NC, 27709. *Product name*: Zampro. *Active ingredients*: Dimethomorph at 20.2% and Ametoctradin at 26.9%. *Proposed classification/Use*: Terrestrial food use for brassica leafy vegetables, bulb vegetables, cucurbit vegetables, fruiting vegetables, grapes, hops, leafy vegetables, and tuberous and corm vegetable.

File Symbol: 7969-GNG. *Applicant*: BASF Corporation, 26 Davis Drive, P.O. Box 13528, Research Triangle Park, NC, 27709. *Product name*: Initium. *Active ingredient*: Ametoctradin at 99.2%. *Proposed classification/Use*: Manufacturing use product.

List of Subjects

Environmental protection, Pesticides and pest.

Dated: April 22, 2010.

G. Jeffrey Herndon,

Acting Director, Registration Division, Office of Pesticide Programs.

[FR Doc. 2010–10408 Filed 5–3–10; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[EPA–R03–OW–2009–0985; FRL–9144–7]

Notice of Public Hearing Regarding Environmental Protection Agency Region III's Proposed Determination To Prohibit, Restrict, or Deny the Specification, or the Use for Specification (Including Withdrawal of Specification), of an Area as a Disposal Site; Spruce No. 1 Surface Mine, Logan County, WV

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of public hearing.

SUMMARY: On April 2, 2010, EPA Region III published its Proposed determination to Prohibit, Restrict, or Deny the Specification, or the Use for Specification (including Withdrawal of Specification), of an Area as a Disposal Site; Spruce No. 1 Surface Mine, Logan County, West Virginia in the **Federal Register** soliciting comments from the public. The permittee is Mingo Logan Coal Company. That notice can be found at *http://www.regulations.gov* (search for EPA–R03–OW–2009–0985). Relevant documents are also available on EPA's Web site at *http://www.epa.gov/region3/mtntop/spruce1.html.* EPA has decided that it would be in the public interest to conduct a public hearing on the Proposed 404(c) Determination for the Spruce No. 1 Surface Mine.

Date and Location: The U.S. Environmental Protection Agency, Region III, (EPA) will hold a public hearing on Tuesday, May 18, 2010, at 7 p.m. at the Charleston Civic Center (South Hall), located at 200 Civic Center Drive, Charleston, WV 25301. Registration will begin at 5 p.m.

FOR FURTHER INFORMATION CONTACT: For information regarding this notice of a public hearing, contact the Office of Environmental Programs;

Environmental Assessment and Innovation Division; U.S. Environmental Protection Agency, Region III; 1650 Arch Street; Philadelphia, Pennsylvania 19103. The telephone number for information about this hearing and to sign up to give oral comments is 877–368–3552. The EPA office can also be reached via electronic mail at *R3_Spruce_Surface_Mine@epa.gov.* This mailbox is for information on the notice only and is not the official comment submission forum. If you would like to submit written comments you may do so at the public hearing or on-line at *http://www.regulations.gov* (search for EPA–R03–OW–2009–0985). For those who have special needs and require auxiliary aids and/or services to fully participate in the public hearing, please call 215–814–2760.

SUPPLEMENTARY INFORMATION:

The purpose of the public hearing is to obtain public testimony or comment on EPA's proposed 404(c) action on the Spruce No. 1 Mine project. The Regional Administrator will designate the official (Presiding Officer) who will preside at the public hearing. Any person may appear at the hearing and submit oral and/or written statements or data and may be represented by counsel or other authorized representatives.

In anticipation of a large turnout for the hearing, advanced sign-up is recommended for all, but especially for those planning to make oral comments due to time and capacity limitations. The following information is requested for sign-up: First name, Last name, City, State, Email address, and Phone number. To sign up, go to *http://www.epa.gov/region3/mtntop/spruce1hearing.html* and click on the link, "Registering ahead of time is recommended." You may also sign up by phone at 877–368–3552. You will receive confirmation that your registration has been received. Speakers will be on a first-registered basis, followed by those who sign up for public comment on-site the day of the public hearing. Audio-visual equipment will not be provided. If you would like to submit written comments you may do so at the public hearing or on-line at *http://www.regulations.gov* (search for EPA–R03–OW–2009–0985).

To maximize the number of individuals who are able to speak at the hearing, oral statements will be limited to two minutes per person. The Presiding Officer will establish other reasonable limits on the nature and length of time for oral presentation. There will be no direct questioning of any hearing participant, although the Presiding Officer may make appropriate inquiries of any such participant. EPA will not respond to questions/comments during the hearing. EPA will consider the comments received at the public hearing and other comments submitted pursuant to the instructions set forth in the public notice at *http://www.regulations.gov* (search for EPA–R03–OW–2009–0985) when it develops its Final Determination to Prohibit, Restrict, or Deny the Specification, or the Use for Specification (including Withdrawal of Specification), of an Area as a Disposal Site; Spruce No. 1 Surface Mine, Logan County, West Virginia.

Dated: April 28, 2010.

Shawn M. Garvin,

Regional Administrator, EPA Region III.

[FR Doc. 2010–10415 Filed 5–3–10; 8:45 am]

BILLING CODE 6560–50–P

FARM CREDIT ADMINISTRATION

Farm Credit Administration Board; Sunshine Act Regular Meeting

AGENCY: Farm Credit Administration.

SUMMARY: Notice is hereby given, pursuant to the Government in the Sunshine Act (5 U.S.C. 552b(e)(3)), of the regular meeting of the Farm Credit Administration Board (Board).

DATE AND TIME: The regular meeting of the Board will be held at the offices of the Farm Credit Administration in McLean, Virginia, on May 13, 2010, from 9 a.m. until such time as the Board concludes its business.

FOR FURTHER INFORMATION CONTACT: Roland E. Smith, Secretary to the Farm Credit Administration Board, (703) 883–4009, TTY (703) 883–4056.

ADDRESSES: Farm Credit Administration, 1501 Farm Credit Drive, McLean, Virginia 22102–5090.

SUPPLEMENTARY INFORMATION: Parts of this meeting of the Board will be open to the public (limited space available), and parts will be closed to the public. In order to increase the accessibility to Board meetings, persons requiring assistance should make arrangements in advance. The matters to be considered at the meeting are:

Open Session

A. *Approval of Minutes*

- April 8, 2010.

B. *New Business*

- Advanced Notice of Proposed Rulemaking—Farmer Mac Non-Program Investments and Liquidity.
- Proposed Bookletter—Evaluating Strategies and Risk for Loan Pricing and Structure.

C. *Reports*

- OMS Quarterly Report.
- OE Quarterly Report.

Closed Session *

- Update on OE Oversight Activities.

Dated: April 30, 2010.

Roland E. Smith,

Secretary, Farm Credit Administration Board.

[FR Doc. 2010–10616 Filed 4–30–10; 4:15 pm]

BILLING CODE 6705–01–P

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collections Being Reviewed by the Federal Communications Commission for Extension Under Delegated Authority, Comments Requested

April 28, 2010.

SUMMARY: The Federal Communications Commission, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collections, as required by the Paperwork Reduction Act (PRA) of 1995, 44 U.S.C. 3501 – 3520. Comments are requested concerning: (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology, and (e) ways to further reduce the information collection burden for small business concerns with fewer than 25 employees.

The FCC may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a currently valid OMB control number.

DATES: Written Paperwork Reduction Act (PRA) comments should be submitted on or before July 6, 2010. If you anticipate that you will be submitting PRA comments, but find it

* Session Closed—Exempt pursuant to 5 U.S.C. 552b(c)(8) and (9).

difficult to do so within the period of time allowed by this notice, you should advise the FCC contact listed below as soon as possible.

ADDRESSES: Direct all PRA comments to Nicholas A. Fraser, Office of Management and Budget, via fax at 202–395–5167 or via email to Nicholas_A._Fraser@omb.eop.gov and to the Federal Communications Commission via email to PRA@fcc.gov and Cathy.Williams@fcc.gov.

FOR FURTHER INFORMATION CONTACT: For additional information, contact Cathy Williams on (202) 418–2918.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0422.

Title: Section 68.5, Waivers (Application for Waivers of Hearing Aid Compatibility Requirements).

Form Number: Not applicable.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for–profit entities.

Number of Respondents and Responses: 10 respondents and 10 responses.

Estimated Time per Response: 3 hours (avg).

Frequency of Response: On occasion reporting requirement.

Obligation to Respond: Required to obtain or retain benefits. The statutory authority for this information collection is contained in 47 U.S.C. 610.

Total Annual Burden: 30 hours.

Total Annual Cost: None.

Privacy Impact Assessment: No impact(s).

Nature and Extent of Confidentiality: An assurance of confidentiality is not offered because this information collection does not require the collection of personal identifiable information (PII) from individuals.

Needs and Uses: Telephone manufacturers seeking a waiver of 47 CFR 68.4(a)(1), which requires that certain telephones be hearing aid compatible, must demonstrate that compliance with the rule is technologically infeasible or too costly. Information is used by FCC staff to determine whether to grant or dismiss the request.

OMB Control Number: 3060–0967.

Title: Section 79.2, Accessibility of Programming Providing Emergency Information.

Form Number: Not applicable.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for–profit entities; Individuals or households; Not–for–profit institutions; and State, local, or tribal Governments.

Number of Respondents and Responses: 100 respondents and 200 responses.

Estimated Time per Response: 1 to 2 hours.

Frequency of Response: On occasion reporting requirement; Third party disclosure requirement.

Obligation To Respond: Required to obtain or retain benefits. The statutory authority for this information collection is contained in Sections 151, 152(a), 154(i), 154(j), 303, 307, 309, 310 and 613 of the Communications Act of 1934, as amended.

Total Annual Burden: 210 hours.

Total Annual Cost: $22,500.

Nature and Extent of Confidentiality: Confidentiality is an issue to the extent that individuals' and households' information is contained in the OSCAR database, which is covered under the Commission's system of records notice (SORN), FCC/CGB–1, "Informal Complaints and Inquiries." The Commission believes that it provides sufficient safeguards to protect the privacy of individuals who file complaints under 47 CFR 79.2(c).

Privacy Impact Assessment: The FCC has completed a Privacy Assessment covering the information system covered by this system of records notice (SORN), which may be reviewed at: http://www.fcc.gov/omd/privacyact/Privacy_Impact_Assessment.html.

Needs and Uses: 47 CFR 79.2 is designed to ensure that persons with hearing and visual disabilities have access to the critical details of emergency information. The Commission adopted the rules to assist persons with hearing disabilities on April 14, 2000, in the Second Report and Order in MM Docket No. 95–176.The Commission modified the rules to assist persons with visual disabilities on July 21, 2000, in the Report and Order in MM Docket No. 99–339.

47 CFR 79.2(c) requires that each complaint transmitted to the Commission include the following: the name of the video programming distributor at issue; the date and time of the omission of the emergency information; and the type of emergency. The Commission then notifies the video programming distributor, which must reply within 30 days.

Federal Communications Commission.

Marlene H. Dortch,

Secretary,

Office of the Secretary,

Office of Managing Director.

[FR Doc. 2010–10407 Filed 5–3–10; 8:45 am]

BILLING CODE 6712–01–S

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection Being Submitted for Review and Approval to the Office of Management and Budget (OMB), Comments Requested

April 28, 2010.

SUMMARY: The Federal Communications Commission, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collection, as required by the Paperwork Reduction Act (PRA) of 1995, 44 U.S.C. 3501 – 3520. Comments are requested concerning: (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology; and (e) ways to further reduce the information collection burden for small business concerns with fewer than 25 employees.

The FCC may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a currently valid OMB control number.

DATES: Written Paperwork Reduction Act (PRA) comments should be submitted on or before June 3, 2010. If you anticipate that you will be submitting PRA comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the FCC contact listed below as soon as possible.

ADDRESSES: Direct all PRA comments to Nicholas A. Fraser, Office of Management and Budget, via fax at 202–395–5167 or via email to Nicholas_A._Fraser@omb.eop.gov and to the Federal Communications Commission via email to PRA@fcc.gov and Cathy.Williams@fcc.gov. To view a copy of this information collection request (ICR) submitted to OMB: (1) Go to the web page http://reginfo.gov/public/do/PRAMain, (2) look for the section of the web page called

"Currently Under Review", (3) click on the downward–pointing arrow in the "Select Agency" box below the "Currently Under Review" heading, (4) select "Federal Communications Commission" from the list of agencies presented in the "Select Agency" box, (5) click the "Submit" button to the right of the "Select Agency" box, and (6) when the list of FCC ICRs currently under review appears, look for the title of this ICR (or its OMB Control Number, if there is one) and then click on the ICR Reference Number to view detailed information about this ICR.

FOR FURTHER INFORMATION CONTACT: For additional information or copies of the information collection, contact Cathy Williams on (202) 418–2918.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–1103.

Title: Section 76.41, Franchise Application Process.

Type of Review: Extension of a currently approved collection.

Form Number: N/A.

Respondents: Business or other for profit entities; State, local or tribal government.

Number of Respondents and Responses: 6,006 respondents; 24,000 responses.

Estimated Hours per Response: 0.5 to 4 hours.

Frequency of Response: On occasion reporting requirement; Third party disclosure requirement.

Total Annual Burden: 54,000 hours.

Total Annual Cost: None.

Privacy Impact Assessment: No impact(s).

Obligation to Respond: Required to obtain or retain benefits. The statutory authority for this information collection is contained in 47 USC 151, 152, 154(i), 157nt, 201, 531, 541 and 542.

Confidentiality: No need for confidentiality required with this collection of information.

Needs and Uses: The Commission adopted on December 20, 2006 a Report and Order In the Matter of Implementation of Section 621(a)(1) of the Cable Communications Policy Act of 1984 as amended by the Cable Television Consumer Protection and Competition Act of 1992 ("R&O"), FCC 06–180, MB Docket 05–311. This R&O provides rules and guidance to implement Section 621 of the Communications Act of 1934, as amended. Section 621 of the Communications Act prohibits franchising authorities from unreasonably refusing to award competitive franchises for the provision of cable services. The Commission has found that the current franchising process constitutes an unreasonable barrier to entry for competitive entrants that impede enhanced cable competition and accelerated broadband deployment. The information collection requirements adopted as a result of FCC 06–180 are as follows:

47 CFR 76.41(b) requires a competitive franchise applicant to include the following information in writing in its franchise application, in addition to any information required by applicable state and local laws: (1) the applicant's name; (2) the names of the applicant's officers and directors; (3) the business address of the applicant; (4) the name and contact information of a designated contact for the applicant; (5) a description of the geographic area that the applicant proposes to serve; (6) the PEG channel capacity and capital support proposed by the applicant; (7) the term of the agreement proposed by the applicant; (8) whether the applicant holds an existing authorization to access the public rights–of–way in the subject franchise service area; (9) the amount of the franchise fee the applicant offers to pay; and (10) any additional information required by applicable state or local laws.

47 CFR 76.41 (d) states when a competitive franchise applicant files a franchise application with a franchising authority and the applicant has existing authority to access public rights–of–way in the geographic area that the applicant proposes to serve, the franchising authority grant or deny the application within 90 days of the date the application is received by the franchising authority. If a competitive franchise applicant does not have existing authority to access public rights–of–way in the geographic area that the applicant proposes to serve, the franchising authority must perform grant or deny the application within 180 days of the date the application is received by the franchising authority. A franchising authority and a competitive franchise applicant may agree in writing to extend the 90–day or 180–day deadline, whichever is applicable.

Federal Communications Commission.

Marlene H. Dortch,

Secretary,

Office of the Secretary,

Office of Managing Director.

[FR Doc. 2010–10409 Filed 5–3–10; 8:45 am]

BILLING CODE 6712–01–S

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collections Approved by the Office of Management and Budget (OMB)

April 28, 2010.

SUMMARY: The Federal Communications Commission (FCC) has received Office of Management and Budget (OMB) approval for the following public information collections pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). An agency may not conduct or sponsor a collection of information unless it displays a currently valid OMB control number, and no person is required to respond to a collection of information unless it displays a currently valid OMB control number. Comments concerning the accuracy of the burden estimates and any suggestions for reducing the burden should be directed to the person listed in the **FOR FURTHER INFORMATION CONTACT** section below.

FOR FURTHER INFORMATION CONTACT: For additional information, send an e-mail to *Cathy.Williams@fcc.gov* or call Cathy Williams on (202) 418–2918.

SUPPLEMENTARY INFORMATION:

OMB Control No.: 3060–0405.

OMB Approval Date: 4/19/2010.

Expiration Date: 4/30/2013.

Title: Application for Authority to Construct or Make Changes in an FM Translator or FM Booster Station, FCC Form 349.

Form No.: FCC Form 349.

Type of Review: Reinstatement without change of a previously approved collection.

Number of Respondents/Responses: 1,200 respondents; 2,400 responses.

Estimated Time per Response: 1 to 1.5 hours.

Total Annual Burden: 4,500 hours.

Total Annual Cost: $4,598,100.

Obligation to Respond: Required to obtain benefits. Statutory authority for this collection of information is contained in Sections 154(i), 303, and 308 of the Communications Act of 1934, as amended.

Nature and Extent of Confidentiality: No need for confidentiality required with this information collection.

Needs and Uses: The Commission requested and received from the Office of Management and Budget (OMB) the reinstatement of OMB control number 3060–0405.

In 2008, we merged the requirements that were previously under this OMB control number into an existing information collection, OMB control number 3060–0029, Application for TV Broadcast Station License, FCC Form

302–TV. Although the requirements were merged under the supporting statement, the forms themselves remained separate and only shared the same OMB control number. Since that time, we find that the merging of these requirements under one OMB control number is ineffective, causing delays in submissions to OMB for review, especially when the various requirements were revised by multiple and simultaneously adopted Commission actions.

FCC Form 349 is used to apply for authority to construct a new FM translator or FM booster broadcast station, or to make changes in the existing facilities of such stations.

Form 349's Newspaper Notice (third party disclosure) requirement; 47 CFR 73.3580: Form 349 also contains a third party disclosure requirement, pursuant to 47 CFR 73.3580. This rule requires stations applying for a new broadcast station, or to make major changes to an existing station, to give local public notice of this filing in a newspaper of general circulation in the community in which the station is located. This local public notice must be completed within 30 days of the tendering of the application. This notice must be published at least twice a week for two consecutive weeks in a three-week period. In addition, a copy of this notice must be placed in the station's public inspection file along with the application, pursuant to 47 CFR 73.3527. This recordkeeping information collection requirement is contained in OMB Control No. 3060–0214, which covers 47 CFR 73.3527.

OMB Control No.: 3060–0837.

OMB Approval Date: 4/19/2010.

Expiration Date: 4/30/2013.

Title: Application for DTV Broadcast Station License, FCC Form 302–DTV.

Form No.: FCC Form 302–DTV.

Type of Review: Reinstatement without change of a previously approved collection.

Number of Respondents/Responses: 300 respondents; 300 responses.

Estimated Time per Response: 2 hours.

Total Annual Burden: 600 hours.

Total Annual Cost: $133,800.

Obligation to Respond: Required to obtain or retain benefits. Statutory authority for this collection of information is contained in Sections 154(i), 303, and 308 of the Communications Act of 1934, as amended.

Nature and Extent of Confidentiality: No need for confidentiality required with this information collection.

Needs and Uses: The Commission requested and received from the Office of Management and Budget (OMB) the reinstatement of OMB control number 3060–0837. In 2008, we merged the requirements that were previously under this OMB control number into an existing information collection, OMB control number 3060–0029, Application for TV Broadcast Station License, FCC Form 302–TV. Although the requirements were merged under the supporting statement, the forms themselves remained separate and only shared the same OMB control number. Since that time, we find the merging of these requirements under one OMB control number as ineffective causing delays for submission to OMB for review especially when the various requirements were revised by multiple Commission actions.

Form 302–DTV is used by licensees and permittees of Digital TV ("DTV") broadcast stations to obtain a new or modified station license and/or to notify the Commission of certain changes in the licensed facilities of those stations. It may be used: (1) To cover an authorized construction permit (or auxiliary antenna), provided that the facilities have been constructed in compliance with the provisions and conditions specified on the construction permit; or (2) to implement modifications to existing licenses as permitted by Section 73.1675(c) or 73.1690(c) of the Commission's rules.

Federal Communications Commission.

Marlene H. Dortch,

Secretary, Office of the Secretary, Office of Managing Director.

[FR Doc. 2010–10410 Filed 5–3–10; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL DEPOSIT INSURANCE CORPORATION

FEDERAL RESERVE SYSTEM

[Docket No. OP–1369]

DEPARTMENT OF THE TREASURY

Office of the Comptroller of the Currency

[Docket ID OCC–2010–0016]

DEPARTMENT OF THE TREASURY

Office of Thrift Supervision

[Docket ID OTS–2010–0013]

Correspondent Concentration Risks

AGENCY: Federal Deposit Insurance Corporation (FDIC); Board of Governors of the Federal Reserve System (Board), Office of the Comptroller of the Currency, Treasury (OCC); and Office of Thrift Supervision, Treasury (OTS).

ACTION: Final guidance.

DATES: Effective upon publication in the **Federal Register**.

SUMMARY: The FDIC, Board, OCC, and OTS (the Agencies) are issuing final guidance on Correspondent Concentration Risks (CCR Guidance). The CCR Guidance outlines the Agencies' expectations for financial institutions to identify, monitor, and manage credit and funding concentrations to other institutions on a standalone and organization-wide basis, and to take into account exposures to the correspondents' affiliates, as part of their prudent risk management practices. Institutions also should be aware of their affiliates' exposures to correspondents as well as the correspondents' subsidiaries and affiliates. In addition, the CCR Guidance addresses the Agencies' expectations for financial institutions to perform appropriate due diligence on all credit exposures to and funding transactions with other financial institutions.

FOR FURTHER INFORMATION CONTACT: *FDIC:* Beverlea S. Gardner, Senior Examination Specialist, Division of Supervision and Consumer Protection, (202) 898–3640; or Mark G. Flanigan, Counsel, Legal Division, (202) 898–7426.

Board: Barbara J. Bouchard, Associate Director, (202) 452–3072; or Craig A. Luke, Supervisory Financial Analyst, Supervisory Guidance and Procedures, (202) 452–6409. For users of Telecommunications Device for the Deaf ("TDD") only, contact (202) 263–4869.

OCC: Kerri R. Corn, Director, Market Risk, (202) 874–4364; or Russell E. Marchand, Technical Lead Expert, Market Risk, (202) 874–4456.

OTS: Lori J. Quigley, Managing Director, Supervision, (202) 906–6265; or William J. Magrini, Senior Project Manager of Credit Policy, (202) 906–5744.

SUPPLEMENTARY INFORMATION:

I. Background

The Agencies developed the CCR Guidance to outline supervisory expectations for financial institutions[1] to address correspondent concentration risks and to perform appropriate due diligence on credit exposures to and funding transactions with correspondents as part of their prudent

[1] This guidance applies to all banks and their subsidiaries, bank holding companies and their nonbank subsidiaries, savings associations and their subsidiaries, and savings and loan holding companies and their subsidiaries.

risk management policies and procedures.[2] Credit (asset) risk is the potential that an obligation will not be paid in a timely manner or in full. Credit concentration risk arises whenever an institution advances or commits a significant volume of funds to a correspondent, as the advancing institution's assets are at risk of loss if the correspondent fails to repay.

Funding (liability) concentration risk arises when an institution depends heavily on the liquidity provided by one particular correspondent or a limited number of correspondents to meet its funding needs. Funding concentration risk can create an immediate threat to an institution's viability if the advancing correspondent suddenly reduces the institution's access to liquid funds. For example, a correspondent might abruptly limit the availability of liquid funding sources as part of a prudent program for limiting credit exposure to one institution or organization or as required by regulation when the financial condition of the institution declines rapidly. The Agencies realize some concentrations arise from the need to meet certain business needs or purposes, such as maintaining large due from balances with a correspondent to facilitate account clearing activities. However, correspondent concentrations represent a lack of diversification that management should consider when formulating strategic plans and internal risk limits.

The Agencies generally consider credit exposures arising from direct and indirect obligations in an amount equal to or greater than 25 percent of total capital[3] as concentrations. Depending on its size and characteristics, a concentration of credit for a financial institution may represent a funding exposure to the correspondent. While the Agencies have not established a funding concentration threshold, the Agencies have seen instances where funding exposures of 5 percent of an institution's total liabilities have posed an elevated risk to the recipient, particularly when aggregated with other similar sized funding concentrations. An example of how these interbank correspondent risks can become concentrated is illustrated below:

Respondent Institution (RI) has $400 million in total assets and is well capitalized with $40 million (10 percent) of total capital. RI maintains $10 million in its due from account held at Correspondent Bank (CB) and sells $20 million in unsecured overnight Federal funds to CB. These relationships collectively result in RI having an aggregate risk exposure of 75 percent of its total capital to CB. CB, which has $2 billion in total assets, $1.8 billion in total liabilities, and is well capitalized with $200 million (10 percent) total capital, has a total of 20 respondent banks (RB) with the same credit exposures to CB as RI has to CB. The 20 RBs' $600 million aggregate relationship represents one-third (33 percent) of CB's total liabilities. These relationships create significant funding risk for CB if a few of the RBs withdraw their funds in close proximity of each other.

These relationships also could threaten the viability of the 20 RBs. The loss of all or a significant portion of the RBs' due from balances and the unsecured Federal funds sold to CB could deplete a significant portion of their capital bases, resulting in multiple institution failures. The RBs' viability also could be jeopardized if CB, in turn, had sold a significant portion of the Federal funds from the RBs to another financial institution that abruptly fails. In addition, the financial institutions that rely on CB for account clearing services may find it difficult to quickly transfer processing services to another provider.

Although these interbank exposures may comply with regulations governing individual relationships, collectively they pose significant correspondent concentration risks that need to be monitored and managed consistent with the institutions' overall risk-management policies and procedures. Therefore, the Agencies published the proposed Correspondent Concentration Risks Guidance (Proposed Guidance) for comment and are now issuing the final CCR Guidance after consideration of the comments received on the Proposed Guidance.

II. Overview of Public Comments

The Agencies received 91 unique comments on the Proposed Guidance primarily from financial institutions and industry trade groups. In general, the commenters agreed with the fundamental principles underlying the CCR Guidance, but some responses characterized the CCR Guidance as excessive, unnecessarily complex, and burdensome. A number of institutions and industry trade groups also voiced concern that the credit and funding thresholds in the CCR Guidance would be applied as "hard caps" rather than as indicators of potentially heightened risk. A few commenters noted that a 5 percent funding threshold was vague and lacked sufficient discussion on relevant issues, such as the type, term and nature of some funding sources. Other commenters raised concerns the CCR Guidance would effectively amend the Board's Regulation F (Regulation F).[4]

The Agencies requested comment on all aspects of the Proposed Guidance. The Agencies also specifically requested comment on:

- The appropriateness of aggregating all credit and funding exposures that an institution or its organization has advanced or committed to another financial institution or its correspondents when calculating concentrations, and whether some types of advances or commitments should be excluded.
- The types of factors institutions should consider when assessing correspondents' financial condition.
- The need to establish internal limits as well as ranges or tolerances for each factor being monitored.
- The types of actions that should be considered for contingency planning and the timeframes for implementing those actions to ensure concentrations that meet or exceed organizations' established internal limits, ranges, or tolerances are reduced in an orderly manner.
- The operational issues the Agencies should consider when issuing the final CCR Guidance, such as the single excess balance account limitation.[5]

In response to the Agencies' specific questions, many commenters responded that the CCR Guidance needed to be flexible, providing financial institutions latitude in establishing relationships with correspondents that are appropriate with the institutions' individual risk management practices and business needs. Almost all of the commenters asked the Agencies to clarify the types of loan participations to be included when calculating credit exposures. Further, many commenters supported using Regulation F's specified factors for assessing institutions' financial condition and timeframes for contingency plans.

Several commenters also suggested that the Agencies should exclude transactions from the credit and funding concentration calculations when these

[2] Unless otherwise indicated, references to "correspondent" include the correspondent's holding company, subsidiaries, and affiliates.

[3] For purposes of this guidance, the term "total capital" means the total risk-based capital as reported for commercial banks and thrifts in the Report of Condition and the Thrift Financial Report, respectively.

[4] 12 CFR part 206.

[5] An excess balance account (EBA) is an account held at a Federal Reserve Bank that is established for purposes of maintaining the excess balances of one or more eligible institutions through an agent. Under the terms of an EBA agreement, an eligible institution is permitted to participate in one EBA at a Federal Reserve Bank.

transactions would have a nominal effect on the calculations, especially when the recordkeeping and cost of tracking complex exposures outweighed the benefit of obtaining this information. Many commenters also raised concerns that the calculation of credit and funding exposures on both a gross and net basis created significant additional burden on financial institutions. Some commenters suggested that the Agencies should provide a detailed example of how to calculate credit and funding exposures. Further, many commenters also strongly supported the use of multiple excess balance accounts.

A small number of commenters stressed that the Agencies need to apply the CCR Guidance uniformly to all financial institutions engaged in correspondent banking services to ensure that smaller scale correspondents are not placed at a competitive disadvantage to large institutions due to a perception of large institutions being "too big to fail" or having government support. In addition, a few commenters asked the Agencies to make the CCR Guidance effective 90 days after its issuance to provide institutions with time to implement any additional procedures that might be needed to ensure compliance. The following discussion summarizes how the Agencies addressed these issues in the CCR Guidance.

III. Revisions to the CCR Guidance

The Agencies made a number of changes to the Proposed Guidance to respond to comments and to provide additional clarity in the CCR Guidance.

Scope of the CCR Guidance

The Agencies revised the CCR Guidance to state that it does not supplant or amend Regulation F, but provides supervisory guidance on correspondent concentration risks. The CCR Guidance clarifies that financial institutions should consider taking actions beyond the minimum requirements established in Regulation F to identify, monitor, and manage correspondent concentration risks in a safe and sound manner, especially when there are rapid changes in market conditions or in a correspondent's financial condition. The revised CCR Guidance also specifies that the credit and funding thresholds are not "hard caps" or firm limits, but are indicators that a financial institution has concentration risk with a correspondent. In addition, the Agencies modified the credit concentration threshold calculation to reflect positions as a percentage of total capital rather than tier 1 capital. This revision provides consistency with Regulation F.

Identifying, Calculating, and Monitoring Correspondent Concentrations

The CCR Guidance clarifies that for risk management purposes, institutions should identify correspondent credit and funding concentrations to assist management in assessing how significant economic events or abrupt deterioration in a correspondent's risk profile might affect their financial condition.[6] In responses to commenters' concerns, the Agencies maintained supervisory flexibility, as the CCR Guidance clarifies that each financial institution should establish appropriate internal parameters (such as information, ratios, trends or other factors) commensurate with the nature, size, and risk characteristics of their correspondent concentrations. An institution's internal parameters should:

- Detail the information, ratios, or trends that will be reviewed for each correspondent on an ongoing basis,
- Instruct management to conduct comprehensive assessments of correspondent concentrations that consider its internal parameters, and
- Revise the frequency of correspondent concentration reviews when appropriate.

The Agencies also clarified the types of loan participations to be included when calculating credit exposures. The Agencies did not exclude transactions that may have a nominal effect from either the credit or funding concentration calculations to ensure consistency with Regulation F.

The Agencies maintained their expectation that, as part of prudent risk management, institutions should calculate their credit and funding exposures with a correspondent on both a gross and net basis. While institutions already calculate their exposures on a net basis, the benefit of management being aware of the institution's overall risk position with a correspondent on a gross basis outweighs the potential burden of conducting a secondary set of calculations to ascertain the institution's aggregate exposure. Further, the CCR Guidance includes examples on the method for calculating credit and funding exposures on a standalone and on an organization-wide basis for illustrative purposes only in response to some commenters' requests for examples.

Other Commenter Issues

The Agencies appreciate the concern of commenters who remarked that failure to apply the CCR Guidance uniformly to all financial institutions engaged in correspondent banking services could cause smaller scale correspondents to be placed at a competitive disadvantage to large institutions due to a perception of large institutions being "too big to fail" or having government support. The Agencies are working together to ensure that the CCR Guidance is applied uniformly to all financial institutions engaged in correspondent banking services. Further, since institutions already have policies and procedures for identifying, monitoring, and managing credit and funding concentrations on a net basis, the Agencies decided not to delay the effective date of the CCR Guidance. In addition, when the Board authorized Federal Reserve Banks to offer excess balance accounts, the Board stated that it would re-evaluate the continuing need for those accounts when more normal market functioning resumes. 74 FR 25,626 (May 29, 2009). The Board will consider these comments within the context of such a re-evaluation.

IV. Text of Final CCR Guidance and Illustrations in Appendix A and Appendix B

The text of the final CCR Guidance and the illustrations in Appendix A and Appendix B follows:

Correspondent Concentration Risks

A financial institution's[7] relationship with a correspondent[8] may result in credit (asset) and funding (liability) concentrations. On the asset side, a credit concentration represents a significant volume of credit exposure that a financial institution has advanced or committed to a correspondent. On the liability side, a funding concentration exists when an institution depends on one or a few correspondents for a

[6] Financial institutions should identify and monitor all direct or indirect relationships with their correspondents. Institutions should take into account exposures of their affiliates to correspondents, and how those relationships may affect the institution's exposure. While each financial institution is responsible for monitoring its own credit and funding exposures, institution holding companies should manage the organization's concentration risk on a consolidated basis.

[7] This guidance applies to all banks and their subsidiaries, bank holding companies and their nonbank subsidiaries, savings associations and their subsidiaries, and savings and loan holding companies and their subsidiaries.

[8] Unless the context indicates otherwise, references to "correspondent" include the correspondent's holding company, subsidiaries, and affiliates. A correspondent relationship results when a financial organization provides another financial organization a variety of deposit, lending, or other services.

disproportionate share of its total funding.

The Agencies[9] realize some concentrations meet certain business needs or purposes, such as a concentration arising from the need to maintain large "due from" balances to facilitate account clearing activities. However, correspondent concentrations represent a lack of diversification, which adds a dimension of risk that management should consider when formulating strategic plans and internal risk limits.

The Agencies have generally considered credit exposures greater than 25 percent of total capital[10] as concentrations. While the Agencies have not established a liability concentration threshold, the Agencies have seen instances where funding exposures as low as 5 percent of an institution's total liabilities have posed an elevated liquidity risk to the recipient institution.

These levels of credit and funding exposures are not firm limits, but indicate an institution has concentration risk with a correspondent. Such relationships warrant robust risk management practices, particularly when aggregated with other similarly sized funding concentrations, in addition to meeting the minimum regulatory requirements specified in applicable regulations. Financial institutions should identify, monitor, and manage both asset and liability correspondent concentrations and implement procedures to perform appropriate due diligence on all credit exposures to and funding transactions with correspondents, as part of their overall risk management policies and procedures.

This guidance does not supplant or amend applicable regulations such as the Board's *Limitations on Interbank Liabilities* (Regulation F).[11] This guidance clarifies that financial institutions should consider taking actions beyond the minimum requirements established in Regulation F to identify, monitor, and manage correspondent concentration risks, especially when there are rapid changes in market conditions or in a correspondent's financial condition, in order to maintain risk management practices consistent with safe and sound operations.

Identifying Correspondent Concentrations

Institutions should implement procedures for identifying correspondent concentrations. For prudent risk management purposes, these procedures should encompass the totality of the institutions' aggregate credit and funding concentrations to each correspondent on a standalone basis, as well as taking into account exposures to each correspondent organization as a whole.[12] In addition, the institution should be aware of exposures of its affiliates to the correspondent and its affiliates.

Credit Concentrations

Credit concentrations can arise from a variety of assets and activities. For example, an institution could have due from bank accounts, Federal funds sold on a principal basis, and direct or indirect loans to or investments in a correspondent. In identifying credit concentrations for risk management purposes, institutions should aggregate all exposures, including, but not limited to:

- Due from bank accounts (demand deposit accounts (DDA) and certificates of deposit (CD)),
- Federal funds sold on a principal basis,
- The over-collateralized amount on repurchase agreements,
- The under-collateralized portion of reverse repurchase agreements,
- Net current credit exposure on derivatives contracts,
- Unrealized gains on unsettled securities transactions,
- Direct or indirect loans to or for the benefit of the correspondent,[13] and
- Investments, such as trust preferred securities, subordinated debt, and stock purchases, in the correspondent.

Funding Concentrations

Depending on its size and characteristics, a concentration of credit for a financial institution may be a funding exposure for the correspondent. The primary risk of a funding concentration is that an institution will have to replace those advances on short notice. This risk may be more pronounced if the funds are credit sensitive, or if the financial condition of the party advancing the funds has deteriorated.

The percentage of liabilities or other measurements that may constitute a concentration of funding is likely to vary depending on the type and maturity of the funding, and the structure of the recipient's sources of funds. For example, a concentration in overnight unsecured funding from one source might raise different concentration issues and concerns than unsecured term funding, assuming compliance with covenants and diversification with short and long-term maturities. Similarly, concerns arising from concentrations in long-term unsecured funding typically increase as these instruments near maturity.

Calculating Credit and Funding Concentrations

When identifying credit and funding concentrations for risk management purposes, institutions should calculate both gross and net exposures to the correspondent on a standalone basis and on a correspondent organization-wide basis as part of their prudent risk management practices. Exposures are reduced to net positions to the extent that the transactions are secured by the net realizable proceeds from readily marketable collateral or are covered by valid and enforceable netting agreements. Appendix A, *Calculating Correspondent Exposures,* contains examples, which are provided for illustrative purposes only.

Monitoring Correspondent Relationships

Prudent management of correspondent concentration risks includes establishing and maintaining written policies and procedures to prevent excessive exposure to any correspondent in relation to the correspondent's financial condition. For risk management purposes, institutions' procedures and frequency for monitoring correspondent relationships may be more or less aggressive depending on the nature, size, and risk of the exposure.

In monitoring correspondent relationships for risk-management purposes, institutions should specify internal parameters relative to what information, ratios, or trends will be reviewed for each correspondent on an ongoing basis. In addition to a

[9] The Agencies consist of the Federal Deposit Insurance Corporation (FDIC), Board of Governors of the Federal Reserve System (Board), Office of the Comptroller of the Currency, Treasury (OCC), and Office of Thrift Supervision, Treasury (OTS) (collectively, the Agencies).

[10] For purposes of this guidance, the term "total capital" means the total risk-based capital as reported for commercial banks and thrifts in the Report of Condition and the Thrift Financial Report, respectively.

[11] 12 CFR part 206. All depository institutions insured by the FDIC are subject to Regulation F.

[12] Financial institutions should identify and monitor all direct or indirect relationships with their correspondents. Institutions should take into account exposures of their affiliates to correspondents, and how those relationships may affect the institution's exposure. While each financial institution is responsible for monitoring its own credit and funding exposures, institution holding companies, if any, should manage the organization's concentration risk on a consolidated basis.

[13] Exclude loan participations purchased without recourse from a correspondent, its holding company, or an affiliate.

correspondent's capital, level of problem loans, and earnings, institutions may want to monitor other factors, which could include, but are not limited to:

- Deteriorating trends in capital or asset quality.
- Reaching certain target ratios established by management, *e.g.,* aggregate of nonaccrual and past due loans and leases as a percentage of gross loans and leases.
- Increasing level of other real estate owned.
- Attaining internally specified levels of volatile funding sources such as large CDs or brokered deposits.
- Experiencing a downgrade in its credit rating, if publicly traded.
- Being placed under a public enforcement action.

For prudent risk management purposes, institutions should implement procedures that ensure ongoing, timely reviews of correspondent relationships. Institutions should use these reviews to conduct comprehensive assessments that consider their internal parameters and are commensurate with the nature, size, and risk of their exposure. Institutions should increase the frequency of their internal reviews when appropriate, as even well capitalized institutions can experience rapid deterioration in their financial condition, especially in economic downturns.

Institutions' procedures also should establish documentation requirements for the reviews conducted. In addition, the procedures should specify when relationships that meet or exceed internal criteria are to be brought to the attention of the board of directors or the appropriate management committee.

Managing Correspondent Concentrations

Institutions should establish prudent internal concentration limits, as well as ranges or tolerances for each factor being monitored for each correspondent. Institutions should develop plans for managing risk when these internal limits, ranges or tolerances are met or exceeded, either on an individual or collective basis. Contingency plans should provide a variety of actions that can be considered relative to changes in the correspondent's financial condition. However, contingency plans should not rely on temporary deposit insurance programs for mitigating concentration risk.

Prudent risk management of correspondent concentration risks should include procedures that provide for orderly reductions of correspondent concentrations that exceed internal parameters over a reasonable timeframe that is commensurate with the size, type, and volatility of the risk in the exposure. Such actions could include, but are not limited to:

- Reducing the volume of uncollateralized/uninsured funds.
- Transferring excess funds to other correspondents after conducting appropriate reviews of their financial condition.
- Requiring the correspondent to serve as agent rather than as principal for Federal funds sold.
- Establishing limits on asset and liability purchases from and investments in correspondents.
- Specifying reasonable timeframes to meet targeted reduction goals for different types of exposures.

Examiners will review correspondent relationships during examinations to ascertain whether an institution's policies and procedures appropriately identify and monitor correspondent concentrations. Examiners also will review the adequacy and reasonableness of institutions' contingency plans to manage correspondent concentrations.

Performing Appropriate Due Diligence

Financial institutions that maintain credit exposures in or provide funding to other financial institutions should have effective risk management programs for these activities. For this purpose, credit or funding exposures may include, but are not limited to, due from bank accounts, Federal funds sold as principal, direct or indirect loans (including participations and syndications), and trust preferred securities, subordinated debt, and stock purchases of the correspondent.

An institution that maintains or contemplates entering into any credit or funding transactions with another financial institution should have written investment, lending, and funding policies and procedures, including appropriate limits, that govern these activities. In addition, these procedures should ensure the institution conducts an independent analysis of credit transactions prior to committing to engage in the transactions. The terms for all such credit and funding transactions should strictly be on an arm's length basis, conform to sound investment, lending, and funding practices, and avoid potential conflicts of interest.

Appendix A

Calculating Respondent Credit Exposures on an Organization-Wide Basis

Respondent Bank's Gross Credit Exposure to a Correspondent, its Holding Company and Affiliates

50,000,000	Due from DDA with correspondent.
1,000,000	Due from DDA with correspondent's two affiliated insured depository institutions (IDIs).
1,000,000	CDs issued by correspondent bank.
500,000	CDs issued by one of correspondent's two affiliated IDIs.
51,500,000	Federal funds sold to correspondent on a principal basis.
2,500,000	Federal funds sold to correspondent's affiliated IDIs on a principal basis.
3,750,000	Reverse Repurchase agreements.
250,000	Net current credit exposure on derivatives.[1]
4,500,000	Direct and indirect loans to or for benefit of a correspondent, its holding company, or affiliates.
2,500,000	Investments in the correspondent, its holding company, or affiliates
117,500,000	Gross Credit Exposure.
100,000,000	Total Capital.
118%	Gross Credit Concentration.

Respondent Bank's Net Credit Exposure to a Correspondent, its Holding Company and Affiliates

17,850,000	Due from DDA (less checks/cash not available for withdrawal & federal deposit insurance (FDI)).[2]
500,000	Due from DDA with correspondent's two affiliated IDIs (less FDI).[2]
750,000	CDs issued by correspondent bank (less FDI).
250,000	CDs issued by one of correspondent's two affiliated IDIs (less FDI).

51,500,000	Federal funds sold on a principal basis.
2,500,000	Federal funds sold to correspondent's affiliated IDIs on a principal basis.
100,000	Under-collateralized amount on reverse repurchase agreements (less the current market value of government securities or readily marketable collateral pledged).[3]
50,000	Uncollateralized net current derivative position.[1]
4,500,000	Direct and indirect loans to or for benefit of a correspondent, its holding company, or affiliates.
2,500,000	Investments in the correspondent, its holding company, or affiliates.
80,500,000	Net Credit Exposure.
100,000,000	Total Capital.
81%	Net Credit Concentration.

Note: Respondent Bank has $1 billion in Total Assets, 10% Total Capital, and 90% Total Liabilities and Correspondent Bank has $1.5 billion in Total Assets, 10% Total Capital, and 90% Total Liabilities.

Calculating Correspondent Funding Exposures on an Organization-Wide Basis

Correspondent Bank's Gross Funding Exposure to a Respondent Bank

50,000,000	Due to DDA with respondent.
1,000,000	Correspondent's two affiliated IDIs' Due to DDA with respondent.
1,000,000	CDs sold to respondent bank.
500,000	CDs sold to respondent from one of correspondent's two affiliated IDIs.
51,500,000	Federal funds purchased from respondent on a principal basis.
2,500,000	Federal funds sold to correspondent's affiliated IDIs on a principal basis.
1,000,000	Repurchase Agreements.
107,500,000	Gross Funding Exposure.
1,350,000,000	Total Liabilities.
7.96%	Gross Funding Concentration.

Correspondent Bank's Net Funding Exposure to a Respondent, its Holding Company and Affiliates

17,850,000	Due to DDA with respondent (less checks and cash not available for withdrawal and FDI).[2]
500,000	Correspondent's two affiliated IDIs' Due to DDA with respondent (less FDI).[2]
750,000	CDs sold to correspondent (less FDI).
250,000	One of correspondent's two affiliated IDIs' CDs sold to respondent (less FDI).[2]
51,500,000	Federal funds purchased from respondent on a principal basis.
2,500,000	Federal funds sold to correspondent's affiliated IDIs on a principal basis.
150,000	Under-collateralized amount of repurchase agreements relative to the current market value of government securities or readily marketable collateral pledged.[3]
73,500,000	Net Funding Exposure.
1,350,000,000	Total Liabilities.
5.44%	Net Funding Concentration.

[1] There are 5 derivative contracts with a mark-to-market fair value position as follows: Contract 1 (100), Contract 2 +400, Contract 3 (50), Contract 4 +150, and Contract 5 (150). Collateral is 200, resulting in an uncollateralized position of 50.

[2] While temporary deposit insurance programs may provide certain transaction accounts higher levels of federal deposit insurance coverage, institutions should not rely on such programs for mitigating concentration risk.

[3] Government securities means obligations of, or obligations fully guaranteed as to principal and interest by, the U.S. government or any department, agency, bureau, board, commission, or establishment of the United States, or any corporation wholly owned, directly or indirectly, by the United States.

Appendix B

Calculating Respondent *Credit Exposures* on a *Correspondent Only* Basis

RESPONDENT BANK'S GROSS CREDIT EXPOSURE TO A CORRESPONDENT

50,000,000	Due from DDA with correspondent.
0	Due from DDA with correspondent's two affiliated insured depository institutions (IDIs).
1,000,000	CDs issued by correspondent bank.
0	CDs issued by one of correspondent's two affiliated IDIs.
51,500,000	Federal funds sold to correspondent on a principal basis.
0	Federal funds sold to correspondent's affiliated IDIs on a principal basis.
3,750,000	Reverse Repurchase agreements.

250,000	Net current credit exposure on derivatives.[1]
4,500,000	Direct and indirect loans to or for benefit of a correspondent, its holding company, or affiliates.
2,500,000	Investments in the correspondent, its holding company, or affiliates.
113,500,000	Gross Credit Exposure.
100,000,000	Total Capital.
114%	Gross Credit Concentration.

Respondent Bank's Net Credit Exposure to a Correspondent

17,850,000	Due from DDA (less checks/cash not available for withdrawal and federal deposit insurance (FDI)).[2]
0	Due from DDA with correspondent's two affiliated IDIs (less FDI).[2]
750,000	CDs issued by correspondent bank (less FDI).
0	CDs issued by one of correspondent's two affiliated IDIs (less FDI).
51,500,000	Federal funds sold on a principal basis.
0	Federal funds sold to correspondent's affiliated IDIs on a principal basis.
100,000	Under-collateralized amount on reverse repurchase agreements (less the current market value of government securities or readily marketable collateral pledged).[3]
50,000	Uncollateralized net current derivative position.[1]
4,500,000	Direct and indirect loans to or for benefit of a correspondent, its holding company, or affiliates.
2,500,000	Investments in the correspondent, its holding company, or affiliates.
77,250,000	Net Credit Exposure.
100,000,000	Total Capital.
77%	Net Credit Concentration.

Note: Respondent Bank has $1 billion in Total Assets, 10% Total Capital, and 90% Total Liabilities and Correspondent Bank has $1.5 billion in Total Assets, 10% Total Capital, and 90% Total Liabilities.

Calculating Respondent *Funding Exposures* on a *Correspondent Only* Basis

Correspondent Bank's Gross Funding Exposure to a Respondent

50,000,000	Due to DDA with respondent.
0	Correspondent's two affiliated IDIs' Due to DDA with respondent.
1,000,000	CDs sold to respondent bank.
0	CDs sold to respondent from one of correspondent's two affiliated IDIs.
51,500,000	Federal funds purchased from respondent on a principal basis.
0	Federal funds sold to correspondent's affiliated IDIs on a principal basis.
1,000,000	Repurchase agreements.
103,500,000	Gross Funding Exposure.
1,350,000,000	Total Liabilities.
7.67%	Gross Funding Concentration.

Correspondent Bank's Net Funding Exposure to a Respondent

17,850,000	Due to DDA with respondent (less checks and cash not available for withdrawal and FDI).[2]
0	Correspondent's two affiliated IDIs' Due to DDA with respondent (less FDI).[2]
750,000	CDs sold to correspondent (less FDI).
0	One of correspondent's two affiliated IDIs' CDs sold to respondent (less FDI).[2]
51,500,000	Federal funds purchased from respondent on a principal basis.
0	Federal funds sold to correspondent's affiliated IDIs on a principal basis.
100,000	Under-collateralized amount on repurchase agreements (less the current market value of government securities or readily marketable collateral pledged).[3]
70,200,000	Net Funding Exposure.
1,350,000,000	Total Liabilities.
5.20%	Net Funding Concentration.

[1] There are 5 derivative contracts with a mark-to-market fair value position as follows: Contract 1 (100), Contract 2 +400, Contract 3 (50), Contract 4 +150, and Contract 5 (150). Collateral is 200, resulting in an uncollateralized position of 50.

[2] While temporary deposit insurance programs may provide certain transaction accounts higher levels of federal deposit insurance coverage, institutions should not rely on such programs for mitigating concentration risk.

[3] Government securities means obligations of, or obligations fully guaranteed as to principal and interest by, the U.S. government or any department, agency, bureau, board, commission, or establishment of the United States, or any corporation wholly owned, directly or indirectly, by the United States.

Dated at Washington, DC, the 27th day of April 2010.

By order of the Federal Deposit Insurance Corporation.

Robert E. Feldman,

Executive Secretary.

By order of the Board of Governors of the Federal Reserve System.

Jennifer J. Johnson,

Secretary of the Board.

John C. Dugan,

Comptroller of the Currency.

Dated: April 9, 2010.

By the Office of Thrift Supervision.

John E. Bowman,

Acting Director.

[FR Doc. 2010–10382 Filed 5–3–10; 8:45 am]

BILLING CODE 6714–01–P, 6210–01–P, 4810–33–P, 6720–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Comment Request

In compliance with the requirement for opportunity for public comment on proposed data collection projects (section 3506(c)(2)(A) of Title 44, United States Code, as amended by the Paperwork Reduction Act of 1995, Pub. L. 104–13), the Health Resources and Services Administration (HRSA) publishes periodic summaries of proposed projects being developed for submission to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995. To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, e-mail *paperwork@hrsa.gov* or call the HRSA Reports Clearance Officer at (301) 443–1129.

Comments are invited on: (a) The proposed collection of information for the proper performance of the functions of the agency; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: Children's Hospital Graduate Medical Education Payment Program (CHGME PP) Annual Report (OMB No. 0915–0313)—Extension

The CHGME PP was enacted by Public Law 106–129 to provide Federal support for graduate medical education (GME) to freestanding children's hospitals, similar to Medicare GME support received by other, non-children's hospitals. The legislation indicates that eligible children's hospitals will receive payments for both direct and indirect medical education. Direct payments are designed to offset the expenses associated with operating approved graduate medical residency training programs and indirect payments are designed to compensate hospitals for expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs.

The CHGME PP program was reauthorized for a period of five years in October 2006 by Public Law 109–307. The reauthorizing legislation requires that participating children's hospitals provide information about their residency training programs in an annual report that will be an addendum to the hospitals' annual applications for funds.

Data are required to be collected on the (1) Types of training programs that the hospital provided for residents such as general pediatrics, internal medicine/pediatrics, and pediatric subspecialties including both medical subspecialties certified and non-medical subspecialties; (2) the number of training positions for residents, the number of such positions recruited to fill, and the number of positions filled; (3) the types of training that the hospital provided for residents related to the health care needs of difference populations such as children who are underserved for reasons of family income or geographic location, including rural and urban areas; (4) changes in residency training including changes in curricula, training experiences, and types of training programs, and benefits that have resulted from such changes and changes for purposed of training residents in the measurement and improvement and the quality and safety of patient care; (5) and the numbers of residents (disaggregated by specialty and subspecialty) who completed training in the academic year and care for children within the borders of the service area of the hospital or within the borders of the State in which the hospital is located.

The estimated annual burden is as follows:

Form name	Number of respondents	Responses per respondent	Total number of responses	Hours per response	Total burden hours	Wage rate ($/hr.)	Total hour cost
Screening Instrument (HRSA 100–1)	57	1	57	10.0	570.0	56.38	32,136.60
Annual Report: Hospital and Program-Level Information (HRSA 100–2 and 3)	57	1	57	74.8	4263.6	56.38	240,381.76
Total	57	.....	57	84.8	4833.6	56.38	272,518.36

E-mail comments to *paperwork@hrsa.gov* or mail the HRSA Reports Clearance Officer, Room 10–33, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: April 28, 2010.

Sahira Rafiullah,

Director, Division of Policy and Information Coordination.

[FR Doc. 2010–10462 Filed 5–3–10; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Comment Request

In compliance with the requirement for opportunity for public comment on proposed data collection projects (section 3506(c)(2)(A) of Title 44, United States Code, as amended by the Paperwork Reduction Act of 1995, Pub. L. 104–13), the Health Resources and Services Administration (HRSA) publishes periodic summaries of proposed projects being developed for submission to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995. To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, e-mail *paperwork@hrsa.gov* or call the HRSA Reports Clearance Officer at (301) 443–1129.

Comments are invited on: (a) The proposed collection of information for the proper performance of the functions of the agency; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: "Health Care and Other Facilities" Construction Program: Web-Based Status Reporting Form: (OMB No. 0915–0309)—[Extension]

The Health Resources and Services Administration's Health Care and Other Facilities (HCOF) Construction Program provides congressional directed funds to health facilities for construction-related activities and/or capital equipment purchases. Awarded facilities are required to provide HRSA with a periodic (quarterly for construction-related projects, annually for equipment only projects) update of the status of the funded project until it is completed. The monitoring period averages about 3 years, although some projects take up to 5 years to complete. The information collected from these updates is vital to program management staff to determine whether projects are progressing according to the established timeframes, meeting deadlines established in the Notice of Grant Award (NGA), drawing down funds appropriately. The data collected from the updates is also shared with the Division of Grants Management Operations (DGMO), which assists in the overall evaluation of each project's progress. A Web-based form has been developed for progress reporting for the HCOF program. This form will allow awardees the ability to directly input the required status update information in a timely, consistent, and uniform manner. The Web-based form will minimize burden to respondents and will inform respondents when there are missing data elements prior to submission.

The annual estimate of burden is as follows:

Instrument	Number of respondents	Responses per respondent	Total responses	Hours per response	Total burden hours
Construction-Related	357	4	1428	.5	714
Equipment Only	905	1	905	.5	453
Total	1262		2333		1167

E-mail comments to *paperwork@hrsa.gov* or mail the HRSA Reports Clearance Officer, Room 10–33, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: April 27, 2010.

Sahira Rafiullah,

Director, Division of Policy and Information Coordination.

[FR Doc. 2010–10456 Filed 5–3–10; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Health Resources and Services Administration (HRSA) publishes abstracts of information collection requests under review by the Office of Management and Budget (OMB), in compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). To request a copy of the clearance requests submitted to OMB for review, call the HRSA Reports Clearance Office on (301) 443–1129.

The following request has been submitted to the Office of Management and Budget for review under the Paperwork Reduction Act of 1995:

Proposed Project: Combating Autism Act Initiative Evaluation (New) .

Background: In response to the growing need for research and resources devoted to autism spectrum disorder (ASD) and other developmental disorders (DD), the U.S. Congress passed the Combating Autism Act (CAA) in 2006. This Act authorized Federal programs to combat ASD and other DD through research, screening, intervention, and education. Through the CAA, the Health Resources and Services Administration (HRSA) is tasked with increasing awareness of ASD and other DD, reducing barriers to screening and diagnosis, promoting evidence-based interventions, and training health care professionals in the use of valid and reliable screening and diagnostic tools.

Purpose: HRSA's activities under this legislation are conducted by the Maternal and Child Health Bureau

(MCHB), which is implementing the Combating Autism Act Initiative (CAAI) in response to the legislative mandate. The purpose of this evaluation is to design and implement a three-year assessment of the effectiveness of MCHB's activities in meeting the goals and objectives of the CAAI, and to provide sufficient data to inform MCHB and the Congress as to the utility of the grant programs funded under the Initiative. To address the requirements for the Report to Congress, the evaluation will focus on short-term indicators related to: (1) Increasing awareness of ASD and other DD among health care providers, other MCH professionals and the general public; (2) reducing barriers to screening and diagnosis; (3) supporting research on evidence-based interventions; (4) promoting the development of evidence-based guidelines and tested/validated intervention tools; and (5) training professionals.

Respondents: Grantees funded by HRSA under the CAAI will be the respondents for this data collection activity. The programs to be evaluated are listed below.

1. Training Programs

- Leadership Education in Neurodevelopmental Disabilities (LEND) training programs with thirty nine grantees; and
- Developmental Behavioral Pediatrics (DBP) training programs with six grantees.

2. Research Programs

- Two Autism Intervention Research Networks that focus on intervention research, guideline development, and information dissemination;
- Five R40 Maternal and Child Health (MCH) Autism Intervention Research Program grantees that support research on evidence-based practices for interventions to improve the health and well-being of children and adolescents with ASD and other DD; and
- Two R40 MCH Autism Intervention Secondary Data Analysis Study (SDAS) Program grantees that support research on evidence-based practices for interventions to improve the health and well-being of children and adolescents with ASD and other DD, utilizing exclusively the analysis of existing secondary data.

3. State Implementation Program Grants for Improving Services for Children and Youth With Autism Spectrum Disorder (ASD) and Other Developmental Disabilities (DD)

- Nine grantees will implement state autism plans and develop models for improving the system of care for children and youth with ASD and other DD.

The data gathered through this evaluation will be used to:

- Evaluate the grantees' performance in achieving the objectives of the CAAI during the three year grant period;
- Assess the short- and intermediate-term impacts of the grant programs on children and
- families affected by ASD and other DD;
- Measure the CAAI outputs and outcomes for the Report to Congress; and
- Provide foundation data for future measurement of the initiative's long-term impact.

The estimated response burden is shown in Table 1.

TABLE 1—ESTIMATED HOUR AND COST BURDEN OF THE DATA COLLECTION

Grant program	No. of respondents	Responses per respondent	Total responses	Average hours per response	Total hour burden	Wage rate	Total hour cost
LEND	39	6	234	.75	175.5	$39.36	$6907.68
DBP	6	6	36	.75	27	39.36	1062.72
State Implementation Program	9	6	54	.75	40.5	38.22	1547.91
Research Program	9	6	54	.75	40.5	39.36	1594.08
Total	63		378		283.5		11,112.39

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to the desk officer for HRSA, either by e-mail to *OIRA_submission@omb.eop.gov* or by fax to 202–395–6974. Please direct all correspondence to the "attention of the desk officer for HRSA."

Dated April 28, 2010.

Sahira Rafiullah,

Director, Division of Policy and Information Coordination.

[FR Doc. 2010–10450 Filed 5–3–10; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2009–N–0535]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; "Real Time" Surveys of Consumers' Knowledge, Perceptions, and Reported Behavior Concerning Foodborne Illness Outbreaks or Food Recalls

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Fax written comments on the collection of information by June 3, 2010.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: FDA Desk Officer, FAX: 202–395–7285, or e-mailed to *oira_submission@omb.eop.gov*. All comments should be identified with the OMB control number 0910–NEW and title "'Real Time' Surveys of Consumers' Knowledge, Perceptions, and Reported Behavior Concerning Foodborne Illness Outbreaks or Food Recalls." Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Denver Presley, Office of Information Management, Food and Drug Administration, 1350 Piccard Dr., PI50–400B, Rockville, MD 20850, 301–796–3793.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

"Real Time" Surveys of Consumers' Knowledge, Perceptions, and Reported Behavior Concerning Foodborne Illness Outbreaks or Food Recalls (OMB Control No. 0910–NEW)

I. Description

FDA communicates with consumers about food recalls directly, at its own Web site, and through various mass media channels, such as television and newspapers, during a foodborne illness outbreak or food recall. In these communications, FDA typically identifies the implicated food, the symptoms of the foodborne illness at issue, any subpopulations at elevated risk of infection or illness, and protective measures individuals can or should take. The purpose of these communications is to provide consumers with information so they can protect themselves from potential health risks associated with an outbreak or food recall. Consumers also get information about an outbreak or recall from other sources, including other Federal and State agencies, industry, consumer groups, and the mass media, which may or may not relay FDA's public announcements.

Existing data show that many consumers do not take appropriate protective actions during a foodborne illness outbreak or food recall (Refs. 1 and 2). For example, 41 percent of U.S. consumers say they have never looked for any recalled product in their home (Ref. 2). Conversely, some consumers overreact to the announcement of a foodborne illness outbreak or food recall. In response to the 2006 fresh, bagged spinach recall which followed a multistate outbreak of *E. coli* O157: H7 infections (Ref. 3), 18 percent of consumers said they stopped buying other bagged, fresh produce because of the spinach recall (Ref. 1). Existing research also suggests that many consumers may not have correct knowledge about products subject to a given recall. For example, in a survey conducted 2 months after the onset of the 2006 spinach recall, one third of respondents did not know that, in addition to bagged spinach, fresh loose spinach was part of the recall, while 22 percent believed that frozen spinach was subject to the recall (it was not) (Refs. 1 and 3). In order for FDA to protect the public health during foodborne illness outbreaks or food recalls, the Agency needs timely information collected from consumers as the events unfold to ensure that consumers understand the extent of the incident and that they are taking appropriate actions. Results from the information collection will indicate to FDA whether the Agency should adjust its communications to help consumers react appropriately.

FDA conducts research and educational and public information programs relating to food safety under its broad statutory authority, set forth in section 903(b)(2) of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 393 (b)(2), to protect the public health by ensuring that foods are "safe, wholesome, sanitary, and properly labeled," and in section 903(d)(2)(C) to conduct research relating to foods, drugs, cosmetics, and devices in carrying out the act.

FDA plans to survey U.S. consumers using a Web-based panel of U.S. households to collect information on consumers' "real time" knowledge, perceptions, beliefs, and self-reported behaviors for up to five foodborne illness outbreaks or food recalls a year. Moreover, because the information environment during certain foodborne illness outbreaks or food recalls evolves as new information emerges, the Agency plans to field up to three waves of independent surveys per event (i.e., outbreak or recall). The surveys will query consumers on topics such as: (1) The products that are subject to the outbreak or recall, (2) the implicated pathogens, (3) the food vehicle of the outbreak or recall, and (4) how consumers can protect themselves. FDA plans to conduct the surveys soon after the onset of an outbreak or recall and whenever the Agency suspects that: (1) Messages are not reaching consumers, and/or (2) consumers do not understand the messages, and/or (3) consumers are not taking appropriate actions in response to the messaging. Collecting information quickly during a foodborne illness outbreak or food recall is important because erroneous perceptions or misinterpreted information about an outbreak or recall can impede consumer adoption of recommended protective behaviors. Criteria for selecting a particular foodborne illness outbreak or food recall for a survey will include a qualitative assessment of the salience of some or all of the following: The geographical dispersion of the event, the number of illnesses or deaths associated with it, the relative familiarity of the food product, the complexity of consumer precaution instructions, and the presence of national media focus.

The Agency will use the survey results to help adjust its communication strategies and messages for foodborne illness outbreaks or food recalls, when needed. The results will not be used to develop population estimates.

In the **Federal Register** of November 18, 2009 (74 FR 59558), FDA published a 60-day notice requesting public comment on the proposed collection of information. No comments were received.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN[1]

Activity	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
Screener	30,000	1	30,000	.0055	165
Pre-test	40	1	40	.167	7
Survey	15,000	1	15,000	.167	2,505
Total					2,677

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Approximately 30,000 respondents of a Web-based consumer panel will be screened (3 waves (independent surveys)) for each of 5 incidents; 2,000 respondents per wave). We estimate that it will take a respondent 20 seconds (0.0055 hours) to complete the screening questions, for a total of 165 hours. We will conduct a pre-test of the first survey with 40 respondents; we estimate that it will take a respondent 10 minutes (0.167 hours) to complete the pre-test, for a total of 7 hours. Fifteen thousand (15,000) respondents will complete the surveys (3 waves (independent surveys)) for each of 5 incidents; 1,000 respondents per wave). We estimate that it will take a respondent 10 minutes (0.167 hours) to complete the survey, for a total of 2,505 hours. Thus, the total estimated burden is 2,677 hours. FDA's burden estimate is based on prior experience with consumer surveys that are similar to these.

II. References

1. Cuite, C., S. Condry, M. Nucci, et al., "Public Response to the Contaminated Spinach Recall of 2006," Publication no. RR–0107–013, New Brunswick, NJ: Rutgers, the State University of New Jersey, Food Policy Institute, 2007.
2. Hallman, W., C. Cuite, N. Hooker, "Consumer Responses to Food Recalls: 2009 National Survey Report," Publication no. RR–0109–018, New Brunswick, NJ: Rutgers, the State University of New Jersey, Food Policy Institute, 2009.
3. Acheson, D., "Outbreak of *Escherichia coli* 0157 Infections Associated With Fresh Spinach—United States, August-September 2006," 2007 (*http://first.fda.gov/cafdas/documents/Acheson_Spinach_Outbreak_2006_FDA_pres.ppt*).

Dated: April 28, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–10357 Filed 5–3–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2010–N–0184]

Agency Information Collection Activities; Proposed Collection; Comment Request; Experimental Study of Patient Information Prototypes

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act of 1995 (the PRA), Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, and to allow 60 days for public comment in response to the notice. This notice solicits comments for research entitled "Experimental Study of Patient Information Prototypes." This study is designed to determine based on different prototype testing whether consumers are able to comprehend serious warnings, directions for use, drug indications and uses, contraindications, and side effects in the material that is presented.

DATES: Submit written or electronic comments on the collection of information by July 6, 2010.

ADDRESSES: Submit electronic comments on the collection of information to *http://www.regulations.gov*. Submit written comments on the collection of information to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. All comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Elizabeth Berbakos, Office of Management Programs (HFA–250), Food and Drug Administration, 1350 Piccard Dr., PI50–400B, Rockville, MD 20850 301–796–3792, *Elizabeth.Berbakos@fda.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

Under the PRA (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. "Collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2) (A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing notice of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on these topics: (1) whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Experimental Study of Patient Information Prototypes—New

In order to make informed decisions about health care and to use their medications correctly, consumers need easy access to up-to-date and accurate information about the risks, benefits and safe use of their prescription drugs. Consumers currently receive multiple pieces of paper with their prescription drugs from the pharmacy, containing information that is developed and distributed through various sources. Written prescription drug information is provided through a voluntary effort (Consumer Medication Information)[1] as well as through FDA mandated use of Medication Guides[2] and Patient Package Inserts (PPI).[3] Patients describe a wide range of experiences and varying degrees of satisfaction with information currently provided at the time medicines are received at the pharmacy. In some cases, the written documents are difficult to read and understand, duplicative and overlapping, incomplete or contradictory. FDA has held multiple public meetings to solicit feedback on providing balanced, comprehensive and up-to-date prescription drug information to consumers.

Since 1968, FDA regulations have required that PPIs written specifically for patients be distributed when certain prescription drugs or classes of prescription drugs are dispensed. PPIs are required for estrogens and oral contraceptives, are considered part of the product labeling, and are to be dispensed to the patient with the product. In the 1970s, FDA began evaluating the general usefulness of patient labeling for prescription drugs resulting in a series of regulatory steps to help ensure the availability of useful written consumer information. Other

[1] Public Law 104–180, August 6, 1996, Title VI. Effective Medication Guides.

[2] 21 CFR part 208.

[3] 21 CFR 310.501 and 310.515.

PPIs are submitted to FDA voluntarily by manufacturers and approved by FDA, but their distribution is not mandated by regulation. In the **Federal Register** of July 6, 1979 (44 FR 40016), FDA proposed regulations that would have required written patient information for all prescription drugs. In the **Federal Register** of September 12, 1980 (45 FR 60754), FDA finalized those regulations. In the **Federal Register** of September 7, 1982 (47 FR 39147), the regulations were revoked based, in part, on assurances that the effort could be handled more efficiently within the private sector.

In the **Federal Register** of August 24, 1995 (60 FR 44182), FDA proposed the Prescription Drug Product Labeling: Medication Guide Requirements, designed to set specific distribution and quality goals and timeframes for distributing written information to patients. In the **Federal Register** of December 1, 1998 (63 FR 66378 at 66396), the agency published a final rule that established a program under which Medication Guides would be required for a small number of drugs considered to pose a serious and significant public health concern (21 CFR 208.20).

Evidence suggests that both the content (e.g., organization) and format (e.g., white space) of a document will impact the comprehension of patient information. Research on reading behavior and document simplification suggests that the use of less complex terminology presented in shorter sentences with a more organized, or *chunked*, structure should improve consumer processing for at least three reasons. First, it should decrease the *cognitive load* engendered by the current physician-directed format. Second, a more structured and organized patient information document should present a less imposing processing demand, increasing consumers' willingness and self-perceived ability to read and understand the presented material. Research with the format of over-the-counter (OTC) drug labels,[4] the nutrition facts label,[5] and other information formats[6] demonstrates that information presented with section headings, graphics (such as bullets), and other design elements is more easily read than information presented in paragraph format. Consumers are more likely to engage in behavior they believe they can successfully complete.[7] Third, a patient information document that provides readers with clearer "signals" regarding the most important information should help readers prioritize the importance of the presented information. This should increase the probability that the set of information identified as important is subjected to more complete mental processing, thereby increasing the communication of that information.[8]

As part of FDA's efforts to improve the patient information received with prescription drugs, a Risk Communications Advisory Committee meeting was held on February 26 and 27, 2009. At this meeting, committee members discussed issues such as the ones described previously in this document and listened to stakeholder problems regarding the design and distribution of patient information. Following the advisory committee meeting, the working group created four prototypes to aid discussion at a public workshop to be held later in the year.

This public workshop was held on September 24 and 25, 2009. During the workshop stakeholders from industry, consumer advocacy, and academia converged to discuss desirable features for a single-document patient leaflet, if that were to be developed, consumer tested and distributed. Participants were divided into six groups to address the pros and cons of the four prototypes with the goal of deciding which features participants appreciated and did not appreciate. Additional information on the September 24 and 25, 2009, public workshop, is available at *http://www.fda.gov/Drugs/NewsEvents/ucm168106.htm*.

Given the information obtained from workshop participants, the working group refined several prototypes and designed a study to investigate the usefulness of three possible patient information formats from a user perspective. The results of this study will inform FDA as to the usefulness and parameters of various format options for the patient information documents.

II. Description of the Project

This project is designed to test different ways of presenting information about prescription drugs to patients who have obtained a prescription. The information used will be based on a fictitious medication for the treatment of rheumatoid arthritis, ankylosing spondylitis, and plaque psoriasis. Data collection will occur via computer at training and testing facilities with orientation and debriefing conducted by interviewers. Participants will include adults who have been diagnosed with one of the conditions the fictitious drug treats. Participants will be prescreened to obtain a reasonable representation of health literacy, including those who score at the lower end of the scale. Questionnaire measures will include open- and closed-ended questions. Extensive pretesting of materials and stimuli will be conducted to refine the experimental stimuli and dependent measures and to ensure the stimuli meet minimum communication requirements and are delivering expected messages.

Proposed Study Design and Protocol

The study is experimental and will have two independent variables in a 3 x 2 design. The independent variables are Format (3 levels: Drug Facts, Minimal Column, and Column Plus) and Order (2 levels: Warning first and Indication first).

[4] Aikin, K.J., "Consumer Comprehension and Preference for Variations in the Proposed Over-The-Counter Drug Labeling Format, Final Report" (1998); Vigilante, W.J., M.S. Wogalter, "The Preferred Order of Over-the-Counter (OTC) Pharmaceutical Label Components," *Drug Information Journal*, 31, 973–988, 1997.

[5] Levy, A.S., S.B. Fein, R.E. Schucker. "More Effective Nutrition Label Formats Are Not Necessarily More Preferred." *Journal of the American Dietetic Association*, 92(10), 1230–1234, 1992.

[6] Lorch, R., E. Lorch, "Effects of Organizational Signals on Text-Processing Strategies," *Journal of Educational Psychology*, 87(4), 537–544, 1995; Lorch, R., E. Lorch, "Effects of Organizational Signals on Free Recall of Expository Text," *Journal of Educational Psychology*, 88(1), 38–48, 1996; Lorch, R., E. Lorch, W. Inman, "Effects of Signaling Topic Structure on Text Recall," *Journal of Educational Psychology*, 85(2), 281–290, 1993.

[7] Wood, R., A. Bandura, "Impact of Conceptions of Ability on Self-regulatory Mechanisms and Complex Decision Making." *Journal of Personality and Social Psychology*, 56(3), 407–415, 1989.

[8] Lorch, R., E. Lorch, "Effects of Organizational Signals on Text-processing Strategies, " *Journal of Educational Psychology*, 87(4), 537–544, 1995; Lorch, R., E. Lorch, "Effects of Organizational Signals on Free Recall of Expository Text," *Journal of Educational Psychology*, 88(1), 38–48, 1996; Lorch, R., E. Lorch, W. Inman, "Effects of Signaling Topic Structure on Text Recall," *Journal of Educational Psychology*, 85(2), 281–290, 1993.

FORMAT

Order	Drug Facts	Minimal Column	Column Plus
Warning first			
Indication first			

The Order manipulation will vary the primacy of the boxed warning information versus the paragraph about the uses to the drug. In terms of Format, the Drug Facts format will follow the conventions of the existing OTC labeling. The Minimal Column condition will contain information in two columns with only basic information in the sections regarding information patients should tell their doctors. The Column Plus condition will also present information in two columns, but will include additional contextual information in the sections about what information patients should report to their doctors.

Participants with relevant medical conditions will be randomly assigned to one of the six experimental conditions and each participant will see only one version of the patient information. Participants will be prescreened to represent a range of health literacy levels, including a portion with low literacy. Thus, all participants in the study will have been diagnosed with rheumatoid arthritis, ankylosing spondylitis, or plaque psoriasis and at least 30 percent of the sample will fall in the lower range of literacy. Because the average reading level in the United States is estimated to be 8th grade[9] and it is recommended that consumer medication information be written at a 5th grade reading level,[10] the low literate cohort will consist of consumers who have 5th to 8th grade reading skills. Education level is not a reliable substitute for literacy testing. At screening, the participants will be assessed for literacy level using a validated instrument.

An additional small study will be conducted via the Internet to determine whether electronic prototype presentation alters the processing of the information in any way. Two-hundred individuals with the same characteristics of the original sample (e.g., medical condition and literacy levels) will be recruited over the Internet and will complete the same questionnaire as original participants.

FDA is undertaking this study because it does not yet have sufficient evidence-based research relating to patient needs, or whether those needs are being effectively met. Research related to the functionality and effectiveness of written patient information consistently identifies the importance of performance-based testing as well as content based testing, which enables the evaluation of materials in order to assure their utility and identify issues in content format, or design. Development of new prescription drug patient materials must be based on consumer testing that focuses on utility to the patient and comprehension of material in the broadest audience possible. FDA has developed three prototypes in order to user test prescription drug information with consumers in order to achieve this goal. For further information, contact Elizabeth Berbakos (see **FOR FURTHER INFORMATION CONTACT**).

The burden table reflects up to three pretests of 180 individuals each, 900 participants in the main study, and 200 participants in the followup study involving electronic administration.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN [1]

21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
	540	1	540	20/60	178
	900	1	900	25/60	369
	200	1	200	25/60	82
Total					629

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Dated: April 28, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–10359 Filed 5–3–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2010–N–0190]

Agency Information Collection Activities; Proposed Collection; Comment Request; Infant Formula Requirements

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act of 1995 (the PRA), Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of

[9] Cotunga N., C.E. Vickery, K.M. Carpenter-Haefele, "Evaluation of Literacy Level of Patient Education Pages in Health-Related Journals," *Journal of Community Health*, 30(3), 213–219, 2005.

[10] Andrus, M.R., M.T. Roth, "Health Literacy: A Review," *Pharmacotherapy*, 22(3), 282–302, 2002.

information, and to allow 60 days for public comment in response to the notice. This notice solicits comments on information collection regarding the manufacture of infant formula, including infant formula labeling, quality control procedures, notification requirements, and recordkeeping.

DATES: Submit written or electronic comments on the collection of information by July 6, 2010.

ADDRESSES: Submit electronic comments on the collection of information to *http://www.regulations.gov*. Submit written comments on the collection of information to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. All comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Denver Presley, Jr., Office of Information Management, Food and Drug Administration, 1350 Piccard Dr., PI50–400B, Rockville, MD 20850, 301–796–3793.

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. "Collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing notice of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on these topics: (1) Whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Infant Formula Requirements—21 CFR Parts 106 and 107 (OMB Control Number 0910–0256)—Extension

Statutory requirements for infant formula under the Federal Food, Drug, and Cosmetic Act (the act) are intended to protect the health of infants and include a number of reporting and recordkeeping requirements. Among other things, section 412 of the act (21 U.S.C. 350a) requires manufacturers of infant formula to establish and adhere to quality control procedures, notify FDA when a batch of infant formula that has left the manufacturers' control may be adulterated or misbranded, and keep records of distribution. FDA has issued regulations to implement the act's requirements for infant formula in parts 106 and 107 (21 CFR parts 106 and 107). FDA also regulates the labeling of infant formula under the authority of section 403 of the act (21 U.S.C. 343). Under the labeling regulations for infant formula in part 107, the label of an infant formula must include nutrient information and directions for use. The purpose of these labeling requirements is to ensure that consumers have the information they need to prepare and use infant formula appropriately. In a notice of proposed rulemaking published in the **Federal Register** of July 9, 1996 (61 FR 36154), FDA proposed changes in the infant formula regulations, including some of those listed in tables 1, 2, and 3 of this document. The document included revised burden estimates for the proposed changes and solicited public comment. In the interim, however, FDA is seeking an extension of OMB approval for the current regulations so that it can continue to collect information while the proposal is pending.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN[1]

Federal Food, Drug, and Cosmetic Act or 21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
Section 412(d) of the act	5	13	65	10	650
21 CFR 106.120(b)	1	1	1	4	4
21 CFR 107.50(b)(3) and (b)(4)	3	2	6	4	24
21 CFR 107.50(e)(2)	1	1	1	4	4
Total					682

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

TABLE 2.—ESTIMATED ANNUAL RECORDKEEPING BURDEN[1]

21 CFR Section	No. of Recordkeepers	Annual Frequency per Recordkeeping	Total Annual Records	Hours per Record	Total Hours
106.100	5	10	50	400	20,000
107.50 (c)(3)	3	10	30	300	9,000

TABLE 2.—ESTIMATED ANNUAL RECORDKEEPING BURDEN[1]—Continued

21 CFR Section	No. of Recordkeepers	Annual Frequency per Recordkeeping	Total Annual Records	Hours per Record	Total Hours
Total					29,000

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

TABLE 3.—THIRD PARTY DISCLOSURE REQUIREMENTS[1]

21 CFR Section	No. of Respondents	Annual Frequency of Disclosure	Total Annual Disclosures	Hours per Disclosure	Total Hours
21 CFR 107.10(a) and 107.20	5	13	65	8	520

[1] There are no capital costs or operating and maintenance costs associated with this collection of information

In compiling these estimates, FDA consulted its records of the number of infant formula submissions received in the past. All infant formula submissions to FDA may be provided in electronic format. The hours per response reporting estimates are based on FDA's experience with similar programs and information received from industry.

FDA estimates that it will receive 13 reports from 5 manufacturers annually under section 412(d) of the act, for a total annual response of 65 reports. Each report is estimated to take 10 hours per response for a total of 650 hours. FDA also estimates that it will receive one notification under § 106.120(b). The notification is expected to take 4 hours per response, for a total of 4 hours.

For exempt infant formula, FDA estimates that it will receive two reports from three manufacturers annually under § 107.50(b)(3) and (b)(4), for a total annual response of six reports. Each report is estimated to take 4 hours per response for a total of 24 hours. FDA also estimates that it will receive one notification under § 107.50(e)(2). The notification is expected to take 4 hours per response, for a total of 4 hours.

FDA estimates that 5 firms will expend approximately 20,000 hours per year to fully satisfy the record keeping requirements in § 106.100. It is estimated that 3 firms will expend approximately 9,000 hours per year to fully satisfy the record keeping requirements in § 107.50(c)(3).

FDA estimates that compliance with the labeling requirements of §§ 107.10(a) and 107.20 will require 520 hours annually by 5 manufacturers.

Dated: April 28, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–10360 Filed 5–3–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2009–N–0507]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; Requirements for Submission of Labeling for Human Prescription Drugs and Biologics in Electronic Format

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Fax written comments on the collection of information by June 3, 2010.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: FDA Desk Officer, FAX: 202–395–7285, or e-mailed to *oira_submission@omb.eop.gov*. All comments should be identified with the OMB control number 0910–0530. Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Elizabeth Berbakos, Office of Information Management, Food and Drug Administration, 1350 Piccard Dr., PI50–400B, Rockville, MD 20850, *Elizabeth.Berbakos@fda.hhs.gov*, 301–796–3792.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Requirements for Submission of Labeling for Human Prescription Drugs and Biologics in Electronic Format—OMB Control Number 0910–0530—Extension

FDA is requesting that OMB extend approval under the Paperwork Reduction Act (44 USC 3501–3520) for the information collection resulting from the requirement that the content of labeling for prescription drug products be submitted to FDA electronically in a form that FDA can process, review, and archive. This requirement was set forth in the final rule entitled "Requirements for Submission of Labeling for Human Prescription Drugs and Biologics in Electronic Format" (December 11, 2003; 68 FR 69009), which amended FDA regulations governing the format in which certain labeling is required to be submitted for FDA review with new drug applications (NDAs) (21 CFR 314.50(l)(1)(i)), including supplemental NDAs, abbreviated new drug applications (ANDAs) (21 CFR 314.94(d)(1)(ii)), including supplemental ANDAs, and annual reports (21 CFR 314.81(b)(2)(iii)(b)) (the final rule also applied to certain Biologics License Applications, but the information collection for these requirements is not part of this OMB approval request).

This OMB approval request is only for the burden associated with the electronic submission of the content of labeling. The burden for submitting labeling as part of NDAs, ANDAs, supplemental NDAs and ANDAs, and annual reports, has been approved by OMB under Control Number 0910–0001.

When we last requested that OMB extend approval for this information collection (see the **Federal Register** of March 29, 2006 (71 FR 15752)), we received several comments. Generally,

the comments said that, unlike FDA's December 11, 2003, final rule, the agency has now identified Extensible Markup Language (XML) as the required file format for Structured Product Label documents (SPL), and that the burden hours and costs that were calculated in the final rule were based on the submission of the content of labeling in PDF (portable document format). The comments said that the burden estimate in the March 29, 2006, **Federal Register** notice does not take into account the amount of time required to obtain, install, and update the program required to create the electronic files in the new format, and that SPL is a relatively new format requiring an initial investment in software, training, and process change that cannot simply be converted from the Word or PDF version of labeling. The comments said that the process for creating the SPL labeling includes significant effort in mapping, coding, recreation of the file, and quality control.

In the December 13, 2006, **Federal Register** (71 FR 74924), we said that we will respond to the comments as soon as we have gathered sufficient information to address the costs specified in the comments, and that the public will have an opportunity to comment on the response at that time. The burden hours and costs associated with making these submissions using the SPL standard are discussed here.

We estimate that it should take applicants approximately 1.25 hours to convert the content of labeling from Word or PDF to SPL format. The main task involved in this conversion is copying the content from one document (Word or PDF) to another (SPL). Over the past few years, several enhancements have been made to SPL authoring software which significantly reduces the burden and time needed to generate well-formed SPL documents. SPL authors may now copy a paragraph from a Word or PDF document and paste the text into the appropriate section of an SPL document. In those cases where an SPL author needs to create a table, the table text may be copied from the Word or PDF document and pasted into each table cell in the SPL document, eliminating the need to retype any information. Enhancements have also been made to the software for conversion vendors. Conversion software vendors have designed tools which will import the Word version of the content of labeling and, within minutes, automatically generate the SPL document (a few formatting edits may have to be made).

Based on the number of content of labeling submissions received during 2006, 2007, and 2008, we estimate that approximately 5,000 content of labeling submissions are made annually with original NDAs, ANDAs, supplemental NDAs and ANDAs, and annual reports by approximately 450 applicants. Therefore, the total annual hours to convert the content of labeling from Word or PDF to SPL format would be approximately 6,250 hours.

Concerning costs, we continue to conclude that there are no capital costs or operating and maintenance costs associated with this collection of information. In May 2009, FDA issued a guidance for industry entitled "Providing Regulatory Submissions in Electronic Format—Drug Establishment Registration and Listing." The guidance describes how to electronically create and submit SPL files using defined code sets and codes for establishment registration and drug listing information, including labeling. The information collection resulting from this guidance, discussed in the **Federal Register** of January 8, 2009 (74 FR 816), has been approved by OMB under Control Number 0910–0045. As discussed in the January 8, 2009, **Federal Register** notice, to create an SPL file and submit it to FDA, a registrant would need the following tools: A computer, appropriate software, access to the Internet, knowledge of terminology and standards, and access to FDA's electronic submission gateway (ESG). Registrants (and most individuals) have computers and Internet access available for their use. If a business does not have an available computer or access to the Internet, free use of computers and the Internet are usually available at public facilities, e.g., a community library. In addition, there should be no additional costs associated with obtaining the appropriate software. In 2008, FDA collaborated with GlobalSubmit to make available free SPL authoring software that SPL authors may utilize to create new SPL documents or edit previous versions. (Information on obtaining this software is explained in section IV.A of the guidance "Providing Regulatory Submissions in Electronic Format—Drug Establishment Registration and Listing.") In addition to the software, FDA also provides technical assistance and other resources, code sets and codes, and data standards regarding SPL files.

After the SPL file is created, the registrant would upload the file through the ESG, as explained in the January 8, 2009, **Federal Register** notice. A digital certificate is needed to use the ESG. The digital certificate binds together the owner's name and a pair of electronic keys (a public key and a private key) that can be used to encrypt and sign documents. A fee of up to $20.00 is charged for the digital certificate and the registrant may need to renew the certificate not less than annually. We are not calculating this fee as a cost for this extension because all applicants who submit content of labeling are also subject to the drug establishment registration and listing requirements and would have already acquired the digital certificate as a result of the May 2009 guidance on drug establishment registration and listing.

In the **Federal Register** of November 6, 2009 (74 FR 57491), FDA published a 60-day notice requesting public comment on the proposed collection of information. No comments were received.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN[1]

Content of labeling submissions in NDAs, ANDAs, supplemental NDAs and ANDAs, and annual reports	Number of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
	450	11.11	5,000	1.25	6,250

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Dated: April 28, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–10361 Filed 5–3–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2010–N–0199]

Agency Information Collection Activities; Proposed Collection; Comment Request; Administrative Procedures for the Clinical Laboratory Improvement Amendments of 1988 Categorization

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act of 1995 (the PRA), Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information including each proposed extension of an existing collection of information, and to allow 60 days for public comment in response to the notice. This notice solicits comments on administrative procedures for the Clinical Laboratory Improvement Amendments of 1988 (CLIA) categorization.

DATES: Submit written or electronic comments on the collection of information by July 6, 2010.

ADDRESSES: Submit electronic comments on the collection of information to *http://www.regulations.gov*. Submit written comments on the collection of information to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. All comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Daniel Gittleson, Office of Information Management, Food and Drug Administration, 1350 Piccard Dr., PI50–400B, Rockville, MD 20850, 301–796–5156, *Daniel.Gittleson@fda.hhs.gov*.

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. "Collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information including each proposed extension an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing notice of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on these topics: (1) Whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Administrative Procedures for CLIA Categorization—42 CFR 493.17 (OMB Control Number 0910–0607–Extension)

A guidance document entitled "Guidance for Administrative Procedures for CLIA Categorization" was released on May 7, 2008. The document describes procedures FDA will use to assign the complexity category to a device. Typically, FDA assigns complexity categorizations to devices at the time of clearance or approval of the device. In this way, no additional burden is incurred by the manufacturer since the labeling (including operating instructions) is included in the 510(k) or PMA. In some cases, however, a manufacturer may request CLIA categorization even if FDA is not simultaneously reviewing a 510(k) or PMA. One example is when a manufacturer requests that FDA assign CLIA categorization to a previously cleared device that has changed names since the original CLIA categorization. Another example is when a device is exempt from premarket review. In such cases, the guidance recommends that manufacturers provide FDA with a copy of the package insert for the device and a cover letter indicating why the manufacturer is requesting a categorization (e.g. name change, exempt from 510(k) review). The guidance recommends that in the correspondence to FDA the manufacturer should identify the product code and classification as well as reference to the original 510(k) when this is available.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN[1]

CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Responses	Total Hours	Total Operating & Maintenance Costs
42 CFR 493.17	60	15	900	1 hr	900 hr	$46,800

[1] There are no capital costs associated with this collection of information.

The number of respondents is approximately 60. On average, each respondent will request categorizations (independent of a 510(k) or PMA) 15 times per year. The cost, not including personnel, is estimated at $52 per hour (52 x 900) totaling $46,800. This includes the cost of copying and mailing copies of package inserts and a cover letter, which includes a statement of the reason for the request and reference to the original 510(k) numbers, including regulation numbers and product codes. The burden hours are based on FDA familiarity with the types of documentation typically included in a sponsor's categorization requests, and costs for basic office supplies (e.g. paper). The costs have been updated based on the Bureau of Labor Statistics estimates of inflation.

Dated: April 28, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–10358 Filed 5–3–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Diabetes and Digestive and Kidney Diseases; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel; Bariatric Surgery and Kidney Function.

Date: June 8, 2010.

Time: 2 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Two Democracy Plaza, 6707 Democracy Boulevard, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: D.G. Patel, PhD, Scientific Review Officer, Review Branch, DEA, NIDDK, National Institutes of Health, Room 756, 6707 Democracy Boulevard, Bethesda, MD 20892–5452, (301) 594–7682, *pateldg@niddk.nih.gov.*

Name of Committee: National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel; Collaborative Interdisciplinary.

Date: June 11, 2010.

Time: 1 p.m. to 3 p.m.

Agenda: To review and evaluate grant applications and/or proposals.

Place: National Institutes of Health, Two Democracy Plaza, 6707 Democracy Boulevard, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: D.G. Patel, PhD, Scientific Review Officer, Review Branch, DEA, NIDDK, National Institutes of Health, Room 756, 6707 Democracy Boulevard, Bethesda, MD 20892–5452, (301) 594–7682, *pateldg@niddk.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.847, Diabetes, Endocrinology and Metabolic Research; 93.848, Digestive Diseases and Nutrition Research; 93.849, Kidney Diseases, Urology and Hematology Research, National Institutes of Health, HHS)

Dated: April 27, 2010.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 2010–10268 Filed 5–3–10; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2010–N–0001]

Drug Safety and Risk Management Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Drug Safety and Risk Management Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the agency on FDA's regulatory issues.

Date and Time: The meeting will be held on September 14, 2010, from 8 a.m. to 5 p.m.

Location: The Marriott Inn and Conference Center, University of Maryland and University College (UMUC), The Ballrooms, 3501 University Blvd. East, Adelphi, MD. The conference center telephone number is 301–985–7300.

Contact Person: Elaine Ferguson, e-mail: *elaine.ferguson@fda.hhs.gov* (*contact information through June 8, 2010*, Elaine Ferguson c/o Melanie Whelan, Food and Drug Administration, 10903 New Hampshire Ave., WO51–6100, Silver Spring, MD 20993–0002, telephone: 301–827–7001, FAX: 301–847–8742), (*contact information beginning June 9, 2010*: Elaine Ferguson c/o Christine Shipe, Food and Drug Administration, 10903 New Hampshire Ave., WO31–2419, Silver Spring, MD 20993–0002, telephone: 301–0796–9001, FAX: 301–847–8532), or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area), code 3014512535. Please call the Information Line for up-to-date information on this meeting. A notice in the **Federal Register** about last minute modifications that impact a previously announced advisory committee meeting cannot always be published quickly enough to provide timely notice. Therefore, you should always check the agency's Web site and call the appropriate advisory committee hot line/phone line to learn about possible modifications before coming to the meeting.

Agenda: On September 14, 2010, the committee will discuss the abuse potential of the drug dextromethorphan and the public health benefits and risks of dextromethorphan use as a cough suppressant in prescription and nonprescription drug products. The Department of Health and Human Services received a request from the Drug Enforcement Administration for a scientific and medical evaluation and scheduling recommendation for dextromethorphan in response to the increased incidence of abuse, especially among adolescents.

FDA intends to make background material available to the public no later than 2 business days before the meeting. If FDA is unable to post the background material on its Web site prior to the meeting, the background material will be made publicly available at the location of the advisory committee meeting, and the background material will be posted on FDA's Web site after the meeting. Background material is available at *http://www.fda.gov/AdvisoryCommittees/Calendar/default.htm*. Scroll down to the appropriate advisory committee link.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person on or before August 30, 2010. Oral presentations from the public will be scheduled between approximately 1 p.m. to 2 p.m. Those desiring to make formal oral presentations should notify the contact person and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation on or before August 20, 2010. Time allotted for each presentation may be limited. If the number of registrants requesting to speak is greater than can be reasonably accommodated during the scheduled open public hearing session, FDA may conduct a lottery to determine the speakers for the scheduled open public hearing session. The contact person will notify interested persons regarding their request to speak by August 23, 2010.

Persons attending FDA's advisory committee meetings are advised that the

agency is not responsible for providing access to electrical outlets.

FDA welcomes the attendance of the public at its advisory committee meetings and will make every effort to accommodate persons with physical disabilities or special needs. If you require special accommodations due to a disability, please contact Elaine Ferguson at least 7 days in advance of the meeting.

FDA is committed to the orderly conduct of its advisory committee meetings. Please visit our Web site at *http://www.fda.gov/AdvisoryCommittees/AboutAdvisoryCommittees/ucm111462.htm* for procedures on public conduct during advisory committee meetings.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: April 27, 2010.

Jill Hartzler Warner,

Acting Associate Commissioner for Special Medical Programs.

[FR Doc. 2010–10384 Filed 5–3–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Aging; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Aging Special Emphasis Panel; Osteoarthritis.

Date: May 26, 2010.

Time: 12 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institute on Aging, Gateway Building, 7201 Wisconsin Avenue, Suite 2C212, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Alicja L. Markowska, PhD, DSC, Scientific Review Officer, Scientific Review Branch, National Institute on Aging, 7201 Wisconsin Avenue, Suite 2C212, Bethesda, MD 20892, 301–496–9666, *markowsa@nia.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.866, Aging Research, National Institutes of Health, HHS)

Dated: April 30, 2010.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 2010–10448 Filed 5–3–10; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

[Docket No. DHS–2010–0019]

National Protection and Programs Directorate; Sector-Specific Agency Executive Management Office Meeting Registration

AGENCY: National Protection and Programs Directorate, DHS.

ACTION: 60-Day Notice and request for comments; New Information Collection Request: 1670–NEW

SUMMARY: The Department of Homeland Security, National Protection and Programs Directorate (NPPD, Office of Infrastructure Protection (IP), Sector-Specific Agency Executive Management Office (SSA EMO), has submitted the following Information Collection Request (ICR) to the Office of Management and Budget (OMB) for review and clearance in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. Chapter 35).

DATES: Comments are encouraged and will be accepted until July 6, 2010. This process is conducted in accordance with 5 CFR 1320.1.

ADDRESSES: Written comments and questions about this Information Collection Request should be forwarded to NPPD/IP/SSA EMO, Attn.: Esther Langer, *Esther.Langer@dhs.gov.* Written comments should reach the contact person listed no later than July 6, 2010. Comments must be identified by DHS–2010–0019 and may be submitted by *one* of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.*
- *E-mail: Esther.Langer@dhs.gov.* Include the docket number in the subject line of the message.

Instructions: All submissions received must include the words "Department of Homeland Security" and the docket number for this action. Comments received will be posted without alteration at *http://www.regulations.gov*, including any personal information provided.

SUPPLEMENTARY INFORMATION: On behalf of DHS, IP manages the Department's program to protect the Nation's 18 Critical Infrastructure and Key Resource (CIKR) Sectors by implementing the National Infrastructure Protection Plan (NIPP). Pursuant to Homeland Security Presidential Directive—7 (HSPD–7) (December 2003), each sector is assigned an SSA to oversee Federal interaction with the array of sector security partners, both public and private. An SSA is responsible for leading a unified public-private sector effort to develop, coordinate, and implement a comprehensive physical, human, and cybersecurity strategy for its assigned sector. The SSA EMO, within IP, executes the SSA responsibilities for the six CIKR sectors assigned to IP: Chemical; Commercial Facilities; Critical Manufacturing; Dams; Emergency Services; and Nuclear Reactors, Materials, and Waste (Nuclear).

The mission of the SSA EMO is to enhance the resiliency of the Nation by leading the unified public-private sector effort to ensure its assigned CIKR are prepared, more secure, and safer from terrorist attacks, natural disasters, and other incidents. To achieve this mission, SSA EMO leverages the resources and knowledge of its CIKR sectors to develop and apply security initiatives that result in significant, measurable benefits to the Nation.

Each SSA EMO branch builds sustainable partnerships with its public and private sector stakeholders to enable more effective sector coordination, information sharing, and program development and implementation. These partnerships are sustained through the Sector Partnership Model, described in the 2009 NIPP pages 18–20.

Information sharing is a key component of the NIPP Partnership Model, and DHS-sponsored conferences are one mechanism for information sharing. To facilitate conference planning and organization, the SSA EMO plans to establish an event registration tool for use by all of its branches. The information collection is voluntary and will be used by the SSAs within the SSA EMO. The six SSAs within SSA EMO will use this information to register public and private sector stakeholders for meetings hosted by the SSA. The SSA EMO will use the information collected to reserve space at a meeting for the registrant; contact the registrant with a reminder about the event; develop meeting materials for attendees; determine key topics of interest; and efficiently generate attendee and speaker nametags.

Additionally, it will allow the SSA EMO to have a better understanding of the organizations participating in the CIKR protection partnership events. By understanding who is participating, the SSA can identify portions of a sector that are underrepresented, and the SSA could then target that underrepresented sector elements through outreach and awareness initiatives.

OMB is particularly interested in comments which:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

3. Enhance the quality, utility, and clarity of the information to be collected; and

4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses.

Analysis

Agency: Department of Homeland Security, National Protection and Programs Directorate.

Title: Sector-Specific Agency Executive Management Officer Online Meeting Registration Tool.

Form: N/A.

OMB Number: 1670–NEW.

Frequency: On occasion.

Affected Public: Private Sector, State, local, or tribal government.

Number of Respondents: 1,900.

Estimated Time per Respondent: 3 minutes.

Total Burden Hours: 95 annual burden hours.

Total Burden Cost (capital/startup): $0.

Total Burden Cost (operating/maintaining): $3,800.00.

Signed: March 26, 2010.

Thomas Chase Garwood, III,

Chief Information Officer, National Protection and Programs Directorate, Department of Homeland Security.

[FR Doc. 2010–10435 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–9P–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Citizenship and Immigration Services

Agency Information Collection Activities: Form I–643; Extension of an Existing Information Collection; Comment Request

ACTION: 60-Day Notice of Information Collection Under Review; Form I–643, Health and Human Services Statistical Data for Refugee/Asylee Adjusting Status; OMB Control No. 1615–0070.

The Department of Homeland Security, U.S. Citizenship and Immigration Services (USCIS) has submitted the following information collection request for review and clearance in accordance with the Paperwork Reduction Act of 1995. The information collection is published to obtain comments from the public and affected agencies. Comments are encouraged and will be accepted for sixty days until July 6, 2010.

During this 60-day period, USCIS will be evaluating whether to revise the Form I–643. Should USCIS decide to revise Form I–643 we will advise the public when we publish the 30-day notice in the **Federal Register** in accordance with the Paperwork Reduction Act. The public will then have 30 days to comment on any revisions to the Form I–643.

Written comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the Department of Homeland Security (DHS), USCIS, Chief, Regulatory Products Division, 111 Massachusetts Avenue NW., Washington, DC 20529–2210. Comments may also be submitted to DHS via facsimile to 202–272–8352 or via e-mail at *rfs.regs@dhs.gov.* When submitting comments by e-mail, please make sure to add OMB Control No. 1615–0070 in the subject box. Written comments and suggestions from the public and affected agencies concerning the collection of information should address one or more of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Overview of This Information Collection

(1) *Type of Information Collection:* Extension of an existing information collection.

(2) *Title of the Form/Collection:* Health and Human Services Statistical Data for Refugee/Asylee Adjusting Status.

(3) *Agency form number, if any, and the applicable component of the Department of Homeland Security sponsoring the collection:* Form I–643; U.S. Citizenship and Immigration Services (USCIS).

(4) *Affected public who will be asked or required to respond, as well as a brief abstract: Primary:* Individuals or households. Refugees and Asylees, Cuban/Haitian Entrants under section 202 of Public Law 99–603, and Amerasians under Public Law 97–359, must use this form when applying for adjustment of status, with the U.S. Citizenship and Immigration Services (USCIS). USCIS will provide the data collected on this form to the Department of Health and Human Services (HHS).

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* 195,000 responses at 55 minutes (.916) per response.

(6) *An estimate of the total public burden (in hours) associated with the collection:* 178,620 annual burden hours.

If you need a copy of the information collection instrument, please visit the Web site at: *http://www.regulations.gov/*.

We may also be contacted at: USCIS, Regulatory Products Division, 111 Massachusetts Avenue, NW., Washington, DC 20529–2210, Telephone number 202–272–8377.

Dated: April 29, 2010.

Sunday Aigbe,

Chief, Regulatory Products Division, U.S. Citizenship and Immigration Services, Department of Homeland Security.

[FR Doc. 2010–10423 Filed 5–3–10; 8:45 am]

BILLING CODE 9111–97–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Citizenship and Immigration Services

Agency Information Collection Activities: Form G–639; Extension of an Existing Information Collection; Comment Request

ACTION: 60-Day Notice of Information Collection Under Review; Form G–639, Freedom of Information/Privacy Act Request; OMB Control No. 1615–0102.

The Department of Homeland Security, U.S. Citizenship and Immigration Services (USCIS) has submitted the following information collection request for review and clearance in accordance with the Paperwork Reduction Act of 1995. The information collection is published to obtain comments from the public and affected agencies. Comments are encouraged and will be accepted for sixty days until July 6, 2010.

During this 60 day period, USCIS will be evaluating whether to revise the Form G–639. Should USCIS decide to revise Form G–639 we will advise the public when we publish the 30-day notice in the **Federal Register** in accordance with the Paperwork Reduction Act. The public will then have 30 days to comment on any revisions to the Form G–639.

Written comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the Department of Homeland Security (DHS), USCIS, Chief, Regulatory Products Division, 111 Massachusetts Avenue NW., Washington, DC 20529–2210. Comments may also be submitted to DHS via facsimile to 202–272–8352 or via e-mail at *rfs.regs@dhs.gov.* When submitting comments by e-mail, please make sure to add OMB Control No. 1615–0102 in the subject box. Written comments and suggestions from the public and affected agencies concerning the collection of information should address one or more of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Overview of this Information Collection:

(1) *Type of Information Collection:* Extension of an existing information collection.

(2) *Title of the Form/Collection:* Freedom of Information/Privacy Act Request.

(3) *Agency form number, if any, and the applicable component of the Department of Homeland Security sponsoring the collection:* Form G–639; U.S. Citizenship and Immigration Services (USCIS).

(4) *Affected public who will be asked or required to respond, as well as a brief abstract:* Primary: Individuals or households. Form G–639 is provided as a convenient means for persons to provide data necessary for identification of a particular record desired under FOIA/PA.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* 100,000 responses at 15 minutes (.25) per response.

(6) *An estimate of the total public burden (in hours) associated with the collection:* 25,000 annual burden hours.

If you need a copy of the information collection instrument, please visit the Web site at: *http://www.regulations.gov/.*

We may also be contacted at: USCIS, Regulatory Products Division, 111 Massachusetts Avenue, NW., Washington, DC 20529–2210, Telephone number 202–272–8377.

Dated: April 29, 2010.

Sunday Aigbe,

Chief, Regulatory Products Division, U.S. Citizenship and Immigration Services, Department of Homeland Security.

[FR Doc. 2010–10412 Filed 5–3–10; 8:45 am]

BILLING CODE 9111–97–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2010–0014]

Assistance to Firefighters Grant Program

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice of guidance.

SUMMARY: This Notice provides guidelines that describe the application process for grants and the criteria for awarding grants in the 2010 Assistance to Firefighters Grant program year, as well as an explanation for any differences from the guidelines recommended by representatives of the Nation's fire service leadership during the annual Criteria Development meeting. The program makes grants directly to fire departments and nonaffiliated emergency medical services organizations for the purpose of enhancing first-responders' abilities to protect the health and safety of the public as well as that of first-responder personnel facing fire and fire-related hazards. In addition, the authorizing statute requires that a minimum of 5 percent of appropriated funds be expended for fire prevention and safety grants, which are also made directly to local fire departments and to local, regional, State or national entities recognized for their expertise in the field of fire prevention and firefighter safety research and development.

Authority: 15 U.S.C. 2229, 2229a.

FOR FURTHER INFORMATION CONTACT: Tom Harrington, Acting Director, Assistance to Firefighters Program Office, U.S. Department of Homeland Security/FEMA, Assistance to Firefighters Grant Program, TechWorld Building—5th Floor South Tower, 800 K Street, NW., Washington, DC, 20472–3620.

SUPPLEMENTARY INFORMATION: The purpose of the Assistance to Firefighters Grant (AFG) Program is to provide grants directly to fire departments and nonaffiliated Emergency Medical Services (EMS) organizations to enhance their ability to protect the health and safety of the public, as well as that of first-responder personnel, with respect to fire and fire-related hazards.

Appropriations

For fiscal year 2010, Congress appropriated $390,000,000 to carry out the activities of the AFG Program. The Department of Homeland Security (DHS) is authorized to use up to

$19,500,000 for administration of the AFG program (5 percent of the appropriated amount); however, the Executive Branch has limited the funds available for administration to 4 percent of the appropriation ($15,600,000). In addition, DHS must set aside no less than $19,500,000 of the funds (5 percent of the appropriation) for the Fire Prevention and Safety Grants (FP&S). However, for fiscal year 2010, DHS will award $35,000,000 for FP&S. Under FP&S, DHS may make grants to, or enter into contracts or cooperative agreements with, national, State, local or community organizations or agencies, including fire departments, for the purpose of carrying out fire prevention grants and firefighter safety research and development grants.

The $339,400,000 will be used for competitive grants to fire departments and nonaffiliated EMS organizations for equipment, training and first responders' safety. Within the portion of funding available for these competitive grants, DHS must assure that no less than 3.5 percent of the appropriation, or $13,650,000, is awarded for EMS equipment and training. However, awards to nonaffiliated EMS organizations are limited to no more than 2 percent of the appropriation or $7,800,000. Therefore, at least the balance of the requisite awards for EMS equipment and training must go to fire departments.

Background

DHS awards the grants on a competitive basis to the applicants that best address the AFG program's priorities and provide the most compelling justification. Applicants whose requests best address the program's priorities will be reviewed by a panel composed of fire service personnel. The panel will review the narrative and evaluate the application in four different areas: (1) The clarity of the proposed project description, (2) the organization's financial need, (3) the benefit to be derived from the proposed project relative to the cost, and (4) the extent to which the grant would enhance the applicant's daily operations and/or how the grant would positively impact the applicant's ability to protect life and property.

The AFG program for 2010 generally mirrors previous years' AFG programs. The program will again segregate the FP&S program from the AFG. DHS will have a separate application period devoted solely to FP&S tentatively scheduled to occur in the Fall of 2010. All applications will be accessible from *https://portal.fema.gov.*

Congress has enacted statutory limits to the amount of funding that a grantee may receive from the AFG program in any fiscal year (15 U.S.C. 2229(b)(10)). These limits are based on population served. A grantee that serves a jurisdiction with 500,000 people or less may not receive grant funding in excess of $1,000,000 in any fiscal year. A grantee that serves a jurisdiction with more than 500,000 but not more than 1,000,000 people may not receive grants in excess of $1,750,000 in any fiscal year. A grantee that serves a jurisdiction with more than 1,000,000 people may not receive grants in excess of $2,750,000 in any fiscal year. DHS may waive these established limits to any grantee serving a jurisdiction of 1,000,000 people or less if DHS determines that extraordinary need for assistance warrants the waiver. No grantee, under any circumstance, may receive "more than the lesser of $2,750,000 or one half of one percent of the funds appropriated under this section for a single fiscal year." (15 U.S.C. 2229(b)(10)(B)).

Grantees must share in the costs of the projects funded under this grant program (15 U.S.C. 2229(b)(6)). Fire departments and nonaffiliated EMS organizations that serve populations of less than 20,000 must match the Federal grant funds with an amount of non-Federal funds equal to 5 percent of the total project cost. Fire departments and nonaffiliated EMS organizations serving areas with a population between 20,000 and 50,000, inclusive, must match the Federal grant funds with an amount of non-Federal funds equal to 10 percent of the total project cost. Fire departments and nonaffiliated EMS organizations that serve populations of over 50,000 must match the Federal grant funds with an amount of non-Federal funds equal to 20 percent of the total project costs. All non-Federal funds must be in cash, *i.e.,* in-kind contributions are not eligible. The only waiver granted for this requirement will be for applicants located in Insular Areas as provided for in 48 U.S.C. 1469a.

The authorizing statute imposes additional requirements on ensuring a distribution of grant funds among career, volunteer, and combination (volunteer and career personnel) fire departments, and among urban, suburban and rural communities. More specifically with respect to department types, DHS must ensure that all-volunteer or combination fire departments receive a portion of the total grant funding that is not less than the proportion of the United States population that those departments protect (15 U.S.C. 2229(b)(11)). There is no corresponding minimum for career departments. Therefore, subject to the other statutory limitations on DHS ability to award funds, DHS will ensure that, for the 2009 program year, no less than 34 percent of the funding available for grants will be awarded to combination departments, and no less than 21 percent will be awarded to all-volunteer departments. These figures were obtained from the National Fire Protection Association report entitled *U.S. Department Profile Through 2008,* issued October 2009. If, and only if, other statutory limitations inhibit DHS ability to ensure this distribution of funding, DHS will ensure that the aggregate combined total percent of funding provided to both combination and volunteer departments is no less than 55 percent.

DHS generally makes funding decisions using rank order resulting from the panel evaluation. However, DHS may deviate from rank order and make funding decisions based on the type of department (career, combination, or volunteer) and/or the size and character of the community the applicant serves (urban, suburban, or rural) to the extent it is required to satisfy statutory provisions.

Fire Prevention and Safety Grant Program

In addition to the grants available to fire departments in fiscal year 2010 through the competitive grant program, DHS will set aside $35,000,000 of the funds available under the AFG program to make grants to, or enter into contracts or cooperative agreements with, national, State, local or community organizations or agencies, including fire departments, for the purpose of carrying out fire prevention and injury prevention projects, and for research and development grants that address firefighter safety.

In accordance with the statutory requirement to fund fire prevention activities, support to Fire Prevention and Safety Grant activities concentrates on organizations that focus on the prevention of injuries to children from fire. In addition to this priority, DHS places an emphasis on funding innovative projects that focus on protecting children under 14, seniors over 65, and firefighters. Because the victims of burns experience both short- and long-term physical and psychological effects, DHS places a priority on programs that focus on reducing the immediate and long-range effects of fire and burn injuries.

DHS will issue an announcement regarding pertinent details of the Fire Prevention and Safety Grant portion of

this program prior to the application period.

Application Process

Prior to the start of the application period, DHS will conduct applicant workshops across the country to inform potential applicants about the AFG program for 2010. In addition, DHS will provide applicants an online Web-based tutorial and other information to use in preparing a quality application. Applicants are advised to access the application electronically at *https://portal.fema.gov.* New applicants will have to register and establish a username and password for secure access to their application. Applicants that have applied to any AFG funding opportunities in the past will have to use their established username and passwords. In completing the application, applicants will provide relevant information on the applicant's characteristics, call volume, and existing capacities. Applicants will answer questions regarding their assistance request that reflects the funding priorities (iterated below). In addition, each applicant will complete a narrative addressing statutory competitive factors: financial need, benefits/costs, and improvement to the organization's daily operations. During the application period, applicants will be encouraged to contact DHS via a toll free number or online help desk with any questions. The electronic application process will permit the applicant to enter data and save the application for further use, and will not permit the submission of incomplete applications. Except for the narrative, the application uses a "point-and-click" selection process, or requires the entry of information (*e.g.,* name and address, call volume numbers, *etc.*).

The application period for the AFG grants will open on or about March 29, 2010, and close on or about April 30, 2010. Interested applicants are encouraged to read the Program Guidance for more details. During the approaching application season, the program office expects to receive between 20,000 and 25,000 applications.

Application Review Process

DHS evaluates all applications in the preliminary screening process to determine which applications best address the program's announced funding priorities. This preliminary screening evaluates and scores the applicants' answers to the activity specific questions. Applications containing multiple activities will be given prorated scores based on the amount of funding requested for each activity. The best applications as determined in the preliminary step are deemed to be in the "competitive range."

Once the competitive range is established DHS will review the list of applicants that are not included in the competitive range to determine if any of those applicants are responsible for protecting DHS-specified critical infrastructure or key resources. If it is determined that an applicant has responsibility for protecting one or more critical infrastructure or key resources but is not included in the competitive range, DHS will determine whether it is appropriate to place that application before the peer review panel due to the importance of its mission to protect these critical resources. Adding additional applications to peer review will not affect the number of applications that would have been reviewed by the peer reviewers or otherwise undermine the process used to determine the competitive range. Peer review panelists will not be aware of which applications may have been added to the universe of applications at panel as a result of this initiative. All applications will be peer reviewed against the criteria described in this document.

All applications in the competitive range are subject to a second level review by a technical evaluation panel made up of individuals from the fire service including, but not limited to, firefighters, fire marshals, and fire training instructors. The panelists will assess the application's merits with respect to the clarity and detail provided about the project, the applicant's financial need, the project's purported benefit to be derived from the cost, and the effectiveness of the project to enhance the health and safety of the public and fire service personnel.

Using the evaluation criteria included here, the panelists will independently score each application before them and then discuss the merits and shortcomings of the application in an effort to reconcile any major discrepancies. A consensus on the score is not required. The panelists will assign a score to each of the elements detailed above. DHS will then consider the highest scoring applications resulting from this second level of review for awards. Applications that involve interoperable communications projects will undergo a separate review by the State Administrative Agency to assure that the communications project is consistent with the Statewide Communications Interoperability Plan (SCIP). If the State determines that the project is inconsistent with the State SCIP, the project will not be funded.

After the completion of the reviews, DHS will select a sufficient number of awardees from this application period to obligate all of the available grant funding. DHS will announce the awards over several months and will notify non-successful applicants as soon as feasible. DHS will not make awards in any specified order, *i.e.,* not by State, program, nor any other characteristic.

Modification to facility projects (including renovations associated with equipment installations) are subject to all applicable environmental and historic preservation requirements. Applicants seeking assistance to modify their facilities or to install equipment requiring renovations may undergo additional screening. Specifically, DHS is required to ascertain to what degree the proposed modifications and renovations might affect an applicant's facility relative to the National Environmental Policy Act, National Historic Preservation Act of 1966, National Flood Insurance Program regulations, and any other applicable laws and Executive Orders. No project that involves a modification to facility can proceed—except for project planning—prior to formal written approval from DHS. If your award includes a modification to a facility, you are responsible for contacting the Program Office so you can be given direction on how to proceed. Noncompliance with these provisions may jeopardize an applicant's award and subsequent funding.

Criteria Development Process

Each year, DHS conducts a criteria development meeting to develop the program's priorities for the coming year. DHS brings together a panel of fire service professionals representing the leadership of the nine major fire service organizations:

- Congressional Fire Service Institute (CFSI),
- International Association of Arson Investigators (IAAI),
- International Association of Fire Chiefs (IAFC),
- International Association of Fire Fighters (IAFF),
- International Society of Fire Service Instructors (ISFSI),
- National Association of State Fire Marshals (NASFM),
- National Fire Protection Association (NFPA),
- National Volunteer Fire Council (NVFC), and
- North American Fire Training Directors (NAFTD).

The criteria development panel is charged with making recommendations to the grants program office regarding the creation and/or modification of program priorities as well as development of criteria and definitions as necessary.

The governing statute requires that DHS publish each year in the **Federal Register** the guidelines that describe the application process and the criteria for grant awards. DHS must also include an explanation of any differences between the published guidelines and the recommendations made by the criteria development panel. The guidelines and the statement regarding the differences between the guidelines and the criteria development panel recommendations must be published in the **Federal Register** prior to making any grants under the program. (15 U.S.C. 2229(b)(14)).

The Fiscal year 2010 criteria development panel meeting occurred July 20–24, 2009. During the criteria development panel meeting, the group discussed the 2010 program year under the assumption that the changes that had been proposed in draft reauthorization language would be implemented in 2010. But, the reauthorization has not been enacted, so the 2010 AFG funding opportunity will replicate the 2009 program with the following exception:

- In 2009, we gave a higher consideration for "source capture" vehicle exhaust extraction systems over either vehicle mounted systems or ambient air systems. For 2010, any system that handles vehicle exhaust will receive the same consideration. The criteria development group did not recommend this equality; they recommended that ambient air systems receive a lower priority.

Review Considerations

Fire Department Priorities

Specific rating criteria for each of the eligible programs and activities are discussed below. The funding priorities described in this Notice have been recommended by a panel of representatives from the Nation's fire service leadership and have been accepted by DHS for the purposes of implementing the AFG. These rating criteria provide an understanding of the grant program's priorities and the expected cost-effectiveness of any proposed project(s). The activities listed below are in no particular order of priority. Within each activity, DHS will consider the population served by the applicant with higher populations afforded a higher consideration than applicants with lower populations. DHS will further explain program priorities in program guidance to be published separately.

(1) *Operations and Firefighter Safety Program.*

(i) *Training Activities.* In implementing the fire service's recommendations, DHS has determined that the most benefit will be derived from instructor-led, hands-on training that leads to a nationally sanctioned or State certification. Training requests that include Web-based home study or distance learning or the purchase of training materials, equipment, or props are a lower priority. Therefore, applications focused on national or State certification training, including train-the-trainer initiatives, will receive a higher competitive rating. Training that (1) involves instructors, (2) requires the students to demonstrate their grasp of knowledge of the training material via testing, and (3) is integral to a certification will receive a high competitive rating. Instructor-led training that does not lead to a certification, and any self-taught courses, are of lower benefit, and therefore will not receive a high priority.

DHS will give higher priority, within the limitations imposed by statute, to training proposals which improve coordination capabilities across disciplines (Fire, EMS, and Police), and jurisdictions (local, State, and Federal). Training related to coordinated incident response (*i.e.,* bomb threat or Improvised Explosive Device response), tactical emergency communications procedures, or similar types of interdisciplinary, inter-jurisdictional training will receive the highest competitive rating.

Due to the inherent differences between urban, suburban, and rural firefighting characteristics, DHS has accepted the recommendations of the criteria development panel for different priorities in the training activities of departments that service these different types of communities. CBRNE awareness training has a high benefit, however, and will receive the highest consideration regardless of the type of community served and regardless of the absence of any national standard.

For fire departments serving rural communities, DHS has determined that funding basic, operational-level firefighting, operational-level rescue, driver training, and first-responder EMS, Emergency Medical Technician-Basic (EMT–B), and Emergency Medical Technician-Intermediate (EMT–I) training (*i.e.,* training in basic firefighting, EMS, and rescue duties) has greater benefit than funding officer training, safety officer training, or incident-command training. In rural communities, after basic training, there is a greater cost-benefit ratio for officer training than for other specialized types of training such as mass casualty, hazardous materials (HAZMAT), advanced rescue and Emergency Medical Technician-Paramedic (EMT–P), or inspector training.

Conversely, for departments that are serving urban or suburban communities, DHS has determined that, due to the number of firefighters and the relatively high percentage of the population protected, any training requests will receive a high priority rating regardless of the level of training requested. As such, when considering applications for training from departments serving urban and suburban communities, DHS will give higher priority to training proposals which improve coordination capabilities across first-responder disciplines (fire, EMS, and law enforcement), and jurisdictions (local, State, and Federal). Training related to coordinated incident response (*e.g.,* weapons of mass destruction awareness and incident operations, chemical or biological operations, or bomb threats), tactical emergency communications procedures, or similar types of interdisciplinary, inter-jurisdictional training will receive the highest competitive rating.

(ii) *Wellness and Fitness Activities.* In implementing the criteria panel's recommendations, DHS has determined that fire departments must offer periodic health screenings, entry physical examinations, and an immunization program to have an effective wellness/fitness program. Accordingly, applicants for grants in this category must currently offer or plan to offer with grant funds *all three benefits* to receive funding for any other initiatives in this activity. After the provision of the three requisite benefits, the criteria development panel recommended providing the highest consideration to candidate physical agility evaluations. DHS will give a lower priority to formal fitness and injury prevention programs. DHS will give the lowest priority to stress management, injury/illness rehabilitation, and employee assistance.

DHS has determined the greatest relative benefit will be realized by supporting new wellness and fitness programs. Therefore, applicants for new wellness/fitness programs will receive higher competitive ratings when compared with applicants whose wellness/fitness programs lack one or more of the three top priority items cited above, and applicants that already

employ the requisite three activities of a wellness/fitness program. Finally, because participation is critical to achieving any benefits from a wellness or fitness program, applications that mandate participation and are open to all personnel or provide incentives for participation will receive higher competitive ratings.

(iii) *Equipment Acquisition.* As stated in the AFG statute, DHS administers this grant program to protect the health and safety of firefighters and the public from fire and fire-related hazards. As such, equipment that has a direct effect on the health and safety of either firefighters or the public will receive a higher competitive rating than equipment that has no such effect. Equipment that promotes interoperability with neighboring jurisdictions (especially for communications equipment interoperable with a regional shared system) will receive additional consideration in the cost-benefit assessment if the application makes it into the competitive range.

The criteria development panel concluded that this grant program will achieve the greatest benefits if the grant program provides funds to purchase firefighting equipment (including rescue, EMS, and/or CBRNE preparedness) that the applicant has not owned prior to the grant, or to replace used or obsolete equipment.

According to the panel, a department takes on a "new mission" when it expands its services into areas not previously offered, such as a fire department seeking funding to provide emergency medical services for the first time. A "new risk" presents itself when a department must address risks that have materialized in the department's area of responsibility, *e.g.*, the construction of a plant that uses significant levels of certain chemicals could constitute a "new risk." An organization taking on "new risks" should be afforded higher consideration than departments taking on a "new mission." New missions receive a lower priority due to the potential that an applicant will not be able to financially support and sustain the new mission beyond the period of the grant.

Departments responding to high call volumes will be afforded a higher competitive rating than departments responding to lower call volumes. In other words, those departments that are required to respond more frequently will receive a higher competitive rating then those that respond less frequently.

The purchase of equipment that brings the department into statutory or regulatory compliance will provide the highest benefit and therefore will receive the highest consideration. The purchase of equipment that brings a department into voluntary compliance with national standards will also receive a high competitive rating, but not as high as for the purchase of equipment that brings a department into statutory compliance. The purchase of equipment that does not affect statutory compliance or voluntary compliance with a national standard will receive a lower competitive rating.

(iv) *Personal Protective Equipment (PPE) Acquisition.* The primary purpose of AFG is to protect the health and safety of the public and of firefighters. To achieve this goal and maximize the benefit to the firefighting community, the FY 2010 AFG will give higher priority to funding applicants needing to purchase PPE for the first time (*i.e.,* for new firefighters) than departments replacing old and obsolete or substandard equipment (*e.g.,* equipment not meeting current NFPA and Occupational Safety and Health Administration standards). In applications that request funding to replace equipment, the age and condition of the PPE that is to be replaced will be the primary consideration with the replacement of older or worn-out equipment receiving higher consideration than requests for replacement of newer equipment.

For departments replacing equipment such as "turnout gear," the condition of the equipment to be replaced will be factored into the score with a higher priority given to replacing equipment that is damaged, torn, or contaminated over equipment that is worn but usable. For departments replacing old or damaged equipment, departments with the oldest equipment will receive the highest priority, and departments with the newest equipment will receive a low priority.

Finally, DHS takes into account the number of fire response calls that a department makes in a year with the higher priority going to departments with higher call volumes, while applications from departments with low call volumes are afforded lower competitive ratings.

(v) *Modifications to Fire Stations and Facilities.* DHS believes that more benefit is derived from modifying fire stations than by modifying fire-training facilities or other fire-related facilities. The highest priority has been assigned to initiatives that have an immediate effect on life and safety of firefighters. Initiatives such as sprinkler systems, and fire/smoke alarm systems will be afforded the highest priority. The next priority has been assigned to generators, exhaust evacuation systems, vehicle mounted exhaust filtration systems and ambient air systems. The frequency of use for any structure has a bearing on the benefits derived from grant funds. As such, DHS will afford facilities occupied 24-hours-per-day/7-days-a-week the highest consideration when contrasted with facilities used on a part-time or irregular basis. Fire stations with sleeping quarters will receive higher consideration than stations where there are no sleeping quarters for firefighters. Facilities open for broad usage and have a high occupancy capacity receive a higher competitive rating than facilities that have limited use and/or low occupancy capacity. The frequency and duration of a facility's occupancy have a direct relationship to the benefits realized from funding in this activity.

(2) *Firefighting Vehicle Acquisition Program.* Due to the inherent differences between urban, suburban, and rural firefighting conventions, DHS has developed different priorities in the vehicle program for departments that service different types of communities. The following chart delineates the priorities in this program area for each type of community. Due to the competitive nature of this program and the imposed limits of funding available for this program, it is unlikely that DHS will fund many vehicles not listed as a Priority One during the 2010 program year.

FIREFIGHTING VEHICLE PROGRAM PRIORITIES

Priority	Urban communities	Suburban communities	Rural communities
Priority One	Pumper Aerial Quint (Aerial < 76′) Quint (Aerial < 76′)	Pumper Aerial Quint (Aerial > 76′) Quint (Aerial > 76′)	Pumper Brush/Attack Tanker/Tender Quint (Aerial < 76′)

FIREFIGHTING VEHICLE PROGRAM PRIORITIES—Continued

Priority	Urban communities	Suburban communities	Rural communities
	Rescue		
Priority Two	Command	Command	
	HAZMAT	HAZMAT	HAZMAT
	Light/Air	Rescue	Rescue
	Rehab	Tanker/Tender	Aerial
	Foam Truck	Brush/Attack	Quint (Aerial > 76′)
	Foam Truck	Foam Truck	
Priority Three	ARFFV [1]	ARFFV [1]	ARFFV [1]
	Brush/Attack	Rehab	Rehab
	Tanker/Tender	Light/Air	Command
	Ambulance	Ambulance	Ambulance
	Fire Boat	Fire Boat	Fire Boat
			Light/Air

[1] Airport Rescue and Firefighting Vehicle.

DHS will evaluate the marginal value derived from an additional vehicle of any given type on the basis of call volume. As a result, departments with fewer vehicles of a given type than other departments who service comparable call volumes are more likely to score competitively than departments with more vehicles of that type and comparable call volume unless the need for an additional vehicle of such type is made apparent in the application.

Applicants from urban and suburban communities may submit requests for more than one vehicle. Applicants must supply sufficient justification for each vehicle contained in the request. For those applications with multiple vehicles, the panelists will be instructed to evaluate the marginal benefit to be derived from funding the additional vehicle(s) given the potential use and the population protected. DHS anticipates that the panels will only recommend an award for a multiple-vehicles application when the cost-benefit justification is adequately compelling.

DHS believes that a greater benefit will be derived from funding an additional vehicle(s) to departments that own fewer or no vehicles of the type requested. As such, DHS assigns a higher competitive rating in the apparatus category to fire departments that own fewer firefighting vehicles relative to other departments serving similar types of communities (*i.e.,* urban, suburban, and rural). DHS assesses all vehicles with similar functions when assessing the number of vehicles a department possesses within a particular type. For example, the "pumper" category includes: pumpers, engines, pumper/tankers (apparatus that carries a minimum of 300 gallons of water and has a pump with a capacity to pump a minimum of 750 gallons per minute), rescue-pumpers, quints (with aerials less than 76 feet in length), and urban interface vehicles (Type I). Apparatus that has water capacity in excess of 1,000 gallons and a pump with pumping capacity of less than 750 gallons per minute are considered to be a tanker/tender.

DHS assigns a higher competitive rating to departments possessing an aged fleet of firefighting vehicles. In evaluating the age of an applicant's fleet, DHS will take into account the oldest vehicle in the class requested as well as the youngest vehicle in the class requested. DHS will also take into account the average age of the applicants' fleet. In each of these instances, older vehicles will receive higher consideration. DHS will also assign a higher competitive rating to departments that respond to a high volume of incidents.

DHS will give lower priority to funding departments seeking apparatus with the goal to expand into new mission areas unless the applicant demonstrates that they will be able to support and sustain the new mission or service area beyond the grant program.

DHS will assign no competitive advantage to the purchase of standard model commercial vehicles relative to custom vehicles, or the purchase of used vehicles relative to new vehicles in the preliminary evaluation of applications. DHS has noted that, depending on the type and size of department, the peer review panelists often prefer low-cost vehicles when evaluating the cost-benefit section of the project narratives. DHS also reserves the right to consider current vehicle costs within the fire service vehicle manufacturing industry when determining the level of funding that will be offered to the potential grantee, particularly if those current costs indicate that the applicant's proposed purchase costs are excessive.

DHS will allow departments serving urban or suburban communities to apply for more than one vehicle. DHS, however, will only allow departments serving rural communities to apply for one vehicle. DHS will limit applications from suburban or urban departments to one vehicle per station as well as per statutory funding limits. DHS will not limit 2010 applications because of a vehicle award from previous AFG program years.

(3) Administrative Costs. Panelists will assess the reasonableness of the administrative costs requested in any application and determine if the request is reasonable and in the best interest of the program.

Nonaffiliated EMS Organization Priorities.

DHS may make grants for the purpose of enhancing the provision of emergency medical services by nonaffiliated EMS organizations. The authorizing statute limits funding for these organizations to no more than 2 percent of the appropriated amount. DHS has determined that it is more cost-effective to enhance or expand an existing emergency medical service organization by providing training and/or equipment than to create a new service. Communities that do not currently offer emergency medical services but are turning to this grant program to initiate such a service received the lowest competitive rating. DHS does not believe creating a nonaffiliated EMS program is a substantial and sufficient benefit under the program.

Specific rating criteria and priorities for each of the grant categories are provided below following the descriptions of this year's eligible programs. The rating criteria, in conjunction with the program description, provide an understanding of the evaluation standards. In each

activity, the amount of the population served by the applicant will be taken into consideration with higher populations afforded more consideration than low populations served. DHS will further explain program priorities in the Program Guidance upon publication thereof.

(1) *EMS Operations and Safety Program.*

Five different activities may be funded under this program area: EMS training, EMS equipment, EMS personal protective equipment, wellness and fitness, and modifications to facilities. Requests for equipment and training to prepare for response to incidents involving CBRNE were available under the applicable equipment and training activities.

(i) *Training Activities.* DHS believes that EMS training is a prerequisite to the effective use of EMS equipment, organizations whose requests are more focused on training activities will receive a higher competitive rating than organizations whose requests are more focused on equipment. A higher competitive rating will be given to nonaffiliated EMS organizations that are planning to upgrade services to Advanced Life Support (ALS) level of response. Specifically, organizations that are seeking to elevate their response level from EMT–B to EMT–I will receive the highest priority and organizations that are seeking to elevate their response level from EMT–I to EMT–P will receive a high priority. Our second priority is to elevate emergency responders' capabilities from first-responder to a Basic Life Support (BLS) level of response (*i.e.*, EMT–B). Due to the time and cost, upgrading an organization's response level from EMT–B to EMT–P is a lower priority. Organizations seeking training in rescue or HAZMAT or rescue operations will receive lower consideration than organizations seeking training for medical services. Our lowest priority is to fund first responder training. Organizations that are seeking to train a high percentage of their active first responders will receive additional consideration when applying under the training activity.

(ii) *EMS Equipment Acquisition.* As noted above, training received a higher competitive rating than equipment. DHS believes that equipment is of no use if the operator is not trained to use it. As such, applicants must demonstrate that users of equipment purchased with the grant either are or will be sufficiently trained to use the equipment. Inability to demonstrate and fulfill this training requirement will result in ineligibility for equipment funding.

Organizations that request training to the ALS level of response, along with basic support equipment, will receive a higher priority. Requests seeking assistance to purchase equipment to support BLS level of response are a secondary priority. Organizations seeking equipment for rescue or HAZMAT operations will receive lower consideration than organizations seeking equipment used to provide medical services. Our lowest priority is to fund first responder training.

As discussed previously, organizations taking on "new risks" will be afforded much higher consideration than an organization taking on a "new mission."

(iii) *EMS Personal Protective Equipment.* DHS gives the same priorities for EMS PPE as it did for fire department PPE discussed above. Acquisition of Personal Alert Safety Systems or any firefighting PPE is not eligible, however, for funding for EMS organizations.

(iv) *Wellness and Fitness Activities.* DHS believes that to have an effective wellness/fitness program, nonaffiliated EMS organizations must offer periodic health screenings, entry physical examinations, and an immunization program similar to the programs for fire departments discussed previously. Accordingly, applicants for grants in this category must currently offer or plan to offer with grant funds *all three benefits* (periodic health screenings, entry physical examinations, and an immunization program) to receive funding for any other initiatives in this activity. The priorities for EMS wellness/fitness programs are the same as for fire departments as discussed above.

(v) *Modification to EMS Stations and Facilities.* DHS believes that the competitive rankings and priorities applied to modification of fire stations and facilities, discussed above, apply equally to EMS stations and facilities.

(2) *EMS Vehicle Acquisition Program.*

DHS gives the highest funding priority to acquisition of ambulances and transport vehicles due to the inherent benefits to the community and EMS service provider. Due to the costs associated with obtaining and outfitting non-transport rescue vehicles relative to the benefits derived from such vehicles, DHS will give non-transport rescue vehicles a lower competitive rating than transport vehicles. DHS anticipates that the EMS vehicle awards will be very competitive due to very limited available funding. Accordingly, DHS will likely only fund vehicles that are listed as a "Priority One" in the 2010 program year.

The following chart delineates the priorities in this program area for EMS vehicle program. The priorities are the same regardless of the type of community served.

EMS VEHICLE PROGRAM PRIORITIES

Priority one	Priority two	Priority three
• Ambulance or transport unit to support EMS functions.	• First responder non-transport vehicles	• Command vehicles.
	• Special operations vehicles	• Hovercraft • Other special access vehicles.

Along with the priorities illustrated above, DHS has accepted the fire service recommendation that emerged from the criteria development process that funding applicants that own few or no vehicles of the type sought will be more beneficial than funding applicants that own numerous vehicles of that same type. DHS assesses the number of vehicles an applicant owns by including all vehicles of the same type. For example, transport vehicles will be considered the same as ambulances. DHS will give a higher competitive rating to applicants that have an aged fleet of emergency vehicles, and to applicants with old, high-mileage vehicles. DHS will give a higher competitive rating to applicants that respond to a significant number of incidents relative to applicants responding less often. Finally, DHS will afford applicants with transport vehicles with high mileage more consideration than applicants with vehicles that are not driven extensively.

(3) Administrative Costs. Panelists assess the reasonableness of the administrative costs requested in each application and determined whether the

request will be reasonable and in the best interest of the program.

Dated: April 28, 2010.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2010–10385 Filed 5–3–10; 8:45 am]

BILLING CODE 9111–64–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–1902–DR; Docket ID FEMA–2010–0002]

Nebraska; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of Nebraska (FEMA–1902–DR), dated April 21, 2010, and related determinations.

DATES: *Effective Date:* April 21, 2010.

FOR FURTHER INFORMATION CONTACT: Peggy Miller, Recovery Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3886.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated April 21, 2010, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the "Stafford Act"), as follows:

I have determined that the damage in certain areas of the State of Nebraska resulting from severe storms, ice jams, and flooding during the period of March 6 to April 3, 2010, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the "Stafford Act"). Therefore, I declare that such a major disaster exists in the State of Nebraska.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the State. Consistent with the requirement that Federal assistance is supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Stephen R. Thompson, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of Nebraska have been designated as adversely affected by this major disaster:

Antelope, Arthur, Boone, Boyd, Butler, Cass, Colfax, Cuming, Dakota, Gage, Greeley, Hayes, Holt, Howard, Jefferson, Johnson, Lancaster, Loup, Madison, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Pierce, Platte, Polk, Richardson, Saline, Seward, Stanton, Thurston, Valley, Wheeler, and York Counties for Public Assistance.

All counties within the State of Nebraska are eligible to apply for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households in Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2010–10331 Filed 5–3–10; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–1900–DR; Docket ID FEMA–2010–0002]

Minnesota; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of Minnesota (FEMA–1900–DR), dated April 19, 2010, and related determinations.

DATES: *Effective Date:* April 19, 2010.

FOR FURTHER INFORMATION CONTACT: Peggy Miller, Recovery Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3886.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated April 19, 2010, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the "Stafford Act"), as follows:

I have determined that the damage in certain areas of the State of Minnesota resulting from flooding beginning on March 1, 2010, and continuing, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the "Stafford Act"). Therefore, I declare that such a major disaster exists in the State of Minnesota.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the State. Direct Federal assistance is authorized. Consistent with the requirement that Federal assistance is supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Lawrence Sommers, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of Minnesota have been designated as adversely affected by this major disaster:

Big Stone, Blue Earth, Brown, Carver, Chippewa, Clay, Kittson, Lac Qui Parle, Marshall, Norman, Polk, Redwood, Renville, Scott, Sibley, Traverse, Wilkin, and Yellow Medicine Counties and the Tribal Nation of the Upper Sioux Community for Public Assistance. Direct Federal assistance is authorized.

All counties and Tribes within the State of Minnesota are eligible to apply for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA);

97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2010–10333 Filed 5–3–10; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–1901–DR; Docket ID FEMA–2010–0002]

North Dakota; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of North Dakota (FEMA–1901–DR), dated April 21, 2010, and related determinations.

DATES: *Effective Date:* April 21, 2010.

FOR FURTHER INFORMATION CONTACT: Peggy Miller, Recovery Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3886.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated April 21, 2010, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the "Stafford Act"), as follows:

I have determined that the damage in certain areas of the State of North Dakota resulting from a severe winter storm during the period of April 1–3, 2010, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the "Stafford Act"). Therefore, I declare that such a major disaster exists in the State of North Dakota.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the State. Consistent with the requirement that Federal assistance is supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Justo Hernandez, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of North Dakota have been designated as adversely affected by this major disaster:

Adams, Benson, Burleigh, Grant, McHenry, McLean, Mercer, Morton, Oliver, Sheridan, Sioux, and Wells Counties and the portion of the Standing Rock Sioux Indian Reservation that lies within the State of North Dakota for Public Assistance.

All counties and Tribes within the State of North Dakota are eligible to apply for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2010–10336 Filed 5–3–10; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–1893–DR; Docket ID FEMA–2010–0002]

West Virginia; Amendment No. 2 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of West Virginia (FEMA–1893–DR), dated March 29, 2010, and related determinations.

DATES: *Effective Date:* April 27, 2010.

FOR FURTHER INFORMATION CONTACT: Peggy Miller, Recovery Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3886.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of West Virginia is hereby amended to include the following area among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of March 29, 2010.

Greenbrier County for Public Assistance (already designated for Individual Assistance).

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2010–10334 Filed 5–3–10; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG–2010–0032]

Houston/Galveston Navigation Safety Advisory Committee

AGENCY: Coast Guard, DHS.

ACTION: Notice of meeting.

SUMMARY: The Houston/Galveston Navigation Safety Advisory Committee ("HOGANSAC" or "the Committee") and its working groups will meet in Houston, Texas to discuss waterway improvements, aids to navigation, area projects impacting safety on the Houston Ship Channel, and various

other navigation safety matters in the Galveston Bay area. All meetings will be open to the public.

DATES: The Committee will meet on Tuesday, May 25, 2010 from 9 a.m. to 12 p.m. The Committee's working groups will meet on Tuesday, May 11, 2010 from 9 a.m. to 12 p.m. These meetings may close early if all business is finished. Written material and requests to make oral presentations should reach the Coast Guard on or before May 18, 2010. Requests to have a copy of your materials distributed to each member of the committee or working group should reach the Coast Guard on or before May 10, 2010. All comments and related material submitted after the meeting must be received by the Coast Guard on or before June 25, 2010.

ADDRESSES: The full Committee will meet at the Charles T. Doyle Convention Center, 2010 5th Avenue North, Texas City, TX 77590, (409) 643–5990. The working group meeting will be held at Western Gulf Maritime Association (WGMA), 1717 East Loop, Suite 200, Houston, Texas 77029, (713) 678–7655.

Send written material and requests to make oral presentations to Commander Michael Zidik, Assistant Designated Federal Officer (ADFO) of HOGANSAC, CG SEC Houston-Galveston, 9640 Clinton Drive, Houston, TX 77029. This notice and documents identified in the **SUPPLEMENTARY INFORMATION** section as being available in the docket may be viewed in our online docket, USCG–2010–0032, at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: If you have questions concerning the meeting, please call or e-mail Lieutenant Junior Grade Margaret Brown, Waterways Management Branch, Coast Guard; telephone 713–678–9001, e-mail *Margaret.A.Brown@uscg.mil.* If you have questions on viewing or submitting material to the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION: Notice of these meetings is given pursuant to the Federal Advisory Committee Act, 5 U.S.C. App. (Pub. L. 92–463).

Agenda of the Meeting

Houston/Galveston Navigation Safety Advisory Committee (HOGANSAC). The tentative agenda is as follows:

(1) Opening Remarks by the Designated Federal Officer (CAPT Woodring) and Committee Chair (Mrs. Tava Foret).

(2) Approval of March 11, 2010 minutes.

(3) Old Business.

(a) Navigation Operations (NAVOPS) subcommittee report;

(b) Dredging subcommittee report;

(c) Technology subcommittee report;

(d) Waterways Safety and Utilization subcommittee report;

(e) Commercial Recovery Contingency (CRC) subcommittee report;

(f) HOGANSAC Outreach subcommittee report;

(g) Freeport working group report;

(h) Area Maritime Security Committee (AMSC) Liaison's report.

(4) New Business.

(a) Discussion on bid for hosting 2011 AMSC/HSC Conference in Houston.

(5) Announcements.

(a) Schedule Next Meetings.

Working Groups Meeting. The tentative agenda for the working groups meeting is as follows:

(1) Presentation by each working group of its accomplishments and plans for the future;

(2) Review and discuss the work completed by each working group;

(3) Put forth any action items for consideration at full committee meeting.

Procedural

Both meetings are open to the public. Please note that meetings may close early if all business is finished. At the Chair's discretion, members of the public may make oral presentations during the meetings. If you would like to make an oral presentation at the Committee meeting, please notify the ADFO no later than May 18, 2010. Written material for distribution at a meeting should reach the Coast Guard no later than May 10, 2010. If you would like a copy of your material distributed to each member of the Committee in advance of the meetings, please submit 19 copies to the Coast Guard no later than May 10, 2010.

Information on Service for Individuals With Disabilities

For information on facilities or services for individuals with disabilities or to request special assistance at the public meeting, contact Lieutenant Junior Grade Margaret Brown at the telephone number or e-mail address indicated under the **FOR FURTHER INFORMATION CONTACT** section of this notice.

Dated: April 14, 2010.

M.E. Woodring,

Captain, U.S. Coast Guard, Commander, Sector Houston-Galveston.

[FR Doc. 2010–10307 Filed 5–3–10; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5376–N–29]

FHA-Insured Mortgage Loan Servicing of Payments, Prepayments, Terminations, Assumptions and Transfers

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below has been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

Information is collected from respondents who are companies (mortgagees) servicing FHA–Insured mortgage loans. This information concerns detailed loan. The information is subject to the Privacy Act and may be made available only to the appropriate Federal, State, and local agencies. The data and information provided is essential for managing HUD's programs and FHA's Mutual Mortgage Insurance Fund.

DATES: *Comments Due Date: June 3, 2010.*

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval Number (2502–New) and should be sent to: HUD Desk Officer, Office of Management and Budget, New Executive Office Building, Washington, DC 20503; fax: 202–395–5806.

FOR FURTHER INFORMATION CONTACT: Leroy McKinney, Jr., Reports Management Officer, QDAM, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410; e-mail Leroy McKinney, Jr. at *Leroy.McKinneyJr@hud.gov* or telephone (202) 402–5564. This is not a toll-free number. Copies of available documents submitted to OMB may be obtained from Mr. McKinney.

SUPPLEMENTARY INFORMATION: This notice informs the public that the Department of Housing and Urban Development has submitted to OMB a request for approval of the Information collection described below. This notice is soliciting comments from members of the public and affected agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection of information is

necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

This notice also lists the following information:

Title of Proposal: FHA–Insured Mortgage Loan Servicing of Payments, Prepayments, Terminations, Assumptions and Transfers.

OMB Approval Number: 2502–New.

Form Numbers: HUD–27050–A Mortgage Insurance Termination, HUD–92210.1 Approval of Purchaser and Release of Seller, HUD–92080 Mortgage Record Change.

Description of the Need for the Information and Its Proposed Use: Information is collected from respondents who are companies (mortgagees) servicing FHA–Insured mortgage loans. This information concerns detailed loan. The information is subject to the Privacy Act and may be made available only to the appropriate Federal, State, and local agencies. The data and information provided is essential for managing HUD's programs and FHA's Mutual Mortgage Insurance Fund.

Frequency of Submission: On occasion, Monthly, Other within 24 hours of request.

	Number of respondents	Annual responses	×	Hours per response	=	Burden hours
Reporting Burden	223	196.61	....	19.004	....	833,250

Total Estimated Burden Hours: 833,250.

Status: New Collection.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: April 27, 2010.

Leroy McKinney, Jr.,

Departmental Reports Management Officer, Office of the Chief Information Officer.

[FR Doc. 2010–10322 Filed 5–3–10; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5376–N–27]

Notice of Proposed Information Collection: American Recovery and Reinvestment Act; Public and Indian Housing Grants Reporting; Comment Request

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

DATES: *Comments Due Date:* July 6, 2010.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number (2577–0264) and should be sent to: Departmental Reports Management Officer, QDAM, Department of Housing and Urban Development, 451 Seventh Street, SW., Room 4178, Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Jeffrey D. Little, Office of the Secretary Recovery Implementation Team, Department of Housing and Urban Development, 451 Seventh Street, SW., Room 10156, Washington, DC 20410; telephone: 202–402–5649, (this is not a toll-free number) or e-mail Mr. Little at *Jeffrey.D.Little@hud.gov.*

SUPPLEMENTARY INFORMATION: The Department will submit the proposed information collection to OMB for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended).

This Notice is soliciting comments from members of the public and affecting agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) enhance the quality, utility, and clarity of the information to be collected; and (4) minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

This Notice also lists the following information:

Title of Proposal: American Recovery and Reinvestment Act Public and Indian Housing Grants Reporting.

OMB Control Number, if applicable: 2577–0264.

Description of the need for the information and proposed use: Public Housing Capital Fund, Assisted Housing Stability and Energy and Green Retrofit Investments Program, Indian Community Development Block Grant Program, Native American Housing Block Grants, Native Hawaiian Housing Block Grants; must provide information to HUD for the reporting Requirements of HUD ARRA Section 1512. ("Recovery Act") grants.

Section 1512 of the Recovery Act details reporting requirements for the recipients of recovery Act funding. Recipients are to report on the obligation and expenditure of Recovery Act funds, details of the projects on which those funds have been obligated and expended, an evaluation of the completion status of projects and the number of jobs created and jobs retained by the project.

Agency form numbers, if applicable: N/A, the data will be collected utilizing a Web-based application.

Members of Affected Public: State, Local or Local Government and Non-profit organization.

Estimation of the total number of hours needed to prepare the information collection including number of respondents, frequency of response, and hours of response: The estimated number of respondents is 5,500 and the number of responses is 4. There will be in total, approximately 22,000 total responses. The total reporting burden is 90,222 hours.

Status of the proposed information collection: Revision of previously approved collection on Recovery Act projects.

Authority: Section 3506 of the Paperwork Reduction Act of 1995, 44 U.S.C. Chapter 35, as amended.

Dated: April 27, 2010.

Peter Grace,

Special Assistant to the Secretary, Office of Strategic Planning and Management.

[FR Doc. 2010–10326 Filed 5–3–10; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5376–N–31]

Request for Withdrawals From Replacements Reserves/Residual Receipts Funds

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below has been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

Project owners are required to submit this information and required supporting documentation when requesting a withdrawal for funds from the Reserves for Replacement and/or Residual Receipt Funds. HUD reviews this information to ensure that funds are withdrawn and used in accordance with regulatory and administrative policy.

DATES: *Comments Due Date:* June 3, 2010.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval Number (2502–0555) and should be sent to: HUD Desk Officer, Office of Management and Budget, New Executive Office Building, Washington, DC 20503; *fax:* 202–395–5806.

FOR FURTHER INFORMATION CONTACT: Leroy McKinney, Jr., Reports Management Officer, QDAM, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410; e-mail Leroy McKinney Jr. at *Leroy.McKinneyJr@hud.gov* or telephone (202) 402–5564. This is not a toll-free number. Copies of available documents submitted to OMB may be obtained from Mr. McKinney.

SUPPLEMENTARY INFORMATION: This notice informs the public that the Department of Housing and Urban Development has submitted to OMB a request for approval of the Information collection described below. This notice is soliciting comments from members of the public and affecting agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) enhance the quality, utility, and clarity of the information to be collected; and (4) minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

This notice also lists the following information:

Title of Proposal: Request for Withdrawals from Replacements Reserves/Residual Receipts Funds.

OMB Approval Number: 2502–0555.

Form Numbers: HUD–9250.

Description of the Need for the Information and its Proposed Use: Project owners are required to submit this information and required supporting documentation when requesting a withdrawal for funds from the Reserves for Replacement and/or Residual Receipt Funds. HUD reviews this information to ensure that funds are withdrawn and used in accordance with regulatory and administrative policy.

Frequency of Submission: On occasion.

	Number of respondents	Annual responses	×	Hours per response	=	Burden hours
Reporting Burden	8,257	1		0.5		4,129

Total Estimated Burden Hours: 4,129.

Status: Extension of a currently approved collection.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: April 29, 2010.

Leroy McKinney, Jr.,

Departmental Reports Management Officer, Office of the Chief Information Officer.

[FR Doc. 2010–10419 Filed 5–3–10; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5376–N–30]

Multifamily Housing Service Coordinator Program

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below has been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

Housing project owners/managers apply for grants under the Housing Service Coordinator Program. The requested information will assist HUD in evaluating grant applicants and to determine how well grant funds meet stated program goals and how well the public was served.

DATES: *Comments Due Date:* June 3, 2010.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval Number (2502–0447) and should be sent to: HUD Desk Officer, Office of Management and Budget, New Executive Office Building, Washington, DC 20503; fax: 202–395–5806.

FOR FURTHER INFORMATION CONTACT: Leroy McKinney, Jr., Reports Management Officer, QDAM, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, DC 20410; e-mail Leroy McKinney Jr. at *Leroy.McKinney, Jr@hud.gov* or telephone (202) 402–5564. This is not a toll-free number. Copies of available documents submitted to OMB may be obtained from Mr. McKinney.

SUPPLEMENTARY INFORMATION: This notice informs the public that the Department of Housing and Urban Development has submitted to OMB a request for approval of the Information collection described below. This notice is soliciting comments from members of

the public and affecting agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) enhance the quality, utility, and clarity of the information to be collected; and (4) minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.*, permitting electronic submission of responses.

This Notice Also Lists the Following Information

Title of Proposal: Multifamily Housing Service Coordinator Program.

OMB Approval Number: 2502–0447.

Form Numbers: HUD–92456, HUD–50080–SCMF, HUD–91186, SF–269–A, SF–424, SF–424–Supp, HUD–2880, SF–LLL, HUD–96010, HUD–91186–A.

Description of the Need for the Information and Its Proposed Use: Housing project owners/managers apply for grants under the Housing Service Coordinator Program. The requested information will assist HUD in evaluating grant applicants and to determine how well grant funds meet stated program goals and how well the public was served.

Frequency of Submission: Quarterly, Semi-annually, Annually.

	Number of respondents	Annual responses	×	Hours per response	=	Burden hours
Reporting Burden	4300	4.837		3.324		69,150

Total Estimated Burden Hours: 69,150.

Status: Extension of a currently approved collection.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: April 28, 2010.

Leroy McKinney, Jr.,

Departmental Reports Management Officer, Office of the Chief Information Officer.

[FR Doc. 2010–10421 Filed 5–3–10; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF THE INTERIOR

Geological Survey

Proposed Information Collection; Assessment of the Business Requirements and Benefits of Enhanced National Elevation Data

AGENCY: United States Geological Survey (USGS), Interior.

ACTION: Notice; request for comments.

SUMMARY: We (U.S. Geological Survey) will ask the Office of Management and Budget (OMB) to approve the information collection (IC) described below. To comply with the Paperwork Reduction Act of 1995 and a part of our continuing efforts to reduce paperwork and respondent burden, we invite the general public and other Federal agencies to comment on this IC. We may not conduct or sponsor and a person is not required to respond to a collection unless it displays a currently valid OMB control number.

DATES: You must submit comment on or before July 6, 2010.

ADDRESSES: Send your comments to the IC to Phadrea Ponds, Information Collections Clearance Officer, U.S. Geological Survey, 2150–C Center Avenue, Fort Collins, CO 80525 (mail); (970) 226–9230 (fax); or *pponds@usgs.gov* (e-mail). Please reference Information Collection 1028–NEW, LiDAR.

FOR FURTHER INFORMATION CONTACT: Gregory Snyder by mail at U.S. Geological Survey, 12201 Sunrise Valley Drive, MS 517, Reston, VA 20192–0001, or by telephone at 703–648–5169.

SUPPLEMENTARY INFORMATION:

I. Abstract

USGS Geography supports some of the most pressing resource management, environmental and climate change science issues faced by our Nation. Light Detection And Ranging (LiDAR) is the leading technology for collecting highly-accurate three-dimensional measurements of the Earth's topography and surface features such buildings, bridges, coastlines, rivers, forests and other landscape characteristics. These data provide an unprecedented tool for scientific understanding and informed National decisions related to ecosystem management, energy development, natural resource conservation and mitigating geologic and flood-related hazards. The USGS now collects LiDAR data to a limited extent and primarily for upgrading bare-earth elevation data for The National Map. This study seeks to establish a baseline of national business needs and associated benefits for LiDAR to enhance the responsiveness of USGS programs, and to design an efficient future program that balances requirements, benefits and costs. The study advances coordinated program development among the numerous federal and state agencies that increasingly rely on LiDAR to enable the fulfillment of their missions. The study is sponsored by the National Digital Elevation Program steering committee and supported by several member agencies.

The information collection process will be guided by an interagency management team led by USGS with support from a professional services contractor. The information collection will be conducted using a standardized template. We will protect information from respondents considered proprietary under the Freedom of Information Act (5 U.S.C. 552) and its implementing regulations (43 CFR part 2), and under regulations at 30 CFR 250.197, "Data and information to be made available to the public or for limited inspection." Responses are voluntary. No questions of a "sensitive" nature are asked.

II. Data

OMB Control Number: None. This is a new collection.

Title: Assessment of the Business Requirements and Benefits of Enhanced National Elevation Data.

Type of Request: New.

Affected Public: States, U.S. Territories, Tribes and selected private natural resource development companies.

Respondent's Obligation: Voluntary.

Frequency of Collection: One time only.

Estimated Annual Number of Respondents: Approximately 300 responses.

Estimated Total Annual Burden Hours: 1,200.

III. Request for Comments

We invite comments concerning this IC on:

(1) Whether or not the collection of information is necessary, including whether or not the information will have practical utility;

(2) the accuracy of our estimate of the burden for this collection of information;

(3) ways to enhance the quality, utility, and clarity of the information to be collected; and

(4) ways to minimize the burden of the collection of information on respondents.

Please note that the comments submitted in response to this notice are a matter of public record. Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment, including your personal identifying information, may be made publicly available at any time. While you can ask OMB in your comment to withhold your personal identifying information from public review, we cannot guarantee that it will be done. To comply with the public process, we hereby publish this **Federal Register** notice announcing that we will submit this IC to OMB for approval. The notice provides the required 60-day public comment period.

USGS Information Collection Clearance Officer: Phadrea D. Ponds, 970–226–9445.

Dated: April 27, 2010.

Bruce K. Quirk,

Land Remote Sensing Program Coordinator.

[FR Doc. 2010–10374 Filed 5–3–10; 8:45 am]

BILLING CODE 4311–AM–P

DEPARTMENT OF THE INTERIOR

National Park Service

Boundary Revision at George Washington Carver National Monument

AGENCY: National Park Service, Interior.

ACTION: Announcement of boundary revision.

SUMMARY: This notice announces a revision of the boundary of George Washington Carver National Monument, Newton County, Missouri, to include adjacent land donated by the Carver Birthplace Association. The boundary revision is authorized by the Act of July 14, 1943, 57 Stat. 563, (16 U.S.C. 450aa).

FOR FURTHER INFORMATION CONTACT: James R. Heaney, Superintendent, George Washington Carver National Monument, 5646 Carver Road, Diamond, Missouri 64840, or by telephone: 417–325–4151.

SUPPLEMENTARY INFORMATION: Notice is hereby provided that the boundaries of George Washington Carver National Monument are revised. This revision, effective upon publication of this notice, includes certain adjacent real property situated in Newton County, Missouri legally described as: Thirty acres squarely off the South side of the Southwest Quarter of the Southeast Quarter (SW¼ SE¼) of Section 7, Township 26 North, Range 31 West, 5th P.M., Newton County, Missouri.

Dated: April 21, 2010.

Ernest Quintana,

Regional Director, Midwest Region, National Park Service.

[FR Doc. 2010–10329 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–BB–P

DEPARTMENT OF THE INTERIOR

Minerals Management Service

Environmental Assessment Prepared for Proposed Cape Wind Energy Project in Nantucket Sound, Offshore Massachusetts

AGENCY: Minerals Management Service (MMS), Interior.

ACTION: Notice of Availability of an Environmental Assessment (EA) and Finding of No New Significant Impact (FONNSI)

SUMMARY: The MMS, in accordance with regulations implementing the National Environmental Policy Act (NEPA), announces the availability of an EA and FONNSI for the Cape Wind Energy Project proposed for Nantucket Sound, offshore Massachusetts. On January 16, 2009, the MMS announced the release of the Final Environmental Impact Statement (FEIS) for the Cape Wind Energy Project. The FEIS assessed the physical, biological, and social/human impacts of the proposed project and 13 alternatives, including a no-action alternative (*i.e.,* the project is not built), and proposed mitigation.

The MMS prepared this EA to determine whether MMS needs to supplement the FEIS for the Cape Wind Energy Project by examining whether there are "substantial changes in the proposed action that are relevant to environmental concerns" or whether "there are significant new circumstances or information relevant to environmental concerns and bearing on the proposed action or its impacts" that either were not fully discussed or did not exist at the time the FEIS was prepared (40 CFR 1502.9). The MMS reviewed information obtained from the scientific/technical literature, government reports and actions, intergovernmental coordination and communications, required consultations, comments made during the FEIS comment period, and comments received during the 30-day comment period after the initial circulation of this EA on March 8, 2010. This included the information discussed in the January 13, 2010, MMS Documentation of Section 106 Finding of Adverse Effect (Revised Finding), contained in the comments received during the 30-day period offered after the Revised Finding was circulated, and the information contained in the April 2, 2010, comment by the Advisory Council on Historic Preservation.

The MMS has determined that there is no new information that would necessitate a re-analysis of the range of the alternatives or the kinds, levels, or locations of the impacts of the Proposed Action on socioeconomic conditions or biologic, physical, or cultural resources. The analyses, potential impacts, and conclusions detailed in the FEIS remain valid. Therefore, the MMS has concluded that a supplemental EIS is not required. The EA and FONNSI are available at *http://www.mms.gov/offshore/RenewableEnergy/CapeWind.htm.*

FOR FURTHER INFORMATION CONTACT: James F. Bennett, Chief, Environmental Assessment Branch, Minerals Management Service, 381 Elden Street MS–4042, Herndon, Virginia 20170.

SUPPLEMENTARY INFORMATION: In November 2001, Cape Wind Associates, LLC, applied for a permit from the U.S. Army Corps of Engineers (USACE) under the Rivers and Harbors Act of 1899 to construct a wind power facility on Horseshoe Shoal in Nantucket Sound, offshore Massachusetts. Following the passage of the Energy Policy Act of 2005 (EPAct) and associated amendments to the Outer Continental Shelf Lands Act (OCSLA), the Department of the Interior was given statutory authority to issue leases, easements, and rights-of-way for renewable energy projects on the Outer Continental Shelf (OCS). Accordingly, Cape Wind Associates, LLC, submitted an application to the MMS in 2005 to construct, operate, and eventually decommission an offshore wind power facility on Horseshoe Shoal in Nantucket Sound.

The project calls for 130, 3.6 megawatt (MW) wind turbine generators, each with a maximum blade height of 440 feet, to be arranged in a grid pattern in 25 square miles of Nantucket Sound, offshore Cape Cod, Martha's Vineyard, and Nantucket Island. With a maximum electric output of 468 MW and an average anticipated output of 182 MW, the facility is projected to generate up to three-

quarters of the Cape and Islands' electricity needs. Each of the 130 wind turbine generators would generate electricity independently. Solid dielectric submarine inner-array cables (33 kilovolt) from each wind turbine generator would interconnect within the array and terminate on an electrical service platform, which would serve as the common interconnection point for all of the wind turbines. The proposed submarine transmission cable system (115 kilovolt) from the electric service platform to the landfall location in Yarmouth would be approximately 12.5 miles in length (7.6 miles of which falls within Massachusetts' territory).

Nantucket Sound is a roughly triangular body of water generally bound by Cape Cod, Martha's Vineyard, and Nantucket Island. Open bodies of water include Vineyard Sound to the West and the Atlantic Ocean to the East and the South. Nantucket Sound encompasses between 500 and 600 square miles of ocean, most of which lies above the OCS. The Cape Wind Energy Project would be located completely on the OCS, except for the transmission cables, which would run through Massachusetts' territory to shore. For reference, the northernmost turbines would be approximately 5.2 miles (8.4 km) from Point Gammon on the mainland; the southernmost turbines would be approximately 11 miles (17.7 km) from Nantucket Island (Great Point); and the westernmost turbines would be approximately 5.5 miles (8.9 km) from the island of Martha's Vineyard (Cape Poge).

Dated: April 28, 2010.

Chris C. Oynes,

Associate Director for Offshore Energy and Minerals Management.

[FR Doc. 2010–10486 Filed 5–3–10; 8:45 am]

BILLING CODE 4310–MR–P

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Intent to Repatriate a Cultural Item: Rochester Museum & Science Center, Rochester, NY

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3005, of the intent to repatriate one cultural item in the possession of the Rochester Museum & Science Center, Rochester, NY, that meets the definitions of "sacred object" and object of "cultural patrimony" under 25 U.S.C. 3001.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the cultural item. The National Park Service is not responsible for the determinations in this notice.

In 1982, the museum acquired a small red stone medicine face (82.54.1). It appears to be a contemporary piece and was donated to the museum by Mrs. Beverly Anderson, Rochester, NY.

Original museum documentation stated that this medicine face could only be generally affiliated with the "Iroquois." Oral evidence presented during consultation with representatives of the Haudenosaunee Standing Committee on Burial Rules and Regulations, as well as historical and anthropological scholarly materials, support the fact that the Onondaga Nation is the Keeper of the Central Fire of the Haudenosaunee Confederacy, and as such has the responsibility within the Haudenosaunee Confederacy to bring back national cultural patrimony and sacred objects that are affiliated with the "Iroquois" generally, and to return those objects to their rightful communities. Therefore, it is the understanding of all the Haudenosaunee Confederacy Nations that any medicine faces affiliated generally as "Iroquois" are affiliated with the Onondaga Nation.

In the course of consultations with members of the Onondaga Nation, it was shown that any individual who carved a medicine face and alienated it to a third party that in turn donated it to the Rochester Museum & Science Center did not have the authority to do so. Furthermore, Onondaga Nation traditional religious leaders have identified this medicine face as being needed for the practice of traditional Native American religions by present-day adherents. Based on consultation with NAGPRA representatives from the Onondaga Nation and other Haudenosaunee and non-Haudenosaunee consultants, the museum has determined that the medicine faces are both sacred objects and objects of cultural patrimony. Accordingly, museum documentation, consultation and oral evidence show that this medicine face is a sacred object and an object of cultural patrimony, and that the medicine face can be culturally affiliated to the Onondaga Nation of New York on behalf of the Haudenosaunee Confederacy (also known as the Iroquois Confederacy or Six Nations, which includes the Mohawk, Oneida, Onondaga, Cayuga, Seneca, and Tuscarora Nations that are in part represented by the following Federally-recognized tribes: Cayuga Nation of New York; Oneida Nation of New York; Oneida Tribe of Indians of Wisconsin; Onondaga Nation of New York; Seneca Nation of New York; Seneca-Cayuga Tribe of Oklahoma; Saint Regis Mohawk Tribe, New York; Tonawanda Band of Seneca Indians of New York; and Tuscarora Nation of New York).

Officials of the Rochester Museum & Science Center have determined, that pursuant to 25 U.S.C. 3001(3)(C), the one cultural item described above is a specific ceremonial object needed by traditional Native American religious leaders for the practice of traditional Native American religions by their present-day adherents. Officials of the Rochester Museum & Science Center have also determined that, pursuant to 25 U.S.C. 3001(3)(D), the one cultural item described above has an ongoing historical, traditional, or cultural importance central to the Native American group or culture itself, rather than property owned by an individual. Lastly, officials of the Rochester Museum & Science Center have determined that, pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the sacred object/object of cultural patrimony and the Onondaga Nation of New York.

Representatives of any other Indian Nation or tribe that believes itself to be culturally affiliated with the sacred object/object of cultural patrimony should contact Adele DeRosa, Rochester Museum & Science Center, Rochester, NY 14607, telephone (585) 271–4552, ext 302, before June 3, 2010. Repatriation of the sacred object/object of cultural patrimony to the Onondaga Nation of New York may proceed after that date if no additional claimants come forward.

The Rochester Museum & Science Center is responsible for notifying the Onondaga Nation of New York that this notice has been published.

Dated: April 27, 2010.

David Tarler,

Acting Manager, National NAGPRA Program.

[FR Doc. 2010–10364 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Intent to Repatriate a Cultural Item: Rochester Museum & Science Center, Rochester, NY

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3005, of the intent to repatriate one cultural item in the possession of the Rochester Museum & Science Center, Rochester, NY, that meets the definitions of "sacred object" and object of "cultural patrimony" under 25 U.S.C. 3001.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the cultural item. The National Park Service is not responsible for the determinations in this notice.

In 1961, the museum acquired a large wooden medicine face (AE 9499/61.334.1) from the Rochester Museum Association that previously had purchased it from M.L. Philpott, Rochester, NY. According to the seller, it had belonged to his father-in-law, a worker on several estates in the Adirondacks, who received it from a Dr. Salisbury in approximately 1913.

Original museum documentation stated that this medicine face could only be generally affiliated with the "Iroquois" (New York State or Canada). Oral evidence presented during consultation with representatives of the Haudenosaunee Standing Committee on Burial Rules and Regulations, as well as historical and anthropological scholarly materials, support the fact that the Onondaga Nation is the Keeper of the Central Fire of the Haudenosaunee Confederacy, and as such has the responsibility within the Haudenosaunee Confederacy to bring back national cultural patrimony and sacred objects that are affiliated with the "Iroquois" generally, and to return those objects to their rightful communities. Therefore, it is the understanding of all the Haudenosaunee Confederacy Nations that any medicine faces affiliated generally as "Iroquois" are affiliated with the Onondaga Nation.

In the course of consultations with members of the Onondaga Nation, it was shown that any individual who carved a medicine face and alienated it to a third party that in turn donated it to the Rochester Museum & Science Center did not have the authority to do so. Furthermore, Onondaga Nation traditional religious leaders have identified this medicine face as being needed for the practice of traditional Native American religions by present-day adherents. Based on consultation with NAGPRA representatives from the Onondaga Nation and other Haudenosaunee and non-Haudenosaunee consultants, the museum has determined that the medicine face is both a sacred object and object of cultural patrimony. Accordingly, museum documentation, consultation and oral evidence show that this medicine face is a sacred object and an object of cultural patrimony, and that the medicine face can be culturally affiliated to the Onondaga Nation of New York on behalf of the Haudenosaunee Confederacy (also known as the Iroquois Confederacy or Six Nations, which includes the Mohawk, Oneida, Onondaga, Cayuga, Seneca, and Tuscarora Nations that are in part represented by the following Federally-recognized tribes: Cayuga Nation of New York; Oneida Nation of New York; Oneida Tribe of Indians of Wisconsin; Onondaga Nation of New York; Seneca Nation of New York; Seneca-Cayuga Tribe of Oklahoma; Saint Regis Mohawk Tribe, New York; Tonawanda Band of Seneca Indians of New York; and Tuscarora Nation of New York).

Officials of the Rochester Museum & Science Center have determined, that pursuant to 25 U.S.C. 3001(3)(C), the one cultural item described above is a specific ceremonial object needed by traditional Native American religious leaders for the practice of traditional Native American religions by their present-day adherents. Officials of the Rochester Museum & Science Center have also determined that, pursuant to 25 U.S.C. 3001(3)(D), the one cultural item described above has an ongoing historical, traditional, or cultural importance central to the Native American group or culture itself, rather than property owned by an individual. Lastly, officials of the Rochester Museum & Science Center have determined that, pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the sacred object/object of cultural patrimony and the Onondaga Nation of New York.

Representatives of any other Indian Nation or tribe that believes itself to be culturally affiliated with the sacred object/object of cultural patrimony should contact Adele DeRosa, Rochester Museum & Science Center, Rochester, NY 14607, telephone (585) 271–4552, ext 302, before June 3, 2010. Repatriation of the sacred object/object of cultural patrimony to the Onondaga Nation of New York may proceed after that date if no additional claimants come forward.

The Rochester Museum & Science Center is responsible for notifying the Onondaga Nation of New York that this notice has been published.

Dated: April 27, 2010.

David Tarler,

Acting Manager, National NAGPRA Program.

[FR Doc. 2010–10376 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Intent to Repatriate a Cultural Item: Virginia Museum of Fine Arts, Richmond, VA

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3005, of the intent to repatriate a cultural item in the possession of the Virginia Museum of Fine Arts, Richmond, VA, that meets the definition of "object of cultural patrimony" under 25 U.S.C. 3001.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the cultural item. The National Park Service is not responsible for the determinations in this notice.

The cultural item is a ceremonial headdress made of wood, eagle or eider down, sea lion whiskers, ermine hide, abalone shell, feathers, and fibers (VMFA accession # 55.31.7). The headdress is approximately 17.25 inches in height, 10 inches in width, and 9.5 inches in diameter (43.7 cm x 25.2 cm x 24.2 cm). The mask portion of the headdress is composed of a polychrome carved wooden bird holding a limp object in its beak, and the right wing of the mask has been broken off and repaired. A stylized face appears beneath the beak, which is flanked by applied vertical wings. The nose of the face is a bird's head, turned upward. The eyes and teeth are made of abalone shell. The top of the headdress is decorated with alternating sea lion

whiskers and red-shafted flicker feathers. The headdress itself is lined with ermine hide, and ermine hide also hangs from the back of the headdress.

In 1955, the headdress was purchased by the Virginia Museum of Fine Arts from the Portland Art Museum, OR (Portland Art Museum accession # 48.3.439). Records from the Portland Art Museum read as follows: "Purchase, Indian Collection Subscription Fund. To be known as the Axel Rassmussen Collection. Vendor, Earl Stendahl."

Representatives of the Central Council of the Tlingit & Haida Indian Tribes, specifically the Lúkaax.ádi clan, a Tlingit clan, have identified that this headdress represents the Kingfisher Fort. The Kingfisher Fort is a site of cultural and historic importance to the Lúkaax.ádi clan, and this Kingfisher Fort Headdress (*Tlax'aneis' Noow Shaakee.át*) is needed for continuing their cultural ceremonies. Representatives of the Central Council of the Tlingit & Haida Indian Tribes have also provided evidence that this headdress is an object of cultural patrimony. It is communally owned and, at the time of removal had - and continues to have - ongoing, historical, traditional, and cultural importance central to the Tlingit society and culture. Furthermore, no tribal member consented to alienate it, and no evidence exists to demonstrate that its transfer outside the tribe was voluntary.

Officials of the Virginia Museum of Fine Arts have determined that, pursuant to 25 U.S.C. 3001(3)(D), the cultural item described above has ongoing historical, traditional, or cultural importance central to the Native American group or culture itself, rather than property owned by an individual. Officials of the Virginia Museum of Fine Arts also have determined that, pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the object of cultural patrimony and the Central Council of the Tlingit & Haida Indian Tribes.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the object of cultural patrimony should contact Kelly Burrow, Assistant Registrar, Virginia Museum of Fine Arts, 200 N. Blvd., Richmond, VA 23220, telephone (804) 204–2669, before June 3, 2010. Repatriation of the object of cultural patrimony to the Central Council of the Tlingit & Haida Indian Tribes may proceed after that date if no additional claimants come forward.

The Virginia Museum of Fine Arts is responsible for notifying the Central Council of the Tlingit & Haida Indian Tribes that this notice has been published.

Dated: March 25, 2010.

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–10365 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Intent to Repatriate Cultural Items: Rochester Museum & Science Center, Rochester, NY

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3005, of the intent to repatriate cultural items in the possession of the Rochester Museum & Science Center, Rochester, NY, that meet the definitions of "sacred objects" and "objects of cultural patrimony" under 25 U.S.C. 3001.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the cultural items. The National Park Service is not responsible for the determinations in this notice.

In 1929, the museum purchased two small wooden medicine faces from Alvin Dewey, Rochester, NY. On March 25, 1922, Alvin Dewey obtained them from Albert G. Heath, Chicago, IL. The first medicine face measures 2 3/4" inches long (AE 2880/D 10922/ 29.259.27). The second medicine face is a small wooden "Leader's" face that measures 2 7/8" long (AE 2881/D 11923/ 29.259.28). According to the documentation, these were individually tied to poles "and carried by the Leader in the Seneca False Face Ceremonies."

Museum documentation indicates that these medicine faces are culturally affiliated with the "Seneca." NAGPRA representative consultants from the Tonawanda Seneca Nation informed the Rochester Museum & Science Center that ethnographic objects identified as "Seneca" should go back to them because the Tonawanda Seneca Nation is the center of the Seneca religious fire. This was agreed upon by representatives from the Seneca Nation of New York, the Tonawanda Band of Seneca Indians of New York, and the Seneca-Cayuga Tribe of Oklahoma.

Tonawanda Seneca Nation traditional religious leaders have identified these medicine faces as being needed for the practice of traditional Native American religions by present-day adherents. During consultation, it was shown that individuals who carved a face did not have the authority to alienate it to a third party or sell it indirectly to the Rochester Museum & Science Center. Therefore, based on consultation with NAGPRA representatives from the Tonawanda Seneca Nation and other Haudenosaunee and non-Haudenosaunee consultants, the museum has determined that the medicine faces are both sacred objects and objects of cultural patrimony.

Officials of the Rochester Museum & Science Center have determined, that pursuant to 25 U.S.C. 3001(3)(C), the two cultural items described above are specific ceremonial objects needed by traditional Native American religious leaders for the practice of traditional Native American religions by their present-day adherents. Officials of the Rochester Museum & Science Center have also determined that, pursuant to 25 U.S.C. 3001(3)(D), the two cultural items described above have an ongoing historical, traditional, or cultural importance central to the Native American group or culture itself, rather than property owned by an individual. Lastly, officials of the Rochester Museum & Science Center have determined that, pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the sacred objects/ objects of cultural patrimony and the Tonawanda Band of Seneca Indians of New York.

Representatives of any other Indian Nation or tribe that believes itself to be culturally affiliated with the sacred objects/objects of cultural patrimony should contact Adele DeRosa, NAGPRA Coordinator/Collections Manager, Rochester Museum & Science Center, 657 East Ave., Rochester, NY 14607, telephone (585) 271–4552, ext 302, before June 3, 2010. Repatriation of the sacred objects/objects of cultural patrimony to the Tonawanda Band of Seneca Indians of New York may proceed after that date if no additional claimants come forward.

The Rochester Museum & Science Center is responsible for notifying the Seneca Nation of New York, Seneca-Cayuga Tribe of Oklahoma, and Tonawanda Band of Seneca Indians of New York that this notice has been published.

Dated: April 12, 2010.

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–10368 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Intent to Repatriate Cultural Items: U.S. Department of the Interior, Bureau of Reclamation, Phoenix Area Office, Phoenix, AZ, and Huhugam Heritage Center, Gila River Indian Community, AZ

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3005, of the intent to repatriate cultural items in the control of the U.S. Department of the Interior, Bureau of Reclamation, Phoenix Area Office, Phoenix, AZ, and in the physical custody of the Huhugam Heritage Center, Gila River Indian Community, AZ, that meet the definition of "unassociated funerary objects" under 25 U.S.C. 3001.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American cultural items. The National Park Service is not responsible for the determinations in this notice.

Human remains and associated funerary objects from the sites described below were originally reported in a Notice of Inventory Completion published in the **Federal Register** (39 FR 8996–9002, February 27, 2002); and subsequently corrected with two additional Notices of Inventory Completion (67 FR 45539–45540, July 9, 2002; 67 FR 78247–78248, December 23, 2002). The materials reported in the earlier notices were repatriated to the affiliated tribes in October and November of 2002. A recent review of Bureau of Reclamation collections, now curated at the Huhugam Heritage Center, Gila River Indian Community, revealed the presence of additional possible isolated Native American human remains and 40 additional funerary objects, all culturally affiliated with the same tribes listed in the original notice. Although these possible isolated human remains were identified, they do not increase the number of individuals listed in the previously published notices. Since the human remains in the previous notices were repatriated, the funerary objects are now considered to be unassociated funerary objects.

Between 1980 and 1981, during legally authorized data recovery efforts undertaken by the Arizona State Museum for the Bureau of Reclamation, human remains representing 20 individuals were recovered from the Siphon Draw site, AZ U: 10:6(ASM), south of Apache Junction, Pinal County, AZ. No known individuals were identified. Previously a total of 141 associated funerary objects were reported as also being recovered. In October 2002, these materials were repatriated to the Gila River Indian Community of the Gila River Indian Reservation, Arizona. An additional four funerary objects were recently identified in the Siphon Draw (AZ U:10:6(ASM)) collections. The four unassociated funerary objects are two unworked whole shells (terrestrial snails), one flotation, and one pollen sample.

On the basis of archeological context, chronometric, architectural, ceramic, and other types of artifactual evidence, the site represents a Hohokam occupation of the Santa Cruz through Sacaton Phases (A.D. 700–1150) of the Preclassic period.

Between 1980 and 1981, during legally authorized data recovery efforts undertaken by the Arizona State Museum for the Bureau of Reclamation, human remains representing 31 individuals were recovered from the Las Fosas site, AZ U:15:19(ASM), in the Gila Valley east of Florence, Pinal County, AZ. No known individuals were identified. Previously a total of 290 associated funerary objects were reported as also being recovered. In October 2002, these materials were repatriated to the Gila River Indian Community of the Gila River Indian Reservation, Arizona. An additional 24 funerary objects were recently identified in the Las Fosas, AZ U:15:19(ASM), collections. The 24 unassociated funerary objects are 1 reconstructable ceramic bowl, 2 individual ceramic sherds, 2 bags ceramic sherds, 1 bag chipped stone, 2 unworked obsidian nodules, 1 bag of unworked faunal bone (including a near-complete macaw), 1 soil sample with possible cremains, 13 unprocessed soil samples, and 1 unprocessed flotation sample.

On the basis of archeological context, chronometric, architectural, ceramic, and other types of artifactual evidence, the site represents a Hohokam occupation of the Classic period (A.D. 1150–1450).

Between 1980 and 1981, during legally authorized data recovery efforts undertaken by the Arizona State Museum for the Bureau of Reclamation, human remains representing a minimum of 31 individuals were recovered from Frogtown, AZ U:15:61(ASM), west of Florence Junction, Pinal County, AZ. No known individuals were identified. Previously a total of 120 associated funerary objects were also reported as being recovered. In October 2002, these materials were repatriated to the Gila River Indian Community of the Gila River Indian Reservation, Arizona. An additional 10 funerary objects were recently identified in the Frogtown (AZ U:15:61(ASM)) collection, as well as possible human remains of a previously repatriated individual. The 10 unassociated funerary objects are 1 stone palette fragment, 3 pieces of worked shell, 1 piece unworked shell, 3 bags of unworked faunal bone mixed with possible human remains, 1 unprocessed flotation sample with possible human remains, and 1 unprocessed flotation sample.

On the basis of archeological context, chronometric, architectural, ceramic, and other types of artifactual evidence, the site represents a Hohokam occupation of the Santa Cruz and Sacaton Phases (A.D. 750–1150) of the Preclassic period.

Between 1980 and 1981, during legally authorized data recovery efforts undertaken by the Arizona State Museum for the Bureau of Reclamation, human remains representing a minimum of six individuals were recovered from site AZ U:15:85(ASM), in Pinal County, AZ. No known individuals were identified. Previously a total of 10 associated funerary objects were also reported as being recovered. In October 2002, these materials were repatriated to the Gila River Indian Community of the Gila River Indian Reservation, Arizona. The two funerary objects recently identified in the AZ U:15:85(ASM) collections are two bags of ceramic sherds.

On the basis of archeological context, chronometric, architectural, ceramic, and other types of artifactual evidence, the site represents a Hohokam occupation of the Classic period (A.D. 1150–1450).

Evidence provided by anthropological, archeological, biological, geographical, historical, kinship, linguistics, and oral tradition sources was considered in determining the cultural affiliation of the funerary objects. Bureau of Reclamation officials

have determined that the preponderance of the evidence suggests that the historic O'odham groups (Ak-Chin Indian Community of the Ak-Chin Indian Reservation, Arizona; Gila River Indian Community of the Gila River Indian Reservation, Arizona; Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona; and the Tohono O'odham Nation of Arizona, including the San Xavier District) have a strong cultural affiliation with the prehistoric Hohokam who occupied the middle Gila Valley and surrounding areas. Great similarities in settlement patterns, economic systems, architecture, and material culture point to a close relationship between the Hohokam and the O'odham groups. The O'odham were well established along the rivers and in the deserts when the Spanish first arrived in northern Sonora and southern Arizona.

One of the two Pima moieties claims descend from the Hohokam, while the other moiety is said to have descended from the "emergers," those who overthrew the Hohokam leaders. Although the O'odham belong to the same linguistic group (Piman) as communities in what is now northern Mexico, shared vocabulary and syntax with Yuman language groups along the Colorado River suggests a long-term history of interaction that stretches back into prehistoric times in what is now southern Arizona.

Evidence also shows the affiliation of ancestral Zuni and Hopi groups with the prehistoric Hohokam. Interaction is indicated by the presence of trade items, particularly ceramics. Such interaction continued into protohistoric and early historic times. In addition to trade, Hopi and Zuni migration traditions indicate that clans originating from areas south of the Colorado Plateau joined the plateau communities late in prehistoric times. These groups contributed ceremonies, societies, and iconography to the plateau groups. Both O'odham and Western Pueblo oral traditions indicate that some Hohokam groups may have left the Salt-Gila River Basin after disastrous floods and social upheaval. These groups traveled north and east, possibly to be assimilated by the Hopi and Zuni. These ties are reflected in some of the traditional ceremonies maintained as part of the annual ceremonial cycle. Therefore, the evidence suggests that the Hopi and Zuni are also culturally affiliated with the Hohokam. Their ancestors had trade relationships and other likely interactions with the Hohokam, similar to those found between groups in the early historic period. Hopi and Zuni oral traditions indicate that segments of the prehistoric Hohokam population migrated to the areas occupied by the Hopi and Zuni and were assimilated into the resident populations.

Officials of the Bureau of Reclamation have determined that, pursuant to 25 U.S.C. 3001(3)(B), the 40 items described above are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony and are believed to have been removed from a specific burial site of Native American individuals. Officials of the Bureau of Reclamation also have determined that, pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the unassociated funerary objects and the Ak-Chin Indian Community of the Maricopa (Ak-Chin) Indian Reservation, Arizona; Gila River Indian Community of the Gila River Indian Reservation, Arizona; Hopi Tribe of Arizona; Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona; Tohono O'odham Nation of Arizona; and Zuni Tribe of the Zuni Reservation, New Mexico.

Representative of any other Indian tribe that believes itself to be culturally affiliated with the unassociated funerary objects should contact in writing Carol Erwin, Area Manager, Bureau of Reclamation, Phoenix Area Office, 6150 West Thunderbird Road, Glendale, AZ 85306–4001, before June 3, 2010. Repatriation of the unassociated funerary objects to the Ak-Chin Indian Community of the Maricopa (Ak-Chin) Indian Reservation, Arizona; Gila River Indian Community of the Gila River Indian Reservation, Arizona; Hopi Tribe of Arizona; Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona; Tohono O'odham Nation of Arizona; and Zuni Tribe of the Zuni Reservation, New Mexico, may proceed after that date if no additional claimants come forward.

The Bureau of Reclamation is responsible for notifying the Ak-Chin Indian Community of the Maricopa (Ak-Chin) Indian Reservation, Arizona; Chemehuevi Indian Tribe of the Chemehuevi Indian Reservation, California; Cocopah Tribe of Arizona; Colorado River Indian Tribes of the Colorado River Indian Reservation, Arizona and California; Fort McDowell Yavapai Nation, Arizona; Fort Mohave Indian Tribe of Arizona, California, and Nevada; Gila River Indian Community of the Gila River Indian Reservation, Arizona; Hopi Tribe of Arizona; Pascua Yaqui Tribe of Arizona; Quechan Tribe of the Fort Yuma Indian Reservation, California and Arizona; Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona; San Carlos Apache Tribe of the San Carlos Reservation, Arizona; Tohono O'odham Nation of Arizona; Tonto Apache Tribe of Arizona; White Mountain Apache Tribe of the Fort Apache Reservation, Arizona; Yavapai-Apache Nation of the Camp Verde Indian Reservation, Arizona; Yavapai-Prescott Tribe of the Yavapai Reservation, Arizona; and Zuni Tribe of the Zuni Reservation, New Mexico, that this notice has been published.

Dated: April 6, 2010.

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–10378 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: Bishop Museum, Honolulu, HI

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains in the possession and control of the Bishop Museum, Honolulu, HI. The human remains were removed from Brooks Island, Contra Costa County, CA.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

A detailed assessment of the human remains was made by Bishop Museum professional staff in consultation with representatives of the the Santa Rosa Indian Community of the Santa Rosa Rancheria, California (Tachi Yokut Tribe).

On February 8, 1958, human remains representing a minimum of one individual were removed from Brooks Island, in San Pablo Bay, Contra Costa County, CA, most likely by A.C. Ziegler. The circumstances of the removal from Brooks Island are not known, but the remains were included in Dr. Ziegler's personal collections donated to the Bishop Museum after his death. The remains were housed in a box labeled "Homo Sapiens (infant)/sex?/Brooks

Island, 5 ft, contra Costa County, California/picked up Feb 9, 1958/part skeleton only/1016 A.C. Ziegler." No known individual was identified. No associated funerary objects are present.

The human remains were listed on the National Park Service Culturally Unidentified Inventory database, and Bishop Museum received information from the Santa Rosa Indian Community of the Santa Rosa Rancheria, California (Tachi Yokut Tribe) establishing their cultural affiliation to the remains through their historic and geographical connection to the Contra Costa County area.

Officials of the Bishop Museum have determined that, pursuant to 25 U.S.C. 3001(9), the human remains described above represent the physical remains of one individual of Native American ancestry. Officials of the Bishop Museum also have determined that, pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and the Santa Rosa Indian Community of the Santa Rosa Rancheria, California (Tachi Yokut Tribe).

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains should contact Betty Lou Kam, Vice-President, Cultural Resources, Bishop Museum, 1525 Bernice St., Honolulu, HI 96817, telephone (808) 848–4144, before June 3, 2010. Repatriation of the human remains to the Santa Rosa Indian Community of the Santa Rosa Rancheria, California (Tachi Yokut Tribe) may proceed after that date if no additional claimants come forward.

The Bishop Museum is responsible for notifying the Santa Rosa Indian Community of the Santa Rosa Rancheria, California (Tachi Yokut Tribe) that this notice has been published.

Dated: April 6, 2010.

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–10366 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: Paul H. Karshner Memorial Museum, Puyallup, WA

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains in the possession of the Paul H. Karshner Memorial Museum, Puyallup, WA. The human remains were removed from the Aleutian Islands, AK.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

A detailed assessment of the human remains was made by the Paul H. Karshner Memorial Museum professional staff in consultation with representatives of the Aleut Corporation.

Prior to 1945, human remains representing a minimum of one individual were removed from the Aleutian Islands in Alaska. On May 5, 1945, the human remains were donated to the museum by Lee Anna (or Lavanna) McAllister (Catalog # 1–93, Accn. #1945–1). Museum records state that the human remains are "one skull from Aleutian Islands. Found at the mouth of the Salmon River on the shores of the Bering Sea". No known individual was identified. No associated funerary objects are present.

Research into the donor has not indicated how she may have acquired the human remains. There is no known "Salmon River" that drains into the Bering Sea, however, "Salmon Lagoon" was a location with significant U.S. military presence during World War II on Kiska Island, Aleutian Islands. Military records were searched to locate a McAllister who may have been stationed on Kiska Island, but no further information was identified. Although no further information could be identified, based on the known military presence on Kiska Island at Salmon Lagoon and the date of the donation (post-World War II), this individual is reasonably believed to have been collected by military personnel.

The museum's inventory book identifies the human remains as being part of the "Native American Collection" and being from the Aleutian Islands, AK. The Aleutian Islands are known to be aboriginal lands for the Aleut Corporation. Based on museum records, geographical location, and consultation, the museum reasonably believes the individual is culturally affiliated with the Aleut Corporation.

Officials of the Paul H. Karshner Memorial Museum have determined that, pursuant to 25 U.S.C. 3001 (9)-(10), the human remains described above represent the physical remains of one individual of Native American ancestry. Officials of the Paul H. Karshner Memorial Museum also have determined that, pursuant to 25 U.S.C. 3001 (2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and the Aleut Corporation.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains should contact Dr. Jay Reifel, Assistant Superintendent, Paul H. Karshner Memorial Museum, telephone (253) 840–8971, or Ms. Beth Bestrom, Museum Curator, Paul H. Karshner Memorial Museum, telephone (253) 841–8748, 309 4th St. NE, Puyallup, WA 98372, before June 3, 2010. Repatriation to the Aleut Corporation may proceed after that date if no additional claimants come forward.

The Paul H. Karshner Memorial Museum is responsible for notifying the Aleut Corporation that this notice has been published.

Dated: April 16, 2010.

David Tarler,

Acting Manager, National NAGPRA Program.

[FR Doc. 2010–10370 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: Alaska State Office, Bureau of Land Management, Anchorage, AK; Museum of the Aleutians, Unalaska, AK; and University of Wisconsin, Madison, WI; Correction

AGENCY: National Park Service, Interior.

ACTION: Notice; correction.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects in the control of the U.S. Department of the Interior, Bureau of Land Management, Alaska State Office, Anchorage, AK, and in the possession of the Museum of the Aleutians, Unalaska, AK, and the University of Wisconsin, Madison, WI. The human remains were removed from Umnak Island, AK.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003 (d)(3). The determinations

in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

This notice corrects a Notice of Inventory Completion published in the **Federal Register** (73 FR 47224, August 13, 2008) with the addition of another individual and associated funerary objects, a repository that has possession of the additional set of Native American human remains and funerary objects, and also amends the determination of shared group relationships. Since publication of the notice, additional Native American human remains and associated funerary objects removed by Dr. William Laughlin from the Chaluka site at the Native Village of Nikolski were found to be in the possession of the University of Wisconsin Curation Facility collections.

The notice published in the **Federal Register** (73 FR 47224, August 13, 2008) is corrected by substituting paragraphs 3–10 with the following:

A detailed assessment of the human remains was made by the Alaska State Office, Bureau of Land Management; Museum of the Aleutians; University of Wisconsin; and the Smithsonian Institution professional staff in consultation with representatives of the Native Village of Nikolski and Chaluka Corporation.

Between 1950 and the 1980s, human remains representing a minimum of 213 individuals were removed from various sites in the southwestern part of Umnak Island, located in the Fox Island group of the eastern Aleutian Islands, AK. These sites included the Chaluka site at the Native Village of Nikolski, Ogalodox site, Sandy Beach site, and other nearby smaller sites. The exact provenience for each individual cannot be determined. All of the human remains were probably removed at the direction of the late Dr. William Laughlin from Umnak Island as they were later found to be among his collections. No known individuals were identified. The 276 associated funerary objects include coffin pieces, cultural materials, fragmentary faunal remains, pebbles, rocks, fabric, buttons, and a snap/button.

According to museum records, the 213 sets of human remains were probably first sent to the University of Wisconsin, where one set is presently located. The other 212 sets of human remains were removed by Dr. William Laughlin to the University of Connecticut at an unknown date. From there, the 212 sets of human remains were shipped by Dr. Laughlin to the Museum of the Aleutians in 1998, where they are presently located. The 276 associated funerary objects are all associated with the one set of human remains at the University of Wisconsin, and most are in a mixed and fragmentary state.

During 1961–62, human remains representing a minimum of nine individuals were removed from the Chaluka site at the Native Village of Nikolski, on Umnak Island in the Fox Island group of the eastern Aleutian Islands, AK. These remains were also all probably removed at the direction of the late Dr. William Laughlin from Umnak Island as they were later found to be among his collections after his death. No known individuals were identified. No associated funerary objects are present.

The remains of the nine individuals were shipped to the University of Wisconsin for study by Dr. William Laughlin, and remained there after his death. In 2006, the Bureau of Land Management sent the remains to the Smithsonian Institution to be inventoried, where they are presently located.

Umnak Island has been inhabited for over 8,000 years by Aleut (Unangan) people. Based on geographical location, oral history, and archeological evidence, the human remains from this island are of Aleut (Unangan) origin. The Aleut (Unangan) are ancestors of inhabitants of the Native Village of Nikolski and Chaluka Corporation, the current and only Indian tribe and Corporation on Umnak Island, AK.

Officials of the Bureau of Land Management have determined that, pursuant to 25 U.S.C. 3001 (9)-(10), the human remains described above represent the physical remains of a minimum of 222 individuals of Native American ancestry. Officials of the Bureau of Land Management have also determined that, pursuant to 25 U.S.C. 3001 (3)(A), the 276 objects described above are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony. Lastly, officials of the Bureau of Land Management have determined that, pursuant to 25 U.S.C. 3001 (2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and associated funerary objects and the Native Village of Nikolski and Chaluka Corporation located on Umnak Island, AK.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains and associated funerary objects should contact Dr. Robert E. King, Alaska State NAGPRA Coordinator, Bureau of Land Management, 222 W. 7th Avenue, #13, Anchorage, AK 99513–7599, telephone (907) 271–5510, before June 3, 2010. Repatriation of the human remains and associated funerary objects to the Native Village of Nikolski and Chaluka Corporation may proceed after that date if no additional claimants come forward.

The Bureau of Land Management is responsible for notifying the Native Village of Nikolski and the Chaluka Corporation that this notice has been published.

Dated: April 14, 2010.

David Tarler,

Acting Manager, National NAGPRA Program.

[FR Doc. 2010–10383 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: U.S. Department of the Interior, Bureau of Land Management, Grand Junction Field Office, Grand Junction, CO and Mesa State College, Grand Junction, CO

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains in the joint control of the U.S. Department of the Interior, Bureau of Land Management, Grand Junction Field Office, Grand Junction, CO, and Mesa State College, Grand Junction, CO. The human remains were removed from Mesa County, CO.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

A detailed assessment of the human remains was made by Bureau of Land Management, Grand Junction Field Office and Mesa State College professional staff, in consultation with representatives of the Hopi Tribe of Arizona; Jicarilla Apache Nation, New Mexico; Kiowa Indian Tribe of Oklahoma; Navajo Nation, Arizona, New Mexico & Utah; Ohkay Owingeh,

New Mexico; Paiute Indian Tribe of Utah; Pueblo of San Ildefonso, New Mexico; Pueblo of Santa Ana, New Mexico; Pueblo of Santa Clara, New Mexico; Pueblo of Pojoaque, New Mexico; Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho; Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado; Standing Rock Sioux Tribe of North & South Dakota; Ute Indian Tribe of the Uintah & Ouray Reservation, Utah; and Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah.

On an unknown date in the 1970s, human remains representing two individuals were removed from an unknown location near Grand Mesa, in Mesa County, CO. On April 1, 2009, the human remains were discovered in the Geology Department of Mesa State College by college staff, and were reported to the Ute Tribe of the Uintah & Ouray Reservation, and subsequently to the Bureau of Land Management. Based on investigations into their origin and placement at Mesa State College, most likely these remains were unofficially removed in the 1970s from public lands near Grand Mesa, CO, by Mesa State College students who were hiking in the area. The students brought the remains to Mesa State College, where they were studied and later stored in the Geology Department. No known individuals were identified. No associated funerary objects are present.

Although the description of the original site location is not specific enough to determine land ownership status, most of the land in the general region was Federal land administered by the Bureau of Land Management at the time the remains were removed. Therefore, the Bureau of Land Management assumes control of the human remains for the purposes of NAGPRA compliance. Because provenience is limited to a regional area, and the remains were collected by Mesa State College students and stored by Mesa State College, the college has shared control with the Bureau of Land Management. After their discovery in the college's Geology Department, the remains were transported by Bureau of Land Management staff to the Museum of Western Colorado for secure storage pending repatriation.

The human remains consist of two adult individuals of considerable antiquity, and are likely Native Americans. Their reported burial within rock crevices correlates with Native American burial practices, particularly those of the Ute culture. Furthermore, the original location of the human remains lies within traditional Ute lands, and within proximity to Ute sites and historic trails.

Officials of the Bureau of Land Management and Mesa State College have determined that, pursuant to 25 U.S.C. 3001 (9)-(10), the human remains described above represent the physical remains of two individuals of Native American ancestry. Officials of the Bureau of Land Management and Mesa State College have also determined that, pursuant to 25 U.S.C. 3001 (2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and the Ute Tribes - Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado; Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah; and, in particular, the Ute Indian Tribe of the Uintah & Ouray Reservation, Utah.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains should contact Dan Haas, State Archaeologist, Bureau of Land Management, Colorado State Office, 2850 Youngfield St., Lakewood, CO 80215–7076, telephone (303) 239–3647, before June 3, 2010. Repatriation of the human remains to the Ute Indian Tribe of the Uintah & Ouray Reservation, Utah, may proceed after that date if no additional claimants come forward.

The Bureau of Land Management is responsible for notifying the Hopi Tribe of Arizona; Jicarilla Apache Nation, New Mexico; Kiowa Indian Tribe of Oklahoma; Navajo Nation, Arizona, New Mexico & Utah; Ohkay Owingeh, New Mexico; Paiute Indian Tribe of Utah; Pueblo of San Ildefonso, New Mexico; Pueblo of Santa Ana, New Mexico; Pueblo of Santa Clara, New Mexico; Pueblo of Pojoaque, New Mexico; Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho; Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado; Standing Rock Sioux Tribe of North & South Dakota; Ute Indian Tribe of the Uintah & Ouray Reservation, Utah; and Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah, that this notice has been published.

Dated: April 16, 2010.

David Tarler,

Acting Manager, National NAGPRA Program.

[FR Doc. 2010–10381 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: Wisconsin Historical Society, Museum Division, Madison, WI

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains in the possession of the Wisconsin Historical Society, Museum Division (aka State Historical Society of Wisconsin), Madison, WI. The human remains were removed from the Bell Site, Winnebago County, WI.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

An assessment of the human remains was made by the Wisconsin Historical Museum professional staff in consultation with representatives of the Sac & Fox Tribe of the Mississippi in Iowa.

In 1959, human remains representing a minimum of one individual were removed from a grave at the Bell Site, 47–Wn–0009, in Winnebago County, WI, during archeological excavations. The excavations were conducted by the Wisconsin Historical Society, the Wisconsin Archaeological Survey, and the Oshkosh Public Museum, all under the supervision of Warren Wittry. No known individual was identified. No associated funerary objects are present.

According to historical and archeological records, the Bell Site is the location of the historic Grand Village of the Meskwaki Nation, dating from approximately A.D. 1680 to 1730. Officials at the Wisconsin Historical Museum have determined that the human remains described above can be directly associated with the Sac & Fox Tribe of the Mississippi in Iowa, as the majority of the Meskwaki Nation resides in Iowa.

Officials of the Wisconsin Historical Society have determined that, pursuant to 25 U.S.C. 3001(9), the human remains described above represent the physical remains of one individual of Native American ancestry. Officials of the Wisconsin Historical Society also have

determined that, pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and the Sac & Fox Tribe of the Mississippi in Iowa.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains should contact Jennifer L. Kolb, Wisconsin Historical Museum, 30 N. Carroll St., Madison, WI 53703, telephone (608) 261–2461, before June 3, 2010. Repatriation of the human remains to the Sac & Fox Tribe of the Mississippi in Iowa may proceed after that date if no additional claimants come forward.

The Wisconsin Historical Society is responsible for notifying the Sac & Fox Tribe of the Mississippi in Iowa that this notice has been published.

Dated: April 12, 2010.

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–10380 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: Denver Museum of Nature & Science, Denver, CO

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains in the possession of the Denver Museum of Nature & Science, Denver, CO. The human remains were removed from Pettis County, MO.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

A detailed assessment of the human remains was made by the Denver Museum of Nature & Science professional staff in consultation with representatives of the Osage Nation, Oklahoma.

In 1933, human remains representing a minimum of two individuals were removed from a mound burial context four miles northwest of Sedalia, Pettis County, MO, by G.D. Householder. Householder donated the individuals to the museum at some point thereafter. In 1994, the human remains were found in the museum's collections during an inventory, and then formally accessioned (DMNS catalogue numbers A1991.1 and A1991.2). The human remains were originally determined to be culturally unidentifiable. No known individuals were identified. No associated funerary objects are present.

Based on physical analysis, the human remains are determined to be Native American. Archeological evidence suggests that Pettis County mound sites generally date to the Mississippian nucleation horizon (A.D. 1350–1650). Oral tradition and historical documentation–supported by geographical, linguistic, folkloric, archeological evidence, and expert opinion–indicate that Pettis County has long been a part of the Osage traditional ancestral homelands and hunting territory. After consultation with the Osage Nation, Oklahoma, the museum reasonably believes that there is a shared group identity between the Osage people and the people of these ancient mounds.

Officials of the Denver Museum of Nature & Science have determined that, pursuant to 25 U.S.C. 2001 (9)-(10), the human remains described above represent the physical remains of two individuals of Native American ancestry. Officials of the Denver Museum of Nature & Science also have determined that, pursuant to 25 U.S.C. 3001 (2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and the Osage Nation, Oklahoma.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains should contact Dr. Chip Colwell-Chanthaphonh, Denver Museum of Nature & Science, 2001 Colorado Blvd., Denver, CO 80205, telephone (303) 370–6378, before June 3, 2010. Repatriation of the human remains to the Osage Nation, Oklahoma may proceed after that date if no additional claimants come forward.

The Denver Museum of Nature & Science is responsible for notifying the Osage Nation, Oklahoma that this notice has been published.

Dated: April 14, 2010.

David Tarler,

Acting Manager, National NAGPRA Program.

[FR Doc. 2010–10367 Filed 5–3–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review: Comment Request

April 22, 2010.

The Department of Labor (DOL) hereby announces the submission of the following public information collection requests (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. chapter 35). A copy of each ICR, with applicable supporting documentation; including among other things a description of the likely respondents, proposed frequency of response, and estimated total burden may be obtained from the RegInfo.gov Web site at *http://www.reginfo.gov/public/do/PRAMain* or by contacting Darrin King on 202–693–4129 (this is not a toll-free number)/e-mail: *DOL_PRA_PUBLIC@dol.gov.*

Interested parties are encouraged to send comments to the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the Department of Labor—Employment and Training Administration (ETA), Office of Management and Budget, Room 10235, Washington, DC 20503, Telephone: 202–395–7316/Fax: 202–395–5806 (these are not toll-free numbers), E-mail: *OIRA_submission@omb.eop.gov* within 30 days from the date of this publication in the **Federal Register.** In order to ensure the appropriate consideration, comments should reference the OMB Control Number (see below).

The OMB is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Agency: Employment and Training Administration.

Type of Review: Extension without change of a currently approved collection.

Title of Collection: Work Application/ Job Order Recordkeeping.

OMB Control Number: 1205–0001.

Agency Form Number: N/A.

Affected Public State, Local, or Tribal Governments.

Total Estimated Number of Respondents: 52.

Total Estimated Annual Burden Hours: 416.

Total Estimated Annual Costs Burden (Operation and Maintenance): $0.

Description: Work applications (commonly referred to as the registrations) are used in One-Stop Career Centers for individuals seeking assistance in finding employment or employability development services. They are used to collect information such as: applicants' identification, qualifications, work experience, and desired pay. They also include services provided to applicants, such as job development, referral to supportive service.

Job orders are used in One-Stop Career Centers to obtain information on employer job vacancies. Information in the job orders include employer identification, job requirements, pay information as well as identification of persons referred, hired, or refused. The information is collected at the employer's request in order to publicize job vacancies. The information is collected by One-Stop Career Centers and posted on electronic job banks. 20 CFR 652.8(d)(5) specifies the one-year retention of information on work applications and job orders. For additional information, see related notice published in the **Federal Register** on January 5, 2010 (75 FR 450).

Agency: Employment and Training Administration.

Type of Review: Extension without change of a currently approved collection.

Title of Collection: Benefit Rights and Experience Report.

OMB Control Number: 1205–0177.

Agency Form Number: ETA–218.

Affected Public State, Local, or Tribal Governments.

Total Estimated Number of Respondents: 53.

Total Estimated Annual Burden Hours: 108.

Total Estimated Annual Costs Burden (Operation and Maintenance): $0.

Description: The Form ETA–218 provides information used in solvency studies, in budgeting projections and for evaluation of adequacy of benefit formulas to analyze effects or proposed changes in state law. For additional information, see related notice published in the **Federal Register** on January 25, 2010 (75 FR 3927).

Agency: Employment and Training Administration.

Type of Review: Extension without change of a currently approved collection.

Title of Collection: Transmittal of Unemployment Insurance Materials.

OMB Control Number: 1205–0222.

Agency Form Number: MA 8–7.

Affected Public: State, Local, or Tribal Governments.

Total Estimated Number of Respondents: 53.

Total Estimated Annual Burden Hours: 11.

Total Estimated Annual Costs Burden (Operation and Maintenance): $0.

Description: Section 303(a)(6), Social Security Act, Public Law 74–271, (SSA), requires, as a condition of receiving administrative grants, that State law contain provision for the "making of such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and compliance with such provisions as the Secretary of Labor may from time to time find necessary to ensure the correctness and verification of such reports." Departmental regulations at 20 CFR 601.3 in part implement this requirement by requiring the submission of "all relevant state materials, such as statutes, executive and administrative orders, legal opinions, rules, regulations, interpretations, court opinions, etc. * * *" Also, the regulations for the Unemployment Compensation (UC) for Federal Civilian Employees (UCFE) program at 20 CFR 609.1(d)(1) and for the UC for ex-service members (UCX) program at 20 CFR 614.1(d)(1) require submission of certain documents to assure that states are properly administering these programs. The Trade Adjustment Assistance (which includes Trade Readjustment Allowances) program (TAA/TRA) regulations provide similar requirements at 20 CFR 617.52(c)(1).

The Form MA 8–7 is the mechanism for implementing these submittal requirements, the purpose of which is to provide the Secretary with sufficient information to determine if (a) employers in a state qualify for tax credits under the Federal Unemployment Tax Act; (b) the state meets the requirements for obtaining administrative grants under Title III, SSA; and (c) the state is fulfilling it obligations under Federal UC programs. For additional information, see related notice published in the **Federal Register** on January 25, 2010 (75 FR 3926).

Darrin A. King,

Departmental Clearance Officer.

[FR Doc. 2010–10303 Filed 5–3–10; 8:45 am]

BILLING CODE 4510–FW–P

NUCLEAR REGULATORY COMMISSION

[NRC–2010–0169]

Biweekly Notice; Applications and Amendments to Facility Operating Licenses Involving No Significant Hazards Considerations

I. Background

Pursuant to section 189a. (2) of the Atomic Energy Act of 1954, as amended (the Act), the U.S. Nuclear Regulatory Commission (the Commission or NRC) is publishing this regular biweekly notice. The Act requires the Commission publish notice of any amendments issued, or proposed to be issued and grants the Commission the authority to issue and make immediately effective any amendment to an operating license upon a determination by the Commission that such amendment involves no significant hazards consideration, notwithstanding the pendency before the Commission of a request for a hearing from any person.

This biweekly notice includes all notices of amendments issued, or proposed to be issued from April 8, 2010 to April 21, 2010. The last biweekly notice was published on April 20, 2010 (75 FR 20627).

Notice of Consideration of Issuance of Amendments to Facility Operating Licenses, Proposed No Significant Hazards Consideration Determination, and Opportunity for a Hearing

The Commission has made a proposed determination that the following amendment requests involve no significant hazards consideration. Under the Commission's regulations in Title 10 of the Code of Federal Regulations (10 CFR), Section 50.92, this means that operation of the facility in accordance with the proposed amendment would not (1) involve a significant increase in the probability or consequences of an accident previously evaluated; or (2) create the possibility of a new or different kind of accident from any accident previously evaluated; or (3) involve a significant reduction in a margin of safety. The basis for this proposed determination for each amendment request is shown below.

The Commission is seeking public comments on this proposed determination. Any comments received within 30 days after the date of publication of this notice will be considered in making any final determination.

Normally, the Commission will not issue the amendment until the expiration of 60 days after the date of publication of this notice. The Commission may issue the license amendment before expiration of the 60-day period provided that its final determination is that the amendment involves no significant hazards consideration. In addition, the Commission may issue the amendment prior to the expiration of the 30-day comment period should circumstances change during the 30-day comment period such that failure to act in a timely way would result, for example in derating or shutdown of the facility. Should the Commission take action prior to the expiration of either the comment period or the notice period, it will publish in the **Federal Register** a notice of issuance. Should the Commission make a final No Significant Hazards Consideration Determination, any hearing will take place after issuance. The Commission expects that the need to take this action will occur very infrequently.

Written comments may be submitted by mail to the Chief, Rules, Announcements and Directives Branch (RADB), TWB–05–B01M, Division of Administrative Services, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, and should cite the publication date and page number of this **Federal Register** notice. Written comments may also be faxed to the RADB at 301–492–3446. Documents may be examined, and/or copied for a fee, at the NRC's Public Document Room (PDR), located at One White Flint North, Public File Area O1F21, 11555 Rockville Pike (first floor), Rockville, Maryland.

Within 60 days after the date of publication of this notice, any person(s) whose interest may be affected by this action may file a request for a hearing and a petition to intervene with respect to issuance of the amendment to the subject facility operating license. Requests for a hearing and a petition for leave to intervene shall be filed in accordance with the Commission's "Rules of Practice for Domestic Licensing Proceedings" in 10 CFR part 2. Interested person(s) should consult a current copy of 10 CFR 2.309, which is available at the Commission's PDR, located at One White Flint North, Public File Area O1F21, 11555 Rockville Pike (first floor), Rockville, Maryland. Publicly available records will be accessible from the Agencywide Documents Access and Management System's (ADAMS) Public Electronic Reading Room on the Internet at the NRC Web site, *http://www.nrc.gov/reading-rm/doc-collections/cfr/.* If a request for a hearing or petition for leave to intervene is filed by the above date, the Commission or a presiding officer designated by the Commission or by the Chief Administrative Judge of the Atomic Safety and Licensing Board Panel, will rule on the request and/or petition; and the Secretary or the Chief Administrative Judge of the Atomic Safety and Licensing Board will issue a notice of a hearing or an appropriate order.

As required by 10 CFR 2.309, a petition for leave to intervene shall set forth with particularity the interest of the petitioner in the proceeding, and how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention should be permitted with particular reference to the following general requirements: (1) The name, address, and telephone number of the requestor or petitioner; (2) the nature of the requestor's/petitioner's right under the Act to be made a party to the proceeding; (3) the nature and extent of the requestor's/petitioner's property, financial, or other interest in the proceeding; and (4) the possible effect of any decision or order which may be entered in the proceeding on the requestor's/petitioner's interest. The petition must also identify the specific contentions which the requestor/petitioner seeks to have litigated at the proceeding.

Each contention must consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the requestor/petitioner shall provide a brief explanation of the bases for the contention and a concise statement of the alleged facts or expert opinion which support the contention and on which the requestor/petitioner intends to rely in proving the contention at the hearing. The requestor/petitioner must also provide references to those specific sources and documents of which the petitioner is aware and on which the requestor/petitioner intends to rely to establish those facts or expert opinion. The petition must include sufficient information to show that a genuine dispute exists with the applicant on a material issue of law or fact. Contentions shall be limited to matters within the scope of the amendment under consideration. The contention must be one which, if proven, would entitle the requestor/petitioner to relief. A requestor/petitioner who fails to satisfy these requirements with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing.

If a hearing is requested, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to decide when the hearing is held. If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it immediately effective, notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment. If the final determination is that the amendment request involves a significant hazards consideration, any hearing held would take place before the issuance of any amendment.

All documents filed in NRC adjudicatory proceedings, including a request for hearing, a petition for leave to intervene, any motion or other document filed in the proceeding prior to the submission of a request for hearing or petition to intervene, and documents filed by interested governmental entities participating under 10 CFR 2.315(c), must be filed in accordance with the NRC E-Filing rule (72 FR 49139, August 28, 2007). The E-Filing process requires participants to submit and serve all adjudicatory documents over the Internet, or in some cases to mail copies on electronic storage media. Participants may not submit paper copies of their filings unless they seek an exemption in accordance with the procedures described below.

To comply with the procedural requirements of E-Filing, at least ten (10) days prior to the filing deadline, the participant should contact the Office of the Secretary by e-mail at *hearing.docket@nrc.gov,* or by telephone at (301) 415–1677, to request (1) a digital ID certificate, which allows the participant (or its counsel or representative) to digitally sign documents and access the E-Submittal server for any proceeding in which it is participating; and (2) advise the Secretary that the participant will be submitting a request or petition for hearing (even in instances in which the participant, or its counsel or

representative, already holds an NRC-issued digital ID certificate). Based upon this information, the Secretary will establish an electronic docket for the hearing in this proceeding if the Secretary has not already established an electronic docket.

Information about applying for a digital ID certificate is available on NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals/apply-certificates.html*. System requirements for accessing the E-Submittal server are detailed in NRC's "Guidance for Electronic Submission," which is available on the agency's public Web site at *http://www.nrc.gov/site-help/e-submittals.html*. Participants may attempt to use other software not listed on the Web site, but should note that the NRC's E-Filing system does not support unlisted software, and the NRC Meta System Help Desk will not be able to offer assistance in using unlisted software.

If a participant is electronically submitting a document to the NRC in accordance with the E-Filing rule, the participant must file the document using the NRC's online, Web-based submission form. In order to serve documents through EIE, users will be required to install a Web browser plug-in from the NRC Web site. Further information on the Web-based submission form, including the installation of the Web browser plug-in, is available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals.html*.

Once a participant has obtained a digital ID certificate and a docket has been created, the participant can then submit a request for hearing or petition for leave to intervene. Submissions should be in Portable Document Format (PDF) in accordance with NRC guidance available on the NRC public Web site at *http://www.nrc.gov/site-help/e-submittals.html*. A filing is considered complete at the time the documents are submitted through the NRC's E-Filing system. To be timely, an electronic filing must be submitted to the E-Filing system no later than 11:59 p.m. Eastern Time on the due date. Upon receipt of a transmission, the E-Filing system time-stamps the document and sends the submitter an e-mail notice confirming receipt of the document. The E-Filing system also distributes an e-mail notice that provides access to the document to the NRC Office of the General Counsel and any others who have advised the Office of the Secretary that they wish to participate in the proceeding, so that the filer need not serve the documents on those participants separately. Therefore, applicants and other participants (or their counsel or representative) must apply for and receive a digital ID certificate before a hearing request/petition to intervene is filed so that they can obtain access to the document via the E-Filing system.

A person filing electronically using the agency's adjudicatory E-Filing system may seek assistance by contacting the NRC Meta System Help Desk through the "Contact Us" link located on the NRC Web site at *http://www.nrc.gov/site-help/e-submittals.html*, by e-mail at *MSHD.Resource@nrc.gov,* or by a toll-free call at (866) 672–7640. The NRC Meta System Help Desk is available between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday, excluding government holidays.

Participants who believe that they have a good cause for not submitting documents electronically must file an exemption request, in accordance with 10 CFR 2.302(g), with their initial paper filing requesting authorization to continue to submit documents in paper format. Such filings must be submitted by: (1) First class mail addressed to the Office of the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Rulemaking and Adjudications Staff; or (2) courier, express mail, or expedited delivery service to the Office of the Secretary, Sixteenth Floor, One White Flint North, 11555 Rockville Pike, Rockville, Maryland, 20852, Attention: Rulemaking and Adjudications Staff. Participants filing a document in this manner are responsible for serving the document on all other participants. Filing is considered complete by first-class mail as of the time of deposit in the mail, or by courier, express mail, or expedited delivery service upon depositing the document with the provider of the service. A presiding officer, having granted an exemption request from using E-Filing, may require a participant or party to use E-Filing if the presiding officer subsequently determines that the reason for granting the exemption from use of E-Filing no longer exists.

Documents submitted in adjudicatory proceedings will appear in NRC's electronic hearing docket which is available to the public at *http://ehd.nrc.gov/EHD_Proceeding/home.asp,* unless excluded pursuant to an order of the Commission, or the presiding officer. Participants are requested not to include personal privacy information, such as social security numbers, home addresses, or home phone numbers in their filings, unless an NRC regulation or other law requires submission of such information. With respect to copyrighted works, except for limited excerpts that serve the purpose of the adjudicatory filings and would constitute a Fair Use application, participants are requested not to include copyrighted materials in their submission.

Petitions for leave to intervene must be filed no later than 60 days from the date of publication of this notice. Non-timely filings will not be entertained absent a determination by the presiding officer that the petition or request should be granted or the contentions should be admitted, based on a balancing of the factors specified in 10 CFR 2.309(c)(1)(i)–(viii).

For further details with respect to this license amendment application, see the application for amendment which is available for public inspection at the Commission's PDR, located at One White Flint North, Public File Area O1F21, 11555 Rockville Pike (first floor), Rockville, Maryland. Publicly available records will be accessible from the ADAMS Public Electronic Reading Room on the Internet at the NRC Web site, *http://www.nrc.gov/reading-rm/adams.html.* Persons who do not have access to ADAMS or who encounter problems in accessing the documents located in ADAMS, should contact the NRC PDR Reference staff at 1–800–397–4209, 301–415–4737, or by e-mail to *pdr.resource@nrc.gov.*

Calvert Cliffs Nuclear Power Plant, LLC, Docket Nos. 50–317 and 50–318, Calvert Cliffs Nuclear Power Plant, Unit Nos. 1 and 2, Calvert County, Maryland

Date of amendments request: November 23, 2009.

Description of amendments request: The amendment would modify the licensing basis and the Technical Specifications by allowing for the transition from Westinghouse Turbo fuel to AREVA Advanced CE–14 High Thermal Performance (HTP) fuel in the Calvert Cliffs reactors. The licensee plans to refuel and operate with AREVA fuel beginning with the refueling outage in 2011 for Unit No. 2 and 2012 for Unit No. 1. The transition is planned to occur over three refueling cycles on each unit.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed amendment involve a significant increase in the probability or consequences of an accident previously evaluated?

No.

The reactor fuel and the analyses associated with it are not accident initiators. The response of the fuel to an accident is analyzed using conservative techniques and the results are compared to approved acceptance criteria. These evaluation results will show that the fuel response to an accident is within approved acceptance criteria for both cores loaded with the new AREVA Advanced CE–14 HTP fuel and cores loaded with both AREVA and Westinghouse Turbo fuel. Therefore, the change in fuel design does not affect accident or transient initiation or consequences.

The proposed change to the Safety Limit Technical Specification (2.1.1.2) does not require any physical change to any plant system, structure, or component. The change to establish the peak fuel centerline temperature as the safety limit is consistent with the Standard Review Plan (SRP) for ensuring that the fuel design limits are met. Operations and analysis will continue to be in compliance with Nuclear Regulatory Commission (NRC) regulations. The peak fuel centerline temperature is the basis for protecting the fuel and is consistent with the analogous wording for other pressurized water reactor (PWR) plants. Providing the peak fuel centerline melt temperature as the safety limit does not impact the initiation or the mitigation of an accident.

The proposed change to remove the total planar radial peaking factor (F^T_{XY}, Technical Specification 3.2.2) is based on a methodology change. During and after the transition to AREVA Advanced CE–14 HTP fuel, the core analyses are performed using AREVA methodologies. These methodologies do not use the total planar radial peaking factor (F^T_{XY}) as an initial value in the accident analyses. The linear heat rate algorithm limits are provided by the total integrated radial peaking factor, azimuthal power tilt, and axial shape index. The linear heat rate is evaluated in accordance with NRC-approved methodology and meets acceptance criteria. The total planar radial peaking factor is not an accident initiator and does not play a role in accident mitigation. A number of other changes are also made to remove references to Technical Specification 3.2.2 throughout the Technical Specifications.

Topical reports have been reviewed and approved by the NRC for use in determining core operating limits. The core operating limits to be developed using the new methodologies will be established in accordance with the applicable limitations as documented in the appropriate NRC Safety Evaluation reports. The proposed change to add and remove various topical reports to Technical Specification 5.6.5 enables the use of appropriate methodologies to re-analyze certain events. The proposed methodologies will ensure that the plant continues to meet applicable design criteria and safety analysis acceptance criteria.

The proposed change to the list of NRC-approved methodologies listed in Technical Specification 5.6.5 is administrative in nature and has no impact on any plant configuration or system performance relied upon to mitigate the consequences of an accident. The proposed change will update the listing of NRC-approved methodologies to remove methods no longer used and add new methods consistent with the transition to AREVA Advanced CE–14 HTP fuel. Changes to the calculated core operating limits may only be made using NRC-approved methods, must be consistent with all applicable safety analysis limits and are controlled by the 10 CFR 50.59 process. The list of methodologies in the Technical Specifications does not impact either the initiation of an accident or the mitigation of its consequences.

Therefore, the proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different type of accident from any accident previously evaluated?

No.

Use of AREVA Advanced CE–14 HTP fuel in the Calvert Cliffs reactor cores is consistent with the current plant design bases and does not adversely affect any fission product barrier, nor does it alter the safety function of safety systems, structures, or components, or their roles in accident prevention or mitigation. The operational characteristics of AREVA Advanced CE–14 HTP fuel are bounded by the safety analyses. The AREVA Advanced CE–14 HTP fuel design performs within fuel design limits and does not create the possibility of a new or different type of accident.

The proposed change to the Safety Limit Technical Specification (2.1.1.2) does not require any physical change to any plant system, structure, or component, nor does it require any change in safety analysis methods or results. The existing analyses remain unchanged and do not affect any accident initiators that would create a new accident.

The proposed change to remove the total planar radial peaking factor (F^T_{XY}, Technical Specification 3.2.2) is based on a change in analytical methods needed to support the physical fuel change. These methodologies do not use the total planar radial peaking factor (F^T_{XY}) as an initial value in the accident analysis. The total planar radial peaking factor does not play a role in accident mitigation and cannot create the possibility of a new or different kind of accident. A number of other changes are made to remove references to Technical Specification 3.2.2 throughout the Technical Specifications.

The proposed change to the list of topical reports used to determine the core operating limits is administrative in nature and has no impact on any plant configuration or on system performance. It updates the list of NRC-approved topical reports used to develop the core operating limits. There is no change to the parameters within which the plant is normally operated. The possibility of a new or different accident is not created.

Therefore, the proposed change does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

No.

Use of AREVA Advanced CE–14 HTP fuel is consistent with the current plant design bases and does not adversely affect any fission product barrier, nor does it alter the safety function of safety systems, structures, or components, or their roles in accident prevention or mitigation. The operational characteristics of AREVA Advanced CE–14 HTP fuel are bounded by the safety analyses. The AREVA Advanced CE–14 HTP fuel design performs within fuel design limits. The proposed changes do not result in exceeding design basis limits. Therefore, all licensed safety margins are maintained.

The proposed change to the Safety Limit Technical Specification (2.1.1.2) does not require any physical change to any plant system, structure, or component, nor does it require any change in safety analysis methods or results. Therefore, by changing the safety limit from peak linear heat rate to peak fuel centerline temperature, the margin as established in the current licensing basis remains unchanged.

The proposed change to remove the total planar radial peaking factor (F^T_{XY},Technical Specification 3.2.2) is based on a methodology change. The linear heat rate algorithm limits are provided by the total integrated radial peaking factor, azimuthal power tilt, and axial shape index. The linear heat rate is evaluated in accordance with NRC-approved methodology and meets acceptance criteria. Therefore, the margin as established for the linear heat rate remains unchanged. A number of other changes are made to remove references to Technical Specification 3.2.2 throughout the Technical Specifications.

The proposed change to the list of topical reports does not amend the cycle specific parameters presently required by the Technical Specifications. The individual Technical Specifications continue to require operation of the plant within the bounds of the limits specified in the COLR [Core Operating Limits Report]. The proposed change to the list of analytical methods referenced in the COLR is administrative in nature and does not impact the margin of safety.

Therefore, the proposed change does not involve a significant reduction in the margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendments request involves no significant hazards consideration.

Attorney for licensee: Carey Fleming, Sr. Counsel—Nuclear Generation, Constellation Generation Group, LLC, 750 East Pratt Street, 17th floor, Baltimore, MD 21202.

NRC Branch Chief: Nancy L. Salgado.

Entergy Nuclear Operations, Inc., Docket No. 50–293, Pilgrim Nuclear Power Station, Plymouth County, Massachusetts

Date of amendment request: March 15, 2010.

Description of amendment request: The proposed amendment would revise a Technical Specification (TS) to address the increased setpoints and setpoint tolerances for Safety Relief Valves (SRVs) and Spring Safety Valves (SSVs) and changes related to the replacement of four Target Rock two-stage SRVs with more reliable three-stage SRVs and two existing Dresser 3.749 inch throat diameter SSVs with Dresser 4.956 inch diameter SSVs.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration which is presented below:

1. Does the proposed change involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed change increases the allowable as-found SRV and SSV setpoint tolerance, determined by test after the valves have been removed from service, from ± 1% to ± 3%. The proposed change also increases the SRV and SSV setpoints. Analysis of these changes demonstrates that reactor pressure will be maintained below the applicable code overpressure limits. The proposed change increases the SSV discharge capacity due to its increased throat diameter. The proposed change does not alter the TS requirements for the number of SRVs and SSVs required to be operable, the allowable as-left lift setpoint tolerance, the testing frequency, or the manner in which the valves are operated. Consistent with current TS requirements, the proposed change continues to require that the safety valves be adjusted to within ± 1% of their nominal lift setpoints following testing. The proposed increase in the SRV and SSV setpoint complies with the ASME Boiler and Pressure Vessel (B&PV) Code (1965 Edition, including January 1966 Addendum) for the pressure vessel, USAS Piping Code Section B31.1 for the steam space piping, and ASME Section III for the reactor coolant system recirculation piping. Since the proposed change does not alter the manner in which the valves are operated, there is no significant impact on the reactor operation.

The proposed change does not involve a change to the safety function of the valves. The proposed TS revision involves no significant changes to the operation of any systems or components in normal or accident operating conditions. Therefore, these changes will not increase the probability of an accident previously evaluated.

Since an SSV setpoint increase and setpoint tolerance will increase the SSV safety valve opening pressure and an increase in the SSV throat size will increase the SSV flow capacity, the SSV dynamic loads are expected to increase. Entergy has evaluated the SSV dynamic loads for the associated piping. All piping and structures were found to meet Code requirements.

Since an SRV setpoint and the setpoint tolerance increase will increase the SRV valve opening pressure, the SRV discharge dynamic loads will increase. Entergy has evaluated the SRV dynamic load increases for the associated piping and torus submerged structures and the evaluation concluded that all piping and structures were found to meet Code requirements.

The proposed revision to the HPCI [high-pressure coolant injection] and RCIC [Reactor Core Isolation Cooling] pump operability determination surveillance follows the format of BWR Standard Technical Specification surveillance, and complies with in-service testing for pump operability determination in accordance with ASME OM Code requirement.

Generic considerations related to the change in setpoints and setpoint tolerance were addressed in NEDC–31753P, "BWROG In-Service Pressure Relief Technical Specification Revision Licensing Topical Report," and were reviewed and approved by the NRC in a safety evaluation dated March 8, 1993. General Electric Hitachi Company (GEH) completed plant-specific analyses to assess the impact of increase in SRV and SSV setpoints and increase in the setpoint tolerance from ± 1% to ± 3%. The impact of the increases in the SRV and SSV setpoints and increases in the setpoint tolerances, as addressed in this analysis, included vessel overpressure, Updated Final Safety Analysis Report (UFSAR) Chapter 14 events, ATWS [Anticipated Transient Without Scram], Loss of Coolant Accident (LOCA), containment response and dynamic loads, high-pressure systems performance, operating mode and equipment out of service. The proposed change is supported by GEH analysis of events that credit the SRVs and SSVs.

The plant specific evaluations, required by the NRC's safety evaluation and performed to support this proposed change, demonstrate that there is no change to the design core thermal limits and adequate margin to the reactor coolant system pressure limits exists. These analyses also demonstrate that operation of Core Standby Cooling Systems (CSCS) is not adversely affected and the containment response following a LOCA is acceptable. The plant systems associated with these proposed changes are capable of meeting applicable design basis requirements and retain the capability to mitigate the consequences of accidents described in the UFSAR. Therefore, these changes do not involve an increase in the consequences of an accident previously evaluated.

Therefore, the proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed change create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed change increases the allowable as-found lift setpoint tolerance for the Pilgrim SRV and SSV valves. The proposed change to increase the tolerance was developed in accordance with the provisions contained in the NRC safety evaluation for NEDC–31753P. SRVs and SSVs installed in the plant following testing will continue to meet the current tolerance acceptance criteria of ± 1% of the nominal setpoint. The proposed change does not affect the manner in which the overpressure protection system is operated; therefore, there are no new failure mechanisms for the overpressure protection system.

The proposed changes do not change the safety function of the SRVs and SSVs, or HPCI and RCIC systems. There is no alteration to the parameters within which the plant is normally operated. The increase in SRV and SSV setpoints, setpoint tolerance, and increased SSV discharge capacity are not precursors to new or different kinds of accidents and do not initiate new or different kinds of accidents. The impact of these changes have been analyzed and found to be acceptable within the design limits and plant operating procedures.

As a result, no new failure modes are being introduced. Therefore, the proposed change does not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the proposed change involve a significant reduction in a margin of safety?

Response: No.

The margin of safety is established through the design of the plant structures, systems, and components, the parameters within which the plant is operated and the establishment of the setpoints for the actuation of equipment relied upon to respond to an event. The proposed change modifies the setpoints at which protective actions are initiated, and [* * *] does not change the requirements governing operation or availability of safety equipment assumed to operate to preserve the margin of safety.

Establishment of the ± 3% SRV and SSV setpoint tolerance limit does not adversely affect the operation of any safety-related component or equipment. Evaluations performed in accordance with the NRC safety evaluation for NEDC–31753P have concluded that all design limits will continue to be met.

Therefore, the proposed change does not involve a significant reduction in the margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Mr. William C. Dennis, Assistant General Counsel, Entergy Nuclear Operations, Inc., 400 Hamilton Avenue, White Plains, NY 10601.

NRC Branch Chief: Nancy Salgado.

Entergy Operations, Inc., Docket No. 50–382, Waterford Steam Electric Station, Unit 3, St. Charles Parish, Louisiana

Date of amendment request: February 22, 2010.

Description of amendment request: The proposed amendment will modify Technical Specification (TS) 3/4.9.4, "Containment Building Penetrations," to allow alternative means of penetration closure during Core Alterations or irradiated fuel movement while in refueling operations. Additional improvements to the TS are also being proposed, as well as the elimination of TS 3/4.9.9, "Containment Purge Valve Isolation System." The proposed changes are consistent with Revision 3 of NUREG–1432, "Standard Technical Specifications Combustion Engineering Plants."

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed change involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

TS 3/4.9.4 currently allows containment penetration flow paths to be open during Core Alterations or movement of irradiated fuel within containment under specific administrative controls. The proposed change would allow additional approved methods for ensuring positive penetration closure. The fuel handling accident (FHA) radiological analysis does not take credit for containment isolation or filtration. Therefore, the time required to close any open penetrations does not affect the radiological analysis dose calculations and the proposed change does not involve a significant increase in the consequences of an accident previously evaluated. The administrative controls for containment penetration closure are conservative even though not required by the accident analysis.

The proposed revision only provides alternate methods of penetration closure and does not alter any plant equipment where the probability of an accident would be increased. The incorporation of purge valve isolation surveillance requirements for assuring purge valve Operability has no effect on the probability or consequences of the analyzed accidents.

Therefore, this change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed change create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

Alternative methods of providing penetration closure do not create accident initiators and do not represent a significant change in the configuration of the plant. The proposed allowance to secure containment penetrations during refueling operations will not adversely effect plant safety functions or equipment operating practices such that a new or different accident could be created.

Therefore, the proposed change does not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the proposed change involve a significant reduction in a margin of safety?

Response: No.

TS Limiting Condition for Operation (LCO) 3.9.4 closure requirements for containment penetrations ensure that the consequences of a postulated FHA inside containment during Core Alterations or fuel handling activities are minimized. The LCO establishes containment closure requirements, which limit the potential escape paths for fission products by ensuring that there is at least one barrier to the release of radioactive material. The proposed change to allow alternate methods of reaching containment penetration closure during Core Alterations or fuel movement does not affect the expected dose consequences of a FHA since it does not credit containment building closure. The proposed administrative controls provide assurance that prompt closure of the penetration flow paths will be accomplished in the event of a FHA inside containment thus minimizing the transmission of radioactive material from the containment to the outside environment. The incorporation of purge valve isolation surveillance requirements does not reduce any margins of safety.

Therefore, the proposed change does not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Joseph A. Aluise, Associate General Council—Nuclear, Entergy Services, Inc., 639 Loyola Avenue, New Orleans, Louisiana 70113.

NRC Branch Chief: Michael T. Markley.

Entergy Operations, Inc., Docket No. 50–382, Waterford Steam Electric Station, Unit 3, St. Charles Parish, Louisiana

Date of amendment request: February 24, 2010.

Description of amendment request: The proposed amendment deletes Operating License Condition 2.C.14 (Fuel Movement in the Fuel Handling Building) due to electing to comply with Section 50.68, "Criticality accident requirements," of Title 10 of the Code of Federal Regulations (10 CFR). The Operating License Condition 2.C.14, "no more than one fuel assembly shall be out of its shipping container or storage location at a given time," was one basis for the exemption from the criticality alarm system requirements of 10 CFR 70.24. The criticality accident requirements can be met either by complying with 10 CFR 70.24 or 10 CFR 50.68 requirements. The 10 CFR 50.68 criteria are now being used; therefore, Operating License Condition 2.C.14 is no longer applicable.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed change involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed amendment deletes Operating License Condition 2.C.14 (Fuel Movement in the Fuel Handling Building) due to electing to comply with 10 CFR 50.68 requirements.

The proposed changes will not alter the configuration of the storage racks or their environment. The fuel racks will not be operated outside of their design limits, and no additional loads will be imposed on them. Therefore, these changes will not affect fuel storage rack performance or reliability. No new equipment will be introduced into the plant. The accuracies and response characteristics of existing instrumentation will not be modified. The proposed changes will not require, or result in, a change in safety system operation, and will not affect any system interface with the fuel storage racks. Fuel assembly placement will continue to be controlled in accordance with approved fuel handling procedures. All the requirements of 10 CFR 50.68 continue to be met which ensures no significant increase in the probability or consequences of an accident previously evaluated.

The proposed changes will not affect any barrier that mitigates dose to the public, and will not result in a new release pathway being created. The functions of equipment designed to control the release of radioactive material will not be impacted, and no mitigating actions described or assumed for an accident in the UFSAR [Updated Final Safety Analysis Report] will be altered or prevented. No assumptions previously made in evaluating the consequences of an accident will need to be modified. Onsite dose will not be increased, so the access of plant personnel to vital areas of the plant will not be restricted, and mitigating actions will not be impeded.

Therefore, it is concluded that the proposed changes do not significantly increase either the probability or consequences of any accident previously evaluated.

2. Does the proposed change create the possibility of a new or different kind of

accident from any accident previously evaluated?

Response: No.

The proposed amendment deletes Operating License Condition 2.C.14 (Fuel Movement in the Fuel Handling Building) due to electing to comply with 10 CFR 50.68 requirements.

10 CFR 50.68(b)(1) provides the requirements to ensure that plant procedures shall prohibit the handling and storage at any one time of more fuel assemblies than have been determined to be safely subcritical under the most adverse moderation conditions feasible by unborated water. By meeting this criteria, the removal of Operating License Condition 2.C.14 will not create the possibility of a new or different kind of accident from any accident previously evaluated.

Therefore, it is concluded that the proposed changes do not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Does the proposed change involve a significant reduction in a margin of safety?

Response: No.

The proposed amendment deletes Operating License Condition 2.C.14 (Fuel Movement in the Fuel Handling Building) due to electing to comply with 10 CFR 50.68 requirements.

10 CFR 50.68(b)(1) provides similar requirements as that contained in Operating License Condition 2.C.14. The NRC has approved the [Waterford Steam Electric Station, Unit 3] use of 10 CFR 50.68 criteria. By meeting the 10 CFR 50.68(b)(1) requirements, there will not be a significant reduction in a margin of safety.

Therefore, it is concluded that the proposed changes do not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Joseph A. Aluise, Associate General Council—Nuclear, Entergy Services, Inc., 639 Loyola Avenue, New Orleans, Louisiana 70113.

NRC Branch Chief: Michael T. Markley.

Exelon Generation Company, LLC, Docket No. 50–461, Clinton Power Station, Unit No. 1, DeWitt County, Illinois

Date of amendment request: February 15, 2010.

Description of amendment request: The proposed amendment would relocate selected Surveillance Requirement frequencies from the Clinton Power Station, Unit No. 1 (Clinton) Technical Specifications (TSs) to a licensee-controlled program. This change is based on the NRC-approved Industry Technical Specifications Task Force (TSTF) change TSTF–425, "Relocate Surveillance Frequencies to Licensee Control—Risk Informed Technical Specification Task Force (RITSTF) Initiative 5b," Revision 3, (Agencywide Documents Access and Management System (ADAMS) Accession Package No. ML090850642). Plant-specific deviations from TSTF–425 are proposed to accommodate differences between the Clinton TSs and the model TSs originally used to develop TSTF–425.

The Nuclear Regulatory Commission (NRC) staff issued a Notice of Availability for TSTF–425 in the **Federal Register** on July 6, 2009 (74 FR 31996). The notice included a model safety evaluation (SE) and a model no significant hazards consideration (NSHC) determination. In its application dated February 15, 2010 (ADAMS Accession No. ML100470787), the licensee affirmed the applicability of the model NSHC determination which is presented below.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), an analysis of the issue of NSHC is presented below:

1. Does the proposed change involve a significant increase in the probability or consequences of any accident previously evaluated?

Response: No. The proposed change relocates the specified frequencies for periodic surveillance requirements to licensee control under a new Surveillance Frequency Control Program. Surveillance frequencies are not an initiator to any accident previously evaluated. As a result, the probability of any accident previously evaluated is not significantly increased. The systems and components required by the technical specifications for which the surveillance frequencies are relocated are still required to be operable, meet the acceptance criteria for the surveillance requirements, and be capable of performing any mitigation function assumed in the accident analysis. As a result, the consequences of any accident previously evaluated are not significantly increased.

Therefore, the proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed change create the possibility of a new or different kind of accident from any previously evaluated?

Response: No. No new or different accidents result from utilizing the proposed change. The changes do not involve a physical alteration of the plant (*i.e.,* no new or different type of equipment will be installed) or change in the methods governing normal plant operation. In addition, the changes do not impose any new or different requirements. The changes do not alter assumptions made in the safety analysis. The proposed changes are consistent with the safety analysis assumptions and current plant operating practice.

Therefore, the proposed changes do not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Does the proposed change involve a significant reduction in the margin of safety?

Response: No. The design, operation, testing methods, and acceptance criteria for systems, structures, and components (SSCs), specified in applicable codes and standards (or alternatives approved for use by the NRC) will continue to be met as described in the plant licensing basis (including the final safety analysis report and bases to TS), since these are not affected by changes to the surveillance frequencies. Similarly, there is no impact to safety analysis acceptance criteria as described in the plant licensing basis. To evaluate a change in the relocated surveillance frequency, Exelon will perform a probabilistic risk evaluation using the guidance contained in NRC approved NEI 04–01, Rev. 1. The methodology provides reasonable acceptance guidelines and methods for evaluating the risk increase of proposed changes to surveillance frequencies consistent with Regulatory Guide 1.177 [An Approach for Plant-Specific, Risk-Informed Decision-making: Technical Specifications].

Therefore, the proposed changes do not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Mr. Bradley J. Fewell, Associate General Counsel, Exelon Generation Company, LLC, 4300 Winfield Road, Warrenville, IL 60555.

NRC Branch Chief: Stephen J. Campbell.

Exelon Generation Company, LLC, Docket No. 50–461, Clinton Power Station, Unit No. 1, DeWitt County, Illinois

Date of amendment request: March 3, 2010.

Description of amendment request: The proposed amendment revises Technical Specification (TS) 3.1.7, "Standby Liquid Control (SLC) System," to extend the completion time (CT) for Condition B (*i.e.,* "Two SLC subsystems inoperable") from 8 hours to 72 hours.

Basis for proposed no significant hazards consideration: As required by 10 CFR 50.91(a), an analysis of the issue of no significant hazards consideration is presented below:

1. Does the proposed amendment involve a significant increase in the probability or

consequences of any accident previously evaluated?

Response: No.

The proposed amendment revises Technical Specification (TS) 3.1.7, "Standby Liquid Control (SLC) System," to extend the completion time (CT) for Condition B (*i.e.,* "Two SLC subsystems inoperable.") from eight hours to 72 hours.

The proposed change is based on a risk-informed evaluation performed in accordance with Regulatory Guides (RG) 1.174, "An Approach for Using Probabilistic Risk Assessment in Risk-Informed Decisions On Plant-Specific Changes to the Licensing Basis," and RG 1.I77, "An Approach for Plant-Specific, Risk-Informed Decision-making: Technical Specifications."

The proposed amendment modifies an existing CT for a dual-train SLC system inoperability. The condition evaluated, the action requirements, and the associated CT do not impact any initiating conditions for any accident previously evaluated.

The proposed amendment does not increase postulated frequencies or the analyzed consequences of an Anticipated Transient Without Scram (ATWS). Requirements associated with 10 CFR 50.62 will continue to be met. In addition, the proposed amendment does not increase postulated frequencies or the analyzed consequences or a large-break loss-of-coolant accident for which the SLC system will be used for pH control. The extended CT provides additional time to implement actions in response to a dual-train SLC system inoperability, while also minimizing the risk associated with continued operation. Therefore, the proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any previously evaluated?

Response: No.

The proposed amendment revises TS 3.1.7 to extend the CT for Condition B from eight hours to 72 hours. The proposed amendment does not involve any change to plant equipment or system design functions. This proposed TS amendment does not change the design function of the SLC system and does not affect the system's ability to perform its design function. The SLC system provides a method to bring the reactor, at any time in a fuel cycle, from full power and minimum control rod inventory to a subcritical condition with the reactor in the most reactive xenon free state without taking credit for control rod movement. Required actions and surveillance requirements are sufficient to ensure that the SLC system functions are maintained. No new accident initiators are introduced by this amendment. Therefore, the proposed amendment does not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

The proposed amendment revises TS 3.1.7 to extend the CT for Condition B from eight hours to 72 hours. The proposed amendment does not involve any change to plant equipment or system design functions. The margin of safety is established through the design of the plant structures, systems, and components, the parameters within which the plant is operated, and the setpoints for the actuation of equipment relied upon to respond to an event.

The proposed amendment does not modify the condition or point at which SLC is initiated, nor does it affect the system's ability to perform its design function. In addition, the proposed change complies with the intent of the defense-in-depth philosophy and the principle that sufficient safety margins are maintained, consistent with RG 1.177 requirements (i.e., Section C, "Regulatory Position," paragraph 2.2 "Traditional Engineering considerations").

Based on the above analysis, EGC concludes that the proposed amendment presents no significant hazards consideration under the standards set forth in 10 CFR 50.92(c), and, accordingly, a finding of "no significant hazards consideration" is justified.

The NRC staff has reviewed the analysis adopted by the licensee and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Mr. Bradley J. Fewell, Associate General Counsel, Exelon Generation Company, LLC, 4300 Winfield Road, Warrenville, IL 60555.

NRC Branch Chief: Stephen J. Campbell.

Exelon Generation Company, LLC, and PSEG Nuclear, LLC, Docket Nos. 50–277 and 50–278, Peach Bottom Atomic Power Station (PBAPS), Units 2 and 3, York and Lancaster Counties, Pennsylvania

Date of amendment request: August 31, 2009.

Description of amendment request: The proposed amendment would modify the PBAPS Technical Specifications (TS) by relocating specific surveillance frequencies to a licensee-controlled program with the implementation of Nuclear Energy Institute (NEI) 04–10, "Risk-Informed Technical Specifications Initiative 5b, Risk-Informed Method for Control of Surveillance Frequencies." Additionally, the change would add a new program, the Surveillance Frequency Control Program, to TS Section 5, Administrative Controls. The changes are based on NRC-approved Industry Technical Specifications Task Force (TSTF) Traveler 425, Revision 3, "Relocate Surveillance Frequencies to Licensee Control—Risk Informed Technical Specification Task Force Initiative 5b," with optional changes and variations as described in Attachment 1, Section 2.2 of the licensee's submittal dated August 31, 2009.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Do the proposed changes involve a significant increase in the probability or consequences of any accident previously evaluated?

Response: No.

The proposed changes relocate the specified frequencies for periodic surveillance requirements to licensee control under a new Surveillance Frequency Control Program [SFCP]. Surveillance frequencies are not an initiator to any accident previously evaluated. As a result, the probability of any accident previously evaluated is not significantly increased. The systems and components required by the technical specifications for which the surveillance frequencies are relocated are still required to be operable, meet the acceptance criteria for the surveillance requirements, and be capable of performing any mitigation function assumed in the accident analysis. As a result, the consequences of any accident previously evaluated are not significantly increased.

Therefore, the proposed changes do not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Do the proposed changes create the possibility of a new or different kind of accident from any previously evaluated?

Response: No.

No new or different accidents result from utilizing the proposed changes. The changes do not involve a physical alteration of the plant (i.e., no new or different type of equipment will be installed) or a change in the methods governing normal plant operation. In addition, the changes do not impose any new or different requirements. The changes do not alter assumptions made in the safety analysis. The proposed changes are consistent with the safety analysis assumptions and current plant operating practice.

Therefore, the proposed changes do not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Do the proposed changes involve a significant reduction in the margin of safety?

Response: No.

[* * * T]here is no impact to safety analysis acceptance criteria as described in the plant licensing basis. To evaluate a change in the relocated surveillance frequency, Exelon will perform a probabilistic risk evaluation using the guidance contained in NRC approved NEI 04–10, Rev. 1 in accordance with the TS SFCP. NEI 04–10, Rev. 1, methodology provides reasonable acceptance guidelines and methods for evaluating the risk increase of proposed changes to surveillance frequencies consistent with Regulatory Guide 1.177. Therefore, the proposed changes do

not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, and with the changes noted above, it appears that the three standards of 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves NSHC.

Attorney for licensee: Mr. J. Bradley Fewell, Associate General Counsel, Exelon Generation Company LLC, 4300 Winfield Road, Warrenville, IL 60555.

NRC Branch Chief: Harold K. Chernoff.

FPL Energy Seabrook, LLC Docket No. 50–443, Seabrook Station, Unit No. 1, Rockingham County, New Hampshire

Date of amendment request: March 16, 2010.

Description of amendment request: The proposed changes would revise the Seabrook Technical Specifications requirement that the Operations Manager shall have held a senior reactor operator license for the Seabrook Station prior to assuming the Operations Manager position. Specifically, the proposed change would require the Operations Manager to meet one of the following: (1) Hold a senior operator license; (2) have held a senior operator license for a similar unit; or (3) have been certified for equivalent senior operator knowledge. In its application dated March 16, 2010, the licensee concluded that the no significant hazards consideration (NSHC) determination presented in the notice is applicable to Seabrook Station.

Basis for proposed NSHC determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of NSHC, which is presented below:

1. The proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

[The requested change would only affect the qualification requirements for the Operations Manager Position]. The proposed change does not impact the configuration or function of plant structures, systems, or components (SSCs) or the manner in which SSCs are operated, maintained, modified, tested, or inspected. No actual facility equipment or accident analyses will be affected by the proposed changes. Therefore, this request has no [significant] impact on the probability or consequences of an accident previously evaluated.

2. The proposed change does not create the possibility of a new or different kind of accident from any accident previously evaluated.

[The requested change would only affect the qualification requirements for the Operations Manager Position]. The proposed change does not alter the plant configuration, require new plant equipment to be installed, alter accident analysis assumptions, add any initiators, or affect the function of plant systems or the manner in which systems are operated, maintained, modified, tested, or inspected. Therefore, this request does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. The proposed change does not involve a significant reduction in a margin of safety.

Margin of safety is associated with confidence in the ability of the fission product barriers (i.e., fuel cladding, reactor coolant system pressure boundary, and containment structure) to limit the level of radiation dose to the public. [The requested change would only affect the qualification requirements for the Operations Manager Position]. No actual plant equipment or accident analyses will be affected by the proposed changes. Additionally, the proposed changes will not relax any criteria used to establish safety limits, will not relax any safety system settings, and will not relax the bases for any limiting conditions for operation. The safety analysis acceptance criteria are not affected by this change. The proposed change will not result in plant operation in a configuration outside the design basis. The proposed change does not adversely affect systems that respond to safely shutdown the plant and to maintain the plant in a safe shutdown condition. Therefore, these proposed changes do not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, and with the changes noted above, it appears that the three standards of 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves NSHC.

Attorney for licensee: M.S. Ross, Florida Power & Light Company, P.O. Box 14000, Juno Beach, FL 33408–0420.

NRC Branch Chief: Harold K. Chernoff.

Northern States Power Company—Minnesota, Docket Nos. 50–282 and 50–306, Prairie Island Nuclear Generating Plant, Units 1 and 2 (PINGP), Goodhue County, Minnesota

Date of amendment request: November 24, 2009.

Description of amendment request: The proposed amendments would make changes to Technical Specification (TS) Section 4.2.1, Fuel Assemblies, and TS Section 5.6.5, Core Operating Limit Report, by revising the TS to allow the use of Optimized ZIRLO™ fuel rod cladding material.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed change involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

Westinghouse Electric Company, LLC (Westinghouse) topical report WCAP–12610–P–A and CENPD–404–P–A, Addendum 1–A "Optimized ZIRLO™", July 2006, provides the details and results of material testing of Optimized ZIRLO™ compared to standard ZIRLO™ as well as the material properties to be used in various models and methodologies when analyzing Optimized ZIRLO™. The Nuclear Regulatory Commission (NRC) has allowed use of Optimized ZIRLO™ fuel cladding material in Westinghouse fueled reactors provided that licensees ensure compliance with the conditions and limitations set forth in the NRC Safety Evaluation (SE) for the topical report. By satisfying the conditions and limitations of the NRC SE through completed actions and its approved reload safety evaluation process, the licensee ensures that the effects of Optimized ZIRLO™ on PINGP core performance are evaluated and that the probability or consequences of previously-evaluated accidents are not increased.

Therefore, the proposed change of adding a cladding material does not result in an increase to the probability or consequences of an accident previously evaluated.

2. Does the proposed change create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

Material properties of this fuel design have been evaluated in Westinghouse topical report WCAP–12610–P–A and CENPD–404–P–A, Addendum 1–A "Optimized ZIRLO™" July 2006. That report provides the details and results of material testing of Optimized ZIRLO™ compared to standard ZIRLO™ as well as the material properties to be used in various models and methodologies when analyzing Optimized ZIRLO™. Neither that topical report nor the associated NRC SE identifies the possibility of a new or different kind of accident resulting from this change for generic application in Westinghouse reactors. As demonstrated in that topical report and stated in the NRC SE, there is reasonable assurance that under both normal and accident conditions, the Optimized ZIRLO™ fuel cladding will be able to safely operate and comply with NRC regulations. By satisfying the conditions and limitations of the NRC SE by virtue of its completed actions and its approved reload safety evaluation process, the licensee ensures that the effects of Optimized ZIRLO™ are evaluated and will not create the possibility of a new or different kind of accident. Assurance that the possibility of new or different type of accidents will not be created on a site-specific basis is inherent to the reload safety evaluation process approved for use at the PINGP. Site specific evaluation of the PINGP core designs with Optimized ZIRLO™ will be performed programmatically and necessarily by the approved reload safety evaluation process.

Therefore, the proposed change of adding a cladding material does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Does the proposed change involve a significant reduction in a margin of safety?

Response: No.

The cladding material used in the fuel rods is designed and tested to prevent excessive fuel temperatures, excessive internal rod gas pressure due to fission gas releases, and excessive cladding stresses and strains. Optimized ZIRLO™ was developed to meet these needs and provides a reduced corrosion rate while maintaining the benefits of mechanical strength and resistance to accelerated corrosion from abnormal chemistry conditions. Westinghouse topical report WCAP–12610–P–A and CENPD–404–P–A, Addendum 1–A "Optimized ZIRLO™, July 2006, provides the details and results of material testing of Optimized ZIRLO™ compared to standard ZIRLO™ as well as the material properties to be used in various models and methodologies when analyzing Optimized ZIRLO™. The NRC has allowed use of Optimized ZIRLO™ fuel cladding material detailed within this topical report as detailed within their SE. Therefore, the change in material does not result in a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment requests involve no significant hazards consideration.

Attorney for licensee: Peter M. Glass, Assistant General Counsel, Xcel Energy Services, Inc., 414 Nicollet Mall, Minneapolis, MN 55401.

NRC Branch Chief: Robert J. Pascarelli.

Northern States Power Company—Minnesota, Docket Nos. 50–282 and 50–306, Prairie Island Nuclear Generating Plant, Units 1 and 2, Goodhue County, Minnesota

Date of amendment request: January 27, 2010.

Description of amendment request: The proposed amendments would make changes to the Technical Specifications (TS) to revise TS 3.8.3, "Diesel Fuel Oil". The amendments would revise the diesel fuel oil (DFO) storage volumes applicable to Unit 1 in TS 3.8.3 Condition statements A and D, and increase the Unit 1 DFO supply required by surveillance requirement 3.8.3.1. The amendments would clarify wording in TS 3.8.3 Condition B statement which applies to both units.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed amendment involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

This license amendment request proposes to increase the emergency diesel generator fuel oil storage volumes specified in the Technical Specification Condition statements and Surveillance Requirements. Also a word was added to a Condition statement to clarify its meaning.

The emergency diesel generators and their supporting diesel fuel oil storage systems are not accident initiators and therefore the proposed fuel oil storage volume increases do not involve an increase in the probability of an accident.

The proposed increased diesel fuel oil storage volumes provide sufficient volumes to maintain the current licensing basis for emergency diesel generator operation. Thus the proposed fuel oil storage volume increases do not involve a significant increase in the consequences of an accident.

The proposed Technical Specification Condition statement wording clarification is administrative and thus does not involve an increase in the probability of an accident or an increase in the consequences of an accident.

Therefore, the proposed Technical Specification changes do not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

This license amendment request proposes to increase the emergency diesel generator fuel oil storage volumes specified in the Technical Specification Condition statements and Surveillance Requirements. Also a word was added to a Condition statement to clarify its meaning.

The proposed Technical Specification changes which increase emergency diesel generator fuel oil storage volumes do not change any system operations or maintenance activities. The changes do not involve physical alteration of the plant, that is, no new or different type of equipment will be installed. The changes do not alter assumptions made in the safety analyses but ensures that the diesel generators operate as assumed in the accident analyses. These changes do not create new failure modes or mechanisms which are not identifiable during testing and no new accident precursors are generated.

The proposed Technical Specification Condition statement wording clarification is administrative and thus does not create the possibility of a new or different kind of accident.

Therefore, the proposed Technical Specification changes do not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

This license amendment request proposes to increase the emergency diesel generator fuel oil storage volumes specified in the Technical Specification Condition statements and Surveillance Requirements. Also a word was added to a Condition statement to clarify its meaning.

Since this license amendment proposes Technical Specification changes which increase the required fuel oil storage volumes, margins of safety are increased and thus no margin of safety is reduced as part of this change.

The proposed Technical Specification Condition statement wording clarification is administrative and thus does not involve a significant reduction in a margin of safety.

Therefore, the proposed Technical Specification changes do not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment requests involve no significant hazards consideration.

Attorney for licensee: Peter M. Glass, Assistant General Counsel, Xcel Energy Services, Inc., 414 Nicollet Mall, Minneapolis, MN 55401.

NRC Branch Chief: Robert J. Pascarelli.

Southern Nuclear Operating Company, Inc., Docket Nos. 50–424 and 50–425, Vogtle Electric Generating Plant, Units 1 and 2, Burke County, Georgia

Date of amendment request: February 2, 2010.

Description of amendment request: The proposed amendments would revise the verification requirements for the Reactor Trip System Instrumentation. Specifically, the amendment proposes the addition to Table 3.3.1–1 of a response time measurement for the verification of the Power Range Neutron High Positive Rate Trip (PFRT) function as recommended by Westinghouse Nuclear Safety Advisory Letter (NSAL–09–01) "Rod Withdrawal at Power Analysis for Reactor Coolant System Overpressure."

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed amendment involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed change to Vogtle Electric Generating Plant (VEGP) Technical Specification (TS) 3.3.1, "Reactor Trip

System (RTS) Instrumentation," Table 3.3.1–1, "Reactor Trip System Instrumentation" does not significantly increase the probability or consequences of an accident previously evaluated in the Updated Final Safety Analysis Report (UFSAR). The overall protection system performance will remain within the bounds of the accident analysis since there are no hardware changes. The design of the Reactor Trip System (RTS) instrumentation, specifically the positive range neutron flux high positive rate trip (PFRT) function, will be unaffected. The reactor protection system will continue to function in a manner consistent with the plant design basis. All design, material, and construction standards that were applicable prior to the request are maintained.

The proposed change adds an additional surveillance requirement to assure that the PFRT is verified to be consistent with the safety analysis and licensing basis. In this specific case, a response time verification requirement will be added to the PFRT function.

The proposed changes will not modify any system interface. The proposed changes will not affect the probability of any event initiators. There will be no degradation in the performance of or an increase in the number of challenges imposed on safety-related equipment assumed to function during an accident situation. There will be no change to normal plant operating parameters or accident mitigation performance. The proposed change will not alter any assumptions nor change any mitigation actions in the radiological consequences evaluations in the UFSAR.

The proposed change does not adversely affect accident initiators or precursors nor alter the design assumptions, conditions, or configuration of the facility or the manner in which the plant is operated and maintained. The proposed changes do not alter nor prevent the ability of SSCs from performing their intended function to mitigate the consequences of an initiating event within the assumed acceptance limits. The proposed change is consistent with the safety analyses assumptions and resultant consequences. The RCS overpressure limit listed in Specification 2.1.2 of the VEGP Technical Specifications (i.e., 2735 psig) is not violated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any previously evaluated?

Response: No.

There are no hardware changes nor are there any changes in the method by which any safety related plant system performs its safety function. This change will not affect the normal method of plant operation nor change any operating parameters.

No performance requirements will be affected; however, the proposed change adds an additional surveillance requirement. The additional surveillance requirement is consistent with assumptions made in the safety analyses and licensing basis.

No new accident scenarios, transient precursors, failure mechanisms, or limiting single failures are introduced as a result of this change. There will be no adverse effect or challenges imposed on any safety-related system as a result of this change.

Therefore, the proposed change does not create the possibility of a new or different accident from any accident previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

The proposed change does not affect the acceptance criteria for any analyzed event nor is there a change to any Safety Limits. There will be no effect on the manner in which Safety Limits or Limiting Conditions of Operations are determined, nor will there be any effect on those plant systems necessary to assure the accomplishment of protection functions.

This change is consistent with the assumptions made in the safety analyses. The addition of a surveillance requirement increases the margin of safety by assuring that the associated safety analysis assumption on the PFRT response time is verified.

Therefore, the proposed change does not involve a significant reduction in the margin of safety.

Based on the above, SNC concludes that the proposed amendment does not involve a significant hazards consideration under the standard set forth in 10 CFR 50.92(c), and, accordingly, a finding of "no significant hazards consideration" is justified.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Previously Published Notices of Consideration of Issuance of Amendments to Facility Operating Licenses, Proposed No Significant Hazards Consideration Determination, and Opportunity for a Hearing

The following notices were previously published as separate individual notices. The notice content was the same as above. They were published as individual notices either because time did not allow the Commission to wait for this biweekly notice or because the action involved exigent circumstances. They are repeated here because the biweekly notice lists all amendments issued or proposed to be issued involving no significant hazards consideration.

For details, see the individual notice in the **Federal Register** on the day and page cited. This notice does not extend the notice period of the original notice.

Entergy Nuclear Operations, Inc., Docket No. 50–255, Palisades Nuclear Plant, Van Buren County, Michigan

Date of amendment request: March 31, 2010.

Brief description of amendment request: The proposed amendment would add new license condition 2.C(4) stating that performance of Technical Specification surveillance requirement 3.1.4.3, which verifies control rod freedom of movement, is not required for control rod drive 22 during cycle 21 until the next entry into Mode 3 in a maintenance or refueling outage, whichever is earlier.

Date of publication of individual notice in **Federal Register:** April 14, 2010 (75 FR 19428).

Expiration date of individual notice: June 13, 2010.

Union Electric Company, Docket No. 50–483, Callaway Plant, Unit 1, Callaway County, Missouri

Date of amendment request: March 29, 2010, as supplemented by letter dated March 29, 2010.

Brief description of amendment request: The proposed amendment would revise the Technical Specification (TS) 3.3.2, "Engineered Safety Feature Actuation System (ESFAS) Instrumentation," regarding function 6.g in TS Table 3.3.2–1. Function 6.g provides an auxiliary feedwater (AFW) start signal that is provided to the motor-driven AFW pumps in the event of a trip of both turbine-driven main feedwater pumps. The changes would revise Condition J for ESFAS instrumentation function 6.g to read, "One or more Main Feedwater Pumps trip channel(s) inoperable." The licensee will make corresponding changes to Required Action J.1 and the Note above Required Actions J.1 and J.2 for consistency with the revised Condition.

Date of publication of individual notice in **Federal Register:** April 14, 2010 (75 FR 19431).

Expiration date of individual notice: April 28, 2010, for public comments; June 14, 2010, for hearing requests.

Notice of Issuance of Amendments to Facility Operating Licenses

During the period since publication of the last biweekly notice, the Commission has issued the following amendments. The Commission has determined for each of these amendments that the application complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations. The Commission has made appropriate findings as required by the Act and the Commission's rules and regulations in 10 CFR Chapter I, which are set forth in the license amendment.

Notice of Consideration of Issuance of Amendment to Facility Operating License, Proposed No Significant

Hazards Consideration Determination, and Opportunity for A Hearing in connection with these actions was published in the **Federal Register** as indicated.

Unless otherwise indicated, the Commission has determined that these amendments satisfy the criteria for categorical exclusion in accordance with 10 CFR 51.22. Therefore, pursuant to 10 CFR 51.22(b), no environmental impact statement or environmental assessment need be prepared for these amendments. If the Commission has prepared an environmental assessment under the special circumstances provision in 10 CFR 51.22(b) and has made a determination based on that assessment, it is so indicated.

For further details with respect to the action see (1) the applications for amendment, (2) the amendment, and (3) the Commission's related letter, Safety Evaluation and/or Environmental Assessment as indicated. All of these items are available for public inspection at the Commission's Public Document Room (PDR), located at One White Flint North, Public File Area 01F21, 11555 Rockville Pike (first floor), Rockville, Maryland. Publicly available records will be accessible from the Agencywide Documents Access and Management System (ADAMS) Public Electronic Reading Room on the internet at the NRC Web site, *http://www.nrc.gov/reading-rm/adams.html.* If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the PDR Reference staff at 1–(800) 397–4209, (301) 415–4737 or by e-mail to *pdr.resource@nrc.gov.*

Entergy Nuclear Operations, Inc., Docket No. 50–333, James A. FitzPatrick Nuclear Power Plant, Oswego County, New York

Date of application for amendment: November 23, 2009, as supplemented by letter dated February 5, 2010.

Brief description of amendment: The amendment modified the Technical Specification (TS) 5.5.7, "Inservice Testing Program," by replacing the references from the American Society of Mechanical Engineers (ASME) Boiler and Pressure Vessel Code to the current Code of Record, the ASME Operation and Maintenance Nuclear Power Plants Code (ASME OM Code), the Code of Record for the James A. FitzPatrick Nuclear Power Plant (JAFNPP) Inservice Testing (IST) Program. This is an administrative amendment to maintain the TS current with the NRC accepted Code of Record for JAFNPP IST Program.

Date of issuance: April 12, 2010.

Effective date: As of the date of issuance, and shall be implemented within 30 days.

Amendment No.: 296.

Renewed Facility Operating License No. DPR–59: The amendment revised the License and the Technical Specifications.

Date of initial notice in **Federal Register:** January 26, 2010 (75 FR 4117).

The February 5, 2010, supplement provided additional information that clarified the application, did not expand the scope of the application as originally noticed, and did not change the NRC staff's original proposed no significant hazards consideration determination as published in the **Federal Register**.

The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated April 12, 2010.

No significant hazards consideration comments received: No.

Exelon Generation Company, LLC, Docket Nos. STN 50–454 and STN 50–455, Byron Station (Byron), Unit Nos. 1 and 2, Ogle County, Illinois

Date of application for amendment: September 24, 2009, as supplemented by letters dated November 13, 2009; January 19, 2010; March 1, 2010; March 9, 2010 (two letters); and March 19, 2010.

Brief description of amendment: The amendments adds a new Completion Time (CT) of 144 hours to restore a unit-specific essential service water train to operable status associated with the Limiting Condition for Operation for Technical Specification (TS) 3.7.8, "Essential Service Water (SX) System." The new CT will be used for maintenance during the Byron, Unit No. 2, spring 2010, refueling outage. The licensee requested the new CT to replace two of the four SX pump suction isolation valves without having to shutdown Byron, Unit No. 1; maintenance history has shown that replacement of the SX pump suction isolation valves cannot be assured within the existing 72 hour CT window.

Date of issuance: April 9, 2010.

Effective date: As of the date of issuance and shall be implemented within 30 days.

Amendment Nos.: Unit No. 1—168; Unit No. 2—168.

Facility Operating License Nos. NPF–37 and NPF–66: The amendments revise the TSs and Licenses.

Date of initial notice in **Federal Register:** December 1, 2009 (74 FR 62835).

The supplemental letters provided additional information that clarified the application, did not expand the scope of the application as originally noticed, and did not change the NRC staff's original proposed no significant hazards consideration determination.

The Commission's related evaluation of the amendments is contained in a Safety Evaluation dated April 9, 2010.

No significant hazards consideration comments received: No.

R.E. Ginna Nuclear Power Plant, LLC, Docket No. 50–244, R.E. Ginna Nuclear Power Plant, Wayne County, New York

Date of application for amendment: September 18, 2009.

Brief description of amendment: The amendment revises Technical Specification (TS) 5.5.7, "Inservice Testing Program," by incorporating TS Task Force Traveler (TSTF)-479, "Changes to Reflect Revision of 10 CFR 50.55a," and TSTF–497, "Limit Inservice Testing Program SR [Surveillance Requirement] 3.0.2 Application to Frequencies of 2 Years or Less." Specifically, the amendments (1) replace references to the American Society of Mechanical Engineers (ASME) Boiler and Pressure Vessel Code, Section XI with the ASME Code for Operation and Maintenance of Nuclear Power Plants for inservice testing activities, and (2) applies the extension allowance of SR 3.0.2 to other normal and accelerated inservice testing frequencies of 2 years or less that were not included in the frequencies listed in TS 5.5.7.a.

Date of issuance: April 8, 2010.

Effective date: As of the date of issuance to be implemented within 60 days.

Amendment No.: 110.

Renewed Facility Operating License No. DPR–18: Amendment revised the License and Technical Specifications.

Date of initial notice in **Federal Register:** November 3, 2009 (74 FR 56887).

The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated April 8, 2010.

No significant hazards consideration comments received: No.

Dated at Rockville, Maryland, this 22nd day of April 2010.

For the Nuclear Regulatory Commission.

Robert A. Nelson,

Deputy Director, Division of Operating Reactor Licensing, Office of Nuclear Reactor Regulation.

[FR Doc. 2010–10105 Filed 5–3–10; 8:45 am]

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NUCLEAR REGULATORY COMMISSION

[Docket No. 72–10; NRC–2009–0534]

Notice of Docketing of Amendment Request for Materials License No. SNM–2506; Northern States Power Company, a Minnesota Corporation; Prairie Island Independent Spent Fuel Storage Installation

AGENCY: U.S. Nuclear Regulatory Commission.

ACTION: Notice of docketing of amendment request for materials license No. SNM–2506.

FOR FURTHER INFORMATION CONTACT: Pamela Longmire, Ph.D., Project Manager, Licensing Branch, Division of Spent Fuel Storage and Transportation, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. Telephone: (301) 492–3562; fax number: (301) 492–3350; e-mail: *Pamela.Longmire@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The U.S. Nuclear Regulatory Commission (NRC or Commission) is considering an application dated March 28, 2008, as supplemented by letter dated August 29, 2008, from Nuclear Management Company, LLC (NMC; now Northern States Power Company, a Minnesota Corporation) to amend its Special Nuclear Materials License No. SNM–2506, under the provisions of 10 CFR part 72, for the receipt, possession, storage and transfer of spent fuel, reactor-related Greater than Class C waste and other radioactive materials associated with spent fuel storage at the Prairie Island Independent Spent Fuel Storage Installation (ISFSI), located at the Prairie Island Nuclear Generating Plant (PINGP), Unit Nos. 1 and 2, site in Goodhue County, Minnesota.

The TN–40 cask is currently used at the Prairie Island ISFSI for storage of spent fuel with characteristics defined in the existing technical specifications. The fuel characteristics limit the fuel that can be stored in the TN–40 cask to a maximum enrichment of 3.85 weight percent (w/o) U–235 and a maximum burnup of 45,000 MWd/MTU. Since the early 1990s, NMC has used fuel with initial enrichment up to 5.0 w/o U–235. These higher enriched fuels received burnup up to 60,000 MWd/MTU while in the PINGP reactor. After being removed from the PINGP reactor, these higher enriched, higher burnup spent fuels must be placed in, and must remain in, the reactor's spent fuel pool (i.e., wet storage) as the TN–40 cask design does not allow for dry storage of such higher enriched, higher burnup spent fuel. If granted, the amendment will approve the NMC's proposed modification of the TN–40 cask design (to be known as the TN–40HT) for dry storage of the higher enriched, higher burnup spent fuel used in the PINGP reactor as well as associated changes to the ISFSI's technical specifications and the reformatting of those technical specifications. The TN–40HT casks, once loaded with the higher enriched, higher burnup spent fuel, will be placed in the Prairie Island ISFSI.

There are currently 23 loaded TN–40 casks at the Prairie Island ISFSI. The ISFSI is licensed for a maximum of 48 casks. Roughly, 250 spent fuel assemblies meeting the TN–40 parameters remain in wet storage, so an additional 6 casks of the TN–40 design could still be loaded and placed on the ISFSI pad. At that point (in 2013, when the Unit 1 license, and the ISFSI license, are scheduled to expire), NMC would need a new cask design to accommodate additional dry storage of the higher enriched, higher burnup fuels used at Prairie Island to support continued plant operation. The dry storage of higher enriched, higher burnup spent fuel in the modified TN–40HT cask is also necessary to support continued operation of the PINGP following plant license renewal, if granted.

This application was docketed under 10 CFR 72.16; the ISFSI Docket No. is 72–10 and will remain the same for this action. The NRC inadvertently failed to promptly publish this notice of docketing in the **Federal Register** after the NRC's receipt of the NMC March 28, 2008, license amendment request. All other procedural requirements in Part 72 will be met as the NRC continues to process this license amendment request (see section II of this notice, "Opportunity to Request a Hearing").

On November 24, 2009, the Commission issued a "Notice of Availability of Environmental Assessment and Finding of No Significant Impact," for this action. This notice was published in the **Federal Register** on December 4, 2009 (74 FR 63798). The Commission will approve the license amendment if it determines that the application meets the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act) and the Commission's regulations, and pursuant to 10 CFR 72.58, the findings required by 10 CFR 72.40. These findings will be documented in a Safety Evaluation Report.

II. Opportunity To Request a Hearing

The Commission may issue either a notice of hearing or a notice of proposed action and opportunity for hearing in accordance with 10 CFR 72.46(b)(1) or, if a determination is made that the amendment does not present a genuine issue as to whether public health and safety will be significantly affected, take immediate action on the amendment in accordance with 10 CFR 72.46(b)(2) and provide notice of the action taken and an opportunity for interested persons to request a hearing on whether the action should be rescinded or modified.

III. Further Information

Documents related to this action, including the application for amendment and supporting documentation, are available electronically at the NRC's Electronic Reading Room at *http://www.nrc.gov/reading-rm/adams.html.* From this site, you can access the NRC's Agencywide Documents Access and Management System (ADAMS), which provides text and image files of NRC's public documents. The ADAMS accession numbers for the documents related to this notice are ML081190039, ML081190040, ML081230257, ML101170260, ML101170254, ML082970575, ML090840025, ML090840028, ML101170235, ML093310293, ML093310303, and ML093080332. If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the NRC Public Document Room (PDR) Reference staff at 1–800–397–4209, 301–415–4737 or by e-mail to *pdr.resource@nrc.gov.*

These documents may also be viewed electronically on the public computers located at the NRC's PDR, O1 F21, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852. The PDR reproduction contractor will copy documents for a fee.

Dated at Rockville, Maryland, this 27th day of April 2010.

For the Nuclear Regulatory Commission.

Pamela Longmire,

Project Manager, Licensing Branch, Division of Spent Fuel Storage and Transportation, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 2010–10398 Filed 5–3–10; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2009–0521]

Final License Renewal Interim Staff Guidance LR–ISG–2009–01: Aging Management of Spent Fuel Pool Neutron-Absorbing Materials Other Than Boraflex; Notice of Availability

AGENCY: Nuclear Regulatory Commission (NRC).

ACTION: Notice of availability.

SUMMARY: The NRC is issuing the final License Renewal Interim Staff Guidance (LR–ISG), LR–ISG–2009–01, "Aging Management of Spent Fuel Pool Neutron-Absorbing Materials other than Boraflex." This LR–ISG provides aging management guidance to address the potential loss of material and loss of neutron-absorbing capability of certain nuclear power plant spent fuel pool neutron-absorbing materials for compliance with part 54, "Requirements for Renewal of Operating Licenses for Nuclear Power Plants," of Title 10 of the Code of Federal Regulations (10 CFR part 54). The final LR–ISG revises the NRC staff's aging management recommendations currently described in NUREG–1801, Volumes 1 and 2, "Generic Aging Lessons Learned (GALL) Report," Revision 1, dated September 2005, which are available in the NRC's Agencywide Documents Access and Management System (ADAMS) under Accession Nos. ML052770419 and ML052780376. The final LR–ISG also includes revisions to the NRC staff's review procedures and acceptance criteria in NUREG–1800, Revision 1, "Standard Review Plan for Review of License Renewal Applications for Nuclear Power Plants" (SRP–LR), available under Accession No. ML052110007. The final LR–ISG–2009–01 is available under Accession No. ML100621321.

FOR FURTHER INFORMATION CONTACT: Mr. Matthew Homiack, Division of License Renewal, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone 301–415–1683; or e-mail *Matthew.Homiack@nrc.gov.*

ADDRESSES: Documents created or received after November 1, 1999, are available electronically at the NRC's Public Electronic Reading Room on the Internet at *http://www.nrc.gov/reading-rm/adams.html.* From this site, the public can gain entry into ADAMS. If you do not have access to the Internet or if there are any problems in accessing the documents located in ADAMS, contact the NRC Public Document Room reference staff at 1–800–397–4209, 301–415–4737, or by e-mail at *PDR.Resource@nrc.gov.*

The NRC posts LR–ISGs on its public Web page under the "License Renewal" heading at *http://www.nrc.gov/reading-rm/doc-collections/isg.*

SUPPLEMENTARY INFORMATION:

Background

The NRC issues LR–ISGs to communicate insights and lessons learned and to address emergent issues that are not addressed in the guidance documents published to facilitate implementation of 10 CFR part 54. The NRC staff and stakeholders use LR–ISGs until their guidance is incorporated into a formal license renewal guidance document revision.

The NRC staff developed draft LR–ISG–2009–01, "Staff Guidance Regarding Plant-Specific Aging Management Review and Aging Management Program for the Neutron-Absorber Material in the Spent Fuel Pool Associated with License Renewal Applications," in light of recent operating experience concerning instances of degradation and deformation of neutron-absorbing materials in the spent fuel pools of nuclear power plants. Primarily, the draft LR–ISG proposed guidance for managing the potential loss of material and loss of neutron-absorbing capability aging effects for spent fuel pool neutron-absorbing materials other than Boraflex. A proposed aging management program was included in the draft LR–ISG to address these aging effects during the period of extended operation, as one approach acceptable to the NRC staff for meeting the requirements of 10 CFR part 54.

On December 1, 2009, the NRC requested public comments on the draft LR–ISG–2009–01 in the **Federal Register** (74 FR 62829). The public comment period ended on December 31, 2009. By letters dated December 17, 2009 (ML093570197), and December 28, 2009 (ML100060388), the NRC received comments from two nuclear power plant licensees, Southern Nuclear Operating Company, Inc., and Exelon Generation Company, LLC, respectively. The NRC also received comments from the Nuclear Energy Institute, an industry group, by letter dated December 31, 2009 (ML100060387). After the comment period closed, the NRC received additional comments from the Nuclear Energy Institute in an e-mail dated January 6, 2010 (ML100280648). No other comments were received. The NRC staff considered all the comments in developing the final LR–ISG–2009–01, as discussed in the "Comments and Responses" section of this notice.

Final Action

By this action, the NRC is making the final LR–ISG–2009–01 available. The NRC staff approves of the LR–ISG for NRC staff and stakeholder use. The NRC staff will also incorporate the approved LR–ISG into the next revision of the GALL Report and the SRP–LR.

The final LR–ISG revises the staff's aging management recommendations concerning spent fuel pool neutron-absorbing materials other than Boraflex, which are currently described in the GALL Report and SRP–LR. Specifically, the LR–ISG provides a program for managing the effects of aging on these spent fuel pool neutron-absorbing materials, whereas before, a plant-specific program was recommended. In addition, the corresponding aging management review line items in both documents are clarified and reference the recommended program instead of recommending further evaluation. The final LR–ISG also includes corresponding revisions to the SRP–LR for the staff's review procedures and acceptance criteria concerning these spent fuel pool components and materials. The title of the LR–ISG has been changed from the draft title, "Staff Guidance Regarding Plant-Specific Aging Management Review and Aging Management Program for the Neutron-Absorber Material in the Spent Fuel Pool Associated with License Renewal Applications," to the final, "Aging Management of Spent Fuel Pool Neutron-Absorbing Materials other than Boraflex," to clarify that the LR–ISG provides guidance concerning generic, not plant-specific, aging management recommendations.

Comments and Responses

The comment providers, in general, recommended clarifications to the draft LR–ISG. The NRC staff included these clarifications in the final LR–ISG as appropriate. One comment indicated that the aging management program in GALL Report, Volume 2, Section XI.M2, "Water Chemistry," should be credited to manage the loss of material aging effect. Another comment requested the NRC staff to provide the technical justification for the testing frequency in the proposed aging management program. Based on its technical evaluations, the NRC staff did not make substantive revisions to the LR–ISG in response to these two comments. Detailed NRC staff responses to all comments are in an appendix to the final LR–ISG document.

Dated at Rockville, Maryland, this 27th day of April, 2010.

For the Nuclear Regulatory Commission.

Brian E. Holian,

Director, Division of License Renewal, Office of Nuclear Reactor Regulation.

[FR Doc. 2010–10389 Filed 5–3–10; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2010–0002]

Sunshine Federal Register Notice

DATES: Weeks of May 3, 10, 17, 24, 31, June 7, 2010.

PLACE: Commissioners' Conference Room, 11555 Rockville Pike, Rockville, Maryland.

STATUS: Public and closed.

Week of May 3, 2010

Tuesday, May 4, 2010

9:30 a.m. Briefing on Human Capital and Equal Employment Opportunity (Public Meeting). (Contact: Kristin Davis, 301–415–2673).

This meeting will be Webcast live at the Web address—*http://www.nrc.gov.*

10:30 a.m. Discussion of Management Issues (Closed—Ex. 2).

Week of May 10, 2010—Tentative

Tuesday, May 11, 2010

9:30 a.m. Briefing on Federal and State Materials and Environmental Management Programs (FSME) Programs, Performance, & Future Plans (Public Meeting). (Contact: George Deegan, 301–415–7834).

This meeting will be Webcast live at the Web address—*http://www.nrc.gov.*

Week of May 17, 2010—Tentative

There are no meetings scheduled for the week of May 17, 2010.

Week of May 24, 2010—Tentative

Thursday, May 27, 2010

9:30 a.m. Briefing on the Results of the Agency Action Review Meeting (AARM) (Public Meeting). (Contact: Nathan Sanfilippo, 301–415–3951).

This meeting will be Webcast live at the Web address—*http://www.nrc.gov.*

Week of May 31, 2010—Tentative

There are no meetings scheduled for the week of May 31, 2010.

Week of June 7, 2010—Tentative

Wednesday, June 9, 2010

1:30 p.m. Meeting with the Advisory Committee on Reactor Safeguards (Public Meeting). (Contact: Cayetano Santos, 301–415–7270).

This meeting will be Webcast live at the Web address—*http://www.nrc.gov.*

* * * * *

* The schedule for Commission meetings is subject to change on short notice. To verify the status of meetings, call (recording)—(301) 415–1292. Contact person for more information: Rochelle Bavol, (301) 415–1651.

* * * * *

Additional Information

By a vote of 4–0 on April 22, 2010, the Commission determined pursuant to U.S.C. 552b(e) and § 9.107(a) of the Commission's rules that Affirmation of: U.S. Department of Energy (High-Level Waste Repository), Docket No. 63–001–HLW; U.S. Department of Energy's Petition for Interlocutory Review be held on April 23, 2010, with less than one week notice to the public. The item was affirmed.

* * * * *

The NRC Commission Meeting Schedule can be found on the Internet at: *http://www.nrc.gov/about-nrc/policy-making/schedule.html.*

* * * * *

The NRC provides reasonable accommodation to individuals with disabilities where appropriate. If you need a reasonable accommodation to participate in these public meetings, or need this meeting notice or the transcript or other information from the public meetings in another format (*e.g.* braille, large print), please notify Angela Bolduc, Chief, Employee/Labor Relations and Work Life Branch, at 301–492–2230, TDD: 301–415–2100, or by e-mail at *angela.bolduc@nrc.gov.* Determinations on requests for reasonable accommodation will be made on a case-by-case basis.

* * * * *

This notice is distributed electronically to subscribers. If you no longer wish to receive it, or would like to be added to the distribution, please contact the Office of the Secretary, Washington, DC 20555 (301–415–1969), or send an e-mail to *darlene.wright@nrc.gov.*

Dated: April 29, 2010.

Rochelle C. Bavol,

Office of the Secretary.

[FR Doc. 2010–10535 Filed 4–30–10; 4:15 pm]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2010–0170]

Notice of Opportunity for Public Comment on the Proposed Models for Plant-Specific Adoption of Technical Specifications Task Force Traveler TSTF–500, "DC Electrical Rewrite—Update to TSTF–360"

AGENCY: Nuclear Regulatory Commission (NRC).

ACTION: Notice of opportunity for public comment.

SUMMARY: The NRC is requesting public comment on the proposed model application (with model no significant hazards consideration determination) and model safety evaluation (SE) for plant-specific adoption of Technical Specifications Task Force (TSTF) Traveler TSTF–500, Revision 2, "DC Electrical Rewrite—Update to TSTF–360." The TSTF–500, Revision 2, is available in the Agencywide Documents Access and Management System (ADAMS) under Accession Number ML092670242. The proposed changes modify technical specification (TS) requirements related to direct current (DC) electrical systems in limiting condition for operation (LCO) 3.8.[4], ["DC Sources—Operating,"] LCO 3.8.[5], ["DC Sources—Shutdown,"] and LCO 3.8.[6], ["Battery Parameters."] A [new or revised] "Battery Monitoring and Maintenance Program" is being proposed for Section [5.5] ["Administrative Controls—Programs and Manuals."] This proposed model SE will facilitate expedited approval of plant-specific adoption of TSTF–500, Revision 2.

DATES: Comment period expires on June 3, 2010. Comments received after this date will be considered, if it is practical to do so, but the Commission is able to ensure consideration only for comments received on or before this date.

ADDRESSES: You may submit comments by any one of the following methods. Please include Docket ID NRC–2010–0170 in the subject line of your comments. Comments submitted in writing or in electronic form will be posted on the NRC Web site and on the Federal rulemaking website Regulations.gov. Because your comments will not be edited to remove any identifying or contact information, the NRC cautions you against including any information in your submission that you do not want to be publicly disclosed.

The NRC requests that any party soliciting or aggregating comments

received from other persons for submission to the NRC inform those persons that the NRC will not edit their comments to remove any identifying or contact information, and therefore, they should not include any information in their comments that they do not want publicly disclosed.

Federal Rulemaking Web site: Go to *http://www.regulations.gov* and search for documents filed under Docket ID NRC–2010–0170. Address questions about NRC dockets to Carol Gallagher 301–492–3668; e-mail *Carol.Gallagher@nrc.gov*.

Mail comments to: Michael T. Lesar, Chief, Rules, Announcements and Directives Branch (RADB), Division of Administrative Services, Office of Administration, Mail Stop: TWB–05–B01M, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, or by fax to RADB at 301–492–3446.

You can access publicly available documents related to this notice using the following methods:

NRC's Public Document Room (PDR): The public may examine and have copied for a fee publicly available documents at the NRC's PDR, Public File Area O1 F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland.

NRC's Agencywide Documents Access and Management System (ADAMS): Publicly available documents created or received at the NRC are available electronically at the NRC's Electronic Reading Room at *http://www.nrc.gov/reading-rm/adams.html*. From this page, the public can gain entry into ADAMS, which provides text and image files of NRC's public documents. If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the NRC's PDR reference staff at 1–800–397–4209, 301–415–4737, or by e-mail to *pdr.resource@nrc.gov*. The proposed model application and SE for plant-specific adoption of TSTF–500, Revision 2, are available electronically under ADAMS Accession Number ML093340412.

Federal Rulemaking Web site: Public comments and supporting materials related to this notice can be found at *http://www.regulations.gov* by searching on Docket ID: NRC–2010–0170.

FOR FURTHER INFORMATION CONTACT: Ms. Michelle C. Honcharik, Senior Project Manager, Licensing Processes Branch, Mail Stop: O–12 D1, Division of Policy and Rulemaking, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC, 20555–0001; telephone 301–415–1774 or e-mail at *michelle.honcharik@nrc.gov*. For technical questions please contact Mr. Gerald Waig, Senior Reactor Systems Engineer, Technical Specifications Branch, Division of Inspection and Regional Support, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone 301–415–2260 or e-mail at *gerald.waig@nrc.gov*.

SUPPLEMENTARY INFORMATION:

This notice provides an opportunity for the public to comment on proposed changes to the standard technical specifications (STS) after a preliminary assessment and finding by the NRC staff that the agency will likely offer the changes for adoption by licensees. This notice solicits comment on a proposed change to the STS, which if implemented by a licensee will modify the plant-specific TS. The NRC staff will evaluate any comments received for the proposed change to the STS and reconsider the change or announce the availability of the change for adoption by licensees. Licensees opting to apply for this TS change are responsible for reviewing the NRC staff's SE, referencing the applicable technical justifications, and providing any necessary plant-specific information. The NRC will process and note each amendment application responding to the notice of availability according to applicable NRC rules and procedures.

TSTF–500, Revision 2, is applicable to all nuclear power reactors. The Traveler modifies the STS requirements related to DC electrical systems.

The NRC staff requests that each licensee applying for the changes proposed in TSTF–500, Revision 2, include in their license amendment request (LAR) letter(s) from battery manufacturer(s) verifying the acceptability of using float current monitoring.

The proposed change does not prevent licensees from requesting an alternate approach or proposing changes other than those proposed in TSTF Traveler–500, Revision 2. However, significant deviations from the approach recommended in this notice or the inclusion of additional changes to the license require additional NRC staff review. This may increase the time and resources needed for the review or result in NRC staff rejection of the LAR. Licensees desiring significant deviations or additional changes should instead submit an LAR that does not claim to adopt TSTF Traveler–500, Revision 2.

Dated at Rockville, Maryland, this 27th day of April 2010.

For the Nuclear Regulatory Commission.

Eric E. Bowman,

Acting Chief, Licensing Processes Branch, Division of Policy and Rulemaking, Office of Nuclear Reactor Regulation.

[FR Doc. 2010–10388 Filed 5–3–10; 8:45 am]

BILLING CODE 7590–01–P

PACIFIC NORTHWEST ELECTRIC POWER AND CONSERVATION PLANNING COUNCIL

Sixth Northwest Electric Power and Conservation Plan

AGENCY: Pacific Northwest Electric Power and Conservation Planning Council (Northwest Power and Conservation Council; the Council).

ACTION: Notice of adoption of the Sixth Northwest Electric Power and Conservation Plan.

SUMMARY: The Pacific Northwest Electric Power Planning and Conservation Act of 1980 (16 U.S.C. 839 *et seq.*) requires the Council to adopt and periodically review and revise a regional power plan, the Northwest Electric Power and Conservation Plan. The Council first adopted the power and conservation plan in 1983, with significant amendments or complete revisions adopted in 1986, 1991, 1998 and 2004. The Council began a review of the power and conservation plan in December 2007, and in September 2009, the Council released for public review and comment the Draft Northwest Sixth Electric Power and Conservation Plan. During the comment period, the Council held public hearings in each of the four Northwest states, as required by the Northwest Power Act, engaged in consultations about the power and conservation plan with various governments, entities and individuals in the region, and accepted and considered substantial written and oral comments.

At the Council's regularly scheduled public meeting in February 2010 in Portland, Oregon, the Council formally adopted the revised power and conservation plan, called the Sixth Northwest Electric Power and Conservation Plan. The revised power and conservation plan meets the requirements of the Northwest Power Act, which specifies the components the power plan is to have, including an energy conservation program, a recommendation for research and development; a methodology for determining quantifiable environmental costs and benefits; a 20-year demand forecast; a forecast of power resources that the Bonneville Power Administration will need to meet its

obligations; and an analysis of reserve and reserve reliability requirements. The power and conservation plan also includes the Council's Columbia River Basin Fish and Wildlife Program, developed pursuant to other procedural requirements under the Northwest Power Act. The Council followed the adoption of the power and conservation plan with decisions at public meetings in March and April 2010, also in Portland, Oregon, to approve supporting technical appendices and a Statement of Basis and Purpose and Response to Comments to accompany the final plan.

A pre-publication version of the final power and conservation plan is available on the Council's Web site, at *http://www.nwcouncil.org/energy/powerplan/6/default.htm*. A formal version will be published in the near future.

FOR FURTHER INFORMATION CONTACT: If you would like more information, or assistance in obtaining a copy of the Sixth Power Plan, please contact the Council's central office. The Council's address is 851 SW. Sixth Avenue, Suite 1100, Portland, Oregon 97204. The Council's telephone numbers are 503–222–5161, and 800–452–5161; the Council's FAX is 503–820–2370, and the Council's Web site is: *http://www.nwcouncil.org*.

Stephen L. Crow,

Executive Director.

[FR Doc. 2010–10373 Filed 5–3–10; 8:45 am]

BILLING CODE P

POSTAL REGULATORY COMMISSION

[Docket No. MC2009–19; Order No. 449]

New Postal Products

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recently-filed Postal Service request to add postal products to the Mail Classification Schedule. This notice addresses procedural steps associated with this filing.

DATES: Comments are due: May 19, 2010.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov*. Commenters who cannot submit their views electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on alternatives to electronic filing.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202–789–6820 and *stephen.sharfman@prc.gov.*

SUPPLEMENTARY INFORMATION: On January 13, 2010, the Commission issued an order approving the addition of certain postal services to the Mail Classification Schedule (MCS) product lists.[1] In approving these additions, the Commission directed the Postal Service to file product descriptions for eight additional services that were being added to the Market Dominant Product List as elements of Address Management Services (AMS). Order No. 391 at 31, Ordering Paragraph 4. In addition, Order No. 391 directed the Postal Service to file an appropriate request to add Stamp Fulfillment Services (SFS) to the MCS Market Dominant Product List.[2] Order No. 391 at 31, Ordering Paragraph 5.

As directed, the Postal Service has filed product descriptions for the eight additional elements of AMS that were being added to the Market Dominant Product List.[3] The Postal Service has also filed a request to add SFS to the Market Dominant Product List.[4]

In its First Response, the Postal Service has proposed AMS product description language based upon the Library Reference, but revised in several respects. First, language concerning one of the eight services that the Commission had directed be added to the Market Dominant Product List, Mailpiece Quality Control Certification, has been removed because the service is no longer being offered. Second, Address Management Services Prices have been edited to remove references to Cartridge pricing since this format is no longer available; to add a description of the Computerized Delivery Sequence (CDS) No Stat service to reflect the fact that the minimum price for this service is treated separately from the CDS service minimum; and to add a previously omitted price for retesting FASTforward MLOCR. Finally, the Postal Service adds information regarding two existing services or license types that were previously overlooked: 99 Percent Accurate Method and NCOA^{Link} Mail Processing Equipment.

In its Request, the Postal Service states that Stamp Fulfillment Services is an existing product and that the Request relates only to the charges for ordering stamps. Attachment A to the Request shows the proposed changes to the MCS in legislative format. Attachment B provides a statement of supporting justification for the Request. The Postal Service asserts these classification changes are consistent with the requirements of 39 U.S.C. 3642. Request at 2–3.

The Commission hereby provides notice of the Postal Service's First Response and its Request, and affords interested persons an opportunity to express views and offer comments on those filings. Comments are due May 19, 2010.

The Commission appoints Emmett Rand Costich to serve as Public Representative in this docket.

It is ordered:

1. Pursuant to 39 U.S.C. 505, Emmett Rand Costich is appointed to serve as officer of the Commission (Public Representative) to represent the interests of the general public in these proceedings.

2. Comments by interested persons in this proceeding are due no later than May 19, 2010.

3. The Secretary shall arrange for publication of this order in the **Federal Register**.

By the Commission.

Shoshana M. Grove,

Secretary.

[FR Doc. 2010–10362 Filed 5–3–10; 8:45 am]

BILLING CODE 7710–FW–S

[1] Order Approving Addition of Postal Services to the Mail Classification Schedule Product Lists, January 13, 2010 (Order No. 391). *See* Notice of Filing of Library Reference, January 13, 2010 (Library Reference).

[2] At the request of the Postal Service, the deadline for the SFS filing was subsequently extended to April 30, 2010. *See* Order Granting Extension of Time, March 24, 2010.

[3] First Response of the United States Postal Service to Order No. 391, Amending Requested MCS Language for Address Management Services, February 23, 2010 (First Response).

[4] Request of the United States Postal Service to Add Stamp Fulfillment Services to the Mail Classification Schedule in Response to Order No. 391, April 26, 2010 (Request). In its filing, the Postal Service states that it is filing separate requests to add charges for orders of philatelic items to the provisional Philatelic Sales nonpostal product and to add charges for personalized stamped envelopes to the Stamped Envelopes ancillary Special Services section of the Mail Classification Schedule. *See* Docket No. MC2009–20, Notice of the United States Postal Service of Amendment to Mail Classification Schedule Language for Nonpostal Activities Required to be Filed By Order No. 154, April 26, 2010; *see also* Docket No. MC2010–23, Notice of the United States Postal Service of Classification Change to Add Existing Shipping Charges to the Mail Classification Schedule Section for Stamped Envelopes, April 26, 2010.

POSTAL REGULATORY COMMISSION

[Docket No. MC2010–23; Order No. 450]

New Postal Products

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recently-filed Postal Service request to

add postal products to the Mail Classification Schedule. This notice addresses procedural steps associated with this filing.

DATES: Comments are due: May 19, 2010.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov.* Commenters who cannot submit their views electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on alternatives to electronic filing.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202–789–6820 and *stephen.sharfman@prc.gov.*

SUPPLEMENTARY INFORMATION: On April 26, 2010, the Postal Service filed a notice of an amendment to the Mail Classification Schedule (MCS) language for the stamped envelope price category in the Ancillary Services product in Special Services.[1] In its filing, the Postal Service points out that the current MCS language for the stamped envelope price category includes pricing for personalized stamped envelopes, but omits applicable shipping charges. *Id.* at 1.

The Postal Service states that while orders for personalized stamped envelopes are placed with its Stamp Fulfillment Services office, orders are actually fulfilled by a private printer located in another state. Currently effective shipping charges for orders fulfilled by that printer are set forth in the Ordering Instructions for Personalized Stamped Envelopes (PS Form 3202–X, October 2009). *Id.*, Attachment A.

The Postal Service states further its belief that the appropriate place to include shipping charges for stamped envelopes is in the Stamped Envelope section of the MCS, rather than in the new Stamp Fulfillment Services product that it has requested be added to the MCS.[2] Attachment B to the Notice shows the proposed changes to the Stamped Envelope MCS language in section 1505.19 of the MCS. These charges are a continuation of the existing charges already being paid by customers.

The Commission hereby provides public notice of the Postal Service's filing and affords interested persons the opportunity to express views and offer comments on the proposed MCS classification change. Comments are due May 19, 2010.

The Commission appoints Emmett Rand Costich to serve as Public Representative in this docket.

It is ordered:

1. The Commission establishes Docket No. MC2010–23 for consideration of the matters raised in this docket.

2. Pursuant to 39 U.S.C. 505, Emmett Rand Costich is appointed to serve as officer of the Commission (Public Representative) to represent the interests of the general public in these proceedings.

3. Comments by interested persons in this proceeding are due no later than May 19, 2010.

4. The Secretary shall arrange for publication of this order in the **Federal Register**.

By the Commission.

Shoshana M. Grove,

Secretary.

[FR Doc. 2010–10399 Filed 5–3–10; 8:45 am]

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[1] Notice of the United States Postal Service of Classification Change to Add Existing Shipping Charges to the Mail Classification Schedule for Stamped Envelopes, April 26, 2010 (Notice).

[2] *See* Docket No. MC2009–19, Request of the United States Postal Service to Add Stamp Fulfillment Services to the Mail Classification Schedule in Response to Order No. 391, April 26, 2010 (Request). The Request was filed at the direction of the Commission. *See* Order Approving Addition of Postal Services to the Mail Classification Schedule Product Lists, January 13, 2010 at 31, Ordering Paragraph 5.

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Public Law 94–409, that the Securities and Exchange Commission will hold a Closed Meeting on Thursday, May 6, 2010 at 2 p.m.

Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the Closed Meeting. Certain staff members who have an interest in the matters also may be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, one or more of the exemptions set forth in 5 U.S.C. 552b(c)(5), (7), 9(B) and (10) and 17 CFR 200.402(a)(5), (7), 9(ii) and (10), permit consideration of the scheduled matters at the Closed Meeting.

Commissioner Paredes, as duty officer, voted to consider the items listed for the Closed Meeting in a closed session.

The subject matter of the Closed Meeting scheduled for Thursday, May 6, 2010 will be:

Settlement of injunctive actions;

A litigation matter;

An adjudicatory matter; and

Other matters relating to enforcement proceedings.

At times, changes in Commission priorities require alterations in the scheduling of meeting items.

For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact: The Office of the Secretary at (202) 551–5400.

Dated: April 29, 2010.

Elizabeth M. Murphy,

Secretary.

[FR Doc. 2010–10490 Filed 4–30–10; 11:15 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–61991; File No. SR–NASDAQ–2010–050]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by the NASDAQ Stock Market LLC Relating to the Opening of Trading in the NASDAQ Options Market

April 27, 2010.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act")[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on April 15, 2010, The NASDAQ Stock Market LLC ("Nasdaq" or the "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

Nasdaq is filing a proposal for the NASDAQ Options Market ("NOM" or "Exchange") to to [sic] modify Chapter VI, Section 8 of the Exchange's rules, dealing with the Nasdaq Opening Cross.

The text of the proposed rule change is available from Nasdaq's Web site at *http://nasdaq.cchwallstreet.com,* at Nasdaq's principal office, and at the Commission's Public Reference Room.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, NASDAQ included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. NASDAQ has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Nasdaq proposes to modify Chapter VI, Section 8 of the rules governing NOM, and in particular governing the opening of trading in that market. Currently, pursuant to Chapter VI, Section 8(b) of NOM's rules, the Nasdaq Opening Cross occurs once certain preconditions are met. Section 8(b) of Chapter VI permits the Opening Cross to occur at or after 9:30 if there is no Imbalance [3], if the dissemination of a quote or trade by the Market for the Underlying Security [4] has occurred (or, in the case of index options, the Exchange has received the opening price of the underlying index) and if a certain number (as the Exchange may determine from time to time) of other options exchanges have disseminated a firm quote on the Options Price Reporting Authority ("OPRA").[5]

Section 8(c) of Chapter VI governs situations in which the requisite number of firm quotes have not been disseminated for an option by other options exchanges. No Opening Cross will occur if firm quotes are not disseminated for an option by the predetermined number of options exchanges until such time during the day that the Exchange determines. In that case, provided dissemination of a quote or trade by the Market for the Underlying Security has occurred (or, in the case of index options, the Exchange has received the opening price of the underlying index) the option will open for trading.[6]

The Exchange is proposing to amend both Section 8(b) and 8(c) of Chapter VI to clarify in each case that the dissemination of a quote or trade by the Market for the Underlying Security must occur during regular trading hours in order for the NOM opening cross to occur in that option. These amendments would establish clearly that this precondition for opening trading in an option on NOM would not be met if, for example, the Market for the Underlying Security were to both open and then halt trading prior to regular trading hours which currently begin at 9:30 a.m.

The Exchange is also proposing to amend Section 8(c)(2) of Chapter VI to clarify that if opening quotes or orders lock or cross each other such that an Opening Cross can be initiated, the Exchange may open for trading in that option even if the orders that would be executed in the Opening Cross are not cancelled or modified so that they no longer lock or cross each other, if and when the number of options exchanges required under the introductory language of Section 8(b) of Chapter VI for the opening of trading of System securities have disseminated a firm quote on OPRA. This amendment will not make a change in the operation of the trading system, but will merely clarify the intended NOM opening process.

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act [7] in general, and furthers the objectives of Section 6(b)(5) of the Act [8] in particular, in that it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general to protect investors and the public interest. Nasdaq believes that the proposal is consistent with this standard because the proposed rule change is designed to clarify its rules for the benefit of all market participants.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Exchange believes that the foregoing proposed rule change may take effect upon filing with the Commission pursuant to Section 19(b)(3)(A) of the Act [9] and Rule 19b–4(f)(6) [10] thereunder because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days after the date of the filing, or such shorter time as the Commission may designate.

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–NASDAQ–2010–050 on the subject line.

[3] "Imbalance" is defined in Section 8(a)(1) of Chapter VI as the number of contracts of Eligible Interest that may not be matched with other order contracts at a particular price at any given time.

[4] Section 8(a)(5) of Chapter VI defines "Market for the Underlying Security" as meaning either the primary listing market, the primary volume market (defined as the market with the most liquidity in that underlying security for the previous two calendar months), or the first market to open the underlying security, as determined by the Exchange on an issue-by-issue basis and announced to the membership on the Exchange's Web site.

[5] If all the conditions specified in Section 8(b) of Chapter VI have been met *except* that there is an Imbalance, Section 8(b)(5) requires one additional Order Imbalance Indicator message to be disseminated, after which the Opening Cross occurs, executing the maximum number of contracts. Any remaining Imbalance that is not executable in the Opening Cross is canceled.

[6] If there is interest in the Opening Cross, the option will not open for trading in that option until the orders that would be executed in the Opening Cross are resolved through the cancellation or modification of the orders by the entering party or parties.

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(5).

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. Nasdaq has satisfied this requirement.

Paper Comments

• Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NASDAQ–2010–050. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission,[11] all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NASDAQ–2010–050 and should be submitted on or before May 25, 2010.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Elizabeth M. Murphy,

Secretary.

[FR Doc. 2010–10275 Filed 5–3–10; 8:45 am]

BILLING CODE 8010–01–P

[11] The text of the proposed rule change is available on the Commission's Web site at *http://www.sec.gov/rules/sro.shtml.*

[12] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–61993; File No. SR–BX–2010–029]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by NASDAQ OMX BX, Inc. To Amend the By-Laws of The NASDAQ OMX Group, Inc.

April 27, 2010.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act") [1], and Rule 19b–4 [2] thereunder, notice is hereby given that on April 9, 2010, NASDAQ OMX BX, Inc. ("BX" or "Exchange") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to file a proposed rule change relating to the By-Laws of its parent corporation, The NASDAQ OMX Group, Inc. ("NASDAQ OMX").

The text of the proposed rule change is available on the Exchange's Web site at *http://www.nasdaqtrader.com/micro.aspx?id=BXRulefilings,* at the principal office of the Exchange, on the Commission's Web site at *http://www.sec.gov,* and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

NASDAQ OMX has proposed making certain amendments to its By-Laws to make improvements in its governance. In SR–NASDAQ–2010–025, The NASDAQ Stock Market LLC ("NASDAQ Exchange") sought Commission approval to adopt these By-Laws changes as part of the rules of NASDAQ Exchange, and the Commission granted approval to these changes in an order dated April 8, 2010.[3] The Exchange is now submitting this filing on an immediately effective basis to adopt the same By-Law changes as rules of the Exchange.

The NASDAQ OMX By-Laws previously provided that each director receiving a plurality of the votes at any election of directors at which a quorum is present is duly elected to the Board. Under Corporate Governance Guidelines adopted by the Board, however, any director in an uncontested election who received a greater number of votes "withheld" from his or her election than votes "for" such election was required to tender his or her resignation promptly following receipt of the certification of the stockholder vote. The NASDAQ OMX Nominating & Governance Committee then considered the resignation offer and recommended to the Board whether to accept it. Within 90 days after the certification of the election results, the Board determined whether to accept or reject the resignation. Promptly thereafter, the Board announced its decision by means of a press release. In a contested election (*i.e.,* where the number of nominees exceeds the number of directors to be elected), the unqualified plurality standard controls.

Uncontested Election

NASDAQ OMX recently amended its By-Laws to adopt a majority vote standard, specifically By-Law Article IV, Section 4.4 of the By-Laws was amended to provide that, in an uncontested election, directors shall be elected by holders of a majority of the votes cast at any meeting for the election of directors at which a quorum is present.[4] Under the majority voting standard, a nominee who fails to receive the requisite vote will not be duly

[3] *See* Securities Exchange Act Release No. 61876 (April 8, 2010), 75 FR 19436 (April 14, 2010) (SR–NASDAQ–2010–025).

[4] NASDAQ OMX also amended its Corporate Governance Guidelines to reflect the majority vote standard for uncontested director elections.

elected to the Board. The By-Laws require that any incumbent nominee, as a condition to his or her nomination for election, must submit in writing an irrevocable resignation, the effectiveness of which is conditioned upon the director's failure to receive the requisite vote in any uncontested election and the Board's acceptance of the resignation. The resignation will be considered by the Nominating & Governance Committee and acted upon by the Board in the same manner described above.[5] Acceptance of that resignation by the Board shall be in accordance with the policies and procedures adopted by the Board for such purpose. NASDAQ OMX specifies its policies and procedures pertaining to the election of its directors in its By-Laws. Specifically, the policies and procedures for the acceptance of the resignation of a director, by the Board, are proposed to be specified in By-Law Article IV, Section 4.4. There are no additional policies and procedures other than what is indicated in the By-Laws. In the event that NASDAQ OMX proposes to further amend its By-Laws with respect to the election of directors, including the adoption of any policies and procedure with respect to such election, NASDAQ OMX shall file a proposed rule change with the Commission to seek approval of those amendments.

Contested Election

NASDAQ OMX codified its process for a contested election. The directors will continue to be elected by a plurality vote in a contested election. There is no change to the process for contested elections because if a majority voting standard were to apply in a contested election, the likelihood of a "failed election" (*i.e.,* a situation in which no director receives the requisite vote) would be more pronounced. Moreover, the rationale underpinning the majority voting policy does not apply in contested elections where stockholders are offered a choice among competing candidates. Directors are elected by a plurality of votes present in person or represented by proxy at a meeting. The directors who receive the greatest number of votes cast for election of directors at the meeting will be elected.

General Election Requirements

The following applies to elections of directors and were not amended. Each share of common stock has one vote,[6] subject to the voting limitation in NASDAQ OMX's certificate of incorporation that generally prohibits a holder from voting in excess of 5% of the total voting power of NASDAQ OMX.[7] In addition, each note holder is entitled to the number of votes equal to the number of shares of common stock into which such note could be converted on the record date, subject to the 5% voting limitation contained in the certificate of incorporation.

The presence of owners of a majority (greater than 50%) of the votes entitled to be cast by holder of NASDAQ OMX voting securities constitutes a quorum. Presence may be in person or by proxy. Any securities not voted, by abstention, will not impact the vote.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the provisions of Section 6 of the Act,[8] in general, and with Sections 6(b)(1) and (b)(5) of the Act,[9] in particular, in that the proposal enables the Exchange to be so organized as to have the capacity to be able to carry out the purposes of the Act and to comply with and enforce compliance by members and persons associated with members with provisions of the Act, the rules and regulations thereunder, and self-regulatory organization rules, and is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. The proposed amendments adopting a majority vote standard would enable the directors to be elected in a manner reflective of the desires of shareholders and provide a mechanism to protect against the election of directors by less than a majority vote of the shareholders.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days after the date of the filing, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, it has become effective pursuant to 19(b)(3)(A) of the Act[10] and Rule 19b–4(f)(6)[11] thereunder.

The Exchange has noted that the proposed rule change is identical to a proposed rule change recently approved by the Commission with respect to the NASDAQ Exchange[12] and has requested that the Commission waive the 30-day operative delay to ensure that NASDAQ OMX is able to implement the proposed rule change without undue delay. The Commission has determined that waiving the 30-day operative delay is consistent with the protection of investors and the public interest because such waiver will enable NASDAQ OMX to implement the proposed rule change without undue delay in a manner consistent with a proposed rule change previously approved by the Commission.[13] Therefore, the Commission designates the proposal operative upon filing.[14]

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

[5] *See* NASDAQ OMX By-Law Article IV, Section 4.5.

[6] *See* NASDAQ OMX Certificate of Incorporation at Article IV, C.1(a).

[7] *See* NASDAQ OMX Certificate of Incorporation at Article IV, C.1(b)2.

[8] 15 U.S.C. 78f.

[9] 15 U.S.C. 78f(b)(2)[sic], (5).

[10] 15 U.S.C. 78s(b)(3)(A).

[11] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[12] *See* Securities Exchange Act Release No. 61876 (April 8, 2010), 75 FR 19436 (April 14, 2010) (SR–NASDAQ–2010–025).

[13] *Id.*

[14] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–BX–2010–029 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–BX–2010–029. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–BX–2010–029 and should be submitted on or before May 25, 2010.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[15]

Elizabeth M. Murphy,

Secretary.

[FR Doc. 2010–10309 Filed 5–3–10; 8:45 am]

BILLING CODE 8010–01–P

[15] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–61996; File No. SR–NSX–2010–04]

Self-Regulatory Organizations; National Stock Exchange, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend the Fee and Rebate Schedule Issued Pursuant to Exchange Rule 16.1(c) With Respect to the Liquidity Adding Rebate for Securities Priced Under One Dollar

April 28, 2010.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (the "Act") [1] and Rule 19b–4 thereunder,[2] notice is hereby given that on April 9, 2010, National Stock Exchange, Inc. filed with the Securities and Exchange Commission ("Commission") the proposed rule change, as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comment on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of the Substance of the Proposed Rule Change

National Stock Exchange, Inc. ("NSX®" or "Exchange") is proposing to amend the Fee and Rebate Schedule (the "Fee Schedule") issued pursuant to Exchange Rule 16.1(c) to adjust the liquidity adding rebate for securities priced under one dollar.

The text of the proposed rule change is available on the Exchange's Web site at *http://www.nsx.com,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

With this rule change, the Exchange is proposing to modify the Fee Schedule to adjust the liquidity adding rebate for securities priced under one dollar in both the Automatic Execution mode of order interaction ("AutoEx") and the Order Delivery mode of order interaction ("Order Delivery").[3]

AutoEx Liquidity Adding Rebate For Securities Priced Under One Dollar

For orders in securities priced under one dollar that provide liquidity in AutoEx, the Fee Schedule currently provides that an ETP Holder receives a rebate of 0.25% of trade value, where "trade value" is defined as the dollar amount equal to the price per share multiplied by the number of shares executed.[4] The proposed rule change adjusts such rebate to be the lesser of the foregoing amount and 25% of the quote spread, where "quote spread" is defined as the dollar amount equal to the number of shares executed multiplied by the difference at the time of execution between (x) the price per share of the national best bid, and (y) the price per share of the national best offer.[5]

Order Delivery Liquidity Adding Rebate For Securities Priced Under One Dollar

For orders in securities priced under one dollar that provide liquidity in Order Delivery, the Fee Schedule currently provides that an ETP Holder receives a rebate of 0.20% of trade value. The proposed rule change adjusts such rebate to be the lesser of 0.20% of trade value and 20% of the quote spread.

In both Order Delivery and AutoEx, no quote spread rebate is payable in the event of locked or crossed quotations. Finally, the proposed rule change modifies for purposes of internal consistency the language in the Fee Schedule to make clear that Zero

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] The Exchange's two modes of order interaction are described in NSX Rule 11.13(b).

[4] See Explanatory Endnote (6) to the Fee Schedule.

[5] See Explanatory Endnote (12) to the Fee Schedule.

Display Reserve Orders of sub-dollar securities in both AutoEx and Order Delivery remain ineligible to receive the liquidity adding rebate.[6]

Rationale

The Exchange has determined that these changes are necessary to maintain an appropriate incentive for ETP Holders to submit increased order volumes of sub-dollar securities in AutoEx and Order Delivery and, ultimately, to increase the revenues of the Exchange for the purpose of continuing to adequately fund its regulatory and general business functions. The Exchange has further determined that the proposed fee adjustments are necessary for competitive reasons. The Exchange believes that these rebate changes will not impair the Exchange's ability to fulfill its regulatory responsibilities.

The proposed modifications are reasonable and equitably allocated to those ETP Holders that opt to submit orders of sub-dollar securities, and are not discriminatory because ETP Holders are free to elect whether or not to send such orders. The proposed modifications continue to incentivize ETP Holders to submit liquidity adding displayed orders over Zero Display Reserve Orders, and AutoEx orders over orders in Order Delivery. Based upon the information above, the Exchange believes that the proposed rule change is consistent with the protection of investors and the public interest.

Operative Date and Notice

The Exchange intends to make the proposed modifications, which are effective on filing of this proposed rule, operative for trading on April 12, 2010. Pursuant to Exchange Rule 16.1(c), the Exchange will "provide ETP Holders with notice of all relevant dues, fees, assessments and charges of the Exchange" through the issuance of a Regulatory Circular of the changes to the Fee Schedule and will post a copy of the rule filing on the Exchange's Web site (*http://www.nsx.com*).

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the provisions of Section 6(b) of the Act,[7] in general, and Section 6(b)(4) of the Act,[8] in particular, in that it is designed to provide for the equitable allocation of reasonable dues, fees and other charges among its members and other persons using the facilities of the Exchange. Moreover, the proposed fee rule change is not discriminatory in that all ETP Holders are eligible to submit (or not submit) trades and quotes at any price in AutoEx and Order Delivery in all tapes, as either displayed or undisplayed, liquidity adding or liquidity taking and sub-dollar or dollar-and-above, and may do so at their discretion.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any inappropriate burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange has neither solicited nor received written comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The proposed rule change has taken effect upon filing pursuant to Section 19(b)(3)(A)(ii) of the Act[9] and subparagraph (f)(2) of Rule 19b–4[10] thereunder, because, as provided in (f)(2), it changes "a due, fee or other charge applicable only to a member" (known on the Exchange as an ETP Holder). At any time within sixty (60) days of the filing of such proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–NSX–2010–04 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NSX–2010–04. This file number should be included on the subject line if e-mail is used.

To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml.)* Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal offices of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NSX–2010–04, and should be submitted on or before May 25, 2010.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[11]

Elizabeth M. Murphy,

Secretary.

[FR Doc. 2010–10363 Filed 5–3–10; 8:45 am]

BILLING CODE 8011–01–P

[6] Specifically, the parenthetical "(except for Zero Display Orders)" is deleted in the Fee Schedule text describing the amounts of the sub-dollar liquidity adding rebates and, consistent with the discussion of dollar-and-higher securities, the word "Displayed" is being added to the types of orders under discussion. The net result (that Zero Display Reserve Orders are not eligible to receive rebates for adding liquidity in sub-dollar securities) remains unchanged.

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(4).

[9] 15 U.S.C. 78s(b)(3)(A)(ii).

[10] 17 CFR 240.19b–4.

[11] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–61992; File No. SR–NASDAQ–2010–048]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by The NASDAQ Stock Market, LLC To Amend the By-Laws of The NASDAQ OMX Group, Inc.

April 27, 2010.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] and Rule 19b–4 [2] thereunder, notice is hereby given that on April 9, 2010, The NASDAQ Stock Market LLC (the "NASDAQ Exchange") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I and II below, which Items have been prepared by the NASDAQ Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The NASDAQ Exchange is filing with the Securities and Exchange Commission ("Commission") a proposed rule change relating to the By-Laws of its parent corporation, The NASDAQ OMX Group, Inc. ("NASDAQ OMX").

The text of the proposed rule change is available on the Exchange's Web site at *http://www.nasdaq.cchwallstreet.com,* at the principal office of the NASDAQ Exchange, on the Commission's Web site at *http://www.sec.gov,* and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the NASDAQ Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The NASDAQ Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

NASDAQ OMX has proposed making certain amendments to its By-Laws to make improvements in its governance. In SR–NASDAQ–2010–025, The NASDAQ Stock Market LLC ("NASDAQ Exchange") sought Commission approval to adopt these By-Laws changes as part of the rules of NASDAQ Exchange, and the Commission granted approval to these changes in an order dated April 8, 2010.[3] The NASDAQ Exchange is now submitting this filing on an immediately effective basis to adopt the same By-Law changes as rules of the Exchange.

The NASDAQ OMX By-Laws previously provided that each director receiving a plurality of the votes at any election of directors at which a quorum is present is duly elected to the Board. Under Corporate Governance Guidelines adopted by the Board, however, any director in an uncontested election who received a greater number of votes "withheld" from his or her election than votes "for" such election was required to tender his or her resignation promptly following receipt of the certification of the stockholder vote. The NASDAQ OMX Nominating & Governance Committee then considered the resignation offer and recommended to the Board whether to accept it. Within 90 days after the certification of the election results, the Board determined whether to accept or reject the resignation. Promptly thereafter, the Board announced its decision by means of a press release. In a contested election (i.e., where the number of nominees exceeds the number of directors to be elected), the unqualified plurality standard controls.

Uncontested Election

NASDAQ OMX recently amended its By-Laws to adopt a majority vote standard, specifically By-Law Article IV, Section 4.4 of the By-Laws was amended to provide that, in an uncontested election, directors shall be elected by holders of a majority of the votes cast at any meeting for the election of directors at which a quorum is present.[4] Under the majority voting standard, a nominee who fails to receive the requisite vote will not be duly elected to the Board. The By-Laws require that any incumbent nominee, as a condition to his or her nomination for election, must submit in writing an irrevocable resignation, the effectiveness of which is conditioned upon the director's failure to receive the requisite vote in any uncontested election and the Board's acceptance of the resignation. The resignation will be considered by the Nominating & Governance Committee and acted upon by the Board in the same manner described above.[5] Acceptance of that resignation by the Board shall be in accordance with the policies and procedures adopted by the Board for such purpose. NASDAQ OMX specifies its policies and procedures pertaining to the election of its directors in its By-Laws. Specifically, the policies and procedures for the acceptance of the resignation of a director, by the Board, are proposed to be specified in By-Law Article IV, Section 4.4. There are no additional policies and procedures other than what is indicated in the By-Laws. In the event that NASDAQ OMX proposes to further amend its By-Laws with respect to the election of directors, including the adoption of any policies and procedure with respect to such election, NASDAQ OMX shall file a proposed rule change with the Commission to seek approval of those amendments.

Contested Election

NASDAQ OMX codified its process for a contested election. The directors will continue to be elected by a plurality vote in a contested election. There is no change to the process for contested elections because if a majority voting standard were to apply in a contested election, the likelihood of a "failed election" (*i.e.,* a situation in which no director receives the requisite vote) would be more pronounced. Moreover, the rationale underpinning the majority voting policy does not apply in contested elections where stockholders are offered a choice among competing candidates. Directors are elected by a plurality of votes present in person or represented by proxy at a meeting. The directors who receive the greatest number of votes cast for election of directors at the meeting will be elected.

General Election Requirements

The following applies to elections of directors and were not amended. Each share of common stock has one vote,[6] subject to the voting limitation in

[3] *See* Securities Exchange Act Release No. 61876 (April 8, 2010), 75 FR 19436 (April 14, 2010) (SR–NASDAQ–2010–025).

[4] NASDAQ OMX also amended its Corporate Governance Guidelines to reflect the majority vote standard for uncontested director elections.

[5] *See* NASDAQ OMX By-Law Article IV, Section 4.5.

[6] *See* NASDAQ OMX Certificate of Incorporation at Article IV, C.1(a).

NASDAQ OMX's certificate of incorporation that generally prohibits a holder from voting in excess of 5% of the total voting power of NASDAQ OMX.[7] In addition, each note holder is entitled to the number of votes equal to the number of shares of common stock into which such note could be converted on the record date, subject to the 5% voting limitation contained in the certificate of incorporation.

The presence of owners of a majority (greater than 50%) of the votes entitled to be cast by holder of NASDAQ OMX voting securities constitutes a quorum. Presence may be in person or by proxy. Any securities not voted, by abstention, will not impact the vote.

2. Statutory Basis

The NASDAQ Exchange believes that the proposed rule change is consistent with the provisions of Section 6 of the Act,[8] in general, and with Sections 6(b)(1) and (b)(5) of the Act,[9] in particular, in that the proposal enables the NASDAQ Exchange to be so organized as to have the capacity to be able to carry out the purposes of the Act and to comply with and enforce compliance by members and persons associated with members with provisions of the Act, the rules and regulations thereunder, and self-regulatory organization rules, and is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. The proposed amendments adopting a majority vote standard would enable the directors to be elected in a manner reflective of the desires of shareholders and provide a mechanism to protect against the election of directors by less than a majority vote of the shareholders.

B. Self-Regulatory Organization's Statement on Burden on Competition

The NASDAQ Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days after the date of the filing, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, it has become effective pursuant to 19(b)(3)(A) of the Act [10] and Rule 19b–4(f)(6) [11] thereunder.

The NASDAQ Exchange has noted that the proposed rule change is identical to a proposed rule change recently approved by the Commission with respect to the NASDAQ Exchange [12] and has requested that the Commission waive the 30-day operative delay to ensure that NASDAQ OMX is able to implement the proposed rule change without undue delay. The Commission has determined that waiving the 30-day operative delay is consistent with the protection of investors and the public interest because such waiver will enable NASDAQ OMX to implement the proposed rule change without undue delay in a manner consistent with a proposed rule change previously approved by the Commission.[13] Therefore, the Commission designates the proposal operative upon filing.[14]

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–NASDAQ–2010–048 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NASDAQ–2010–048. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the NASDAQ Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NASDAQ–2010–048 and should be submitted on or before May 25, 2010.

[7] *See* NASDAQ OMX Certificate of Incorporation at Article IV, C.1(b)2.

[8] 15 U.S.C. 78f.

[9] 15 U.S.C. 78f(b)(2)[sic], (5).

[10] 15 U.S.C. 78s(b)(3)(A).

[11] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The NASDAQ Exchange has satisfied this requirement.

[12] *See* Securities Exchange Act Release No. 61876 (April 8, 2010), 75 FR 19436 (April 14, 2010) (SR–NASDAQ–2010–025).

[13] *Id.*

[14] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[15]

Elizabeth M. Murphy,

Secretary.

[FR Doc. 2010–10301 Filed 5–3–10; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–61959; File No. SR–ISE–2010–33]

Self-Regulatory Organizations; International Securities Exchange, LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Establish Strike Price Intervals and Trading Hours for Options on Index-Linked Securities

April 22, 2010.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (the "Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on April 16, 2010, the International Securities Exchange, LLC (the "Exchange" or the "ISE") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II, and III below, which items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to establish strike price intervals and trading hours for options on index-linked securities. The text of the proposed rule change is as follows (deletions are in [brackets]; additions are in italics):

* * *

Rule 504. Series of Options Contracts Open for Trading

(a)–(h) No change.

Supplementary Material to Rule 504

.01–.05 No change.

.06 Notwithstanding Supplementary Material .01 above, the interval between strike prices of series of options on Index-Linked Securities, as defined in Rule 502(k)(1), will be $1 or greater when the strike price is $200 or less and $5 or greater when the strike price is greater than $200.

* * *

Rule 700. Days and Hours of Business

No change.

(a)–(c) No change.

(d) *Options on Index-Linked Securities, as defined in Rule 502(k)(1), may be traded on the Exchange until 4:15 p.m. each business day.*

[(d)]*(e)* The Exchange shall not be open for business on the following holidays: New Year's Day, Martin Luther King, Jr. Day, Presidents' Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day or Christmas Day. When any holiday observed by the Exchange falls on a Saturday, the Exchange will not be open for business on the preceding Friday. When any holiday observed by the Exchange falls on a Sunday, the Exchange will not be open for business on the following Monday, unless unusual business conditions exist at the time.

* * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Prior to the commencement of trading options on Index-Linked Securities, the Exchange is proposing to establish strike price intervals and trading hours for these new products.

The Securities and Exchange Commission (the "Commission") has approved ISE's and other option exchanges' proposals to enable the listing and trading of options on Index-Linked Securities.[3] Options trading has not commenced to date and is contingent upon the Commission's approval of The Options Clearing Corporation's ("OCC") proposed supplement to the Options Disclosure Document ("ODD") that will provide disclosure regarding options on Index-Linked Securities.[4]

$1 Strikes for Options on Index-Linked Securities

Prior to the commencement of trading options on Index-Linked Securities, the Exchange is proposing to establish that strike price intervals of $1 will be permitted where the strike price is less than $200. Where the strike price is greater than $200, $5 strikes will be permitted. These proposed changes are reflected by the proposed addition of new .06 of the Supplementary Material to Rule 504.

Without discounting the differences between exchange-traded funds ("ETFs") and Index-Linked Securities, the Exchange seeks to extend the trading conventions applicable to options on ETFs to options on Index-Linked Securities. ISE contends that the proposed strike price intervals for options on Index-Linked Securities are consistent with the strike price intervals currently permitted for options on ETFs. The Exchange believes that $1 strike price intervals for options on Index-Linked Securities will provide investors with greater flexibility by allowed [sic] them to establish positions that are better tailored to meet their investment objectives. ISE has analyzed its capacity and represents that it and the Options Price Reporting Authority have the necessary systems capacity to handle the additional traffic associated with the listing and trading of an expanded number of series as proposed by this filing.

Trading Hours for Options on Index-Linked Securities

Similar to the trading hours for ETF options, the Exchange proposes to amend Rule 700 by renumbering the current subparagraph (d) to (e) and adding a new subparagraph (d) to provide that options on Index-Linked Securities, as defined under .06 of the Supplementary Material to Rule 504, may be traded on the Exchange until 4:15 p.m. each business day.

2. Statutory Basis

The basis under the Securities Exchange Act of 1934 (the "Act") for this proposed rule change is the requirement under Section 6(b)(5) that an exchange have rules that are designed to promote

[15] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release Nos. 58985 (November 10 [sic], 2008), 73 FR 72538 (November 28, 2008) (approving SR–ISE–2008–86); 58204 (July 22, 2008), 73 FR 43807 (July 28, 2008) (approving SR–CBOE–2008–64); 58203 (July 22, 2008), 73 FR 43812 (July 28, 2008) (approving SR–NYSEArca-2008–57).

[4] OCC previously received Commission approval to clear options based on Index-Linked Securities. *See* Securities Exchange Act Release No. 60872 (October 23, 2009), 74 FR 55878 (October 29, 2009) (SR–OCC–2009–14).

just and equitable principles of trade, and to remove impediments to and perfect the mechanism for a free and open market and a national market system, and in general, to protect investors and the public interest. In particular, the proposal will lessen investor confusion by having strike price intervals and trading hours established prior to the commencement of trading in options on Index-Linked Securities.

B. Self-Regulatory Organization's Statement on Burden on Competition

The proposed rule change does not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange has not solicited, and does not intend to solicit, comments on this proposed rule change. The Exchange has not received any unsolicited written comments from members or other interested parties.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days after the date of the filing, or such shorter time as the Commission may designate, it has become effective pursuant to Section 19(b)(3)(A) of the Act [5] and Rule 19b–4(f)(6) thereunder.[6]

The Exchange believes the proposed rule change is non-controversial in that it is similar to a Chicago Board Options Exchange rule change recently approved by the Commission.[7] Further, the Exchange believes the proposed rule change may eliminate confusion for investors by establishing strike price intervals and trading hours for options on Index-Linked Securities prior to the commencement of trading. The Exchange also believes that the proposed rule change does not raise any new, unique or substantive issues, and is beneficial for competitive purposes and to promote a free and open market for the benefit of investors.

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–ISE–2010–33 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–ISE–2010–33. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–ISE–2010–33 and should be submitted on or before May 25, 2010.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[8]

Elizabeth M. Murphy,

Secretary.

[FR Doc. 2010–10300 Filed 5–3–10; 8:45 am]

BILLING CODE 8011–01–P

[5] 15 U.S.C. 78s(b)(3)(A).

[6] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b4(f)(6)(iii) requires the Exchange to give the Commission written notice of the Exchange's intent to file the proposed rule change along with a brief description and text of the proposed rule change, or such shorted time as designated by the Commission. The Exchange provided a copy of this rule filing to the Commission at least five business days prior to the date of this filing.

[7] *See* Securities and Exchange Act Release No. 61696 (March 12, 2010), 75 FR 13174 (March 18, 2010) (approving SR–CBOE 2010–005).

[8] 17 CFR 200.30–3(a)(12).

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2010–0018]

Occupational Information System

AGENCY: Social Security Administration (SSA).

ACTION: Request for comments.

SUMMARY: We are requesting comments on the recommendations submitted to us by the Occupational Information Development Advisory Panel (Panel) in its report entitled "Content Model and Classification Recommendations for the Social Security Administration Occupational Information System, September 2009." The complete Panel report (including appendices) is available online at: *http://www.socialsecurity.gov/oidap/Documents/FinalReportRecommendations.pdf.*

DATES: To ensure that we receive your feedback in a timely manner for consideration as the project develops, please submit your comments no later than June 30, 2010.

ADDRESSES: You may submit comments by any one of three methods—Internet, fax, or mail. Do not submit the same comments multiple times or by more than one method. Regardless of which method you choose, please state that your comments refer to Docket No. SSA–2010–0018 so that we may associate your comments with the correct document.

Caution: You should be careful to include in your comments only information that you wish to make publicly available. We strongly urge you not to include in your comments any personal information, such as Social Security numbers or medical information.

1. *Internet:* We strongly recommend that you submit your comments via the

Internet. Please visit the Federal eRulemaking portal at *http://www.regulations.gov.* Use the Search function of the Web page to find docket number SSA–2010–0018. The system will issue a tracking number to confirm your submission. You will not be able to view your comment immediately because we must post each comment manually. It may take up to a week for your comment to be viewable.

2. *Fax:* Fax comments to (410) 597–0825.

3. *Mail:* Address your comments to the Office of Program Development and Research, Occupational Information Development Project, Social Security Administration, 3–E–26 Operations Building, 6401 Security Boulevard, Baltimore, MD 21235–6401.

Comments are available for public viewing on the Federal eRulemaking portal at *http://www.regulations.gov* or in person, during regular business hours, by sending a request to the project staff at *OIDAP@ssa.gov.*

FOR FURTHER INFORMATION CONTACT: Occupational Information Development Advisory Panel, Social Security Administration, 6401 Security Boulevard, 3–E–26 Operations, Baltimore, MD 21235–0001. Fax: 202–410–597–0825. E-mail to *OIDAP@ssa.gov.* For additional information, please visit the Panel Web site at *http://www.ssa.gov/oidap.*

For information on eligibility or filing for benefits, call our national toll-free number, 1–800–772–1213 or TTY 1–800–325–0778, or visit our Internet site, Social Security Online, at *http://www.socialsecurity.gov.*

SUPPLEMENTARY INFORMATION:

Electronic Version

The electronic file of this document is available on the date of publication of this notice in the **Federal Register** at *http://www.gpoaccess.gov/fr/index.html.*

Background

In 2008, we established the Occupational Information Development Advisory Panel to provide independent advice and recommendations on creating an occupational information system tailored specifically for our disability programs and adjudicative needs. The Panel's advice and recommendations will relate to our disability programs in the following areas:

1. Medical and vocational analysis of disability claims;

2. Occupational analysis, including definitions, ratings, and capture of physical and mental/cognitive demands of work;

3. Occupational information critical to our disability programs;

4. Data collection; and,

5. Other area(s) that will enable us to develop an occupational information system (OIS) and improve our medical-vocational adjudication policies and processes.

Request for Comments

In the first year, the Panel presented general recommendations regarding an occupational information system and also identified attributes of occupations and people that we should measure for purposes of disability adjudication. For occupations, these attributes included the work activities and related demands that a job requires of workers. For people, these attributes described characteristics that each worker brings to the job situation that may be involved when performing the job successfully. The Panel presented the full report, including the following seven general recommendations, to the Commissioner in September 2009. Both the recommendations and the proposed OIS are specific to our disability program needs.

1. A New Occupational Information System: Technical, Legal, and Data Requirements

The Panel recommended that SSA develop a new OIS to replace the Dictionary of Occupational Titles for use in our disability adjudication process. The Panel recommended that we design the new OIS to assure its data are not only useful, but also reliable, valid, and able to withstand any legal challenges.

Characteristics to support these requirements include: (a) Grouping of occupations at a level to support individualized disability assessment; (b) a cross-reference to the Standard Occupational Classification; (c) precise occupationally-specific data; (d) core work activities; (e) minimum levels of requirements needed to perform work; (f) discrete, observable measures of both work activities and worker characteristics; (g) a manageable number of data elements; (h) sampling methodology capturing the full range of work; (i) measures that are psychometrically sound; (j) collection of high quality data; (k) valid, accurate, and reproducible data; (l) information about whether core work activities could be performed in alternative ways; and, (m) terminology that is consistent with medical practice and human function.

2. Data Elements for the New Occupational Information System

Based upon previous research related to job analytic techniques, the Panel recommended a list of work activities applicable to all occupations and recommended that this list serve as a stimulus to develop SSA-specific instruments that measure the requirements of work. The Panel also recommended that new instruments include not only work activities, but also the physical and psychological abilities required to do work, work context, and any other attributes appropriate to disability adjudication.

3. The Classification of Occupations

The Panel recommended that once a large database representative of all work in the national economy is available, we should use various methods to classify jobs based upon work activities and identify work activities that we can use as a common language to match the abilities of people to appropriate work available within the economy.

4. Development of Internal and External Expertise for the Creation and Maintenance of the New Occupational Information System

The Panel recommended that we make the creation and continued maintenance of an up-to-date and legally defensible OIS a priority and, to support that effort, we should develop an independent, internal unit staffed with experts on work analysis and other related disability research needs. The Panel also recommended that we develop and maintain online research and professional communities to inform the unit's emerging and ongoing ideas, research, and methods.

5. Need for Basic & Applied Research

The Panel acknowledged that developing a new OIS requires significant research and recommended that early efforts should focus on the development and pilot-tests of measures of work requirements, usability analysis of these measures, and creation of an appropriate sampling plan. The Panel recommended that we conduct research to determine the most accurate and defensible sources of data for the OIS, the best methods for measuring the required work attributes, and if any other attributes are appropriate for study due to their potential for use in the adjudication process. They also cited the need to perform research focused on exploring and validating the link between the work requirements and attributes of the person, the environment, and other job-related factors. Finally, the Panel recommended

applied research examining user needs and the effects of new instruments on our disability process and programs.

6. Measurement Considerations

In addition to the research needs described in Recommendation 5, the Panel recommended that we should consider research related to appropriate scales for inclusion in any new instruments that we develop. The Panel further stated that we should use scales that are legally defensible for our needs and focus on observable, discrete, characteristics such as frequency and duration.

7. Communication with Users, the Public & the Scientific Community

The Panel recommended that we use both traditional and emerging government and private media outlets to inform or solicit input from various audiences about all activities regarding the OIS development.

Dated: April 26, 2010.

Debra Tidwell-Peters,

Designated Federal Officer, Occupational Information Development Advisory Panel.

[FR Doc. 2010–10297 Filed 5–3–10; 8:45 am]

BILLING CODE 4191–02–P

SUSQUEHANNA RIVER BASIN COMMISSION

Notice of Actions Taken at March 18, 2010, Meeting

AGENCY: Susquehanna River Basin Commission.

ACTION: Notice of Commission actions.

SUMMARY: At its regular business meeting on March 18, 2010, in State College, Pennsylvania, the Commission held a public hearing as part of its regular business meeting. At the public hearing, the Commission: (1) Approved and tabled certain water resources projects; (2) rescinded approval for a water resources project; and (3) approved settlements involving three water resources projects. Details concerning these and other matters addressed at the public hearing and business meeting are contained in the Supplementary Information section of this notice.

DATES: March 18, 2010.

ADDRESSES: Susquehanna River Basin Commission, 1721 N. Front Street, Harrisburg, PA 17102–2391.

FOR FURTHER INFORMATION CONTACT: Richard A. Cairo, General Counsel, telephone: (717) 238–0423, ext. 306; fax: (717) 238–2436; e-mail: *rcairo@srbc.net;* or Stephanie L. Richardson, Secretary to the Commission, telephone: (717) 238–0423, ext. 304; fax: (717) 238–2436; e-mail: *srichardson@srbc.net.* Regular mail inquiries may be sent to the above address.

SUPPLEMENTARY INFORMATION: In addition to the public hearing and its related action items identified below, the following items were also presented or acted on at the business meeting: (1) A presentation by Pennsylvania Department of Conservation and Natural Resources Deputy Secretary for Parks & Forestry James Grace on Marcellus Shale natural gas leasing in Pennsylvania state forests; (2) an update on the implementation of the SRBC Remote Water Quality Monitoring Network; (3) a report on hydrologic conditions in the Susquehanna Basin with an emphasis on National Flood Safety Week; (4) approval/ratification of one grant related to the Susquehanna Flood Forecast and Warning System, and five contracts related to ArcGIS, establishment of an SRBC satellite office in Sayre, PA, consulting services for instream flow studies, aquatic resource surveys, and flood mapping; (5) ratified the Executive Director's retention of outside counsel and other professional services regarding the relicensing proceedings for lower Susquehanna River hydroelectric projects; and (6) approved a revision of the FY–2011 Budget. The Commission also heard counsel's report on legal matters affecting the Commission and recognized retiring Chief Administrative Officer Duane A. Friends for his 25 years of valuable service. The Commission convened a public hearing and took the following actions:

Public Hearing—Compliance Actions

The Commission approved a settlement in lieu of civil penalties for the following projects:

1. Chesapeake Energy Corporation—Eastern Division. Pad ID: Ward (ABR–20090519), Burlington Township, and Sullivan 1 (ABR–20080715), Athens Township, Bradford County, Pa.—$20,000.

2. Novus Operating, LLC. Pad ID: Sylvester 1H and North Fork 1H, Brookfield Township, Tioga County, Pa.—$100,000.

3. Southwestern Energy Production Company. Pad ID: Ferguson, Wyalusing Township, Bradford County, Pa.—$50,000.

Public Hearing—Projects Approved

1. Project Sponsor and Facility: Carrizo Oil & Gas, Inc. (Mosquito Creek—Hoffman), Karthaus Township, Clearfield County, Pa. Surface water withdrawal of up to 0.720 mgd.

2. Project Sponsor and Facility: EQT Production Company (West Branch Susquehanna River—Kuntz), Greenwood Township, Clearfield County, Pa. Surface water withdrawal of up to 0.900 mgd.

3. Project Sponsor and Facility: EXCO–North Coast Energy, Inc. (West Branch Susquehanna River—Johnson), Clinton Township, Lycoming County, Pa. Surface water withdrawal of up to 0.999 mgd.

4. Project Sponsor and Facility: Fortuna Energy Inc. (Fall Brook—Bense), Troy Township, Bradford County, Pa. Surface water withdrawal of up to 1.000 mgd.

5. Project Sponsor and Facility: Fortuna Energy Inc. (Unnamed Tributary to North Branch Sugar Creek—Besley), Columbia Township, Bradford County, Pa. Surface water withdrawal of up to 2.000 mgd.

6. Project Sponsor and Facility: Fortuna Energy Inc. (South Branch Sugar Creek—Shedden), Troy Township, Bradford County, Pa. Surface water withdrawal of up to 0.900 mgd.

7. Project Sponsor and Facility: Fortuna Energy Inc. (Sugar Creek—Hoffman), West Burlington Township, Bradford County, Pa. Surface water withdrawal modification increase from 0.250 mgd up to 2.000 mgd (Docket No. 20090327).

8. Project Sponsor: Graymont (PA), Inc. Project Facility: Pleasant Gap Facility, Spring Township, Centre County, Pa. Groundwater withdrawal of 0.050 mgd (30-day average) from the Plant Make-up Well.

9. Project Sponsor and Facility: Harley-Davidson Motor Company Operations, Inc., Springettsbury Township, York County, Pa. Modification to project features of the withdrawal approval (Docket No. 19900715).

10. Project Sponsor and Facility: Harley-Davidson Motor Company Operations, Inc., Springettsbury Township, York County, Pa. Modification to add a groundwater withdrawal of 0.585 mgd (30-day average) from Well CW–20 to the remediation system, without any increase to total system withdrawal quantity (Docket No. 19980901).

11. Project Sponsor and Facility: Healthy Properties, Inc. (Sugar Creek—owner), North Towanda Township, Bradford County, Pa. Surface water withdrawal of up to 0.450 mgd.

12. Project Sponsor and Facility: Mountain Energy Services, Inc. (Tunkhannock Creek—Deer Park Lumber, Inc.), Tunkhannock Township, Wyoming County, Pa. Surface water withdrawal of up to 0.999 mgd.

13. Project Sponsor and Facility: Randy M. Wiernusz (Bowman Creek—owner), Eaton Township, Wyoming County, Pa. Surface water withdrawal of up to 0.249 mgd.

14. Project Sponsor and Facility: TerrAqua Resource Management (Tioga River—Losey), Lawrenceville Borough, Tioga County, Pa. Surface water withdrawal of up to 0.375 mgd and consumptive water use of up to 0.375 mgd.

15. Project Sponsor and Facility: XTO Energy, Inc. (Lick Run—Dincher), Shrewsbury Borough, Lycoming County, Pa. Surface water withdrawal of up to 0.249 mgd.

16. Project Sponsor and Facility: XTO Energy, Inc. (Little Muncy Creek—Temple), Moreland Township, Lycoming County, Pa. Surface water withdrawal of up to 0.249 mgd.

Public Hearing—Projects Tabled

1. Project Sponsor: Chester County Solid Waste Authority. Project Facility: Lanchester Landfill, Salisbury and Caernarvon Townships, Lancaster County, Pa. Application for groundwater withdrawal of 0.190 mgd (30-day average) from two wells and three collection sumps.

2. Project Sponsor: Chester County Solid Waste Authority. Project Facility: Lanchester Landfill, Salisbury and Caernarvon Townships, Lancaster County, Pa. Application for consumptive water use of up to 0.075 mgd.

3. Project Sponsor: Chester County Solid Waste Authority. Project Facility: Lanchester Landfill, Salisbury and Caernarvon Townships, Lancaster County, Pa. Application for an existing into-basin diversion of up to 0.050 mgd from the Delaware River Basin.

4. Project Sponsor and Facility: Sunnyside Ethanol, LLC (West Branch Susquehanna River—1—owner), Curwensville Borough, Clearfield County, Pa. Application for surface water withdrawal of up to 1.270 mgd.

5. Project Sponsor and Facility: Sunnyside Ethanol, LLC (West Branch Susquehanna River—2—owner), Curwensville Borough, Clearfield County, Pa. Application for surface water withdrawal of up to 0.710 mgd.

6. Project Sponsor and Facility: Sunnyside Ethanol, LLC, Curwensville Borough, Clearfield County, Pa. Application for consumptive water use of up to 1.980 mgd.

7. Project Sponsor and Facility: Walker Township Water Association, Walker Township, Centre County, Pa. Modification to increase the total groundwater system withdrawal limit (30-day average) from 0.523 mgd to 0.962 mgd (Docket No. 20070905).

Public Hearing—Rescission of Project Approval

1. Project Sponsor and Facility: Chesapeake Appalachia, LLC (Susquehanna River) (Docket No. 20080907), Oakland Township, Susquehanna County, Pa.

Authority: Pub. L. 91–575, 84 Stat. 1509 *et seq.,* 18 CFR parts 806, 807, and 808.

Dated: April 20, 2010.

Thomas W. Beauduy,

Deputy Director.

[FR Doc. 2010–10395 Filed 5–3–10; 8:45 am]

BILLING CODE 7040–01–P

SUSQUEHANNA RIVER BASIN COMMISSION

Notice of Projects Approved for Consumptive Uses of Water

AGENCY: Susquehanna River Basin Commission.

ACTION: Notice of approved projects.

SUMMARY: This notice lists the projects approved by rule by the Susquehanna River Basin Commission during the period set forth in **DATES.**

DATES: February 1, 2010, through March 31, 2010.

ADDRESSES: Susquehanna River Basin Commission, 1721 North Front Street, Harrisburg, PA 17102–2391.

FOR FURTHER INFORMATION CONTACT: Richard A. Cairo, General Counsel, telephone: (717) 238–0423, ext. 306; fax: (717) 238–2436; e-mail: *rcairo@srbc.net* or Stephanie L. Richardson, Secretary to the Commission, telephone: (717) 238–0423, ext. 304; fax: (717) 238–2436; e-mail: *srichardson@srbc.net.* Regular mail inquiries may be sent to the above address.

SUPPLEMENTARY INFORMATION: This notice lists the projects, described below, receiving approval for the consumptive use of water pursuant to the Commission's approval by rule process set forth in 18 CFR 806.22(e) and 18 CFR 806.22(f) for the time period specified above:

Approvals By Rule Issued Under 18 CFR § 806.22(e):

1. Allegheny Energy Supply Company, LLC, Hunlock Creek Unit 4, ABR–20100316, Hunlock Township, Luzerne County, Pa.; Approval Date: March 9, 2010.

Approvals By Rule Issued Under 18 CFR 806.22(f):

1. Southwestern Energy Company, Pad ID: Ferguson; ABR–20100201, Herrick Township, Bradford County, Pa.; Approval Date: February 1, 2010.

2. Chief Oil & Gas, LLC, Pad ID: Bacon Drilling Pad #1; ABR–20100202, Burlington Township, Bradford County, Pa.; Approval Date: February 2, 2010.

3. XTO Energy Incorporated, Pad ID: TLT, ABR–20100203, Jordan Township, Lycoming County, Pa.; Approval Date: February 2, 2010.

4. Alta Operating Company, LLC, Pad ID: Blye Pad Site, ABR–20100204, Middletown Township, Susquehanna County, Pa.; Approval Date: February 8, 2010.

5. Chief Oil & Gas, LLC, Pad ID: Kensinger 3H Drilling Pad #1, ABR–20100205, Penn Township, Lycoming County, Pa.; Approval Date: February 9, 2010.

6. Chesapeake Appalachia, LLC, Pad ID: Yengo, ABR–20100206, Cherry Township, Sullivan County, Pa.; Approval Date: February 9, 2010.

7. Anadarko E&P Company, LP, Pad ID: Texas Blockhouse F&G Pad B, ABR–20100207, Pine Township, Lycoming County, Pa.; Approval Date: February 9, 2010.

8. Seneca Resources Corporation; Pad ID: Wilcox Pad F, ABR–20090505.1, Covington Township, Tioga County, Pa.; Approval Date: February 9, 2010.

9. Seneca Resources Corporation, Pad ID: DCNR 595 Pad D, ABR–20090827.1, Bloss Township, Tioga County, Pa.; Approval Date: February 9, 2010, including a partial waiver of 18 CFR 806.15.

10. East Resources, Inc., Pad ID: Ackley 806, ABR–20100208, Clymer Township, Tioga County, Pa.; Approval Date: February 11, 2010.

11. XTO Energy, Incorporated, Pad ID: Kepner 8503H, ABR–20100209, Shrewsbury Township, Lycoming County, Pa.; Approval Date: February 11, 2010.

12. Chesapeake Appalachia, LLC, Pad ID: Dan Ellis, ABR–20100210, Monroe Township, Bradford Township, Pa.; Approval Date: February 11, 2010.

13. XTO Energy, Incorporated, Pad ID: Hazlak 8504, ABR–20100211, Shrewsbury Township, Lycoming County, Pa.; Approval Date: February 12, 2010.

14. Fortuna Energy, Inc., Pad ID: Putnam 01 077, ABR–20100212, Armenia Township, Bradford County, Pa.; Approval Date: February 12, 2010.

15. Fortuna Energy, Inc., Pad ID: Lutz 01 015, ABR–20100213, Troy Township, Bradford County, Pa.; Approval Date: February 12, 2010.

16. Chief Oil & Gas, LLC, Pad ID: Dale Bower Drilling Pad #1, ABR–20100214, Penn Township, Lycoming County, Pa.; Approval Date: February 15, 2010.

17. Cabot Oil & Gas Corporation, Pad ID: BerryD P1, ABR–20100215, Dimock Township, Susquehanna County, Pa.; Approval Date: February 17, 2010.

18. Chesapeake Appalachia, LLC, Pad ID: Masso, ABR–20100216, Auburn Township, Susquehanna Township, Pa.; Approval Date: February 18, 2010.

19. Chesapeake Appalachia, LLC, Pad ID: Welles 5, ABR–20100217, Terry Township, Bradford Township, Pa.; Approval Date: February 19, 2010.

20. WhitMar Exploration Company, Pad ID: Farrell 1H, ABR–20100218, Lake Township, Luzerne County, Pa.; Approval Date: February 19, 2010.

21. Fortuna Energy, Inc., Pad ID: DCNR 587 02 018, ABR–20100219, Ward Township, Tioga County, Pa.; Approval Date: February 19, 2010.

22. Seneca Resources Corporation, Pad ID: J. Pino Pad G, ABR–20090717.1, Covington Township, Tioga County, Pa.; Approval Date: February 19, 2010.

23. Seneca Resources Corporation, Pad ID: D. M. Pino Pad H, ABR–20090933.1, Covington Township, Tioga County, Pa.; Approval Date: February 19, 2010.

24. Fortuna Energy, Inc., Pad ID: DCNR 587 02 008, ABR–20100220, Ward Township, Tioga County, Pa.; Approval Date: February 22, 2010.

25. East Resources, Inc., Pad ID: Burt 518, ABR–20100221, Richmond Township, Tioga County, Pa.; Approval Date: February 22, 2010.

26. East Resources, Inc., Pad ID: Cascarino 443, ABR–20100222, Shippen Township, Tioga County, Pa.; Approval Date: February 22, 2010.

27. Fortuna Energy, Inc., Pad ID: Longenecker 03 008, ABR–20100223, Columbia Township, Bradford County, Pa.; Approval Date: February 22, 2010.

28. Chief Oil & Gas, LLC, Pad ID: Kupscznk Drilling Pad #1H, ABR–20100224, Springville Township, Susquehanna County, Pa.; Approval Date: February 22, 2010.

29. Fortuna Energy, Inc., Pad ID: Harvest Holdings 01 036, ABR–20100225, Canton Township, Bradford County, Pa.; Approval Date: February 22, 2010.

30. East Resources, Inc., Pad ID: Salese 802, ABR–20100226, Clymer Township, Tioga County, Pa.; Approval Date: February 23, 2010.

31. WhitMar Exploration Company, Pad ID: Lansberry Perry 1V, ABR–20100227, Lehman Township, Luzerne County, Pa.; Approval Date: February 23, 2010.

32. Chief Oil & Gas, LLC, Pad ID: Stone Drilling Pad #1, ABR–20100228, Springville Township, Susquehanna County, Pa.; Approval Date: February 25, 2010.

33. East Resources, Inc., Pad ID: Sharretts 805, ABR–20100229, Clymer Township, Tioga County, Pa.; Approval Date: February 25, 2010.

34. Fortuna Energy, Inc., Pad ID: Barrett 03 009, ABR–20100230, Columbia Township, Bradford County, Pa.; Approval Date: February 25, 2010.

35. Cabot Oil and Gas Corporation, Pad ID: RussoB P1, ABR–20100231, Springville Township, Susquehanna County, Pa.; Approval Date: February 26, 2010.

36. Fortuna Energy, Inc., Pad ID: Boor 03 015, ABR–20100232, Columbia Township, Bradford County, Pa.; Approval Date: February 26, 2010.

37. Fortuna Energy, Inc., Pad ID: Putnam 01 076, ABR–20100233, Armenia Township, Bradford County, Pa.; Approval Date: February 26, 2010.

38. WhitMar Exploration Company, Pad ID: Buda 1H, ABR–20100301, Fairmount Township, Luzerne County, Pa.; Approval Date: March 1, 2010.

39. Talisman Energy USA, Inc., Pad ID: Morgan 01 074, ABR–20100302, Armenia Township, Bradford County, Pa.; Approval Date: March 1, 2010.

40. Anadarko E&P Company, LP, Pad ID: COP Tract 255A, ABR–20100303, Snow Shoe Township, Centre County, Pa.; Approval Date: March 1, 2010, including a partial waiver of 18 CFR 806.15.

41. Anadarko E&P Company, LP, Pad ID: COP Tract 231C, ABR–20100304, Boggs Township, Centre County, Pa.; Approval Date: March 1, 2010, including a partial waiver of 18 CFR 806.15.

42. Chesapeake Appalachia, LLC, Pad ID: Updike, ABR–20100305, West Burlington Township, Bradford County, Pa.; Approval Date: March 1, 2010.

43. EXCO Resources (PA), Inc., Pad ID: Bogumil, ABR–20100306, North Abington Township, Lackawanna County, Pa.; Approval Date: March 1, 2010.

44. Seneca Resources Corporation, Pad ID: DCNR 595 Pad E, ABR–20100307, Blossburg Borough, Tioga County, Pa.; Approval Date: March 1, 2010, including a partial waiver of 18 CFR 806.15.

45. Talisman Energy USA, Inc., Pad ID: DCNR 587 02 013, ABR–20100308, Ward Township, Tioga County, Pa.; Approval Date: March 1, 2010.

46. Talisman Energy USA, Inc., Pad ID: DCNR 587 02 014, ABR–20100309, Ward Township, Tioga County, Pa.; Approval Date: March 1, 2010.

47. Cabot Oil and Gas Corporation, Pad ID: KellyP P1, ABR–20100310, Dimock Township, Susquehanna County, Pa.; Approval Date: March 3, 2010.

48. East Resources, Inc., Pad ID: Parthemer 284, ABR–20100311, Charleston Township, Tioga County, Pa.; Approval Date: March 3, 2010.

49. Chesapeake Appalachia, LLC, Pad ID: Cappucci, ABR–20100312, Mehoopany Township, Wyoming County, Pa.; Approval Date: March 5, 2010.

50. Novus Operating, LLC, Pad ID: Austinburg 1H, ABR–20100313, Brookfield Township, Tioga County, Pa.; Approval Date: March 8, 2010.

51. Ultra Resources, Inc., Pad ID: Paul 906, ABR–20100314, West Branch Township, Potter County, Pa.; Approval Date: March 8, 2010.

52. XTO Energy Incorporated, Pad ID: Dietterick, ABR–20100315, Jordan Township, Lycoming County, Pa.; Approval Date: March 9, 2010.

53. Seneca Resources Corporation, Pad ID: Murray Pad A, ABR–2010317, Richmond Township, Tioga County, Pa.; Approval Date: March 10, 2010.

54. Chesapeake Appalachia, LLC, Pad ID: Otis, ABR–20100318, Herrick Township, Bradford County, Pa.; Approval Date: March 10, 2010.

55. Chesapeake Appalachia, LLC, Pad ID: Claude, ABR–20100319, Auburn Township, Susquehanna County, Pa.; Approval Date: March 10, 2010.

56. Chesapeake Appalachia, LLC, Pad ID: Sivers, ABR–20100320, Tuscarora Township, Bradford County, Pa.; Approval Date: March 10, 2010.

57. Chesapeake Appalachia, LLC, Pad ID: Marbaker, ABR–20100321, Auburn Township, Susquehanna County, Pa.; Approval Date: March 11, 2010.

58. Cabot Oil and Gas Corporation, Pad ID: HinkleyR P1, ABR–20100322, Springville Township, Susquehanna County, Pa.; Approval Date: March 12, 2010.

59. Chesapeake Appalachia, LLC, Pad ID: Engelke, ABR–20100323, Troy Township, Bradford County, Pa.; Approval Date: March 12, 2010.

60. Chesapeake Appalachia, LLC, Pad ID: Acla, ABR–20100324, Terry Township, Bradford County, Pa.; Approval Date: March 15, 2010.

61. Cabot Oil and Gas Corporation, Pad ID: BlaisureJo P1, ABR–20100325, Jessup Township, Susquehanna County, Pa.; Approval Date: March 15, 2010.

62. Cabot Oil and Gas Corporation, Pad ID: RussoB P2, ABR–20100326, Springville Township, Susquehanna County, Pa.; Approval Date: March 15, 2010.

63. Chesapeake Appalachia, LLC, Pad ID: Rose, ABR–20100327, Towanda Township, Bradford County, Pa.; Approval Date: March 16, 2010.

64. Chesapeake Appalachia, LLC, Pad ID: Hoffman, ABR–20100328, Towanda Township, Bradford County, Pa.; Approval Date: March 17, 2010.

65. Chesapeake Appalachia, LLC, Pad ID: Walt, ABR–20100329, Albany Township, Bradford County, Pa.; Approval Date: March 17, 2010.

66. East Resources, Inc., Pad ID: Waskiewicz 445, ABR–20100330, Delmar Township, Tioga County, Pa.; Approval Date: March 17, 2010.

67. Cabot Oil and Gas Corporation, Pad ID: WarnerA P1, ABR–20100331, Dimock Township, Susquehanna County, Pa.; Approval Date: March 17, 2010.

68. Chesapeake Appalachia, LLC, Pad ID: Kalinowski, ABR–20100332, West Burlington Township, Bradford County, Pa.; Approval Date: March 18, 2010.

69. Cabot Oil and Gas Corporation, Pad ID: GrosvenorD P1, ABR–20100333, Dimock Township, Susquehanna County, Pa.; Approval Date: March 18, 2010.

70. Chief Oil & Gas, LLC, Pad ID: Duane Jennings Drilling Pad #1, ABR–20100334, Granville Township, Bradford County, Pa.; Approval Date: March 22, 2010.

71. East Resources, Inc., Pad ID: Webster 549, ABR–20100335, Delmar Township, Tioga County, Pa.; Approval Date: March 22, 2010.

72. Chief Oil & Gas, LLC, Pad ID: Kingsley Drilling Pad #1, ABR–20100336, Monroe Township, Bradford County, Pa.; Approval Date: March 23, 2010.

73. Chief Oil & Gas, LLC, Pad ID: Sechrist Drilling Pad #1, ABR–20100337, Canton Township, Bradford County, Pa.; Approval Date: March 23, 2010.

74. Chief Oil & Gas, LLC, Pad ID: Ransom Drilling Pad #1, ABR–20100338, Lenox Township, Susquehanna County, Pa.; Approval Date: March 23, 2010.

75. Chesapeake Appalachia, LLC, Pad ID: Elevation, ABR–20100339, North Towanda Township, Bradford County, Pa.; Approval Date: March 24, 2010.

76. Chesapeake Appalachia, LLC, Pad ID: Lundy, ABR–20100340, Standing Stone Township, Bradford County, Pa.; Approval Date: March 24, 2010.

77. Chesapeake Appalachia, LLC, Pad ID: Plymouth, ABR–20100341, Terry Township, Bradford County, Pa.; Approval Date: March 24, 2010.

78. Chesapeake Appalachia, LLC, Pad ID: Leaman, ABR–20100342, West Burlington Township, Bradford County, Pa.; Approval Date: March 24, 2010.

79. Cabot Oil & Gas Corporation, Pad ID: Depaola P1, ABR–20100343, Dimock Township, Susquehanna County, Pa.; Approval Date: March 25, 2010.

80. Ultra Resources, Inc., Pad ID: 808 Thomas, ABR–20100344, Elk Township, Tioga County, Pa.; Approval Date: March 26, 2010.

81. Chesapeake Appalachia, LLC, Pad ID: Schoonover, ABR–20100345, Wysox Township, Bradford County, Pa.; Approval Date: March 26, 2010.

82. Penn Virginia Oil & Gas Corporation, Pad ID: Kibbe #1, ABR–20100346, Harrison Township, Potter County, Pa.; Approval Date: March 27, 2010.

83. Talisman Energy USA, Inc., Pad ID: Moretz 03 036, ABR–20100347, Wells Township, Bradford County, Pa.; Approval Date: March 27, 2010.

84. Chesapeake Appalachia, LLC, Pad ID: Rosalie, ABR–20100348, Windham Township, Wyoming County, Pa.; Approval Date: March 29, 2010.

85. Anadarko E&P Company, LP, Pad ID: COP Tract 342 D, ABR–20100349, Beech Creek Township, Clinton Township, Pa.; Approval Date: March 29, 2010, including a partial waiver of 18 CFR 806.15.

86. East Resources, Inc., Pad ID: Cummings 823, ABR–20100350, Chatham Township, Tioga County, Pa.; Approval Date: March 29, 2010.

87. East Resources, Inc., Pad ID: Bartlett 531, ABR–20100351, Richmond Township, Tioga County, Pa.; Approval Date: March 29, 2010.

88. EOG Resources, Inc., Pad ID: PHC Pad B, ABR–20100352, Lawrence Township, Clearfield County, Pa.; Approval Date: March 29, 2010.

89. EOG Resources, Inc., Pad ID: PHC Pad A, ABR–20100353, Lawrence Township, Clearfield County, Pa.; Approval Date: March 29, 2010.

90. Talisman Energy USA, Inc., Pad ID: DCNR 587 02 005, ABR–20100354, Ward Township, Tioga County, Pa.; Approval Date: March 30, 2010.

91. Talisman Energy USA, Inc., Pad ID: DCNR 587 02 006, ABR–20100355, Ward Township, Tioga County, Pa.; Approval Date: March 30, 2010.

92. Turm Oil, Inc., Pad ID: J. Bowen, ABR–20100356, Rush Township, Susquehanna County, Pa.; Approval Date: March 30, 2010.

93. Turm Oil, Inc., Pad ID: L. Hardic, ABR–20100357, Rush Township, Susquehanna County, Pa.; Approval Date: March 30, 2010.

94. Turm Oil, Inc., Pad ID: B Poulsen, ABR–20100358, Auburn Township, Susquehanna County, Pa.; Approval Date: March 30, 2010.

95. Turm Oil, Inc., Pad ID: La Rue, ABR–20100359, Rush Township, Susquehanna County, Pa.; Approval Date: March 30, 2010.

96. Turm Oil, Inc., Pad ID: MJ Barlow, ABR–20100360, Auburn Township, Susquehanna County, Pa.; Approval Date: March 30, 2010.

Authority: Pub. L. 91–575, 84 Stat. 1509 *et seq.,* 18 CFR parts 806, 807, and 808.

Dated: April 26, 2010.

Stephanie L. Richardson,

Secretary to the Commission.

[FR Doc. 2010–10393 Filed 5–3–10; 8:45 am]

BILLING CODE 7040–01–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

[Docket No. FRA–2010–0005–N–10]

Proposed Agency Information Collection Activities; Comment Request

AGENCY: Federal Railroad Administration, DOT.

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 and its implementing regulations, the Federal Railroad Administration (FRA) hereby announces that it is seeking renewal of the following currently approved information collection activities. Before submitting these information collection requirements for clearance by the Office of Management and Budget (OMB), FRA is soliciting public comment on specific aspects of the activities identified below.

DATES: Comments must be received no later than July 6, 2010.

ADDRESSES: Submit written comments on any or all of the following proposed activities by mail to either: Mr. Robert Brogan, Office of Safety, Planning and Evaluation Division, RRS–21, Federal Railroad Administration, 1200 New Jersey Ave., SE., Mail Stop 17, Washington, DC 20590, or Ms. Kimberly Toone, Office of Information Technology, RAD–20, Federal Railroad Administration, 1200 New Jersey Ave., SE., Mail Stop 35, Washington, DC 20590. Commenters requesting FRA to acknowledge receipt of their respective comments must include a self-addressed stamped postcard stating, "Comments on OMB control number ___." Alternatively, comments may be transmitted via facsimile to (202) 493–6216 or (202) 493–6497, or via e-mail to Mr. Brogan at *Robert.Brogan@dot.gov*, or to Ms. Toone at *Kimberly.Toone@dot.gov*. Please refer to the assigned OMB control number in any correspondence submitted. FRA will summarize comments received in

response to this notice in a subsequent notice and include them in its information collection submission to OMB for approval.

FOR FURTHER INFORMATION CONTACT: Mr. Robert Brogan, Office of Planning and Evaluation Division, RRS–21, Federal Railroad Administration, 1200 New Jersey Ave., SE., Mail Stop 25, Washington, DC 20590 (telephone: (202) 493–6292) or Ms. Kimberly Toone, Office of Information Technology, RAD–20, Federal Railroad Administration, 1200 New Jersey Ave., SE., Mail Stop 35, Washington, DC 20590 (telephone: (202) 493–6132). (These telephone numbers are not toll-free.)

SUPPLEMENTARY INFORMATION:

The Paperwork Reduction Act of 1995 (PRA), Public Law 104–13, section 2, 109 Stat. 163 (1995) (codified as revised at 44 U.S.C. 3501–3520), and its implementing regulations, 5 CFR part 1320, require Federal agencies to provide 60-days notice to the public for comment on information collection activities before seeking approval for reinstatement or renewal by OMB. 44 U.S.C. 3506(c)(2)(A); 5 CFR 1320.8(d)(1), 1320.10(e)(1), 1320.12(a). Specifically, FRA invites interested respondents to comment on the following summary of proposed information collection activities regarding (i) whether the information collection activities are necessary for FRA to properly execute its functions, including whether the activities will have practical utility; (ii) the accuracy of FRA's estimates of the burden of the information collection activities, including the validity of the methodology and assumptions used to determine the estimates; (iii) ways for FRA to enhance the quality, utility, and clarity of the information being collected; and (iv) ways for FRA to minimize the burden of information collection activities on the public by automated, electronic, mechanical, or other technological collection techniques or other forms of information technology (*e.g.*, permitting electronic submission of responses). *See* 44 U.S.C. 3506(c)(2)(A)(i)–(iv); 5 CFR 1320.8(d)(1)(i)–(iv). FRA believes that soliciting public comment will promote its efforts to reduce the administrative and paperwork burdens associated with the collection of information mandated by Federal regulations. In summary, FRA reasons that comments received will advance three objectives: (i) Reduce reporting burdens; (ii) ensure that it organizes information collection requirements in a "user friendly" format to improve the use of such information; and (iii) accurately assess the resources expended to retrieve and produce information requested. *See* 44 U.S.C. 3501.

Below are brief summaries of the two currently approved information collection activities that FRA will submit for clearance by OMB as required under the PRA:

Title: Foreign Railroads' Foreign-Based (FRFB) Employees Who Perform Train or Dispatching Service in the United States.

OMB Control Number: 2130–0555.

Abstract: The collection of information is used by FRA to determine compliance of FRFB train and dispatching service employees and their employers with the prohibition against the abuse of alcohol and controlled substances. Because of the increase in cross-border train operations and the increased risk posed to the safety of train operations in the United States, FRA seeks to apply all of the requirements of 49 CFR part 219 to FRFB train and dispatching service employees. The basic information—evidence of unauthorized use of drugs and alcohol—is used by FRA to help prevent accidents/incidents by screening FRFB who perform safety-sensitive functions for unauthorized drug or alcohol use. FRFB train and dispatching service employees testing positive for unauthorized use of alcohol and drugs are removed from service, thereby enhancing safety and serving as a deterrent to other FRFB train and dispatching service employees who might be tempted to engage in the unauthorized use of drugs or alcohol.

Form Number(s): None.

Respondent Universe: 2 Railroads.

Frequency of Submission: On occasion.

Affected Public: Foreign-Based Railroads and Their Employees.

Reporting Burden:

CFR section	Respondent universe	Total annual responses	Average time per response	Total annual burden hours
219.4—Recognition of Foreign Railroads' Workplace Testing Programs: Petitions to Agency.	2 railroads	1 petition	10 hours	10
Comments on Petition	2 railroads/public	2 comments + 2 comment copies	2 hours	4
219.403/405—Evaluation by Substance Abuse Professional.	2 railroads	3 reports/referrals	2 hours	6
219.405(c)(1)—Report by a Co-worker.	2 railroads	1 report	5 minutes	.08
219.609—Notice by Employee Asking to be Excused from Random Alcohol Testing.	200 employees	2 excuses	15 minutes	.5
219.903—Retention of Urine Drug Testing Records.	2 railroads	80 records	5 minutes	7

Total Responses: 91.

Total Estimated Total Annual Burden: 28 hours.

Type of Request: Extension of a Currently Approved Collection.

Title: Special Notice For Repairs.

OMB Control Number: 2130–0504.

Abstract: The Special Notice For Repairs is issued to notify the carrier in writing of an unsafe condition involving a locomotive, car, or track. The carrier must return the form after repairs have been made. The collection of information is used by State and Federal inspectors to remove freight cars or locomotives until they can be restored to a serviceable condition. It is also used by State and Federal inspectors to reduce the maximum authorized speed on a section of track until repairs can be made.

Form Number(s): FRA F 6180.8; FRA F 6180.8a.

Affected Public: Businesses.

Respondent Universe: 728 railroads.

Frequency of Submission: On occasion.

Total Responses: 41.

Total Estimated Annual Burden: 11 hours.

Type of Request: Extension of a Currently Approved Collection.

Pursuant to 44 U.S.C. 3507(a) and 5 CFR 1320.5(b), 1320.8(b)(3)(vi), FRA informs all interested parties that it may not conduct or sponsor, and a

respondent is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Authority: 44 U.S.C. 3501–3520.

Issued in Washington, DC on April 28, 2010.

Kimberly Coronel,

Director, Office of Financial Management, Federal Railroad Administration.

[FR Doc. 2010–10446 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–06–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Intent To Rule on Request To Release Airport Property at the Reading Regional Airport, Reading, PA

AGENCY: Federal Aviation Administration (FAA) DOT.

ACTION: Notice of request to release airport property.

SUMMARY: The FAA proposes to rule and invite public comment on the release of land at the Reading Regional Airport, Reading, Pennsylvania under the provisions of Section 47125(a) of Title 49 United States Code (U.S.C.).

DATES: Comments must be received on or before June 3, 2010.

ADDRESSES: Comments on this application may be mailed or delivered to the following address:

Terry P. Sroka, Manager, Reading Regional Airport Authority, 2501 Bernville Road, Reading, PA 19605,

and at the FAA Harrisburg Airports District Office:

Lori K. Pagnanelli, Manager, Harrisburg Airports District Office, 3905 Hartzdale Dr., Suite 508, Camp Hill, PA 17011.

FOR FURTHER INFORMATION CONTACT: Rick Harner, Program Manager Harrisburg Airports District Office location listed above. The request to release property may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA invites public comment on the request to release property at the Reading Regional Airport under the provisions of Section 47125(a) of Title 49 U.S.C. On March 30, 2010, the FAA determined that the request to release property at the Reading Regional Airport submitted by the Reading Regional Airport Authority (Authority) met the procedural requirements.

The following is a brief overview of the request:

The Reading Regional Airport Authority requests the release of real property totaling 154.93 acres (Lot #1), excluding 2.54 acres (Lot #5 Reading Regional Airport Waste Water Treatment Plant), of non-aeronautical airport property to Berks County Industrial Development Authority. The property was transferred to the City of Reading through the Surplus Property Act of 1944 via the Quit Claim Deed. A portion of the property is currently leased to a private company, which will be transferred to the buyer. The property is located on the east side of the airport and is bordered by Aviation Road running east and turning north. The purpose of this release is to allow the Reading Regional Airport Authority to sell the subject land that does not serve any aeronautical purpose at the airport. There are no impacts to the Airport and the land is not needed for airport development as shown on the Airport Layout Plan. Any proceeds from the sale of property are to be used for the capital and operating costs of the airport.

Any person may inspect the request by appointment at the FAA office address listed above. Interested persons are invited to comment on the proposed release from obligations. All comments will be considered by the FAA to the extent practicable.

Issued in Camp Hill, Pennsylvania, April 26, 2010.

Lori K. Pagnanelli,

Manager, Harrisburg Airports District Office.

[FR Doc. 2010–10319 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Commercial Space Transportation Grant Program

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of request for grant proposals for the Commercial Space Transportation Grant Program.

SUMMARY: The FAA's Office of Commercial Space Transportation (AST) requests grant proposals pursuant to its newly funded Commercial Space Transportation Grant Program. This program has an initial appropriation of $500,000 to be used for space transportation infrastructure projects. The FAA desires to award the appropriated funds before the end of fiscal year 2010. The FAA will review and evaluate all applications for a grant under 49 U.S.C. chapter 703 (Chapter 703). The FAA may make one or more grant awards based upon its evaluations of the grant proposals. All grants awarded under this program are discretionary awards.

DATES: Commercial Space Transportation Grant applications are due on or before July 6, 2010.

ADDRESSES: You can get more information about the Commercial Space Transportation Grant Program by:

1. Accessing the Office of Commercial Space Transportation Web site at *http://www.faa.gov/go/ast;* and

2. Contacting Glenn Rizner or Michael McElligott, AST–100, or, for legal questions, Laura Montgomery, AGC–200, 800 Independence Avenue, SW., Washington, DC 20591;

	Phone	Email	FAX
Glenn Rizner	202–267–3194	*Glenn.H.Rizner@faa.gov*	202–267–5463
Michael McElligott	202–267–7859	*Michael.McElligott@faa.gov*	202–267–5463
Laura Montgomery	202–267–3150	*Laura.Montgomery@faa.gov*	202–267–7971

SUPPLEMENTARY INFORMATION:

Background

One of the main purposes of the Commercial Space Transportation Grant Program is to ensure the resiliency of the space transportation infrastructure in the United States. To help further the United States' goals, Congress established a Space Transportation Infrastructure Grant program under 49 U.S.C. Subtitle IX—Commercial Space Transportation—Chapter 703—Space Transportation Infrastructure Matching Grants, Section 70305, Authorization of appropriations. Public Law (Pub. L.) 103–272, Sec. 1(e), 108 Stat. 1345 (July 5, 1994). This legislation authorizes the use of Federal monies in conjunction with matching state, local government, and private funds.

Although the Congressional authorization has been in effect for some

time, FY 2010 is the first year Federal funds have been appropriated. The Consolidated Appropriations Act for 2010 (Pub. L. 111–117) appropriated $500,000.00 for the FAA's Commercial Space Transportation Grant program. The FAA's Office of Commercial Space Transportation is responsible for overseeing the program. Although the FAA will be developing more detailed guidance to administer this program, the FAA intends to disburse these funds on or before August 31, 2010. Accordingly, applicants must submit their grant proposals by July 6, 2010, which will fall before more detailed guidance becomes available.

The Commercial Space Transportation Grant Program

The Commercial Space Transportation Grant Program is intended to "ensure the resiliency of the space transportation infrastructure of the United States * * *" 49 U.S.C. 70302. Development projects eligible for funding include technical and environmental studies; construction, improvement, and design and engineering of space transportation infrastructure, including facilities and associated equipment; and real property to meet the needs of the United States commercial space transportation industry.

Who May Apply for a Commercial Space Transportation Grant

The FAA may make project grants to sponsors. 49 U.S.C. 70303(a). Chapter 703 defines a sponsor as a public agency that submits an application for a project grant. 49 U.S.C. 70301(6). A public agency is a State or an agency of a State, a political subdivision of a State, or a tax-supported organization. 49 U.S.C. 70301(5).

How To Apply for a Commercial Space Transportation Grant

Applicants for grants under the Commercial Space Transportation Grant Program must submit grant proposals to the FAA AST. A complete SF–424, Application for Federal Assistance (OMB Number 4040–0004) is a component of all grant proposals. SF–424 forms are available on the Grants.gov Web site: *http://www.grants.gov/agencies/aforms_repository_ information.jsp.* In addition, a grant applicant should use SF–424A for non-construction proposals or SF–424C for construction proposals. These forms request specific applicant information, proposed project information, and an estimate of project funding and duration. The grant proposal should detail how the proposed project meets the requirements of Chapter 703. In addition, the forms request detailed and thorough project budget information. The Commercial Space Transportation Grant Program will not fund more than 50% of the total project cost, and project financing must include a private component of at least 10% of the total project cost. 49 U.S.C. 70302.

Given that the FAA may award multiple grants, the grant proposals may include multiple or alternative funding proposals for financing the proposed project. Applicants may submit multiple grant proposals.

The grant proposal should also indicate how applicable environmental requirements were or will be satisfied. *See Guidelines for Compliance with the National Environmental Policy Act and Related Environmental Review Statutes for the Licensing of Commercial Launches and Launch Sites; http://www.faa.gov/about/office_org/headquarters_offices/ast/environmental/review.*

Applicants must submit an original plus three copies of the completed grant proposal to: Federal Aviation Administration, Office of Commercial Space Transportation, Space Systems Development Division (AST–100), 800 Independence Avenue, SW., Suite 331, Washington, DC 20591.

Grant proposals are due on or before July 6, 2010. Given the time constraints on the FAA to award its grants, there will be no allowance for extensions of time.

Grant Application Review

The FAA will review grant proposals using the criteria of Chapter 703 and will consider the following factors in its evaluation:

1. The contribution of the project to industry capabilities that serve the United States Government's space transportation needs;
2. The extent of industry's financial contribution to the project;
3. The extent of industry's participation in the project;
4. The positive impact of the project on the international competitiveness of the United States space transportation industry;
5. The extent of State contributions to the project; and
6. The impact of the project on launch operations and other activities at Government launch ranges.

49 U.S.C. 70303(b). All grant awards made under this program are discretionary. The FAA may approve an application only if satisfied that—

1. The project will contribute to ensuring the resiliency of the space transportation infrastructure of the United States;
2. The project is reasonably consistent with plans of public agencies that are authorized by the State in which the project is located and responsible for development of the surrounding area;
3. The consent of the head of the appropriate agency for the use of any government property has been obtained;
4. The project will be completed without unreasonable delay;
5. The sponsor has the legal authority to engage in the project.

49 U.S.C. 70303(c). Additionally, the FAA may make a project grant only if at least 10 percent of the total cost of the project will be paid by the private sector and the grant will not be for more than 50 percent of the total cost of the project. 49 U.S.C. 70302(b). Applicants should submit the information necessary for the FAA to make these determinations as part of their applications.

Environmental Requirements

Approval of grant funding is a federal action subject to review under the National Environmental Policy Act of 1969, 42 U.S.C. 4321 *et seq.,* as implemented by the regulations of the Council on Environmental Quality at 40 CFR part 1500 and FAA Order 1050.1E, and other Federal environmental laws. Because of this, the FAA anticipates that it may be most cost-effective for applicants who have already undergone a NEPA review to apply for a grant this fiscal year. For example, a launch site that has already received a license to operate will have conducted a NEPA review. The launch site operator could seek a grant for projects that the FAA approved as part of that license.

Under 49 U.S.C. 70304, infrastructure development projects selected for a Commercial Space Transportation Grant must meet three additional environmental requirements. First, such projects must provide for the protection and enhancement of the natural resources and the quality of the environment of the United States. Specifically, if a project will have a significant adverse environmental impact, the FAA shall approve the grant application only after finding that no feasible and prudent alternative to the project exists and that all reasonable steps have been taken to minimize the adverse effect. Second, the project sponsor must certify that an opportunity for a public hearing has been provided to consider potential environmental impacts of the project and its consistency with the goals of any planning carried out by the community. Third, the Governor of the State in

which the project is located, or his or her designee, must certify that there is reasonable assurance the project will be located, designed, constructed, and operated to comply with applicable air and water quality standards.

Planning projects such as technical and environmental studies normally qualify for categorical exclusion under NEPA and would not trigger the requirements under 49 U.S.C. 70304 and as set forth above. If, absent consideration of section 70304, the project normally qualifies for a categorical exclusion from environmental review, the grant proposal should reference the relevant paragraph in FAA Order 1050.1E, *Policies and Procedures for Considering Environmental Impacts,* and address whether extraordinary circumstances exist that warrant preparation of an environmental assessment.

For more details about the environmental review for commercial space transportation activities see *Guidelines for Compliance with the National Environmental Policy Act and Related Environmental Review Statutes for the Licensing of Commercial Launches and Launch Sites. http://www.faa.gov/about/office_org/headquarters_offices/ast/environmental/review.*

Grant Award

The FAA Office of Commercial Space Transportation intends to award Commercial Space Transportation Grants on or before August 31, 2010. An FAA grant offer letter may contain requirements for assurances to ensure the grants are consistent with Chapter 703. These grant assurances are currently in development and not finalized at the date of this publication. The FAA anticipates that the Commercial Space Transportation Grant Assurances will be similar in nature and purpose to those required under the Airport Improvement Program.

Issued in Washington, DC, on April 28, 2010.

George C. Nield,

Associate Administrator for Commercial Space Transportation.

[FR Doc. 2010–10320 Filed 5–3–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Transit Administration

Discretionary Bus and Bus Facilities Program

AGENCY: Federal Transit Administration (FTA), DOT.

ACTION: Notice of Availability of FTA State of Good Repair Bus and Bus Facilities Initiative Funds: Solicitation of Project Proposals.

SUMMARY: The Federal Transit Administration (FTA) announces the availability of discretionary Section 5309 Bus and Bus Facilities grant funds in support of its "State of Good Repair" initiative. The State of Good Repair (SGR) Bus initiative will be funded with up to $775 million in unallocated Fiscal Year (FY) 2010 discretionary Bus and Bus Facilities Program funds, authorized by 49 USC 5309(b) of the Safe, Accountable, Flexible, Efficient, Transportation Equity Act: A Legacy For Users (SAFETEA–LU), Public Law 109–59, August 10, 2005. FTA may use additional Bus and Bus Facilities program funding that becomes available in the future to further support this initiative.

The SGR Bus initiative will make funds available to public transit providers to finance capital projects to replace, rehabilitate, and purchase buses and related equipment and to construct/rehabilitate bus-related facilities, including programs of bus and bus-related projects which may include assistance to subrecipients that are public agencies, private companies engaged in public transportation, or private non-profit organizations. This Notice includes priorities established by FTA for these discretionary funds, the criteria FTA will use to identify meritorious projects for funding, and describes how to apply.

This announcement is available on the FTA Web site at: *http://www.fta.dot.gov*. FTA will announce final selections on the Web site and in the **Federal Register**. A synopsis of this announcement will be posted in the FIND module of the government-wide electronic grants Web site at *http://www.grants.gov*.

DATES: Complete proposals for the SGR Bus initiative must be submitted by June 18, 2010. All proposals must be submitted electronically through the GRANTS.GOV APPLY function. In order to apply through GRANTS.GOV, proposers should initiate the process of registering on the GRANTS.GOV site immediately to ensure completion of registration before the deadline for submission. Proposers will receive two confirmation e-mails. The first email will confirm that the application was received and a subsequent e-mail will be sent indicating whether the application was validated or rejected by the system.

FOR FURTHER INFORMATION CONTACT: Contact the appropriate FTA Regional Administrator (see Appendix) for proposal-specific information and issues. For information on the SGR Bus initiative, contact Darren Jaffe, Office of Program Management, (202) 366–4008, e-mail: *darren.jaffe@dot.gov*. A TDD is available at 1–800–877–8339 (TDD/FIRS).

SUPPLEMENTARY INFORMATION:

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I. Funding Opportunity Description

A. Authority

The bus and bus facilities program is authorized under 49 U.S.C. 5309(b), as amended by section 3011 of SAFETEA–LU:

> "The Secretary may make grants under this section to assist State and local governmental authorities in financing capital projects * * * to replace, rehabilitate, and purchase buses and related equipment and to construct bus-related facilities, including programs of bus and bus-related projects for assistance to subrecipients that are public agencies, private companies engaged in public transportation, or private non-profit organizations."

B. Background

Maintaining the nation's public transportation fleet, infrastructure, and equipment in a state of good repair is essential to providing reliable, high-quality, and safe transit services to the tens of millions of Americans who depend on it daily. Transit not only provides mobility options for the American public, but contributes to the livability of our nation's communities and to environmental and energy sustainability. However, given recent limitations in State and local resources and the need to meet projected growth in demand for transit service, many local transit agencies are finding it difficult to meet their basic re-investment needs. FTA's April 2009 *Rail Modernization Study* estimated a combined $50 billion repair and replacement backlog in the bus and rail systems of the seven oldest and largest U.S. transit agencies.

The state of repair of transit infrastructure is an important issue for both large and small systems across the country. According to the U.S. Department of Transportation's *2008*

Status of the Nation's Highways, Bridges, and Transit Conditions and Performance Report to Congress, over 36 percent of urban bus maintenance facilities were estimated to be in marginal or poor condition in 2006, five percent higher than in 2004. This report also found that nearly 50 percent of the nation's bus facilities were over 20 years old and that 18 percent of the nation's bus fleet was in need of replacement. The average bus age and condition have stabilized recently and are even expected to improve due to the number of vehicles purchased recently with American Recovery and Reinvestment Act funds. Buses are relatively short-lived assets, however, and some 8,000 must be replaced each year.

Preliminary FTA research indicates that while most transit agencies employ maintenance management systems and have capital improvement plans, few possess asset management plans and systems that support prioritization of asset replacement, as practiced by most state highway agencies and other major public infrastructure managers. Indications are that potential improvements in investment efficiency from better asset management can considerably outweigh the cost of implementation.

Recognizing growing investment needs and the large backlog of transit assets needing repair or replacement, the FTA proposed a $2.9 billion Bus and Rail State of Good Repair formula program in the President's FY 2011 budget. In advance of the implementation of this program, this notice makes available up to $775 million in FY 2010 Section 5309 bus and bus discretionary program resources for a "State of Good Repair Bus" (SGR Bus) grant initiative.

C. Program Purpose

Improving and maintaining America's buses and bus facilities so that the nation's public transportation systems are in good physical condition and successfully accomplish their performance objectives is a key strategic goal of the DOT and FTA. The SGR Bus initiative is intended to contribute to the improvement of the condition of transit capital assets by providing financial assistance for recapitalization of buses and bus facilities. In addition, funding under this SGR Bus initiative may be used for the development and implementation of new, or improvement of existing, transit asset management systems. Transportation asset management is a strategic and systematic process of operating, maintaining, improving, and expanding physical assets effectively throughout their life cycle. Successful systems focus on good business and engineering policy, practices and procedures for resource allocation and utilization with the objective of better decision-making based upon quality information and well defined objectives.

II. Award Information

Federal transit funds are available to State or local governmental authorities as recipients and other public transportation providers as subrecipients. There is no floor or upper limit for any single grant under this program; however, FTA intends to fund as many meritorious projects as possible. In addition, FTA will take into consideration the geographic diversity of its award decisions.

Consistent with 49 U.S.C. 5309(m)(8), the Secretary shall consider the age and condition of buses, bus fleets, bus-related facilities and equipment of applicants in its award of State of Good Repair Bus grants.

III. Eligibility Information

A. Eligible Proposers

Eligible proposers and eventual grant applicants under this initiative are Direct Recipients under the Section 5307 Urbanized Area Formula program, States, and Indian Tribes. Proposals for funding eligible projects in rural (nonurbanized) areas must be submitted as part of a consolidated State proposal with the exception of nonurbanized projects to Indian Tribes. Tribes, States, and Direct Recipients may also submit consolidated proposals for projects in urbanized areas.

Proposals shall contain projects to be implemented by the Recipient or its subrecipients. Eligible subrecipients include public agencies, private non-profit organizations, and private providers engaged in public transportation.

B. Eligible Expenses

SAFETEA–LU grants authority to the Secretary to make grants to assist State and local governmental authorities in financing capital projects to replace, rehabilitate, and purchase buses and related equipment and to construct or rehabilitate bus-related facilities, including programs of bus and bus-related projects for assistance to subrecipients that are public agencies, private companies engaged in public transportation, or private non-profit organizations.

Projects eligible for funding under the SGR Bus initiative are capital projects such as: purchase, replacement, or rehabilitation of, buses and vans and related equipment (including Intelligent Transportation Systems (ITS), fare equipment, communication devices that are FCC mandatory narrow-banding compliant); replacement or the modernization of bus maintenance and revenue service (passenger) facilities; and the development and implementation of transit asset management systems, that address the objectives identified in the Program Purpose subsection above.

C. Cost Sharing

Costs will be shared at the following ratio: 80 percent FTA/20 percent local contribution, unless the grantee requests a lower Federal share. FTA will not approve deferred local share requests under this program.

The Federal share may exceed 80 percent for certain projects related to the Americans with Disabilities Act (ADA) and the Clean Air Act (CAA) as follows: ADA—The Federal share is 90 percent for the cost of vehicle-related equipment or facilities attributable to compliance with the ADA of 1990 (42 U.S.C. 12101 *et seq*); CAA—The Federal share is 90 percent for the cost of vehicle related equipment or facilities (including clean-fuel or alternative-fuel vehicle related equipment or facilities) attributable to compliance with the CAA (42 U.S.C. 7401 *et seq*). For administrative simplicity, FTA allows recipients to compute the Federal share at 83 percent for eligible ADA and CAA vehicle purchases.

The FY 2010 Appropriations Act allows a 90 percent Federal share for the total cost of a biodiesel bus. The Act also allows a 90 percent Federal share for the net capital cost of factory installed or retrofitted hybrid electric propulsion systems and any equipment related to such a system. For administrative simplicity, FTA allows recipients to compute the Federal share at 83 percent for eligible vehicle purchases.

IV. Proposal Submission Information

A. Proposal Submission Process

Project proposals must be submitted electronically through *http://www.grants.gov*. Mail and fax submissions will not be accepted except for supplemental information that cannot be sent electronically.

B. Proposal Content

1. Proposal Information

Proposals should provide basic sponsor identifying information, including:

a. Proposer's name and FTA recipient ID number.

b. Contact information for notification of project selection (including contact name, title, address, congressional district, email, fax and phone number).

c. A general description of services provided by the agency including ridership, fleet size, areas served, etc.

d. A description of the agency's technical, legal, and financial capacity to implement the proposed project. Some of this information is included in Standard Form 424 when applying through GRANTS.GOV.

2. Project Information

Every proposal must:

a. Describe concisely, but completely, the project scope to be funded. As FTA may elect to only partially fund some project proposals (see below), the scope should be "scalable" with specific components of independent utility clearly identified.

b. Address each of the evaluation criteria separately, demonstrating how the project responds to each criterion.

c. Provide a line-item budget for the total project, with enough detail to describe the various key components of the project. As FTA may elect to only partially fund some project proposals, the budget should provide for the minimum amount necessary to fund specific project components of independent utility.

d. Provide the Federal amount requested.

e. Document the matching funds, including amount and source of the match, demonstrating strong local or private sector financial participation in the project.

f. Provide support documentation, including audited financial statements, bond-ratings, and documents supporting the commitment of non-federal funding to the project, or a timeframe upon which those commitments would be made.

g. Provide a project time-line, including significant milestones such as the date anticipated to issue a request for proposals for vehicles, or contract for purchase of vehicle(s), and actual or expected delivery date of vehicles, or notice of request for proposal and notice to proceed for capital construction/rehabilitation projects.

C. Submission Dates and Times

Complete proposals for the State of Good Repair Bus initiative must be submitted June 18, 2010 electronically through the GRANTS.GOV Web site by the same date. Proposers are encouraged to begin the process of registration on the GRANTS.GOV site well in advance of the submission deadline. Registration is a multi-step process, which may take several weeks to complete before a proposal application can be submitted. FTA will announce project selections when the competitive selection process is complete. Successful proposers must then apply for a grant in FTA's Web-based grant system, TEAM, for the scope and amount approved.

D. Funding Restrictions

Only proposals from eligible recipients for eligible activities will be considered for funding (see Section III). Due to funding limitations, proposers that are selected for funding may receive less than the amount originally requested.

E. Other Submission Requirements

Proposers should submit three (3) copies of any supplemental information that cannot be submitted electronically to the appropriate regional office. Supplemental information submitted in hardcopy must be postmarked by June 18, 2010.

V. Proposal Review, Selection, and Notification

A. Project Evaluation Criteria

Projects will be evaluated by FTA based on the proposals submitted according to the following criteria. Each proposer is encouraged to demonstrate the responsiveness of a project to any and all of the selection criteria with the most relevant information that the proposer can provide, regardless of whether such information has been specifically requested, or identified, in this notice. FTA will assess the extent to which a project addresses the following criteria.

1. Planning and prioritization at the local/regional level:

a. Project is consistent with the transit priorities identified in the long range plan and/or contingency/illustrative projects. Proposer should note if project could not be included in the financially constrained Transportation Improvement Program (TIP)/Statewide Transportation Improvement Program (STIP) due to lack of funding (if selected, project must be in TIP before grant award).

b. Local support is demonstrated by availability of local match and letters of support for project.

c. In an area with more than one transit operator, the proposal demonstrates coordination with, and support of, other transit operators, or other related projects within the proposer's MPO or the geographic region within which the proposed project will operate.

2. The project is ready to implement:

a. Any required environmental work has been initiated for construction projects requiring an Environmental Assessment (EA) or Environmental Impact Statement (EIS).

b. Project implementation plans are complete, including initial design of facilities projects.

c. TIP/STIP can be amended (evidenced by MPO/State endorsement).

d. Project funds can be obligated and the project implemented quickly, if selected.

3. Technical, legal, and financial capacity to implement the particular project proposed:

a. The proposer has the technical capacity to administer the project.

b. There are no outstanding legal, technical, or financial issues with the grantee that would make this a high-risk project to implement quickly.

c. Source of local match is identified and is available for prompt project implementation if selected (no deferred local share will be allowed).

In addition, for each of the project types below, the following criteria will apply:

1. For bus projects:

a. The age of the asset to be replaced or rehabilitated by the proposed project, relative to its useful life.

b. The degree to which the proposed project addresses a demonstrated and verifiable backlog of deferred maintenance.

c. Consistency with the proposer's bus fleet management plan.

d. Condition and performance of the asset to be replaced by the proposed project, as ascertained through field inspections or otherwise, if available.

e. Demonstrated positive impact on air quality.

f. The degree to which the proposed project supports emerging or advanced technologies for transit buses.

g. The project conforms to FTA's spare ratio guidelines.

2. For bus facility and equipment projects:

a. The age of the asset to be rehabilitated or replaced relative to its useful life.

b. The degree to which proposed project addresses a demonstrated and verifiable backlog of deferred maintenance.

c. Supports emerging or advanced technologies for transit facilities and equipment.

d. For facilities, evidence of proposed project compliance with "Green Building" certification.

3. For transit asset management system projects:

If asset management system development or upgrades are proposed,

the proposal shall describe, as applicable, the system element(s) the proposer is seeking to improve; including:

a. How asset management plans/systems will be developed or upgraded.

b. How asset inventories will be maintained physically and fiscally.

c. How assets initial condition will be assessed.

d. How assets will be inspected and monitored, and at what frequency.

e. How logistical decision support tools (including options and tradeoff analysis) will be used in the proposer's day-to-day operations.

f. Demonstrated long-term financial and management commitment of the proposer to using the asset management system.

B. Review and Selection Process

Proposals will be evaluated by the appropriate FTA regional office using the criteria above. The FTA Administrator will determine the final selection and amount of funding for each project. Selected projects will be announced in September 2010. FTA will publish the list of all selected projects and funding levels in the Federal Register. Regional offices will also notify successful proposers and the amount of funding to be awarded to the project.

VI. Award Administration

A. Award Notices

FTA will award grants for the selected projects to the proposer through the FTA electronic grants management and award system, TEAM, after receipt of a complete application in TEAM. These grants will be administered and managed by the FTA regional offices in accordance with the Federal requirements of the Section 5309 Bus program. At the time the project selections are announced, FTA will extend pre-award authority for the selected projects. There is no blanket pre-award authority for these projects before announcement.

B. Administrative and National Policy Requirements

1. Grant Requirements

If selected, applicants will apply for a grant through TEAM and adhere to the customary FTA grant requirements of the Section 5309 Bus and Bus Facilities program, including those of FTA C 9300.1B Circular and C 5010.1D and S. 5333(b) labor protections. Discretionary grants greater than $500,000 will be subject to the Congressional Notification and release process. Technical assistance regarding these requirements is available from each FTA regional office.

2. Planning

Applicants are encouraged to notify the appropriate State Departments of Transportation and MPO in areas likely to be served by the project funds made available under this program. Incorporation of funded projects in the long-range plans and transportation improvement programs of States and metropolitan areas is required of all funded projects.

3. Standard Assurances

The applicant assures that it will comply with all applicable Federal statutes, regulations, executive orders, FTA circulars, and other Federal administrative requirements in carrying out any project supported by the FTA grant. The applicant acknowledges that it is under a continuing obligation to comply with the terms and conditions of the grant agreement issued for its project with FTA. The applicant understands that Federal laws, regulations, policies, and administrative practices might be modified from time to time and affect the implementation of the project. The applicant agrees that the most recent Federal requirements will apply to the project, unless FTA issues a written determination otherwise. The applicant must submit the Certifications and Assurances before receiving a grant if it does not have current certifications on file.

C. Reporting

Post-award reporting requirements include submission of Financial Status Reports and Milestone Reports in TEAM on a quarterly basis for all projects. Documentation is required for payment. In addition, project sponsors receiving grants for asset management systems and innovative technologies may be required to report on the performance of these systems and technologies.

VII. Agency Contacts

Contact the appropriate FTA Regional Administrator (Appendix A) for proposal specific information and issues. For information on the SGR Bus and Bus Facilities Initiative, contact Darren Jaffe, Office of Program Management, (202) 366–4008, e-mail: *darren.jaffe@dot.gov*. A TDD is available at 1–800–877–8339 (TDD/FIRS).

Issued in Washington, DC this 29th day of April, 2010.

Peter Rogoff,

Administrator.

APPENDIX A—FTA REGIONAL AND METROPOLITAN OFFICES

Richard H. Doyle, Regional Administrator, Region 1–Boston, Kendall Square, 55 Broadway, Suite 920, Cambridge, MA 02142–1093, Tel. 617–494–2055 States served: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	Robert C. Patrick, Regional Administrator, Region 6–Ft. Worth, 819 Taylor Street, Room 8A36, Ft. Worth, TX 76102, Tel. 817–978–0550. States served: Arkansas, Louisiana, Oklahoma, New Mexico and Texas.
Brigid Hynes-Cherin, Regional Administrator, Region 2–New York, One Bowling Green, Room 429, New York, NY 10004–1415, Tel. 212–668–2170 States served: New Jersey, New York New York Metropolitan Office, Region 2–New York, One Bowling Green, Room 428, New York, NY 10004–1415, Tel. 212–668–2202.	Mokhtee Ahmad, Regional Administrator, Region 7–Kansas City, MO, 901 Locust Street, Room 404, Kansas City, MO 64106, Tel. 816–329–3920. States served: Iowa, Kansas, Missouri, and Nebraska.
Letitia Thompson, Regional Administrator, Region 3–Philadelphia, 1760 Market Street, Suite 500, Philadelphia, PA 19103–4124, Tel. 215–656–7100 States served: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and District of Columbia Philadelphia Metropolitan Office, Region 3–Philadelphia, 1760 Market Street, Suite 500, Philadelphia, PA 19103–4124, Tel. 215–656–7070 Washington, D.C. Metropolitan Office, 1990 K Street, NW., Room 510, Washington, DC 20006, Tel. 202–219–3562	Terry Rosapep, Regional Administrator, Region 8–Denver, 12300 West Dakota Ave., Suite 310, Lakewood, CO 80228–2583, Tel. 720–963–3300. States served: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming.

APPENDIX A—FTA REGIONAL AND METROPOLITAN OFFICES—Continued

Yvette Taylor, Regional Administrator, Region 4–Atlanta, 230 Peachtree Street, NW., Suite 800, Atlanta, GA 30303, Tel. 404–865–5600 States served: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, Puerto Rico, South Carolina, Tennessee, and Virgin Islands	Leslie T. Rogers, Regional Administrator, Region 9–San Francisco, 201 Mission Street, Room 1650, San Francisco, CA 94105–1926, Tel. 415–744–3133. States served: American Samoa, Arizona, California, Guam, Hawaii, Nevada, and the Northern Mariana Islands. Los Angeles Metropolitan Office, Region 9–Los Angeles, 888 S. Figueroa Street, Suite 1850, Los Angeles, CA 90017–1850, Tel. 213–202–3952.
Marisol Simon, Regional Administrator, Region 5–Chicago, 200 West Adams Street, Suite 320, Chicago, IL 60606, Tel. 312–353–2789 States served: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin Chicago Metropolitan Office, Region 5–Chicago, 200 West Adams Street, Suite 320, Chicago, IL 60606, Tel. 312–353–2789	Rick Krochalis, Regional Administrator, Region 10–Seattle, Jackson Federal Building, 915 Second Avenue, Suite 3142, Seattle, WA 98174–1002, Tel. 206–220–7954. States served: Alaska, Idaho, Oregon, and Washington.

[FR Doc. 2010–10430 Filed 4–30–10; 11:15 am]
BILLING CODE P

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

Blocking of Specially Designated National Pursuant to Executive Order 13413

AGENCY: Office of Foreign Assets Control, Treasury.

ACTION: Notice.

SUMMARY: The Treasury Department's Office of Foreign Assets Control ("OFAC") is publishing the name of five individuals whose property and interests in property have been blocked pursuant to Executive Order 13413 of October 27, 2006, "Blocking Property of Certain Persons Contributing to the Conflict in the Democratic Republic of Congo".

DATES: The designation by the Director of OFAC of the five individuals identified in this notice, pursuant to Executive Order 13413 of October 27, 2006, is effective on April 28, 2010.

FOR FURTHER INFORMATION CONTACT: Assistant Director, Compliance Outreach & Implementation, Office of Foreign Assets Control, Department of the Treasury, Washington, DC 20220, tel.: 202/622–2490.

SUPPLEMENTARY INFORMATION:

Electronic and Facsimile Availability

This document and additional information concerning OFAC are available from OFAC's Web site (*http://www.treas.gov/ofac*) via facsimile through a 24-hour fax-on demand service, tel.: (202) 622–0077.

Background

On October 27, 2006, the President signed Executive Order 13413 (the "Order") pursuant to, inter alia, the International Emergency Economic Powers Act (50 U.S.C. 1701 *et seq.*) (IEEPA), section 5 of the United Nations Participation Act, as amended (22 U.S.C. 287c) (UNPA), and section 301 of title 3, United States Code. In the Order, the President found that the situation in the Democratic Republic of the Congo constitutes an unusual and extraordinary threat. The President identified seven individuals as subject to the economic sanctions in the Annex to the Order.

Section 1 of the Order blocks, with certain exceptions, all property and interests in property that are in, or thereafter come within, the United States, or within the possession or control of United States persons, of the persons listed in the Annex, as well as those persons determined by the Secretary of the Treasury, after consultation with the Secretary of State, to meet any of the criteria set forth in subparagraphs (a)(i)–(a)(ii)(G) of Section 1.

On April 28, 2010, the Director of OFAC exercised the Secretary of the Treasury's authority to designate, pursuant to one or more of the criteria set forth in Section 1 of the Order, the individuals listed below, whose property and interests in property are blocked pursuant to E.O. 13413.

The listing of the blocked individuals is as follows:

NTAGANDA, Bosco (a.k.a. BAGANDA, Bosco; a.k.a. NTAGANDA, Jean Bosco; a.k.a. NTAGENDA, Bosco; a.k.a. NTANGANA, Bosco; a.k.a. NTANGANDA, Bosco; a.k.a. TAGANDA, Bosco; a.k.a. TANGANDA, Bosco), Runyoni, Rutshuru, North Kivu, Congo, Democratic Republic of the; DOB 1973; POB Nord-Kivu, DRC; alt. POB Rwanda; nationality Congo, Democratic Republic of the (individual) [DRCONGO]

LUBANGA, Thomas (a.k.a. DYILO, Thomas Lubanga); DOB 29 Dec 1960; POB Djiba, Utcha Sector, Djugu Territory, Ituri District, Orientale Province, DRC; nationality Congo, Democratic Republic of the (individual) [DRCONGO]

KATANGA, Germain; DOB 28 Apr 1978; POB Mambasa, Mambasa Territory, Ituri District, DRC; nationality Congo, Democratic Republic of the (individual) [DRCONGO]

NGUDJOLO, Matthieu Cui (a.k.a. CUI NGUDJOLO; a.k.a. NGUDJOLO CHUI, Mathieu; a.k.a. NGUDJOLO, Cui Cui; a.k.a. NGUDJOLO, Mathieu; a.k.a. TCHUI, Mathieu Ngudjolo); DOB 8 Oct 1970; POB Bunia, Ituri District, DRC; nationality Congo, Democratic Republic of the (individual) [DRCONGO]

MUTEBUTSI, Jules (a.k.a. COLONEL MUTEBUTSI; a.k.a. MUTEBUSI, Jules; a.k.a. MUTEBUZI, Jules), Rwanda; DOB 6 Jul 1960; POB South Kivu, DRC; nationality Congo, Democratic Republic of the (individual) [DRCONGO]

Dated: April 28, 2010.

Adam J. Szubin,

Director, Office of Foreign Assets Control.

[FR Doc. 2010–10298 Filed 5–3–10; 8:45 am]
BILLING CODE 4811–45–P

DEPARTMENT OF VETERANS AFFAIRS

Joint Biomedical Laboratory Research and Development and Clinical Science Research and Development Services Scientific Merit Review Board; Notice of Meetings

The Department of Veterans Affairs gives notice under Public Law 92–463 (Federal Advisory Committee Act), that the panels of the Joint Biomedical Laboratory Research and Development and Clinical Science Research and

Development Services Scientific Merit Review Board will meet from 8 a.m. to 5 p.m. on the dates indicated below:

Panel	Date(s)	Location
Cardiovascular Studies	May 24, 2010	St. Gregory Hotel & Suites.
Immunology-A	May 25, 2010	L'Enfant Plaza Hotel.
Mental Hlth & Behav Sci-B	May 26, 2010	Embassy Suites—Chevy Chase.
Neurobiology-E	May 26, 2010	*VA Central Office.
Hematology	May 28, 2010	*VA Central Office.
Epidemiology	June 2, 2010	*VA Central Office.
Neurobiology-A	June 4, 2010	Embassy Suites—Chevy Chase.
Nephrology	June 4, 2010	Hotel Palomar.
Infectious Diseases-B	June 4, 2010	L'Enfant Plaza Hotel.
Endocrinology-B	June 4, 2010	*VA Central Office.
Cellular & Molecular Medicine	June 7, 2010	Hotel Palomar.
Surgery	June 7, 2010	Crowne Plaza.
Endocrinology-A	June 7, 2010	L'Enfant Plaza Hotel.
Mental Hlth & Behav Sci-A	June 7, 2010	L'Enfant Plaza Hotel.
Clinical Research Program	June 9, 2010	*VA Central Office.
Oncology	June 10–11, 2010	L'Enfant Plaza Hotel.
Neurobiology-C	June 10–11, 2010	L'Enfant Plaza Hotel.
Gastroenterology	June 10, 2010	L'Enfant Plaza Hotel.
Neurobiology-D	June 10, 2010	L'Enfant Plaza Hotel.
Respiration	June 11, 2010	L'Enfant Plaza Hotel.
Infectious Diseases-A	June 11, 2010	L'Enfant Plaza Hotel.
Eligibility	July 19, 2010	The Ritz-Carlton.

The addresses of the hotels and VA Central Office are:
Crowne Plaza Washington DC/Silver Spring, 8777 Georgia Avenue, Silver Spring, MD.
Embassy Suites at the Chevy Chase Pavilion, 4300 Military Road, NW., Washington, DC.
Hotel Palomar, 2121 P Street, NW., Washington, DC.
L'Enfant Plaza Hotel, 480 L'Enfant Plaza, SW., Washington, DC.
St. Gregory Hotel & Suites, 2033 M Street, NW., Washington, DC.
The Ritz-Carlton, 1150—22nd Street, NW., Washington, DC.
* VA Central Office, 1722 Eye Street, NW., Washington, DC.
* Teleconference.

The purpose of the Merit Review Board is to provide advice on the scientific quality, budget, safety and mission relevance of investigator-initiated research proposals submitted for VA merit review consideration. Proposals submitted for review by the Board involve a wide range of medical specialties within the general areas of biomedical, behavioral and clinical science research.

The panel meetings will be open to the public for approximately one hour at the start of each meeting to discuss the general status of the program. The remaining portion of each panel meeting will be closed to the public for the review, discussion, and evaluation of initial and renewal research proposals.

The closed portion of each meeting involves discussion, examination, reference to staff and consultant critiques of research proposals. During this portion of each meeting, discussion and recommendations will deal with qualifications of personnel conducting the studies, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, as well as research information, the premature disclosure of which could significantly frustrate implementation of proposed agency action regarding such research proposals.

As provided by subsection 10(d) of Public Law 92–463, as amended, closing portions of these panel meetings is in accordance with 5 U.S.C., 552b(c) (6) and (9)(B). Those who plan to attend or would like to obtain a copy of minutes of the panel meetings and rosters of the members of the panels should contact Leroy G. Frey, Ph.D., Chief, Program Review (121F), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420 at (202) 461–1664.

Dated: April 29, 2010.

By Direction of the Secretary.

Vivian Drake,

Acting Committee Management Officer.

[FR Doc. 2010–10394 Filed 5–3–10; 8:45 am]

BILLING CODE P

DEPARTMENT OF VETERANS AFFAIRS

Special Medical Advisory Group; Notice of Meeting

The Department of Veterans Affairs (VA) gives notice under Public Law 92–463 (Federal Advisory Committee Act) that the Special Medical Advisory Group will meet on May 14, 2010, in Room 830 at VA Central Office, 810 Vermont Avenue, NW., Washington, DC, from 8:30 a.m. to 3 p.m. The meeting is open to the public.

The purpose of the Group is to advise the Secretary of Veterans Affairs and the Under Secretary for Health on the care and treatment of disabled Veterans, and other matters pertinent to the Department's Veterans Health Administration (VHA).

The agenda for the meeting will include discussions of the Vision for VHA, the Group's charter, update on Blue Ribbon Panel on VA-Medical School Affiliations Report Implementation, update on Transformational Initiatives, and VA/DoD Interoperability.

Any member of the public wishing to attend should contact Juanita Leslie, Office of Administrative Operations (10B2), at (202) 461–7019 or *j.t.leslie@va.gov.* No time will be set aside at this meeting for receiving oral presentations from the public. Statements, in written form, may be submitted to Ms. Leslie before the meeting or within 10 days after the meeting.

Dated: April 29, 2010.

By Direction of the Secretary.

Vivian Drake,

Committee Management Officer.

[FR Doc. 2010–10411 Filed 5–3–10; 8:45 am]

BILLING CODE P

Federal Register

Tuesday,
May 4, 2010

Book 2 of 2 Books
Pages 23851–24362

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, et al.
Medicare Program; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 440, 441, 482, 485, and 489

[CMS–1498–P]

RIN 0938–AP80

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2011 Rates; Effective Date of Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services Medicaid Program: Accreditation Requirements for Providers of Inpatient Psychiatric Services for Individuals Under Age 21

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems. In addition, in the Addendum to this proposed rule, we describe the proposed changes to the amounts and factors used to determine the rates for Medicare acute care hospital inpatient services for operating costs and capital-related costs. These proposed changes would be applicable to discharges occurring on or after October 1, 2010. We also are setting forth the proposed update to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The proposed updated rate-of-increase limits would be effective for cost reporting periods beginning on or after October 1, 2010.

We are proposing to update the payment policy and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). In the Addendum to this proposed rule, we also set forth the proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS. These proposed changes would be applicable to discharges occurring on or after October 1, 2010.

We are proposing changes affecting the Medicare conditions of participation for hospitals relating to the types of practitioners who may provide rehabilitation services and respiratory care services.

We are proposing changes affecting the determination of the effective date of provider agreements and supplier approvals under Medicare.

Finally, we are proposing to offer psychiatric hospitals, hospitals with inpatient psychiatric programs, and psychiatric facilities that are not hospitals increased flexibility in obtaining accreditation to participate in the Medicaid program. Psychiatric hospitals would have the choice of meeting the existing regulatory requirements to participate in Medicare as a psychiatric hospital or to obtaining accreditation from a national accrediting organization whose psychiatric hospital accrediting program has been approved by CMS. Hospitals with inpatient psychiatric programs would have the choice of meeting the existing regulatory requirements for participation in Medicare as a hospital or obtaining accreditation from a national accrediting organization whose hospital accreditation program has been approved by CMS. In addition, psychiatric facilities that are not hospitals would be afforded the flexibility in obtaining accreditation by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State.

DATES: To be assured consideration, comments on this proposed rule must be received at one of the addresses provided below, no later than 5 p.m. Eastern Daylight Time (E.D.T.) on June 18, 2010.

ADDRESSES: When commenting on issues presented in this proposed rule, please refer to file code CMS–1498–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation at *http://www.regulations.gov.* Follow the instructions for "Comment or Submission" and enter the file code CMS–1498–P to submit comments on this proposed rule.

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1498–P, P.O. Box 8011, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1498–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

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

b. 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

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

FOR FURTHER INFORMATION CONTACT: Tzvi Hefter, (410) 786–4487, and Ing-Jye Cheng, (410) 786–4548, Operating Prospective Payment, MS–DRGs, Hospital Acquired Conditions (HAC), Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Acute Care Transfers, Capital Prospective Payment, Excluded Hospitals, Direct and Indirect Graduate Medical Education Payments, Disproportionate Share Hospital (DSH), and Critical Access Hospital (CAH) Issues.

Michele Hudson, (410) 786–4487, and Judith Richter, (410) 786–2590, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

James Poyer, (410) 786–2261, Reporting of Hospital Quality Data for Annual Payment Update—Program Administration, Validation, and Reconsideration Issues.

Shaheen Halim, (410) 786–0641, Reporting of Hospital Quality Data for Annual Payment Update—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems.

Elizabeth Goldstein, (410) 786–6665 Reporting of Hospital Quality Data for Annual Payment Update—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Marcia Newton, (410–786–5265) and CDR Scott Cooper (U.S. Public Health Service), (410) 786–9465, Hospital Conditions of Participation for Rehabilitation Services and Respiratory Therapy Care Issues.

Marilyn Dahl, (410) 786–8665, Provider Agreement and Supplier Approval Issues.

Melissa Harris, (410) 786–3397 or Adrienne Delozier, (410) 786–0278, Accreditation of Providers of Inpatient Psychiatric Services to Individuals under Age 21 Issues.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions at that Web site to view public comments.

Comments received timely will also be available for public inspection, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Electronic Access

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

Acronyms

3M 3M Health Information System
AAHKS American Association of Hip and Knee Surgeons
AAMC Association of American Medical Colleges
ACGME Accreditation Council for Graduate Medical Education
AHA American Hospital Association
AHIC American Health Information Community
AHIMA American Health Information Management Association
AHRQ Agency for Healthcare Research and Quality
ALOS Average length of stay
ALTHA Acute Long Term Hospital Association
AMA American Medical Association
AMGA American Medical Group Association
AOA American Osteopathic Association
APR DRG All Patient Refined Diagnosis Related Group System
ARRA American Recovery and Reinvestment Act of 2009, Public Law 111–5
ASC Ambulatory surgical center
ASCA Administrative Simplification Compliance Act of 2002, Public Law 107–105
ASITN American Society of Interventional and Therapeutic Neuroradiology
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
BIC Beneficiary Identification Code
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106–554
BLS Bureau of Labor Statistics
CAH Critical access hospital
CARE [Medicare] Continuity Assessment Record & Evaluation [Instrument]
CART CMS Abstraction & Reporting Tool
CBSAs Core-based statistical areas
CC Complication or comorbidity
CCR Cost-to-charge ratio
CDAC [Medicare] Clinical Data Abstraction Center
CDAD *Clostridium difficile*-associated disease
CIPI Capital input price index
CMI Case-mix index
CMS Centers for Medicare & Medicaid Services
CMSA Consolidated Metropolitan Statistical Area
COBRA Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99–272
COLA Cost-of-living adjustment
CoP [Hospital] condition of participation
CPI Consumer price index
CRNA Certified Registered Nurse Anesthetist
CY Calendar year
DPP Disproportionate patient percentage
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DRG Diagnosis-related group
DSH Disproportionate share hospital
ECI Employment cost index
EDB [Medicare] Enrollment Database
EMR Electronic medical record
FAH Federation of Hospitals
FDA Food and Drug Administration
FFY Federal fiscal year
FHA Federal Health Architecture
FIPS Federal information processing standards
FQHC Federally qualified health center
FTE Full-time equivalent
FY Fiscal year
GAAP Generally Accepted Accounting Principles
GAF Geographic Adjustment Factor
GME Graduate medical education
HACs Hospital-acquired conditions
HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems
HCFA Health Care Financing Administration
HCO High-cost outlier
HCRIS Hospital Cost Report Information System
HHA Home health agency
HHS Department of Health and Human Services
HICAN Health Insurance Claims Account Number
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
HIPC Health Information Policy Council
HIS Health information system
HIT Health information technology
HMO Health maintenance organization
HPMP Hospital Payment Monitoring Program
HSA Health savings account
HSCRC [Maryland] Health Services Cost Review Commission
HSRV Hospital-specific relative value
HSRVcc Hospital-specific relative value cost center
HQA Hospital Quality Alliance
HQI Hospital Quality Initiative
HwH Hospital-within-a-hospital
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification
ICD–10–CM International Classification of Diseases, Tenth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Revision, Procedure Coding System
ICR Information collection requirement
IHS Indian Health Service
IME Indirect medical education
I–O Input-Output
IOM Institute of Medicine
IPF Inpatient psychiatric facility
IPPS [Acute care hospital] inpatient prospective payment system

IRF Inpatient rehabilitation facility
LAMCs Large area metropolitan counties
LOS Length of stay
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MA Medicare Advantage
MAC Medicare Administrative Contractor
MCC Major complication or comorbidity
MCE Medicare Code Editor
MCO Managed care organization
MCV Major cardiovascular condition
MDC Major diagnostic category
MDH Medicare-dependent, small rural hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare Provider Analysis and Review File
MEI Medicare Economic Index
MGCRB Medicare Geographic Classification Review Board
MIEA–TRHCA Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006, Pub. L. 109–432
MIPPA Medicare Improvements for Patients and Providers Act of 2008, Pub. L. 110–275
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. 110–173
MPN Medicare provider number
MRHFP Medicare Rural Hospital Flexibility Program
MRSA Methicillin-resistant *Staphylococcus aureus*
MSA Metropolitan Statistical Area
MS–DRG Medicare severity diagnosis-related group
MS–LTC–DRG Medicare severity long-term care diagnosis-related group
NAICS North American Industrial Classification System
NALTH National Association of Long Term Hospitals
NCD National coverage determination
NCHS National Center for Health Statistics
NCQA National Committee for Quality Assurance
NCVHS National Committee on Vital and Health Statistics
NECMA New England County Metropolitan Areas
NP Nurse practitioner
NQF National Quality Forum
NTIS National Technical Information Service
NTTAA National Technology Transfer and Advancement Act of 1991 (Pub. L. 104–113)
NVHRI National Voluntary Hospital Reporting Initiative
OACT [CMS'] Office of the Actuary
OBRA 86 Omnibus Budget Reconciliation Act of 1996, Pub. L. 99–509
OES Occupational employment statistics
OIG Office of the Inspector General
OMB Executive Office of Management and Budget
OPM U.S. Office of Personnel Management
O.R. Operating room
OSCAR Online Survey Certification and Reporting [System]
PA Physician assistant
PIP Periodic interim payment
PLI Professional liability insurance
PMSAs Primary metropolitan statistical areas
POA Present on admission
PPACA Patient Protection and Affordable Care Act, Pub. L. 111–148
PPI Producer price index
PPS Prospective payment system
PRM Provider Reimbursement Manual
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
PRTFs Psychiatric residential treatment facilities
PSF Provider-Specific File
PS&R Provider Statistical and Reimbursement (System)
QIG Quality Improvement Group, CMS
QIO Quality Improvement Organization
RCE Reasonable compensation equivalent
RHC Rural health clinic
RHQDAPU Reporting hospital quality data for annual payment update
RNHCI Religious nonmedical health care institution
RPL Rehabilitation psychiatric long-term care (hospital)
RRC Rural referral center
RTI Research Triangle Institute, International
RUCAs Rural-urban commuting area codes
RY Rate year
SAF Standard Analytic File
SCH Sole community hospital
SFY State fiscal year
SIC Standard Industrial Classification
SNF Skilled nursing facility
SOCs Standard occupational classifications
SOM State Operations Manual
SSN Social Security number
SSO Short-stay outlier
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
TEP Technical expert panel
TMA TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007, Pub. L. 110–90
UHDDS Uniform hospital discharge data set

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1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system (PPS). Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

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

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS, known as the indirect medical education (IME) adjustment. This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies or medical services that have been approved for special add-on payments. To qualify, a new technology or medical service must demonstrate that it is a substantial clinical improvement over technologies or services otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any eligible outlier payment is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology or medical service add-on adjustments.

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital-specific rate based on their costs in a base year. For example, sole community

hospitals (SCHs) receive the higher of a hospital-specific rate based on their costs in a base year (the highest of FY 1982, FY 1987, FY 1996, or FY 2006) or the IPPS Federal rate based on the standardized amount. Through and including FY 2006, a Medicare-dependent, small rural hospital (MDH) received the higher of the Federal rate or the Federal rate plus 50 percent of the amount by which the Federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. As discussed below, for discharges occurring on or after October 1, 2007, but before October 1, 2011, an MDH will receive the higher of the Federal rate or the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987, or FY 2002 hospital-specific rate. SCHs are the sole source of care in their areas, and MDHs are a major source of care for Medicare beneficiaries in their areas. Specifically, section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that is located more than 35 road miles from another hospital or that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of hospital inpatient services reasonably available to Medicare beneficiaries. In addition, certain rural hospitals previously designated by the Secretary as essential access community hospitals are considered SCHs. Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area, has not more than 100 beds, is not an SCH, and has a high percentage of Medicare discharges (not less than 60 percent of its inpatient days or discharges in its cost reporting year beginning in FY 1987 or in two of its three most recently settled Medicare cost reporting years). Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services "in accordance with a prospective payment system established by the Secretary." The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital IPPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Capital IPPS payments are also adjusted for IME and DSH, similar to the adjustments made under the operating IPPS. In addition, hospitals may receive outlier payments for those cases that have unusually high costs.

The existing regulations governing payments to hospitals under the IPPS are located in 42 CFR part 412, Subparts A through M.

2. Hospitals and Hospital Units Excluded From the IPPS

Under section 1886(d)(1)(B) of the Act, as amended, certain hospitals and hospital units are excluded from the IPPS. These hospitals and units are: rehabilitation hospitals and units; long-term care hospitals (LTCHs); psychiatric hospitals and units; children's hospitals; and cancer hospitals. Religious nonmedical health care institutions (RNHCIs) are also excluded from the IPPS. Various sections of the Balanced Budget Act of 1997 (BBA, Pub. L. 105–33), the Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA, Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, Pub. L. 106–554) provide for the implementation of PPSs for rehabilitation hospitals and units (referred to as inpatient rehabilitation facilities (IRFs)), LTCHs, and psychiatric hospitals and units (referred to as inpatient psychiatric facilities (IPFs)). (We note that the annual updates to the LTCH PPS are now included as part of the IPPS annual update document. Updates to the IRF PPS and IPF PPS are issued as separate documents.) Children's hospitals, cancer hospitals, and RNHCIs continue to be paid solely under a reasonable cost-based system subject to a rate-of-increase ceiling on inpatient operating costs per discharge.

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

3. Long-Term Care Hospital Prospective Payment System (LTCH PPS)

The Medicare prospective payment system (PPS) for LTCHs applies to hospitals described in section 1886(d)(1)(B)(iv) effective for cost reporting periods beginning on or after October 1, 2002. The LTCH PPS was established under the authority of sections 123(a) and (c) of Public Law 106–113 and section 307(b)(1) of Public Law 106–554 (as codified under section 1886(m)(1) of the Act). During the 5-year (optional) transition period, a LTCH's payment under the PPS was based on an increasing proportion of the LTCH Federal rate with a corresponding decreasing proportion based on reasonable cost principles. Effective for cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the Federal rate. The existing regulations governing payment under the LTCH PPS are located in 42 CFR part 412, Subpart O. Beginning October 1, 2009, we issue the annual updates to the LTCH PPS in the same documents that update the IPPS (73 FR 26797 through 26798).

4. Critical Access Hospitals (CAHs)

Under sections 1814(l), 1820, and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services are generally based on 101 percent of reasonable cost. Reasonable cost is determined under the provisions of section 1861(v)(1)(A) of the Act and existing regulations under 42 CFR parts 413 and 415.

5. Payments for Graduate Medical Education (GME)

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act. The amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year. The existing regulations governing payments to the various types of hospitals are located in 42 CFR part 413.

B. Provisions of the Patient Protection and Affordable Care Act (Pub. L. 111–148), as Amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152)

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public L. 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new

legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

C. Major Content of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs of acute care hospitals in FY 2011. We also are setting forth proposed changes relating to payments for IME costs and payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis.

In addition, in this proposed rule, we are setting forth proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for FY 2011. We note that because the annual update of payment rates for the LTCH PPS will now take place on the same schedule and in the same publication as for the IPPS, for the sake of clarity, in section VII.D. of this proposed rule, we are proposing to use "fiscal year (FY)" instead of "rate year (RY) when referring to updates and changes to the LTCH PPS to be effective October 1, 2010. Therefore, throughout this proposed rule, we are using the phrase "fiscal year (FY)" in referring to proposed updates and changes to the LTCH PPS.

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

1. Proposed Changes to MS–DRG Classifications and Recalibrations of Relative Weights

In section II. of the preamble of this proposed rule, we included—

- Proposed changes to MS–DRG classifications based on our yearly review.
- Proposed application of the documentation and coding adjustment to hospital-specific rates for FY 2011 resulting from implementation of the MS–DRG system.
- A discussion of the Research Triangle International, Inc. (RTI) and RAND Corporation reports and recommendations relating to charge compression.
- Proposed recalibrations of the MS–DRG relative weights.

We also presented a listing and discussion of hospital-acquired conditions (HACs), including infections, that are subject to the statutorily required quality adjustment in MS–DRG payments for FY 2011.

We discuss the FY 2011 status of two new technologies approved for add-on payments for FY 2010 and presented our evaluation and analysis of the FY 2011 applicants for add-on payments for high-cost new medical services and technologies (including public input, as directed by Pub. L. 108–173, obtained in a town hall meeting).

2. Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

In section III. of the preamble to this proposed rule, we are proposing revisions to the wage index for acute care hospitals and the annual update of the wage data. Specific issues addressed include the following:

- Budget neutrality for the rural floor and imputed floor.
- Changes to titles and principal cities of CBSA designations.
- The proposed FY 2011 wage index update using wage data from cost reporting periods beginning in FY 2007.
- Analysis and implementation of the proposed FY 2011 occupational mix adjustment to the wage index for acute care hospitals, including discussion of the 2010 occupational mix survey.
- Proposed revisions to the wage index for acute care hospitals based on hospital redesignations and reclassifications.
- The proposed adjustment to the wage index for acute care hospitals for FY 2011 based on commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index.
- The timetable for reviewing and verifying the wage data used to compute the proposed FY 2011 hospital wage index.
- Determination of the labor-related share for the proposed FY 2011 wage index.

3. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs

In section IV. of the preamble of this proposed rule, we discussed a number of the provisions of the regulations in 42 CFR parts 412, 413, and 489, including the following:

- The reporting of hospital quality data as a condition for receiving the full annual payment update increase.
- Payment for transfer cases from Medicare participating hospitals to nonparticipating hospitals and CAHs.
- A change to the definition criteria for MDHs.
- The proposed updated national and regional case-mix values and discharges for purposes of determining RRC status.
- The statutorily required IME adjustment factor for FY 2011.
- The proposed policy change relating to the determination of the SSI ratio of the Medicare fraction in the formula for determining the payment adjustments for disproportionate share hospitals.
- A proposed clarification of "approved medical residency programs" policies relating to payment for IME and direct GME and our proposal to accept the electronic submission of Medicare GME affiliation agreements.
- Proposed policy change for payments for services furnished by certified registered nurse anesthetists (CRNAs) in rural hospitals and CAHs.
- Discussion of the status of the Rural Community Hospital Demonstration Program.

4. Proposed FY 2011 Policy Governing the IPPS for Capital-Related Costs

In section V. of the preamble to this proposed rule, we discussed the proposed payment policy requirements for capital-related costs and capital payments to hospitals for FY 2011 and the proposed MS–DRG documentation and coding adjustment for FY 2011.

5. Proposed Changes to the Payment Rates for Certain Excluded Hospitals: Rate-of-Increase Percentages

In section VI. of the preamble of this proposed rule, we discussed—

- Proposed changes to payments to excluded hospitals.
- Proposed changes relating to the election by CAHs of the optional method of payment for outpatient services
- Proposed clarification of the policies on costs of provider taxes as allowable costs for CAHs.

6. Proposed Changes to the LTCH PPS

In section VII. of the preamble of this proposed rule, we set forth proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for FY 2011, including the annual update of the MS–LTC–DRG classifications and relative weights for use under the LTCH PPS for FY 2011 and the proposed MS–DRG documentation and coding adjustment for FY 2011.

7. Proposed Changes Relating to Effective Date of Provider Agreements and Supplier Approvals

In section VIII. of the preamble of this proposed rule, we set forth our proposed change in policies for

determining the effective date of provider agreements and supplier approvals and to make changes to assure that accredited and nonaccredited facilities are treated in the same manner in determining this effective date.

8. Proposed Changes to Medicare Conditions of Participation Affecting Hospital Rehabilitation Services and Respiratory Care Services

In section IX. of the preamble of this proposed rule, we are proposing changes to the Medicare conditions of participation regarding which practitioners are allowed to order rehabilitation and respiratory care services in the hospital setting.

9. Proposed Changes to the Accreditation Requirements for Medicaid Providers of Inpatient Psychiatric Services for Individuals under Age 21

In section X. of the preamble of this proposed rule, we are proposing to remove the requirement for accreditation by The Joint Commission of psychiatric hospitals and hospitals with inpatient psychiatric programs. Hospitals with inpatient psychiatric programs would be afforded the flexibility in obtaining accreditation by a national accrediting organization whose hospital accrediting program has been approved by CMS, and psychiatric rehabilitation treatment facilities would be afforded flexibility in obtaining accreditation by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State.

10. Determining Proposed Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits for Acute Care Hospitals

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the proposed FY 2011 prospective payment rates for operating costs and capital-related costs for acute care hospitals. We also are establishing the proposed threshold amounts for outlier cases. In addition, we address the proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2011 for certain hospitals excluded from the IPPS.

11. Determining Proposed Prospective Payment Rates for LTCHs

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the proposed FY 2011 prospective standard Federal rate. We also are establishing the proposed adjustments for wage levels, the labor-related share, the cost-of-living adjustment, and high-cost outliers, including the fixed-loss amount, and the LTCH cost-to-charge ratios (CCRs) under the LTCH PPS.

12. Impact Analysis

In Appendix A of this proposed rule, we set forth an analysis of the impact that the proposed changes would have on affected acute care hospitals and LTCHs.

13. Recommendation of Update Factors for Operating Cost Rates of Payment for Hospital Inpatient Services

In Appendix B of this proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provide our recommendations of the appropriate percentage changes for FY 2011 for the following:

- A single average standardized amount for all areas for hospital inpatient services paid under the IPPS for operating costs of acute care hospitals (and hospital-specific rates applicable to SCHs and MDHs).
- Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by certain hospitals excluded from the IPPS.
- The standard Federal rate for hospital inpatient services furnished by LTCHs.

14. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, no later than March 1 of each year, in which MedPAC reviews and makes recommendations on Medicare payment policies. MedPAC's March 2010 recommendations concerning hospital inpatient payment policies address the update factor for hospital inpatient operating costs and capital-related costs under the IPPS, for hospitals and distinct part hospital units excluded from the IPPS. We address these recommendations in Appendix B of this proposed rule. For further information relating specifically to the MedPAC March 2008 report or to obtain a copy of the report, contact MedPAC at (202) 220–3700 or visit MedPAC's Web site at: *http://www.medpac.gov.*

E. Interim Final Rule With Comment Period That Implemented Certain Provisions of the ARRA Relating to Payments to LTCHs and LTCH Satellite Facilities

Section 4302 of the American Recovery and Reinvestment Act of 2009 (ARRA, Public Law 111–5) included several amendments to section 114 of Public Law 110–173 (MMSEA) relating to payments to LTCHs and LTCH satellite facilities that were discussed under section X. of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43976 through 43990). These amendments are effective as if they were enacted as part of section 114 of Public Law 110–173 (MMSEA). We issued instructions to the fiscal intermediaries and Medicare administrative contractors (MACs) to interpret these amendments (Change Request 6444). In section XI. of the FY 2010/RY 2010 LTCH PPS final rule (74 FR 43990), we implemented the provisions of section 4302 of Public Law 111–5 through an interim final rule with comment period. We will respond to the public comments that we received in a timely manner on this interim final rule with comment period and finalize the interim final rule with any necessary modification in the final rule for this proposed rule.

II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS–DRG) Classifications and Relative Weights

A. Background

Section 1886(d) of the Act specifies that the Secretary shall establish a classification system (referred to as DRGs) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.

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

adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

B. MS–DRG Reclassifications

1. General

As discussed in the preamble to the FY 2008 IPPS final rule with comment period (72 FR 47138), we focused our efforts in FY 2008 on making significant reforms to the IPPS consistent with the recommendations made by MedPAC in its "Report to the Congress, Physician-Owned Specialty Hospitals" in March 2005. MedPAC recommended that the Secretary refine the entire DRG system by taking severity of illness into account and applying hospital-specific relative value (HSRV) weights to DRGs.[1] We began this reform process by adopting cost-based weights over a 3-year transition period beginning in FY 2007 and making interim changes to the DRG system for FY 2007 by creating 20 new CMS DRGs and modifying 32 other DRGs across 13 different clinical areas involving nearly 1.7 million cases. As described in more detail below, these refinements were intermediate steps towards comprehensive reform of both the relative weights and the DRG system as we undertook further study. For FY 2008, we adopted 745 new Medicare Severity DRGs (MS–DRGs) to replace the CMS DRGs. We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full detailed discussion of how the MS–DRG system, based on severity levels of illness, was established (72 FR 47141).

Currently, cases are classified into MS–DRGs for payment under the IPPS based on the following information reported by the hospital: The principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay. (We refer readers to section II.G.11.c. of this proposed rule for a discussion of our efforts to increase our internal systems capacity to process diagnosis and procedures on hospital claims to 25 diagnosis codes and 25 procedure codes prior to the use of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10 PCS) for inpatient hospital procedure coding, effective October 1, 2013.) In a small number of MS–DRGs, classification is also based on the age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) prior to October 1, 2013. We refer readers to section II.G.11.b. of this proposed rule for a reference to the replacement of ICD–9–CM, Volumes 1 and 2, including the Official ICD–9–CM Guidelines for Coding and Reporting, Volume 3, with the ICD–10–CM and ICD–10–PCS, including the Official ICD–10–CM and ICM–10–PCS Guidelines for Coding and Reporting, effective October 1, 2013 (FY 2014).

The process of developing the MS–DRGs was begun by dividing all possible principal diagnoses into mutually exclusive principal diagnosis areas, referred to as Major Diagnostic Categories (MDCs). The MDCs were formulated by physician panels to ensure that the DRGs would be clinically coherent. The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. Thus, in order to maintain the requirement of clinical coherence, no final MS–DRG could contain patients in different MDCs. For example, MDC 6 is Diseases and Disorders of the Digestive System. This approach is used because clinical care is generally organized in accordance with the organ system affected. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)). For FY 2010, cases are assigned to one of 746 MS–DRGs in 25 MDCs. The table below lists the 25 MDCs.

MAJOR DIAGNOSTIC CATEGORIES (MDCS)

1	Diseases and Disorders of the Nervous System.
2	Diseases and Disorders of the Eye.
3	Diseases and Disorders of the Ear, Nose, Mouth, and Throat.
4	Diseases and Disorders of the Respiratory System.
5	Diseases and Disorders of the Circulatory System.
6	Diseases and Disorders of the Digestive System.
7	Diseases and Disorders of the Hepatobiliary System and Pancreas.
8	Diseases and Disorders of the Musculoskeletal System and Connective Tissue.
9	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast.
10	Endocrine, Nutritional and Metabolic Diseases and Disorders.
11	Diseases and Disorders of the Kidney and Urinary Tract.
12	Diseases and Disorders of the Male Reproductive System.
13	Diseases and Disorders of the Female Reproductive System.
14	Pregnancy, Childbirth, and the Puerperium.
15	Newborns and Other Neonates with Conditions Originating in the Perinatal Period.
16	Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders.
17	Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms.
18	Infectious and Parasitic Diseases (Systemic or Unspecified Sites).
19	Mental Diseases and Disorders.
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
21	Injuries, Poisonings, and Toxic Effects of Drugs.
22	Burns.
23	Factors Influencing Health Status and Other Contacts with Health Services.
24	Multiple Significant Trauma.
25	Human Immunodeficiency Virus Infections.

[1] Medicare Payment Advisory Commission: *Report to the Congress, Physician-Owned Specialty Hospitals,* March 2005, page viii.

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to an MS–DRG. However, under the most recent version of the Medicare GROUPER (Version 27.0), there are 13 MS–DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These MS–DRGs are for heart transplant or implant of heart assist systems; liver and/or intestinal transplants; bone marrow transplants; lung transplants; simultaneous pancreas/kidney transplants; pancreas transplants; and tracheostomies. Cases are assigned to these MS–DRGs before they are classified to an MDC. The table below lists the 13 current pre-MDCs.

PRE-MAJOR DIAGNOSTIC CATEGORIES (PRE-MDCS)

MS–DRG 001 ...	Heart Transplant or Implant of Heart Assist System with MCC.
MS–DRG 002 ...	Heart Transplant or Implant of Heart Assist System without MCC.
MS–DRG 003 ...	ECMO or Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnosis with Major O.R.
MS–DRG 004 ...	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnosis with Major O.R.
MS–DRG 005 ...	Liver Transplant with MCC or Intestinal Transplant.
MS–DRG 006 ...	Liver Transplant without MCC.
MS–DRG 007 ...	Lung Transplant.
MS–DRG 008 ...	Simultaneous Pancreas/Kidney Transplant.
MS–DRG 009 ...	Bone Marrow Transplant.
MS–DRG 010 ...	Pancreas Transplant.
MS–DRG 011 ...	Tracheostomy for Face, Mouth, and Neck Diagnoses with MCC.
MS–DRG 012 ...	Tracheostomy for Face, Mouth, and Neck Diagnoses with CC.
MS–DRG 013 ...	Tracheostomy for Face, Mouth, and Neck Diagnoses without CC/MCC.

Once the MDCs were defined, each MDC was evaluated to identify those additional patient characteristics that would have a consistent effect on hospital resource consumption. Because the presence of a surgical procedure that required the use of the operating room would have a significant effect on the type of hospital resources used by a patient, most MDCs were initially divided into surgical DRGs and medical DRGs. Surgical DRGs are based on a hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. Medical DRGs generally are differentiated on the basis of diagnosis and age (0 to 17 years of age or greater than 17 years of age). Some surgical and medical DRGs are further differentiated based on the presence or absence of a complication or comorbidity (CC) or a major complication or comorbidity (MCC).

Generally, nonsurgical procedures and minor surgical procedures that are not usually performed in an operating room are not treated as O.R. procedures. However, there are a few non-O.R. procedures that do affect MS–DRG assignment for certain principal diagnoses. An example is extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones. Lithotripsy procedures are not routinely performed in an operating room. Therefore, lithotripsy codes are not classified as O.R. procedures. However, our clinical advisors believe that patients with urinary stones who undergo extracorporeal shock wave lithotripsy should be considered similar to other patients who undergo O.R. procedures. Therefore, we treat this group of patients similar to patients undergoing O.R. procedures.

Once the medical and surgical classes for an MDC were formed, each diagnosis class was evaluated to determine if complications or comorbidities would consistently affect hospital resource consumption. Each diagnosis was categorized into one of three severity levels. These three levels include a major complication or comorbidity (MCC), a complication or comorbidity (CC), or a non-CC. Physician panels classified each diagnosis code based on a highly iterative process involving a combination of statistical results from test data as well as clinical judgment. As stated earlier, we refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full detailed discussion of how the MS–DRG system was established based on severity levels of illness (72 FR 47141).

A patient's diagnosis, procedure, discharge status, and demographic information is entered into the Medicare claims processing systems and subjected to a series of automated screens called the Medicare Code Editor (MCE). The MCE screens are designed to identify cases that require further review before classification into an MS–DRG.

After patient information is screened through the MCE and any further development of the claim is conducted, the cases are classified into the appropriate MS–DRG by the Medicare GROUPER software program. The GROUPER program was developed as a means of classifying each case into an MS–DRG on the basis of the diagnosis and procedure codes and, for a limited number of MS–DRGs, demographic information (that is, sex, age, and discharge status).

After cases are screened through the MCE and assigned to an MS–DRG by the GROUPER, the PRICER software calculates a base MS–DRG payment. The PRICER calculates the payment for each case covered by the IPPS based on the MS–DRG relative weight and additional factors associated with each hospital, such as IME and DSH payment adjustments. These additional factors increase the payment amount to hospitals above the base MS–DRG payment.

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible MS–DRG classification changes and to recalibrate the MS–DRG weights. However, in the FY 2000 IPPS final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for us to consider using particular non-MedPAR data, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the non-MedPAR data submitted. Generally, however, a significant sample of the non-MedPAR data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule. This date allows us time to test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

As we indicated above, for FY 2008, we made significant improvements in the DRG system to recognize severity of illness and resource usage by adopting MS–DRGs that were reflected in the FY 2008 GROUPER, Version 25.0, and were effective for discharges occurring on or after October 1, 2007. Our MS–DRG analysis for the FY 2009 final rule was based on data from the March 2008 update of the FY 2007 MedPAR file, which contained hospital bills received through March 31, 2008, for discharges occurring through September 30, 2007. For this proposed rule, for FY 2011, our MS–DRG analysis is based on data from the September 2009 update of the FY 2009 MedPAR file, which contains hospital bills received through September 30, 2009, for discharges occurring through September 30, 2009.

2. Yearly Review for Making MS–DRG Changes

Many of the changes to the MS–DRG classifications we make annually are the result of specific issues brought to our attention by interested parties. We encourage individuals with comments about MS–DRG classifications to submit these comments no later than early December of each year so they can be carefully considered for possible inclusion in the annual proposed rule and, if included, may be subjected to public review and comment. Therefore, similar to the timetable for interested parties to submit non-MedPAR data for consideration in the MS–DRG recalibration process, comments about MS–DRG classification issues should be submitted no later than early December in order to be considered and possibly included in the next annual proposed rule updating the IPPS.

The actual process of forming the MS–DRGs was, and will likely continue to be, highly iterative, involving a combination of statistical results from test data combined with clinical judgment. In the FY 2008 IPPS final rule (72 FR 47140 through 47189), we described in detail the process we used to develop the MS–DRGs that we adopted for FY 2008. In addition, in deciding whether to make further modification to the MS–DRGs for particular circumstances brought to our attention, we considered whether the resource consumption and clinical characteristics of the patients with a given set of conditions are significantly different than the remaining patients in the MS–DRG. We evaluated patient care costs using average charges and lengths of stay as proxies for costs and relied on the judgment of our medical advisors to decide whether patients are clinically distinct or similar to other patients in the MS–DRG. In evaluating resource costs, we considered both the absolute and percentage differences in average charges between the cases we selected for review and the remainder of cases in the MS–DRG. We also considered variation in charges within these groups; that is, whether observed average differences were consistent across patients or attributable to cases that were extreme in terms of charges or length of stay, or both. Further, we considered the number of patients who will have a given set of characteristics and generally preferred not to create a new MS–DRG unless it would include a substantial number of cases.

C. Adoption of the MS–DRGs in FY 2008

In the FY 2006, FY 2007, and FY 2008 IPPS final rules, we discussed a number of recommendations made by MedPAC regarding revisions to the DRG system used under the IPPS (70 FR 47473 through 47482; 71 FR 47881 through 47939; and 72 FR 47140 through 47189). As we noted in the FY 2006 IPPS final rule, we had insufficient time to complete a thorough evaluation of these recommendations for full implementation in FY 2006. However, we did adopt severity-weighted cardiac DRGs in FY 2006 to address public comments on this issue and the specific concerns of MedPAC regarding cardiac surgery DRGs. We also indicated that we planned to further consider all of MedPAC's recommendations and thoroughly analyze options and their impacts on the various types of hospitals in the FY 2007 IPPS proposed rule.

For FY 2007, we began this process. In the FY 2007 IPPS proposed rule, we proposed to adopt Consolidated Severity DRGs (CS DRGs) for FY 2008 (if not earlier). Based on public comments received on the FY 2007 IPPS proposed rule, we decided not to adopt the CS DRGs. In the FY 2007 IPPS final rule (71 FR 47906 through 47912), we discussed several concerns raised by commenters regarding the proposal to adopt CS DRGs. We acknowledged the many comments suggesting the logic of Medicare's DRG system should continue to remain in the public domain as it has since the inception of the PPS. We also acknowledged concerns about the impact on hospitals and software vendors of moving to a proprietary system. Several commenters suggested that CMS refine the existing DRG classification system to preserve the many policy decisions that were made over the last 20 years and were already incorporated into the DRG system, such as complexity of services and new device technologies. Consistent with the concerns expressed in the public comments, this option had the advantage of using the existing DRGs as a starting point (which was already familiar to the public) and retained the benefit of many DRG decisions that were made in recent years. We stated our belief that the suggested approach of incorporating severity measures into the existing DRG system was a viable option that would be evaluated.

Therefore, we decided to make interim changes to the existing DRGs for FY 2007 by creating 20 new DRGs involving 13 different clinical areas that would significantly improve the CMS DRG system's recognition of severity of illness. We also modified 32 DRGs to better capture differences in severity. The new and revised DRGs were selected from 40 existing CMS DRGs that contained 1,666,476 cases and represented a number of body systems. In creating these 20 new DRGs, we deleted 8 existing DRGs and modified 32 existing DRGs. We indicated that these interim steps for FY 2007 were being taken as a prelude to more comprehensive changes to better account for severity in the DRG system by FY 2008.

In the FY 2007 IPPS final rule (71 FR 47898), we indicated our intent to pursue further DRG reform through two initiatives. First, we announced that we were in the process of engaging a contractor to assist us with evaluating alternative DRG systems that were raised as potential alternatives to the CMS DRGs in the public comments. Second, we indicated our intent to review over 13,000 ICD–9–CM diagnosis codes as part of making further refinements to the current CMS DRGs to better recognize severity of illness based on the work that CMS (then HCFA) did in the mid-1990's in connection with adopting severity DRGs. We describe below the progress we have made on these two initiatives and our actions for FYs 2008, 2009, and 2010, and our proposals for FY 2011 based on our continued analysis of reform of the DRG system. We note that the adoption of the MS–DRGs to better recognize severity of illness has implications for the outlier threshold, the application of the postacute care transfer policy, the measurement of real case-mix versus apparent case-mix, and the IME and DSH payment adjustments. We discuss these implications for FY 2011 in other sections of this preamble and in the Addendum to this proposed rule.

In the FY 2007 IPPS proposed rule, we discussed MedPAC's recommendations to move to a cost-based HSRV weighting methodology using HSRVs beginning with the FY

2007 IPPS proposed rule for determining the DRG relative weights. Although we proposed to adopt the HSRV weighting methodology for FY 2007, we decided not to adopt the proposed methodology in the final rule after considering the public comments we received on the proposal. Instead, in the FY 2007 IPPS final rule, we adopted a cost-based weighting methodology without the HSRV portion of the proposed methodology. The cost-based weights were adopted over a 3-year transition period in ⅓ increments between FY 2007 and FY 2009. In addition, in the FY 2007 IPPS final rule, we indicated our intent to further study the HSRV-based methodology as well as other issues brought to our attention related to the cost-based weighting methodology adopted in the FY 2007 final rule. There was significant concern in the public comments that our cost-based weighting methodology does not adequately account for charge compression—the practice of applying a higher percentage charge markup over costs to lower cost items and services and a lower percentage charge markup over costs to higher cost items and services. Further, public commenters expressed concern about potential inconsistencies between how costs and charges are reported on the Medicare cost reports and charges on the Medicare claims. In the FY 2007 IPPS final rule, we used costs and charges from the cost report to determine departmental level cost-to-charge ratios (CCRs) which we then applied to charges on the Medicare claims to determine the cost-based weights. The commenters were concerned about potential distortions to the cost-based weights that would result from inconsistent reporting between the cost reports and the Medicare claims. After publication of the FY 2007 IPPS final rule, we entered into a contract with RTI International (RTI) to study both charge compression and to what extent our methodology for calculating DRG relative weights is affected by inconsistencies between how hospitals report costs and charges on the cost reports and how hospitals report charges on individual claims. Further, as part of its study of alternative DRG systems, the RAND Corporation analyzed the HSRV cost-weighting methodology. We refer readers to section II.E. of the preamble of this proposed rule for discussion of the issue of charge compression and the cost-weighting methodology for FY 2011.

We believe that revisions to the DRG system to better recognize severity of illness and changes to the relative weights based on costs rather than charges are improving the accuracy of the payment rates in the IPPS. We agree with MedPAC that these refinements should be pursued. Although we continue to caution that any prospective payment system based on grouping cases will always present some opportunities for providers to specialize in cases they believe have higher margins, we believe that the changes we have adopted and the continuing reforms we are proposing to make in this proposed rule for FY 2011 will improve payment accuracy and reduce financial incentives to create specialty hospitals.

We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full discussion of how the MS–DRG system was established based on severity levels of illness (72 FR 47141).

D. Proposed FY 2011 MS–DRG Documentation and Coding Adjustment, Including the Applicability to the Hospital-Specific Rates and the Puerto Rico-Specific Standardized Amount

1. Background on the Prospective MS–DRG Documentation and Coding Adjustments for FY 2008 and FY 2009 Authorized by Public Law 110–90

As we discussed earlier in this preamble, we adopted the MS–DRG patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. (Currently, there are 746 DRGs for FY 2010; there would be 747 DRGs in FY 2011, with our proposals in this proposed rule to delete one MS–DRG and to create two new MS–DRGs.) By increasing the number of MS–DRGs and more fully taking into account patients' severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs encourage hospitals to improve their documentation and coding of patient diagnoses. In the FY 2008 IPPS final rule with comment period (72 FR 47175 through 47186), we indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule with comment period, we exercised our authority under section 1886(d)(3)(A)(vi) of the Act, which authorizes us to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. Our actuaries estimated that maintaining budget neutrality required an adjustment of −4.8 percent to the national standardized amount. We provided for phasing in this −4.8 percent adjustment over 3 years. Specifically, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010.

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007, Public Law 110–90. Section 7(a) of Public Law 110–90 reduced the documentation and coding adjustment made as a result of the MS–DRG system that we adopted in the FY 2008 IPPS final rule with comment period to −0.6 percent for FY 2008 and −0.9 percent for FY 2009. Section 7(a) of Public Law 110–90 did not adjust the FY 2010 −1.8 percent documentation and coding adjustment promulgated in the FY 2008 IPPS final rule with comment period. To comply with section 7(a) of Public Law 110–90, we promulgated a final rule on November 27, 2007 (72 FR 66886) that modified the IPPS documentation and coding adjustment for FY 2008 to −0.6 percent, and revised the FY 2008 payment rates, factors, and thresholds accordingly. These revisions were effective on October 1, 2007.

For FY 2009, section 7(a) of Public Law 110–90 required a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment established in the FY 2008 IPPS final rule with comment period. As discussed in the FY 2009 IPPS final rule (73 FR 48447) and required by statute, we applied a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amount. The documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period, as amended by Public Law 110–90, are cumulative. As a result, the −0.9 percent documentation and coding adjustment for FY 2009 was in addition to the −0.6 percent adjustment for FY 2008, yielding a combined effect of −1.5 percent.

2. Prospective Adjustment to the Average Standardized Amounts Required by Section 7(b)(1)(A) of Public Law 110–90

Section 7(b)(1)(A) of Public Law 110–90 requires that, if the Secretary determines that implementation of the

MS–DRG system resulted in changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 or FY 2009 that are different than the prospective documentation and coding adjustments applied under section 7(a) of Public Law 110–90, the Secretary shall make an appropriate adjustment under section 1886(d)(3)(A)(vi) of the Act. Section 1886(d)(3)(A)(vi) of the Act authorizes adjustments to the average standardized amounts for subsequent fiscal years in order to eliminate the effect of such coding or classification changes. These adjustments are intended to ensure that future annual aggregate IPPS payments are the same as the payments that otherwise would have been made had the prospective adjustments for documentation and coding applied in FY 2008 and FY 2009 reflected the change that occurred in those years.

3. Recoupment or Repayment Adjustments in FYs 2010 Through 2012 Required by Public Law 110–90

If, based on a retroactive evaluation of claims data, the Secretary determines that implementation of the MS–DRG system resulted in changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 or FY 2009 that are different from the prospective documentation and coding adjustments applied under section 7(a) of Public Law 110–90, section 7(b)(1)(B) of Public Law 110–90 requires the Secretary to make an additional adjustment to the standardized amounts under section 1886(d) of the Act. This adjustment must offset the estimated increase or decrease in aggregate payments for FYs 2008 and 2009 (including interest) resulting from the difference between the estimated actual documentation and coding effect and the documentation and coding adjustment applied under section 7(a) of Public Law 110–90. This adjustment is in addition to making an appropriate adjustment to the standardized amounts under section 1886(d)(3)(A)(vi) of the Act as required by section 7(b)(1)(A) of Public Law 110–90. That is, these adjustments are intended to recoup (or repay) spending in excess of (or less than) spending that would have occurred had the prospective adjustments for changes in documentation and coding applied in FY 2008 and FY 2009 precisely matched the changes that occurred in those years. Public Law 110–90 requires that the Secretary make these recoupment or repayment adjustments for discharges occurring during FYs 2010, 2011, and 2012.

4. Retrospective Evaluation of FY 2008 Claims Data

In order to implement the requirements of section 7 of Public Law 110–90, we indicated in the FY 2009 IPPS final rule (73 FR 48450) that we planned a thorough retrospective evaluation of our claims data. We stated that the results of this evaluation would be used by our actuaries to determine any necessary payment adjustments to the standardized amounts under section 1886(d) of the Act to ensure the budget neutrality of the MS–DRGs implementation for FY 2008 and FY 2009, as required by law. In the FY 2009 IPPS proposed rule (73 FR 23541 through 23542), we described our preliminary plan for a retrospective analysis of inpatient hospital claims data and invited public input on our proposed methodology.

In that proposed rule, we indicated that we intended to measure and corroborate the extent of the overall national average changes in case-mix for FY 2008 and FY 2009. We expected that the two largest parts of this overall national average change would be attributable to underlying changes in actual patient severity of illness and to documentation and coding improvements under the MS–DRG system. In order to separate the two effects, we planned to isolate the effect of shifts in cases among base DRGs from the effect of shifts in the types of cases within-base DRGs.

The MS–DRGs divide the base DRGs into three severity levels (with MCC, with CC and without CC); the previously used CMS DRGs had only two severity levels (with CC and without CC). Under the CMS DRG system, the majority of hospital discharges had a secondary diagnosis which was on the CC list, which led to the higher severity level. The MS–DRGs significantly changed the code lists of what was classified as an MCC or a CC. Many codes that were previously classified as a CC are no longer included on the MS–DRG CC list because the data and clinical review showed these conditions did not lead to a significant increase in resource use. The addition of a new level of high severity conditions, the MCC list, also provided a new incentive to code more precisely in order to increase the severity level. We anticipated that hospitals would examine the MS–DRG MCC and CC code lists and then work with physicians and coders on documentation and coding practices so that coders could appropriately assign codes from the highest possible severity level. We note that there have been numerous seminars and training sessions on this particular coding issue. The topic of improving documentation practices in order to code conditions on the MCC list was also discussed extensively by participants at the March 11–12, 2009 ICD–9–CM Coordination and Maintenance Committee meeting. Participants discussed their hospitals' efforts to encourage physicians to provide more precise documentation so that coders could appropriately assign codes that would lead to a higher severity level. Because we expected most of the documentation and coding changes under the MS–DRG system would occur in the secondary diagnoses, we believed that the shifts among base DRGs were less likely to be the result of the MS–DRG system and the shifts within-base DRGs were more likely to be the result of the MS–DRG system. We also anticipated evaluating data to identify the specific MS–DRGs and diagnoses that contributed significantly to the documentation and coding payment effect and to quantify their impact. This step entailed analysis of the secondary diagnoses driving the shifts in severity within specific base DRGs.

In that same proposed rule, we also stated that, while we believed that the data analysis plan described previously would produce an appropriate estimate of the extent of case-mix changes resulting from documentation and coding changes, we might decide, if feasible, to use historical data from our Hospital Payment Monitoring Program (HPMP) to corroborate the within-base DRG shift analysis. The HPMP is supported by the Medicare Clinical Data Abstraction Center (CDAC).

In the FY 2009 IPPS proposed rule, we solicited public comments on the analysis plans described above, as well as suggestions on other possible approaches for performing a retrospective analysis to identify the amount of case-mix changes that occurred in FY 2008 and FY 2009 that did not reflect real increases in patients' severity of illness.

A few commenters, including MedPAC, expressed support for the analytic approach described in the FY 2009 IPPS proposed rule. A number of other commenters expressed concerns about certain aspects of the approach and/or suggested alternate analyses or study designs. In addition, one commenter recommended that any determination or retrospective evaluation by the actuaries of the impact of the MS–DRGs on case-mix be open to public scrutiny prior to the

implementation of the payment adjustments beginning in FY 2010.

We took these comments into consideration as we developed our proposed analysis plan and in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24092 through 24101) solicited public comment on our methodology and analysis. For the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we performed a retrospective evaluation of the FY 2008 data for claims paid through December 2008. Based on this evaluation, our actuaries determined that implementation of the MS–DRG system resulted in a 2.5 percent change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008

In the analysis of data for that proposed rule, we found that the within-base DRG increases were almost entirely responsible for the case-mix change, supporting our conclusion that the 2.5 percent estimate was an accurate reflection of the FY 2008 effect of changes in documentation and coding under the MS–DRG system. In fact, almost every base DRG that was split into different severity levels under the MS–DRG system experienced increases in the within-base DRGs. We then further analyzed the changes in the within-base DRGs to determine which MS–DRGs had the highest contributions to this increase. The results of the analysis for the proposed rule provided additional support for our conclusion that the proposed 2.5 percent estimate accurately reflected the FY 2008 increases in documentation and coding under the MS–DRG system. While we attempted to use the CDAC data to distinguish real increase in case-mix growth from documentation and coding in the overall case-mix number, we found aberrant data and significant variation across the FY 1999 through FY 2007 analysis period. It was not possible to distinguish changes in documentation and coding from changes in real case-mix in the CDAC data. Therefore, we concluded that the CDAC data would not support analysis of real case-mix growth that could be used in our retrospective evaluation of the FY 2008 claims data.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43768 through 43772), we responded to comments on our methodology for the retrospective evaluation of FY 2008 claims data. Commenters raised concerns that CMS' estimate in the proposed rule did not fully consider other potential causes of increased case-mix, such as patients requiring less complex services receiving care in other settings and "healthier" patients enrolling in Medicare Advantage plans in increasing numbers. Other commenters indicated that factors such as the changes in the CC/MCC definitions, limitations on the number of codes used by CMS for payment and ratesetting, resequencing of secondary diagnoses, the transition to the cost-based weights, less use of "not otherwise specified" codes, and increases in real case-mix due to health reform efforts also resulted in an inaccurate documentation and coding analysis. One commenter indicated that, of the overall case-mix increase, 1.0 percent to 1.5 percent is "real" case-mix increase, while 1.0 percent to 1.5 percent is due to documentation and coding or other increases.

In considering these comments concerning historical real case-mix, in the FY 2010 final rule, we calculated overall increases in case-mix for the period from FY 2000 to FY 2007 using the cases from each year and the GROUPER and relative weights applicable for each year. The results are shown in the following chart:

OVERALL CASE-MIX INCREASES FOR FY 2000 TO FY 2007

Year	Overall case-mix change from prior year (in percent)
FY 2000	−0.7
FY 2001	−0.4
FY 2002	1.0
FY 2003	1.4
FY 2004	1.0
FY 2005	0.9
FY 2006	1.2
FY 2007	−0.2

Overall case-mix growth is predominately comprised of three factors: Real case-mix growth; a documentation and coding effect; and a measurement effect. Under the reasonable assumption that there has been a relatively small measurement effect in those years, the assertion that there is a historical pattern of steady annual increases of 1.2 to 1.3 percent in real case-mix implies that the documentation and coding effect in many of those years was negative. For example, as discussed in that rule (74 FR 43769), we estimated a recent measurement effect of +0.3 percent. The overall case-mix growth of −0.2 percent in FY 2007 net of a measurement effect of +0.3 percent results in growth of +0.1 percent. A real case-mix growth of +1.2 percent in FY 2007, therefore, implies a negative documentation and coding effect of approximately −1.1 percent. It is not obvious why documentation and coding would have had such a large negative effect in FY 2007, or in any other year where the overall case-mix change is significantly less than the commenter's claimed average annual trend, calling into question the assertion that real case-mix growth is a steady 1.2 to 1.3 percent per year.

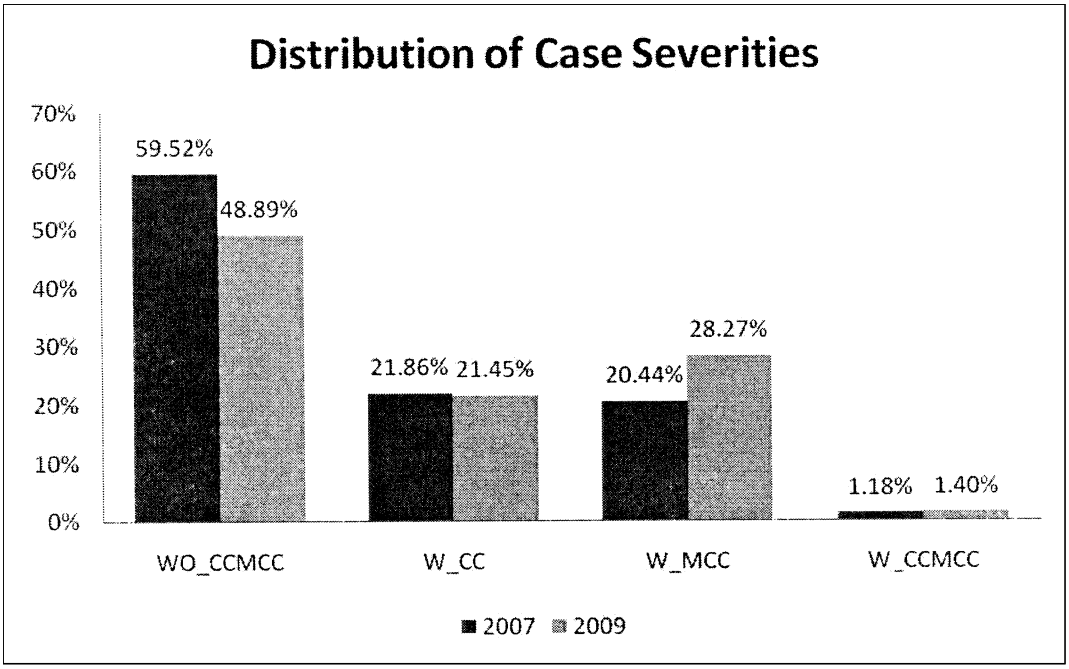
In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43770 through 43771), we indicated that our estimate of the overall case-mix growth for FY 2008 based on more recent data than the data used in the FY 2010 proposed rule was 2.0 percent, still less than our actuaries' estimate of a 2.5 percent documentation and coding increase. With respect to the concerns raised by commenters about our finding of negative real case-mix growth in FY 2008, a finding of negative real case-mix growth is consistent with the fact that, in some years, overall case-mix growth has been negative, as shown in the chart presented above in this response.

5. Retrospective Analysis of FY 2009 Claims Data

We performed the same analysis for FY 2009 claims data using the same methodology as we did for FY 2008 claims in the FY 2010 final rule. We first divided the case-mix index (CMI) obtained by grouping the FY 2009 claims data through the FY 2009 GROUPER (Version 26.0) by the CMI obtained by grouping these same FY 2009 claims through the FY 2007 GROUPER (Version 24.0). This resulted in a value of 1.056. Because these cases are the same FY 2009 cases grouped using the Versions 24.0 and 26.0 of the GROUPER, we attribute this increase primarily to two factors: (1) The effect of changes in documentation and coding under the MS–DRG system; and (2) the measurement effect from the calibration of the GROUPER. We estimated the measurement effect from the calibration of the GROUPER by dividing the CMI obtained by grouping cases in the FY 2007 claims data through the FY 2009 GROUPER by the CMI obtained by grouping cases in these same claims through the FY 2007 GROUPER. This resulted in a value of 1.0019. In order to isolate the documentation and coding effect, we then divided the combined effect of the changes in documentation and coding and measurement (1.056) by the measurement effect (1.0019) to yield 1.054. Therefore, our estimate of the documentation and coding increase that did not reflect real changes in case-mix for discharges was 5.4 percent.

We then sought to corroborate this 5.4 percent estimate by examining the increases in the within-base DRGs as compared to the increases in the across

base DRGs as described earlier in our analysis plan. In other words, we looked for improvements in code selection that would lead to a secondary diagnosis increasing the severity level to either a CC or an MCC level. We found that the within-base DRG increases were almost entirely responsible for the case mix change, supporting our conclusion that the 5.4 percent estimate was an accurate reflection of the FY 2009 effect of changes in documentation and coding under the MS–DRG system. We then further analyzed the changes in the within-base DRGs to determine which MS–DRGs had the highest contributions to this increase. The results of the analysis for the proposed rule provided additional support for our conclusion that the proposed 5.4 percent estimate accurately reflected the FY 2009 increases in documentation and coding under the MS–DRG system.



As reflected in the above chart, for short-term acute care hospitals, SCHs, and MDHs, there is an 8 percentage point increase in the discharge severity with MCCs from 20 percent to 28 percent, and a corresponding decrease of 8 percentage points in discharge severity without CC/MCC from 57 percent to 49 percent.

Consistent with the expectations of our medical coding experts concerning areas with potential for documentation and coding improvements, the top contributors were heart failure, chronic obstructive pulmonary disease, and simple pneumonia and pleurisy. Heart failure is a very common secondary diagnosis among Medicare hospital admissions. The heart failure codes are assigned to all three severity levels. Some codes are classified as non-CCs, while other codes are on the CC and MCC lists. By changing physician documentation to more precisely identify the type of heart failure, coders are able to appropriately change the severity level of cases from the lowest level (non-CC) to a higher severity level (CC or MCC). This point was stressed repeatedly at the March 11–12, 2009 ICD–9–CM Coordination and Maintenance Committee meeting as coders discussed their work with physicians on this coding issue. Many of the participants indicated that additional work was still needed with their physicians in order to document conditions in the medical record more precisely.

The results of the analysis for the proposed rule provided additional support for our conclusion that the proposed 5.4 percent estimate accurately reflected the FY 2009 increases in documentation and coding under the MS–DRG system.

As in prior years, the FY 2008 and FY 2009 MedPAR files are available to the public to allow independent analysis of the FY 2008 and FY 2009 documentation and coding effect. Interested individuals may still order these files through the Web site at: *http://www.cms.hhs.gov/LimitedDataSets/* by clicking on MedPAR Limited Data Set (LDS)-Hospital (National). This Web page describes the file and provides directions and further detailed instructions for how to order.

Persons placing an order must send the following: a Letter of Request, the LDS Data Use Agreement and Research Protocol (refer to the Web site for further instructions), the LDS Form, and a check for $3,655 to:

Mailing address if using the U.S. Postal Service: Centers for Medicare & Medicaid Services, RDDC Account, Accounting Division, P.O. Box 7520, Baltimore, MD 21207–0520.

Mailing address if using express mail: Centers for Medicare & Medicaid Services, OFM/Division of Accounting—RDDC, 7500 Security Boulevard, C3–07–11, Baltimore, MD 21244–1850.

6. Prospective Adjustment for FY 2010 and Subsequent Years Authorized by Section 7(b)(1)(A) of Public Law 110–90 and Section 1886(d)(3)(vi) of the Act

Based on our evaluation of FY 2008 Medicare claims data that were most current at the time of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, the estimated 2.5 percent change in FY 2008 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 exceeded the −0.6 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 by 1.9 percentage points. Under section 7(b)(1)(A) of Public Law 119–90,

the Secretary is required to make an appropriate adjustment under section 1886(d)(3)(A)(vi) of the Act to the average standardized amounts for subsequent fiscal years in order to eliminate the full effect of the documentation and coding changes on future payments. As we have consistently stated since the initial implementation of the MS–DRG system, we do not believe it is appropriate for expenditures to increase due to MS–DRG-related changes in documentation and coding that do not reflect real changes in case-mix.

We also estimated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule that the additional change in case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2009 was 2.3 percent, which would exceed by 1.4 percentage points the −0.9 percent prospective documentation and coding adjustment for FY 2009 applied under section 7(a) of Public Law 100–90. We had the statutory authority to adjust the FY 2010 rates for this estimated 1.4 percentage point increase. However, given that Public Law 100–90 requires a retrospective claims evaluation for the additional adjustments (as described in section II.D.3. of this preamble), we stated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule and final rule (74 FR 24096 and 43772, respectively) that we believed our evaluation of the extent of the overall national average changes in case-mix for FY 2009 should also be based on a retrospective evaluation of all FY 2009 claims data. Because we did not receive all FY 2009 claims data prior to publication of the FY 2010 final rule, we indicated we would address any difference between the additional increase in FY 2009 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 in the FY 2011 rulemaking cycle.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24096), we solicited public comment on the proposed −1.9 percent prospective adjustment to the standardized amounts under section 1886(d) of the Act to address the effects of documentation and coding changes unrelated to changes in real case-mix in FY 2008. In addition, we solicited public comments on addressing in the FY 2011 rulemaking cycle any differences between the increase in FY 2009 case-mix due to changes in documentation and coding changes that do not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90. In response to the proposed rule, MedPAC summarized its comments on when CMS should reduce payment rates to prevent further overpayments and to recover overpayments occurring in 2008 and 2009 as follows: "We support CMS's proposal to reduce IPPS payments in 2010 by 1.9 percent to prevent further overpayments. While we and the CMS actuaries believe that a 1.9 percent reduction will not fully prevent overpayments from continuing in 2010, this is a reasonable first step toward reducing overpayments." Most of the other commenters opposed the proposed −1.9 percent prospective FY 2010 adjustment for FY 2008 documentation and coding increases, but supported the proposal not to apply a FY 2010 prospective adjustment for estimated FY 2009 documentation and coding increases. Many commenters expressed concern over the financial impact of the proposed −1.9 percent adjustment and the methodology for calculating the adjustment. Other commenters recommended that CMS seek to extend the timeframe beyond 2 years to phase in the estimated −6.6 percent adjustment to the standardized amount.

In the final FY 2010 IPPS/RY 2010 LTCH PPS rule in response to these commenters, we indicated that we fully understood that our proposed adjustment of −1.9 percent would reduce the increase in payments that affected hospitals would have received in FY 2009 in the absence of the adjustment. We explained that, although we are required to make an prospective adjustment to eliminate the full effect of coding or classification changes that did not reflect real changes in case-mix for discharges occurring during FY 2008, we believed we had some discretion regarding when to implement this adjustment. Section 7(b)(1)(A) of Public Law 110–90 requires that if the Secretary determines that implementation of the MS–DRG system resulted in changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 or FY 2009 that are different than the prospective documentation and coding adjustments applied under section 7(a) of Public Law 110–90, the Secretary shall make an "appropriate" adjustment under section 1886(d)(3)(A)(vi) of the Act.

Thus, we determined that it would be appropriate to postpone adopting documentation and coding adjustments as authorized under section 7(a) of Public Law 110–90 and section 1886(d)(3)(A)(vi) of the Act until a full analysis of case-mix changes could be completed. We indicated that while we had the statutory authority to make this −1.9 percent prospective adjustment entirely in FY 2010, we believed it would be prudent to wait until we had completed data on the magnitude of the documentation and coding effect in FY 2009. Specifically, we stated that if the documentation and coding effect were to be less in FY 2009 than our then-current estimates, it could lessen the anticipated adjustment that we had estimated we would have had to make for FY 2008 and FY 2009 combined. We indicated that, in future rulemaking, we would consider applying a prospective adjustment based upon a complete analysis of FY 2008 and FY 2009 claims data, beginning in FY 2011. We indicated that we intended to address any difference between the increase in FY 2009 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 in the FY 2011 rulemaking cycle.

After analysis of the FY 2009 claims data, we have found a total prospective documentation and coding effect of 1.054. After accounting for the −0.6 percent and the −0.9 percent documentation and coding adjustments in FYs 2008 and 2009, we find a remaining documentation and coding effect of 3.9 percent. As we have discussed, an additional cumulative adjustment of −3.9 percent would be necessary to meet the requirements of section 7(b)(1)(A) of Public Law 110–90 to make an adjustment to the average standardized amounts in order to eliminate the full effect of the documentation and coding changes on future payments. Unlike section 7(b)(1)(B) of Public Law 110–90, section 7(b)(1)(A) does not specify when we must apply the prospective adjustment, but merely requires us to make an "appropriate" adjustment. Therefore, we believe we have some discretion as to the manner in which we apply the prospective adjustment of −3.9 percent. Applying the full prospective adjustment of −3.9 percent for FY 2011, in combination with the proposed recoupment adjustment of −2.9 percent, discussed below, would require an aggregate adjustment of −6.8 percent. As we discuss more fully

below, it has been our practice to moderate payment adjustments when necessary to mitigate the effects of significant downward adjustments on hospitals, to avoid what could be widespread, disruptive effects of such adjustments on hospitals. As we also discuss below, we are required to implement the adjustment in section 7(b)(1)(B) of Public Law 110–90 no later than FY 2012, and accordingly, we are proposing an adjustment under that section for FY 2011. Therefore, we believe it is appropriate to not implement any or all of the −3.9 percent prospective adjustment in FY 2011. Accordingly, we are not proposing a prospective adjustment under section 7(b)(1)(A) of Public Law 110–90 for FY 2011. We note that, as a result, payments in FY 2011 (and in each future year until we implement the requisite adjustment) will be 3.9 percent higher than they would have been if we had implemented an adjustment under section 7(b)(1)(A) of Public Law 110–90.

We are seeking public comment on our proposal not to apply in FY 2011 the −3.9 percent prospective adjustment to the average standardized amounts required under section 7(b)(1)(A) of Public Law 110–90 in order to eliminate the full effect of the documentation and coding changes on future payments. We note that this proposal would require us to apply the −3.9 percent adjustment in future payment years, which may be applied all at once in a single year or phased in over more than one year. We intend to update our analysis with FY 2009 data on claims paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

7. Recoupment or Repayment Adjustment for FY 2010 Authorized by Section 7(b)(1)(B) of Public Law 110–90

As indicated in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43773), we estimated a 2.5 percent change (estimated from analysis of more recent data for the FY 2010 final rule than the data used for that proposed rule) due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008, exceeding the −0.6 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 by 1.9 percentage points. We stated that our actuaries had estimated that this 1.9 percentage point increase resulted in an increase in aggregate payments of approximately $2.2 billion. As described earlier, section 7(b)(1)(B) of Public Law 110–90 requires an adjustment for discharges occurring in FYs 2010, 2011, and/or 2012 to offset the estimated amount of this increase in aggregate payments (including interest). Although section 7(b)(1)(B) of Public Law 110–90 requires us to make this adjustment in FYs 2010, 2011, and/or 2012, we have discretion as to when during this 3 year period we will apply the adjustment.

We did not propose to make an adjustment to the FY 2010 average standardized amounts to offset, in whole or in part, the estimated increase in aggregate payments for discharges occurring in FY 2008, but stated in the proposed rule that we intended to address this issue in future rulemaking. That is, we stated that we would address recouping the additional expenditures that occurred in FY 2008 as a result of the 1.9 percentage point difference between the actual changes in documentation and coding that do not reflect real changes in case-mix (2.5 percent), and the −0.6 percent adjustment applied under Public Law 110–90 in FY 2011 and/or FY 2012, as required by law. We indicated that, while we had the statutory authority to make this −1.9 percent recoupment adjustment entirely in FY 2010, we were delaying the adjustment until FY 2011 and FY 2012 because we did not yet have any data on the magnitude of the documentation and coding effect in FY 2009. We stated that as we have the authority to recoup the aggregate effect of this 1.9 percentage point difference in FY 2008 IPPS payments in FY 2011 or FY 2012 (with interest), delaying this adjustment would have no effect on Federal budget outlays. We indicated that we intended to wait until we have a complete year of data on the FY 2009 documentation and coding effect before applying a recoupment adjustment for IPPS spending that occurred in FY 2008 or we estimate will occur in FY 2009.

As discussed above, section 7(b)(1)(B) of Public Law 110–90 requires the Secretary to make an adjustment to the standardized amounts under section 1886(d) of the Act to offset the estimated increase or decrease in aggregate payments for FY 2009 (including interest) resulting from the difference between the estimated actual documentation and coding effect and the documentation and coding adjustments applied under section 7(a) of Public Law 110–90. This determination must be based on a retrospective evaluation of claims data. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43774), we stated that because we would not receive all FY 2009 claims data prior to publication of the final rule, we would address any increase or decrease in FY 2009 payments in future rulemaking for FY 2011 and 2012 after we perform a retrospective evaluation of the FY 2009 claims data. At that time, our actuaries estimated that this adjustment would be approximately −3.3 percent. This reflected the difference between the estimated 4.8 percent cumulative actual documentation and coding changes for FY 2009 (2.5 percent for FY 2008 and an additional 2.3 percent for FY 2009) and the cumulative −1.5 percent documentation and coding adjustments applied under section 7(a) of Public Law 110–90 (−0.6 percent in FY 2008 and −0.9 percent in FY 2009). We noted that the actual adjustments were multiplicative and not additive. This estimated 4.8 percent cumulative actual documentation and coding changes for FY 2009 included the impact of the changes in documentation and coding first occurring in FY 2008 because we believed hospitals would continue these changes in documentation and coding in subsequent fiscal years. Consequently, we believed that these documentation and coding changes would continue to impact payments under the IPPS absent a prospective adjustment to account for the effect of these changes.

We note that, unlike the adjustment to the standardized amounts under section 7(b)(1)(A) of Public Law 110–90 described earlier, any adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90 would not be cumulative, but would be removed for subsequent fiscal years once we have offset the increase in aggregate payments for discharges for FY 2008 expenditures and FY 2009 expenditures, if any.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24096), we did not propose to offset the 1.9 percent increase in aggregate payments (including interest) for discharges occurring in FY 2008 resulting from the adoption of the MS–DRGs, but to instead address this issue in future rulemaking for FYs 2011 and 2012.

In response to the FY 2010 proposed rule, MedPAC stated in its comments on the adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90: "In addition, it would be desirable for CMS to minimize year-to-year changes in payment adjustments it must make to recover overpayments that were made in 2008 and 2009. To achieve this goal, CMS should consider spreading the recovery of 2008 overpayments over 3 years, beginning in 2010." Some commenters recommended that CMS seek to extend the timeframe beyond 2 years to phase in the estimated −6.6 percent adjustment to the standardized amount. The commenters asked CMS to seek

necessary legislative action to accommodate such a policy. Most commenters expressed concern with the significant negative financial impacts that would be incurred by providers if CMS adopted that proposed −1.9 percent documentation and coding adjustment in FY 2010. The commenters cited providers' already small or negative margins for Medicare payments, and requested that CMS not further reduce payments during the current period of economic instability and reduced State funding. Other commenters indicated that it would be appropriate to delay any adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90 until after CMS has the opportunity to fully examine the FY 2009 claims data.

In response to these comments in FY 2010, we indicated that we recognized that any adjustment to account for the documentation and coding effect observed in the FY 2008 and FY 2009 claims data may result in significant future payment reductions for providers. However, we indicated that we are required under section 7(b)(1)(B) of Public Law 110–90 to recapture the difference of actual documentation and coding effect in FY 2008 and FY 2009 that is greater than the prior adjustments. We agreed with the commenters who requested that CMS delay any adjustment and, for the reasons stated above, indicated that we expect to address this issue in this FY 2011 rulemaking.

As indicated in section II.D.4. of this preamble, the change due to documentation and coding that did not reflect real changes in case mix for discharges occurring during FY 2008 and FY 2009 exceeded the −0.6 and −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 for those 2 years respectively by 1.9 percentage points in FY 2008 and 3.9 percentage points in FY 2009. In total, this change exceeded the cumulative prospective adjustments by 5.8 percentage points. Our actuaries currently estimate that this 5.8 percentage point increase resulted in an increase in aggregate payments of approximately $6.9 billion. We note that there may be a need to actuarially adjust the recoupment adjustment to accurately reflect accumulated interest. Therefore, an aggregate adjustment of −5.8 percent in FYs 2011 and 2012, subject to actuarial adjustment to reflect accumulated interest, is necessary in order to meet the requirements of section 7(b)(1)(B) of Public Law 110–90 to adjust the standardized amounts for discharges occurring in FYs 2010, 2011, and/or 2012 to offset the estimated amount of the increase in aggregate payments (including interest) in FYs 2008 and 2009. We intend to take into account the need to reflect accumulated interest in proposing a recoupment adjustment under section (b)(1)(B) of Public Law 110–90 for FY 2012. We will invite comments on our proposal at that time.

It is often our practice to phase in rate adjustments over more than one year in order to moderate the effect on rates in any one year. Therefore, consistent with the policies we have adopted in many similar cases, we are proposing to make an adjustment to the standardized amount of −2.9 percent, representing approximately half of the aggregate adjustment required under section 7(b)(1)(B) of Public Law 110–90, for FY 2011. An adjustment of this magnitude allows us to moderate the effects on hospitals in one year while simultaneously making it possible to implement the entire adjustment within the timeframe required under section 7(b)(1)(B) of Public Law 110–90. As we have previously noted, unlike the prospective adjustment to the standardized amounts under section 7(b)(1)(A) of Public Law 110–90 described earlier, the recoupment or repayment adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90 is not cumulative, but would be removed for subsequent fiscal years once we have offset the increase in aggregate payments for discharges for FY 2008 expenditures and FY 2009 expenditures. In keeping with our practice of moderating payment adjustments wherever possible, we can anticipate that this proposal will have an additional, and significant, moderating effect on implementing the requirements of section 7(b)(1)(B) of Public Law 110–90 for FY 2012. Specifically, an advantage of our proposal for FY 2011 is that we anticipate removing this proposed FY 2011 −2.9 percent adjustment from the rates in FY 2012, when it would also be necessary under current law to apply the remaining approximately −2.9 percent adjustment required by section 7(b)(1)(B) of Public Law 110–90. These two steps in FY 2012, restoring the FY 2011 −2.9 percent adjustment, and applying the remaining adjustment of approximately −2.9 percent, would effectively cancel each other out. The result would be an aggregate adjustment of approximately 0.0 percent (subject to the need to account for accumulated interest, as discussed above) under section 7(b)(1)(B) of Public Law 110–90 in FY 2012. However, while we are noting this anticipated effect of our FY 2011 proposal, we are not making a formal proposal for the further implementation of section 7(b)(1)(B) of Public Law 110–90 in FY 2012 in this proposed rule.

We are seeking public comment on our proposal to offset part of the total 5.8 percent increase in aggregate payments (including interest) for discharges occurring in FY 2008 and FY 2009 resulting from the adoption of the MS–DRGs in FY 2011, noting that this proposal would result in a −2.9 percent adjustment to the standardized amount. We intend to update our analysis with FY 2009 data on claims paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

FY 2011 MS–DRG Documentation and Coding Adjustment

	Required prospective adjustment for FYs 2008–2009	Required recoupment adjustment for FYs 2008–2009	Total adjustment	Proposed recoupment adjustment for FY 2011	Remaining adjustment
FY 2011 Proposal Amount of Adjustment	−3.9	−5.8	−9.7	−2.9	−6.8

8. Background on the Application of the Documentation and Coding Adjustment to the Hospital-Specific Rates

Under section 1886(d)(5)(D)(i) of the Act, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge. Under

section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate based on the greatest of the FY 1982, FY 1987, or FY 2002 costs per discharge. In the FY 2008 IPPS final rule with comment period (72 FR 47152 through 47188), we established a policy of applying the documentation and coding adjustment to the hospital-specific rates. In that final rule with comment period, we indicated that because SCHs and MDHs use the same DRG system as all other hospitals, we believe they should be equally subject to the budget neutrality adjustment that we are applying for adoption of the MS–DRGs to all other hospitals. In establishing this policy, we relied on section 1886(d)(3)(A)(vi) of the Act, which provides us with the authority to adjust "the standardized amount" to eliminate the effect of changes in coding or classification that do not reflect real change in case-mix.

However, in the final rule that appeared in the **Federal Register** on November 27, 2007 (72 FR 66886), we rescinded the application of the documentation and coding adjustment to the hospital-specific rates retroactive to October 1, 2007. In that final rule, we indicated that, while we still believe it would be appropriate to apply the documentation and coding adjustment to the hospital-specific rates, upon further review, we decided that the application of the documentation and coding adjustment to the hospital-specific rates is not consistent with the plain meaning of section 1886(d)(3)(A)(vi) of the Act, which only mentions adjusting "the standardized amount" under section 1886(d) of the Act and does not mention adjusting the hospital-specific rates.

In the FY 2009 IPPS proposed rule (73 FR 23540), we indicated that we continued to have concerns about this issue. Because hospitals paid based on the hospital-specific rate use the same MS–DRG system as other hospitals, we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. In section 1886(d)(3)(A)(vi) of the Act, Congress stipulated that hospitals paid based on the standardized amount should not receive additional payments based on the effect of documentation and coding changes that do not reflect real changes in case-mix. Similarly, we believe that hospitals paid based on the hospital-specific rates should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. While we continue to believe that section 1886(d)(3)(A)(vi) of the Act does not provide explicit authority for application of the documentation and coding adjustment to the hospital-specific rates, we believe that we have the authority to apply the documentation and coding adjustment to the hospital-specific rates using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. The special exceptions and adjustment provision authorizes us to provide "for such other exceptions and adjustments to [IPPS] payment amounts * * * as the Secretary deems appropriate." In the FY 2009 IPPS final rule (73 FR 48448 through 48449), we indicated that, for the FY 2010 rulemaking, we planned to examine our FY 2008 claims data for hospitals paid based on the hospital-specific rate. We further indicated that if we found evidence of significant increases in case-mix for patients treated in these hospitals that do not reflect real changes in case-mix, we would consider proposing application of the documentation and coding adjustments to the FY 2010 hospital-specific rates under our authority in section 1886(d)(5)(I)(i) of the Act.

In response to public comments received on the FY 2009 IPPS proposed rule, we stated in the FY 2009 IPPS final rule that we would consider whether such a proposal is warranted for FY 2010. To gather information to evaluate these considerations, we indicated that we planned to perform analyses on FY 2008 claims data to examine whether there has been a significant increase in case-mix for hospitals paid based on the hospital-specific rate. If we found that application of the documentation and coding adjustment to the hospital-specific rates for FY 2010 is warranted, we indicated that we would include a proposal to do so in the FY 2010 IPPS proposed rule.

9. Proposed Documentation and Coding Adjustment to the Hospital-Specific Rates for FY 2011 and Subsequent Fiscal Years

In the FY 2010 IPPS/RY 2010 LTCH proposed rule and final rule (74 FR 24098 through 24100 and 74 FR 43775 through 43776, respectively), we discussed our performance of a retrospective evaluation of the FY 2008 claims data for SCHs and MDHs using the same methodology described earlier for other IPPS hospitals. We found that, independently for both SCHs and MDHs, the change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 slightly exceeded the proposed 2.5 percent result discussed earlier, but did not significantly differ from that result.

Again, for the FY 2010 proposed rule, we found that the within-base DRG increases were almost entirely responsible for the case-mix change. In that proposed rule, we presented two Figures to display our results.

Therefore, consistent with our statements in prior IPPS rules, we proposed to use our authority under section 1886(d)(5)(I)(i) of the Act to prospectively adjust the hospital-specific rates by the proposed −2.5 percent in FY 2010 to account for our estimated documentation and coding effect in FY 2008 that does not reflect real changes in case-mix. We proposed to leave this adjustment in place for subsequent fiscal years in order to ensure that changes in documentation and coding resulting from the adoption of the MS–DRGs do not lead to an increase in aggregate payments for SCHs and MDHs not reflective of an increase in real case-mix. The proposed −2.5 percent adjustment to the hospital-specific rates exceeded the −1.9 percent adjustment to the national standardized amount under section 7(b)(1)(A) of Public Law 110–90 because, unlike the national standardized rates, the FY 2008 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24100), we solicited public comment on the proposed −2.5 percent prospective adjustment to the hospital-specific rates under section 1886(d)(5)(I)(i) of the Act and our proposal to address in the FY 2011 rulemaking cycle any changes in FY 2009 case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2009. We also indicated that we intended to update our analysis with FY 2008 data on claims paid through March 2008 [sic] for the FY 2010 IPPS final rule. (We note that the March 2008 update claims paid data date in the proposed rule should have been March 2009.)

Consistent with our approach for IPPS hospitals discussed earlier, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we also delayed adoption of a documentation and coding adjustment to the hospital-specific rate until FY 2011. Similar to our approach for IPPS

hospitals, we indicated that we would consider, through future rulemaking, phasing in the documentation and coding adjustment over an appropriate period. We also indicated that we would address, through future rulemaking, any changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2009. We noted that, unlike the national standardized rates, the FY 2009 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs. However, as we noted earlier with regard to IPPS hospitals, if the estimated documentation and coding effect determined based on a full analysis of FY 2009 claims data is more or less than our current estimates, it would change, possibly lessen, the anticipated cumulative adjustments that we currently estimate we would have to make for the FY 2008 and FY 2009 combined adjustment. Therefore, we believed that it would be more prudent to delay implementation of the documentation and coding adjustment to allow for a more complete analysis of FY 2009 claims data for hospitals receiving hospital-specific rates.

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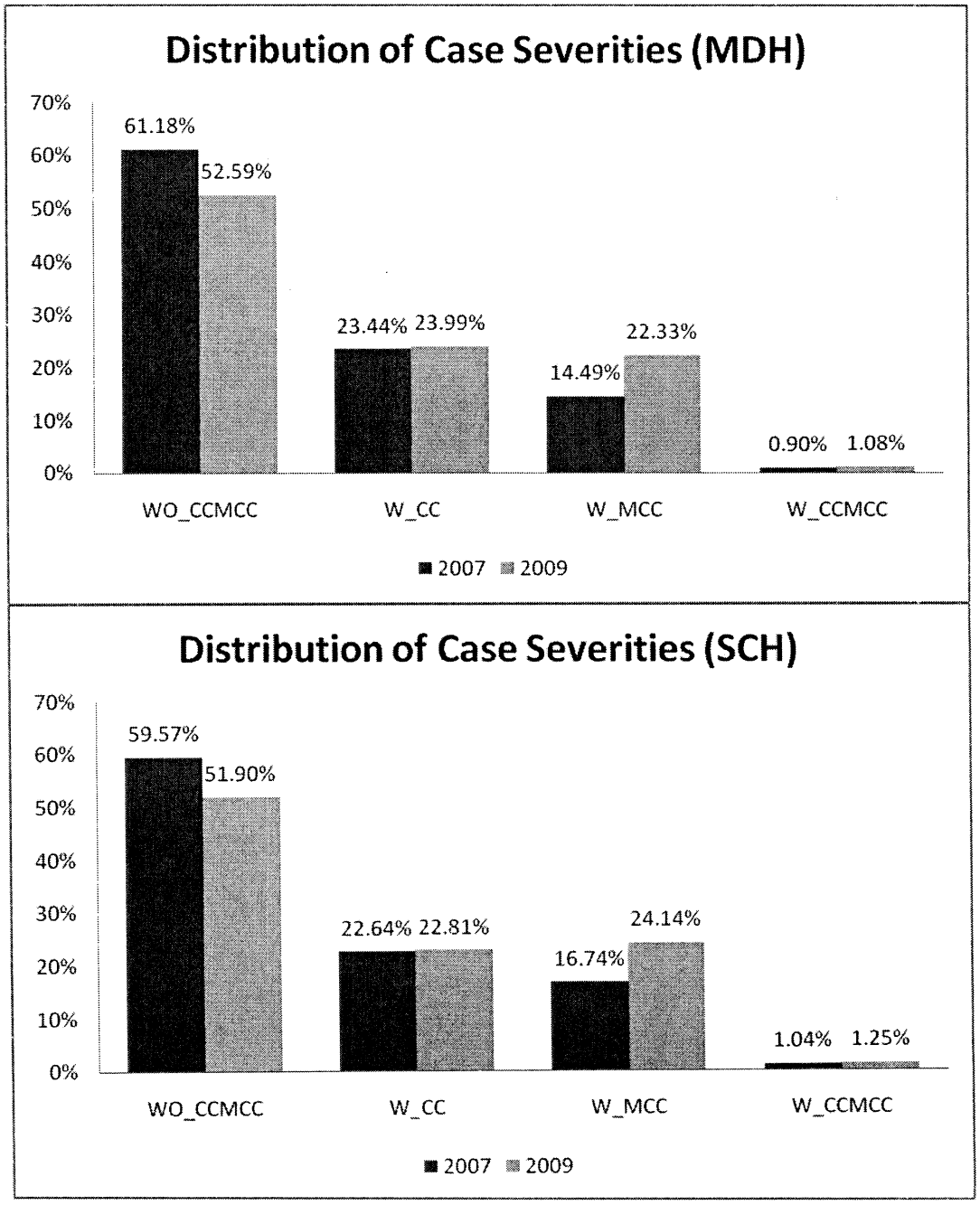

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Consistent with our analysis of IPPS hospitals, the two charts above show that we found after analysis of FY 2009 discharge data that the distribution of severity discharges for MDH and SCH both proportionally shifted from the

without CC/MCC to with MCC category. Similarly, we found using a methodology consistent with our analysis of IPPS hospitals that, independently for both SCHs and MDHs, the change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009 slightly exceeded the proposed 2.5 percent result discussed earlier, but did not significantly differ from that result.

As we have noted above, because SCHs and MDHs use the same MS–DRG system as all other hospitals, we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Therefore, we believe they should be equally subject to a prospective budget neutrality adjustment that we are applying for adoption of the MS–DRGs to all other hospitals. We believe the documentation and coding estimates for all subsection (d) hospitals should be the same. While the findings for the documentation and coding effect for all IPPS hospitals are similar to the effect for SCHs and slightly different to the effect for MDHs, we continue to believe that this is the appropriate policy so as to neither advantage or disadvantage different types of providers. As we have also discussed above, our best estimate, based on the most recently available data, is that a cumulative adjustment of −5.4 percent is required to eliminate the full effect of the documentation and coding changes on future payments. Unlike the case of standardized amounts paid to IPPS hospitals, we have not made any previous adjustments to the hospital-specific rates paid to SCHs and MDHs to account for documentation and coding changes. Therefore, the entire −5.4 percent adjustment remains to be implemented.

As discussed above, we are proposing to make an adjustment to the standardized amount for IPPS hospitals of −2.9 percent under section 7(b)(1)(B) of Public Law 110–90, for FY 2011. As we also discussed above, it has been our practice to moderate payment adjustments when necessary to mitigate the effects of significant downward adjustments on hospitals, to avoid what could be widespread, disruptive effects of such adjustments on hospitals. Because payments for non-SCH and non-MDH IPPS hospitals and SCHs and MDHs are determined on the basis of the same MS–DRG system, SCHs and MDHs have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Therefore, in determining the level and pace of adjustments to account for such documentation and coding changes, we believe that it is important to maintain, as much as possible, both consistency and equity among these classes of hospitals. In addition, as in the case of the documentation and coding adjustment for non-SCH and non-MDH IPPS hospitals, we also believe that it is important to provide as much as possible for moderating the effects of adjustments on hospital payments. Therefore we are proposing an adjustment of −2.9 percent in FY 2011 to the hospital-specific rates paid to SCHs and MDHs. This proposal is consistent with our proposed adjustment for IPPS hospitals in two ways. First, as in the case of the IPPS adjustment, we are not proposing to implement the entire adjustment that is warranted by our data (in this case, 5.4 percent) in one year. Second, we are maintaining consistency by proposing the same numerical level of adjustment for both groups of hospitals in FY 2011. While this proposed adjustment to the hospital-specific rates represents somewhat over half of the of the entire adjustment that is appropriate for SCHs and MDHs, it allows us to maintain complete consistency, at least for FY 2011, in the effects on the relevant classes of hospitals. Although the proposed adjustment for SCHs and MDHs is cumulative and prospective, as opposed to the noncumulative recoupment adjustment we are proposing for other IPPS hospitals, we believe that proposing equal numerical adjustments in this first year is the most appropriate means to maintain such consistency and equity at this time. We will continue, as much as possible, consistent with sections 7(b)(1) of Public Law 110–90 and section 1886(d)(5)(I)(i) of the Act, to take such consistency and equity into account in developing future proposals for implementing documentation and coding adjustments.

We are seeking public comment on the proposed −2.9 percent prospective adjustment to hospital-specific rates under section 1886(d)(5)(I)(i) of the Act and addressing in future rule making cycles changes in FY 2008 and FY 2009 case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008 and FY 2009, noting that our current estimates of the remaining adjustment is −2.5 percent. We intend to update our analysis with FY 2009 data on claims paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

10. Background on the Application of the Documentation and Coding Adjustment to the Puerto Rico-Specific Standardized Amount

Puerto Rico hospitals are paid based on 75 percent of the national standardized amount and 25 percent of the Puerto Rico-specific standardized amount. As noted previously, the documentation and coding adjustment we adopted in the FY 2008 IPPS final rule with comment period relied upon our authority under section 1886(d)(3)(A)(vi) of the Act, which provides the Secretary the authority to adjust "the standardized amounts computed under this paragraph" to eliminate the effect of changes in coding or classification that do not reflect real changes in case-mix. Section 1886(d)(3)(A)(vi) of the Act applies to the national standardized amounts computed under section 1886(d)(3) of the Act, but does not apply to the Puerto Rico-specific standardized amount computed under section 1886(d)(9)(C) of the Act. In calculating the FY 2008 payment rates, we made an inadvertent error and applied the FY 2008 −0.6 percent documentation and coding adjustment to the Puerto Rico-specific standardized amount, relying on our authority under section 1886(d)(3)(A)(vi) of the Act. However, section 1886(d)(3)(A)(vi) of the Act authorizes application of a documentation and coding adjustment to the national standardized amount and does not apply to the Puerto Rico specific standardized amount. In the FY 2009 IPPS final rule (73 FR 48449), we corrected this inadvertent error by removing the −0.6 percent documentation and coding adjustment from the FY 2008 Puerto Rico-specific rates.

While section 1886(d)(3)(A)(vi) of the Act is not applicable to the Puerto Rico-specific standardized amount, we believe that we have the authority to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. Similar to SCHs and MDHs that are paid based on the hospital-specific rate, we believe that Puerto Rico hospitals that are paid based on the Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. Consistent with the approach described for SCHs and

MDHs, in the FY 2009 IPPS final rule (73 FR 48449), we indicated that we planned to examine our FY 2008 claims data for hospitals in Puerto Rico. We indicated in the FY 2009 IPPS proposed rule (73 FR 23541) that if we found evidence of significant increases in case-mix for patients treated in these hospitals, we would consider proposing application of the documentation and coding adjustments to the FY 2010 Puerto Rico-specific standardized amount under our authority in section 1886(d)(5)(I)(i) of the Act.

11. Proposed Documentation and Coding Adjustment to the Puerto Rico-Specific Standardized Amount

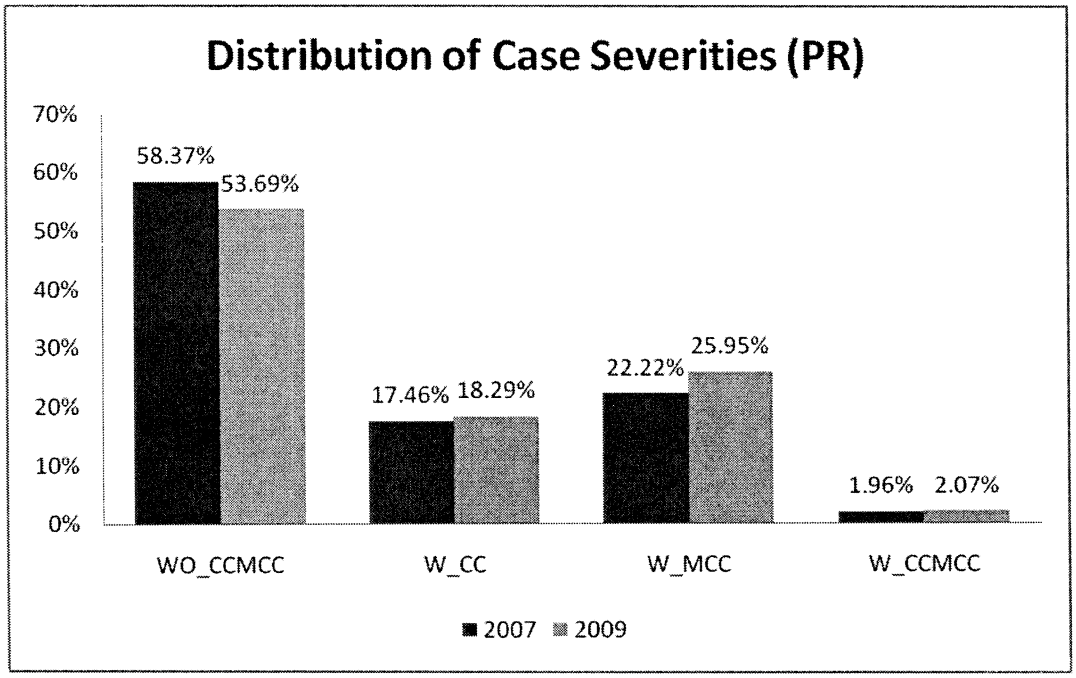
For the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we performed a retrospective evaluation of the FY 2008 claims data for Puerto Rico hospitals using the same methodology described earlier for IPPS hospitals paid under the national standardized amounts under section 1886(d) of the Act. We found that, for Puerto Rico hospitals, the increase in payments for discharges occurring during FY 2008 due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 was approximately 1.1 percent. When we calculated the within-base DRG changes and the across-base DRG changes for Puerto Rico hospitals, we found that responsibility for the case-mix change between FY 2007 and FY 2008 is much more evenly shared. Across-base DRG shifts accounted for 44 percent of the changes, and within-base DRG shifts accounted for 56 percent. Thus, the change in the percentage of discharges with an MCC was not as large as that for other IPPS hospitals. In Figure 4 in the FY 2010 proposed rule, we showed that, for Puerto Rico hospitals, there was a 3 percentage point increase in the discharges with an MCC from 22 percent to 25 percent and a corresponding decrease of 3 percentage points from 58 percent to 55 percent in discharges without a CC or an MCC.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24101), we solicited public comment on the proposed −1.1 percent prospective adjustment to the hospital-specific rates under section 1886(d)(5)(I)(i) of the Act and our intent to address in the FY 2011 rulemaking cycle any changes in FY 2009 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009. We also stated that we intended to update our analysis with FY 2008 data on claims paid through March 2009 for the FY 2010 IPPS final rule.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43777), we indicated that, given these documentation and coding increases, consistent with our statements in prior IPPS rules, we would use our authority under section 1886(d)(5)(I)(i) of the Act to adjust the Puerto Rico-specific rate. However, in parallel to our decision to postpone adjustments to the Federal standardized amount, we indicated that we were adopting a similar policy for the Puerto Rico-specific rate for FY 2010 and would consider the phase-in of this adjustment over an appropriate time period through future rulemaking. The adjustment would be applied to the Puerto Rico-specific rate that accounts for 25 percent of payments to Puerto Rico hospitals, with the remaining 75 percent based on the national standardized amount. Consequently, the overall reduction to the payment rates for Puerto Rico hospitals to account for documentation and coding changes will be slightly less than the reduction for IPPS hospitals paid based on 100 percent of the national standardized amount. We noted that, as with the hospital-specific rates, the Puerto Rico-specific standardized amount had not previously been reduced based on estimated changes in documentation and coding associated with the adoption of the MS–DRGs. However, as we note earlier for IPPS hospitals and hospitals receiving hospital-specific rates, if the estimated documentation and coding effect are determined based on a full analysis of FY 2009 claims data is more or less than our current estimates, it would change, possibly lessen, the anticipated cumulative adjustments that we currently estimate we would have to make for the FY 2008 and FY 2009 combined adjustment. Therefore, we believed that it would be more prudent to delay implementation of the documentation and coding adjustment to allow for a more complete analysis of FY 2009 claims data for Puerto Rico hospitals.

Consistent with our approach for IPPS hospitals for FY 2010, we indicated that we would address in the FY 2011 rulemaking cycle any change in FY 2009 case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009. We noted that, unlike the national standardized rates, the FY 2009 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs.

As we have noted above, similar to SCHs and MDHs, hospitals in Puerto Rico use the same MS–DRG system as all other hospitals and we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Therefore, we believe they should be equally subject to the prospective budget neutrality adjustment that we intend to apply to prospective payment rates for IPPS hospitals including SCHs and MDHs in order to eliminate the full effect of the documentation and coding changes associated with implementation of the MS–DRG system.



In the above chart, consistent with our findings for IPPS hospitals, for Puerto Rico hospitals, there is a 4 percentage point increase in the discharge severity with MCCs from 22 percent to 26 percent, and a corresponding decrease of 4 percentage points in discharge severity without CC/MCC from 58 percent to 54 percent.

Using the same methodology we applied to estimate documentation and coding changes under IPPS for non-Puerto Rico hospitals, as we have also discussed above, our best estimate, based on the most recently available data, is that a cumulative adjustment of −2.4 percent is required to eliminate the full effect of the documentation and coding changes on future payments from the Puerto Rico-specific rate. Unlike the case of standardized amounts paid to IPPS hospitals, we have not made any previous adjustments to the hospital-specific rates paid to Puerto Rico hospitals to account for documentation and coding changes. Therefore, the entire −2.4 percent adjustment remains to be implemented.

As we stated above, we believe it important to maintain both consistency and equity among all hospitals paid on the basis of the same MS–DRG system. At the same time, however, we recognize that the estimated cumulative impact on aggregate payment rates resulting from implementation of the MD–DRG system was smaller for Puerto Rico hospitals as compared to IPPS hospitals and SCHs and MDHs. We therefore are proposing an adjustment of −2.4 percent in FY 2011 to Puerto Rico-specific rate that accounts for 25 percent of payments to Puerto Rico hospitals, with the remaining 75 percent based on the national standardized amount, which we are proposing to adjust as described above. Consequently, the overall reduction to rates for Puerto Rico hospitals to account for the documentation and coding changes will be slightly less than the reduction for IPPS hospitals based on 100 percent of the national standardized amount. We note that this proposed −2.4 percent prospective adjustment would eliminate the full effect of the documentation and coding changes on the portion of future payments to Puerto Rico hospitals based on the Puerto Rico-specific rate. We believe that this proposed adjustment is the most appropriate means to take into full account the effect of documentation and coding changes on payments, and to maintain equity as much as possible between hospitals paid on the basis of different prospective rates. One reason for proposing the full −2.4 percent adjustment for the Puerto Rico-specific rate in FY 2011 is to maintain equity as much as possible in the documentation and coding adjustments applied to various hospital rates in FY 2011. Because this proposed −2.4 percent adjustment represents the full adjustment that is warranted for the Puerto Rico-specific rate, we do not anticipate proposing any additional adjustments to the rate for documentation and coding effects.

We are seeking public comment on the proposed −2.4 percent prospective adjustment to Puerto Rico-specific standardized amount under section 1886(d)(5)(I)(i) of the Act. We intend to update our analysis with FY 2009 data on claim paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

E. Refinement of the MS–DRG Relative Weight Calculation

1. Background

In the FY 2009 IPPS final rule (73 FR 48450), we continued to implement significant revisions to Medicare's inpatient hospital rates by completing our 3-year transition from charge-based relative weights to cost-based relative weights. Beginning in FY 2007, we implemented relative weights based on cost report data instead of based on charge information. We had initially proposed to develop cost-based relative weights using the hospital-specific relative value cost center (HSRVcc) methodology as recommended by MedPAC. However, after considering concerns expressed in the public comments we received on the proposal, we modified MedPAC's methodology to exclude the hospital-specific relative weight feature. Instead, we developed national CCRs based on distinct hospital departments and engaged a contractor to evaluate the HSRVcc methodology for future consideration. To mitigate payment instability due to the adoption of cost-based relative weights, we decided to transition cost-based weights over 3 years by blending them with charge-based weights beginning in FY 2007. (We refer readers to the FY 2007 IPPS final rule for details on the HSRVcc methodology and the 3-year

transition blend from charge-based relative weights to cost-based relative weights (71 FR 47882 through 47898).)

In FY 2008, we adopted severity-based MS–DRGs, which increased the number of DRGs from 538 to 745. Many commenters raised concerns as to how the transition from charge-based weights to cost-based weights would continue with the introduction of new MS–DRGs. We decided to implement a 2-year transition for the MS–DRGs to coincide with the remainder of the transition to cost-based relative weights. In FY 2008, 50 percent of the relative weight for each DRG was based on the CMS DRG relative weight and 50 percent was based on the MS–DRG relative weight.

In FY 2009, the third and final year of the transition from charge-based weights to cost-based weights, we calculated the MS–DRG relative weights based on 100 percent of hospital costs. We refer readers to the FY 2007 IPPS final rule (71 FR 47882) for a more detailed discussion of our final policy for calculating the cost-based DRG relative weights and to the FY 2008 IPPS final rule with comment period (72 FR 47199) for information on how we blended relative weights based on the CMS DRGs and MS–DRGs.

a. Summary of the RTI Study of Charge Compression and CCR Refinement

As we transitioned to cost-based relative weights, some commenters raised concerns about potential bias in the weights due to "charge compression," which is the practice of applying a higher percentage charge markup over costs to lower cost items and services, and a lower percentage charge markup over costs to higher cost items and services. As a result, the cost-based weights would undervalue high-cost items and overvalue low-cost items if a single CCR is applied to items of widely varying costs in the same cost center. To address this concern, in August 2006, we awarded a contract to RTI to study the effects of charge compression in calculating the relative weights and to consider methods to reduce the variation in the CCRs across services within cost centers. RTI issued an interim draft report in January 2007 with its findings on charge compression (which was posted on the CMS Web site at: *http://www.cms.hhs.gov/reports/downloads/Dalton.pdf*). In that report, RTI found that a number of factors contribute to charge compression and affect the accuracy of the relative weights. RTI's findings demonstrated that charge compression exists in several CCRs, most notably in the Medical Supplies and Equipment CCR.

In its interim draft report, RTI offered a number of recommendations to mitigate the effects of charge compression, including estimating regression-based CCRs to disaggregate the Medical Supplies Charged to Patients, Drugs Charged to Patients, and Radiology cost centers, and adding new cost centers to the Medicare cost report, such as adding a "Devices, Implants and Prosthetics" line under "Medical Supplies Charged to Patients" and a "CT Scanning and MRI" subscripted line under "Radiology-Diagnostics". Despite receiving public comments in support of the regression-based CCRs as a means to immediately resolve the problem of charge compression, particularly within the Medical Supplies and Equipment CCR, we did not adopt RTI's recommendation to create additional regression-based CCRs. (For more details on RTI's findings and recommendations, we refer readers to the FY 2009 IPPS final rule (73 FR 48452).) RTI subsequently expanded its analysis of charge compression beyond inpatient services to include a reassessment of the regression-based CCR models using both outpatient and inpatient charge data. This interim report was made available in April 2008 during the public comment period on the FY 2009 IPPS proposed rule and can be found on RTI's Web site at: *http://www.rti.org/reports/cms/HHSM-500-2005-0029I/PDF/Refining_Cost_to_Charge_Ratios_200804.pdf*. The IPPS-specific chapters, which were separately displayed in the April 2008 interim report, as well as the more recent OPPS chapters, were included in the July 3, 2008 RTI final report entitled, "Refining Cost-to-Charge Ratios for Calculating APC [Ambulatory Payment Classification] and DRG Relative Payment Weights," that became available at the time of the development of the FY 2009 IPPS final rule. The RTI final report can be found on RTI's Web site at: *http://www.rti.org/reports/cms/HHSM-500-2005-0029I/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf.*

RTI's final report found that, under the IPPS and the OPPS, accounting improvements to the cost reporting data reduce some of the sources of aggregation bias without having to use regression-based adjustments. In general, with respect to the regression-based adjustments, RTI confirmed the findings of its March 2007 report that regression models are a valid approach for diagnosing potential aggregation bias within selected services for the IPPS and found that regression models are equally valid for setting payments under the OPPS.

RTI also noted that cost-based weights are only one component of a final prospective payment rate. There are other rate adjustments (wage index, IME, and DSH) to payments derived from the revised cost-based weights, and the cumulative effect of these components may not improve the ability of final payment to reflect resource cost. RTI endorsed short-term regression-based adjustments, but also concluded that more refined and accurate accounting data are the preferred long-term solution to mitigate charge compression and related bias in hospital cost-based weights. For a more detailed summary of RTI's findings, recommendations, and public comments we received on the report, we refer readers to the FY 2009 IPPS final rule (73 FR 48452 through 48453).

b. Summary of the RAND Corporation Study of Alternative Relative Weight Methodologies

One of the reasons that we did not implement regression-based CCRs at the time of the FY 2008 IPPS final rule with comment period was our inability to investigate how regression-based CCRs would interact with the implementation of MS–DRGs. In the FY 2008 final rule with comment period (72 FR 47197), we stated that we engaged the RAND Corporation as the contractor to evaluate the HSRV methodology in conjunction with regression-based CCRs, and that we would consider its analysis as we prepared for the FY 2009 IPPS rulemaking process.

RAND evaluated six different methods that could be used to establish relative weights; CMS' current relative weight methodology of 15 national CCRs and 5 alternatives, including a method in which the 15 national CCRs are disaggregated using the regression-based methodology, and a method using hospital-specific CCRs for the 15 cost center groupings. In addition, RAND analyzed our standardization methodologies that account for systematic cost differences across hospitals. The purpose of standardization is to eliminate systematic facility-specific differences in cost so that these cost differences do not influence the relative weights. Overall, RAND found that none of the methods it studied of calculating the relative weights represented a marked improvement in payment accuracy over the current method, and there was little difference across methods in their ability to predict cost at either the discharge-level or the hospital-level. In their regression analysis, RAND found

that, after controlling for hospital payment factors, the relative weights are compressed (that is, understated). However, RAND also found that the hospital payment factors are overstated and increase more rapidly than cost. Therefore, while the relative weights are compressed, these payment factors offset the compression such that total payments to hospitals increase more rapidly than hospitals' costs.

In the FY 2009 IPPS final rule (73 FR 48453 through 48457), we provided a summary of the RAND report and the public comments we received in response to the FY 2009 IPPS proposed rule. The report may be found on RAND's Web site at: *http://www.rand.org/pubs/working_papers/WR560/.*

2. Proposals for FY 2011 and Timeline for Changes to the Medicare Cost Report

In the FY 2009 IPPS final rule (73 FR 48458 through 48467), in response to the RTI's recommendations concerning cost report refinements, and because of RAND's finding that regression-based adjustments to the CCRs do not significantly improve payment accuracy, we discussed our decision to pursue changes to the cost report to split the cost center for Medical Supplies Charged to Patients into one line for "Medical Supplies Charged to Patients" and another line for "Implantable Devices Charged to Patients." We acknowledged, as RTI had found, that charge compression occurs in several cost centers that exist on the Medicare cost report. However, as we stated in the final rule, we focused on the CCR for Medical Supplies and Equipment because RTI found that the largest impact on the MS–DRG relative weights could result from correcting charge compression for devices and implants. In determining what should be reported in these respective cost centers, we adopted the commenters' recommendation that hospitals should use revenue codes established by AHA's National Uniform Billing Committee to determine what should be reported in the "Medical Supplies Charged to Patients" and the "Implantable Devices Charged to Patients" cost centers.

When we developed the FY 2009 IPPS final rule, we considered all of the public comments we received both for and against adopting regression-based CCRs. Also noteworthy is RAND's belief that regression-based CCRs may not significantly improve payment accuracy, and that it is equally, if not more, important to consider revisions to the current IPPS hospital payment factor standardization method in order to improve payment accuracy. For FY 2010, we solicited comments on improving the standardization process, although we did not make any changes to the standardization process for FY 2010. We also stated that we continued to believe that, ultimately, improved and more precise cost reporting is the best way to minimize charge compression and improve the accuracy of the cost weights. Accordingly, a new subscripted line 55.01 for Implantable Devices Charged to Patients was created in July 2009 as part of CMS' Transmittal 20 update to the existing cost report Form CMS–2552–96. This new subscripted cost center is available for use for cost reporting periods beginning on or after May 1, 2009.

With respect to the initiative to reform, update, and streamline the Medicare cost report, which has been the subject of many comments and our responses in the IPPS (and OPPS) **Federal Register** notices of rulemaking over the past several years, CMS is continuing to work on this project. The new draft hospital cost report Form CMS–2552–10 was published in the **Federal Register** on July 2, 2009, and was subject to a 60-day review and comment period, which ended August 31, 2009. CMS received numerous comments on the draft hospital cost report Form CMS–2552–10, specifically regarding the creation of new cost centers from which data would be ultimately used in the relative weights calculation, even though CMS had not proposed to add these cost centers. The public comments on the July 2, 2009 **Federal Register** notice will be addressed in detail in the **Federal Register** notice that will be issued to finalize Form CMS–2525–10. We now plan to issue the revised draft of the hospital cost report Form CMS–2552–10, which will include a standard cost center for Implantable Devices Charged to Patients, through a notice in the **Federal Register**, which will allow for a 30-day comment period, in the spring or summer of 2010. However, in part in this IPPS proposed rule, we are providing a summary of the public comments received on the July 2, 2009 notice that specifically related to the relative weights and responding to those comments. Our responses to the comments in this IPPS proposed rule constitute our proposals for FY 2011 regarding the relative weights.

Several commenters asked that CMS create cost centers to house the costs of magnetic resonance imaging (MRI), Computed Tomography (CT), nuclear medicine services, cardiac catheterization, drugs that require detailed coding, and magnetoencephalography (MEG). One commenter indicated, that in RTI's July 2008 report (*http://www.rti.org/reports/cms/*), RTI made an argument that CMS should create new standard cost centers in which hospitals would report the costs of MRI scans, CT scans, cardiac catheterization, and drugs that require detailed coding, in addition to the new cost center for "Implantable Devices Charged to Patients." The commenter stated that these additional lines are needed to distinguish items and services that hospitals tend to markup differently within existing revenue centers, citing RTI's finding that CT scans have a significantly higher markup than most other radiology services. The commenter indicated that when CMS uses the overall radiology department CCR to convert charges for CT scans to costs, it overestimates the cost of these services, resulting in overstated relative weights for MS–DRGs under the IPPS and for APCs under the OPPS that incorporate CT scanning. The commenter argued that having a separate cost center for each of these services would resolve the problem. The commenter also stated that, while CMS has done something similar with the creation of the cost center for high cost medical devices, making cost center changes for some services, but not others, where such changes are warranted could create additional distortion in the relative weights. The commenter further argued that cost center changes should be made for all service areas with significant volume where services with sizable differences in markup are currently combined in a single cost center. The commenter asserted that creating these cost centers should not create reporting burden for hospitals because the RTI report indicated that roughly one-third of the hospitals are already reporting costs for CT scans, MRI scans, and cardiac catheterization under the specific nonstandard cost centers currently available in the cost report.

Another commenter also recommended the creation of the cost centers for CT scans, MRI scans, and nuclear medicine services, but for different reasons than the first commenter. Specifically, this commenter believed these new cost centers are necessary in order for the high capital costs to be appropriately allocated to these services and to be correctly reflected in the CCRs that are used in the establishment of the MS–DRG and APC payment rates for the services. The commenter stated that, under the existing cost report structure, some providers are allocating high capital costs for these services in a

single radiology line, diluting the high capital costs associated with CT scans, MRI scans, and nuclear medicine services across all radiology services, including low cost services. Therefore, the commenter concluded that the resulting radiology CCRs that CMS applies to charges for CT scans, MRI scans, and nuclear medicine services to arrive at the relative costs used to set payment rates for both the IPPS and OPPS understate the cost of high cost radiology services and overstate the cost of low cost radiology services, resulting in payments that are too low for the high cost services. The commenter indicated that CMS should not only create these new costs centers but should also require all hospitals to use them, and should issue explicit instructions on how to report the costs of these services in the new standard cost centers.

We agree that it is appropriate to create standard cost centers for CT scans, MRI scans, and cardiac catheterization and to require that hospitals report the costs and charges for these services under new cost centers on the revised Medicare cost report Form CMS 2552–10. As we discussed in the FY 2009 IPPS and CY 2009 OPPS proposed and final rules, RTI found that the costs and charges of CT scans, MRI scans, and cardiac catheterization differ significantly from the costs and charges of other services included in the standard associated cost center. RTI also concluded that both the IPPS and OPPS relative weights would better estimate the costs of those services if CMS were to add standard costs centers for CT scanning, MRIs, and cardiac catheterization in order for hospitals to report separately the costs and charges for those services and in order for CMS to calculate unique CCRs to estimate the cost from charges on claims data.

In its analysis, RTI concluded that the estimated costs for CT scanning and MRI scans would decline significantly and that the estimated cost for cardiac catheterization would increase modestly if specific standard cost centers were used. RTI found that cardiac catheterization has very different cost inputs from most cardiac testing (for example, electrocardiograms or cardiac stress testing) captured in the 5300 "Electrocardiology" cost center and that the accuracy of the CCR for both types of services, cardiac catheterization and other cardiac testing, would improve with creation of a standard cost center for cardiac catheterization. RTI also found that one-third of hospitals already report cardiac catheterization costs and charges separately through the available nonstandard cost center or through subscripted lines to the "Electrocardiology" cost center. Similarly, RTI found that approximately one-third of hospitals already separately report the costs for CT scanning and MRI scans on their Medicare cost report through subscripted lines and the available nonstandard cost centers. We believe the current prevalence of reporting for the nonstandard cost centers for these three services suggests a modest hospital burden required to adopt these cost centers.

We discussed the possibility of creating standard cost centers for these three different services in our CY 2009 OPPS proposed and final rule with comment period (73 FR 41432 and 73 FR 68525) and solicited general comments on RTI's recommendations. The commenters who objected to the creation of the standard cost centers for CT scanning and MRI scans largely did so based on RTI projected lower estimated costs for these services if CMS created these cost centers. The commenters suggested that the current CCRs for advanced imaging may reflect a misallocation of capital costs and requested that CMS not adopt separate cost centers or statistical adjustment simulating lower CCRs for CT scanning and MRI until CMS could understand how providers are allocating the extensive capital costs for these services to the revenue producing cost centers. We also received comments suggesting that the accuracy of estimated costs would improve with better allocation, potentially increasing the CCR as more capital cost would be appropriately allocated to both CT scanning and MRI and not spread across all services in the radiology cost center. We noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68525) that our recommended allocation of moveable equipment costs in Worksheet A of the Medicare cost report is based on dollar value, and that it would be important to encourage improved accuracy of capital allocation through dollar value or direct assignment if we were to make these cost centers standard cost centers. At this time, we do not know the impact on CCRs and estimated costs of adopting standard cost centers specific to CT scanning and MRI. However, we believe that, because these areas constitute significant payment under both the IPPS and OPPS and because these are common imaging services already widely reported by hospitals, we are proposing to adopt new standard cost centers for CT scanning and MRI. We agree with those commenters who asserted that creation of standard cost centers for CT scanning and MRI would improve the accuracy of cost estimation for these services, in part by creating incentives for hospitals to more accurately allocate the capital and equipment associated with these services.

With regard to cardiac catheterization, we received one comment on the CY 2009 OPPS/ASC proposed rule suggesting that hospitals might find it difficult to allocate costs for these services to specific cost centers, especially for cardiac catheterization, and that allocated overhead costs would, in most cases, be an estimate (73 FR 68527). However, given the number of hospitals already reporting the nonstandard cost center for cardiac catheterization and the number subscripting these costs and charges (approximately 50 percent, according to RTI's July 2008 report (pages 71 and 72) at: *http://www.rti.org/reports/cms/HHSM–500–2005–0029I/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf*), we believe that hospitals do allocate overhead costs to a cardiac catheterization-specific cost center. For these reasons, we are proposing to create standard cost centers for CT scanning, MRI, and cardiac catheterization in Form CMS 2552–10.

We also received public comments on the cost report notice urging us to create standard cost centers for nuclear medicine services, for drugs that require detailed coding, and for MEG. We continue to believe that it is not appropriate to create standard cost centers for these three services. The Medicare cost report already contains standard cost center 4300 (Radioisotope) to capture the costs and charges for the radioisotopes used in nuclear medicine services, the items that may have significantly different costs and hospital markup than the supplies and equipment used in other radiology services. Moreover, the cost report already contains standard cost center 4100 (Diagnostic Radiology) in which the costs of staff, equipment, and supplies for diagnostic nuclear medicine services can be reported. Therefore, we continue to believe that creating a new standard cost center for nuclear medicine services is not necessary. We also continue to believe that it is not appropriate to create a standard cost center for drugs that require detailed coding. We refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68655) for a detailed discussion on our final decision not to create this cost center. Finally, with respect to MEG services, the extremely low volume of

claims for MEG services furnished to Medicare beneficiaries in the hospital outpatient setting and the extremely low number of hospitals that report these codes relative to the volumes we typically have considered in adding both standard and nonstandard cost centers to the cost report lead us to conclude that a specific cost center for MEG is not justified at this time.

There is typically a 3-year lag between the availability of the cost report data that we use to calculate the relative weights both under the IPPS and the OPPS and a given fiscal or calendar year. We expect the data from the proposed standard cost centers for CT scans, MRI, and cardiac catheterization respectively, should they be finalized, to be available for possible use in calculating the relative weights not earlier than 3 years after Form CMS–2552–10 becomes available. At that time, we would analyze the data and determine if it is appropriate to use those data to create distinct CCRs from these cost centers for use in the relative weights for the respective payment systems. If we decide to finalize these proposed new cost centers, the upcoming **Federal Register** notice that will finalize Form CMS–2552–10 will provide more information regarding the addition of these proposed new standard cost centers for CT scans, MRI, and cardiac catheterization, including the instructions for completing these cost centers on the new cost report.

F. Preventable Hospital-Acquired Conditions (HACs), Including Infections

1. Background

a. Statutory Authority

Section 1886(d)(4)(D) of the Act addresses certain hospital-acquired conditions (HACs), including infections. Section 1886(d)(4)(D) of the Act specifies that by October 1, 2007, the Secretary was required to select, in consultation with the Centers for Disease Control and Prevention (CDC), at least two conditions that: (a) Are high cost, high volume, or both; (b) are assigned to a higher paying MS–DRG when present as a secondary diagnosis (that is, conditions under the MS–DRG system that are CCs or MCCs); and (c) could reasonably have been prevented through the application of evidence-based guidelines. Section 1886(d)(4)(D) of the Act also specifies that the list of conditions may be revised, again in consultation with CDC, from time to time as long as the list contains at least two conditions.

Section 1886(d)(4)(D)(iii) of the Act requires that hospitals, effective with discharges occurring on or after October 1, 2007, submit information on Medicare claims specifying whether diagnoses were present on admission (POA). Section 1886(d)(4)(D)(i) of the Act specifies that effective for discharges occurring on or after October 1, 2008, Medicare no longer assigns an inpatient hospital discharge to a higher paying MS–DRG if a selected condition is not POA. Thus, if a selected condition that was not POA manifests during the hospital stay, it is considered a HAC and the case is paid as though the secondary diagnosis was not present. However, even if a HAC manifests during the hospital stay, if any nonselected CC/MCC appears on the claim, the claim will be paid at the higher MS–DRG rate. Under the HAC payment policy, all CCs/MCCs on the claim must be HACs in order to generate a lower MS–DRG payment. In addition, Medicare continues to assign a discharge to a higher paying MS–DRG if a selected condition is POA.

The POA indicator reporting requirement and the HAC payment provision apply to IPPS hospitals only. Non-IPPS hospitals, including CAHs, LTCHs, IRFs, IPFs, cancer hospitals, children's hospitals, hospitals in Maryland operating under waivers, rural health clinics, federally qualified health centers, RNHCIs, and Department of Veterans Affairs/Department of Defense hospitals, are exempt from POA reporting and the HAC payment provision. Throughout this section, the term "hospital" refers to an IPPS hospital.

The HAC provision found in section 1886(d)(4)(D) of the Act is part of an array of Medicare value-based purchasing (VBP) tools that we are using to promote increased quality and efficiency of care. Those tools include measuring performance, using payment incentives, publicly reporting performance results, applying national and local coverage policy decisions, enforcing conditions of participation, and providing direct support for providers through Quality Improvement Organization (QIO) activities. The application of VBP tools, such as this HAC provision, is transforming Medicare from a passive payer to an active purchaser of higher value health care services. We are applying these strategies for inpatient hospital care and across the continuum of care for Medicare beneficiaries.

These VBP tools are highly compatible with the underlying purposes as well as existing structural features of Medicare's IPPS. Under the IPPS, hospitals are encouraged to treat patients efficiently because they receive the same DRG payment for stays that vary in length and in the services provided, which gives hospitals an incentive to avoid unnecessary costs in the delivery of care. In some cases, conditions acquired in the hospital do not generate higher payments than the hospital would otherwise receive for cases without these conditions. To this extent, the IPPS encourages hospitals to avoid complications.

However, the treatment of certain conditions can generate higher Medicare payments in two ways. First, if a hospital incurs exceptionally high costs treating a patient, the hospital stay may generate an outlier payment. Because the outlier payment methodology requires that hospitals experience large losses on outlier cases before outlier payments are made, hospitals have an incentive to prevent outliers. Second, under the MS–DRGs system that took effect in FY 2008 and that has been refined through rulemaking in subsequent years, certain conditions can generate higher payments even if the outlier payment requirements are not met. Under the MS–DRG system, there are currently 258 sets of MS–DRGs that are split into 2 or 3 subgroups based on the presence or absence of a CC or an MCC. The presence of a CC or MCC generally results in a higher payment. However, since we implemented the HAC provisions, if a secondary diagnosis acquired during a hospital stay is a HAC and no other CCs or MCCs are present, the hospital receives a payment under the MS–DRGs as if the HACs were not present. (We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a discussion of DRG reforms (72 FR 47141).)

b. HAC Selection

In the FY 2007 IPPS proposed rule (71 FR 24100), we sought public input regarding conditions with evidence-based prevention guidelines that should be selected in implementing section 1886(d)(4)(D) of the Act. The public comments we received were summarized in the FY 2007 IPPS final rule (71 FR 48051 through 48053).

In the FY 2008 IPPS proposed rule (72 FR 24716 through 24726), we sought public comment on conditions that we proposed to select. In the FY 2008 IPPS final rule with comment period (72 FR 47200 through 47218), we selected 8 categories to which the HAC payment provisions would apply.

In the FY 2009 IPPS proposed rule (73 FR 23547), we proposed several additional candidate HACs as well as refinements to the previously selected HACs. In the FY 2009 IPPS final rule (73 FR 48471), we expanded and refined

several of the previously selected HACs, and we selected 2 additional categories of HACs.

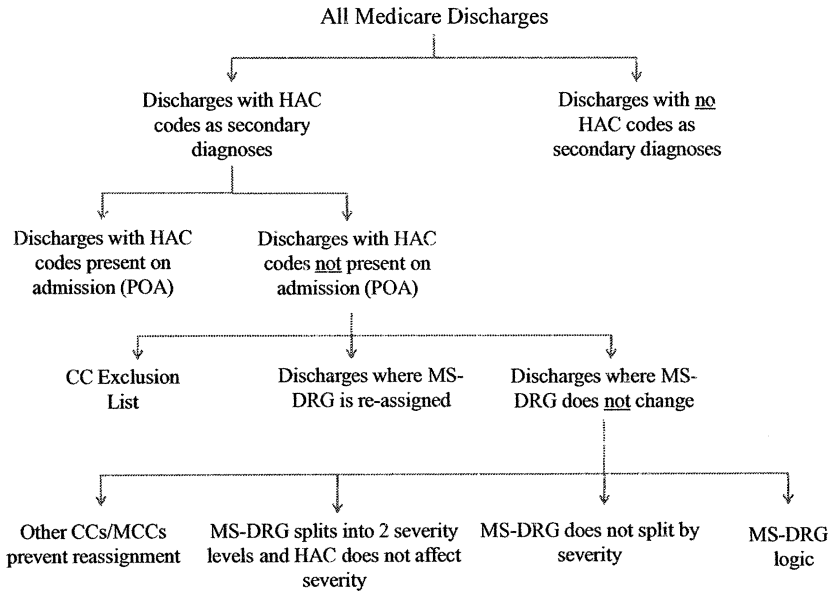
In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24106), we proposed the addition of ICD–9–CM codes 813.46 (Torus fracture of ulna) and 813.47 (Torus fracture of radius and ulna) to more precisely define the previously selected HAC category of Falls and Trauma. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43784), we finalized the addition of these codes. A complete list of the 10 current categories of HACs is included in section II.F.2. of this preamble.

c. Collaborative Process

In establishing the HAC payment policy under section 1886(d)(4)(D) of the Act, our experts have worked closely with public health and infectious disease professionals from across the Department of Health and Human Services, including CDC, the Agency for Healthcare Research and Quality (AHRQ), and the Office of Public Health and Science (OPHS), to identify the candidate preventable HACs, review comments, and select HACs. CMS and CDC have also collaborated on the process for hospitals to submit a POA indicator for each diagnosis listed on IPPS hospital Medicare claims and on the payment implications of the various POA reporting options. As discussed below, we have also used rulemaking and Listening Sessions to receive public input.

d Application of HAC Payment Policy to MS–DRG Classifications

As described above, in certain cases application of the HAC payment policy provisions can result in MS–DRG reassignment to a lower paying MS–DRG. The following diagram portrays the logic of the HAC payment policy provision as adopted in the FY 2008 IPPS final rule (72 FR 47200) and in the FY 2009 IPPS final rule (73 FR 48471):



e. Public Input Regarding Selected and Potential Candidate HACs

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24104 through 24106), we did not propose to add or remove categories of HACs. However, as we indicated in that proposed rule, we continue to encourage public dialogue about refinements to the HAC list. During and after the December 18, 2008 Listening Session, we received many oral and written stakeholder comments about both previously selected and potential candidate HACs. In response to the Listening Session, commenters strongly supported using information gathered from early experience with the HAC payment provision to inform maintenance of the HAC list and consideration of future potential candidate HACs. Commenters also emphasized the need for a robust program evaluation prior to modifying the HAC list.

In response to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24106), commenters expressed strong support for a program evaluation prior to modifying the HAC list. We responded to these commenters and expressed our appreciation for the public's support for our decision to undertake a program evaluation. We indicated that we planned to include updates and findings from the evaluation on CMS' Hospital-Acquired Conditions and Present on Admission Indicator Web site available at: *http://www.cms.hhs.gov/HospitalAcqCond/*. We also responded to commenters regarding POA indicator reporting as well as to comments addressing other topics related to HACs and POA reporting (74 FR 43785).

f. POA Indicator Reporting

Collection of POA indicator data is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision as well as for broader public health uses of Medicare data. Through Change Request No. 5679 (released on June 20, 2007), we issued instructions requiring IPPS hospitals to submit POA indicator data for all diagnosis codes on Medicare claims. We also issued Change Request No. 6086 (released on June 13, 2008) regarding instructions for processing non-IPPS claims. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the *ICD–9–CM Official Guidelines for Coding and Reporting,* available on the CDC Web site at: *http://www.cdc.gov/nchs/data/icd9/icdguide09.pdf.* Additional information regarding POA indicator reporting and application of the POA reporting

options is available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalAcqCond.* Historically we have not provided coding advice. Rather, we collaborate with the American Hospital Association (AHA) through the *Coding Clinic for ICD–9–CM.* We have been collaborating with the AHA to promote the *Coding Clinic for ICD–9–CM* as the source for coding advice about the POA indicator.

There are five POA indicator reporting options, as defined by the *ICD–9–CM Official Guidelines for Coding and Reporting:*

Indicator	Descriptor
Y	Indicates that the condition was present on admission.
W	Affirms that the hospital has determined that, based on data and clinical judgment, it is not possible to document when the onset of the condition occurred.
N	Indicates that the condition was not present on admission.
U	Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
1	Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD–9–CM diagnosis codes is available in the *ICD–9–CM Official Guidelines for Coding and Reporting.*

In the FY 2009 IPPS final rule (73 FR 48486 through 48487), we adopted as final our proposal to: (1) Pay the CC/MCC MS–DRGs for those HACs coded with "Y" and "W" indicators; and (2) not pay the CC/MCC MS–DRGs for those HACs coded with "N" and "U" indicators.

Beginning on or after January 1, 2011, hospitals will begin reporting with the 5010 format. The 5010 format removes the need to report a POA indicator of "1" for codes that are exempt from POA reporting. The POA indicator of "1" is being used because of reporting restrictions from the use of the 4010 format. Therefore, hospitals that begin reporting with the 5010 format on and after January 1, 2011, will no longer report a POA indicator of "1" for POA exempt codes. The POA field will instead be left blank for codes exempt from POA reporting. We are planning to issue CMS instructions on this reporting change.

2. Proposed HAC Conditions for FY 2011

As changes to diagnosis codes and new diagnosis codes are proposed and finalized for the list of CCs and MCCs, we will modify the list of selected HACs to reflect these changes. In Table 6A in the Addendum to this proposed rule, we have listed the proposed addition of five new ICD–9–CM diagnosis codes to replace existing ICD–9–CM code 999.6 (ABO incompatibility reaction) for FY 2011. ICD–9–CM code 999.6 is currently the only code identified under the Blood Incompatibility HAC category. We are proposing to delete code 999.6 and form a new subcategory of 999.6 to identify new diagnoses relating to ABO incompatibility reaction due to transfusion of blood or blood products. These diagnoses meet the criteria for the Blood Incompatibility HAC category based on the predecessor code 999.6 being a selected HAC.

As shown in Table 6C in the Addendum to this proposed rule, we are proposing that code 999.6 become invalid as a diagnosis code in FY 2011 with the creation of this new ICD–9–CM subcategory. This proposed new subcategory would allow room for expansion and the creation of the following new diagnosis codes:

ICD–9–CM code	Code descriptor	Proposed CC/MCC designation
999.60	ABO incompatibility reaction, unspecified	CC
999.61	ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed	CC
999.62	ABO incompatibility with acute hemolytic transfusion reaction	CC
999.63	ABO incompatibility with delayed hemolytic transfusion reaction	CC
999.69	Other ABO incompatibility reaction	CC

We are inviting public comments on the proposed adoption of the five ICD–9–CM diagnosis codes as CCs that are listed above, which, if finalized, would be added to the current HAC Blood Incompatibility category.

The following table lists the current HACs categories and the ICD–9–CM codes that identify the conditions that have been finalized through FY 2010. For FY 2011, we are proposing that these conditions continue to be subject to the HAC payment provision, with a proposed refinement to the codes to identify blood incompatibility as described above.

HAC	CC/MCC (ICD–9–CM code)
Foreign Object Retained After Surgery	998.4 (CC)
	998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC)
	707.24 (MCC)
Falls and Trauma	Codes within these ranges on the CC/MCC list:
—Fracture	800–829
—Dislocation	830–839
—Intracranial Injury	850–854

HAC	CC/MCC (ICD–9–CM code)
—Crushing Injury	925–929
—Burn	940–949
—Electric Shock	991–994
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10–250.13 (MCC) 250.20–250.23 (MCC) 251.0 (CC) 249.10–249.11 (MCC) 249.20–249.21 (MCC)
Surgical Site Infections	
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01–81.08, 81.23–81.24, 81.31–81.38, 81.83, 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	*Principal Diagnosis*—278.01 998.59 (CC) And one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40–453.42 (CC) And one of the following procedure codes: 00.85–00.87, 81.51–81.52, or 81.54

We refer readers to section II.F.6. of the FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218) and to section II.F.7. of the FY 2009 IPPS final rule (73 FR 48474 through 48486) for detailed analyses supporting the selection of each of these HACs. We invite public comments on our proposal that these conditions continue to be subject to the HAC payment provision, with a proposed refinement of the codes to identify blood incompatibility as described above.

3. RTI Program Evaluation Summary

a. Background

On September 30, 2009, a contract was awarded to Research Triangle Incorporated (RTI) to evaluate the impact of the Hospital-Acquired Condition-Present on Admission (HAC–POA) provisions on the changes in the incidence of selected conditions, effects on Medicare payments, impacts on coding accuracy, unintended consequences, and infection and event rates. This is an intra-agency project with funding and technical support coming from CMS, OPHS, AHRQ, and CDC. The evaluation will also examine the implementation of the program and evaluate additional conditions for future selection.

RTI's evaluation of the HAC–POA provisions is divided into several parts, only some of which will be complete prior to the publication date of this proposed rule. Below we summarize the analyses that are complete. RTI's analyses of POA indicator reporting, frequencies and net savings associated with current HACs, and frequencies of previously considered candidate HACs reflect MedPAR claims from October 2008 through June 2009. In the final rule, we intend to update our summary of these analyses with additional data that have become available.

b. Preliminary RTI Analysis on POA Indicator Reporting Across Medicare Discharges

To better understand the impact of HACs on the Medicare program, it is necessary to first examine the incidence of POA indicator reporting across all eligible Medicare discharges. As mentioned previously, only IPPS hospitals are required to submit POA indicator data for all diagnosis codes on Medicare claims. Therefore, all non-IPPS hospitals were excluded, as well as providers in waiver States (Maryland) and territories other than Puerto Rico.

Using MedPAR claims data from October 2008 through June 2009, RTI found a total of approximately 50.22 million secondary diagnoses across approximately 7.17 million discharges. As shown in Chart A below, the majority of all secondary diagnoses (83.52 percent) were reported with a POA indicator of "Y," meaning the condition was POA.

CHART A—POA CODE DISTRIBUTION ACROSS ALL SECONDARY DIAGNOSES

	Number	Percentage
Total Discharges in Final File	7,175,139	
Total Number of Secondary Diagnoses Across Total Discharges	50,216,195	100.00

POA	Indicator Description		
Y	Condition present on admission	41,938,234	83.52
W	Status cannot be clinically determined	12,547	0.02
N	Condition not present on admission	3,440,815	6.85
U	Documentation not adequate to determine if condition was present on admission.	110,771	0.22
1	Exempted ICD–9–CM code	4,713,828	9.39

Source: RTI Analysis of MedPAR IPPS Claims, October 2008 through June 2009.

c. Preliminary RTI Analysis on POA Indicator Reporting of Current HACs

Following the initial analysis of POA indicator reporting for all secondary diagnoses, RTI then evaluated POA indicator reporting for specific HAC-associated secondary diagnoses. The term "HAC-associated secondary diagnosis" refers to those diagnoses that are on the selected HAC list and were reported as a secondary diagnosis. Chart B below shows a summary of the HAC categories with the frequency in which each HAC was reported as a secondary diagnosis and the corresponding POA indicators assigned on the claims. It is important to note that, because more than one HAC-associated diagnosis code can be reported per discharge (that is, on a single claim), the frequency of HAC-associated diagnosis codes may be more than the actual number of discharges that have a HAC-associated diagnosis code reported as a secondary diagnosis. Below we discuss the frequency of each HAC-associated diagnosis code and the POA indicators assigned to those claims.

RTI analyzed the frequency of each reported HAC-associated secondary diagnosis (across all 7.17 million discharges) and the POA indicator assigned to the claim. Chart B below shows that the most frequently reported conditions were in the Falls and Trauma HAC category, with a total of 132,666 HAC-associated diagnosis codes being reported for that HAC category. Of these 132,666 diagnoses, 4,081 reported a POA indicator of "N" for not POA and 128,286 diagnoses reported a POA indicator of "Y" for POA. The lowest frequency appears in the Surgical Site Infection (SSI) Following Bariatric Surgery for Obesity HAC category with only 12 HAC-associated secondary diagnosis codes (and procedure codes) reported.

CHART B—POA STATUS OF CURRENT HACS: OCTOBER 2008 THROUGH JUNE 2009

Selected HAC	Frequency as a Secondary Diagnosis	Not Present on Admission				Present on Admission			
		POA = N		POA = U		POA = Y		POA = W	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
1. Foreign Object Retained After Surgery (CC)	378	172	45.5	0	0.0	206	54.5	0	0.0
2. Air Embolism (MCC)	29	23	79.3	0	0.0	6	20.7	0	0.0
3. Blood Incompatibility (CC)	23	8	34.8	0	0.0	15	65.2	0	0.0
4. Pressure Ulcer Stages III & IV (MCC)	80,190	944	1.2	56	0.1	79,165	98.7	25	0.0
5. Falls and Trauma (MCC & CC)	132,666	4,081	3.1	232	0.2	128,286	96.7	67	0.1
6. Catheter-Associated UTI (CC)	11,424	1,887	16.5	15	0.1	9,496	83.1	26	0.2
7. Vascular Catheter-Associated Infection (CC)	5,470	2,091	38.2	19	0.3	3,348	61.2	12	0.2
8. Poor Glycemic Control (MCC)	11,070	344	3.1	9	0.1	10,711	96.8	6	0.1
9A. Surgical Site Infection Mediastinitis CABG (CC)	29	21	72.4	0	0.0	8	27.6	0	0.0
9B. Surgical Site Infection Following Bariatric Surgery for Obesity (CC)	12	10	83.3	0	0.0	2	16.7	0	0.0
9B. Surgical Site Infection Following Certain Orthopedic Procedures (CC)	202	125	61.9	1	0.5	75	37.1	1	0.5
10. Pulmonary Embolism & DVT Orthopedic (MCC)	2,706	2,029	75.0	15	0.6	647	23.9	15	0.6
Total *	244,199			347				152	

* Discharges can appear in more than one row. The total figure is not adjusted for the 47 discharges with more than one HAC that appear as secondary diagnoses (15 of these discharges resulted in MS–DRG reassignment).

We welcome public comments on these data that can provide insight into the accuracy of the data, using comparative data sets or analysis such as how aspects of the coding system might influence these data.

As described earlier, in the FY 2009 IPPS final rule (73 FR 48486 through 48487), we adopted as final our proposal to: (1) Pay the CC/MCC MS–DRGs for those HACs coded with "Y" and "W" indicators; and (2) not pay the CC/MCC MS–DRGs for those HACs coded with "N" and "U" indicators. We also discussed the comments we received urging CMS to strongly consider changing the policy and to pay for those HACs assigned a POA indicator of "U" (documentation is insufficient to determine if the condition was present at the time of admission). We stated we would monitor the extent to which and under what circumstances the "U" POA reporting option is used. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we also discussed and responded to comments regarding HACs coded with the "U" indicator (74 FR 43784 and 43785). As shown in Chart B above, RTI's analysis provides some initial data on a total of 347 HAC-associated secondary diagnoses reported with a POA indicator of "U". Of those diagnoses, 232 (0.2 percent) were assigned to the Falls and Trauma HAC category.

We continue to believe that better documentation will result in more accurate public health data. Because the RTI analysis is based on preliminary data, at this time we are not proposing to change our policy under which CMS does not pay at the higher CC/MCC amount when a selected HAC diagnosis code is reported with a POA indicator of "U."

We encourage readers to further review the RTI detailed report which demonstrates the frequency of each individual HAC-associated diagnosis code within the HAC categories. For example, in the Foreign Object Retained After Surgery HAC category, there are two unique ICD–9–CM diagnosis codes to identify that condition: code 998.4 (Foreign body accidentally left during a procedure) and code 998.7 (Acute reaction to foreign substance accidentally left during a procedure). In the detailed RTI report, readers can view that code 998.4 was reported 368 times and code 998.7 was reported 10 times, for a total of 378 times, as shown in Chart B above. The RTI detailed report is available at the following Web site: *http://www.rti.org/reports/cms/*.

d. Preliminary RTI Analysis of Frequency of Discharges and POA Indicator Reporting for Current HACs

RTI further analyzed the effect of the HAC provision by studying the frequency in which a HAC-associated diagnosis was reported as a secondary diagnosis with a POA indicator of "N" or "U" and, of that number, how many resulted in MS–DRG reassignment. In Chart C below, Column A shows the number of discharges for each HAC category where the HAC-associated diagnosis was reported as a secondary diagnosis. For example, there were 29 discharges that reported Air Embolism as a secondary diagnosis. Column C shows the number of discharges for each HAC reported with a POA indicator of "N" or "U." Continuing with the example of Air Embolism, the chart shows that, of the 29 reported discharges, 23 discharges (79.31 percent) had a POA indicator of "N" or "U" and was identified as a HAC discharge. There were a total of 23 discharges to which the HAC policy applies and that could, therefore, have had an MS–DRG reassignment. Column E shows the number of discharges where an actual MS–DRG reassignment occurred. As shown in Column E, the number of discharges with an Air Embolism that resulted in actual MS–DRG reassignments is 12 (52.17 percent of the 23 discharges with a POA indicator of "N" or "U"). Thus, while there were 23 discharges (79.31 percent of the original 29) with an Air Embolism reported with a POA indicator of "N" or "U" identified as a HAC discharge that could have caused MS–DRG reassignment, the end result was 12 (52.17 percent) actual MS–DRG reassignments. There are a number of reasons why a selected HAC reported with a POA indicator of "N" or "U" will not result in MS–DRG reassignment. These reasons were illustrated with the diagram in section II.F.1.c. of this preamble and will be discussed in further detail in section II.F.3.e. of this preamble.

Chart C below also shows that, of the 216,764 discharges with a HAC-associated diagnosis as a secondary diagnosis, 3,038 discharges ultimately resulted in MS–DRG reassignment. As will be discussed below, there were 15 claims that resulted in MS–DRG reassignment where two HACs were reported on the same admission. The four HAC categories that had the most discharges resulting in MS–DRG reassignment were: (1) Falls and Trauma; (2) Pressure Ulcer Stages III & IV; (3) Pulmonary Embolism and DVT Orthopedic (Orthopedic PE/DVT); and (4) Catheter-Associated Urinary Tract Infection (UTI). Codes falling under the Falls and Trauma HAC category were the most frequently reported secondary diagnoses with 109,728 discharges. Of these 109,728 discharges, 3,852 (3.51 percent) were coded as not POA and identified as HAC discharges. This category also contained the greatest number of discharges that resulted in an MS–DRG reassignment. Of the 3,852 discharges within this HAC category that were not POA, 1,476 (38.32 percent) resulted in an MS–DRG reassignment.

Of the 216,764 total discharges reporting HAC-associated diagnoses as a secondary diagnosis, 2,494 discharges were coded with a secondary diagnosis of Orthopedic PE/DVT. Of these 2,494 discharges, 1,892 (75.86 percent) were coded as not POA and identified as HAC discharges. This category contained the second greatest number of discharges resulting in an MS–DRG reassignment. Of the 1,892 discharges in this HAC category that were not POA, 845 discharges (44.66 percent) resulted in an MS–DRG reassignment.

The Pressure Ulcer Stages III & IV category had the second most frequently coded secondary diagnoses, with 76,014 discharges. Of these discharges, 960 (1.26 percent) were coded as not POA and identified as HAC discharges. This category contained the third greatest number of discharges resulting in an MS–DRG reassignment. Of the 960 discharges in this HAC category that were not POA, 337 discharges (35.10 percent) resulted in an MS–DRG reassignment.

The Catheter-Associated UTI category had the third most frequently coded secondary diagnoses, with 11,434 discharges. Of these discharges, 1,896 (16.60 percent) were coded as not POA and identified as HAC discharges. This category contained the fourth greatest number of discharges resulting in an MS–DRG reassignment. Of the 1,896 discharges in this HAC category that were not POA, 197 discharges (10.39 percent) resulted in a MS–DRG reassignment.

The remaining 6 HAC categories only had 183 discharges that ultimately resulted in MS–DRG reassignment. We note that, even in cases where a large number of HAC-associated secondary diagnoses were coded as not POA, this finding did not necessarily translate into a large number of discharges that resulted in MS–DRG reassignment. For example, only 23 of the 2,107 Vascular Catheter-Associated Infection secondary diagnoses that were coded as not POA and identified as HAC discharges resulted in a MS–DRG reassignment.

There were a total of 277 discharges with a HAC-associated secondary diagnosis reporting a POA indicator of "N" or "U" that were excluded from acting as a HAC discharge (subject to MS–DRG reassignment) due to the CC Exclusion List logic within the GROUPER. The CC Exclusion List identifies secondary diagnosis codes designated as a CC or MCC that are disregarded by the GROUPER logic when reported with certain principal diagnoses. For example, a claim with the principal diagnosis code of 250.83 (Diabetes with other specified manifestations, type 1 [juvenile type], uncontrolled) and a secondary diagnosis code of 250.13 (Diabetes with ketoacidosis, type 1, [juvenile type], uncontrolled) with a POA indicator of "N" would result in the HAC-associated secondary diagnosis code 250.13 being ignored as a CC. According to the CC Exclusion List, code 250.13 is excluded from acting as a CC when code 250.83 is the principal diagnosis. As a result, the HAC logic would not be applicable to that case. For a detailed discussion on the CC Exclusion List, we refer readers to section II.G.9. of this preamble.

Discharges where the HAC logic was not applicable due to the CC Exclusion List occurred among the following 4 HAC categories: Pressure Ulcer Stages III and IV (29 cases), Falls and Trauma (206 cases), Catheter-Associated UTI (6 cases), Vascular Catheter-Associated Infection (3 cases), and Manifestations of Poor Glycemic Control (33 cases). Further information regarding the specific number of cases that were excluded for each HAC-associated secondary diagnosis code within each of the above mentioned HAC categories is also available. We refer readers to the RTI detailed report at the following Web site: *http://www.rti.org/reports/cms/*.

In summary, Chart C below demonstrates that there were a total of 216,764 discharges with a reported HAC-associated secondary diagnosis. Of the total 216,764 discharges, 11,383 (5.25 percent) discharges were HACs reported with a POA indicator of "N" or "U" that were identified as a HAC discharge. Of these 11,383 discharges, the number of discharges resulting in MS–DRG reassignments was 3,038 (26.69 percent).

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CHART C.—DISCHARGE FREQUENCIES OF CURRENT CMS HACS OCTOBER 2008 THRUGH JUNE 2009

Selected HAC Category	Discharges With This Condition as Secondary Diagnosis		Discharges Identified as a HAC		Discharges That Change MS-DRG Due to HAC	
	Number (Column A)	Percent[2] (Column B)	Number (Column C)	Percent[3] (Column D)	Number (Column E)	Percent[4] (Column F)
1. Foreign Object Retained After Surgery	378	0.01%	172	45.50%	40	23.26%
2. Air Embolism	29	0.00%	23	79.31%	12	52.17%
3. Blood Incompatibility	23	0.00%	8	34.78%	0	0.00%
4. Pressure Ulcer Stages III & IV	76,041	1.06%	960	1.26%	337	35.10%
a. Stage III	42,659	0.59%	726	1.70%	286	39.39%
b. Stage IV	37,531	0.52%	245	0.65%	53	23.27%
5. Falls and Trauma	109,728	1.53%	3,852	3.51%	1,476	38.32%
a. Fracture	98,624	1.37%	3,343	3.39%	1,267	37.90%
b. Dislocation	763	0.01%	19	2.49%	3	15.79%
c. Intracranial Injury	10,469	0.15%	478	4.57%	213	44.56
d. Crushing Injury	32	0%	1	3.13%	0	0
e. Burn	1,663	0.02%	33	1.98%	6	18.18%
f. Electric Shock	466	0.01%	8	1.72%	1	12.50%
6. Catheter-Associated UTI	11,424	0.16%	1,896	16.60%	197	10.39%
7. Vascular Catheter-Associated Infection	5,470	0.08%	2,107	38.52%	23	1.09%
8. Poor Glycemic Control	10,937	0.15%	319	2.92%	98	30.72%
9a. SSI Mediastinitis CABG	29	0.04%	21	72.41%	5	23.81%

Selected HAC Category	Discharges With This Condition as Secondary Diagnosis		Discharges Identified as a HAC		Discharges That Change MS-DRG Due to HAC	
	Number (Column A)	Percent[2] (Column B)	Number (Column C)	Percent[3] (Column D)	Number (Column E)	Percent[4] (Column F)
9b. SSI Orthopedic	199	0.26%	123	61.81%	4	3.25%
9c. SSI Bariatric	12	0.11%	10	83.33%	1	10.00%
10. Pulmonary Embolism & DVT Orthopedic	2,494	0.84%	1,892	75.86%	845	44.66%
Total[1]	216,764		11,383	5.25%	3,038	26.69%

[1] Discharges can appear in more than one row. The total figure is not adjusted for the 47 discharges with more than one HAC that appear as secondary diagnoses (15 of these resulted in MS-DRG reassignment).
[2] Percent computed relative to total discharges "at risk" for MS-DRG reassignment. For HACs 1 – 8, this is 7,175,139. For HAC 9a, this is 73,184. For HAC 9b, this is 76,104. For HAC 9c, this is 10,445. For HAC 10, this is 296,405.
[3] Percent computed relative to discharges with condition as a secondary diagnosis.
[4] Percent computed relative to discharges with condition as a secondary diagnosis and identified as a HAC (that is, coded as not present on admission), as identified in the Column E.

SOURCE: RTI Analysis of MedPAR IPPS Claims, October 2008 through June 2009.

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An extremely small number of discharges had multiple HACs reported during the same stay. In reviewing the 7.17 million claims, RTI found 47 cases in which two HACs were reported on the same discharge. Chart D below summarizes these cases. There were eight cases in which a Falls and Trauma HAC was reported in addition to a Pressure Ulcer Stages III & IV HAC. Eighteen of the cases with two HACs involved Pressure Ulcer Stages III & IV and 15 cases involved Falls or Trauma. Other multiple HAC cases included 9 Catheter-Associated UTI cases and 5 Vascular Catheter-Associated Infection cases.

Some of these cases with multiple HACs reported had both HAC codes ignored in the MS–DRG assignment. Of these 47 claims, 32 did not receive higher payments based on the presence of one or both of these reported HACs and we describe these claims below in section II.F.3.f.(2) of this preamble. Depending on the MS–DRG to which the cases were originally assigned, ignoring the HAC codes would have led to a MS–DRG reassignment if there were no other MCCs or CCs reported, if the MS–DRG was subdivided into severity levels, and if the case were not already in the lowest severity level prior to ignoring the HAC codes.

CHART D—CLAIMS WITH MORE THAN ONE HAC SECONDARY DIAGNOSIS OCTOBER 2008 THROUGH JUNE 2009

HAC	4. Pressure ulcer stages III & IV—MCC	5. Falls and trauma—MCC & CC	6. Catheter-associated UTI—CC	7. Vascular catheter-associated infection—CC
2. Air embolism—MCC		1		
5. Falls and Trauma—MCC & CC	8			
6. Catheter-Associated UTI—CC	2	3		
7. Vascular Catheter-Associated Infection—CC	5	4	6	
8. Poor Glycemic Control—MCC	1			1
9C. Surgical Site Infection Following Bariatric Surgery for Obesity—CC			2	1
10. Pulmonary Embolism & DVT Orthopedic—MCC	2	7	1	3
Total	18	15	9	5

e. Preliminary RTI Analysis of Circumstances When Application of HAC Provisions Would Not Result in MS–DRG Reassignment for Current HACs

As discussed in section II.F.1. and illustrated in the diagram in section II.F.1.c. of this preamble, there are instances when the MS–DRG assignment does not change even when a HAC-associated secondary diagnosis has a POA indicator of either "N" or "U." In analyzing our claims data, RTI identified four main reasons why a MS–DRG assignment would not change despite the presence of a HAC. Those four reasons are described below and are shown in Chart E below. Column A shows the frequency of discharges that included a HAC-associated secondary diagnosis. Column B shows the frequency of discharges where the HAC-associated secondary diagnosis was

coded as not POA and identified as a HAC discharge. Column C shows the frequency of discharges in which the HAC-associated secondary diagnosis coded as not POA resulted in a change in MS–DRG. Columns D, E, F, and G show the frequency of discharges in which the HAC-associated secondary diagnosis coded as not POA did not result in a change in MS–DRG assignment. Columns D, E, F, and G are explained in more detail below.

(1) Other MCCs/CCs Prevent Reassignment

Column D (Other MCC/CCs that Prevent Reassignment) in Chart E below indicates the number of cases reporting a HAC-associated secondary diagnosis code that did not have a MS–DRG reassignment because of the presence of other secondary diagnoses on the MCC or CC list. A claim that is coded with a HAC-associated secondary diagnoses and a POA status of either "N" or "U" may have other secondary diagnoses that are classified as an MCC or a CC. In such cases, the presence of these other MCC and CC diagnoses will still lead to the assignment of a higher severity level, despite the fact that the GROUPER software is disregarding the ICD–9–CM code that identifies the selected HAC in making the MS–DRG assignment for that claim. For example, there were 83 cases in which the ICD–9–CM codes for the Foreign Object Retained After Surgery HAC category were present, but the presence of other secondary diagnoses that were MCCs or CCs resulted in no change to the MS–DRG assignment. Chart E shows that a total of 6,074 cases did not have a change in the MS–DRG assignment because of the presence of other reported MCCs and CCs.

(2) Two Severity Levels Where HAC Does Not Impact MS–DRG Assignment

Column E (Number of MS–DRGs with Two Severity Levels Where HAC Does Not Impact MS–DRG Assignment) shows the frequency with which discharges with a HAC as a secondary diagnosis coded as not POA did not result in an MS–DRG change because the MS–DRG is subdivided solely by the presence or absence of an MCC. A claim with a HAC and a POA indicator of either "N" or "U" may be assigned to an MS–DRG that is subdivided solely by the presence or absence of an MCC. In such cases, removing a HAC ICD–9–CM CC code will not lead to further changes in the MS–DRG assignment. Examples of these MS–DRG subdivisions are shown in the footnotes to the chart and include the following examples:

- MS–DRGs 100 and 101 (Seizures with or without MCC, respectively)
- MS–DRGs 102 and 103 (Headaches with or without MCC, respectively)

The codes that fall under the HAC category of Foreign Object Retained After Surgery are CCs. If this case were assigned to a MS–DRG with an MCC subdivision such as MS–DRGs 100 and 101, the presence of the HAC code would not affect the MS–DRG severity level assignment. In other words, if the Foreign Object Retained After Surgery code were the only secondary diagnosis reported, then the case would be assigned to MS–DRG 101. If the POA indicator was "N," the HAC Foreign Object Retained After Surgery code would be ignored in the MS–DRG assignment logic. Despite the fact that the code was ignored, the case would still be assigned to the same, lower severity level MS–DRG. Therefore, there would be no impact on the MS–DRG assignment.

Column E in Chart E below shows that there were 1,446 cases where the HAC code was "N" or "U" and the MS–DRG assignment did not change because the case was already assigned to the lowest severity level.

(3) No Severity Levels

Column F (Number of MS–DRGs with No Severity Levels) shows the frequency with which discharges with an HAC as a secondary diagnosis coded as not POA did not result in an MS–DRG change because the MS–DRG is not subdivided by severity levels. A claim with a HAC and a POA of "N" or "U" may be assigned to a MS–DRG with no severity levels. For instance, MS–DRG 311 (Angina Pectoris) has no severity level subdivisions; this MS–DRG is not split based on the presence of an MCC or a CC. If a patient assigned to this MS–DRG develops a secondary diagnosis such as a Stage III pressure ulcer after admission, the condition would be considered to be a HAC. The code for the Stage III pressure ulcer would be ignored in the MS–DRG assignment because the condition developed after the admission (the POA indicator was "N"). Despite the fact that the ICD–9–CM code for the HAC Stage III pressure ulcer was ignored, the MS–DRG assignment would not change. The case would still be assigned to MS–DRG 311. Chart E below shows that 818 cases reporting a HAC-associated secondary diagnosis did not undergo a change in the MS–DRG assignment based on the fact that the case was assigned to a MS–DRG that had no severity subdivisions (that is, the MS–DRG is not subdivided based on the presence or absence of an MCC or a CC, rendering the presence of the HAC irrelevant for payment purposes).

(4) MS–DRG Logic

Column G (MS–DRG Logic Issues) shows the frequency with which a HAC as a secondary diagnosis coded as not POA did not result in an MS–DRG change because of MS–DRG assignment logic. There were seven discharges where the HAC criteria were met and the HAC logic was applied, however, due to the structure of the MS–DRG logic, these cases did not result in MS–DRG reassignment. These cases may appear similar to those discharges where the MS–DRG is subdivided into two severity levels by the presence or absence of an MCC and did not result in MS–DRG reassignment; however, these discharges differ slightly in that the MS–DRG logic also considers specific procedures that were reported on the claim. In other words, for certain MS–DRGs, a procedure may be considered the equivalent of an MCC or CC. The presence of the procedure code dictates the MS–DRG assignment despite the presence of the HAC-associated secondary diagnosis code with a POA indicator of "N" or "U".

For example, a claim with the principal diagnosis code of 441.1 (Thoracic aneurysm, ruptured) with HAC-associated secondary diagnosis code of 996.64 (Infection and inflammatory reaction due to indwelling urinary catheter) and diagnosis code 599.0 (Urinary tract infection, site not specified), having POA indicators of "Y", "N", "N", respectively, and procedure code 39.73 (Endovascular implantation of graft in thoracic aorta) results in an assignment to MS–DRG 237 (Major Cardiovascular Procedures with MCC or Thoracic Aortic Aneurysm Repair). In this case, the thoracic aortic aneurysm repair is what dictated the MS–DRG assignment and the presence of the HAC-associated secondary diagnosis code, 996.64, did not affect the MS–DRG assigned. Other examples of MS–DRGs that are subdivided in this same manner are as follows:

- MS–DRG 029 (Spinal procedures with CC or Spinal Neurostimulators)
- MS–DRG 129 (Major Head & Neck Procedures with CC/MCC or Major Device)
- MS–DRG 246 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with MCC or 4+ Vessels/Stents)

Column G in the chart below shows that four of the seven cases that did not result in MS–DRG reassignment due to the MS–DRG logic were in the Catheter Associated UTI HAC category, one case was in the Foreign Body Retained after

Surgery HAC Category, one case was in the Falls and Trauma HAC category, and one case was in the Vascular Catheter-Associated Infection HAC Category.

In conclusion, a total of 8,345 cases (6,074 + 1,446 + 818 + 7) did not have a change in MS–DRG assignment, regardless of the presence of a HAC. The reasons described above explain why only 3,038 cases had a change in MS–DRG assignment despite the fact that there were 11,383 HAC cases with a POA of "N" or "U."

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CHART E.—REASONS HAC DID NOT CHANGE MS-DRG ASSIGNMENT OCTOBER 2008 THROUGH JUNE 2009

Selected HAC Category	Number of Discharges with This Condition as Secondary Diagnosis (Column A)	Number of Discharges Identified as a HAC (Column B	Number of HAC Discharges That Change MS-DRG Due to HAC (Column C)	HAC Discharges That Do Not Change MS-DRG			
				Number of Other MCCs/CCs That Prevent Reassign-ment (Column D)	Number of MS-DRGs with Two Severity Levels Where HAC Does Not Impact MS-DRG Assignment* (Column E)	Number of MS-DRGs with No Severity Levels (Column F)	Other MS-DRG Logic Issues ** (Column G)
1. Foreign Object Retained After Surgery – CC	378	172	40	83	42	6	1
2. Air Embolism – MCC	29	23	12	9	0	2	0
3. Blood Incompatibility-CC	23	8	0	4	3	1	0
4. Pressure Ulcer Stages III & IV – MCC	76,041	960	337	481	0	142	0
5. Falls and Trauma – MCC & CC	109,728	3,852	1,476	1,762	367	246	1
6. Catheter-Associated UTI- CC	11,424	1,896	197	1,326	250	119	4
7. Vascular Catheter-Associated Infection – CC	5,470	2,107	23	1,717	122	244	1
8. Poor Glycemic Control – MCC & CC	10,937	319	98	187	1	33	0
9A. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG) – MCC	29	21	5	13	0	3	0

Selected HAC Category	Number of Discharges with This Condition as Secondary Diagnosis (Column A)	Number of Discharges Identified as a HAC (Column B	Number of HAC Discharges That Change MS-DRG Due to HAC (Column C)	HAC Discharges That Do Not Change MS-DRG			
				Number of Other MCCs/CCs That Prevent Reassign-ment (Column D)	Number of MS-DRGs with Two Severity Levels Where HAC Does Not Impact MS-DRG Assignment* (Column E)	Number of MS-DRGs with No Severity Levels (Column F)	Other MS-DRG Logic Issues ** (Column G)
9B. Surgical Site Infection Following Certain Orthopedic Procedures – CC	199	123	4	68	48	3	0
9C. Surgical Site Infection Following Bariatric Surgery for Obesity – CC	12	10	1	9	0	0	0
10. Pulmonary Embolism & DVT Orthopedic – MCC & CC	2,494	1,892	845	415	613	19	0
Total[1]	216,764	11,383	3,038	6,074	1446	818	7

[1] Discharges can appear in more than one row. The total figure is not adjusted for the 47 discharges with more than one HAC that appear as secondary diagnoses (15 of these resulted in MS-DRG reassignment).
*Examples where an HAC classified as a CC would not impact the DRG assignment if it were removed. The MS-DRG is subdivided by the presence or absence of an MCC. A CC would not impact this DRG assignment.
MS-DRGs 100 and 101 (Seizures with or without MCC, respectively)
MS-DRGs 102 and 103 (Headaches with or without MCC, respectively)
**Cases where HAC did not change MS-DRG assignment because of the MS-DRG logic.
MS-DRG 029 (Spinal Procedures with CC or Spinal Neurostimulators)
MS-DRG 129 (Major Head & Neck Procedures with CC/MCC or Major Device)

SOURCE: RTI Analysis of MedPAR IPPS Claims, October 2008 through June 2009

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f. Preliminary RTI Analysis of Coding Changes for HAC-Associated Secondary Diagnoses for Current HACs

In addition to studying claims from October 2008 through June 2009, RTI evaluated claims data from 2 years prior to determine if there were significant changes in the number of discharges with a HAC being reported as a secondary diagnosis. To provide consistency with the FY 2009 data studied, RTI examined claims using discharge dates from October 2006 through June 2007 (for FY 2007) and October 2007 through June 2008 (for FY 2008) and compared these data to the FY 2009 data.

RTI's analysis found that there was an increase in the reporting of secondary diagnoses that are currently designated as HACs from FY 2007 to FY 2008. The most significant increase was in the Falls and Trauma HAC category, with 108,397 discharges being reported in FY 2007, while 116,832 discharges were reported in FY 2008, an increase of 8,435 cases.

However, the analysis found that there was a decrease in reported HAC-associated secondary diagnoses from FY 2008 to FY 2009. The most significant decrease was in the Falls and Trauma HAC category, with 116,832 discharges being reported in FY 2008, while 109,246 discharges were reported in FY 2009, a decrease of 7,586 cases. We point out that because diagnosis codes for the Pressure Ulcer Stages III & IV HAC did not become effective until October 1, 2008, there are no data available for FY 2007 or FY 2008.

We refer readers to the RTI detailed report for all the conditions in each fiscal year (FY 2007 through FY 2009) as described above at the following Web site: *http://www.rti.org/reports/cms/.*

g. Preliminary RTI Analysis of Estimated Net Savings for Current HACs

RTI determined preliminary estimates of the net savings generated by the HAC payment policy based on MedPAR claims from October 2008 through June 2009 for the 9-month period.

(1) Net Savings Estimation Methodology

The payment impact of a HAC is the difference between the IPPS payment amount under the initially assigned MS–DRG and the amount under the reassigned MS–DRG. The amount for the reassigned MS–DRG appears on the MedPAR files. To construct this, RTI modeled the IPPS payments for each MS–DRG following the same approach that we use to model the impact of IPPS annual rule changes. Specifically, RTI replicated the payment computations carried out in the IPPS PRICER program using payment factors for IPPS providers as identified in various CMS downloaded files. The files used are as follows:

- Version 26 of the Medicare Severity GROUPER software (applicable to discharges between October 1, 2008 and September 30, 2009). IPPS MedPAR claims were run through this file to obtain needed HAC–POA output variables.
- The FY 2009 MS–DRG payment weight file. This file includes the weights, geometric mean length of stay (GLOS), and the postacute transfer payment indicators.
- CMS standardized operating and capital rates. Tables 1A through 1C, as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009,* include the full update and reduced update amounts, as well as the information needed to compute the blended amount for providers located in Puerto Rico.
- The IPPS impact files for FY 2009, also as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009/.* This file includes the wage index and geographic adjustment factors, plus the provider type variable to identify providers qualifying for alternative hospital-specific amounts and their respective HSP rates.
- The IPPS impact files for FY 2010, as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/10FR/.* This file includes indirect medical education (IME) and disproportionate share (DSH) percent adjustments that were in effect as of March 2009.
- CMS historical provider-specific files (PSF). This includes the indicator to identify providers subject to the full or reduced standardized rates and the applicable operating and capital cost-to-charge ratios. An SAS version was downloaded from the Web site at: *http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp.*

There were 50 providers with discharges in the final HAC analysis file that did not appear in the FY 2009 impact file, of which 11 also did not appear in the FY 2010 impact file. For these providers, we identified the geographic CBSA from the historical PSF and assigned the wage index using values from Tables 4A and 4C as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009/.* For providers in the FY 2010 file but not the FY 2009 file, we used IME and DSH rates from FY 2010. The 11 providers in neither impact file were identified as non-IME and non-DSH providers in the historical PSF file.

The steps for estimating the HAC payment impact are as follows:

Step 1: Re-run the Medicare Severity GROUPER on all records in the analysis file. This is needed to obtain information on actual HAC-related MS–DRG reassignments in the file, and to identify the CCs and MCCs that contribute to each MS–DRG assignment.

Step 2: Model the base payment and outlier amounts associated with the initial MS–DRG if the HAC were excluded using the computations laid out in the CMS file "Outlier Example FY2007 new.xls," as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage,* and modified to accommodate FY 2009 factors. RTI's first round of computations treated all claims as though paid under standard IPPS rules without adjusting for short-stay transfers or HSP amounts.

Step 3: Model the base payment and outlier amounts associated with the final MS–DRG where the HAC was excluded using the computations laid out in the CMS file "Outlier Example FY2007 new.xls," as downloaded from the Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage* and modified to accommodate FY 2009 factors. RTI's first round of computations treated all claims as though paid under standard IPPS rules without adjusting for short-stay transfers or HSP amounts.

Step 4: Compute MS–DRG base savings as the difference between the nonoutlier payments for the initial and final MS–DRGs. Compute outlier amounts as the difference in outlier amounts due under the initial and final reassigned MS–DRG. Compute net savings due to HAC reassignment as the sum of base savings plus outlier amounts.

Step 5: Adjust the model to incorporate short-stay transfer payment adjustments.

Step 6: Adjust the model to incorporate hospital-specific payments for qualifying rural providers receiving the hospital-specific payment rates.

It is important to mention that using the methods described above, the MS–DRG and outlier payments amounts that are modeled for the final assigned MS–DRG do not always match the DRG price and outlier amounts that appear in the MedPAR record. There are several reasons for this. Some discrepancies are caused by using single wage index, IME and DSH factors for the full period

covered by the discharges, when in practice these payment factors can be adjusted for individual providers during the course of the fiscal year. In addition, RTI's approach disregards any Part A coinsurance amounts owed by individual beneficiaries with greater than sixty covered days in a spell of illness. Five percent of all HAC discharges showed at least some Part A coinsurance amount due from the beneficiary, although less than two percent of reassigned discharges (55 cases in the analysis file) showed Part A coinsurance amounts due. Any Part A coinsurance payments would reduce the actual savings incurred by the Medicare program.

There are also a number of less common special IPPS payment situations that are not factored into RTI's modeling. These could include new technology add-on payments, payments for blood clotting factors, reductions for replacement medical devices, adjustments to the capital rate for new providers, and adjustments to the capital rate for certain classes of providers who are subject to a minimum payment level relative to capital cost.

(2) Net Savings Estimate

Chart F below summarizes the estimated net savings of current HACs based on MedPAR claims from October 2008 through 2009, based on the methodology described above. Column A shows the number of discharges where an MS–DRG reassignment for each HAC category occurred. For example, there were 12 discharges with an Air Embolism that resulted in an actual MS–DRG reassignment. Column B shows the total net savings caused by MS–DRG reassignments for each HAC category. Continuing with the example of Air Embolism, the chart shows that the 12 discharges with an MS–DRG reassignment resulted in a total net savings of $148,394. Column C shows the net savings per discharge for each HAC category. For the Air Embolism HAC category, the net savings per discharge is $12,366.

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CHART F.—ESTIMATED NET SAVINGS OF CURRRENT HACs OCTOBER 2008 THROUGH JUNE 2009

Selected HAC	Number of Discharges That Change MS-DRG Due to HAC (Column A)	Net Savings (In Dollars) (Column B)	Net Savings Per Discharge (In Dollars) (Column C)
1. Foreign Object Retained After Surgery	40	$142,681	$3,567
2. Air Embolism	12	$148,394	$12,366
3. Blood Incompatibility	0	$0	$0
4. Pressure Ulcer Stages III & IV	337	$1,869,956	$5,549
a. Stage III	286	$1,552,057	$5,427
b. Stage IV	57	$340, 263	$5,970
5. Falls and Trauma	1,476	$7,580,774	$5,136
a. Fracture	1,267	$6,523,144	$5,148
b. Dislocation	3	$13,984	$4,661
c. Intracranial Injury	213	$1,089,813	$5,116
d. Crushing Injury	0	$0	$0
e. Burn	6	$21,639	$3,607
f. Shock	1	$12,749	$12,749
6. Catheter-Associated UTI	197	$567,933	$2,883
7. Vascular Catheter-Associated Infection	23	$74,586	$3,243
8. Poor Glycemic Control	98	$489,733	$4,997
9a. SSI Mediastinitis CABG	5	$54,276	$10,855
9b. SSI Orthopedic	4	$39,363	$9,841
9c. SSI Bariatric	1	$2,381	$2,381
10. Pulmonary Embolism & DVT Orthopedic	845	$5,605,229	$6,633
Total[1]	3,038	$16,442,185[2]	$5,456

[1] Discharges can appear in more than one row. The total figure is not adjusted for the 47 discharges with more than one HAC that appear as secondary diagnoses (15 of these resulted in MS-DRG reassignment).
[2] Total net savings is adjusted by -$133,122 for 15 claims that have multiple HACs.

SOURCE: RTI Analysis of MedPAR IPPS Claims, October 2008 through June 2009.

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As shown in Chart F above, the total net savings calculated for the 9-month period from October 2008 through June 2009 was roughly $16.44 million. The three HACs with the largest number of discharges resulting in MS–DRG reassignment, Falls and Trauma, Orthopedic PE/DVT, and Pressure Ulcer Stages III & IV, generated $15.10 million of net savings for the 9-month period. Estimated net savings for the 9-month period associated with the Falls and Trauma category were $7.58 million. Estimated net savings associated with Orthopedic PE/DVT for the 9-month period were $5.61 million. Estimated net savings for the 9-month period associated with Pressure Ulcer Stages III & IV were $1.87 million.

The mean net savings per discharge calculated for the 9-month period from October 2008 through June 2009 was roughly $5,456. The HAC categories of Air Embolism; SSI, Mediastinitis, Following Coronary Artery Bypass Graft (CABG); and SSI Following Certain Orthopedic Procedures had the highest net savings per discharge, but represented a small proportion of total net savings because the number of discharges that resulted in MS–DRG reassignment for these HACs was low. With the exception of Blood Incompatibility, where no savings occurred because no discharges resulted in MS–DRG reassignment, SSI Following Bariatric Surgery for Obesity and Catheter-Associated UTI had the lowest net savings per discharge.

We refer readers to the RTI detailed report available at the following Web site: *http://www.rti.org/reports/cms/*.

As mentioned previously, an extremely small number of cases in the 9-month period of FY 2009 analyzed by RTI had multiple HACs during the same stay. In reviewing our 7.17 million claims, RTI found 47 cases where two HACs were reported on the same admission as noted in section II.F.3.g.(2) of this preamble. Of these 47 claims, 15 resulted in MS–DRG reassignment. Chart G below summarizes these cases. There were 15 cases that had two HACs not POA that resulted in an MS–DRG reassignment. Of these, 5 discharges involved Pressure Ulcer Stages III & IV and Falls and Trauma and 4 discharges involved Orthopedic PE/DVT and Falls and Trauma.

CHART G—CLAIMS WITH MORE THAN ONE HAC SECONDARY DIAGNOSIS WHERE MS–DRG REASSIGNMENT OCCURRED OCTOBER 2008 THROUGH JUNE 2009

Selected HAC	4. Pressure ulcer stages III & IV—MCC	5. Falls and trauma—MCC & CC	6. Catheter-associated UTI—CC
3. Blood Incompatibility—CC		1	
5. Falls and Trauma—MCC & CC	5		
6. Catheter-Associated Urinary Tract Infection (UTI)—CC	1	1	
7. Vascular Catheter-Associated Infection—CC		1	1
10. Pulmonary Embolism & DVT Orthopedic—MCC	1	4	
Total	7	7	1

As we discuss in section II.F.1.b. of this preamble, implementation of this policy is the part of an array of Medicare VBP tools that we are using to promote increased quality and efficiency of care. We point out that a decrease over time in the number of discharges where these conditions are not POA is a desired consequence. We recognize that estimated net savings would likely decline as the number of such discharges decline. However, we believe that the sentinel effect resulting from CMS identifying these conditions is critical. (We refer readers to section IV.A. of this preamble for a discussion of the inclusion of the incidence of these conditions in the RHQDAPU program.) It is our intention to continue to monitor trends associated with the frequency of these HACs and the estimated net payment impact through RTI's program evaluation and possibly beyond.

h. Previously Considered Candidate HACs—Preliminary RTI Analysis of Frequency of Discharges and POA Indicator Reporting

RTI evaluated the frequency of conditions previously considered, but not adopted as HACs in prior rulemaking, that were reported as secondary diagnoses (across all 7.17 million discharges) as well as the POA indicator assignments for these conditions. Chart H below indicates that the three previously considered candidate conditions most frequently reported as a secondary diagnosis were: (1) Clostridium Difficile-Associated Disease (CDAD), which demonstrated the highest frequency, with a total of 66,502 secondary diagnoses codes being reported for that condition, of which 23,323 reported a POA indicator of "N"; (2) Staphylococcus aureus Septicemia, with a total of 17,662 secondary diagnoses codes being reported for that condition, with 3,949 of those reporting a POA indicator of "N"; and (3) Iatrogenic Pneumothorax, with a total of 16,765 secondary diagnoses codes being reported for that condition, with 14,604 of those reporting a POA indicator of "N." As these three conditions had the most significant impact for reporting a POA indicator of "N," it is reasonable to believe that these same three conditions would have the greatest number of potential MS–DRG reassignments. The frequency of discharges for the previously considered HACs that could lead to potential changes in MS–DRG assignment is discussed in the next section. We take this opportunity to remind readers that because more than one previously considered HAC diagnosis code can be reported per discharge (on a single claim) that the frequency of these diagnosis codes may be more than the actual number of discharges with a previously considered candidate condition reported as a secondary diagnosis.

CHART H.--POA STATUS OF PREVIOUSLY CONSIDERED "CANDIDATE" HAC CONDITIONS--OCTOBER 2008 THROUGH JUNE 2009

Previously Considered HAC Condition	Frequency as a Secondary Diagnosis	Not Present on Admission				Present on Admission			
		POA = N		POA = U		POA =Y		POA = W	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
1. Clostridium Difficile-Associated Disease (CDAD)	66,502	23,323	35.1	379	0.6	42,702	64.2	98	0.1
2. Delirium	528	136	25.8	0	0.0	392	74.2	0	0.0
3. Legionnaire's Disease	249	14	5.6	3	1.2	232	93.2	0	0.0
4. Staphylococcus aureus Septicemia	17,662	3,949	44.4	45	0.5	13,641	154.8	27	0.3
5. Methicillin-Resistant Staphylococcus aureus	54,744	1,834	6.0	136	0.9	52,737	192.6	37	0.5
6. Iatrogenic Pneumothorax	16,765	14,604	87.1	12	0.1	2,149	12.8	0	0.0
7. Ventilator-Associated Pneumonia	3,253	2,576	79.2	4	0.1	672	20.7	1	0.0

In Chart I below, Column A shows the number of discharges for each previously considered candidate HAC category when the condition was reported as a secondary diagnosis. For example, there were 66,502 discharges that reported CDAD as a secondary diagnosis. Previously considered candidate HACs reported with a POA indicator of "N" or "U" may cause MS–DRG reassignment (which would result in reduced payment to the facility). Column C shows the discharges for each previously considered candidate HAC reported with a POA indicator of "N" or "U." Continuing with the example of CDAD, Chart I shows that, of the 66,502 discharges, 23,702 discharges (35.64 percent) had a POA indicator of "N" or "U." Therefore, there were a total of 23,702 discharges that could potentially have had an MS–DRG reassignment. Column E shows the number of discharges where an actual MS–DRG reassignment could have occurred; the number of discharges with CDAD that could have resulted in actual MS–DRG reassignments is 739 (3.12 percent). Thus, while there were 23,702 discharges with CDAD reported with a POA indicator of "N" or "U" that could potentially have had an MS–DRG reassignment, the result was 739 (3.12 percent) potential MS–DRG reassignments. As discussed above, there are a number of reasons why a condition reported with a POA indicator of "N" or "U" would not result in a MS–DRG reassignment.

In summary, Chart I below demonstrates there were a total of 159,485 discharges with a previously considered candidate HAC reported as a secondary diagnosis. Of those, 47,010 discharges were reported with a POA indicator of "N" or "U." The total number of discharges that could have resulted in MS–DRG reassignments is 2,932.

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CHART I.--PREVIOUSLY CONSIDERED "CANDIDATE" HAC DISCHARGE FREQUENCIES--OCTOBER 2008 THROUGH JUNE 2009

Previously Considered HAC Condition	Discharges with this Condition as Secondary Diagnosis[2]		Discharges with this Condition Not Present on Admission (POA = "N" or "U")[3]		Cases that Could Change MS-DRG Due to Previously Considered Candidate HAC[4]	
	Number (Column A)	Percent (Column B)	Number (Column C)	Percent (Column D)	Number (Column E)	Percent (Column F)
1. Clostridium Difficile-Associated Disease (CDAD)	66,502	0.93%	23,702	35.64%	739	3.12%
2. Delirium	528	0.01%	136	25.76%	11	8.09%
3. Legionnaire's Disease	249	0.00%	17	6.83%	1	5.88%
4. Staphylococcus aureus Septicemia	17,630	0.25%	3,991	22.64%	90	2.26%
5. Methicillin-Resistant Staphylococcus aureus (MRSA)	54,558	0.76%	1,968	3.61%	2	0.10%
6. Iatrogenic Pneumothorax	16,765	0.23%	14,616	87.18%	2,088	14.29%
7. Ventilator-Associated Pneumonia	3,253	0.05%	2,580	79.31%	1	0.04%
Total[1]	159,485		47,010		2,932	

[1] Discharges can appear in more than one row.
[2] Percent computed relative to total cases "at risk," which is 7,175,139 for all candidate conditions.
[3] Percent computed relative to discharges with condition as a secondary diagnosis.
[4] Percent computed relative to discharges with condition as a secondary diagnosis and identified as a previously considered HAC (that is, coded as not present on admission).

SOURCE: RTI Analysis of MedPAR IPPS Claims, October 2008 through June 2009.

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i. Current and Previously Considered Candidate HACs—RTI Report on Evidence-Based Guidelines

The RTI program evaluation includes a report that provides references for all evidence-based guidelines available for each of the selected and previously considered candidate HACs that provide recommendations for the prevention of the corresponding conditions. Guidelines were primarily identified using the AHRQ National Guidelines Clearing House (NGCH) and the CDC, along with relevant professional societies. Guidelines published in the United States were used, if available. In the absence of U.S. guidelines for a specific condition, international guidelines were included.

Evidence-based guidelines that included specific recommendations for the prevention of the condition were identified for each of the 10 selected conditions. In addition, evidence-based guidelines were also found for the previously considered candidate conditions.

RTI prepared a final report to summarize its findings regarding evidence-based guidelines, which can be found on the Web site at: *http://www.rti.org/reports/cms.*

j. Proposals Regarding Current HACs and Previously Considered Candidate HACs

We believe that the RTI analysis summarized above does not provide additional information that would require us to change our previous determinations regarding either current HACs (as described in section II.F.2. of this preamble) or previously considered candidate HACs in the FY 2008 IPPS final rule with comment period and FY 2009 IPPS final rule (72 FR 47200 through 47218 and 73 FR 48471 through 48491, respectively). Accordingly, we are not proposing to add or remove categories of HACs at this time, although we note that we are proposing

to revise the Blood Incompatibility HAC category as discussed in section II.F.2. of this preamble. (We also note that, as discussed in section II.F.3.b. of this preamble, we are not proposing to change our current policy regarding the treatment of the "U" POA indicator.) However, we continue to encourage public dialogue about refinements to the HAC list.

We refer readers to section II.F.6. of the FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218) and to section II.F.7. of the FY 2009 IPPS final rule (73 FR 48474 through 48491) for detailed discussion supporting our determination regarding each of these conditions.

G. Proposed Changes to Specific MS–DRG Classifications

We are inviting public comment on each of the MS–DRG classification proposed changes described below, as well as our proposals to maintain certain existing MS–DRG classifications, which are also discussed below. In some cases, we are proposing changes to the MS–DRG classifications based on our analysis of claims data. In other cases, we are proposing to maintain the existing MS–DRG classification based on our analysis of claims data.

1. Pre-Major Diagnostic Categories (MDCs)

a. Postsurgical Hypoinsulinemia (MS–DRG 008 (Simultaneous Pancreas/Kidney Transplant)

Diabetes mellitus is a pancreatic disorder in which the pancreas fails to produce sufficient insulin, or in which the body cannot process insulin. Many patients with diabetes will eventually experience complications of the disease, including poor kidney function. When these patients show signs of advanced kidney disease, they are usually referred for transplant evaluation. Currently, many doctors recommend that individuals with diabetes being evaluated for kidney transplantation also be considered for pancreas transplantation. A successful pancreas transplant may prevent, stop, or reverse the complications of diabetes.

Occasionally, secondary diabetes may be surgically induced following a pancreas transplant. This condition would be identified by using ICD–9–CM diagnosis code 251.3 (Postsurgical hypoinsulinemia). However, currently the list of principal diagnosis codes assigned to surgical MS–DRG 008 (Simultaneous Pancreas/Kidney Transplant) does not include diagnosis code 251.3. Therefore, when diagnosis code 251.3 is assigned to a case as a principal diagnosis, the case is not assigned to MS–DRG 008. Instead, these cases are grouped to MS–DRG 652 (Kidney Transplant) under MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract). In addition, the use of diagnosis code 251.3 as a principal diagnosis without a secondary diagnosis of diabetes mellitus and with a procedure code for pancreas transplant only during that admission results in assignment of the case to MS–DRG 628, 629, or 630 (Other Endocrine, Nutritional & Metabolic Operating Room Procedures with MCC, with CC, and without CC/MCC, respectively) under MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders).

We believe that the exclusion of diagnosis code 251.3 from the list of principal diagnosis codes assigned to surgical MS–DRG 008 is an error of omission. Therefore, we are proposing to add diagnosis code 251.3 to the list of principal or secondary diagnosis codes assigned to MS–DRG 008. As a conforming change, we also are proposing to add diagnosis code 251.3 to the list of principal or secondary diagnosis codes assigned to MS–DRG 010 (Pancreas Transplant).

b. Bone Marrow Transplants

We received two requests to review whether cost differences between an autologous bone marrow transplant (where the patient's own bone marrow or stem cells are used) and an allogeneic bone marrow transplant (where bone marrow or stem cells come from either a related or unrelated donor) necessitate the creation of separate MS DRGs to more appropriately account for the clinical nature of the services being rendered as well as the costs. One of the requestors stated that there are dramatic differences in the costs between the two types of transplants where allogeneic cases are significantly more costly.

Bone marrow transplantation and peripheral blood stem cell transplantation are used in the treatment of certain cancers and bone marrow diseases. These procedures restore stem cells that have destroyed by high doses of chemotherapy and/or radiation treatment. Currently, all bone marrow transplants are assigned to MS–DRG 009 (Bone Marrow Transplant).

We performed an analysis of the FY 2009 MedPAR data and found 1,664 total cases assigned to MS–DRG 009 with average costs of approximately $43,877 and an average length of stay of approximately 21 days. Of these MS–DRG 009 cases, 395 of them were allogeneic bone marrow transplant cases reported with one of the following ICD–9–CM procedure codes: 41.02 (Allogeneic bone marrow transplant with purging); 41.03 (Allogeneic bone marrow transplant without purging); 41.05 (Allogeneic hematopoietic stem cell transplant without purging); 41.06 (Cord blood stem cell transplant); or 41.08 (Allogeneic hematopoietic stem cell transplant). The average costs of these allogeneic cases, approximately $64,845, were higher than the overall average costs of all cases in MS–DRG 009, approximately $43,877. The average length of stay for the allogeneic cases, approximately 28 days, was slightly higher than the average length of stay for all cases assigned to MS–DRG 009, approximately 21 days.

We found 1,269 autologous bone marrow transplant cases reported with one of the following ICD–9–CM procedure codes: 41.00 (Bone marrow transplant, not otherwise specified); 41.01 (Autologous bone marrow transplant without purging); 41.04 (Autologous hematopoietic stem cell transplant without purging); 41.07 (Autologous hematopoietic stem cell transplant with purging); or 41.09 (Autologous bone marrow transplant with purging). The average costs of these cases, approximately $37, 350, was less than the overall average costs of all cases in MS–DRG 009 and the average costs associated with the allogeneic bone marrow transplant cases. The average length of stay, of approximately 19 days, was less than the average lengths of stay for all the cases assigned to MS–DRG 009 and for the allogeneic bone marrow transplant cases. We included in our analysis of the autologous bone marrow transplants cases, 5 cases that were reported with procedure code 41.00 (Bone marrow transplant, not otherwise specified). These 5 cases had average costs of approximately $41,084 and an average length of stay of approximately 12 days, which was similar to the other autologous bone marrow transplant cases.

The table below illustrates our findings:

MS–DRG	Number of cases	Average length of stay	Average cost
009—All cases	1,664	21.22	$43,877
009—Cases with allogeneic bone marrow transplants	395	27.7	64,845
009—Cases with autologous bone marrow transplants	1,269	19.1	37,350

As a result of our analysis, the data support the requestor's suggestion that there are cost differences associated with the autologous bone marrow transplants and allogeneic bone marrow transplants and warrants a separate MS–DRG for these procedures. Therefore, we are proposing to delete MS–DRG 009 and create two new MS–DRGs: MS–DRG 014 (Allogeneic Bone Marrow Transplant) and MS–DRG 015 (Autologous Bone Marrow Transplant).

Proposed MS–DRG 014 would include cases reported with one of the following ICD–9–CM procedure codes:

- 41.02, Allogeneic bone marrow transplant with purging
- 41.03, Allogeneic bone marrow transplant without purging
- 41.05, Allogeneic hematopoietic stem cell transplant without purging
- 41.06, Cord blood stem cell transplant
- 41.08, Allogeneic hematopoietic stem cell transplant

Proposed MS–DRG 015 would include cases reported with one of the following ICD–9–CM procedure codes:

- 41.00 (Bone marrow transplant, not otherwise specified)
- 41.01 (Autologous bone marrow transplant without purging)
- 41.04 (Autologous hematopoietic stem cell transplant without purging)
- 41.07 (Autologous hematopoietic stem cell transplant with purging)
- 41.09 (Autologous bone marrow transplant with purging)

2. MDC 1 (Nervous System): Administration of Tissue Plasminogen Activator (tPA) (rtPA)

During the comment period for the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we received a public comment that had not been the subject of a proposal in that proposed rule. The commenter had requested that CMS conduct an analysis of diagnosis code V45.88 (Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility) under MDC 1 (Diseases and Disorders of the Nervous System). Diagnosis code V45.88 was created for use beginning October 1, 2008, to identify patients who are given tissue plasminogen activator (tPA) at one institution and then transferred and admitted to a comprehensive stroke center for further care. This situation is referred to as the "drip-and-ship" issue that was discussed at detail in the FY 2009 IPPS final rule (73 FR 48493).

According to the commenter, the concern at the receiving facilities is that the costs associated with [caring for] more complex stroke patients that receive tPA are much higher than the cost of the drug, presumably because stroke patients initially needing tPA have more complicated strokes and outcomes. However, because these patients do not receive the tPA at the second or transfer hospital, the receiving hospital will not be assigned to one of the higher weighted tPA stroke MS–DRGs when it admits these patients whose care requires the use of intensive resources. The MS–DRGs that currently include codes for the use of tPA are: 061 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC); 062 (Acute Ischemic Stroke with Use of Thrombolytic Agent with CC); and 063 (Acute Ischemic Stroke with Use of Thrombolytic Agent without CC/MCC). These MS–DRGs have higher relative weights than the next six MS–DRGs relating to brain injury in the hierarchy. The commenter requested an analysis of the use of diagnosis code V45.88 reflected in the MedPAR data for FY 2009 and FY 2010. The commenter believed that the data would show that the use of this code could potentially result in a new MS–DRG or a new set of MS–DRGs in FY 2011.

In addressing this public comment in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43798), we noted that the comment was out of scope for the FY 2010 proposed rule and reiterated that the deadline for requesting data review and potential MS–DRG changes had been the previous December. We are now able to address the commenter's concern because we have been able to conduct an analysis of MedPAR claims data for this diagnosis code for this proposed rule.

For this proposed rule, we undertook an analysis of MedPAR claims data for FY 2009. For our analysis, we did not include claims for patient cases assigned to MS–DRGs 061, 062, or 063 because patients whose cases were assigned to these MS–DRGs would have been given the tPA at the initial hospital, with assignment of procedure code 99.10 (Injection or infusion of thrombolytic agent), prior to their transfer to a comprehensive stroke center. The tPA should not have been given at the receiving hospital; therefore, inclusion of code 99.10 on their claims would constitute erroneous coding. Likewise, we did not include MS–DRGs 067 and 068 (Nonspecific CVA & Precerebral Occlusion without Infarction with MCC, and without MCC, respectively), or MS–DRG 069 (Transient Ischemia). Claims assigned to MS–DRGs 067, 068, and 069 are unlikely to contain cases in which tPA had been administered.

Our data analysis included MS–DRGs 064, 065, and 066 (Intracranial Hemorrhage or Cerebral Infarction with MCC, with CC, and without CC/MCC, respectively) because claims involving diagnosis code V45.88 would be properly reported in the data for these MS–DRGs for FY 2009. The following table reflects the results of our analysis of the MedPAR data in which diagnosis code V45.88 was reported as a secondary diagnosis for FY 2009.

MS–DRG	Number of cases	Average length of stay	Average cost
MS–DRG 064—All Cases	65,884	6.80	$11,305
MS–DRG 064—Cases with secondary diagnosis code V45.88	249	7.00	12,285
MS–DRG 065—All Cases	96,274	4.75	7,264
MS–DRG 065—Cases with secondary diagnosis code V45.88	448	5.06	8,732
MS–DRG 066—All Cases	62,337	3.29	5,291

MS–DRG	Number of cases	Average length of stay	Average cost
MS–DRG 066—Cases with secondary diagnosis code V45.88	210	3.35	6,325

Based on our review of the data for all of the cases in MS–DRGs 064, 065, and 066, compared to the subset of cases containing the V45.88 secondary diagnosis code, we concluded that the movement of cases with diagnosis code V45.88 as a secondary diagnosis from MS–DRGs 064, 065, and 066 into MS–DRGs 061, 062, and 063 is not warranted. We determined that the differences in the average lengths of stay and the average costs are too small to warrant an assignment to the higher weighted MS–DRGs. Likewise, neither the lengths of stay nor the average costs are substantial enough to justify the creation of an additional MS–DRG for transferred tPA cases, or to create separate MS–DRGs that would mirror the MCC, CC or without CC/MCC severity levels.

Therefore, for FY 2011, we are not proposing any change to MS–DRGs 061, 062, 063, 064, 065, or 066, or any change involving the assignment of diagnosis code V45.88.

3. MDC 5 (Diseases and Disorders of the Circulatory System): Intraoperative Fluorescence Vascular Angiography (IFVA) and X–Ray Coronary Angiography in Coronary Artery Bypass Graft Surgery

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR43785 through 43787), we discussed a request we received to reassign cases reporting the use of intraoperative fluorescence vascular angiography (IFVA) with coronary artery bypass graft (CABG) procedures from MS–DRGs 235 and 236 (Coronary Bypass without Cardiac Catheterization with and without MCC, respectively) to MS–DRG 233 (Coronary Bypass with Cardiac Catheterization with MCC) and MS–DRG 234 (Coronary Bypass with Cardiac Catheterization without MCC). Effective October 1, 2007, procedure code 88.59 (Intraoperative fluorescence vascular angiography (IFVA)) was established to describe this technology.

In addition, we also discussed receiving related requests (74 FR 43798 through 43799) that were outside the scope of issues addressed for MDC 5 in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. There were three components to these requests. The first component involved the creation of new MS–DRGs. One request was to create four new MS–DRGs that would differentiate the utilization of resources between intraoperative angiography and IFVA when utilized with CABG. A second request was to create only one new MS–DRG to separately identify the use of intraoperative angiography, by any method, in CABG surgery. The second component involved reviewing the ICD–9–CM procedure codes. Currently, the ICD–9–CM procedure codes do not distinguish between preoperative, intraoperative, and postoperative angiography. Procedure code 88.59 (Intraoperative fluorescence vascular angiography (IFVA)) is one intraoperative angiography technique that allows visualization of the coronary vasculature. The third component involved reassigning cases with procedure code 88.59 to the "Other Cardiovascular MS–DRG"s: MS–DRGs 228, 229, and 230 (Other Cardiothoracic Procedures with MCC, CC, and without CC/MCC, respectively). We stated our intent to consider these requests during the FY 2011 rulemaking process.

After publication of the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we were contacted by one of the requestors, the manufacturer of the IFVA technology. We met with the requestor in mid-November 2009 to discuss evaluating the data for IFVA (procedure code 88.59) again in consideration of a proposal to create new MS–DRGs and to discuss a request for a new procedure code(s).

IFVA technology consists of a mobile device imaging system with software. It is used to test cardiac graft patency and technical adequacy at the time of coronary artery bypass grafting (CABG). While this system does not involve fluoroscopy or cardiac catheterization, it has been suggested that it yields results that are similar to those achieved with selective coronary arteriography and cardiac catheterization. Intraoperative coronary angiography provides information about the quality of the anastomosis, blood flow through the graft, distal perfusion, and durability. For additional information regarding IFVA technology, we refer readers to the September 28–29, 2006 ICD–9–CM Coordination and Maintenance Committee meeting handout at the following Web site: *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp#TopOfPage.*

a. New MS–DRGs for Intraoperative Fluorescence Vascular Angiography (IFVA) With CABG

As stated earlier, the manufacturer requested that we create four new MS–DRGs for CABG to distinguish CABG surgeries performed with IFVA and those performed without IFVA. According to the requestor, these four new MS–DRGs would correspond to the existing MS–DRG for CABG but would also include intraoperative angiography. The requestor proposed the following four new MS–DRGs:

MS–DRG XXX (Coronary Bypass with Cardiac Catheterization with MCC with Intraoperative Angiography)

MS–DRG XXX (Coronary Bypass with Cardiac Catheterization without MCC with Intraoperative Angiography)

MS–DRG XXX (Coronary Bypass without Cardiac Catheterization with MCC with Intraoperative Angiography)

MS–DRG XXX (Coronary Bypass without Cardiac Catheterization without MCC with Intraoperative Angiography)

Using claims data from the FY 2009 MedPAR file, we examined cases identified by procedure code 88.59 in MS–DRGs 233, 234, 235, and 236. As shown in the table below, for both MS–DRGs 235 and 236, the cases utilizing IFVA technology (code 88.59) have a shorter length of stay and lower average costs compared to all cases in MS–DRGs 235 and 236. There were a total of 10,281 cases in MS–DRG 235 with an average length of stay of 10.61 days and average costs of $34,639. There were 114 cases identified by procedure code 88.59 with an average length of stay of 10.38 days with average costs of $28,238. In MS–DRG 236, there were a total of 22,410 cases with an average length of stay of 6.37 days and average costs of $23,402; and there were 186 cases identified by procedure code 88.59 with an average length of stay of 6.54 days and average costs of $19,305. Similar to the data reported last year, the data for FY 2009 clearly demonstrate that the IFVA cases (identified by procedure code 88.59) are assigned appropriately to MS–DRGs 235 and 236. We also examined cases identified by procedure code 88.59 in MS–DRGs 233 and 234. Likewise, in MS–DRGs 233 and 234 cases identified by code 88.59 reflect shorter lengths of stay and lower

average costs compared to the remainder of the cases in those MS–DRGs; and there were a total of 16,475 cases in MS–DRG 233 with an average length of stay of 13.47 days and average costs of $42,662. There were 58 cases identified by procedure code 88.59 with an average length of stay of 12.12 days and average costs of $35,940. In MS–DRG 234, there were a total of 23,478 cases with an average length of stay of 8.61 days and average costs of $29,615; and there were 67 cases identified by procedure code 88.59 with an average length of stay of 8.85 days and average costs of $25,379. The data clearly demonstrate the IFVA cases (identified by procedure code 88.59) are appropriately assigned to MS–DRGs 233 and 234.

MS–DRG	Number of cases	Average length of stay	Average cost
235—All cases	10,281	10.61	$34,639
235—Cases with procedure code 88.59	114	10.38	28,238
235—Cases without procedure code 88.59	10,167	10.62	34,711
236—All cases	22,410	6.37	23,402
236—Cases with code procedure 88.59	186	6.54	19,305
236—Cases without procedure code 88.59	22,224	6.37	23,436

MS–DRG	Number of cases	Average length of stay	Average cost
233—All cases	16,475	13.47	$42,662
233—Cases with procedure code 88.59	58	12.12	35,940
233—Cases without procedure code 88.59	16,417	13.47	42,686
234—All cases	23,478	8.61	29,615
234—Cases with procedure code 88.59	67	8.85	25,379
234—Cases without procedure code 88.59	23,411	8.61	29,627

If the cases identified by procedure code 88.59 were proposed to be reassigned from MS–DRGs 235 and 236 to MS–DRGs 233 and 234, they would be significantly overpaid. In addition, because the cases in MS–DRGs 235 and 236 did not actually have a cardiac catheterization performed, a proposal to reassign cases identified by procedure code 88.59 would result in lowering the relative weights of MS–DRGs 233 and 234 where a cardiac catheterization is truly performed.

In summary, the data do not support moving IFVA cases (procedure code 88.59) from MS–DRGs 235 and 236 to MS–DRGs 233 and 234. Therefore, we are not proposing to make any MS–DRG modifications for cases reporting procedure code 88.59 for FY 2011.

b. New MS–DRG for Intraoperative Angiography, by Any Method, With CABG

We also received a request to create a single MS–DRG for any type of intraoperative angiography utilized in CABG surgery. The requestor suggested the following title for the proposed new MS–DRG: XXX Coronary Bypass with Intraoperative Angiography, by any Method.

Currently, the only ICD–9–CM procedure code that identifies an intraoperative angiography is procedure code 88.59 (Intraoperative fluorescence vascular angiography), as described in the previous section. Due to the structure of the ICD–9–CM procedure classification system, it is not possible to distinguish when other types of angiography are performed intraoperatively. Therefore, we are unable to evaluate any data, other than that for procedure code 88.59, as shown in the tables above. We are not proposing to create a new MS–DRG in FY 2011 for coronary bypass with intraoperative angiography, by any method.

c. New Procedure Codes

In response to our invitation to submit public comments regarding the proposal not to make any MS–DRG modifications for cases reporting procedure code 88.59 in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24106–24107), one requestor presented another option involving the creation of new ICD–9–CM procedure codes. According to the requestor, the purpose of these new codes would be to separately identify the two technologies used to perform intraoperative coronary angiography in CABG surgery: X-ray coronary angiography with cardiac catheterization and fluoroscopy versus intraoperative fluorescence coronary angiography (IFVA). The requestor stated that due to the structure of the current codes and MS–DRGs for CABG, it is difficult to identify when x-ray angiography is performed.

X-ray angiography is commonly performed as a separate procedure in a catheterization laboratory. Currently, there are no procedure codes to distinguish if this angiography was performed preoperatively, intraoperatively, and/or postoperatively. We informed the requestor that they could submit a proposal for creating a new procedure code(s) to the ICD–9–CM Coordination and Maintenance Committee for its consideration. Therefore, this topic will be further evaluated through the ICD–9–CM Coordination and Maintenance Committee meeting process.

d. MS–DRG Reassignment of Intraoperative Fluorescence Vascular Angiography (IFVA)

One requestor suggested reassigning procedure code 88.59 (Intraoperative Fluorescence Vascular Angiography), to the "Other Cardiovascular MS–DRGs:" MS–DRGs 228, 229, and 230 (Other Cardiothoracic Procedures with MCC, CC, and without CC/MCC, respectively). The requestor noted that these MS–DRGs have three levels of severity and that other procedures assigned to these MS–DRGs (for example, transmyocardial revascularization) are frequently performed at the same time as a CABG. The requestor believed that reassigning cases that report IFVA (procedure code 88.59) to these MS–DRGs would not result in a significant overpayment to hospitals.

We point out that, in the surgical hierarchy, MS–DRGs 228, 229, and 230 rank higher than MS–DRGs 233, 234, 235, and 236, which were evaluated in the above tables for CABG procedures

performed with IFVA (procedure code 88.59). The surgical hierarchy reflects the relative resource requirements of various surgical procedures. For example, if a CABG surgery were performed along with another procedure currently assigned to MS–DRGs 228, 229, and 230, the case would be assigned to one of the "Other Cardiothoracic Procedures MS–DRGs" (228, 229, and 230) because patients with multiple procedures are assigned to the highest surgical hierarchy to which one of the procedures is assigned.

Therefore, as the data shown above did not demonstrate that IFVA utilized an equivalent (or additional) amount of resources as a cardiac catheterization to warrant a proposal to reassign IFVA cases to MS–DRGs 233 and 234 and the fact that IFVA cases with CABG performed with a procedure assigned to MS–DRGs 228, 229, and 230 would already be grouped to those same MS–DRGs, we are not proposing to reassign cases reporting procedure code 88.59 to MS–DRGs 228, 229, and 230 for FY 2011.

4. MDC 6 (Diseases and Disorders of the Digestive System): Gastrointestinal Stenting

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR43799), we discussed a request we received to create new MS–DRGs in FY 2011 to better identify patients who undergo the insertion of a gastrointestinal stent. The request was considered outside the scope of issues addressed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule; therefore, we stated our intent to consider this request during the FY 2011 rulemaking process.

Gastrointestinal stenting is performed by inserting a tube (stent) into the esophagus, duodenum, biliary tract or colon to reestablish or maintain patency of these structures and allow swallowing, drainage, or passage of waste. The commenter requested that the new MS–DRGs be subdivided into three severity levels (with MCC, with CC, and without CC/MCC) to better align payment rates with resource consumption and improve the clinical coherence of these cases.

In its own analysis using FY 2008 MedPAR data, the commenter identified gastrointestinal stenting cases using relevant diagnosis codes and a combination of procedure codes with revenue code 0278 in MS–DRGs 374, 375, and 376 (Digestive Malignancy with MCC, with CC, and without CC/MCC, respectively), MS–DRGs 391and 392 (Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders with MCC and without MCC, respectively), and MS–DRGs 393, 394, and 395 (Other Digestive System Diagnoses with MCC, with CC, and without CC/MCC, respectively) in MDC 6 (Diseases and Disorders of the Digestive System); and MS–DRGs 435, 436, and 437 (Malignancy of Hepatobiliary System or Pancreas with MCC, with CC, and without CC/MCC, respectively) in MDC 7 (Diseases and Disorders of the Hepatobiliary System and Pancreas).

As stated above, the commenter utilized a combination of procedure codes along with revenue code 0278 for its analysis. There were a total of six procedure codes included, of which, only three (procedure codes 42.81, 51.87, and 52.93) actually describe the insertion of a stent. The complete list of procedure codes is as follows:

- 42.81 (Insertion of permanent tube into esophagus)
- 45.13 (Other endoscopy of small intestine)
- 45.22 (Endoscopy of large intestine through artificial stoma)
- 46.85 (Dilation of intestine)
- 51.87 (Endoscopic insertion of stent (tube) into bile duct)
- 52.93 (Endoscopic insertion of stent (tube) into pancreatic duct)

The commenter aggregated the results by the previously mentioned MS–DRG groupings and did not present results for individual stenting procedures. According to the commenter, mean standardized charges for gastrointestinal stenting procedures were higher than those for nonstenting procedures across all levels of severity of illness. In addition, the commenter believed that the difference in charges was not simply related to the costs of the stents, but rather that the extent of the difference in charges reflected the severity of illness and resource intensity associated with gastrointestinal stenting procedures.

In response to the commenter's request, we point out that we do not utilize revenue codes in our process to evaluate if new MS–DRGs are warranted. The use of revenue codes in the MS–DRG reclassification process would require a major structural change from the current process that has been utilized since the inception of the IPPS. In addition, the commenter included procedure codes in its analysis that do not identify the insertion of a stent; thereby, the data are unreliable. Furthermore, two procedure codes describing the insertion of a colonic stent were recently implemented, effective with discharges occurring on or after October 1, 2009—procedure code 46.86 (Endoscopic insertion of colonic stent(s)) and procedure code 46.87 (Other insertion of colonic stent(s)). However, we do not have data currently available on these two new procedure codes to include them in a comprehensive analysis. Lastly, as the commenter indicated, the differences between those procedures with and without stents is a reflection on the severity of illness and resource consumption associated with these types of procedures. The commenter also acknowledged that patients receiving a gastrointestinal stent who are severely debilitated due to prolonged illness are reflected by the fact that the majority of cases are assigned to MS–DRGs for patients with MCCs (major complications or comorbidities). Therefore, the medical MS–DRGs to which these procedures are currently assigned already account for the severity of illness and intensity of resources utilized.

Using FY 2009 MedPAR data, we analyzed the three procedure codes that truly identify and describe the insertion of a stent (procedure codes 42.81, 51.87, and 52.93) within the MS–DRGs referenced above. Similar to the commenter's findings, our analysis demonstrated a small volume of cases in which insertion of a gastrointestinal stent occurred in the specified MS–DRGs. Of the 411,390 total cases across the digestive system MS–DRGs the requestor identified, there were only 2,011cases that involved the actual insertion of a gastrointestinal stent. These cases had average costs ranging from a low of $5,846 to a high of $17,626. Based on these findings, we do not believe it is appropriate to assign cases with such disparity in costs into a single, new MS–DRG. Furthermore, in applying the five criteria used to establish new MS–DRGs, the data do not support the creation of new MS–DRGs with three severity levels (with MCC, with CC, and without CC/MCC).

For the reasons stated above, we invite the public to submit comments on our proposal not to make any MS–DRG modifications at this time to cases involving the use of gastrointestinal stents for FY 2011.

5. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Pedicle-Based Dynamic Stabilization

As we did for FY 2009 (73 FR 45820), we received a request from a manufacturer to reassign procedure code 84.82 (Insertion or replacement of pedicle-based dynamic stabilization device(s)), effective October 1, 2007, from MS–DRG 490 (Back and Neck Procedures Except Spinal Fusion with CC/MCC or Disc Device/Neurostimulator) to MS–DRG 460

(Spinal Fusion Except Cervical without MCC). According to the manufacturer, the technology that is identified by this procedure code, the Dynesys® Dynamic Stabilization System, is clinically similar to lumbar spinal fusion and requires similar utilization of resources.

Dynamic stabilization is a concept that utilizes a flexible system to stabilize the spine without fusion. The primary goals of dynamic stabilization are to limit the amount of unnatural spinal motion and preserve as much of the patient's natural anatomic structures as possible. The Dynesys® Dynamic Stabilization System is comprised of three components with specific functions: Titanium alloy pedicle screws that anchor the system to the spine; a polyethylene-terephthalate (PET) cord that connects the Dynesys® screws; and a polycarbonate-urethane (PCU) spacer that runs over the cord between the Dynesys® screws. The system is placed under tension creating a dynamic interaction between the components.

The MS–DRGs are comprised of clinically coherent groups of patients who consume similar utilization of resources and complexity of services. The insertion of a Dynesys® Dynamic Stabilization System is clinically not a lumbar fusion. As stated previously, dynamic stabilization is a concept that utilizes a flexible system to stabilize the spine without fusion. Therefore, it would be clinically inappropriate to reassign cases reporting procedure code 84.82 in the fusion MS–DRG.

In conclusion, the Dynesys® Dynamic Stabilization System is currently FDA approved for use only as an adjunct to spinal fusion, there is uncertainty regarding the coding and reporting of procedure code 84.82, as well as off-label use, and currently, all other similar nonfusion devices are assigned to MS–DRG 490.

For the reasons listed above, we are not proposing to reassign cases reporting procedure code 84.82 from MS–DRG 490 to MS–DRG 460 for FY 2011.

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

a. Discharges/Transfers of Neonates to a Designated Cancer Center or Children's Hospital

We received a request to add patient discharge status code 05 (Discharged/transferred to a designated cancer center or children's hospital) to the MS–DRG GROUPER logic for MS–DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility). Currently, neonate cases with the discharge status code 05 are being assigned to MS–DRG 795 (Normal Newborn).

The definition of discharge status code 05 was changed on April 1, 2008, from "discharged/transferred to another type of health care institution not defined elsewhere in this code list" to "discharged/transferred to a designated cancer center or children's hospital." We examined cases in the FY 2009 MedPAR file but did not find any cases with the discharge status code 05 that were assigned to either MS–DRG 789 or MS–DRG 795. However, we believe that the request has merit in identifying neonate cases appropriately. Therefore, for FY 2011, we are proposing to add discharge status code 05 to the MS–DRG GROUPER logic for MS–DRG 789.

b. Vaccinations of Newborns

We received a request to examine the assignment of code V64.05 (Vaccination not carried out because of caregiver refusal) to MS–DRG 794 (Neonate with Other Significant Problems). Code V64.05 is currently being reported when a physician documents that a parent/caregiver has refused immunization for a child. The reporting of this code as a principal or secondary diagnosis impacts the MS–DRG assignment for normal newborns cases being assigned to MS–DRG 794.

We examined cases in the FY 2009 MedPAR file but did not find any cases of code V64.05 assigned to MS–DRG 794. Our medical advisors agree that code V64.05 should not be assigned to MS–DRG 794. We determined that the presence of code V64.05 does not indicate that there is a significant problem with the newborn and should not be assigned to MS–DRG 794. Therefore, we believe that assignment of code V64.05 to MS–DRG 795 (Normal Newborn) would be more appropriate for this code because it does not identify a significant problem.

The logic for MS–DRG 795 contains a list of principal diagnosis codes for normal newborn and no secondary diagnosis or a list of only secondary diagnosis codes. Therefore, in this proposed rule, for FY 2011, we are proposing to remove code V64.05 from MS–DRG 794 and add this code to the only secondary diagnosis list for MS–DRG 795.

7. Medicare Code Editor (MCE) Changes

As explained under section II.B.1. of the preamble of this proposed rule, the Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into a MS–DRG. For FY 2011, we intend to make the following changes to the MCE edits and invite public input on whether or not we should do so:

a. Unacceptable Principal Diagnosis Edit: Addition of Code for Gastroparesis

It has been brought to our attention that code 536.3 (Gastroparesis) has a "code first underlying disease" note. This note indicates that code 536.3 should not be used as a principal diagnosis. Therefore, code 536.3 should have been included on the list of unacceptable principal diagnoses in the MCE.

We agree that code 536.3 should have been included on the list of unacceptable principal diagnoses in the MCE. Therefore, for FY 2011, we intend to add code 536.3 to that list.

b. Open Biopsy Check Edit

The Open Biopsy Check edit in the MCE dates back to the early years of the IPPS when the surgical and medical DRGs were not as expansive as they are today. In the mid-1980s when the Open Biopsy Check edit was created, the ICD–9–CM codes did not have many biopsy procedure codes that clearly showed the approach, such as codes for open, percutaneous, and closed biopsies. Furthermore, under the current MS–DRGs, the open biopsy codes do not have as significant an impact as they did in the early versions of the DRGs. We believe that the Open Biopsy Check edit no longer serves a useful purpose. Therefore, for FY 2011, we intend to delete the entire Open Biopsy Check edit from the MCE, which means removing the following 63 codes from the edit:

- 01.11 (Closed [Percutaneous] [Needle] biopsy of cerebral meninges)
- 01.12 (Open biopsy of cerebral meninges)
- 01.13 (Closed [Percutaneous] [Needle] biopsy of brain)
- 01.14 (Open biopsy of brain)
- 04.11 (Closed [Percutaneous] [Needle] biopsy of cranial or peripheral nerve or ganglion)
- 04.12 (Open biopsy of cranial or peripheral nerve or ganglion)
- 06.11 (Closed [Percutaneous] [Needle] biopsy of thyroid gland)
- 06.12 (Open biopsy of thyroid gland)
- 07.11 (Closed [Percutaneous] [Needle] biopsy of adrenal gland)
- 07.12 (Open biopsy of adrenal gland)

- 22.11 (Closed [Endoscopic] [Needle] biopsy of nasal sinus)
- 22.12 (Open biopsy of nasal sinus)
- 25.01 (Closed [Needle] biopsy of tongue)
- 25.02 (Open biopsy of tongue)
- 26.11 (Closed [Needle] biopsy of salivary gland or duct)
- 26.12 (Open biopsy of salivary gland or duct)
- 31.43 (Closed [Endoscopic] biopsy of larynx)
- 31.44 (Closed [Endoscopic] biopsy of trachea)
- 31.45 (Open biopsy of larynx or trachea)
- 33.24 (Closed [Endoscopic] biopsy of bronchus)
- 33.25 (Open biopsy of bronchus)
- 33.26 (Closed [Percutaneous] [Needle] biopsy of lung)
- 33.28 (Open biopsy of lung)
- 34.25 (Closed [Percutaneous] [Needle] biopsy of mediastinum)
- 34.26 (Open mediastinal biopsy)
- 41.32 (Closed [Aspiration] [Percutaneous] biopsy of spleen)
- 41.33 (Open biopsy of spleen)
- 42.24 (Closed [Endoscopic] biopsy of esophagus)
- 42.25 (Open biopsy of esophagus)
- 44.14 (Closed [Endoscopic] biopsy of stomach)
- 44.15 (Open biopsy of stomach)
- 45.14 (Closed [Endoscopic] biopsy of small intestine)
- 45.15 (Open biopsy of small intestine)
- 45.25 (Closed [Endoscopic] biopsy of large intestine)
- 45.26 (Open biopsy of large intestine)
- 48.24 (Closed [Endoscopic] biopsy of rectum)
- 48.25 (Open biopsy of rectum)
- 50.11 (Closed (Percutaneous) [Needle] biopsy of liver)
- 50.12 (Open biopsy of liver)
- 51.12 (Percutaneous biopsy of gallbladder or bile ducts)
- 51.13 (Open biopsy of gallbladder or bile ducts)
- 52.11 (Closed [Aspiration] [Needle] [Percutaneous] biopsy of pancreas)
- 52.12 (Open biopsy of pancreas)
- 54.23 (Biopsy of peritoneum)
- 54.24 (Closed [Percutaneous] [Needle] biopsy of intra-abdominal mass)
- 55.23 (Closed [Percutaneous] [Needle] biopsy of kidney)
- 55.24 (Open biopsy of kidney)
- 56.32 (Closed percutaneous biopsy of ureter)
- 56.34 (Open biopsy of ureter)
- 57.33 (Closed [Transurethral] biopsy of bladder)
- 57.34 (Open biopsy of bladder)
- 60.11 (Closed [Percutaneous] [Needle] biopsy of prostate)
- 60.12 (Open biopsy of prostate)
- 60.13 (Closed [Percutaneous] biopsy of seminal vesicles)
- 60.14 (Open biopsy of seminal vesicles)
- 62.11 (Closed [Percutaneous] [Needle] biopsy of testis)
- 62.12 (Open biopsy of testis)
- 68.13 (Open biopsy of uterus)
- 68.14 (Open biopsy of uterine ligaments)
- 68.15 (Closed biopsy of uterine ligaments)
- 68.16 (Closed biopsy of uterus)
- 85.11 (Closed [Percutaneous] [Needle] biopsy of breast)
- 85.12 (Open biopsy of breast)

c. Noncovered Procedure Edit

The ICD–9–CM procedure codes 52.80 (Pancreatic transplant, not otherwise specified) and 52.82 (Homotransplant of pancreas) alone (that is, without procedure code 55.69 (Other kidney transplantation)) are considered noncovered procedures, except when either one is combined with at least one specific principal or secondary diagnosis code. These specific diagnosis codes identify Type I diabetes mellitus, not stated as uncontrolled, or else identified as uncontrolled.

To conform to the proposed change to Pre-MDC MS–DRGs 008 and 010 as discussed in section II.G.1. of this preamble, in which we are proposing to add code 251.3 (Postsurgical hypoinsulinemia) to those MS–DRGs, we intend to add procedure code 251.3 to the list of acceptable principal or secondary diagnosis codes in the MCE.

8. Surgical Hierarchies

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

Because the relative resource intensity of surgical classes can shift as a function of MS–DRG reclassification and recalibrations, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications and recalibrations, to determine if the ordering of classes coincides with the intensity of resource utilization.

A surgical class can be composed of one or more MS–DRGs. For example, in MDC 11, the surgical class "kidney transplant" consists of a single MS–DRG (MS–DRG 652) and the class "major bladder procedures" consists of three MS–DRGs (MS–DRGs 653, 654, and 655). Consequently, in many cases, the surgical hierarchy has an impact on more than one MS–DRG. The methodology for determining the most resource-intensive surgical class involves weighting the average resources for each MS–DRG by frequency to determine the weighted average resources for each surgical class. For example, assume surgical class A includes MS–DRGs 1 and 2 and surgical class B includes MS–DRGs 3, 4, and 5. Assume also that the average costs of MS–DRG 1 is higher than that of MS–DRG 3, but the average costs of MS–DRGs 4 and 5 are higher than the average costs of MS–DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weigh the average costs of each MS–DRG in the class by frequency (that is, by the number of cases in the MS–DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of "other O.R. procedures" as discussed below.

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

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average cost is ordered above a surgical class with a higher average cost. For example, the "other O.R. procedures" surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the average costs for the MS–DRG or MS–DRGs in that surgical class may be higher than those for other surgical classes in the MDC. The "other O.R. procedures" class is a group of procedures that are only infrequently related to the diagnoses in the MDC, but are still occasionally performed on patients in the MDC with these diagnoses. Therefore, assignment to these surgical classes should only occur

if no other surgical class more closely related to the diagnoses in the MDC is appropriate.

A second example occurs when the difference between the average costs for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy because, as a result of reassigning cases on the basis of the hierarchy change, the average costs are likely to shift such that the higher-ordered surgical class has a lower average costs than the class ordered below it.

Based on the changes that we are proposing for FY 2011, as discussed in section II.C.2 of this preamble, we are proposing to revise the surgical hierarchy for Pre-MDCs and MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders) to reflect the resource intensiveness of the MS–DRGs, as follows:

In Pre-MDCs, we are proposing to reorder proposed new MS–DRG 014 (Allogeneic Bone Marrow Transplant) above MS–DRG 007 (Lung Transplant); and proposed new MS–DRG 015 (Autologous Bone Marrow Transplant) above MS–DRG 010 (Pancreas Transplant).

In MDC 10, we are proposing to reorder MS–DRG 614 (Adrenal and Pituitary Procedures With CC/MCC) and MS–DRG 615 (Adrenal and Pituitary Procedures Without CC/MCC) above MS–DRG 625 (Thyroid, Parathyroid and Thyroglossal Procedures With MCC).

9. Complications or Comorbidity (CC) Exclusions List

a. Background

As indicated earlier in the preamble of this proposed rule, under the IPPS MS–DRG classification system, we have developed a standard list of diagnoses that are considered CCs. Historically, we developed this list using physician panels that classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial complication or comorbidity. A substantial complication or comorbidity was defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least 1 day in at least 75 percent of the patients. We refer readers to section II.D.2. and 3. of the preamble of the FY 2008 IPPS final rule with comment period for a discussion of the refinement of CCs in relation to the MS–DRGs we adopted for FY 2008 (72 FR 47121 through 47152).

b. Proposed CC Exclusions List for FY 2011

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

In the May 19, 1987 proposed notice (52 FR 18877) and the September 1, 1987 final notice (52 FR 33154), we explained that the excluded secondary diagnoses were established using the following five principles:

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

The creation of the CC Exclusions List was a major project involving hundreds of codes. We have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC.[2]

(1) Proposed Limited Revisions Based on Changes to the ICD–9–CM Diagnosis Codes

For FY 2011, we are proposing to make limited revisions to the CC Exclusions List for FY 2011 to take into account the changes made in the ICD–9–CM diagnosis coding system effective October 1, 2009. (We refer readers to section II.G.11. of the preamble of this proposed rule for a discussion of ICD–9–CM changes.) We are proposing to make these changes in accordance with the principles established when we created the CC Exclusions List in 1987. In addition, we are indicating on the CC Exclusions List some changes as a result of updates to the ICD–9–CM codes to reflect the exclusion of codes from being MCCs under the MS–DRG system that we adopted in FY 2008.

(2) Suggested Changes to Severity Levels for Obesity-Related and Major Osseous Defect Diagnosis Codes

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43793 through 43794), we indicated that several commenters on the FY 2010 IPPS proposed rule recommended that CMS consider making further adjustments to the MS–DRG assignments based on obesity and major osseous defects. The commenters stated that obesity, high Body Mass Index (BMI) ratings, and major osseous defects add to the complexity of care for patients such as those patients undergoing orthopedic procedures. The commenters recommended the following changes to the list of MCCs and CCs:

Several commenters recommended that CMS add the following diagnosis codes, which are classified as non-CCs, to the CC or MCC list:

[2] See the FY 1989 final rule (53 FR 38485, September 30, 1988), for the revision made for the discharges occurring in FY 1989; the FY 1990 final rule (54 FR 36552, September 1, 1989), for the FY 1990 revision; the FY 1991 final rule (55 FR 36126, September 4, 1990), for the FY 1991 revision; the FY 1992 final rule (56 FR 43209, August 30, 1991) for the FY 1992 revision; the FY 1993 final rule (57 FR 39753, September 1, 1992), for the FY 1993 revision; the FY 1994 final rule (58 FR 46278, September 1, 1993), for the FY 1994 revisions; the FY 1995 final rule (59 FR 45334, September 1, 1994), for the FY 1995 revisions; the FY 1996 final rule (60 FR 45782, September 1, 1995), for the FY 1996 revisions; the FY 1997 final rule (61 FR 46171, August 30, 1996), for the FY 1997 revisions; the FY 1998 final rule (62 FR 45966, August 29, 1997) for the FY 1998 revisions; the FY 1999 final rule (63 FR 40954, July 31, 1998), for the FY 1999 revisions; the FY 2001 final rule (65 FR 47064, August 1, 2000), for the FY 2001 revisions; the FY 2002 final rule (66 FR 39851, August 1, 2001), for the FY 2002 revisions; the FY 2003 final rule (67 FR 49998, August 1, 2002), for the FY 2003 revisions; the FY 2004 final rule (68 FR 45364, August 1, 2003), for the FY 2004 revisions; the FY 2005 final rule (69 FR 49848, August 11, 2004), for the FY 2005 revisions; the FY 2006 final rule (70 FR 47640, August 12, 2005), for the FY 2006 revisions; the FY 2007 final rule (71 FR 47870) for the FY 2007 revisions; the FY 2008 final rule (72 FR 47130) for the FY 2008 revisions, the FY 2009 final rule (73 FR 48510), and the FY 2010 final rule (74 FR 43799). In the FY 2000 final rule (64 FR 41490, July 30, 1999, we did not modify the CC Exclusions List because we did not make any changes to the ICD–9–CM codes for FY 2000.

- 731.3 (Major osseous defects)
- V85.35 (Body mass index 35.0–35.9, adult)
- V85.36 (Body mass index 36.0–36.9, adult)
- V85.37 (Body mass index 37.0–37.9, adult)
- V85.38 (Body mass index 38.0–38.9, adult)
- V85.39 (Body mass index 39.0–39.9, adult)

Several commenters recommended that CMS add the following diagnosis code, which is on the CC list, to the MCC list:

- V85.40 (Body mass index 40 and over, adult)

We stated that we believed these comments were outside the scope of the proposal in the proposed rule. We did not propose significant revisions to the MS–DRGs in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24091) for these codes. We stated that we were encouraging individuals with comments about MS–DRG classifications to submit these comments no later than early December of each year so they can be carefully considered for possible inclusion in the annual proposed rule and, if included, may be subjected to public review and comment. Therefore, we did not add these codes to the MCC list or the CC list for FY 2010. We stated that we would consider their appropriateness for inclusion in next year's annual proposed rule.

In addition to the diagnosis codes mentioned above, we also have received requests that we consider changing the following diagnosis codes from a non-CC to a CC:

- 278.00 (Obesity NOS)
- 278.01 (Morbid obesity)
- 278.02 (Overweight)

We analyzed claims data for the diagnosis codes mentioned above related to obesity and major osseous defects. We used the same approach we used in initially creating the MS–DRGs and classifying secondary diagnosis codes as non-CCs, CCs, or MCC. A detailed discussion of the process and criteria we used in this process is described in the FY 2008 IPPS final rule (72 FR 47158 through 47161). We refer the readers to this discussion for complete information on our approach to developing the non-CC, CC, and MCC lists. Each diagnosis for which Medicare data were available was evaluated to determine its impact on resource use and to determine the most appropriate CC subclass (non-CC, CC, or MCC) assignment. In order to make this determination, the average cost for each subset of cases was compared to the expected cost for cases in that subset. The following format was used to evaluate each diagnosis:

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3

Count (Cnt) is the number of patients in each subset. C1, C2, and C3 are a measure of the impact on resource use of patients in each of the subsets. The C1, C2, and C3 values are a measure of the ratio of average costs for patients with these conditions to the expected average cost across all cases. The C1 value reflects a patient with no other secondary diagnosis or with all other secondary diagnoses that are non-CCs. The C2 value reflects a patient with at least one other secondary diagnosis that is a CC but none that is a MCC. The C3 value reflects a patient with at least one other secondary diagnosis that is a MCC. A value close to 1.0 in the C1 field would suggest that the diagnosis code produces the same expected value as a non-CC. A value close to 2.0 suggests the condition is more like a CC than a non-CC but not as significant in resource usage as an MCC. A value close to 3.0 suggests the condition is expected to consume resources more similar to an MCC than a CC or non-CC. For additional details on this analysis, we refer readers to the FY 2008 IPPS final rule at 72 FR 47158 through 47161.

The following chart shows the analysis for each of the obesity related and major osseous defect diagnosis codes that are currently classified as non-CCs.

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3
278.00	Obesity NOS	130,310	1.0755	116,304	1.7234	45,565	2.3843
278.01	Morbid obesity	51,832	1.2619	106,169	1.9630	52,398	2.6787
278.02	Overweight	5,242	0.9948	3,594	1.7042	1,033	2.3471
731.3	Major osseous defects	215	1.3833	575	2.3390	186	2.7627
V85.35	BMI 35.0–35.9, adult	2,621	0.9759	1,480	1.6932	499	2.3664
V85.36	BMI 36.0–36.9, adult	2,359	0.9729	1,298	1.6536	466	2.3107
V85.37	BMI 37.0–37.9, adult	2,305	0.9849	1,271	1.7225	473	2.4032
V85.38	BMI 38.0–38.9, adult	2,152	0.9713	1,231	1.5964	432	2.2743
V85.39	BMI 39.0–39.9, adult	2,253	0.9857	1,141	1.7741	445	2.4919

The C1 findings do not support a reclassification of any of these diagnosis codes from a non-CC to a CC. As can be seen by the C1 findings, the codes range from a low of 0.9729 for code V85.35 to a high of 1.3833 for diagnosis code 731.3. These findings are consistent with a classification as a non-CC. Therefore, for FY 2011, we are not proposing to change the CC classification of any of the diagnosis codes mentioned in the chart above from a non-CC to a CC. Our clinical advisors agree with this recommendation.

We also examined claims data for diagnosis code V85.4 (Body mass index 40 and over, adult), which is classified as a CC. We received a request to reclassify this code as a MCC. The following chart summaries our findings for this diagnosis code:

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3
V85.4	BMI 40 and over, adult	51,871	1.2323	59,941	2.1711	57,220	3.0465

We note that the C1 finding of 1.2323 does not support a reclassification of this diagnosis code from a CC to a MCC. This finding is much more consistent with classifying the code as a non-CC. Our clinical advisors recommended that CMS not reclassify this diagnosis code from a CC to a non-CC at this time. They recommended that CMS analyze data associated with this diagnosis code again in the future to determine if it continues to act like a non-CC. We are not recommending any change in the severity classification of diagnosis code V85.4. We are proposing to retain it as a CC for FY 2011.

We welcome public comments on our proposal not to change the severity levels of the diagnosis codes mentioned above.

(3) Suggested Change to the Severity Level for Alzheimer's Disease Diagnosis Code

We received a request to change the severity classification for diagnosis code 331.0 (Alzheimer's disease). Currently, this diagnosis code is classified as a non-CC. We analyzed claims data for this diagnosis code. The following chart shows our findings:

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3
331.0	Alzheimer's disease	83,743	1.1381	114,445	1.8890	77,841	2.4185

The C1 finding of 1.1381 for Alzheimer's disease supports the current classification of this diagnosis code as a non-CC. Our clinical advisors agree with this classification. Therefore, we are not proposing to change the severity classification of diagnosis code 331.0 from a non-CC to a CC for FY 2011. We believe the code is appropriately classified as a non-CC.

(4) Proposed Change to the Severity Level for Acute Renal Failure, Unspecified Diagnosis Code

We received a request to reclassify diagnosis code 584.9 (Acute renal failure, unspecified) from a MCC to a CC. The commenter stated that this code is being widely used to capture degrees of renal failure that range from that which is caused by mild dehydration with only minor laboratory abnormalities all the way through severe renal failure that requires dialysis. The commenter pointed out that there are no clinical criteria for assigning diagnosis code 584.9 (Acute renal failure, unspecified). The attending physician must simply document the presence of acute renal failure for the diagnosis code to be assigned. The concern is that the diagnosis code for Acute renal failure, unspecified (diagnosis code 584.9) is being assigned to patients with a low clinical severity level.

We also point out that the Editorial Advisory Board of Coding Clinic for ICD–9–CM has received a number of requests to clarify the use of diagnosis code 584.9. Coders are observing the terminology of "acute renal failure" being applied to patients who are simply dehydrated. These patients do not require renal dialysis, and they do not appear to be severely ill. Coders have stated that there appears to be an increase in the use of the terminology of acute renal failure for patients who were previously referred to as acute renal insufficiency. When acute renal insufficiency is documented, the ICD–9–CM index directs the use of code 593.9 (Unspecified disorder of kidney and ureter). Diagnosis code 593.9 includes acute renal insufficiency and is classified as a non-CC. The problem is further compounded by the fact that there is no consistent convention among clinicians for documenting acute renal insufficiency versus acute renal failure.

We examined claims data on diagnosis code 584.9, and our findings are shown in the table below:

Code	Diagnosis	Cnt1	C1	Cnt2	C2	Cnt3	C3
584.9	Acute kidney failure, unspecified	124,428	1.8364	411,667	2.6151	417,359	3.2429

The C1 finding of 1.8364 is more consistent with a classification of a CC. Our clinical advisors agreed that cases captured by diagnosis code 584.9 are more appropriately classified as a CC. This unspecified type of kidney failure is clearly not capturing patients with a MCC severity level. Therefore, we are proposing to change the severity level for diagnosis code 584.9 from a MCC to a CC for FY 2011.

Tables 6G and 6H, Additions to and Deletions from the CC Exclusion List, respectively, which are effective for discharges occurring on or after October 1, 2010, are not being published in the Addendum to this proposed rule because of the length of the two tables. Instead, we are making them available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS.* Each of these principal diagnoses for which there is a CC exclusion is shown in Tables 6G and 6H in the Addendum to this proposed rule with an asterisk, and the conditions that will not count as a CC, are provided in an indented column immediately following the affected principal diagnosis.

A complete updated MCC, CC, and Non-CC Exclusions List is also available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS.* Beginning with discharges on or after October 1, 2010, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

To assist readers in identifying the changes to the MCC and CC lists that occurred as a result of updates to the ICD–9–CM codes, as described in Tables 6A, 6C, and 6E of the Addendum to this proposed rule, we are providing the following summaries of those MCC and CC changes.

There were no additions to the MS–DRG MCC List for FY 2011 (Table 6I.1).

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SUMMARY OF DELETIONS FROM THE MS-DRG MCC LIST--TABLE 6I.2

Code	Description
584.9	Acute renal failure, unspecified

SUMMARY OF ADDITIONS TO THE MS-DRG CC LIST--TABLE 6J.1

Code	Description
584.9	Acute renal failure, unspecified
786.30	Hemoptysis, unspecified
786.31	Acute idiopathic pulmonary hemorrhage in infants [AIPHI]
786.39	Other hemoptysis
999.60	ABO incompatibility reaction, unspecified
999.61	ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.62	ABO incompatibility with acute hemolytic transfusion reaction
999.63	ABO incompatibility with delayed hemolytic transfusion reaction
999.69	Other ABO incompatibility reaction
999.70	Rh incompatibility reaction, unspecified
999.71	Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.72	Rh incompatibility with acute hemolytic transfusion reaction
999.73	Rh incompatibility with delayed hemolytic transfusion reaction
999.74	Other Rh incompatibility reaction
999.75	Non-ABO incompatibility reaction, unspecified
999.76	Non-ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
999.77	Non-ABO incompatibility with acute hemolytic transfusion reaction
999.78	Non-ABO incompatibility with delayed hemolytic transfusion reaction
999.79	Other non-ABO incompatibility reaction
999.83	Hemolytic transfusion reaction, incompatibility unspecified
999.84	Acute hemolytic transfusion reaction, incompatibility unspecified
999.85	Delayed hemolytic transfusion reaction, incompatibility unspecified
V85.41	Body Mass Index 40.0-44.9, adult
V85.42	Body Mass Index 45.0-49.9, adult
V85.43	Body Mass Index 50.0-59.9, adult
V85.44	Body Mass Index 60.0-69.9, adult
V85.45	Body Mass Index 70 and over, adult

SUMMARY OF DELETIONS FROM THE MS-DRG CC LIST--TABLE 6J.2

Code	Description
786.3	Hemoptysis
999.6	ABO incompatibility reaction
999.7	Rh incompatibility reaction
V85.4	Body Mass Index 40 and over, adult

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Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current MS–DRG Definitions Manual, Version 27.0, is available for $250.00, which includes shipping and handling. Version 27.0 of the manual is also available on a CD for $200.00; a combination hard copy and CD is available for $400.00. Version 28.0 of this manual, which will include the final FY 2011 MS–DRG changes, will be available on CD only for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303, or by obtaining an order form at the Web site: *http://www.3MHIS.com*. Please specify the revision or revisions requested.

10. Review of Procedure Codes in MS DRGs 981 Through 983; 984 Through 986; and 987 Through 989

Each year, we review cases assigned to former CMS DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), CMS DRG 476 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis), and CMS DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among these CMS DRGs. Under the MS–DRGs that we adopted for FY 2008, CMS DRG 468 was split three ways and became MS–DRGs 981, 982, and 983 (Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively). CMS DRG 476 became MS–DRGs 984, 985, and 986 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively). CMS DRG 477 became MS–DRGs 987, 988, and 989 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively).

MS–DRGs 981 through 983, 984 through 986, and 987 through 989 (formerly CMS DRGs 468, 476, and 477, respectively) are reserved for those cases in which none of the O.R. procedures performed are related to the principal diagnosis. These MS–DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. MS–DRGs 984 through 986 (previously CMS DRG 476) are assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

- 60.0, Incision of prostate
- 60.12, Open biopsy of prostate
- 60.15, Biopsy of periprostatic tissue
- 60.18, Other diagnostic procedures on prostate and periprostatic tissue
- 60.21, Transurethral prostatectomy
- 60.29, Other transurethral prostatectomy
- 60.61, Local excision of lesion of prostate
- 60.69, Prostatectomy, not elsewhere classified
- 60.81, Incision of periprostatic tissue
- 60.82, Excision of periprostatic tissue
- 60.93, Repair of prostate
- 60.94, Control of (postoperative) hemorrhage of prostate
- 60.95, Transurethral balloon dilation of the prostatic urethra
- 60.96, Transurethral destruction of prostate tissue by microwave thermotherapy
- 60.97, Other transurethral destruction of prostate tissue by other thermotherapy
- 60.99, Other operations on prostate

All remaining O.R. procedures are assigned to MS–DRGs 981 through 983 and 987 through 989, with MS–DRGs 987 through 989 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis.[3]

Our review of MedPAR claims data showed that there were 59 cases in which procedures related to the prostate were arrayed across 10 different MDCs. None of the 59 cases were cases that should logically be assigned to any of the other MDCs. For example, there were a total of 16 cases of other transurethral prostate surgery that occurred in MDC 5 (Diseases and Disorders of the Circulatory System). In addition, none of the cases had lengths of stay or average charges that would indicate that these cases were anything other than some of the expected irregularities of medical care. Therefore, for FY 2011, we are not proposing to change the procedures assigned among these MS–DRGs.

a. Moving Procedure Codes From MS–DRGs 981 Through 983 or MS–DRGs 987 Through 989 Into MDCs

We annually conduct a review of procedures producing assignment to MS–DRGs 981 through 983 (Extensive O.R. procedure unrelated to principal diagnosis with MCC, with CC, and without CC/MCC, respectively) or MS–DRGs 987 through 989 (Nonextensive O.R. procedure unrelated to principal diagnosis with MCC, with CC, and without CC/MCC, respectively) on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these MS–DRGs into one of the surgical MS–DRGs for the MDC into which the principal diagnosis falls. The data are arrayed in two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical MS–DRGs for the MDC in which the diagnosis falls. Our review of claims data showed that there were 4,443 cases in MS–DRGs 981 through 983. These 4,443 cases were arrayed across 18 MDCs. The single most common procedure was code 00.66 (Percutaneous transluminal coronary angioplasty [PTCA] of coronary atherectomy), 21 cases, located in MDC 1 (Diseases and Disorders of the Nervous System). These cases represent a very small volume of cases that are unlikely to indicate medical practice trends. In addition, from a clinical coherence standpoint, we do not believe it benefits the GROUPER system to add cardiac procedures to the nervous system MDC. The same situation was evident in MS–DRGs 987 through 989. There were a total of 1,601 cases across 17 MDCs and, again, the cases did not

[3] The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the FY 1989 final rule (53 FR 38591). As part of the FY 1991 final rule (55 FR 36135), the FY 1992 final rule (56 FR 43212), the FY 1993 final rule (57 FR 23625), the FY 1994 final rule (58 FR 46279), the FY 1995 final rule (59 FR 45336), the FY 1996 final rule (60 FR 45783), the FY 1997 final rule (61 FR 46173), and the FY 1998 final rule (62 FR 45981), we moved several other procedures from DRG 468 to DRG 477, and some procedures from DRG 477 to DRG 468. No procedures were moved in FY 1999, as noted in the final rule (63 FR 40962); in FY 2000 (64 FR 41496); in FY 2001 (65 FR 47064); or in FY 2002 (66 FR 39852). In the FY 2003 final rule (67 FR 49999) we did not move any procedures from DRG 477. However, we did move procedure codes from DRG 468 and placed them in more clinically coherent DRGs. In the FY 2004 final rule (68 FR 45365), we moved several procedures from DRG 468 to DRGs 476 and 477 because the procedures are nonextensive. In the FY 2005 final rule (69 FR 48950), we moved one procedure from DRG 468 to 477. In addition, we added several existing procedures to DRGs 476 and 477. In the FY 2006 (70 FR 47317), we moved one procedure from DRG 468 and assigned it to DRG 477. In FY 2007, we moved one procedure from DRG 468 and assigned it to DRGs 479, 553, and 554. In FYs 2008, 2009, and FY 2010, no procedures were moved, as noted in the FY 2008 final rule with comment period (72 FR 46241), the FY 2009 final rule (73 FR 48513), and the FY 2010 final rule (74 FR 43796).

represent clinically coherent examples of medical care that warranted movement of procedure codes into additional MS–DRGs. Examples of cases that we reviewed included six cases of bone biopsies in MDC 21 (Injuries, Poisonings and Toxic Effects of Drugs) and one case of a destruction of a lesion of the knee in MDC 13 (Diseases and Disorders of the Female Reproductive System). Again, the volume of these cases is negligible, and clinical coherence is not demonstrated to the degree that a change in the MS–DRGs is warranted. Therefore, for FY 2011, we are not proposing to remove any procedures from MS–DRGs 981 through 983 or MS–DRGs 987 through 989 into one of the surgical MS–DRGs for the MDC into which the principal diagnosis is assigned.

b. Reassignment of Procedures Among MS–DRGs 981 Through 983, 984 Through 986, and 987 Through 989

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to MS–DRGs 981 through 983, 984 through 986 (Prostatic O.R. procedure unrelated to principal diagnosis with MCC, with CC, or without CC/MCC, respectively), and 987 through 989, to ascertain whether any of those procedures should be reassigned from one of these three MS–DRGs to another of the three MS–DRGs based on average charges and the length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting MS–DRG assignment illogical. If we find these shifts, we would propose to move cases to keep the MS–DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data.

To reiterate, our review of claims data showed that 18 MDCs were represented in MS–DRGs 981 through 983, for a total of 4,443 cases. There were 10 MDCs represented in MS–DRGs 984 through 986, which contained 59 cases. In addition, our review of claims data for MS–DRGs 987 through 989 showed 1,601 cases across 17 MDCs. However, these cases represent such disparate situations as one case of a large bowel incision assigned to MDC 1 (Diseases and Disorders of the Nervous System) and one case of a revision of the femoral component of a hip replacement assigned to MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat). We do not believe that any of these cases represent shifts in either treatment practice or reporting practice. As these types of cases do not represent clinical coherence, we do not believe that the addition of these procedure codes identified in our review would positively benefit the overall MS–DRG logic. Therefore, for FY 2011, we are not proposing to move any procedure codes among these MS–DRGs.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on the review of cases in the MDCs as described above in sections G.10.a. and b., we are not proposing to add any diagnosis or procedure codes to MDCs for FY 2011.

11. Changes to the ICD–9–CM Coding System, Including Discussion of the Replacement of the ICD–9–CM Coding System With the ICD–10–CM and ICD–10–PCS Systems in FY 2014

a. ICD–9–CM Coding System

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

The Official Version of the ICD–9–CM contains the list of valid diagnosis and procedure codes. (The Official Version of the ICD–9–CM is available from the Government Printing Office on CD–ROM for $19.00 by calling (202) 512–1800.) Complete information on ordering the CD–ROM is also available at: *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/05_CDROM.asp#TopOfPage.* The Official Version of the ICD–9–CM is no longer available in printed manual form from the Federal Government; it is only available on CD–ROM. Users who need a paper version are referred to one of the many products available from publishing houses.

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

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

The Committee presented proposals for coding changes for implementation in FY 2011 at a public meeting held on September 16–17, 2009 and finalized the coding changes after consideration of comments received at the meetings and in writing by November 20, 2009. Those coding changes are announced in Tables 6A through 6F in the Addendum to this proposed rule. The Committee held its 2010 meeting on March 9–10, 2010. New codes for which there was a consensus of public support and for which complete tabular and indexing changes are made by May 2010 will be included in the October 1, 2010 update to ICD–9–CM. Code revisions that were discussed at the March 9–10, 2010 Committee meeting but that could not be finalized in time to include them in the Addendum to this proposed rule will be included in Tables 6A through 6F of the final rule and will be marked with an asterisk (*).

Copies of the minutes of the procedure codes discussions at the Committee's September 16–17, 2009 meeting and March 9–10, 2010 meeting can be obtained from the CMS Web site at: *http://cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.* The minutes of the diagnosis codes discussions at the September 16–17, 2009 meeting and March 9–10, 2010 meeting are found at: *http://www.cdc.gov/nchs/icd.htm.* These Web sites also provide detailed

information about the Committee, including information on requesting a new code, attending a Committee meeting, and timeline requirements and meeting dates.

We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, NCHS, Room 2402, 3311 Toledo Road, Hyattsville, MD 20782. Comments may be sent by e-mail to: *dfp4@cdc.gov.*

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. Comments may be sent by e-mail to: *patricia.brooks2@cms.hhs.gov.*

The ICD–9–CM code changes that have been approved will become effective October 1, 2010. The new ICD–9–CM codes are listed, along with their MS–DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved.

In this proposed rule, we are soliciting comments on the proposed classification of these new codes, which are shown in Tables 6A and 6B of the Addendum to this proposed rule.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A in the Addendum to this proposed rule. New procedure codes are shown in Table 6B in the Addendum to this proposed rule. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes) in the Addendum to this proposed rule. These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2010. Table 6D in the Addendum to this proposed rule contains invalid procedure codes. These invalid procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2010. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles) in the Addendum to this proposed rule, which also includes the MS–DRG assignments for these revised codes. Table 6F in the Addendum to this proposed rule includes revised procedure code titles for FY 2011.

In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include proposals for procedure codes that would describe new technology discussed and approved at the Spring meeting as part of the code revisions effective the following October. As stated previously, ICD–9–CM codes discussed at the March 9–10, 2010 Committee meeting that receive consensus and that are finalized by May 2010 will be included in Tables 6A through 6F in the Addendum to the final rule.

Section 503(a) of Public Law 108–173 included a requirement for updating ICD–9–CM codes twice a year instead of a single update on October 1 of each year. This requirement was included as part of the amendments to the Act relating to recognition of new technology under the IPPS. Section 503(a) amended section 1886(d)(5)(K) of the Act by adding a clause (vii) which states that the "Secretary shall provide for the addition of new diagnosis and procedure codes on April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date." This requirement improves the recognition of new technologies under the IPPS system by providing information on these new technologies at an earlier date. Data will be available 6 months earlier than would be possible with updates occurring only once a year on October 1.

While section 1886(d)(5)(K)(vii) of the Act states that the addition of new diagnosis and procedure codes on April 1 of each year shall not require the Secretary to adjust the payment, or DRG classification, under section 1886(d) of the Act until the fiscal year that begins after such date, we have to update the DRG software and other systems in order to recognize and accept the new codes. We also publicize the code changes and the need for a mid-year systems update by providers to identify the new codes. Hospitals also have to obtain the new code books and encoder updates, and make other system changes in order to identify and report the new codes.

The ICD–9–CM Coordination and Maintenance Committee holds its meetings in the spring and fall in order to update the codes and the applicable payment and reporting systems by October 1 of each year. Items are placed on the agenda for the ICD–9–CM Coordination and Maintenance Committee meeting if the request is received at least 2 months prior to the meeting. This requirement allows time for staff to review and research the coding issues and prepare material for discussion at the meeting. It also allows time for the topic to be publicized in meeting announcements in the **Federal Register** as well as on the CMS Web site. The public decides whether or not to attend the meeting based on the topics listed on the agenda. Final decisions on code title revisions are currently made by March 1 so that these titles can be included in the IPPS proposed rule. A complete addendum describing details of all changes to ICD–9–CM, both tabular and index, is published on the CMS and NCHS Web sites in May of each year. Publishers of coding books and software use this information to modify their products that are used by health care providers. This 5-month time period has proved to be necessary for hospitals and other providers to update their systems.

A discussion of this timeline and the need for changes are included in the December 4–5, 2005 ICD–9–CM Coordination and Maintenance Committee minutes. The public agreed that there was a need to hold the fall meetings earlier, in September or October, in order to meet the new implementation dates. The public provided comment that additional time would be needed to update hospital systems and obtain new code books and coding software. There was considerable concern expressed about the impact this new April update would have on providers.

In the FY 2005 IPPS final rule, we implemented section 1886(d)(5)(K)(vii) of the Act, as added by section 503(a) of Public Law 108–173, by developing a mechanism for approving, in time for the April update, diagnosis and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We also established the following process for making these determinations. Topics considered during the Fall ICD–9–CM Coordination and Maintenance Committee meeting are considered for an April 1 update if a strong and convincing case is made by the requester at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at

the meeting and those reviewing the Committee meeting summary report are provided the opportunity to comment on this expedited request. All other topics are considered for the October 1 update. Participants at the Committee meeting are encouraged to comment on all such requests. There were no requests approved for an expedited April 1, 2010 implementation of an ICD–9–CM code at the September 16–17, 2009 Committee meeting. Therefore, there were no new ICD–9–CM codes implemented on April 1, 2010.

Current addendum and code title information is published on the CMS Web site at: *http://www.cms.hhs.gov/icd9ProviderDiagnosticCodes/01_overview.asp#TopofPage.* Information on ICD–9–CM diagnosis codes, along with the Official ICD–9–CM Coding Guidelines, can be found on the Web site at: *http://www.cdc.gov/nchs/icd9.htm.* Information on new, revised, and deleted ICD–9–CM codes is also provided to the AHA for publication in the *Coding Clinic for ICD–9–CM.* AHA also distributes information to publishers and software vendors.

CMS also sends copies of all ICD–9–CM coding changes to its Medicare contractors for use in updating their systems and providing education to providers.

These same means of disseminating information on new, revised, and deleted ICD–9–CM codes will be used to notify providers, publishers, software vendors, contractors, and others of any changes to the ICD–9–CM codes that are implemented in April. The code titles are adopted as part of the ICD–9–CM Coordination and Maintenance Committee process. Thus, although we publish the code titles in the IPPS proposed and final rules, they are not subject to comment in the proposed or final rules. We will continue to publish the October code updates in this manner within the IPPS proposed and final rules. For codes that are implemented in April, we will assign the new procedure code to the same MS–DRG in which its predecessor code was assigned so there will be no MS–DRG impact as far as MS–DRG assignment. Any midyear coding updates will be available through the Web sites indicated above and through the *Coding Clinic for ICD–9–CM.* Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software systems. We will strive to have the April 1 updates available through these Web sites 5 months prior to implementation (that is, early November of the previous year), as is the case for the October 1 updates.

b. Code Freeze

The International Classification of Diseases, 10th Revision (ICD–10) coding system applicable to hospital inpatient services will be implemented on October 1, 2013, as described in the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Modifications to Medical Data code Set Standards to Adopt ICD–10–CM and ICD–10–PCS final rule (74 FR 3328 through 3362, January 16, 2009). The ICD–10 coding system includes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) for inpatient hospital procedure coding, as well as the Official ICD–10–CM and ICM–10–PCS Guidelines for Coding and Reporting. In the January 16, 2009 ICD–10–CM and ICD–10–PCS final rule (74 FR 3328 through 3362), there was a discussion of the need for a partial or total freeze in the annual updates to both ICD–9–CM and ICD–10–CM and ICD–10–PCS codes. The public comment addressed in this final rule stated that the annual code set updates should cease l year prior to the implementation of ICD–10. The commenters stated that this freeze of code updates would allow for instructional and/or coding software programs to be designed and purchased early, without concern that an upgrade would take place immediately before the compliance date, necessitating additional updates and purchases.

We responded to comments in the ICD–10 final rule that the ICD–9–CM Coordination and Maintenance Committee has jurisdiction over any action impacting the ICD–9–CM and ICD–10 code sets. Therefore, the issue of consideration of a moratorium on updates to the ICD–9–CM, ICD–10–CM, and ICD–10–PCS code sets in anticipation of the adoption of ICD–10–CM and ICD–10–PCS would be addressed through the Committee at a future public meeting.

At the March 11–12, 2009 ICD–9–CM Coordination and Maintenance Committee meeting, the public was notified that there would be a discussion of whether there was a need to freeze updates to ICD–9–CM and/or ICD–10–CM and ICD–10–PCS prior to the implementation of ICD–10. The audience was asked to consider this issue and be prepared to discuss the topic at the September 16–17, 2009 ICD–9–CM Coordination and Maintenance Committee meeting. Advance written comments on this topic were welcomed. The first part of the meeting was devoted to this topic.

CMS received comments in advance of the meeting. CMS staff summarized these advanced comments at the meeting as follows:

No ICD–9–CM or ICD–10–CM/PCS updates beginning October 1, 2010 (36 months for implementation activities without annual code updates). This approach involves updating ICD–9–CM and ICD–10 codes on October 1, 2010, and not updating them again until after ICD–10 implementation on October 1, 2013. The commenters mentioned the extensive work needed to prepare for the transition to ICD–10 which will affect vendors, payers, providers, trainers, clearinghouses, and all claims handling organizations. The commenters stated that the 36 months between the last ICD–9–CM and ICD–10 updates on October 1, 2010 and the implementation of ICD–10 on October 1, 2013, were necessary to prepare and train for the transition.

No ICD–9–CM or ICD–10–CM/PCS updates beginning October 1, 2011 (24 months for implementation activities without annual code updates). This approach involves updating ICD–9–CM and ICD–10 codes on October 1, 2011, and not updating them again until after ICD–10 implementation on October 1, 2013. The commenters raised similar concerns to those mentioned above. The commenters stated that, if codes continue to change, the changes would make it difficult for vendors, payers, and providers to be ready and for coder training to be successful. One commenter suggested that a provision be developed to perform limited annual updates to capture new technologies or new diagnoses.

No ICD–10–CM/PCS updates beginning October 1, 2012 but continue annual updates to ICD–9–CM. This commenter supported annual updates to ICD–9–CM to capture advances in medical science. However, the commenter supported a freeze of ICD–10 beginning October 1, 2012, to give the industry time to update systems and prepare for ICD–10 implementation.

No ICD–10 updates on October 1, 2012, but update ICD–9–CM without interruption. (No period for implementation activities without annual code updates.) The commenter recommended no ICD–10 updates on October 1, 2012, but then updating ICD–10 again on October 1, 2013. The commenter recommended updating ICD–9–CM continuously through a final update on October 1, 2012. The commenter stated that having a two or three year gap between updating the

code books would lead to a loss of data. The commenter stated that there is a need to retain the ability to update the code books to capture conditions such as Swine flu.

Update both ICD–9–CM and ICD–10–CM/PCS annually through October 1, 2013 (no period for implementation activities without annual code updates). The commenter stated that codes should not be frozen prior to the implementation of ICD–10. The commenter stated that freezing the updates would inhibit the recognition of new technologies.

Many of the commenters suggested a resumption of updates to ICD–10–CM and ICD–10–PCS beginning on October 1, 2014. However, one commenter suggested annual updates of ICD–10–CM and ICD–10–PCS without interruptions, including on October 1, 2013.

The topic was then opened for public discussion at the Committee meeting. CMS received a variety of comments from the participants that mirrored the advance written comments. These comments ranged from those supporting a complete freeze for both coding systems to those who recommended that both coding systems continue to be updated annually prior to ICD–10 implementation. There were also many comments that supported a more limited update process beginning on October 1, 2011, or October 1, 2012, which would allow only a small number of new codes to capture new technologies or new diseases. A number of commenters pointed out that section 503(a) of Public Law 108–173 included a requirement for updating ICD–9–CM codes twice a year to capture new technologies. The commenters stated that CMS must make a provision to capture new technologies despite any requests to freeze code updates.

Commenters voiced concerns about the impact on vendors creating new ICD–10 products when both ICD–9–CM and ICD–10–CM and ICD–10–PCS codes were extensively updated on an annual basis. Commenters stated that vendors and educators were reluctant to begin ICD–10 products and training materials until there was a period of stability without extensive annual updates. Some commenters stated that it was important for physician offices to have time to prepare for the implementation of ICD–10. Reducing the annual ICD–9–CM and ICD–10 annual updates would be helpful to physician offices.

Other commenters stated that it was important to update codes annually so that information on new diseases and technologies can be captured. These commenters stated that vendors, providers, system maintainers, and coders were used to annual code updates, and that they should continue.

One commenter requested that ICD–10–CM codes be frozen on October 1, 2011 so that ICD–10–CM codes could be coordinated with the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition. The commenter stated that the American Psychiatric Association plans to publish the fifth edition in 2012. Updates to ICD–10–CM on or after October 1, 2011, would disrupt those plans.

One commenter suggested an approach that would greatly reduce the number of updates and provide more stability in the coding systems during the implementation period. This commenter suggested that the large, regular code updates on ICD–9–CM be discontinued beginning on October 1, 2011, or October 1, 2012. The commenter suggested that CMS and CDC raise the bar for new code requests at that time and only consider requests for new codes that clearly describe a new technology or a new disease. The commenter stated that this may lead to the creation of some new procedure codes which do not ultimately receive FDA approval, as is the case now.

CMS and CDC have carefully reviewed the comments received at the ICD–9–CM Coordination and Maintenance Committee meeting as well as the written comments submitted. Most commenters proposed a limited freeze on code updates to both ICD–9–CM and ICD–10–CM and ICD–10–PCS code sets, with an exception made for adding codes for new technologies and diseases. Providing this exception would comply with section 503(a) of Public Law 108–173, which, as previously stated, includes a requirement for updating ICD–9–CM codes twice a year to capture new technologies. There was support for making the last regular update on October 1, 2011. The commenters recommended that the ICD–9–CM Coordination and Maintenance Committee continue to discuss any new code updates for both coding systems. However, new codes would only be added to ICD–9–CM or ICD–10 to capture new technologies, as required by section 503(a) of Public Law 108–173. Other coding issues raised would be held for consideration after ICD–10 is implemented.

In this proposed rule, we are soliciting additional input on this subject, especially in light of the requirements on hospitals for meaningful use of electronic health records. We welcome public comments that explore whether a freeze is needed to help with adoption of health IT, given other priorities such as achievement of meaningful use and implementation of ICD–10 by FY 2013. We welcome input on having the last regular, annual update to both ICD–9–CM and ICD–10 be made on October 1, 2011. On October 1, 2012, there would be only limited code updates to both the ICD–9–CM and ICD–10 coding systems to capture new technologies and diseases. On October 1, 2013, there would be only limited code updates to ICD–10 to capture new technologies and diagnoses. Any other issues raised would be considered for implementation in ICD 10 on October 1, 2014, a year after ICD–10 is implemented. We agree with commenters that there is a need to provide the provider, payer, and vendor community time to prepare for the implementation of ICD–10 and the accompanying system and product updates. The vendor community is especially interested in providing a more stable code set for ICD–10 while they are developing new products.

We believe that this advance notice of a partial code freeze would provide the health care industry ample time to request last major code updates to ICD–9–CM and ICD–10, which could be discussed at the September 15–16, 2010 and the March 2011 ICD–9–CM Coordination and Maintenance Committee meeting. Codes discussed at these two meetings would be considered for the final major code updates on October 1, 2011. Any code issues raised after that time would be addressed at the ICD–9–CM Coordination and Maintenance Committee meetings in September 2011 through March 2013 to determine if they represented new technologies or new diseases. Any new technologies and diseases would be added during the regular annual updates. Other code requests would be held for implementation on October 1, 2014.

We welcome additional input on having the last regular code updates to ICD–9–CM and ICD–10 on October 1, 2011, and to only add codes for new technologies and diseases on October 1, 2012 and 2013. We also welcome additional input on having the next regular update to ICD–10 occur again on October 1, 2014.

Information on ICD–10 can be found on the CMS Web site at: *http://www.cms.hhs.gov/ICD10*. The final ICD–10 version of MS–DRGs would be adopted under the formal rulemaking process as part of our annual IPPS updates.

c. Processing of 25 Diagnosis Codes and 25 Procedure Codes on Hospital Inpatient Claims

We have received repeated requests from the hospital community to process all 25 diagnosis codes and 25 procedure codes submitted on electronic hospital inpatient claims. Hospitals can submit up to 25 diagnoses and 25 procedures; however, CMS' current system limitations allow for the processing of only the first 9 diagnoses and 6 procedures. While CMS accepts all 25 diagnoses and 25 procedures submitted on the claims, we do not process all of the codes because of these system limitations. We recognize that much valuable information is lost by not processing the additional diagnosis and procedure codes that are reported by hospitals.

We responded to hospitals' requests that we process up to 25 diagnosis codes and 25 procedure codes in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43798). In that final rule, we referred readers to the ICD–10 final rule (74 FR 3328 through 3362) where we discuss the updating of Medicare systems prior to the implementation of ICD–10 on October 1, 2013. We mentioned that part of the system updates in preparation for ICD–10 is the "expansion of our ability to process more diagnosis and procedure codes." In the FY 2009 IPPS final rule (73 FR 48433 through 48444), we also responded to multiple requests to increase the number of codes processed from 9 diagnosis and 6 procedure codes to 25 diagnosis and 25 procedure codes.

CMS is currently undergoing extensive system updates as part of the move to 5010, which includes the ability to accept ICD–10 codes. This complicated transition involves converting many internal systems prior to October 1, 2013, when ICD–10 will be implemented. One important step in this planned conversion process is the expansion of our ability to process additional diagnosis and procedure codes. We are currently planning to complete the expansion of this internal system capability so that we are able to process up to 25 diagnoses and 25 procedures on hospital inpatient claims as part of the HIPPA ASC X12 Technical Reports Type 3, Version 005010 (Version 5010) standards system update. CMS will be able to process up to 25 diagnosis codes and 25 procedure codes when received on the 5010 format starting on January 1, 2011. We recognize the value of the additional information provided by this coded data for multiple uses such as for payment, quality measures, outcome analysis, and other important uses. We will continue to pursue this additional processing capacity as aggressively as possible in response to the multiple requests from the hospital industry. We appreciate the support of the health care community for this extensive system update process that will allow us to process more of this important data. Therefore, for claims submitted on the 5010 format beginning January 1, 2011, we will increase the capacity to process diagnosis and procedure codes on hospital inpatient claims from the current 9 diagnoses and 6 procedures up to 25 diagnoses and 25 procedures.

H. Recalibration of MS–DRG Weights

In developing the proposed FY 2011 system of weights, we used two data sources: Claims data and cost report data. As in previous years, the claims data source is the MedPAR file. This file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2009 MedPAR data used in this proposed rule include discharges occurring on October 1, 2008, through September 30, 2009, based on bills received by CMS through December 31, 2009, from all hospitals subject to the IPPS and short-term, acute care hospitals in Maryland (which are under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2009 MedPAR file used in calculating the proposed relative weights includes data for approximately 11,004,046 Medicare discharges from IPPS providers. Discharges for Medicare beneficiaries enrolled in a Medicare Advantage managed care plan are excluded from this analysis. The data exclude CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken. The second data source used in the cost-based relative weighting methodology is the FY 2008 Medicare cost report data files from HCRIS (that is, cost reports beginning on or after October 1, 2007, and before October 1, 2008), which represents the most recent full set of cost report data available. We used the December 31, 2009 update of the HCRIS cost report files for FY 2008 in setting the relative cost-based weights.

The methodology we used to calculate the DRG cost-based relative weights from the FY 2009 MedPAR claims data and FY 2008 Medicare cost report data is as follows:

- To the extent possible, all the claims were regrouped using the proposed FY 2011 MS–DRG classifications discussed in sections II.B. and G. of the preamble of this proposed rule.
- The transplant cases that were used to establish the relative weights for heart and heart-lung, liver and/or intestinal, and lung transplants (MS–DRGs 001, 002, 005, 006, and 007, respectively) were limited to those Medicare-approved transplant centers that have cases in the FY 2009 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average cost for each MS–DRG and before eliminating statistical outliers.
- Claims with total charges or total lengths of stay less than or equal to zero were deleted. Claims that had an amount in the total charge field that differed by more than $10.00 from the sum of the routine day charges, intensive care charges, pharmacy charges, special equipment charges, therapy services charges, operating room charges, cardiology charges, laboratory charges, radiology charges, other service charges, labor and delivery charges, inhalation therapy charges, emergency room charges, blood charges, and anesthesia charges were also deleted.
- At least 96.1 percent of the providers in the MedPAR file had charges for 10 of the 15 cost centers. Claims for providers that did not have charges greater than zero for at least 10 of the 15 cost centers were deleted.
- Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the total charges per case and the total charges per day for each MS–DRG.
- Effective October 1, 2008, because hospital inpatient claims include a POA indicator field for each diagnosis present on the claim, only for purposes of relative weight-setting, the POA indicator field was reset to "Y" for "Yes" for all claims that otherwise have an "N" (No) or a "U" (documentation insufficient to determine if the condition was present at the time of inpatient admission) in the POA field.

Under current payment policy, the presence of specific HAC codes, as indicated by the POA field values, can generate a lower payment for the claim.

Specifically, if the particular condition is present on admission (that is, a "Y" indicator is associated with the diagnosis on the claim), then it is not a HAC, and the hospital is paid for the higher severity (and, therefore, the higher weighted MS–DRG). If the particular condition is not present on admission (that is, an "N" indicator is associated with the diagnosis on the claim) and there are no other complicating conditions, the DRG GROUPER assigns the claim to a lower severity (and, therefore, the lower weighted MS–DRG) as a penalty for allowing a Medicare inpatient to contract a HAC. While the POA reporting meets policy goals of encouraging quality care and generates program savings, it presents an issue for the relative weight-setting process. Because cases identified as HACs are likely to be more complex than similar cases that are not identified as HACs, the charges associated with HACs are likely to be higher as well. Thus, if the higher charges of these HAC claims are grouped into lower severity MS–DRGs prior to the relative weight-setting process, the relative weights of these particular MS–DRGs would become artificially inflated, potentially skewing the relative weights. In addition, we want to protect the integrity of the budget neutrality process by ensuring that, in estimating payments, no increase to the standardized amount occurs as a result of lower overall payments in a previous year that stem from using weights and case-mix that are based on lower severity MS–DRG assignments. If this would occur, the anticipated cost savings from the HAC policy would be lost.

To avoid these problems, we reset the POA indicator field to "Y" only for relative weight-setting purposes for all claims that otherwise have a "N" or an "U" in the POA field. This resetting "forced" the more costly HAC claims into the higher severity MS–DRGs as appropriate, and the relative weights calculated for each MS–DRG more closely reflect the true costs of those cases.

Once the MedPAR data were trimmed and the statistical outliers were removed, the charges for each of the 15 cost groups for each claim were standardized to remove the effects of differences in area wage levels, IME and DSH payments, and for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment. Because hospital charges include charges for both operating and capital costs, we standardized total charges to remove the effects of differences in geographic adjustment factors, cost-of-living adjustments, and DSH payments under the capital IPPS as well. Charges were then summed by MS–DRG for each of the 15 cost groups so that each MS–DRG had 15 standardized charge totals. These charges were then adjusted to cost by applying the national average CCRs developed from the FY 2008 cost report data.

The 15 cost centers that we used in the relative weight calculation are shown in the following table. The table shows the lines on the cost report and the corresponding revenue codes that we used to create the 15 national cost center CCRs.

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Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
Routine Days	Private Room Charges	011X and 014X	Adults & Pediatrics (General Routine Care)	C_1_C5_25	C_1_C6_25	D4_HOS_C2_25
	Semi-Private Room Charges	010X, 012X, 013X and 016X-019X			C_1_C7_25	D4_HOS_C2_26
	Ward Charges	015X				
Intensive Days	Intensive Care Charges	020X	Intensive Care Unit	C_1_C5_26	C_1_C6_26	D4_HOS_C2_26
					C_1_C7_26	
	Coronary Care Charges	021X	Coronary Care Unit	C_1_C5_27	C_1_C6_27	D4_HOS_C2_27
					C_1_C7_27	
			Burn Intensive Care Unit	C_1_C5_28	C_1_C6_28	D4_HOS_C2_28
					C_1_C7_28	
			Surgical Intensive Care Unit	C_1_C5_29	C_1_C6_29	D4_HOS_C2_29
					C_1_C7_29	
			Other Special Care Unit	C_1_C5_30	C_1_C6_30	D4_HOS_C2_30
					C_1_C7_30	
Drugs	Pharmacy Charges	025X, 026X and 063X	Intravenous Therapy	C_1_C5_48	C_1_C6_48	D4_HOS_C2_48

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
					C_1_C7_48	
			Drugs Charged To Patient	C_1_C5_56	C_1_C6_56	D4_HOS_C2_56
					C_1_C7_56	
Supplies and Equipment	Medical/Surgical Supply Charges	027X and 062X	Medical Supplies Charged to Patients	C_1_C5_55	C_1_C6_55	D4_HOS_C2_55
					C_1_C7_55	
	Durable Medical Equipment Charges	0290, 0291, 0292 and 0294-0299	DME-Rented	C_1_C5_66	C_1_C6_66	D4_HOS_C2_66
					C_1_C7_66	
	Used Durable Medical Charges	0293	DME-Sold	C_1_C5_67	C_1_C6_67	D4_HOS_C2_67
					C_1_C7_67	
Therapy Services	Physical Therapy Charges	042X	Physical Therapy	C_1_C5_50	C_1_C6_50	D4_HOS_C2_50
					C_1_C7_50	
	Occupational Therapy Charges	043X	Occupational Therapy	C_1_C5_51	C_1_C6_51	D4_HOS_C2_51
					C_1_C7_51	
	Speech Pathology Charges	044X and 047X	Speech Pathology	C_1_C5_52	C_1_C6_52	D4_HOS_C2_52

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
					C_1_C7_52	
Inhalation Therapy	Inhalation Therapy Charges	041X and 046X	Respiratory Therapy	C_1_C5_49	C_1_C6_49 C_1_C7_49	D4_HOS_C2_49
Operating Room For all DRGs but Labor & Delivery	Operating Room Charges	036X, 071X and 072X	Operating Room	C_1_C5_37	C_1_C6_37 C_1_C7_37	D4_HOS_C2_37
			Recovery Room	C_1_C5_38	C_1_C6_38 C_1_C7_38	D4_HOS_C2_38
Labor & Delivery **ONLY FOR THE 6 Labor & Delivery DRGs** **370, 371, 372, 373, 374, 375**	Operating Room Charges	036X, 071X and 072X	Delivery Room and Labor Room	C_1_C5_39	C_1_C6_39 C_1_C7_39	D4_HOS_C2_39
	Clinic Charges	051X	Obstetrics Clinic	C_1_C5_63	C_1_C6_63 C_1_C7_63	D4_HOS_C2_63
Anesthesia	Anesthesia Charges	037X	Anesthesi-ology	C_1_C5_40	C_1_C6_40	D4_HOS_C2_40

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
					C_1_C7_40	
Cardiology	Cardiology Charges	048X and 073X	Electro-cardiology	C_1_C5_53	C_1_C6_53	D4_HOS_C2_53
					C_1_C7_53	
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X	Laboratory	C_1_C5_44	C_1_C6_44	D4_HOS_C2_44
					C_1_C7_44	
			PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45	D4_HOS_C2_45
					C_1_C7_45	
			Electro-encep halography	C_1_C5_54	C_1_C6_54	D4_HOS_C2_54
					C_1_C7_54	
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X	Radiology - Diagnostic	C_1_C5_41	C_1_C6_41	D4_HOS_C2_41
					C_1_C7_41	
	MRI Charges	061X	Radiology - Therapeutic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42
			Radioisotope	C_1_C5_43	C_1_C6_43	D4_HOS_C2_43

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
						C_1_C7_43	
Emergency Room	Emergency Room Charges	045x		Emergency	C_1_C5_61	C_1_C6_61	D4_HOS_C2_61
						C_1_C7_61	
Blood and Blood Products	Blood Charges	038x		Whole Blood & Packed Red Blood Cells	C_1_C5_46	C_1_C6_46	D4_HOS_C2_46
						C_1_C7_46	
	Blood Storage / Processing	039x		Blood Storing, Processing, & Transfusing	C_1_C5_47	C_1_C6_47	D4_HOS_C2_47
						C_1_C7_47	
Other Services	Lithotripsy Charge	079X					
	Other Service Charge	0002-0099, 022X, 023X, 024X,052X,053X 055X-060X, 064X-070X, 076X-078X, 090X-095X and 099X					
				ASC (Non Distinct Part)	C_1_C5_58	C_1_C6_58	D4_HOS_C2_58
						C_1_C7_58	
	Outpatient Service Charges	049X and 050X		Other Ancillary	C_1_C5_59	C_1_C6_59	D4_HOS_C2_59
						C_1_C7_59	

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
				Clinic	C_1_C5_60	C_1_C6_60	D4_HOS_C2_60
						C_1_C7_60	
	Ambulance Charges	054X					
	ESRD Revenue Setting Charges	080X and 082X-088X		Observation beds	C_1_C5_62	C_1_C6_62	D4_HOS_C2_62
						C_1_C7_62	
	Clinic Visit Charges (excluding Labor & Delivery DRGs)	051X		Observation beds	C_1_C5_6201	C_1_C6_6201	D4_HOS_C2_62 01
						C_1_C7_6201	
				Rural Health Clinic	C_1_C5_6350	C_1_C6_6350	D4_HOS_C2_63 50
	Professional Fees Charges	096X, 097X, and 098X				C_1_C7_6350	
				FQHC	C_1_C5_6360	C_1_C6_6360	D4_HOS_C2_63 60
						C_1_C7_6360	
				Home Program Dialysis	C_1_C5_64	C_1_C6_64	D4_HOS_C2_64
						C_1_C7_64	
				Ambulance	C_1_C5_65	C_1_C6_65	D4_HOS_C2_65
						C_1_C7_65	

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
				Other Reimbursable	C_1_C5_68	C_1_C6_68 C_1_C7_68	D4_HOS_C2_68

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We developed the national average CCRs as follows:

Taking the FY 2008 cost report data, we removed CAHs, Indian Health Service hospitals, all-inclusive rate hospitals, and cost reports that represented time periods of less than 1 year (365 days). We included hospitals located in Maryland as we are including their charges in our claims database. We then created CCRs for each provider for each cost center (see prior table for line items used in the calculations) and removed any CCRs that were greater than 10 or less than 0.01. We normalized the departmental CCRs by dividing the CCR for each department by the total CCR for the hospital for the purpose of trimming the data. We then took the logs of the normalized cost center CCRs and removed any cost center CCRs where the log of the cost center CCR was greater or less than the mean log plus/minus 3 times the standard deviation for the log of that cost center CCR. Once the cost report data were trimmed, we calculated a Medicare-specific CCR. The Medicare-specific CCR was determined by taking the Medicare charges for each line item from Worksheet D–4 and deriving the Medicare-specific costs by applying the hospital-specific departmental CCRs to the Medicare-specific charges for each line item from Worksheet D–4. Once each hospital's Medicare-specific costs were established, we summed the total Medicare-specific costs and divided by the sum of the total Medicare-specific charges to produce national average, charge-weighted CCRs.

After we multiplied the total charges for each MS–DRG in each of the 15 cost centers by the corresponding national average CCR, we summed the 15 "costs" across each MS–DRG to produce a total standardized cost for the MS–DRG. The average standardized cost for each MS–DRG was then computed as the total standardized cost for the MS–DRG divided by the transfer-adjusted case count for the MS–DRG. The average cost for each MS–DRG was then divided by the national average standardized cost per case to determine the relative weight.

The new cost-based relative weights were then normalized by an adjustment factor of 1.57461 so that the average case weight after recalibration was equal to the average case weight before recalibration. The normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS, as required by section 1886(d)(4)(C)(iii) of the Act.

The 15 proposed national average CCRs for FY 2011 are as follows:

Group	CCR
Routine Days	0.553
Intensive Days	0.480
Drugs	0.200
Supplies & Equipment	0.348
Therapy Services	0.415
Laboratory	0.163
Operating Room	0.282
Cardiology	0.181
Radiology	0.161
Emergency Room	0.278
Blood and Blood Products	0.424
Other Services	0.426
Labor & Delivery	0.462
Inhalation Therapy	0.201
Anesthesia	0.136

Since FY 2009, the relative weights have been based on 100 percent cost weights based on our MS–DRG grouping system.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. In this FY 2011 proposed rule, we are proposing to use that same case threshold in recalibrating the MS–DRG weights for FY 2011. Using the FY 2009 MedPAR data set, there are 8 MS–DRGs that contain fewer than 10 cases. Under the MS–DRGs, we have fewer low-volume DRGs than under the CMS DRGs because we no longer have separate DRGs for patients age 0 to 17 years. With the exception of newborns, we previously separated some DRGs based on whether the patient was age 0 to 17 years or age 17 years and older. Other than the age split, cases grouping to these DRGs are identical. The DRGs for patients age 0 to 17 years generally have very low volumes because children are typically ineligible for Medicare. In the past, we have found that the low volume of cases for the pediatric DRGs could lead to significant year-to-year instability in their relative weights. Although we have always encouraged non-Medicare payers to develop weights applicable to their own patient populations, we have heard frequent complaints from providers about the use of the Medicare relative weights in the pediatric population. We believe that eliminating this age split in the MS–DRGs will provide more stable payment for pediatric cases by determining their payment using adult cases that are much higher in total volume. Newborns are unique and require separate MS–DRGs that are not mirrored in the adult population. Therefore, it remains necessary to retain separate MS–DRGs for newborns. All of the low-volume MS–DRGs listed below are for newborns. In FY 2011, because we do not have sufficient MedPAR data to set accurate and stable cost weights for these low-volume MS–DRGs, we are proposing to compute weights for the low-volume MS–DRGs by adjusting their FY 2010 weights by the percentage change in the average weight of the cases in other MS–DRGs. The crosswalk table is shown below:

Low-Volume MS–DRG	MS–DRG title	Crosswalk to MS–DRG
768	Vaginal Delivery with O.R. Procedure Except Sterilization and/or D&C.	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
789	Neonates, Died or Transferred to Another Acute Care Facility	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate.	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
791	Prematurity with Major Problems	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
792	Prematurity without Major Problems	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
793	Full-Term Neonate with Major Problems	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
794	Neonate with Other Significant Problems	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
795	Normal Newborn	FY 2010 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).

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

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as "new technologies") under the IPPS. Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered new if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that a new medical service or technology may be considered for new technology add-on payment if, "based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate." We note that beginning with FY 2008, CMS transitioned from CMS–DRGs to MS–DRGs.

The regulations implementing these provisions specify three criteria for a new medical service or technology to receive the additional payment: (1) The medical service or technology must be new; (2) the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies. These three criteria are explained below in the ensuing paragraphs in further detail.

Under the first criterion, as reflected in 42 CFR 412.87(b)(2), a specific medical service or technology will be considered "new" for purposes of new medical service or technology add-on payments until such time as Medicare data are available to fully reflect the cost of the technology in the MS–DRG weights through recalibration. Typically, there is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market (generally on the date that the technology receives FDA approval/clearance) and when data reflecting the use of the medical service or technology are used to calculate the MS–DRG weights. For example, data from discharges occurring during FY 2009 are used to calculate the proposed FY 2011 MS–DRG weights in this proposed rule. Section 412.87(b)(2) of the regulations therefore provides that "a medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the MS–DRGs, based on available data to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered 'new' under the criterion for this section."

The 2-year to 3-year period during which a medical service or technology can be considered new would ordinarily begin on the date on which the medical service or technology received FDA approval or clearance. (We note that, for purposes of this section of this proposed rule, we generally refer to both FDA approval and FDA clearance as FDA "approval.") However, in some cases, there may be few to no Medicare data available for the new service or technology following FDA approval. For example, the newness period could extend beyond the 2-year to 3-year period after FDA approval is received in cases where the product initially was generally unavailable to Medicare patients following FDA approval, such as in cases of a national noncoverage determination or a documented delay in bringing the product onto the market after that approval (for instance, component production or drug production has been postponed following FDA approval due to shelf life concerns or manufacturing issues). After the MS–DRGs have been recalibrated to reflect the costs of an otherwise new medical service or technology, the medical service or technology is no longer eligible for special add-on payment for new medical services or technologies (as specified under § 412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2008 and entered the market at that time may be eligible to receive add-on payments as a new technology for discharges occurring before October 1, 2011 (the start of FY 2012). Because the FY 2012 MS–DRG weights would be calculated using FY 2010 MedPAR data, the costs of such a new technology would be fully reflected in the FY 2012 MS–DRG weights. Therefore, the new technology would no longer be eligible to receive add-on payments as a new technology for discharges occurring in FY 2012 and thereafter.

We do not consider a service or technology to be new if it is substantially similar to one or more existing technologies. That is, even if a technology receives a new FDA approval, it may not necessarily be considered "new" for purposes of new technology add-on payments if it is "substantially similar" to a technology that was approved by FDA and has been on the market for more than 2 to 3 years. In the FY 2006 IPPS final rule (70 FR

47351), we explained our policy regarding substantial similarity in detail and its relevance for assessing if the hospital charge data used in the development of the relative weights for the relevant DRGs reflect the costs of the technology. In that final rule, we stated that, for determining substantial similarity, we consider (1) whether a product uses the same or a similar mechanism of action to achieve a therapeutic outcome, and (2) whether a product is assigned to the same or a different DRG. We indicated that both of the above criteria should be met in order for a technology to be considered "substantially similar" to an existing technology. However, in that same final rule, we also noted that, due to the complexity of issues regarding the substantial similarity component of the newness criterion, it may be necessary to exercise flexibility when considering whether technologies are substantially similar to one another. Specifically, we stated that we may consider additional factors, depending on the circumstances specific to each application.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43813 and 43814), we noted that the discussion of substantial similarity in the FY 2006 IPPS final rule related to comparing two separate technologies made by different manufacturers. Nevertheless, we stated that the criteria discussed in the FY 2006 IPPS final rule also are relevant when comparing the similarity between a new use and existing uses of the same technology (or a very similar technology manufactured by the same manufacturer). In other words, we stated that it is necessary to establish that the new indication for which the technology has received FDA approval is not substantially similar to that of the prior indication. We explained that such a distinction is necessary to determine the appropriate start date of the newness period in evaluating whether the technology would qualify for add-on payments (that is, the date of the "new" FDA approval or that of the prior approval), or whether the technology could qualify for separate new technology add-on payments under each indication.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43814), we added a third factor of consideration to our analysis of whether a new technology is substantially similar to one or more existing technologies. Specifically, in making a determination of whether a technology is substantially similar to an existing technology, we will consider whether the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population (74 FR 24130), in addition to considering the already established factors described in the FY 2006 IPPS final rule (that is, (1) whether a product uses the same or a similar mechanism of action to achieve a therapeutic outcome; and (2) whether a product is assigned to the same or a different DRG). As we noted in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, if all three components are present and the new use is deemed substantially similar to one or more of the existing uses of the technology (that is beyond the newness period), we would conclude that the technology is not new and, therefore, is not eligible for the new technology add-on payment.

Under the second criterion, § 412.87(b)(3) further provides that, to be eligible for the add-on payment for new medical services or technologies, the MS–DRG prospective payment rate otherwise applicable to the discharge involving the new medical services or technologies must be assessed for adequacy. Under the cost criterion, to assess the adequacy of payment for a new technology paid under the applicable MS–DRG prospective payment rate, we evaluate whether the charges for cases involving the new technology exceed certain threshold amounts. In the FY 2004 IPPS final rule (68 FR 45385), we established the threshold at the geometric mean standardized charge for all cases in the MS–DRG plus 75 percent of 1 standard deviation above the geometric mean standardized charge (based on the logarithmic values of the charges and converted back to charges) for all cases in the MS–DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant MS–DRGs, if the new medical service or technology occurs in more than one MS–DRG).

However, section 503(b)(1) of Public Law 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide that, beginning in FY 2005, CMS will apply "a threshold * * * that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved." (We refer readers to section IV.D. of the preamble to the FY 2005 IPPS final rule (69 FR 49084) for a discussion of the revision of the regulations to incorporate the change made by section 503(b)(1) of Pub. L. 108–173.) Table 10 that was included in the final rule published in the **Federal Register** on August 27, 2009, contains the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2011 (74 FR 44173). We note that we plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions addressing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and the LTCH PPS. At the time we issue those documents, we plan to update Table 10 that was published in the **Federal Register** on August 27, 2009 and Table 10 in the Addendum to this proposed rule.

In the September 7, 2001 final rule that established the new technology add-on payment regulations (66 FR 46917), we discussed the issue of whether the HIPAA Privacy Rule at 45 CFR Parts 160 and 164 applies to claims information that providers submit with applications for new technology add-on payments. Specifically, we explained that health plans, including Medicare, and providers that conduct certain transactions electronically, including the hospitals that would be receiving payment under the FY 2001 IPPS final rule, are required to comply with the HIPAA Privacy Rule. We further explained how such entities could meet the applicable HIPAA requirements by discussing how the HIPAA Privacy Rule permitted providers to share with health plans information needed to ensure correct payment, if they had obtained consent from the patient to use that patient's data for treatment, payment, or health care operations. We also explained that, because the information to be provided within applications for new technology add-on payment would be needed to ensure correct payment, no additional consent would be required. The HHS Office for Civil Rights has since amended the HIPAA Privacy Rule, but the results remain. The HIPAA Privacy Rule no longer requires covered entities to obtain consent from patients to use or disclose protected health information for treatment, payment, or health care operations, and expressly permits such entities to use or to disclose protected health information for any of these purposes. (We refer readers to 45 CFR 164.502(a)(1)(ii), and 164.506(c)(1) and (c)(3), and the Standards for Privacy of Individually Identifiable Health Information published in the **Federal Register** on August 14, 2002, for a full discussion of changes in consent requirements.)

Under the third criterion, § 412.87(b)(1) of our existing regulations

provides that a new technology is an appropriate candidate for an additional payment when it represents "an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries." For example, a new technology represents a substantial clinical improvement when it reduces mortality, decreases the number of hospitalizations or physician visits, or reduces recovery time compared to the technologies previously available. (We refer readers to the September 7, 2001 final rule for a complete discussion of this criterion (66 FR 46902).)

The new medical service or technology add-on payment policy under the IPPS provides additional payments for cases with relatively high costs involving eligible new medical services or technologies while preserving some of the incentives inherent under an average-based prospective payment system. The payment mechanism is based on the cost to hospitals for the new medical service or technology. Under § 412.88, if the costs of the discharge (determined by applying cost to charge ratios ("CCRs") as described in § 412.84(h)) exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of: (1) 50 percent of the estimated costs of the new technology (if the estimated costs for the case including the new technology exceed Medicare's payment); or (2) 50 percent of the difference between the full DRG payment and the hospital's estimated cost for the case. Unless the discharge qualifies for an outlier payment, Medicare payment is limited to the full MS–DRG payment plus 50 percent of the estimated costs of the new technology.

Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual MS–DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not more or less than they were in the prior fiscal year (i.e., they are "budget neutral"). Therefore, in the past, we accounted for projected payments under the new medical service and technology provision during the upcoming fiscal year, while at the same time estimating the payment effect of changes to the MS–DRG classifications and recalibration. The impact of additional payments under this provision was then included in the budget neutrality factor, which was applied to the standardized amounts and the hospital-specific amounts. However, section 503(d)(2) of Public Law 108–173 provides that there shall be no reduction or adjustment in aggregate payments under the IPPS due to add-on payments for new medical services and technologies. Therefore, in accordance with section 503(d)(2) of Public Law 108–173, add-on payments for new medical services or technologies for FY 2005 and later years have not been subjected to budget neutrality.

In the FY 2009 IPPS final rule (73 FR 48561 through 48563), we modified our regulations at § 412.87 to codify our current practice of how CMS evaluates the eligibility criteria for new medical service or technology add-on payment applications. We also amended § 412.87(c) to specify that all applicants for new technology add-on payments must have FDA approval for their new medical service or technology by July 1 of each year prior to the beginning of the fiscal year that the application is being considered.

The Council on Technology and Innovation (CTI) at CMS oversees the agency's cross-cutting priority on coordinating coverage, coding and payment processes for Medicare with respect to new technologies and procedures, including new drug therapies, as well as promoting the exchange of information on new technologies between CMS and other entities. The CTI, composed of senior CMS staff and clinicians, was established under section 942(a) of Public Law 108–173. The Council is co-chaired by the Director of the Office of Clinical Standards and Quality (OCSQ) and the Director of the Center for Medicare Management (CMM), who is also designated as the CTI's Executive Coordinator.

The specific processes for coverage, coding, and payment are implemented by CMM, OCSQ, and the local claims-payment contractors (in the case of local coverage and payment decisions). The CTI supplements, rather than replaces, these processes by working to assure that all of these activities reflect the agency-wide priority to promote high-quality, innovative care. At the same time, the CTI also works to streamline, accelerate, and improve coordination of these processes to ensure that they remain up to date as new issues arise. To achieve its goals, the CTI works to streamline and create a more transparent coding and payment process, improve the quality of medical decisions, and speed patient access to effective new treatments. It is also dedicated to supporting better decisions by patients and doctors in using Medicare-covered services through the promotion of better evidence development, which is critical for improving the quality of care for Medicare beneficiaries.

CMS plans to continue its Open Door forums with stakeholders who are interested in CTI's initiatives. In addition, to improve the understanding of CMS' processes for coverage, coding, and payment and how to access them, the CTI has developed an "innovator's guide" to these processes. The intent is to consolidate this information, much of which is already available in a variety of CMS documents and in various places on the CMS Web site, in a user-friendly format. This guide was published in August 2008 and is available on the CMS Web site at: *http://www.cms.hhs.gov/CouncilonTechInnov/Downloads/InnovatorsGuide8_25_08.pdf.*

As we indicated in the FY 2009 IPPS final rule (73 FR 48554), we invite any product developers or manufacturers of new medical technologies to contact the agency early in the process of product development if they have questions or concerns about the evidence that would be needed later in the development process for the agency's coverage decisions for Medicare.

The CTI aims to provide useful information on its activities and initiatives to stakeholders, including Medicare beneficiaries, advocates, medical product manufacturers, providers, and health policy experts. Stakeholders with further questions about Medicare's coverage, coding, and payment processes, or who want further guidance about how they can navigate these processes, can contact the CTI at *CTI@cms.hhs.gov* or from the "Contact Us" section of the CTI home page (*http://www.cms.hhs.gov/CouncilonTechInnov/*).

We note that applicants for add-on payments for new medical services or technologies for FY 2012 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate that the medical service or technology meets the high-cost threshold. Complete application information, along with final deadlines for submitting a full application, will be posted as it becomes available on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp.* To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2012, the Web

site also will list the tracking forms completed by each applicant.

2. Public Input Before Publication of a Notice of Proposed Rulemaking on Add-On Payments

Section 1886(d)(5)(K)(viii) of the Act, as amended by section 503(b)(2) of Public Law 108–173, provides for a mechanism for public input before publication of a notice of proposed rulemaking regarding whether a medical service or technology represents a substantial clinical improvement or advancement. The process for evaluating new medical service and technology applications requires the Secretary to—

- Provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of Medicare beneficiaries;
- Make public and periodically update a list of the services and technologies for which applications for add-on payments are pending;
- Accept comments, recommendations, and data from the public regarding whether a service or technology represents a substantial clinical improvement; and
- Provide, before publication of a proposed rule, for a meeting at which organizations representing hospitals, physicians, manufacturers, and any other interested party may present comments, recommendations, and data regarding whether a new medical service or technology represents a substantial clinical improvement to the clinical staff of CMS.

In order to provide an opportunity for public input regarding add-on payments for new medical services and technologies for FY 2011 prior to publication of this FY 2011 IPPS/RY 2011 LTCH PPS proposed rule, we published a notice in the **Federal Register** on November 27, 2009 (74 FR 62339 through 62342), and held a town hall meeting at the CMS Headquarters Office in Baltimore, MD, on February 19, 2010. In the announcement notice for the meeting, we stated that the opinions and alternatives provided during the meeting would assist us in our evaluations of applications by allowing public discussion of the substantial clinical improvement criterion for each of the FY 2011 new medical service and technology add-on payment applications before the publication of this FY 2011 proposed rule.

Approximately 80 individuals registered to attend the town hall meeting in person, while additional individuals listened over an open telephone line. Each of the three FY 2011 applicants presented information on its technology, including a discussion of data reflecting the substantial clinical improvement aspect of the technology. We considered each applicant's presentation made at the town hall meeting, as well as written comments submitted on the applications, in our evaluation of the new technology add-on applications for FY 2011 in this proposed rule.

In response to the published notice and the new technology town hall meeting, we received 11 written comments regarding applications for FY 2011 new technology add-on payments. We summarized these comments or, if applicable, indicated that there were no comments received, at the end of each discussion of the individual applications in this proposed rule.

Comment: One commenter, a medical technology association, recommended that CMS, in its consideration as to whether a new technology meets the substantial clinical improvement criterion, judge a diagnostic device on the basis of a diagnostic outcome (improved diagnosis) rather than a therapeutic outcome, recognizing that earlier and improved detection of disease often leads to improved patient outcomes.

Response: We thank the commenter for its comments on the substantial clinical improvement criterion. Similar to our statements in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43817 through 43819), section 1886(d)(5)(K)(vi) of the Act authorizes the Secretary to establish through notice and comment rulemaking the criteria that a new medical service or technology must meet in order to be eligible for the new technology add-on payment. Under this authority, in the September 7, 2001 final rule, we established three criteria through notice and comment rulemaking—the newness criterion, the cost criterion, and the substantial clinical improvement criterion (66 FR 46924). Specifically, § 412.87(b)(1) of the regulations provides that a new medical service or technology must "represent an advance that substantially improves, relating to technologies previously available, the diagnosis or treatment of Medicare beneficiaries."

As we explained in the September 7, 2001 final rule, we consider a diagnostic technology to meet the substantial clinical improvement criterion if the technology not only "offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods," but also if "use of the device to make a diagnosis affects the management of the patient" (66 FR 46914). We believe that this evidence is necessary to determine whether the new technology affords a "clear improvement over the use of previously available technologies." We do not consider any particular type of evidence to be dispositive; instead, we consider all information presented for each application to determine whether there is evidence to support a conclusion that "use of the device to make a diagnosis affects the management of the patient" (in the case of a diagnostic technology). Specifically, we consider whether the peer-reviewed medical literature supports or clinical studies indicate that the diagnostic device should generally be used by providers in guiding the management of their patients. In addition, we consider evidence demonstrating clinically accepted use of the device in a manner that actually affects the management of patients.

Under the commenter's recommendation, a diagnostic technology effectively would only need to receive FDA approval and be the only technology approved for a particular diagnostic capability in order to be deemed a "substantial improvement" for purposes of new technology add-on payments, regardless of its ability to positively affect patient management. This approach would deem a device that led to the identification of new information as a substantial improvement in diagnosis even if such detection has not been "demonstrated to represent a substantial improvement in caring for Medicare beneficiaries" and was not linked to evidence-based, significant, and positive changes in the management of patients or, ultimately, to changes in clinical outcomes. We do not believe this rationale is consistent with our prior statements regarding the substantial clinical improvement criterion of the new technology add-on payment provision.

Comment: One commenter, a medical device association, recommended that CMS "deem a device to satisfy the substantial clinical improvement criteria if it was granted a humanitarian device exemption or priority review based on the fact that it represents breakthrough technologies, which offer significant advantages over existing approved alternatives, for which no alternatives exist, or the availability of which is in the best interests of the patients." In addition, the commenter

remarked that this process would simplify CMS' evaluation of applications for new technology add-on payments and would promote access to innovative treatments, as intended by Congress. Although the commenter also made remarks that were unrelated to substantial clinical improvement, because the purpose of the town hall meeting was specifically to discuss substantial clinical improvement of pending new technology applications, those comments are not summarized in this proposed rule.

Response: We thank the commenter for its comments. We note that we have previously addressed the comment concerning automatically approving technologies that have a humanitarian device exemption (HDE) in the FY 2008 IPPS final rule (72 FR 47302). We refer readers to that rule for our response. A further discussion of our evaluation of the applications and the documentation for new technology add-on payments submitted for FY 2011 approval is provided under the specified areas under this section.

3. FY 2011 Status of Technologies Approved for FY 2010 Add-On Payments

a. Spiration® IBV® Valve System

Spiration, Inc. submitted an application for new technology add-on payments for the Spiration® IBV® Valve System (Spiration® IBV®). The Spiration® IBV® is a device that is used to place, via bronchoscopy, small, one-way valves into selected small airways in the lung in order to limit airflow into selected portions of lung tissue that have prolonged air leaks following surgery while still allowing mucus, fluids, and air to exit, thereby reducing the amount of air that enters the pleural space. The device is intended to control prolonged air leaks following three specific surgical procedures: lobectomy; segmentectomy; or lung volume reduction surgery (LVRS). According to the applicant, an air leak that is present on postoperative day 7 is considered "prolonged" unless present only during forced exhalation or cough. In order to help prevent valve migration, there are five anchors with tips that secure the valve to the airway. The implanted valves are intended to be removed no later than 6 weeks after implantation.

With regard to the newness criterion, the Spiration® IBV® received an HDE approval from the FDA on October 24, 2008. We were unaware of any previously FDA-approved predicate devices, or otherwise similar devices, that could be considered substantially similar to the Spiration® IBV®. However, the applicant asserted that the FDA had precluded the device from being used in the treatment of any patients until Institutional Review Board (IRB) approvals regarding its study sites. Therefore, the Spiration® IBV® met the newness criterion once it obtained at least one IRB approval because the device would then be available on the market to treat Medicare beneficiaries.

After evaluation of the newness, costs, and substantial clinical improvement criteria for new technology payments for the Spiration® IBV® and consideration of the public comments we received on the FY 2010 IPPS proposed rule, including the additional analysis of clinical data and supporting information submitted by the applicant, we approved the Spiration® IBV® for new technology add-on payments for FY 2010. The Spiration® IBV® is the only device currently approved for the purpose of treating prolonged air leaks following lobectomy, segmentectomy, and LVRS patients in the United States. We stated that without the availability of this device, patients with prolonged air leaks (following lobectomy, segmentectomy, and LVRS) might otherwise remain inpatients in the hospital (and have a longer length of stay than they might otherwise have without the Spiration® IBV®) or might even require additional invasive surgeries to resolve the air leak. We also noted that use of the Spiration® IBV® may lead to more rapid beneficial resolution of prolonged air leaks and reduce recovery time following the three lung surgeries mentioned above.

However, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43823), we indicated that we remained interested in seeing whether the clinical evidence continues to find it to be effective. This approval was on the basis of using the Spiration® IBV® consistent with the FDA approval (HDE), and we emphasized the need for appropriate patient selection accordingly. Therefore, we limited the add-on payment to cases involving prolonged air leaks following lobectomy, segmentectomy and LVRS in MS–DRGs 163, 164, and 165. Cases involving the Spiration® IBV® that are eligible for the new technology add-on payment are identified by assignment to MS–DRGs 163, 164, and 165 with procedure code 33.71 or 33.73 in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41, or 32.49.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we stated that the average cost of the Spiration® IBV® is reported as $2,750. Based on data from the FY 2010 application, the average amount of valves per case is 2.5. Therefore, the total maximum cost for the Spiration® IBV® was expected to be $6,875 per case ($2,750 × 2.5). Under § 412.88(a)(2) of our regulations, new technology add-on payments are limited to the lesser of 50 percent of the average cost of the device or 50 percent of the costs in excess of the MS–DRG payment for the case. As a result, we finalized a maximum add-on payment for a case involving the Spiration® IBV® as $3,437.50.

b. CardioWest™ Temporary Total Artificial Heart System (CardioWest™ TAH-t)

SynCardia Systems, Inc. submitted an application for approval of the CardioWest™ temporary Total Artificial Heart system (TAH-t) in FY 2009. The TAH-t is a technology that is used as a bridge to heart transplant device for heart transplant-eligible patients with end-stage biventricular failure. The TAH-t pumps up to 9.5 liters of blood per minute. This high level of perfusion helps improve hemodynamic function in patients, thus making them better heart transplant candidates.

The TAH-t was approved by the FDA on October 15, 2004, for use as a bridge to transplant device in cardiac transplant-eligible candidates at risk of imminent death from biventricular failure. The TAH-t is intended to be used in hospital inpatients. One of the FDA's post-approval requirements is that the manufacturer agrees to provide a post-approval study demonstrating that success of the device at one center can be reproduced at other centers. The study was to include at least 50 patients who would be followed up to 1 year, including (but not limited to) the following endpoints: survival to transplant; adverse events; and device malfunction.

In the past, Medicare did not cover artificial heart devices, including the TAH-t. However, on May 1, 2008, CMS issued a final national coverage determination (NCD) expanding Medicare coverage of artificial hearts when they are implanted as part of a study that is approved by the FDA and is determined by CMS to meet CMS' Coverage with Evidence Development (CED) clinical research criteria. (The final NCD is available on the CMS Web site at: *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=211.)*

We indicated in the FY 2009 IPPS/RY 2009 LTCH PPS final rule (73 FR 48555) that, because Medicare's previous coverage policy with respect to this device had precluded payment from Medicare, we did not expect the costs associated with this technology to be

currently reflected in the data used to determine the relative weights of MS–DRGs. As we have indicated in the past, and as we discussed in the FY 2009 IPPS/RY 2009 LTCH PPS final rule, although we generally believe that the newness period would begin on the date that FDA approval was granted, in cases where the applicant can demonstrate a documented delay in market availability subsequent to FDA approval, we would consider delaying the start of the newness period. This technology's situation represented such a case. We also noted that section 1886(d)(5)(K)(ii)(II) of the Act requires that we provide for the collection of cost data for a new medical service or technology for a period of at least 2 years and no more than 3 years "beginning on the date on which an inpatient hospital code is issued with respect to the service or technology." Furthermore, the statute specifies that the term "inpatient hospital code" means any code that is used with respect to inpatient hospital services for which payment may be made under the IPPS and includes ICD–9–CM codes and any subsequent revisions. Although the TAH-t has been described by the ICD–9–CM code(s) since the time of its FDA approval, because the TAH-t had not been covered under the Medicare program (and, therefore, no Medicare payment had been made for this technology), this code could not be "used with respect to inpatient hospital services for which payment" is made under the IPPS, and thus we assumed that none of the costs associated with this technology would be reflected in the Medicare claims data used to recalibrate the MS–DRG relative weights for FY 2009. For this reason, as discussed in the FY 2009 IPPS/RY 2009 LTCH PPS final rule, despite the FDA approval date of the technology, we determined that TAH-t would still be eligible to be considered "new" for purposes of the new technology add-on payment because the TAH-t met the newness criterion on the date that Medicare coverage began, consistent with issuance of the final NCD, effective on May 1, 2008.

After evaluation of the newness, costs, and substantial clinical improvement criteria for new technology add-on payments for the TAH-t and consideration of the public comments we received in response to the FY 2009 IPPS/RY 2009 LTCH PPS proposed rule, we approved the TAH-t for new technology add-on payments for FY 2009 (73 FR 48557). We indicated that we believed the TAH-t offered a new treatment option that previously did not exist for patients with end-stage biventricular failure. However, we indicated that we recognized that Medicare coverage of the TAH-t is limited to approved clinical trial settings. The new technology add-on payment status does not negate the restrictions under the NCD nor does it obviate the need for continued monitoring of clinical evidence for the TAH-t. We remain interested in seeing whether the clinical evidence demonstrates that the TAH-t continues to be effective. If evidence is found that the TAH-t may no longer offer a substantial clinical improvement, we reserve the right to discontinue new technology add-on payments, even within the 2- to 3-year period that the device may still be considered to be new. We also continued to make new technology add-on payments for the TAH-t in FY 2010. We welcome public comment regarding whether there is new evidence that demonstrates that the TAH–t continues to be effective and whether it should still be considered to be a substantial clinical improvement for FY 2011.

The new technology add-on payment for the TAH-t for FY 2010 is triggered by the presence of ICD–9–CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and the diagnosis code reflecting clinical trial—V70.7 (Examination of participant in clinical trial). For FY 2010, we finalized a maximum add-on payment of $53,000 (that is, 50 percent of the estimated operating costs of the device of $106,000) for cases that involve this technology.

Our practice has been to begin and end new technology add-on payments on the basis of a fiscal year. In general, we extend add-on payments for an additional year only if the 3-year anniversary date of the product's entry on the market occurs in the latter half of the fiscal year (70 FR 47362). The TAH-t is still eligible to be considered "new" for purposes of the new technology add-on payment because the 3-year anniversary date of the TAH-t entry on the market was in the second half of the fiscal year and the TAH-t met the newness criterion on the date that Medicare coverage began, consistent with issuance of the final NCD, effective on May 1, 2008. Therefore, for FY 2011, we are proposing to continue new technology add-on payments for cases involving the TAH-t in FY 2011 with a maximum add-on payment of $53,000.

4. FY 2011 Applications for New Technology Add-On Payments

We received five applications to be considered for new technology add-on payment for FY 2011. However, two applicants withdrew their applications: Nycomed Austria GmbH, which submitted an application for new technology add-on payments for FY 2011 for TachoSil®; and Zimmer, which submitted an application for new technology add-on payments for FY 2011 for the Dynesys Dynamic Stabilization System. Nycomed Austria GmbH withdrew its application from further review in January 2010, and Zimmer withdrew its application in February 2010. Because both applications were withdrawn prior to the town hall meeting and publication of this proposed rule, we are not discussing these two applications in this proposed rule.

A discussion of the remaining three applications is presented below. At the time this proposed rule was developed, one of the technologies had not yet received FDA approval. Consequently, our discussion below of this application may be limited.

a. Auto Laser Interstitial Thermal Therapy (AutoLITT™) System

Monteris Medical submitted an application for new technology add-on payments for FY 2011 for the AutoLITT™. We note that the applicant submitted an application for new technology add-on payments for FY 2010 but withdrew its application prior to the FY 2010 IPPS/RY 2010 LTCH PPS final rule. AutoLITT™ is a minimally invasive, MRI-guided catheter tipped laser designed to destroy malignant brain tumors with interstitial thermal energy causing immediate coagulation and necrosis of diseased tissue. The applicant asserts that the AutoLITT™ delivers laser energy to the lesion with a proprietary 3mm diameter probe that directs the energy radially (that is, at right angle to the axis of the probe, or side-firing) toward the targeted tumor tissue in a narrow beam profile and at the same time, a proprietary probe cooling system removes heat from tissue not directly in the path of the laser beam, ostensibly protecting it from thermal damage and enabling the physician to selectively ablate only targeted tissue. The AutoLITT™ received a 510K FDA clearance in May 2009. The AutoLITT™ is indicated for use to necrotize or coagulate soft tissue through interstitial irradiation or thermal therapy in medicine and surgery in the discipline of neurosurgery with 1064 nm lasers. The AutoLITT™ may be used in patients with glioblastoma multiforme brain tumors. The applicant stated in its application and through supplemental information that, due to required

updates, the technology was actually introduced to the market in December 2009. The applicant explained that it was necessary to reduce the thermal damage lines from three to one and complete International Electrotechnical Commission/Underwriter Laboratory testing, which led to the introduction of the technology to the market in December 2009, although the technology was approved by FDA in May 2009. The applicant also stated through supplementary information to its application that the first sale of the product took place on March 19, 2010. However, because the product was already available for use in December 2009, it appears that the newness date would begin in December 2009. We welcome public comments on this issue.

With regard to the newness criterion, we are concerned that the AutoLITT™ may be substantially similar to the device that it listed as its predicate device in its application to the FDA for approval. Specifically, in making a determination of substantial similarity, we consider the following: (1) Whether a product uses the same or similar mechanism of action to achieve a therapeutic action; and (2) whether a product is assigned to the same of different MS–DRG; and (3) whether the new use of a technology involves the treatment of the same or similar type of disease and the same or similar patient population. The applicant identified Visual-ase as its predicate device (which was approved by the FDA in 2006), which is also used to treat tumors of the brain. The applicant maintains that AutoLITT™; can be distinguished from the Visual-ase by its mechanism of action (that is, side-firing laser versus elliptical firing). Additionally, as mentioned above, the technology contains a proprietary probe cooling system that removes heat from tissue not directly in the path of the laser beam. We welcome comments from the public regarding whether or not the AutoLITT™ is substantially similar to the Visual-ase and if it meets the newness criteria.

The technology can be identified by ICD–9–CM procedure codes 17.61 (Laser interstitial thermal therapy [LITT] of lesion or tissue of brain under guidance), and 17.62 (Laser interstitial thermal therapy [LITT] of lesion or tissue of head and neck under guidance), which were effective on October 1, 2009.

In an effort to demonstrate that AutoLITT™ meets the cost criterion, the applicant used 2007 Medicare data from the Healthcare Cost and Utilization Project (HCUP). We first note that the applicant believes that cases eligible for the AutoLITT™ will map to MS–DRG 25 (Craniotomy and Endovascular Intracranial Procedures with MCC), MS–DRG 26 (Craniotomy and Endovascular Intracranial Procedures with CC), and MS–DRG 27 (Craniotomy and Endovascular Intracranial Procedures without CC or MCC). The applicant explained through supplemental information to its application that most cases of the AutoLITT™ would map to MS–DRG 25 in the near-term. As the technology becomes more widely available, clinicians will use the technology instead of performing a craniotomy for brain cancer and on other different types of brain cancers including metastases, which would map to other MS–DRGs aside from MS–DRG 25. The applicant further stated that life expectancy with brain cancer is predicated on the removal of as much of the cancer as possible and asserted that over time the AutoLITT™ will do a better job of removing the majority of the cancer that is present within the brain tissue compared to other procedures. The applicant believes that physicians with the AutoLITT™ have a better tool at removing more cancer and killing it more precisely and accessing parts of the brain that surgical resection cannot access. Lastly, the applicant believes that the minimally invasive nature of the procedure will also result in broader usage to other less complicated procedures (as clinical and patient awareness expands).

The applicant searched HCUP hospital data for cases potentially eligible for the AutoLITT™ that was assigned one of the following ICD–9–CM diagnosis codes: a diagnosis code that begins with a prefix of 191 (Malignant neoplasm of brain); diagnosis code 225.0 (Benign neoplasm of brain and other parts of nervous system); or diagnosis code 239.6 (Neoplasm of the brain of unspecified nature). The applicant found 41,021 cases and weighted the standardized charge per case based on the number of cases found within each of the diagnosis codes listed above rather than the percentage of cases that would group to different MS–DRGs. Based on this analysis, the applicant calculated an average standardized charge per case was $57,511. While the applicant's analysis established a case-weighted average charge per case in the aggregate, it did not provide a case-weighted average standardized charge per case by MS–DRG (as required by the application).

The applicant also noted that their estimate of the case-weighted average standardized charge per case of $57,511 did not include charges related to the AutoLITT™. Therefore, it is necessary to add the charges related to the device to the case-weighted average standardized charge per case in evaluating the cost threshold criterion. Although the applicant submitted data related to the estimated cost of the AutoLITT™ per case, the applicant stated that the cost of the device was proprietary information. Based on a study of charge compression data by RTI [4] and charge master data from Stanford University and University of California, San Francisco, the applicant estimates $38,886 in charges related to the AutoLITT™ (we note that some of the data used a markup of 294 percent of the costs). Adding the estimated charges related to the device to the average standardized charge per case resulted in a total average standardized charge per case of $96,397 ($57,511 plus $38,886). We note, in the applicant's discussion of substantial clinical improvement below, the applicant maintains that improved clinical outcomes using nonfocused LITT included reduced recovery time and a reduced rate of complications. Therefore, we are seeking comment on how reduced recovery time and a reduced rate of complications would affect the total case-weighted average standardized charge per case and the average length of stay (for cases eligible for the AutoLITT™).

As noted above, the applicant's analysis established a case-weighted average charge per case in the aggregate, but it did not provide a case-weighted average standardized charge per case by MS–DRG. However, the applicant explained through supplemental information to its application that the total average standardized charge per case significantly exceeds the cost threshold established by CMS for FY 2011 in Table 10 (74 FR 44173) of $84,185 for MS–DRG 25. Additionally, the applicant further explained that the total average standardized charge per case would also exceed the cost thresholds established by CMS of $58,612 for MS–DRGs 26 and $47,053 for MS–DRG 27. Because the total average standardized charge per case exceeds the threshold amount for each individual MS–DRG to which the technology would map (MS–DRGs 25, 26, and 27), the applicant maintains that the AutoLITT™ would meet the cost criterion. We invite public comment on whether or not the AutoLITT™ meets the cost criterion for a new technology add-on payment for FY 2011.

[4] RTI International, A Study of Charge Compression in Calculating DRG Relative Weights, RTI Project No. 0207964.012.008; January 2007.

With respect to the substantial clinical improvement criterion, the applicant maintains that it meets this criterion in its application. Specifically, the applicant stated that several non-AutoLITT™ clinical trials have demonstrated that nonfocused LITT (and more recently, the use of LITT plus MRI) improved survival, quality of life, and recovery in patients with advanced glioblastoma multiforme tumors and advanced metastatic brain tumors that cannot be effectively treated with surgery, radiosurgery, radiation, chemotherapy, or any currently available clinical procedure. In a number of these patients, nonfocused LITT was the treatment of last resort, due to either the unresponsiveness or inability of these therapies to treat the brain tumor (due to tumor location, type, or size, among others). The applicant also maintains that when compared to craniotomy, it offers improved clinical outcomes using nonfocused LITT, including reduced recovery time and a reduced rate of complications (that is, infection, brain edema). The applicant stated that these factors, as discussed in the FY 2001 final rule (66 FR 46914 through 46915) demonstrate that the AutoLITT™ meets the new technology criterion for substantial clinical improvement.

The applicant further asserts that AutoLITT™ would represent a substantial clinical improvement over existing standards of care for a number of reasons and should build upon less sophisticated, nonfocused LITT therapies. These clinical improvements cited by the applicant include: A less invasive method of tumor ablation, potentially leading to lower complication rates post procedure (infection, edema); an ability to employ multiple interventions over shorter periods of time and an ability to be used as a treatment of last resort (radiosurgery is limited due to radiation dosing and craniotomy is limited to 1 to 2 procedures); an ability to be used in hard-to-reach brain tumors (the AutoLITT™ may be used as a treatment of last resort); and a shorter recovery time (the possibility for same day surgery, which has been demonstrated above with nonfocused LITT).

We appreciate the applicant's summary of why this technology represents a substantial clinical improvement. While we recognize the future potential of this interesting therapy, we have concerns that to date the AutoLITT™ has been used for the treatment of only a few patients as part of a safety evaluation with no comparative efficacy data and, therefore, there may not be sufficient objective clinical evidence to determine if the AutoLITT™ meets the substantial clinical improvement criteria. The applicant did note in its presentation at the new technology town hall meeting that it is currently conducting a clinical trial with a summary report expected in the near future. We welcome additional clinical data to demonstrate whether the AutoLITT™ meets the substantial clinical improvement criterion and invite public comment on whether or not the AutoLITT™ meets the substantial clinical improvement criterion.

We did not receive any written public comments regarding this application for new technology add-on payments concerning the new technology town hall meeting.

b. LipiScan™ Coronary Imaging System

InfraReDx, Inc. submitted an application for new technology add-on payments for FY 2011 for the LipiScan™ Coronary Imaging System (LipiScan™). We note that an application was also submitted for FY 2010, but the application was denied on the grounds that it did not meet the substantial clinical improvement criterion at that time. The application for FY 2011 contains some additional clinical and charge data that were not available at the time that the FY 2010 new technology add-on payment decisions were made.

The LipiScan™ device is a diagnostic tool that uses Intravascular Near Infrared Spectroscopy (INIRS) during an invasive coronary catheterization to scan the artery wall in order to determine coronary plaque composition. The purpose of the device is to identify lipid-rich areas in the artery because such areas have been shown to be more prone to rupture. The procedure does not require flushing or occlusion of the artery. INIRS identifies the chemical content of plaque by focusing near infrared light at the vessel wall and measuring reflected light at different wavelengths (that is, spectroscopy). The LipiScan™ system collects approximately 1,000 measurements per 12.5 mm of pullback, with each measurement interrogating an area of 1 to 2 mm^2 of lumen surface perpendicular to the longitudinal axis of the catheter. When the catheter is in position, the physician activates the pullback and rotation device and the scan is initiated providing 360 degree images of the length of the artery. The rapid acquisition speed for the image freezes the motion of the heart and permits scanning of the inside of the arterial wall in less than 2 minutes. When the catheter pullback is completed, the console displays the scan results, which are referred to as a "chemogram" image. The chemogram image requires reading by a trained user, but, according to the applicant was designed to be simple to interpret.

With regard to the newness criterion, the LipiScan™ received a 510K FDA clearance for a new indication on April 25, 2008, and was available on the market immediately thereafter. On June 23, 2006, InfraReDx, Inc. was granted a 510K FDA clearance for the "InfraReDx Near Infrared (NIR) Imaging System." Both devices are under the common name of "Near Infrared Imaging System" according to the 510K summary document from the FDA. However, the InfraReDx NIR Imaging System device that was approved by the FDA in 2006 was approved "for the near infrared imaging of the coronary arteries," whereas the Lipiscan™ device cleared by the FDA in 2008 is for a modified indication. The modified indication specified that Lipiscan™ is "intended for the near-infrared examination of coronary arteries* * *, the detection of lipid-core-containing plaques of interest* * *[and] for the assessment of coronary artery lipid core burden." In the FY 2010 IPPS/RY 201 LTCH PPS proposed rule (74 FR 24132 through 24134), we noted that we had concerns with whether Lipiscan™ was substantially similar to its predicate device that was approved by the FDA in 2006. However, those concerns were addressed by the manufacturer during the comment period. Specifically, the manufacturer stated that there were technical problems with the original device and that LipiScan™ had to be modified in the following ways:

	2006 NIRS device	Marketed 2008 lipiScan
Console	No display of results of scan	Results displayed immediately.
Catheter	Saline-filled with microbubble problem obscuring many scans.	Air-filled with no microbubble problem.

	2006 NIRS device	Marketed 2008 lipiScan
Algorithm	No algorithmic processing of NIR signals—no means of certifying that lipid core plaque is present.	Algorithm validated in over 1,000 autopsy measurements proving that NIRS can detect lipid core plaque, and providing diagnosis of lipid core plaque to the MD during the case.

The problems with the LipiScan™ device that was approved in 2006 were addressed in the second device that was granted FDA approval in April 2008. The LipiScan™ device was not marketed until after its second FDA clearance. Therefore, we no longer needed to make a determination as to whether the newer device was substantially similar to the predicate device and we determined in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43815) that Lipiscan™ would be considered to be "new" to the market as of the date of its FDA approval in April 2008. Because a technology may be considered new for a period of up to 3 years if, during the third year, the technology is new for more than 6 months of the fiscal year, it appears that the technology would still be in the newness period for FY 2011. We welcome public comment on whether Lipiscan™ meets the newness criterion.

We note that the Lipiscan™ technology is identified by ICD–9–CM procedure code 38.23 (Intravascular spectroscopy), which became effective October 1, 2008, and cases involving the use of this device generally map to MS–DRG 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent(s) with MCC or 4+ Vessels/Stents); MS–DRG 247 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent(s) without MCC); MS–DRG 248 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent(s) with MCC or 4+ Vessels/Stents); MS–DRG 249 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent(s) without MCC); MS–DRG 250 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent with MCC); and MS–DRG 251 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent without MCC).

In an effort to demonstrate that the technology meets the cost criterion, the applicant used the FY 2010 final rule After Outliers Removed (AOR) file (posted on the CMS Web site) to identify cases potentially eligible for Lipiscan™. The applicant believes that every case within MS–DRGs 246, 247, 248, 249, 250, and 251 is eligible for Lipiscan™. In addition, the applicant believes that Lipiscan™ will be evenly distributed across patients in each of those six MS–DRGs (16.7 percent within each MS–DRG). Using data from the AOR file, the applicant found the average standardized charge per case for MS–DRGs 246, 247, 248, 249, 250, and 251 was $67,531, $44,485, $62,936, $40,149, $59,416, and $38,864, respectively, equating to a case-weighted average standardized charge per case of $52,230 (calculation performed using unrounded numbers). The applicant indicated that the case-weighted average standardized charge per case does not include charges related to Lipiscan™; therefore, it is necessary to add the charges related to the device to the average case-weighted standardized charge per case to evaluate the cost threshold criterion. Although the applicant submitted data related to the estimated cost per case of Lipiscan™, the applicant stated that the cost of the device is proprietary information. Based on a sampling of all 10 non-VA hospitals that are actively using the device, the applicant determined that the average charge for the device was $7,497. Adding the estimated average charge related for the device to the case-weighted standardized charge per case (based on the case distribution from the applicant's FY 2010 AOR analysis) results in a total case-weighted average standardized charge per case of $59,727 ($52,230 plus $7,497). Using the FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173), the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $56,487 (all calculations above were performed using unrounded numbers). Because the applicant's calculation of the total case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount, the applicant maintains that Lipiscan™ meets the cost criterion.

We note that in the applicant's analysis of the cost criterion, instead of determining the case-weighted average standardized charge per case and the case-weighted threshold amount based on the actual number of cases from the FY 2010 AOR file in the applicable MS–DRGs that are eligible for the Lipiscan™, the applicant's analysis assumed an even distribution of patients in the applicable MS–DRGs. However, the data from the FY 2010 AOR file shows a varied distribution of cases in each of the applicable MS–DRGs. We believe the more appropriate way to determine the case-weighted average standardized charge per case and the case-weighted threshold amount for evaluating the cost criterion is to use the actual distribution of cases in the applicable MS–DRGs based on the number of cases from the AOR file because this would more accurately reflect the number and type of Medicare cases typically treated in the applicable MS–DRGs. Moreover, this would better conform with the applicant's assertion that the probability of use of Lipiscan™ is the same in each of those six MS–DRGs. Using data from the FY 2010 AOR file, for MS–DRGs 246, 247, 248, 249, 250, and 251, there were 30,411, 147,952, 19,736, 67,964, 8,184, and 38,091 cases, respectively. Using this case distribution and the average standardized charge per case for MS–DRGs 246, 247, 248, 249, 250, and 251 from the application (that is, $67,531, $44,485, $62,936, $40,149, $59,416, and $38,864, respectively, as stated above), the case-weighted average standardized charge per case is $46,657. As the applicant indicated above, the case-weighted average standardized charge per case does not include charges related to Lipiscan™. Therefore, it is necessary to add the average charge of $7,497 related to the device to the case-weighted standardized charge per case to evaluate the cost threshold criterion. Adding the estimated charges related to the device to the case-weighted average standardized charge per case (based on the case distribution from the FY 2010 AOR final rule file) results in a total case-weighted average standardized charge per case of $54,154 ($46,657 plus $7,497). Using the FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173) and the actual case distribution from the AOR file, the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $52,700 (all calculations above were performed using unrounded numbers). Because this alternative calculation of total case-weighted average standardized charge per case for the applicable MS–DRGs also exceeds the case-weighted threshold amount, it appears that Lipiscan™ would meet the cost criterion. We invite public comment on

whether or not Lipiscan™ meets the cost criterion.

With regard to substantial clinical improvement, CMS determined that the FY 2010 new technology add-on payment application for Lipiscan™ did not meet the substantial clinical improvement criterion because the evidence and information available at the time the new technology decisions were made did not allow CMS to determine that the application represented a substantial clinical improvement over existing technologies. Specifically, CMS found that there was a lack of evidence that demonstrated that Lipiscan™ affected the medical management of patients in which the device was used.

The applicant maintains that the device meets this criterion for the following reasons. The applicant noted that from November 2008 to 2009, the number of patients in whom Lipiscan™ has been used for clinical purposes has increased from 100 to 500 and during the same period, the number of hospitals using the product has increased from 6 to 16. In addition, the applicant asserts that "during the past year, two Lipiscan™ publications demonstrate that dilation of a lipid core plaque is responsible for slow or no reflow and myocardial infarction during the procedure." The applicant noted that this is important because "several treatments are available that could prevent this stenting complication." The applicant referenced the "700 patient PROSPECT Study" which was presented at Transcatheter Cardiovascular Therapeutics Conference in September 2009 and found that 20.4 percent of patients experience a new event in the 3.4 years following stenting. The applicant pointed to that finding as evidence that there is a need for improved safety and efficacy of stenting and maintained that Lipiscan™ offers clinicians the ability to make decisions that result in such improvements.

The PROSPECT (Providing Regional Observations to Study Predictors of Events in the Coronary Tree) study is a cohort study of patients with acute coronary syndrome who underwent percutaneous coronary angioplasty and stenting (percutaneous coronary intervention). Following the procedure, angiography and intravascular ultrasound (IVUS) were performed. If a patient had a subsequent event, a new angiogram and IVUS image were obtained and compared to the original results. The investigators reported that "angiographically mild lesions with certain morphologic features on grayscale and IVUS present with a 3 year cardiac event rate of 17%, versus other morphologies (indistinguishable by conventional angiograms) with three year event risks of less than 1%." We are concerned that with this type of study design, it is not possible to determine whether the information for the IVUS image would have altered the angioplasty and stenting procedures since the images were collected after the procedure. The results are suggestive, but a prospective study is needed to determine the clinical utility of IVUS and whether use of IVUS leads to changes in clinical practice or improvements in health outcomes. The PROSPECT study generated a hypothesis that use of IVUS may help determine which plaques are vulnerable to future events but further clinical research is needed to confirm this hypothesis. We note that the PROSPECT study was presented at the Transcatheter Cardiovascular Therapeutics Conference in 2009, but that the study results have yet to be published in a peer-reviewed journal. We also note that methods and conclusions from a study may change from what was verbally presented during the peer review process that is required to publish the study results.

As it did in its prior application, the applicant noted that the September 1, 2001 final rule states that one facet of the criterion for substantial clinical improvement is "the device offers the ability to diagnose a medical condition in a patient population where the medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods. There must also be evidence that use of the device to make a diagnosis affects the management of the patient" (66 FR 46914). The applicant believes that Lipiscan™ meets all facets of this criterion. The applicant asserted that the device is able to detect a condition that is not currently detectable. The applicant explained that LipiScan™ is the first device of its kind to be able to detect lipid-core-containing plaques of interest and to assess of coronary artery lipid core burden. The applicant further noted that FDA, in its approval documentation, has indicated that "This is the first device that can help assess the chemical makeup of coronary artery plaques and help doctors identify those of particular concern."

In addition, the applicant stated that the LipiScan™ chemogram permits a clinician to detect lipid-core-containing plaques in the coronary arteries compared to other currently available devices that do not have this ability. The applicant explained that the angiogram, the conventional test for coronary atherosclerosis, shows only minimal coronary narrowing. However, the applicant indicated that the LipiScan™ chemogram has the ability to reveal when an artery contains extensive lipid-core-containing plaque at an earlier stage.

The applicant also noted that the device has the ability to make a diagnosis that better affects the management of the patient. Specifically, the applicant asserted that LipiScan™ "is currently used in the management of patients undergoing coronary stenting to improve the safety and efficacy of the procedure" and that while stenting has steadily improved, its results are not optimal in approximately 30 percent of cases due to 3 problems: (1) Peri-stenting MI due to embolization of lipid core contents and side branch occlusion; (2) major adverse coronary events (MACE) post stenting from difficulties at the stented site; and (3) MACE post stenting for non-stented vulnerable sites. We note that in order to demonstrate that the technology represents a substantial clinical improvement, there must be evidence that use of the device to make a diagnosis affects the medical management of the patient and leads to improved clinical outcomes.

The applicant described three case studies where each of the above problems was addressed by use of the LipiScan™. In addition, the applicant asserts that the chemogram results are available to the interventional cardiologist during the PCI procedure, and have been found to be useful in decision-making. According to the applicant, physicians have reported changes in therapy based on LipiScan™ findings in 20 to 50 percent of patients in which the device has been used. According to the applicant, the most common use of LipiScan™ results has been by physicians for selection of the length of artery to be stented. In some cases a longer stent has been used when there is a lipid-core-containing plaque adjacent to the area that is being stented because a flow-limiting stenosis is present. The applicant also noted that, in some cases, physicians have chosen to use down-stream protective devices during stenting procedures on the basis of information gathered by use of Lipiscan™ in several patients, and that this has directly impacted their outcome by capturing emboli and preventing further cardiac damage. Therefore, the applicant contends that the use of LipiScan™ by clinicians to select the length of artery to be stented and as an aid in selection of intensity of lipid-altering therapy, demonstrates that

LipiScan™ affects the management of patients.

While we recognize that the identification of lipid-rich plaques in the coronary vasculature holds promise in the management of coronary artery disease, we are concerned that statements in the FDA approval documents, as well as statements made by investigators in the literature, suggest that the clinical implications of identifying these lipid-rich plaques are not yet certain and that further studies need to be done to understand the clinical implications of obtaining this information.

The applicant also submitted commentary from Interventional Cardiologists (a group of clinicians who currently utilize the LipiScan™ device) explaining the clinical benefits of the device. The applicant further noted that the device may have other potential uses that would be of clinical benefit, and studies are currently being conducted to investigate these other potential uses. The applicant explained that LipiScan™ offers promise as a means to enhance progress against the two leading problems in coronary disease management: (1) The high rate of second events that occur even after catheterization, revascularization, and the institution of optimal medical therapy; and (2) the failure to diagnose coronary disease early, which results in sudden death or MI being the first sign of the disease in most patients. The applicant further stated that the identification of coronary lipid-core-containing plaques, which can most readily be done in those already undergoing catheterization, is likely to be of benefit in the prevention of second events. In the longer term, the applicant stated that the identification of lipid-core-containing plaques by LipiScan™ may contribute to the important goal of primary prevention of coronary events, which, in the absence of adequate diagnostic methods, continue to cause extensive morbidity, mortality and health care expenditures in Medicare beneficiaries and the general population.

We welcome public comment regarding whether or not the LipiScan™ technology represents a substantial clinical improvement in the Medicare population.

We received approximately nine public comments during the town hall meeting public comment period on the LipiScan™ and LipiScan™ IVUS. The comments relating to LipiScan™ IVUS are summarized at the end of the LipiScan™ IVUS application.

Comment: Several commenters supported approving the LipiScan™ device for new technology add-on payments. They stated (using nearly identical language) that LipiScan™ provided accurate information about the presence of lipid core plaques that was previously unavailable. They also stated that the device "permits the detection of an earlier stage of coronary artery disease." The commenters also stated that, "over the past year evidence has been obtained documenting that the presence of a lipid-core plaque at a stenotic site (as detected by LipiScan™) is an excellent predictor or peri-stenting myocardial infarction due to distal embolization of the lipid core following balloon dilation. This valuable diagnostic information can be combined with well-established treatments (prophylactic administration of vasodilators and/or direct stenting) as a means to reduce the stenting complication of peri-stenting MI."

One commenter stated that "the knowledge that a patient possesses lipid laden atheroma will markedly alter medical therapy in order to prevent thrombotic events. These heretofore unrecognized (asymptomatic) patients identified to be at high risk by the Lipiscan chemogram will be treated with intensive antihyperlipdemic therapy and other medical strategies that otherwise would not have been implemented to modify risk." Some commenters indicated that other potential uses of LipiScan™ include "determination of the length of the artery to be stented and selection of the intensity of lipid-altering therapy."

Several commenters stated that the "lack of specific reimbursement" for the technology was an impediment to the use and development of it.

Response: We thank the commenters for their comments. We have considered the comments concerning the town hall meeting in this proposed rule. As stated above, we invite additional public comment on objective data regarding the assertions made by the commenters. Specifically, we welcome additional information (including specific case-descriptions) regarding how the use of the technology has affected the medical management of patients and how the changes in management have led to improved clinical outcomes for those patients (again, specific examples are welcomed).

In response to the comments concerning Medicare reimbursement for LipiScan™, we note that LipiScan™ is currently covered by Medicare and would thus be included in the MS–DRG payment made to the hospital. In general, the MS–DRG payment is considered to cover all costs associated with the case including those of new technologies. As noted above, typically, there is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market (generally on the date that the technology receives FDA approval/clearance) and when data reflecting the use of the medical service or technology are used to calculate the MS–DRG weights. In addition, Congress specified that a new medical service or technology may be considered for new technology add-on payment if, "based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate." While we agree with the commenter that at this time there is no specific reimbursement for Lipiscan™ within the MS–DRGs in the form of a new technology add-on payment, because Lipiscan™ has applied for new technology add-on payments, we will evaluate it to determine whether it meets the criteria to receive new technology add-on payments in FY 2011. If the technology does not meet the new technology add-on payment criteria, it will continue to be paid as part of the regular MS–DRG payment and once the lag of 2 to 3 years is over, the costs associated of Lipiscan™ will be fully reflected in the relative weights that are used to recalibrate the MS–DRGs.

c. LipiScan™ Coronary Imaging System With Intravascular Ultrasound (IVUS)

InfraReDx, Inc. submitted an application for new technology add-on payments for FY 2011 for the LipiScan™ Coronary Imaging System with Intravascular Ultrasound (LipiScan™ IVUS). The LipiScan™ IVUS device is a diagnostic device that uses Intravascular near infrared spectroscopy (INIRS) combined with intravascular ultrasound (IVUS) during an invasive coronary angiography to determine the chemical composition of coronary plaques, which is accomplished using near infrared spectroscopy (INIRS) and to visualize stents and the structural features of coronary lesions, which is accomplished using IVUS. This new technology combines both capabilities in a single catheter. The IVUS part of the device utilizes sound to interrogate the artery and, according to the applicant, provides an image of the size of the plaque, the degree of stenosis produced by the plaque, the size of the artery and the degree of expansion of the stent. The device consists of a single-use catheter, a console and a "single pullback with the artery." The

device is intended to be used in patients already undergoing coronary stenting.

With respect to the newness criterion, we note that this device is not currently approved by the FDA, but the manufacturer anticipates that FDA approval will be granted in the second quarter of 2010. We also note that IVUS has existed for over 20 years. Therefore, IVUS, on its own, would not meet the newness criterion. The applicant asserts that one difference from the Lipiscan™ product, for which it has also submitted an application for new technology add-on payments, is that the catheter for the combined product is filled with saline (which is required for transmission of sound). The manufacturer has also stated that the combined device only requires the use of one catheter, as opposed to two separate ones. The manufacturer asserts that the single-use catheter for the combined technologies is only supplied by InfraRedX (the manufacturer of LipiScan™). However, we note that a physician could use LipiScan™ and IVUS as two separate products in the same patient (through the use of two catheters) and still be able to obtain the INIRS image and the ultrasound that are achieved through the combined product albeit separately.

We welcome public comments regarding whether the combined LipiScan™ IVUS device should be considered to be "new" as of the date of the existing LipiScan™ device received FDA approval or whether it should be considered new from the FDA approval date for LipiScan™ IVUS (should such an approval be granted). We also welcome public comments regarding whether LipiScan™ IVUS, as a combined technology, should be considered to be substantially similar to each individual technology separately as of the date that each separate technology received FDA approval (or the date that each technology became available on the market, if either technology was not available on the market until a date after FDA approval).

As stated above, in making a determination of substantial similarity, we consider the following: (1) Whether a product uses the same or similar mechanism of action to achieve a therapeutic action; (2) whether a product is assigned to the same or a different DRG; and (3) whether new use of a technology involves treatment of the same or similar type of disease and the same or similar patient population. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we stated that "due to the complexity of issues regarding the substantial similarity component of the newness criterion, it may be necessary to exercise flexibility when considering whether technologies are substantially similar to one another (74 FR 43813).

We note that the LipiScan™ IVUS device is identified by ICD–9–CM procedure codes 38.23 (Intravascular spectroscopy) and 00.24 (Intravascular imaging of coronary vessels). Cases involving the use of this device generally map to MS–DRG 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent(s) with MCC or 4+ Vessels/Stents); MS–DRG 247 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent(s) without MCC); MS–DRG 248 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent(s) with MCC or 4+ Vessels/Stents); MS–DRG 249 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent(s) without MCC); MS–DRG 250 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent with MCC); and MS–DRG 251 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent without MCC).

In an effort to demonstrate that the technology meets the cost criterion, the applicant used the FY 2010 final rule After Outliers Removed (AOR) file (posted on the CMS Web site) to identify cases potentially eligible for Lipiscan™ IVUS. The applicant believes that every case within MS–DRGs 246, 247, 248, 249, 250, and 251 is eligible for Lipiscan™ IVUS. In addition, the applicant believes that Lipiscan™ IVUS will be evenly distributed across patients in each of those six MS–DRGs (16.7 percent within each MS–DRG). Using data from the AOR file, the applicant found the average standardized charge per case for MS–DRGs 246, 247, 248, 249, 250, and 251 was $67,531, $44,485, $62,936, $40,149, $59,416, and $38,864 respectively, equating to a case-weighted average standardized charge per case of $52,230 (calculation performed using unrounded numbers). The applicant indicated that the case-weighted average standardized charge per case does not include charges related to Lipiscan™ IVUS. Therefore, it is necessary to add the charges related to the device to the average case-weighted standardized charge per case to evaluate the cost threshold criterion. Although the applicant submitted data related to the estimated cost per case of Lipiscan™ IVUS, the applicant stated that the cost of the device is proprietary information. The applicant analyzed Hospital Cost Report Information System ("HCRIS") data from 2008 to determine the charges related to the device. Specifically, the applicant searched for the 100 cardiac catheterization labs that had the highest volume of cases in the United States. Based on the HCRIS data from these 100 labs, the applicant determined the mean cost-to-charge ratio was 0.188 with a mark-up of 532 percent yielding a charge of $15,957 for Lipiscan™ IVUS. (We note that this estimate of charges related to the Lipiscan™ IVUS is significantly higher than the estimate of charges related to the Lipiscan™ device.) Adding the estimated average charge related for the device to the case-weighted standardized charge per case (based on the case distribution from the applicant's FY 2010 AOR analysis) results in a total case-weighted average standardized charge per case of $68,190 ($52,230 plus $15,960). Using the FY 2011 thresholds published in Table 10 of the FY 2011 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173), the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $56,487 (all calculations above were performed using unrounded numbers). Because the applicant's calculation of the total case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount, the applicant maintains that Lipiscan™ IVUS meets the cost criterion.

We note that in the applicant's analysis of the cost criterion, instead of determining the case-weighted average standardized charge per case and the case-weighted threshold amount based on the actual number of cases from the FY 2010 AOR file in the applicable MS–DRGs that are eligible for the Lipiscan™ IVUS, the applicant's analysis assumed an even distribution of patients in the applicable MS–DRGs. However, the data from the FY 2010 AOR file shows a varied distribution of cases in each of the applicable MS–DRGs. We believe the more appropriate way to determine the case-weighted average standardized charge per case and the case-weighted threshold amount for evaluating the cost criterion is to use the actual distribution of cases in the applicable MS–DRGs based on the number of cases from the AOR file because this would more accurately reflect the number and type of Medicare cases typically treated in the applicable MS–DRGs. Moreover, this would better conform with the applicant's assertion that that the probability of use of Lipiscan™ is the same in each of those six MS–DRGs. Using data from the FY 2010 AOR file, for MS–DRGs 246, 247, 248, 249, 250, and 251, there were 30,411, 147,952, 19,736, 67,964, 8,184, and 38,091 cases, respectively. Using this case distribution and the average standardized charge per case for MS–

DRGs 246, 247, 248, 249, 250, and 251 from the application (that is, $67,531, $44,485, $62,936, $40,149, $59,416, and $38,864, respectively, as stated above), the case-weighted average standardized charge per case is $46,657. As the applicant indicated above, the case-weighted average standardized charge per case does not include charges related to Lipiscan™ IVUS. Therefore, it is necessary to add the average charge of $15,960 related to the device to the case-weighted standardized charge per case to evaluate the cost threshold criterion. Adding the estimated charges related to the device to the case-weighted average standardized charge per case (based on the case distribution from the FY 2010 AOR final rule file) results in a total case-weighted average standardized charge per case of $62,617 ($46,657 plus $15,960). Using the FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173) and the actual case distribution from the AOR file, the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $52,700 (all calculations above were performed using unrounded numbers). Because this alternative calculation of total case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount, it appears that Lipiscan™ IVUS would meet the cost criterion.

In addition to the analysis above, the applicant searched the FY 2008 MedPAR file for cases potentially eligible for use of the Lipiscan™ IVUS. Because the technology can potentially be used for all cases within MS–DRGs 246 through 251, the applicant searched the FY 2008 MedPAR file for all cases within these MS–DRGs. The applicant found 30,265 cases (or 9.7 percent of all cases) in MS–DRG 246; 147,695 cases (or 47.4 percent of all cases) in MS–DRG 247; 19,642 cases (or 6.3 percent of all cases) in MS–DRG 248; 67,840 cases (or 21.8 percent of all cases) in MS–DRG 249; 8,120 cases (or 2.6 percent of all cases) in MS–DRG 250; and 38,022 cases (or 12.2 percent of all cases) in MS–DRG 251. The average standardized charge per case was $66,958 for MS–DRG 246, $50,192 for MS–DRG 247, $72,099 for MS–DRG 248, $45,086 for MS–DRG 249, $71,355 for MS–DRG 250, and $46,141 for MS–DRG 251, equating to a case-weighted average standardized charge per case of $45,964.

Similar to above, the average standardized charge per case does not include charges related to the Lipiscan™ IVUS; therefore, it is necessary to add the charges related to the device to the average standardized charge per case in evaluating the cost threshold criterion. Although the applicant submitted data related to the estimated cost of Lipiscan™ IVUS per case, the applicant noted that the cost of the device was proprietary information. Based on 2008 HCRIS data from the cardiac catheterization laboratories for all IPPS hospitals, the applicant determined a mean cost-to-charge ratio of 0.246 with a markup of 351 percent, yielding a charge of $10,543 for Lipiscan™ IVUS. Assuming that the Lipiscan™ IVUS device was marked up 351 percent, the total case-weighted average standardized charge per case for cases involving the use of Lipiscan™ IVUS would be $56,507 ($45,964 plus $10,543) across MS–DRGs 246 through 251.

Using the FY 2011 thresholds published in Table 10 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44173), the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 is $52,692 (all calculations above were performed using unrounded numbers). Because the applicant's calculation of the total case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount, the applicant maintains that Lipiscan™ IVUS meets the cost criterion. We invite public comment on whether or not Lipiscan™ IVUS meets the cost criterion.

With regard to substantial clinical improvement, the applicant asserts that LipiScan™ IVUS lends all the same benefits of LipiScan™ by itself (see discussion of LipiScan™ with respect to clinical improvement in the above application analysis) and also gives added benefits of IVUS. Specifically, the applicant maintains that LipiScan™ IVUS is superior to perfusion imaging and coronary angiography because those procedures only provide information about the lumen, but not the wall of the vessel. The applicant asserts that it is superior to IVUS (by itself) because IVUS alone cannot identify plaque composition. The applicant further maintains that LipiScan™ IVUS provides a substantial clinical benefit over Optical Coherence Tomography (OCT) because OCT cannot be used if blood is present in the field of view and identification of lipid by OCT is "time-consuming with a requirement for expert interpretation." In contrast, "the LipiScan™ signal is available immediately after the coronary pullback and does not require expert interpretation."

The applicant also states that LipiScan™ IVUS makes it possible to find the lipid core plaques that are strongly associated with peri-stenting MI and adverse events post MI that current methods of diagnosis fail to find.

Finally, the applicant asserts that LipiScan™ IVUS affects the management of the patient by improving the safety and efficacy of stenting. Further, the applicant states that while stenting has steadily improved, its results are not optimal in approximately 30% of cases due to 3 problems: (1) Peri-stenting MI due to embolization of lipid core contents and side branch occlusion; (2) major adverse coronary events (MACE) post stenting from difficulties at the stented site; and (3) MACE post stenting for non-stented vulnerable sites."

The applicant described three case studies where each of the above problems were addressed by use of the LipiScan™ IVUS. LipiScan™ IVUS achieves its utility to differentiate lipid core plaque from fibrotic plaque, a differentiation that cannot be made by angiography or grayscale IVUS.

The applicant referenced the "700 patient PROSPECT Study" which was presented at Transcatheter Cardiovascular Therapeutic Conference in September 2009 and found that 20.4 percent of patients experience a new event in the 3.4 years following stenting. The applicant pointed to that finding as evidence that there is a need for improved safety and efficacy of stenting and maintained that Lipiscan™ offers clinicians the ability to make decisions that result in such improvements.

The PROSPECT (Providing Regional Observations to Study Predictors of Events in the Coronary Tree) study is a cohort study of patients with acute coronary syndrome who underwent percutaneous coronary angioplasty and stenting (percutaneous coronary intervention). Following the procedure, angiography and IVUS were performed. If a patient had a subsequent event, a new angiogram and IVUS image were obtained and compared to the original results. The investigators reported that "angiographically mild lesions with certain morphologic features on grayscale and IVUS present with a 3 year cardiac event rate of 17%, versus other morphologies (indistinguishable by conventional angiograms) with three year event risks of less than 1%." We are concerned that with this type of study design, it is not possible to determine whether the information for the IVUS image would have altered the angioplasty and stenting procedures since the images were collected after the procedure. The results are suggestive, but a prospective study is needed to determine the clinical utility of IVUS

and whether use of IVUS leads to changes in clinical practice or improvements in health outcomes. The PROSPECT study generated a hypothesis that use of IVUS may help determine which plaques are vulnerable to future events but further clinical research is needed to confirm this hypothesis. We note that the PROSPECT study was presented at the Transcatheter Cardiovascular Therapeutics Conference in 2009, but that the study results have yet to be published in a peer reviewed journal. We also note that methods and conclusions from a study may change from what was verbally presented during the peer review process that is required to publish the study results.

We are concerned that, in the LipiScan™ IVUS application, the applicant has generally repeated the statements made regarding use of LipiScan™ alone and has not provided information that indicates that combined use of LipiScan™ plus IVUS offers additional clinical benefit. Indeed, we note that most of the studies that were presented in an effort to support that LipiScan™ by itself was a substantial clinical improvement, were also included to support the LipiScan™ IVUS application. The applicant did not present any published peer-reviewed journal articles that were specifically related to the clinical merits of the combined LipiScan™ IVUS device.

We welcome public comments on whether the LipiScan™ IVUS represents a substantial clinical improvement over existing technologies as well as public comments on what is the appropriate comparison for LipiScan™ IVUS.

As we noted at the end of the discussion of the LipiScan™ application, we received approximately nine public comments on both the LipiScan™ and the LipiScan™ IVUS applications.

Comment: Several commenters acknowledged that LipiScan™ IVUS is not yet approved by the FDA, but stated that they would support the LipiScan™ IVUS being approved for new technology add-on payments should FDA approval be granted. With regard to the clinical merits of LipiScan™ IVUS, the commenters stated that the LipiScan™ IVUS afforded all the same diagnostic abilities of the LipiScan™, but also provided the added benefit of IVUS, which has "been used in patients for over 20 years [and] is already supported by the [American College of Cardiologists and the American Hospital Association] for usage in stenting."

One commenter stated that once the LipiScan™ IVUS becomes approved by the FDA, he plans to use it in all of his patients who need IVUS imaging "because of the wealth of added information regarding the presence of lipid laden plaque, a harbinger of myocardial infarction and sudden death."

Response: We thank the commenters for their comments. However, we note that unless the technology is approved by the FDA by July 1, 2010, it cannot be approved for add-on payments in FY 2011 since it would not be considered "new." Should the technology receive FDA approval by July 1, 2010, we will take these comments into consideration in our review of the application for new technology add-on payments for FY 2011.

III. Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the proposed FY 2011 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.C. of this preamble.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section of the Act provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The proposed adjustment for FY 2011 is discussed in section II.B. of the Addendum to this proposed rule.

As discussed below in section III.I. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating IPPS payment amounts. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. The proposed budget neutrality adjustment for FY 2011 is discussed in section II.A.4.b. of the Addendum to this proposed rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we are proposing to apply beginning October 1, 2010 (the proposed FY 2011 wage index) appears under section III.D. of this preamble.

B. Wage Index Reform

1. Wage Index Study Required under the MIEA–TRHCA

a. Legislative Requirement

Section 106(b)(1) of the MIEA–TRHCA (Pub. L. 109–432) required MedPAC to submit to Congress, not later than June 30, 2007, a report on the Medicare wage index classification system applied under the Medicare IPPS. Section 106(b) of MIEA–TRHCA required the report to include any alternatives that MedPAC recommends to the method to compute the wage index under section 1886(d)(3)(E) of the Act.

In addition, section 106(b)(2) of the MIEA–TRHCA instructed the Secretary of Health and Human Services, taking into account MedPAC's recommendations on the Medicare wage index classification system, to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. The Secretary was also to consider each of the following:

- Problems associated with the definition of labor markets for the wage index adjustment.
- The modification or elimination of geographic reclassifications and other adjustments.
- The use of Bureau of Labor of Statistics (BLS) data or other data or methodologies to calculate relative wages for each geographic area.

• Minimizing variations in wage index adjustments between and within MSAs and statewide rural areas.

• The feasibility of applying all components of CMS' proposal to other settings.

• Methods to minimize the volatility of wage index adjustments while maintaining the principle of budget neutrality.

• The effect that the implementation of the proposal would have on health care providers on each region of the country.

• Methods for implementing the proposal(s), including methods to phase in such implementations.

• Issues relating to occupational mix such as staffing practices and any evidence on quality of care and patient safety including any recommendation for alternative calculations to the occupational mix.

In the FY 2009 IPPS final rule (73 FR 48563 through 48567), we discussed the MedPAC's study and recommendations, the CMS contract with Acumen, L.L.C. for assistance with impact analysis and study of wage index reform, and public comments we received on the MedPAC recommendations and the CMS/Acumen study and analysis.

b. Interim and Final Reports on Results of Acumen's Study

(1) Interim Report on Impact Analysis of Using MedPAC's Recommended Wage Index

In the FY 2009 IPPS final rule (73 FR 48566 through 48567), we discussed the analysis conducted by Acumen comparing use of the MedPAC recommended wage indices to the current CMS wage index. We refer readers to section III.B.1.e. of that final rule for a full discussion of the impact analysis as well as to Acumen's interim report available on the Web site: *http://www.acumenllc.com/reports/cms.*

(2) Acumen's Final Report on Analysis of the Wage Index Data and Methodology

Acumen's final report addressing the issues in section 106(b)(2) of the MIEA–TRHCA is divided into two parts. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43824), we provided a description of Acumen's analyses for both parts. The first part of Acumen's final report analyzed the strengths and weaknesses of the data sources used to construct the MedPAC and CMS indexes. The first part of the report was published on Acumen's Web site after the publication of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. In its conclusion, Acumen suggested that MedPAC's recommended methods for revising the wage index represented an improvement over the existing methods, and that the BLS data should be used so that the MedPAC approach can be implemented.

The second part of Acumen's final report focuses on the methodology of wage index construction and covers issues related to the definition of wage areas and methods of adjusting for differences among neighboring wage areas, as well as reasons for differential impacts of shifting to a new index. Acumen published the second part of its final report in March 2010 on its Web site at: *http:/www./acumenllc.com/reports/cms.* In particular, the report analyzes MedPAC's recommended method of improving upon the definition of the wage areas used in the current wage index. MedPAC's method first blends MSA and county-level wages and then implements a "smoothing" step that limits differences in wage index values between adjacent counties to no more than 10 percent. Acumen found MedPAC's method to be an improvement over the current wage index construct. However, although MedPAC's method diminishes the size of differences between adjacent areas, Acumen suggested that MedPAC's method does not guarantee an accurate representation of a hospital labor market and would not necessarily eliminate or reduce hospitals' desire to reclassify for a higher wage index. Acumen recommended further exploration of labor market area definitions using a wage area framework based on hospital-specific characteristics, such as commuting times from hospitals to population centers, to construct a more accurate hospital wage index. Acumen suggested that such an approach offers the greatest potential for replacing or greatly reducing the need for hospital reclassifications and exceptions.

We indicated in the FY 2009 IPPS final rule (73 FR 48566) that, in developing any proposal(s) for additional wage index reform that may be included in the FY 2010 IPPS proposed rule, we would consider all of the public comments on the MedPAC recommendations that we had received in that proposed rulemaking cycle, along with the interim and final reports to be submitted to us by Acumen. As Acumen's study was not complete at the time of issuance of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we did not propose any additional changes to the hospital wage index for the FY 2010 IPPS. We also are not proposing any additional changes regarding reforming the wage index for the FY 2011 IPPS. We welcome comments regarding the second part of Acumen's final report.

2. FY 2009 Policy Changes in Response to Requirements Under Section 106(b) of the MIEA–TRHCA

To implement the requirements of section 106(b) of the MIEA–TRHCA and respond to MedPAC's recommendations in its June 2007 report to Congress, in the FY 2009 IPPS final rule (73 FR 48567 through 48574), we made the following policy changes relating to the hospital wage index. (We refer readers to the FY 2009 IPPS final rule for a full discussion of the basis for the proposals, the public comments received, and the FY 2009 final policy.) In the FY 2010 IPPS final rule (74 FR 43825), we reiterated these policy changes, especially as they related to the FY 2010 IPPS.

a. Reclassification Average Hourly Wage Comparison Criteria

In the FY 2009 IPPS final rule, we adopted the policy to adjust the reclassification average hourly wage standard, comparing a reclassifying hospital's (or county hospital group's) average hourly wage relative to the average hourly wage of the area to which it seeks reclassification. We provided for a phase-in of the adjustment over 2 years. For applications for reclassification for the first transitional year, FY 2010, the average hourly wage standards were set at 86 percent for urban hospitals and group reclassifications and 84 percent for rural hospitals. For applications for reclassification for FY 2011 (for which the application deadline was September 1, 2009) and for subsequent fiscal years, the average hourly wage standards are 88 percent for urban and group reclassifications and 86 percent for rural hospitals (§§ 412.230, 412.232, and 412.234 of the regulations). As stated above, these policies were adopted in the FY 2009 IPPS final rule and are reflected in the wage index in the Addendum to this proposed rule. We note that these criteria were recently changed by provisions of section 3137(c) of the PPACA (Pub. L. 111–148). We will address the changes made by Public Law 111–148 in a separate rulemaking document in the **Federal Register**.

b. Budget Neutrality Adjustment for the Rural and Imputed Floors

In the FY 2009 IPPS final rule (73 FR 48574 through 48575), we adopted State level budget neutrality (rather than the national budget neutrality adjustment) for the rural and imputed floors, effective beginning with the FY 2009

wage index. The transition from the national budget neutrality adjustment to the State level budget neutrality adjustment was phased in over a 3-year period. In FY 2009, hospitals received a blended wage index that was 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. In FY 2010, the blended wage index reflects 50 percent of the State level adjustment and 50 percent of the national adjustment. In FY 2011, as reflected in the IPPS wage index in this proposed rule, the adjustment will be completely transitioned to the State level methodology.

In the FY 2009 IPPS final rule, we incorporated this policy in our regulation at § 412.64(e)(4). Specifically, the regulations specify that CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105–33) and the imputed floor under § 412.64(h)(4) are made in a manner that ensures that aggregate payments to hospitals are not affected and that, beginning October 1, 2008, CMS would transition from a nationwide adjustment to a statewide adjustment, with a statewide adjustment fully in place by October 1, 2010.

As stated above, these policies for the rural and imputed floors were adopted in the FY 2009 IPPS final rule and are reflected in the wage index in the Addendum to this proposed rule. However, these policies were recently changed by the provisions of section 3141 of the PPACA (Pub. L. 111–148). We will address the provisions of section 3141 of Public Law 111–148 in a separate rulemaking document in the **Federal Register**.

C. Core-Based Statistical Areas for the Hospital Wage Index

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, beginning with FY 2005, we define hospital labor market areas based on the Core-Based Statistical Areas (CBSAs) established by OMB and announced in December 2003 (69 FR 49027). For a discussion of OMB's revised definitions of CBSAs and our implementation of the CBSA definitions, we refer readers to the preamble of the FY 2005 IPPS final rule (69 FR 49026 through 49032).

As with the FY 2010 final rule, in this FY 2011 proposed rule, we are proposing to provide that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, for each hospital, we are proposing to determine a wage index for FY 2011 employing wage index data from hospital cost reports for cost reporting periods beginning during FY 2007 and using the CBSA labor market definitions. We consider CBSAs that are MSAs to be urban, and CBSAs that are Micropolitan Statistical Areas as well as areas outside of CBSAs to be rural. In addition, it has been our longstanding policy that where an MSA has been divided into Metropolitan Divisions, we consider the Metropolitan Division to comprise the labor market areas for purposes of calculating the wage index (69 FR 49029) (regulations at § 412.64(b)(1)(ii)(A)).

On December 1, 2009, OMB announced changes to the principal cities and, if applicable, titles of a number of CBSAs and Metropolitan Divisions (OMB Bulletin No. 10–2). The changes to the principal cities and titles are as follows:

- San Marcos, TX qualifies as a new principal city of the Austin-Round Rock, TX CBSA. The new title is Austin-Round Rock-San Marcos, TX CBSA.
- Delano, CA qualifies as a new principal city of the Bakersfield, CA CBSA. The new title: Bakersfield-Delano, CA CBSA.
- Conroe, TX qualifies as a new principal city of the Houston-Sugar Land-Baytown, TX CBSA. The CBSA title is unchanged.
- North Port, FL qualifies as a new principal city of the Bradenton-Sarasota-Venice, FL CBSA. The new title is North Port-Bradenton-Sarasota, FL CBSA. The new code is CBSA 35840.
- Sanford, FL qualifies as a new principal city of the Orlando-Kissimmee, FL CBSA. The new title is Orlando-Kissimmee-Sanford, FL CBSA.
- Glendale, AZ qualifies as a new principal city of the Phoenix-Mesa-Scottsdale, AZ CBSA. The new title is Phoenix-Mesa-Glendale, AZ CBSA.
- Palm Desert, CA qualifies as a new principal city of the Riverside-San Bernardino-Ontario, CA CBSA. The CBSA title is unchanged.
- New Braunfels, TX qualifies as a new principal city of the San Antonio, TX CBSA. The new title is San Antonio-New Braunfels, TX CBSA.
- Auburn, WA qualifies as a new principal city of the Seattle-Tacoma-Bellevue, WA CBSA. The CBSA title is unchanged.

The changes to titles resulting from changes to the order of principal cities based on population are as follows:

- Rockville, MD replaces Frederick, MD as the second most populous principal city in the Bethesda-Frederick-Rockville, MD Metropolitan Division. The new title is Bethesda-Rockville-Frederick, MD Metropolitan Division.
- Rock Hill, SC replaces Concord, NC as the third most populous principal city in the Charlotte-Gastonia-Concord, NC–SC CBSA. The new title is Charlotte-Gastonia-Rock Hill, NC–SC CBSA.
- Joliet, IL replaces Naperville, IL as the second most populous principal city in the Chicago-Naperville-Joliet, IL Metropolitan Division. The new title is Chicago-Joliet-Naperville, IL Metropolitan Division.
- Crestview, FL replaces Fort Walton Beach, FL as the most populous principal city in the Fort Walton Beach-Crestview-Destin, FL CBSA. The new title is Crestview-Fort Walton Beach-Destin, FL CBSA. The new code is 18880.
- Hillsboro, OR replaces Beaverton, OR as the third most populous principal city in the Portland-Vancouver-Beaverton, OR–WA CBSA. The new title is Portland-Vancouver-Hillsboro, OR–WA CBSA.
- Steubenville, OH replaces Weirton, WV as the most populous principal city in the Weirton-Steubenville, WV–OH CBSA. The new title is Steubenville-Weirton, OH–WV CBSA. The new CBSA code is 44600.

The OMB bulletin is available on the OMB Web site at *http://www.whitehouse.gov/OMB—go* to "Agency Information" and click on "Bulletins". CMS will apply these changes to the IPPS beginning October 1, 2010.

D. Proposed Occupational Mix Adjustment to the Proposed FY 2011 Wage Index

As stated earlier, section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, for application beginning October 1, 2004 (the FY 2005 wage index). The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather

than geographic differences in the costs of labor.

1. Development of Data for the Proposed FY 2011 Occupational Mix Adjustment Based on the 2007–2008 Occupational Mix Survey

As provided for under section 1886(d)(3)(E) of the Act, we collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program.

For the FY 2010 hospital wage index, we used occupational mix data collected on a revised 2007–2008 Medicare Wage Index Occupational Mix Survey (the 2007–2008 survey) to compute the occupational mix adjustment for FY 2010. (We refer readers to the FY 2010 IPPS final rule (74 FR 43827) for a detailed discussion of the 2007–2008 survey.) Again, for the proposed FY 2011 hospital wage index, we used data from the 2007–2008 survey (including revised data for 45 hospitals) to compute the proposed FY 2011 adjustment.

2. New 2010 Occupational Mix Survey for the FY 2013 Wage Index

As stated earlier, section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. We used occupational mix data collected on the 2007–2008 survey to compute the occupational mix adjustment for FY 2010 and the proposed FY 2011 wage index in this proposed rule. We also plan to use the 2007–2008 survey data for the FY 2012 wage index. Therefore, a new measurement of occupational mix will be required for FY 2013.

Since we implemented the 2007–2008 survey, we received several public comments suggesting further improvements to the occupational mix survey. Specifically, commenters recommended that CMS use the calendar year (that is, January 1 through December 31) as the 1-year reporting period instead of July 1 through June 30. Commenters also requested that CMS allow for a 6-month period after the end of the survey reporting period for hospitals to complete and submit their data to their Medicare fiscal intermediaries and MACs. The commenters suggested that these changes will allow hospitals more time to develop their occupational mix data before submitting the data to the Medicare contractors and CMS for use in development of the wage index. Based on these comments, we revised the occupational mix survey. The new 2010 survey (Form CMS–10079 (2010)) will provide for the collection of hospital-specific wages and hours data for calendar year 2010 (that is, payroll periods ending between January 1, 2010 and December 31, 2010) and will be applied beginning with the FY 2013 wage index.

On September 4, 2009, we published in the **Federal Register** a notice soliciting comments on the proposed 2010 survey (74 FR 45860). The comment period for the notice ended on November 3, 2009. After considering the comments we received, we made a few minor editorial changes and published the final 2010 survey in the **Federal Register** on January 15, 2010 (75 FR 2548). The survey was approved by OMB on February 26, 2010 (OMB control number 0938–0907) and is available on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage,* and through the fiscal intermediaries/MACs. Hospitals are required to submit their completed 2010 surveys to their fiscal intermediaries/MACs by July 1, 2011. The preliminary, unaudited 2010 survey data will be released in early October 2011, along with the FY 2009 Worksheet S–3 wage data, for the FY 2013 wage index review and correction process.

3. Calculation of the Proposed Occupational Mix Adjustment for FY 2011

For FY 2011 (as we did for FY 2010), we are proposing to calculate the occupational mix adjustment factor using the following steps:

Step 1—For each hospital, determine the percentage of the total nursing category attributable to a nursing subcategory by dividing the nursing subcategory hours by the total nursing category's hours. Repeat this computation for each of the four nursing subcategories: registered nurses; licensed practical nurses; nursing aides, orderlies, and attendants; and medical assistants.

Step 2—Determine a national average hourly rate for each nursing subcategory by dividing a subcategory's total salaries for all hospitals in the occupational mix survey database by the subcategory's total hours for all hospitals in the occupational mix survey database.

Step 3—For each hospital, determine an adjusted average hourly rate for each nursing subcategory by multiplying the percentage of the total nursing category (from Step 1) by the national average hourly rate for that nursing subcategory (from Step 2). Repeat this calculation for each of the four nursing subcategories.

Step 4—For each hospital, determine the adjusted average hourly rate for the total nursing category by summing the adjusted average hourly rate (from Step 3) for each of the nursing subcategories.

Step 5—Determine the national average hourly rate for the total nursing category by dividing total nursing category salaries for all hospitals in the occupational mix survey database by total nursing category hours for all hospitals in the occupational mix survey database.

Step 6—For each hospital, compute the occupational mix adjustment factor for the total nursing category by dividing the national average hourly rate for the total nursing category (from Step 5) by the hospital's adjusted average hourly rate for the total nursing category (from Step 4).

If the hospital's adjusted average hourly rate is less than the national average hourly rate (indicating the hospital employs a less costly mix of nursing employees), the occupational mix adjustment factor is greater than 1.0000. If the hospital's adjusted average hourly rate is greater than the national average hourly rate, the occupational mix adjustment factor is less than 1.0000.

Step 7—For each hospital, calculate the occupational mix adjusted salaries and wage-related costs for the total nursing category by multiplying the hospital's total salaries and wage-related costs (from Step 5 of the unadjusted wage index calculation in section III.G. of this preamble) by the percentage of the hospital's total workers attributable to the total nursing category (using the occupational mix survey data, this percentage is determined by dividing the hospital's total nursing category salaries by the hospital's total salaries for "nursing and all other") and by the total nursing category's occupational mix adjustment factor (from Step 6 above).

The remaining portion of the hospital's total salaries and wage-related costs that is attributable to all other employees of the hospital is not adjusted by the occupational mix. A hospital's all other portion is determined by subtracting the hospital's nursing category percentage from 100 percent.

Step 8—For each hospital, calculate the total occupational mix adjusted salaries and wage-related costs for a hospital by summing the occupational mix adjusted salaries and wage-related costs for the total nursing category (from Step 7) and the portion of the hospital's

salaries and wage-related costs for all other employees (from Step 7).

To compute a hospital's occupational mix adjusted average hourly wage, divide the hospital's total occupational mix adjusted salaries and wage-related costs by the hospital's total hours (from Step 4 of the unadjusted wage index calculation in section III.G. of this preamble).

Step 9—To compute the occupational mix adjusted average hourly wage for an urban or rural area, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the area, then sum the total hours for all hospitals in the area. Next, divide the area's occupational mix adjusted salaries and wage-related costs by the area's hours.

Step 10—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the Nation, then sum the total hours for all hospitals in the Nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours. The proposed FY 2011 occupational mix adjusted national average hourly wage is $34.9124.

Step 11—To compute the occupational mix adjusted wage index, divide each area's occupational mix adjusted average hourly wage (Step 9) by the national occupational mix adjusted average hourly wage (Step 10).

Step 12—To compute the Puerto Rico specific occupational mix adjusted wage index, follow Steps 1 through 11 above. The proposed FY 2011 occupational mix adjusted Puerto Rico-specific average hourly wage is $14.7567.

The table below is an illustrative example of the occupational mix adjustment.

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Example of Occupational Mix Adjustment

Hospital A								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	**Provider Occupational Mix Salaries**	**Provider % by Subcategory**	**National AHWs by Subcategory**	**Provider Adjusted AHW**	**National Adjusted Nurse AHW**	**Nurse Occupational Mix Adjustment Factor**	**Provider % by Total**
Registered Nurses	1,642,129	18,125,763	**79.84%**	$40.00	**$31.94**			
Licensed Practical Nurses and Surgical Technologists	67,860	404,822	**3.30%**	$20.00	**$0.66**			
Nursing Aides, Orderlies, & Attendants	259,177	1,762,579	**12.60%**	$13.00	**$1.64**			
Medical Assistants	87,622	577,045	**4.26%**	$12.00	**$0.51**			
Total Nurse Hours and Salaries	**2,056,788**	**20,870,209**			**$34.75**	**$27.00**	**0.7771**	**52.40%**
ALL OTHER	5,000,000	$18,957,010			Step 4			**47.60%**
TOTAL	**7,056,788**	**$39,827,219**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$83,312,942.55							
Hours (From S-3, Parts II and III)	3,836,299.60							
Hospital A Unadjusted AHW	**$21.72**							
Nurse Occupational Mix Wages	**$33,925,838**	Step 7						
All Other Unadjusted Occupational Mix Wages	**$39,655,400**	Step 7						
Total Occupational Mix Wages	**$73,581,237**	Step 8						
Hospital A Final Occupational Mix Adjusted AHW	**$19.18**	Step 8						

Hospital B								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	**Provider Occupational Mix Salaries**	**Provider % by Subcategory**	**National AHWs by Subcategory**	**Provider Adjusted AHW**	**National Adjusted Nurse AHW**	**Nurse Occupational Mix Adjustment Factor**	**Provider % by Total**
Registered Nurses	1,142,129	18,125,763	**72.43%**	$30.00	**$21.73**			
Licensed Practical Nurses and Surgical Technologists	67,860	404,822	**4.30%**	$20.00	**$0.86**			
Nursing Aides, Orderlies, & Attendants	279,177	1,762,579	**17.71%**	$13.00	**$2.30**			
Medical Assistants	87,622	577,045	**5.56%**	$12.00	**$0.67**			
Total Nurse Hours and Salaries	**1,576,788**	**20,870,209**			**$25.56**	**$27.00**	**1.0564**	**52.40%**
ALL OTHER	5,000,000	18,957,010			Step 4			**47.60%**
TOTAL	**6,576,788**	**$39,827,219**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$25,979,714							
Hours (From S-3, Parts II and III)	1,097,585							
Hospital B Unadjusted AHW	**$23.67**							
Nurse Occupational Mix Wages	**$14,381,144**	Step 7						
All Other Unadjusted Occupational Mix Wages	**$12,365,857**	Step 7						
Total Occupational Mix Wages	**$26,747,001**	Step 8						
Hospital B Final Occupational Mix Adjusted AHW	**$24.37**	Step 8						
Note: The numbers in this example are hypothetical, including all National AHW amounts.								

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Because the occupational mix adjustment is required by statute, all hospitals that are subject to payments under the IPPS, or any hospital that would be subject to the IPPS if not granted a waiver, must complete the occupational mix survey, unless the hospital has no associated cost report wage data that are included in the proposed FY 2011 wage index. For the FY 2007–2008 survey, the response rate was 90.4 percent.

In computing the proposed FY 2011 wage index, if a hospital did not respond to the occupational mix survey, or if we determined that a hospital's submitted data were too erroneous to include in the wage index, we assigned the hospital the average occupational mix adjustment for the labor market area. We believe this method had the least impact on the wage index for other hospitals in the area. For areas where no hospital submitted data for purposes of calculating the proposed occupational mix adjustment, we applied the national occupational mix factor of 1.0000 in calculating the area's proposed FY 2011 occupational mix adjusted wage index. In addition, if a hospital submitted a survey, but that survey data could not be used because we determine it to be aberrant, we also assigned the hospital the average occupational mix adjustment for its labor market area. For example, if a hospital's individual nurse category average hourly wages were out of range (that is, unusually high or low), and the hospital did not provide sufficient documentation to explain the aberrancy, or the hospital did not submit any registered nurse salaries or hours data, we assigned the hospital the average occupational mix adjustment for the labor market area in which it is located.

In calculating the average occupational mix adjustment factor for a labor market area, we replicated Steps 1 through 6 of the calculation for the occupational mix adjustment. However, instead of performing these steps at the hospital level, we aggregated the data at the labor market area level. In following these steps, for example, for CBSAs that contain providers that did not submit occupational mix survey data, the occupational mix adjustment factor ranged from a low of 0.9252 (CBSA 17780, College Station-Bryan, TX), to a high of 1.1199 (CBSA 40980, Saginaw-Saginaw Township North, MI). Also, in computing a hospital's occupational mix adjusted salaries and wage-related costs for nursing employees (Step 7 of the calculation), in the absence of occupational mix survey data, we multiplied the hospital's total salaries and wage-related costs by the percentage of the area's total workers attributable to the area's total nursing category. For FY 2011, there are 5 CBSAs (that include 5 hospitals) for which we did not have occupational mix data for any of its hospitals. The CBSAs are:

- CBSA 21940 Fajardo, PR (one hospital)
- CBSA 22140 (Farmington, NM (one hospital)
- CBSA 36140 Ocean City, NJ (one hospital)
- CBSA 41900 San German-Cabo Rojo, PR (two hospitals)
- CBSA 49500 Yauco, PR (one hospital)

Since the FY 2007 IPPS final rule, we have periodically discussed applying a hospital-specific penalty to hospitals that fail to submit occupational mix survey data. (71 FR 48013 through 48014; 72 FR 47314 through 47315; 73 FR 48580; and 74 FR 43832). During the FY 2008 rulemaking cycle, some commenters suggested a penalty equal to a 1- to 2-percent reduction in the hospital's wage index value or a set percentage of the standardized amount. During the FY 2009 and FY 2010 rulemaking cycles, several commenters reiterated their view that full participation in the occupational mix survey is critical, and that CMS should develop a methodology that encourages hospitals to report occupational mix survey data but does not unfairly penalize neighboring hospitals. We indicated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule that, while we were not proposing a penalty at that time, we would consider the public comments we previously received, as well as any public comments on the proposed rule, as we develop the proposed FY 2011 wage index.

To gain a better understanding of why some hospitals are not submitting the occupational mix data, beginning with the new 2010 occupational mix survey (discussed in section III.D.2. of this preamble), we will require hospitals that do not submit occupational mix data to provide an explanation for not complying with the submission requirements. We will instruct fiscal intermediaries/MACs to gather this information as part of the FY 2013 wage index desk review process. We note that we reserve the right to apply a different approach in future years, including potentially penalizing nonresponsive hospitals.

E. Worksheet S–3 Wage Data for the Proposed FY 2011 Wage Index

The proposed FY 2011 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2007 (the FY 2010 wage index was based on data from cost reporting periods beginning during FY 2006).

1. Included Categories of Costs

The proposed FY 2011 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

- Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty)
- Home office costs and hours
- Certain contract labor costs and hours (which includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services, and certain contract indirect patient care services (as discussed in the FY 2008 final rule with comment period (72 FR 47315))
- Wage-related costs, including pensions and other deferred compensation costs. We note that, for developing pension and deferred compensation costs for purposes of the wage index, CMS requires hospitals to comply with the requirements in 42 CFR 413.100, the Provider Reimbursement Manual (PRM), Part I, Sections 2140, 2141, and 2142, and related Medicare program instructions, as discussed in the cost reporting instructions for Worksheet S–3, Part II, Lines 13 through 20, and in the FY 2006 IPPS final rule (70 FR 47369). On March 28, 2008, CMS published Revision 436, a technical clarification to the PRM, Part I policies for pension and deferred compensation costs. In addition, in November 2009, CMS released, through a Joint Signature Memorandum, instructions and a spreadsheet to assist hospitals and Medicare contractors in determining the annual allowable defined benefit pension cost for the FY 2011 wage index (JSM/TDL–10061, 11–20–09, December 3, 2009). These instructions and spreadsheet crosswalk the current interest, liability, and normal cost terminology found in the Medicare reimbursement policies under Section 2142 of the PRM, Part I to the new terminology applicable under the Pension Protection Act of 2006. The spreadsheet and instructions can be downloaded from the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1231035&intNumPerPage=10.*

2. Excluded Categories of Costs

Consistent with the wage index methodology for FY 2009, the wage index for FY 2010 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The proposed FY 2011 wage index also excludes the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours, and wage-related costs of CAHs are excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

3. Use of Wage Index Data by Providers Other Than Acute Care Hospitals under the IPPS

Data collected for the IPPS wage index are also currently used to calculate wage indices applicable to other providers, such as SNFs, home health agencies (HHAs), and hospices. In addition, they are used for prospective payments to IRFs, IPFs, and LTCHs, and for hospital outpatient services. We note that, in the IPPS rules, we do not address comments pertaining to the wage indices for non-IPPS providers, other than for LTCHs. Such comments should be made in response to separate proposed rules for those providers.

F. Verification of Worksheet S–3 Wage Data

The wage data for the proposed FY 2011 wage index were obtained from Worksheet S–3, Parts II and III of the Medicare cost report for cost reporting periods beginning on or after October 1, 2006, and before October 1, 2007. For wage index purposes, we refer to cost reports during this period as the "FY 2007 cost report," the "FY 2007 wage data," or the "FY 2007 data." Instructions for completing Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual (PRM), Part II, sections 3605.2 and 3605.3. The data file used to construct the wage index includes FY 2007 data submitted to us as of March 3, 2010. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries/MACs to revise or verify data elements that resulted in specific edit failures. For the proposed FY 2011 wage index, we identified and excluded 14 providers with data that was too aberrant to include in the proposed wage index, although if data elements for some of these providers are corrected, we intend to include some of these providers in the FY 2011 final wage index. We instructed fiscal intermediaries/MACs to complete their data verification of questionable data elements and to transmit any changes to the wage data no later than April 14, 2010. We believe all unresolved data elements will be resolved by the date the final rule is issued. The revised data will be reflected in the FY 2011 IPPS final rule.

In constructing the proposed FY 2011 wage index, we included the wage data for facilities that were IPPS hospitals in FY 2007, inclusive of those facilities that have since terminated their participation in the program as hospitals, as long as those data did not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period and to ensure that the current wage index represents the labor market area's current wages as compared to the national average of wages. However, we excluded the wage data for CAHs as discussed in the FY 2004 IPPS final rule (68 FR 45397). For this proposed rule, we removed 8 hospitals that converted to CAH status between February 16, 2009, the cut-off date for CAH exclusion from the FY 2010 wage index, and February 15, 2010, the cut-off date for CAH exclusion from the FY 2011 wage index. After removing hospitals with aberrant data and hospitals that converted to CAH status, the proposed FY 2011 wage index is calculated based on 3,513 hospitals.

In the FY 2008 final rule with comment period (72 FR 47317) and the FY 2009 IPPS final rule (73 FR 48582), we discussed our policy for allocating a multicampus hospital's wages and hours data, by full-time equivalent (FTE) staff, among the different labor market areas where its campuses are located. During the FY 2011 wage index desk review process, we requested fiscal intermediaries/MACs to contact multicampus hospitals that had campuses in different labor market areas to collect the data for the allocation. The proposed FY 2011 wage index in this proposed rule includes separate wage data for campuses of three multicampus hospitals.

For FY 2011, we are again allowing hospitals to use FTE or discharge data for the allocation of a multicampus hospital's wage data among the different labor market areas where its campuses are located. The Medicare cost report was updated in May 2008 to provide for the reporting of FTE data by campus for multicampus hospitals. Because the data from cost reporting periods that begin in FY 2008 will not be used in calculating the wage index until FY 2012, a multicampus hospital will still have the option, through the FY 2011 wage index, to use either FTE or discharge data for allocating wage data among its campuses by providing the information from the applicable cost reporting period to CMS through its fiscal intermediary/MAC. Two of the three multicampus hospitals chose to have their wage data allocated by their Medicare discharge data for the FY 2011 wage index. One of the hospitals provided FTE staff data for the allocation. The average hourly wage associated with each geographical location of a multicampus hospital is reflected in Table 2 of the Addendum to this proposed rule.

G. Method for Computing the Proposed FY 2011 Unadjusted Wage Index

The method used to compute the proposed FY 2011 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we are basing the proposed FY 2011 wage index on wage data reported on the FY 2007 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 2006, and before October 1, 2007. In addition, we included data from some hospitals that had cost reporting periods beginning before October 2006 and reported a cost reporting period covering all of FY 2007. These data are included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2007 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2007 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2006, and before October 1, 2007), we included wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and

the periods were equal in length, we included the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. (We note that, beginning with FY 2008 (72 FR 47315), we include Lines 22.01, 26.01, and 27.01 of Worksheet S–3, Part II for overhead services in the wage index. However, we note that the wages and hours on these lines are not incorporated into Line 101, Column 1 of Worksheet A, which, through the electronic cost reporting software, flows directly to Line 1 of Worksheet S–3, Part II. Therefore, the first step in the wage index calculation for FY 2011 is to compute a "revised" Line 1, by adding to the Line 1 on Worksheet S–3, Part II (for wages and hours respectively) the amounts on Lines 22.01, 26.01, and 27.01.) In calculating a hospital's average salaries plus wage-related costs, we subtract from Line 1 (total salaries) the GME and CRNA costs reported on Lines 2, 4.01, 6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and exclude salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtract from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we add to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

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

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

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocate overhead costs to areas of the hospital excluded from the wage index calculation. First, we determine the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S–3). We then compute the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we compute the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determine the ratio of overhead hours (Part III, Line 13 minus the sum of lines 22.01, 26.01, and 27.01) to revised hours excluding the sum of lines 22.01, 26.01, and 27.01 (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, 8.01, 22.01, 26.01, and 27.01). (We note that for the FY 2008 and subsequent wage index calculations, we are excluding the sum of lines 22.01, 26.01, and 27.01 from the determination of the ratio of overhead hours to revised hours because hospitals typically do not provide fringe benefits (wage-related costs) to contract personnel. Therefore, it is not necessary for the wage index calculation to exclude overhead wage-related costs for contract personnel. Further, if a hospital does contribute to wage-related costs for contracted personnel, the instructions for Lines 22.01, 26.01, and 27.01 require that associated wage-related costs be combined with wages on the respective contract labor lines.); (2) we compute overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, and 18; and (3) we multiply the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtract the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjust the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimate the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 2003, through April 15, 2005, for private industry hospital workers from the BLS' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. We also note that, since April 2006 with the publication of March 2006 data, the BLS' ECI uses a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SICs), which no longer exist. We have consistently used the ECI as the data source for our wages and salaries and other price proxies in the IPPS market basket and we are not proposing to make any changes to the usage for FY 2011. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment Factor
10/14/2006	11/15/2006	1.04377
11/14/2006	12/15/2006	1.04077
12/14/2006	01/15/2007	1.03786
01/14/2007	02/15/2007	1.03508
02/14/2007	03/15/2007	1.03243
03/14/2007	04/15/2007	1.02981
04/14/2007	05/15/2007	1.02709
05/14/2007	06/15/2007	1.02430
06/14/2007	07/15/2007	1.02153
07/14/2007	08/15/2007	1.01891
08/14/2007	09/15/2007	1.01643
09/14/2007	10/15/2007	1.01394
10/14/2007	11/15/2007	1.01127
11/14/2007	12/15/2007	1.00844
12/14/2007	01/15/2008	1.00556
01/14/2008	02/15/2008	1.00275
02/14/2008	03/15/2008	1.00000
03/14/2008	04/15/2008	0.99732

For example, the midpoint of a cost reporting period beginning January 1, 2007, and ending December 31, 2007, is June 30, 2007. An adjustment factor of 1.02153 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 2007 and covered a period of less than 360 days or more than 370 days, we annualize the data to reflect a 1-year cost report. Dividing the data by the number of days in the cost report and then multiplying the results by 365 accomplishes annualization.

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

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

Step 8—We add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the Nation and then divide the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the proposed national average hourly wage (unadjusted for occupational mix) is $34.9330.

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

Step 10—Following the process set forth above, we develop a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We add the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divide the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall proposed average hourly wage (unadjusted for occupational mix) of $14.7351 for Puerto Rico. For each labor market area in Puerto Rico, we calculate the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. The areas affected by this provision are identified in Table 4D–2 of the Addendum to this proposed rule.

In the FY 2005 IPPS final rule (69 FR 49109), we adopted the "imputed" floor as a temporary 3-year measure to address a concern by some individuals that hospitals in all-urban States were disadvantaged by the absence of rural hospitals to set a wage index floor in those States. The imputed floor was originally set to expire in FY 2007, but we extended it an additional year in the FY 2008 IPPS final rule with comment period (72 FR 47321). In the FY 2009 IPPS final rule (73 FR 48570 through 48574 and 48584), we extended the imputed floor for an additional 3 years, through FY 2011.

H. Analysis and Implementation of the Proposed Occupational Mix Adjustment and the Proposed FY 2011 Occupational Mix Adjusted Wage Index

As discussed in section III.D. of this preamble, for FY 2011, we are proposing to apply the occupational mix adjustment to 100 percent of the proposed FY 2011 wage index. We calculated the proposed occupational mix adjustment using data from the 2007–2008 occupational mix survey data, using the methodology described in section III.D.3. of this preamble.

Using the occupational mix survey data and applying the occupational mix adjustment to 100 percent of the proposed FY 2011 wage index results in a proposed national average hourly wage of $34.9124 and a proposed Puerto-Rico specific average hourly wage of $14.7567. After excluding data of hospitals that either submitted aberrant data that failed critical edits, or that do not have FY 2007 Worksheet S–3 cost report data for use in calculating the proposed FY 2011 wage index, we calculated the proposed FY 2011 wage index using the occupational mix survey data from 3,178 hospitals. Using the Worksheet S–3 cost report data of 3,513 hospitals and occupational mix survey data from 3,178 hospitals represents a 90.4 percent survey response rate. The proposed FY 2011 national average hourly wages for each occupational mix nursing subcategory as calculated in Step 2 of the occupational mix calculation are as follows:

Occupational mix nursing subcategory	Average hourly wage
National RN	36.100857731
National LPN and Surgical Technician	20.877391755
National Nurse Aide, Orderly, and Attendant	14.632232352
National Medical Assistant	16.482939594
National Nurse Category	30.504184147

The proposed national average hourly wage for the entire nurse category as computed in Step 5 of the occupational mix calculation is $30.504184147. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of greater than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of less than 1.0. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of less than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of greater than 1.0.

Based on the 2007–2008 occupational mix survey data, we determined (in Step 7 of the occupational mix calculation) that the national percentage of hospital employees in the nurse category is 44.32 percent, and the national percentage of hospital employees in the all other occupations category is 55.68 percent. At the CBSA level, the percentage of hospital employees in the nurse category ranged from a low of 29.08 percent in one CBSA, to a high of 70.76 percent in another CBSA.

We compared the proposed FY 2011 occupational mix adjusted wage indices for each CBSA to the proposed unadjusted wage indices for each CBSA. As a result of applying the occupational mix adjustment to the wage data, the proposed wage index values for 203(51.9 percent) urban areas and 32 (68.1 percent) rural areas would increase. One hundred five (26.9 percent) urban areas would increase by 1 percent or more, and 6 (1.5 percent) urban areas would increase by 5 percent or more. Eighteen (38.3 percent) rural areas would increase by 1 percent or more, and no rural areas would increase by 5 percent or more. However, the wage index values for 188 (48.1 percent) urban areas and 15 (31.9 percent) rural areas would decrease. Ninety (23.0 percent) urban areas would decrease by 1 percent or more, and no urban area would decrease by 5 percent or more. Seven (14.9 percent) rural areas would decrease by 1 percent or more, and no rural areas will decrease by 5 percent or more. The largest positive impacts are 7.83 percent for an urban area and 2.87 percent for a rural area. The largest negative impacts are 3.98 percent for an urban area and 2.41 percent for a rural area. No urban or rural areas are unaffected. These results indicate that a larger percentage of rural areas (68.1 percent) benefit from the occupational mix adjustment than do urban areas (51.9 percent). While these results are more positive overall for rural areas than under the previous occupational mix adjustment that used survey data from 2006, approximately one-third (31.9 percent) of rural CBSAs will still experience a decrease in their wage indices as a result of the occupational mix adjustment.

The proposed wage index values for FY 2011 (except those for hospitals receiving wage index adjustments under section 1886(d)(13) of the Act) included in Tables 4A, 4B, 4C, and 4F of the Addendum to this proposed rule include the proposed occupational mix adjustment.

Tables 3A and 3B in the Addendum to this proposed rule list the 3-year average hourly wage for each labor market area before the redesignation or reclassification of hospitals based on FYs 2009, 2010, and 2011 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital from the FY 2005 and FY 2006 cost reporting periods, as well as the FY 2007 period used to calculate the proposed FY 2011 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period. The proposed average hourly wages in Tables 2, 3A, and 3B in the Addendum to this proposed rule include the proposed occupational mix adjustment. The proposed wage index values in Tables 4A, 4B, 4C, and 4D–1 also include the proposed State-specific rural floor and imputed floor budget neutrality adjustments.

I. Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications

1. General

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify 13 months prior to the start of the fiscal year for which reclassification is sought (generally by September 1). Generally, hospitals must be proximate to the labor market area to which they

are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in 42 CFR 412.230 through 412.280.

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

Section 304(b) of Public Law 106–554 provides that the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. The implementing regulations for this provision are located at 42 CFR 412.235.

Section 1886(d)(8)(B) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the labor market area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards for designating MSAs and if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs. In light of the CBSA definitions and the Census 2000 data that we implemented for FY 2005 (69 FR 49027), we undertook to identify those counties meeting these criteria. Eligible counties are discussed and identified under section III.I.5. of this preamble.

2. Effects of Reclassification/ Redesignation

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

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals increases the wage index value for the urban area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value. Otherwise, the hospitals located in the urban area receive a wage index excluding the wage data of hospitals redesignated into the area.

Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred (otherwise, redesignated rural hospitals are excluded from the calculation of the rural wage index). The wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

CMS also has adopted the following policies:

- The wage data for a reclassified urban hospital is included in both the wage index calculation of the urban area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.
- In cases where hospitals have reclassified to rural areas, such as urban hospitals reclassifying to rural areas under 42 CFR 412.103, the hospital's wage data are: (a) Included in the rural wage index calculation, unless doing so would reduce the rural wage index; and (b) included in the urban area where the hospital is physically located. The effect of this policy, in combination with the statutory requirement at section 1886(d)(8)(C)(ii) of the Act, is that rural areas may receive a wage index based upon the highest of: (1) Wage data from hospitals geographically located in the rural area; (2) wage data from hospitals geographically located in the rural area, but excluding all data associated with hospitals reclassifying out of the rural area under section 1886(d)(8)(B) or section 1886(d)(10) of the Act; or (3) wage data associated with hospitals geographically located in the area plus all hospitals reclassified into the rural area.

In addition, in accordance with the statutory language referring to "hospitals" in the plural under sections 1886(d)(8)(C)(i) and 1886(d)(8)(C)(ii) of the Act, our longstanding policy is to consider reclassified hospitals as a group when deciding whether to include or exclude them from both urban and rural wage index calculations.

3. FY 2011 MGCRB Reclassifications

a. FY 2011 Reclassifications Requirements and Approvals

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. The specific procedures and rules that apply to the geographic reclassification process are outlined in 42 CFR 412.230 through 412.280.

At the time this proposed rule was constructed, the MGCRB had completed its review of FY 2011 reclassification requests. Based on such reviews, there were 311 hospitals approved for wage index reclassifications by the MGCRB for FY 2011. Because MGCRB wage index reclassifications are effective for 3 years, for FY 2011, hospitals reclassified during FY 2009 or FY 2010 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications. There were 258 hospitals approved for wage index reclassifications in FY 2009 and 254 hospitals approved for wage index reclassifications in FY 2010. Of all of the hospitals approved for reclassification for FY 2009, FY 2010, and FY 2011, based upon the review at the time of this proposed rule, 832 hospitals are in a reclassification status for FY 2011.

Under 42 CFR 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the

publication of a proposed rule. Generally stated, the request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2011 has to be received by the MGCRB within 45 days of the publication of the proposed rule. Hospitals may also cancel prior reclassification withdrawals or terminations in certain circumstances. For further information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer the reader to 42 CFR 412.273, as well as the FY 2002 IPPS final rule (66 FR 39887) and the FY 2003 IPPS final rule (67 FR 50065). Additional discussion on withdrawals and terminations, and clarifications regarding reinstating reclassifications and "fallback" reclassifications, were included in the FY 2008 IPPS final rule (72 FR 47333).

Changes to the wage index that result from withdrawals of requests for reclassification, terminations, wage index corrections, appeals, and the Administrator's review process for FY 2011 will be incorporated into the wage index values published in the FY 2011 IPPS/LTCH PPS final rule. These changes affect not only the wage index value for specific geographic areas, but also the wage index value redesignated/reclassified hospitals receive; that is, whether they receive the wage index that includes the data for both the hospitals already in the area and the redesignated/reclassified hospitals. Further, the wage index value for the area from which the hospitals are redesignated/reclassified may be affected.

b. Applications for Reclassifications for FY 2012

Applications for FY 2012 reclassifications are due to the MGCRB by September 1, 2010. We note that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under 42 CFR 412.273(d). Applications and other information about MGCRB reclassifications may be obtained, beginning in mid-July 2010, via the CMS Internet Web site at: *http://cms.hhs.gov/MGCRB/02_instructions_and_applications.asp,* or by calling the MGCRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

c. Appeals of MGCRB Denials of Withdrawals and Terminations

Section 412.278 of the regulations permits a hospital or a group of hospitals dissatisfied with the MGCRB's decision regarding its geographic designation to request the Administrator's review of the decision. Section 412.273(e) permits a hospital to file an appeal to the Administrator regarding the MGCRB's denial of the hospital's request for withdrawal of an application. However, currently, this section of the regulations does not address Administrator review of the MGCRB's denial of a hospital's request for termination; that is, "terminations" are not specified in the regulations at § 412.273(e).

We are proposing to revise the regulations to specify the availability of Administrator review of MGCRB decisions regarding withdrawals and terminations, as well as cancellations of withdrawals or terminations. Because reclassifications are considered budget neutral actions, we believe these proposed revisions would have no impact on total IPPS payments.

In addition, during our review of § 412.273, we determined that some of the existing language in the section could be clarified to make it more easily understood. For example, we believe it would be helpful to clarify the distinction between terminations and withdrawals by defining these terms in a new paragraph (a), which would also include the timing provisions now under existing paragraph (b)(1)(ii). To account for this new paragraph, we are proposing to redesignate the existing contents of paragraph (e) as paragraph (f) and also to revise the language to specify the ability of a hospital to appeal an MGCRB denial of a request for "termination" of an approved reclassification, as well as cancellation of a withdrawal or termination. We also believe it would be helpful (1) to establish the introductory language of existing paragraph (a) as a general rule under new paragraph (b); (2) to establish a new paragraph (c) that addresses the timing provisions currently in paragraphs (a)(1), (a)(2), and (b)(1)(i); (3) to clarify the existing language of paragraphs (b)(2)(i), (b)(2)(ii), (b)(2)(iii), and (d) and incorporate it under new paragraph (d); and (4) to redesignate the existing contents of paragraph (c) as new paragraph (e).

4. Redesignations of Hospitals Under Section 1886(d)(8)(B) of the Act

Section 1886(d)(8)(B) of the Act requires us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA if certain criteria are met. Effective beginning FY 2005, we use OMB's 2000 CBSA standards and the Census 2000 data to identify counties in which hospitals qualify under section 1886(d)(8)(B) of the Act to receive the wage index of the urban area. Hospitals located in these counties have been known as "Lugar" hospitals and the counties themselves are often referred to as "Lugar" counties. We provide the FY 2011 chart below with the listing of the rural counties containing the hospitals designated as urban under section 1886(d)(8)(B) of the Act. For discharges occurring on or after October 1, 2010, hospitals located in the rural county in the first column of this chart will be redesignated for purposes of using the wage index of the urban area listed in the second column.

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Rural Counties Containing Hospitals Redesignated as Urban under Section 1886(d)(8)(B) of the Act (Based on CBSAs and Census 2000 Data)

Rural County	CBSA
Cherokee, AL	Rome, GA
Macon, AL	Auburn-Opelika, AL
Talladega, AL	Anniston-Oxford, AL
Hot Springs, AR	Hot Springs, AR
Windham, CT	Hartford-West Hartford-East Hartford, CT
Bradford, FL	Gainesville, FL
Hendry, FL	West Palm Beach-Boca Raton-Boynton, FL
Levy, FL	Gainesville, FL
Walton, FL	Fort Walton Beach-Crestview-Destin, FL
Banks, GA	Gainesville, GA
Chattooga, GA	Chattanooga, TN-GA
Jackson, GA	Atlanta-Sandy Springs-Marietta, GA
Lumpkin, GA	Atlanta-Sandy Springs-Marietta, GA
Morgan, GA	Atlanta-Sandy Springs-Marietta, GA
Peach, GA	Macon, GA
Polk, GA	Atlanta-Sandy Springs-Marietta, GA
Talbot, GA	Columbus, GA-AL
Bingham, ID	Idaho Falls, ID
Christian, IL	Springfield, IL
DeWitt, IL	Bloomington-Normal, IL
Iroquois, IL	Kankakee-Bradley, IL
Logan, IL	Springfield, IL
Mason, IL	Peoria, IL
Ogle, IL	Rockford, IL
Clinton, IN	Lafayette, IN
Henry, IN	Indianapolis-Carmel, IN
Spencer, IN	Evansville, IN-KY
Starke, IN	Gary, IN
Warren, IN	Lafayette, IN
Boone, IA	Ames, IA
Buchanan, IA	Waterloo-Cedar Falls, IA
Cedar, IA	Iowa City, IA
Allen, KY	Bowling Green, KY
Assumption Parish, LA	Baton Rouge, LA
St. James Parish, LA	Baton Rouge, LA
Allegan, MI	Holland-Grand Haven, MI
Montcalm, MI	Grand Rapids-Wyoming, MI

Rural County	CBSA
Oceana, MI	Muskegon-Norton Shores, MI
Shiawassee, MI	Lansing-East Lansing, MI
Tuscola, MI	Saginaw-Saginaw Township North, MI
Fillmore, MN	Rochester, MN
Dade, MO	Springfield, MO
Pearl River, MS	Gulfport-Biloxi, MS
Caswell, NC	Burlington, NC
Davidson, NC	Greensboro-High Point, NC
Granville, NC	Durham, NC
Harnett, NC	Raleigh-Cary, NC
Lincoln, NC	Charlotte-Gastonia-Concord, NC-SC
Polk, NC	Spartanburg, SC
Los Alamos, NM	Santa Fe, NM
Lyon, NV	Carson City, NV
Cayuga, NY	Syracuse, NY
Columbia, NY	Albany-Schenectady-Troy, NY
Genesee, NY	Rochester, NY
Greene, NY	Albany-Schenectady-Troy, NY
Schuyler, NY	Ithaca, NY
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY
Wyoming, NY	Buffalo-Niagara Falls, NY
Ashtabula, OH	Cleveland-Elyria-Mentor, OH
Champaign, OH	Springfield, OH
Columbiana, OH	Youngstown-Warren-Boardman, OH-PA
Cotton, OK	Lawton, OK
Linn, OR	Corvallis, OR
Adams, PA	York-Hanover, PA
Clinton, PA	Williamsport, PA
Greene, PA	Pittsburgh, PA
Monroe, PA	Allentown-Bethlehem-Easton, PA-NJ
Schuylkill, PA	Reading, PA
Susquehanna, PA	Binghamton, NY
Clarendon, SC	Sumter, SC
Lee, SC	Sumter, SC
Oconee, SC	Greenville, SC
Union, SC	Spartanburg, SC
Meigs, TN	Cleveland, TN
Bosque, TX	Waco, TX
Falls, TX	Waco, TX
Fannin, TX	Dallas-Plano-Irving, TX
Grimes, TX	College Station-Bryan, TX

Rural County	CBSA
Harrison, TX	Longview, TX
Henderson, TX	Dallas-Plano-Irving, TX
Milam, TX	Austin-Round Rock, TX
Van Zandt, TX	Dallas-Plano-Irving, TX
Willacy, TX	Brownsville-Harlingen, TX
Buckingham, VA	Charlottesville, VA
Floyd, VA	Blacksburg-Christiansburg-Radford, VA
Middlesex, VA	Virginia Beach-Norfolk-Newport News, VA
Page, VA	Harrisonburg, VA
Shenandoah, VA	Winchester, VA-WV
Island, WA	Seattle-Bellevue-Everett, WA
Mason, WA	Olympia, WA
Wahkiakum, WA	Longview, WA
Jackson, WV	Charleston, WV
Roane, WV	Charleston, WV
Green, WI	Madison, WI
Green Lake, WI	Fond du Lac, WI
Jefferson, WI	Milwaukee-Waukesha-West Allis, WI
Walworth, WI	Milwaukee-Waukesha-West Allis, WI

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As in the past, hospitals redesignated under section 1886(d)(8)(B) of the Act are also eligible to be reclassified to a different area by the MGCRB. Affected hospitals may compare the reclassified wage index for the labor market area in Table 4C in the Addendum to the proposed rule into which they would be reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals may withdraw from an MGCRB reclassification within 45 days of the publication of this proposed rule.

5. Reclassifications Under Section 1886(d)(8)(B) of the Act

As discussed in the FY 2009 IPPS final rule (73 FR 48588), Lugar hospitals are treated like reclassified hospitals for purposes of determining their applicable wage index and receive the reclassified wage index for the urban area to which they have been redesignated. Because Lugar hospitals are treated like reclassified hospitals, when they are seeking reclassification by the MGCRB, they are subject to the rural reclassification rules set forth at 42 CFR 412.230. The procedural rules set forth at § 412.230 list the criteria that a hospital must meet in order to reclassify as a rural hospital. Lugar hospitals are subject to the proximity criteria and payment thresholds that apply to rural hospitals. Specifically, the hospital must be no more than 35 miles from the area to which it seeks reclassification (§ 412.230(b)(1)); and the hospital must show that its average hourly wage is at least 106 percent of the average hourly wage of all other hospitals in the area in which the hospital is located (§ 412.230(d)(1)(iii)(C)). In accordance with policy adopted in the FY 2009 IPPS final rule (73 FR 48568 and 48569), beginning with reclassifications for the FY 2010 wage index, a Lugar hospital must also demonstrate that its average hourly wage is equal to at least 84 percent (for FY 2010 reclassifications) and 86 percent (for reclassifications for FY 2011 and subsequent fiscal years) of the average hourly wage of hospitals in the area to which it seeks redesignation (§ 412.230(d)(1)(iv)(C)).

Hospitals not located in a Lugar county seeking reclassification to the urban area where the Lugar hospitals have been redesignated are not permitted to measure to the Lugar county to demonstrate proximity (no more than 15 miles for an urban hospital, and no more than 35 miles for a rural hospital or the closest urban or rural area for RRCs or SCHs) in order to be reclassified to such urban area. These hospitals must measure to the urban area exclusive of the Lugar County to meet the proximity or nearest urban or rural area requirement. We treat New England deemed counties in a manner consistent with how we treat Lugar counties. (We refer readers to FY 2008 IPPS final rule with comment period (72 FR 47337) for a discussion of this policy.)

6. Reclassifications Under Section 508 of Public Law 108–173

Section 508 of Public Law 108–173 allowed certain qualifying hospitals to receive wage index reclassifications and assignments that they otherwise would not have been eligible to receive under the law. Although section 508 originally was scheduled to expire after a 3-year period, Congress extended the provision several times, as well as certain special exceptions that would have otherwise expired. For a discussion of the original section 508 provision and its various extensions, we refer readers to the FY 2009 IPPS final rule (73 FR 48588). The most recent extension of the provision was included in section 124 of Public Law 110–275 (MIPPA). Section 124 extended, through FY 2009, section 508 reclassifications as well as certain special exceptions. Because the section 124 extension of these provisions expired on September 30, 2009 (and, therefore, will not be applicable in FY 2011 unless there is intervening legislation to extend the provisions), we are not proposing to make any changes related to these provisions in this proposed rule for FY 2011.

We note that section 508 and special exceptions reclassifications were recently extended again, through September 30, 2010, under section 10317 of the PPACA (Pub. L. 111–148). We intend to imminently issue instructions regarding implementation of section 10317 of Public Law 111–148.

J. Proposed FY 2011 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

In accordance with the broad discretion under section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, beginning with FY 2005, we established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees (the "out-migration" adjustment). The process, outlined in the FY 2005 IPPS final rule (69 FR 49061), provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Such adjustments to the wage index are effective for 3 years, unless a hospital requests to waive the application of the adjustment. A county will not lose its status as a qualifying county due to wage index changes during the 3-year period, and counties will receive the same wage index increase for those 3 years. However, a county that qualifies in any given year may no longer qualify after the 3-year period, or it may qualify but receive a different adjustment to the wage index level. Hospitals that receive this adjustment to their wage index are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Adjustments under this provision are not subject to the budget neutrality requirements under section 1886(d)(3)(E) of the Act.

Hospitals located in counties that qualify for the wage index adjustment are to receive an increase in the wage index that is equal to the average of the differences between the wage indices of the labor market area(s) with higher wage indices and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any labor market area with a higher wage index. Beginning with the FY 2008 wage index, we use post-reclassified wage indices when determining the out-migration adjustment (72 FR 47339).

For the proposed FY 2011 wage index, we are proposing to calculate the out-migration adjustment using the same formula described in the FY 2005 IPPS final rule (69 FR 49064), with the addition of using the post-reclassified wage indices, to calculate the out-migration adjustment. This adjustment is calculated as follows:

Step 1—Subtract the wage index for the qualifying county from the wage index of each of the higher wage area(s) to which hospital workers commute.

Step 2—Divide the number of hospital employees residing in the qualifying county who are employed in such higher wage index area by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area. For each of the higher wage index areas, multiply this result by the result obtained in Step 1.

Step 3—Sum the products resulting from Step 2 (if the qualifying county has workers commuting to more than one higher wage index area).

Step 4—Multiply the result from Step 3 by the percentage of hospital employees who are residing in the qualifying county and who are employed in any higher wage index area.

These adjustments will be effective for each county for a period of 3 fiscal years. For example, hospitals that received the adjustment for the first time in FY 2010 will be eligible to retain the adjustment for FY 2011. For hospitals in newly qualified counties, adjustments to the wage index are effective for 3 years, beginning with discharges occurring on or after October 1, 2010.

Hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of the Act are not eligible for reclassification under sections 1886(d)(8) or (d)(10) of the Act unless they waive the out-migration adjustment. Consistent with our FYs 2005 through 2010 IPPS final rules, we are specifying that hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(d)(10) of the Act will be deemed to have chosen to retain their redesignation or reclassification. Section 1886(d)(10) hospitals that wish to receive the out-migration adjustment, rather than their reclassification adjustment, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this proposed rule. Otherwise, they will be deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8) of the Act will be deemed to have waived the out-migration adjustment unless they explicitly notify CMS within 45 days from the publication of this proposed rule that they elect to receive the out-migration adjustment instead. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attention: Wage Index Adjustment Waivers, Division of Acute Care, Room C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Table 4J in the Addendum to this proposed rule lists the proposed out-migration wage index adjustments for FY 2011. Hospitals that are not otherwise reclassified or redesignated under section 1886(d)(8) or section 1886(d)(10) of the Act will automatically receive the listed adjustment. In accordance with the procedures discussed above, redesignated/reclassified hospitals will be deemed to have waived the out-migration adjustment unless CMS is otherwise notified within the necessary timeframe. In addition, hospitals eligible to receive the out-migration wage index adjustment and that withdraw their application for reclassification will automatically receive the wage index adjustment listed in Table 4J in the Addendum to this proposed rule. The wage index is updated annually and, as such, hospitals wishing to waive their Lugar redesignation in order to receive their home area wage index plus the out-migration adjustment must request the waiver annually.

K. Process for Requests for Wage Index Data Corrections

The preliminary, unaudited Worksheet S–3 wage data and occupational mix survey data files for the proposed FY 2011 wage index were made available on October 5, 2009, through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

In the interest of meeting the data needs of the public, beginning with the proposed FY 2009 wage index, we post an additional public use file on our Web site that reflects the actual data that are used in computing the proposed wage index. The release of this new file does not alter the current wage index process or schedule. We notified the hospital community of the availability of these data as we do with the current public use wage data files through our Hospital Open Door forum. We encouraged hospitals to sign up for automatic notifications of information about hospital issues and the scheduling of the Hospital Open Door forums at: *http://www.cms.hhs.gov/OpenDoorForums/*.

In a memorandum dated October 21, 2009, we instructed all fiscal intermediaries/MACs to inform the IPPS hospitals they service of the availability of the wage index data files and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries/MACs to advise hospitals that these data were also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in the October 5, 2009 wage and occupational mix data files, the hospital was to submit corrections along with complete, detailed supporting documentation to its fiscal intermediary/MAC by December 7, 2009. Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage index data files on the Internet, through the October 21, 2009 memorandum referenced above.

In the October 21, 2009 memorandum, we also specified that a hospital requesting revisions to its occupational mix survey data was to copy its record(s) from the CY 2007–2008 occupational mix preliminary files posted to our Web site in October, highlight the revised cells on its spreadsheet, and submit its spreadsheet(s) and complete documentation to its fiscal intermediary/MAC no later than December 7, 2009.

The fiscal intermediaries/MACs notified the hospitals by mid-February 2010 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals' early-December revision requests. The fiscal intermediaries/MACs also submitted the revised data to CMS by mid-February 2010. CMS published the proposed wage index public use files that included hospitals' revised wage index data on February 22, 2010. Hospitals had until March 8, 2010, to submit requests to the fiscal intermediaries/MACs for reconsideration of adjustments made by the fiscal intermediaries/MACs as a result of the desk review, and to correct errors due to CMS's or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the wage index data. Hospitals also were required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries/MACs are to transmit any additional revisions resulting from the hospitals' reconsideration requests by April 14, 2010. The deadline for a hospital to request CMS intervention in cases where the hospital disagrees with the fiscal intermediary's (or, if applicable, the MAC's) policy interpretations is April 21, 2010.

Hospitals should examine Table 2 in the Addendum to this proposed rule. Table 2 in the Addendum to this proposed rule contains each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2007 data used to construct the proposed FY 2011 wage index. We note that the hospital average hourly wages shown in Table 2 only reflect changes made to a hospital's data and transmitted to CMS in March 2010.

We will release the final wage index data public use files by May 7, 2010 on the Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*. The May 2010 public use files are made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary/MAC in the entry of the final wage index data that resulted from the correction process described above (revisions submitted to CMS by the fiscal intermediaries/MACs by April 14, 2010). If, after reviewing the May 2010 final files, a hospital believes that its wage or occupational mix data are incorrect due to a fiscal intermediary/MAC or CMS error in the entry or tabulation of the final data, the hospital should send a letter to both its fiscal intermediary/MAC and CMS that outlines why the hospital believes an error exists and provide all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries (or, if applicable, the MACs) must receive these requests no later than June 7, 2010.

Each request also must be sent to the fiscal intermediary/MAC. The fiscal intermediary/MAC will review requests upon receipt and contact CMS immediately to discuss any findings.

At this point in the process, that is, after the release of the May 2010 wage index data files, changes to the wage and occupational mix data will only be made in those very limited situations involving an error by the fiscal intermediary/MAC or CMS that the hospital could not have known about before its review of the final wage index data files. Specifically, neither the fiscal intermediary/MAC nor CMS will approve the following types of requests:

- Requests for wage index data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries or the MACs on or before April 21, 2010.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 22, 2010 wage index public use files.
- Requests to revisit factual determinations or policy interpretations made by the fiscal intermediary or the MAC or CMS during the wage index data correction process.

Verified corrections to the wage index data received timely by CMS and the fiscal intermediaries or the MACs (that is, by June 7, 2010) will be incorporated into the final wage index in the FY 2011 IPPS/LTCH PPS final rule, which will be effective October 1, 2010.

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2011 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the fiscal intermediary's (or, if applicable, the MAC's) decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision. (See *W. A. Foote Memorial Hospital v. Shalala,* No. 99–CV–75202–DT (E.D. Mich. 2001) and *Palisades General Hospital* v. *Thompson,* No. 99–1230 (D.D.C. 2003).) We refer readers also to the FY 2000 IPPS final rule (64 FR 41513) for a discussion of the parameters for appealing to the PRRB for wage index data corrections.

Again, we believe the wage index data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage and occupational mix data to the fiscal intermediary's (or, if applicable, the MAC's) attention. Moreover, because hospitals have access to the final wage index data by early May 2010, they have the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or the MAC or CMS before the development and publication of the final FY 2011 wage index by August 2010, and the implementation of the FY 2011 wage index on October 1, 2010. If hospitals availed themselves of the opportunities afforded to provide and make corrections to the wage and occupational mix data, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that

errors are identified by hospitals and brought to our attention after June 7, 2010, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with 42 CFR 412.64(k)(1) of our existing regulations, we make midyear corrections to the wage index for an area only if a hospital can show that: (1) The fiscal intermediary or the MAC or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, "before the beginning of the fiscal year" means by the June 7 deadline for making corrections to the wage data for the following fiscal year's wage index. This provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index for the labor market area. As indicated earlier, because CMS makes the wage index data available to hospitals on the CMS Web site prior to publishing both the proposed and final IPPS rules, and the fiscal intermediaries or the MACs notify hospitals directly of any wage index data changes after completing their desk reviews, we do not expect that midyear corrections will be necessary. However, under our current policy, if the correction of a data error changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is made.

In the FY 2006 IPPS final rule (70 FR 47385), we revised 42 CFR 412.64(k)(2) to specify that, effective on October 1, 2005, that is, beginning with the FY 2006 wage index, a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when: (1) The fiscal intermediary (or, if applicable, the MAC) or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the fiscal intermediary (or, if applicable, the MAC) and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage index data, before the beginning of the fiscal year for the applicable IPPS update (that is, by the June 7, 2010 deadline for the FY 2011 wage index); and (3) CMS agreed that the fiscal intermediary (or, if applicable, the MAC) or CMS made an error in tabulating the hospital's wage index data and the wage index should be corrected.

In those circumstances where a hospital requested a correction to its wage index data before CMS calculates the final wage index (that is, by the June 7, 2010 deadline), and CMS acknowledges that the error in the hospital's wage index data was caused by CMS' or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the data, we believe that the hospital should not be penalized by our delay in publishing or implementing the correction. As with our current policy, we indicated that the provision is not available to a hospital seeking to revise another hospital's data. In addition, the provision cannot be used to correct prior years' wage index data; and it can only be used for the current Federal fiscal year. In other situations where our policies would allow midyear corrections, we continue to believe that it is appropriate to make prospective-only corrections to the wage index.

We note that, as with prospective changes to the wage index, the final retroactive correction will be made irrespective of whether the change increases or decreases a hospital's payment rate. In addition, we note that the policy of retroactive adjustment will still apply in those instances where a judicial decision reverses a CMS denial of a hospital's wage index data revision request.

L. Labor-Related Share for the Proposed FY 2011 Wage Index

Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related: "The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *" We refer to the portion of hospital costs attributable to wages and wage-related costs as the labor-related share. The labor-related share of the prospective payment rate is adjusted by an index of relative labor costs, which is referred to as the wage index.

Section 403 of Public Law 108–173 amended section 1886(d)(3)(E) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this "would result in lower payments to a hospital than would otherwise be made." However, this provision of Public Law 108–173 did not change the legal requirement that the Secretary estimate "from time to time" the proportion of hospitals' costs that are "attributable to wages and wage-related costs." We believe that this reflected Congressional intent that hospitals receive payment based on either a 62-percent labor-related share, or the labor-related share estimated from time to time by the Secretary, depending on which labor-related share resulted in a higher payment.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43850 through 43856), we rebased and revised the hospital market basket for operating costs. We established a FY 2006-based IPPS hospital market basket to replace the FY 2002-based IPPS hospital market basket, effective October 1, 2009. In that final rule, we presented our analysis and conclusions regarding the frequency and methodology for updating the labor-related share for FY 2010. We also recalculated a labor-related share of 68.8 percent, using the FY 2006-based IPPS market basket, for discharges occurring on or after October 1, 2009. In addition, we implemented this revised and rebased labor-related share in a budget neutral manner, but consistent with section 1886(d)(3)(E) of the Act, we did not take into account the additional payments that would be made as a result of hospitals with a wage index less than or equal to 1.0 being paid using a labor-related share lower than the labor-related share of hospitals with a wage index greater than 1.0.

The labor-related share is used to determine the proportion of the national IPPS base payment rate to which the area wage index is applied. In this proposed rule, we are not proposing to make any further changes to the national average proportion of operating costs that are attributable to wages and salaries, fringe benefits, contract labor, the labor-related portion of professional fees, administrative and business support services, and all other labor-related services (previously referred to in the FY 2002-based IPPS market basket as labor-intensive). Therefore, we are proposing to continue to use a labor-related share of 68.8 percent for discharges occurring on or after October 1, 2010. Tables 1A and 1B in the Addendum to this proposed rule reflects this proposed labor-related share. We note that section 403 of Public Law 108–173 amended sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this employment "would result in lower payments to a hospital than would otherwise be made." Therefore, for all IPPS hospitals whose wage indices are less than 1.0000, we are applying the wage index to a labor-related share of 62

percent of the national standardized amount. For all IPPS hospitals whose wage indices are greater than 1.0000, we are applying the wage index to a labor-related share of 68.8 percent of the national standardized amount.

For Puerto Rico hospitals, the national labor-related share will always be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0. We are proposing to continue to use a labor-related share for the Puerto Rico-specific standardized amounts of 62.1 percent for discharges occurring on or after October 1, 2010. This Puerto Rico labor-related share of 62.1 percent was also adopted in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43857) at the time the FY 2006-based hospital market basket was established, effective October 1, 2009. Consistent with our methodology for determining the national labor-related share, we added the Puerto Rico-specific relative weights for wages and salaries, fringe benefits, contract labor, the labor-related portion of professional fees, administrative and business support services, and all other labor-related services (previously referred to in the FY 2002-based IPPS market basket as labor-intensive) to determine the labor-related share. Puerto Rico hospitals are paid based on 75 percent of the national standardized amounts and 25 percent of the Puerto Rico-specific standardized amounts. The labor-related share of a hospital's Puerto Rico-specific rate will be either the Puerto Rico-specific labor-related share of 62.1 percent or 62 perecent, depending on which results in higher payments to the hospital. If the hospital has a Puerto Rico-specific wage index of greater than 1.0, we will set the hospital's rates using a labor-related share of 62.1 percent for the 25 percent portion of the hospital's payment determined by the Puerto Rico standardized amounts because this amount will result in higher payments. Conversely, a hospital with a Puerto Rico-specific wage index of less than 1.0 will be paid using the Puerto Rico-specific labor-related share of 62 percent of the Puerto Rico-specific rates because the lower labor-related share will result in higher payments. The proposed Puerto Rico labor-related share of 62.1 percent for FY 2011 is reflected in the Table 1C of the Addendum to this proposed rule.

V. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs

A. Reporting of Hospital Quality Data for Annual Hospital Payment Update

1. Background

a. Overview

CMS is seeking to promote higher quality and more efficient health care for Medicare beneficiaries. This effort is supported by the adoption of an increasing number of widely-agreed upon quality measures. CMS has worked with relevant stakeholders to define measures of quality in almost every setting and currently measures some aspect of care for almost all Medicare beneficiaries. These measures assess structural aspects of care, clinical processes, patient experiences with care, and, increasingly, outcomes.

CMS has implemented quality measure reporting programs for multiple settings of care. To measure the quality of hospital inpatient services, CMS implemented the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. In addition, CMS has implemented quality reporting programs for hospital outpatient services, the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), and for physicians and other eligible professionals, the Physician Quality Reporting Initiative (PQRI). CMS has also implemented quality reporting programs for home health agencies and skilled nursing facilities that are based on conditions of participation, and an end-stage renal disease quality reporting program that is based on conditions for coverage.

b. Hospital Quality Data Reporting Under Section 501(b) of Public Law 108–173

Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, added section 1886(b)(3)(B)(vii) to the Act. This section established the authority for the RHQDAPU program and revised the mechanism used to update the standardized payment amount for inpatient hospital operating costs. Specifically, section 1886(b)(3)(B)(vii)(I) of the Act, before it was amended by section 5001(a) of Public Law 109–171, provided for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for FY 2005 through FY 2007 for any subsection (d) hospital that did not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. It also provides that any reduction would apply only to the fiscal year involved, and would not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. The statute thereby established an incentive for IPPS hospitals to submit data on the quality measures established by the Secretary, and also built upon the previously established Voluntary Hospital Quality Data Reporting Program that we described in the FY 2009 IPPS final rule (73 FR 48598).

We implemented section 1886(b)(3)(B)(vii) of the Act in the FY 2005 IPPS final rule (69 FR 49078) and codified the applicable percentage change in § 412.64(d) of our regulations. We adopted additional requirements under the RHQDAPU program in the FY 2006 IPPS final rule (70 FR 47420).

c. Hospital Quality Data Reporting Under Section 5001(a) of Public Law 109–171

Section 5001(a) of the Deficit Reduction Act of 2005 (DRA), Public Law 109–171, further amended section 1886(b)(3)(B) of the Act to revise the mechanism used to update the standardized payment amount for hospital inpatient operating costs, in particular, by adding new section 1886(b)(3)(B)(viii) to the Act. Specifically, sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year be reduced by 2.0 percentage points for any subsection (d) hospital that does not submit quality data in a form and manner, and at a time, specified by the Secretary. Section 1886(b)(3)(B)(viii)(I) of the Act also provides that any reduction in a hospital's payment update will apply only with respect to the fiscal year involved, and will not be taken into account for computing the applicable percentage increase for a subsequent fiscal year. In the FY 2007 IPPS final rule (71 FR 48045), we amended our regulations at § 412.64(d)(2) to reflect the 2.0 percentage point reduction in the payment update for FY 2007 and subsequent fiscal years for subsection (d) hospitals that do not comply with requirements for reporting quality data, as provided for under section 1886(b)(3)(B)(viii) of the Act.

(1) Quality Measures

Section 1886(b)(3)(B)(viii)(III) of the Act requires that the Secretary expand the "starter set" of 10 quality measures that was established by the Secretary as of November 1, 2003, as the Secretary

determines to be appropriate for the measurement of the quality of care furnished by a hospital in inpatient settings. In expanding this set of measures, section 1886(b)(3)(B)(viii)(IV) of the Act requires that, effective for payments beginning with FY 2007, the Secretary begin to adopt the baseline set of performance measures as set forth in a report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of Public Law 108–173.[5]

Section 1886(b)(3)(B)(viii)(V) of the Act requires that, effective for payments beginning with FY 2008, the Secretary add other quality measures that reflect consensus among affected parties, and to the extent feasible and practicable, have been set forth by one or more national consensus building entities. The NQF is a voluntary consensus standard-setting organization with a diverse representation of consumer, purchaser, provider, academic, clinical, and other health care stakeholder organizations. The NQF was established to standardize health care quality measurement and reporting through its consensus development process. We have generally adopted NQF-endorsed measures. However, we believe that consensus among affected parties also can be reflected by other means, including consensus achieved during the measure development process, consensus shown through broad acceptance and use of measures, and consensus through public comment.

Section 1886(b)(3)(B)(viii)(VI) of the Act authorizes the Secretary to replace any quality measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance with a measure, or the measures or indicators have been subsequently shown to not represent the best clinical practice. Thus, the Secretary is granted broad discretion to replace measures that are no longer appropriate for the RHQDAPU program.

In the FY 2007 IPPS final rule, we began to expand the RHQDAPU program measures by adding 11 quality measures to the 10-measure starter set to establish an expanded set of 21 quality measures for the FY 2007 payment determination (71 FR 48033 through 48037, 48045).

In the CY 2007 OPPS/ASC final rule (71 FR 68201), we adopted six additional quality measures for the FY 2008 payment determination, for a total of 27 measures. Two of these measures (30-Day Risk Standardized Mortality Rates for Heart Failure and 30-Day Risk Standardized Mortality Rates for AMI) were calculated using existing administrative Medicare claims data; thus, no additional data submission by hospitals was required for these two measures. The measures used for the FY 2008 payment determination included, for the first time, the HCAHPS patient experience of care survey.

In the FY 2008 IPPS final rule (72 FR 47348 through 47358) and the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875 through 66877), we added three additional process measures to the RHQDAPU program measure set. (These three measures are SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose, SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal, and Pneumonia 30-day mortality (Medicare patients).) The addition of these 3 measures brought the total number of RHQDAPU program measures to be used for the FY 2009 payment determination to 30 (72 FR 66876). The 30 measures used for the FY 2009 annual payment determination are listed in the FY 2009 IPPS final rule (73 FR 48600 through 48601).

For the FY 2010 payment determination, we added 15 new measures to the RHQDAPU program measure set and retired one measure from the program (PN–1: Oxygenation Assessment). Of the new measures, 13 were adopted in the FY 2009 IPPS final rule (73 FR 48602 through 48611) and two additional measures were finalized in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68780 through 68781). This resulted in an expansion of the RHQDAPU program measures from 30 measures for the FY 2009 payment determination to 44 measures for the FY 2010 payment determination. The RHQDAPU program measures for the FY 2010 payment determination consist of: 26 chart-abstracted process measures, which measure quality of care provided for Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), and Surgical Care Improvement (SCIP); 6 claims-based measures, which evaluate 30-day mortality and 30-day readmission rates for AMI, HF, or PN; 9 claims-based AHRQ patient safety indicators and inpatient quality indicators; 1 claims-based nursing sensitive measure; 1 structural measure that assesses participation in a systematic database for cardiac surgery; and the HCAHPS patient experience of care survey. The measures are listed in the IPPS FY 2009 final rule at 73 FR 46809 and in the CY 2009 OPPS/ASC final rule with comment period at 73 FR 68781.

On December 31, 2008, CMS advised hospitals that they would no longer be required to submit data for the RHQDAPU program measure AMI–6–Beta blocker at arrival, beginning with discharges occurring on April 1, 2009. This change was based on the evolving evidence regarding AMI patient care, as well as changes in the American College of Cardiology/American Heart Association (ACC/AHA) practice guidelines for ST-segment elevation myocardial infarction and non-ST segment elevation myocardial infarction, upon which AMI-6 is based. CMS took action to remove the measure from reporting initiatives based on the lack of support by the measure developer and the clinical and scientific considerations described in the FY 2010 IPPS/RY 2010 LTCH PPS final rule at 74 FR 43863.

We had previously discussed considerations relating to retiring or replacing measures in the FY 2008 IPPS final rule with comment period and the FY 2009 IPPS final rule, including the "topping out" of hospitals' performance under a measure (72 FR 47358 through 47359 and 73 FR 48603 through 48604, respectively). However, in this instance, the measure no longer "represent[s] the best clinical practice," an additional basis under section 1886(b)(3)(B)(viii)(VI) of the Act for retiring a measure. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we formally retired the AMI–6 measure from the RHQDAPU program for the FY 2011 payment determination and subsequent payment determinations.

For the FY 2011 payment determination, we retained 41 of the FY 2010 quality measures; harmonized two FY 2010 RHQDAPU program quality measures (combining PSI 04—Death among surgical patients with treatable serious complications; and Nursing Sensitive-Failure to rescue into a single measure (Death among surgical inpatients with serious, treatable complications); added two chart-abstracted measures (SCIP-Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2 and SCIP-Infection-10: Perioperative Temperature Management); and added two structural measures (1) Participation in a Systematic Clinical Database Registry for Stroke Care; and (2) Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care) (74 FR 43868 through 43873). The 46 measures

[5] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005, available at: *http://www.iom.edu/CMS/3809/19805/31310.aspx*. IOM set forth these baseline measures in a November 2005 report. However, the IOM report was not released until December 1, 2005 on the IOM Web site.

we adopted for the FY 2011 payment determination are:

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Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination as Finalized in FY 2010 IPPS/RY 2010 LTCH PPS Final Rule
Acute Myocardial Infarction (AMI)	
	• AMI-1 Aspirin at arrival
	• AMI-2 Aspirin prescribed at discharge
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• AMI-4 Adult smoking cessation advice/counseling
	• AMI-5 Beta blocker prescribed at discharge
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
Heart Failure (HF)	
	• HF-1 Discharge instructions
	• HF-2 Left ventricular function assessment
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	• PN-2 Pneumococcal vaccination status
	• PN-3b Blood culture performed before first antibiotic received in hospital
	• PN-4 Adult smoking cessation advice/counseling
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival
	• PN-6 Appropriate initial antibiotic selection
	• PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal

Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination as Finalized in FY 2010 IPPS/RY 2010 LTCH PPS Final Rule
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2*
	• SCIP-Infection-10: Perioperative Temperature Management*
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS survey
Readmission Measure (Medicare Patients)	
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Mortality for selected surgical procedures (composite)
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care**	
	• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care*
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care*

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(2) Maintenance of Technical Specifications for Quality Measures

The technical specifications for the RHQDAPU program measures, or links to Web sites hosting technical specifications, are contained in the CMS/The Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures (Specifications Manual). This Specifications Manual is posted on the CMS QualityNet Web site at *https://www.QualityNet.org/.* We maintain the technical specifications by updating this Specifications Manual semiannually, or more frequently in unusual cases, and include detailed instructions and calculation algorithms for hospitals to use when collecting and submitting data on required measures. These semiannual updates are accompanied by notifications to users, providing sufficient time between the change and the effective date in order to allow users to incorporate changes and updates to the specifications into data collection systems.

(3) Public Display of Quality Measures

Section 1886(b)(3)(B)(viii)(VII) of the Act requires that the Secretary establish procedures for making quality data available to the public after ensuring that a hospital has the opportunity to review its data before they are made public. To meet this requirement, data from the RHQDAPU program are typically displayed on CMS Web sites such as the *Hospital Compare* Web site, *http://www.hospitalcompare.hhs.gov* after a 30-day preview period. An interactive Web tool, this Web site assists beneficiaries by providing information on hospital quality of care to those who need to select a hospital. It further serves to encourage beneficiaries to work with their doctors and hospitals to discuss the quality of care hospitals provide to patients, thereby providing an additional incentive to hospitals to improve the quality of care that they furnish. The RHQDAPU program currently includes process of care measures, risk adjusted outcome measures, the HCAHPS patient experience of care survey, and structural measures, all of which are featured on the *Hospital Compare* Web site. However, information that may not be salient to or understood by beneficiaries and information for which there are unresolved display issues or design considerations for inclusion on *Hospital Compare* may be made available on other CMS Web sites that are not intended to be used as an interactive Web tool, such as *http://www.cms.hhs.gov/HospitalQualityInits/.* Publicly reporting the information in this manner, though not on the *Hospital Compare* Web site, allows CMS to meet the requirement under section 1886(b)(3)(B)(viii)(VII) of the Act for establishing procedures to make quality data used for RHQDAPU payment determinations available to the public following a preview period. In such circumstances, affected parties are notified via CMS listservs, CMS e-mail blasts, national provider calls, and QualityNet announcements regarding the release of preview reports followed by the posting of data on a Web site other than *Hospital Compare.*

2. Retirement of RHQDAPU Program Measures

a. Considerations in Retiring Quality Measures From the RHQDAPU Program

Unless stated otherwise, we generally retain measures from the current year's RHQDAPU program measure set for subsequent years' measure set. We have previously retired one measure, PN–1: Oxygenation Assessment for Pneumonia, from the RHQDAPU program on the basis of high unvarying performance among hospitals, as measures with very high performance among hospitals present little opportunity for improvement, and do not provide meaningful distinctions in performance for consumers. We also have retired one measure from the program because it no longer "represent[ed] the best clinical practice," as stated under section 1886(b)(3)(B)(viii)(VI) of the Act. In this latter situation, we stated that when there is reason to believe that the continued collection of a measure as it is currently specified raises potential patient safety concerns that it is appropriate for CMS to take immediate action to remove a measure from the RHQDAPU program and not wait for the annual rulemaking cycle. Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we stated that we would promptly retire such measures followed by subsequent confirmation of the retirement in the next IPPS rulemaking. When we do so, we will notify hospitals and the public through the usual hospital and QIO communication channels used for the RHQDAPU program, which include memo and email notification and QualityNet Web site articles and postings.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we invited public comment regarding additional RHQDAPU program measures that should be considered for retirement along with criteria that should be used for retiring measures. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, commenters recommended 11 RHQDAPU program measures for retirement for various reasons (74 FR 43865). Among the criteria suggested by commenters that CMS should consider when determining whether to retire RHQDAPU program measures were: (1) Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made; (2) performance or improvement on a measure does not result in better patient outcomes; (3) a measure does not align with current clinical guidelines or practice; (4) the availability of a more broadly applicable (across settings, populations, or conditions) quality measure for the topic; (5) the availability of a measure that is more proximal in time to desired patient outcomes for the particular topic; (6) the availability of a measure that is more strongly associated with desired patient outcomes for the particular topic; (7) collection and/or public reporting of a measure leads to negative unintended consequences other than patient harm. We agreed with commenters that these criteria should be among those considered in evaluating current RHQDAPU program measures for retirement. We again invite commenters to submit suggestions for additional measure retirement criteria for CMS to consider.

b. Proposed Retirement of Quality Measures Under the RHQDAPU Program for the FY 2011 Payment Determination and Subsequent Years

In the FY 2009 IPPS final rule, for the FY 2010 payment determination we adopted nine measures that were developed by the Agency for Healthcare Research and Quality (AHRQ), and in the FY 2010 IPPS/RY 2010 LTCH PPS we subsequently retained these measures for the FY 2011 payment determination. One of these measures was the AHRQ Mortality for Selected Surgical Procedures Composite, which is comprised of measures from the AHRQ Inpatient Quality Indicator (IQI) measure set. In late June of 2009, following an NQF steering committee evaluation of the AHRQ Mortality for Selected Surgical Procedures composite, the AHRQ issued guidance [6] that this composite is "not recommended for comparative reporting" as specified due to significant evidence gaps, and that these significant evidence gaps are

[6] AHRQ. Guidance on Using the AHRQ QI for Hospital-Level Comparative Reporting. June 2009. *http://www.qualityindicators.ahrq.gov/downloads/publications/AHRQ%20QI%20Guide%20to%20Comparative%20Reporting%20v10.pdf.*

unlikely to be addressed with further development or validation work. This guidance is available at: *http://www.qualityindicators.ahrq.gov/downloads/publications/AHRQ%20QI%20Guide%20to%20Comparative%20Reporting%20v10.pdf*.

For this reason, we are proposing to retire the Mortality for Selected Procedures Composite from the RHQDAPU program measure set from the RHQDAPU program measure set for the FY 2011 payment determination and for subsequent payment determinations because the measure is not considered suitable for purposes of comparative reporting by the measure developer. We will neither calculate this measure for the FY 2011 payment determination, nor display results for this measure on *Hospital Compare.* We invite comment on our proposal to retire this measure from the RHQDAPU program for the FY 2011 payment determination and for subsequent payment determinations. We also invite commenters to submit suggestions and rationales for retirement of other RHQDAPU program measures.

Set out below are the RHQDAPU program quality measures for the FY 2011 payment determination reflecting our proposed retirement of one measure:

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Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination Reflecting Proposed Retirement of One Measure
Acute Myocardial Infarction (AMI)	
	• AMI-1 Aspirin at arrival
	• AMI-2 Aspirin prescribed at discharge
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• AMI-4 Adult smoking cessation advice/counseling
	• AMI-5 Beta blocker prescribed at discharge
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
Heart Failure (HF)	
	• HF-1 Discharge instructions
	• HF-2 Left ventricular function assessment
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	• PN-2 Pneumococcal vaccination status
	• PN-3b Blood culture performed before first antibiotic received in hospital
	• PN-4 Adult smoking cessation advice/counseling
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival
	• PN-6 Appropriate initial antibiotic selection
	• PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal

Topic	RHQDAPU Program Quality Measures for the FY 2011 Payment Determination Reflecting Proposed Retirement of One Measure
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2*
	• SCIP-Infection-10: Perioperative Temperature Management*
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS survey
Readmission Measure (Medicare Patients)	
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care**	
	• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care*
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care*

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3. Proposed Expansion Plan for Quality Measures for the FY 2012, FY 2013, and FY 2014 Payment Determinations

a. Considerations in Expanding and Updating Quality Measures Under the RHQDAPU Program

In the FY 2009 IPPS final rule (73 FR 48613) and the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43866 through 43869), we acknowledged the data collection burden for hospitals participating in the RHQDAPU program, and reiterated our desire to expand the RHQDAPU program measure set while minimizing burden and seeking to provide alternative mechanisms for data submission for the RHQDAPU program. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we also stated that in future expansions and updates to the RHQDAPU program measure set, we would be taking into consideration several important goals. These goals include: (a) Expanding the types of measures beyond process of care measures to include an increased number of outcome measures, efficiency measures, and patients' experience-of-care measures; (b) expanding the scope of hospital services to which the measures apply; (c) considering the burden on hospitals in collecting chart-abstracted data; (d) harmonizing the measures used in the RHQDAPU program with other CMS quality programs to align incentives and promote coordinated efforts to improve quality; (e) seeking to use measures based on alternative sources of data that do not require chart abstraction or that utilize data already being reported by many hospitals, such as data that hospitals report to clinical data registries, or all-payer claims data bases; and (f) weighing the relevance and utility of the measures compared to the burden on hospitals in submitting data under the RHQDAPU program. Specifically, we give priority to quality measures that assess performance on: (a) Conditions that result in the greatest mortality and morbidity in the Medicare population; (b) conditions that are high volume and high cost for the Medicare program; and (c) conditions for which wide cost and treatment variations have been reported, despite established clinical guidelines. We have used and continue to use these criteria to guide our decisions regarding what measures to add to the RHQDAPU program measure set.

RHQDAPU program measures were initially based solely on a hospital's submission of chart-abstracted quality measure data. However, in recent years we have adopted measures that do not require chart abstraction, including structural and claims-based quality measures which we can calculate using other data sources. This supports our goal of expanding the measures for the RHQDAPU program while minimizing the burden on hospitals and, in particular, without significantly increasing the chart abstraction burden.

In addition to structural and claims-based measures, we previously noted that registries [7] and electronic health records (EHRs) are potential alternative sources of hospital data for the RHQDAPU program. We observed that many hospitals already submit data to and participate in existing registries, and that registries often capture outcome information and provide ongoing quality improvement feedback to registry participants. We envisioned that instead of requiring hospitals to submit the same data to CMS that many hospitals are already submitting to registries, that we would collect the data directly from the registries. This could enable the expansion of the RHQDAPU program measure set without increasing the burden of data collection for those hospitals participating in the registries. We cited as examples of registries actively used by hospitals the Society of Thoracic Surgeons (STS) Cardiac Surgery Registry (with approximately 90 percent participation by cardiac surgery programs), the AHA Stroke Registry (with approximately 1200 hospitals participating), and the American Nursing Association (ANA) Nursing Sensitive Measures Registry (with approximately 1400 hospitals participating). In the FY 2009 IPPS final rule (73 FR 48608 through 48609), we adopted the first RHQDAPU program measure related to registries: Participation in a Systematic Database for Cardiac Surgery. Subsequently, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43870 through 43872), we adopted two additional structural measures of registry participation for the topics of Stroke and Nursing Sensitive Care. We continue to evaluate the feasibility of leveraging registry-based data collection mechanisms for the RHQDAPU program and we are proposing to collect such data for the FY 2013 payment determination.

We also stated our intention to explore mechanisms for data submission using EHRs (73 FR 48614; 74 FR 43866, 43892). Establishing such a system will require interoperability between EHRs and CMS data collection systems, additional infrastructure development on the part of hospitals and CMS, and the adoption of standards for the capturing, formatting, and transmission of data elements that make up the measures. However, once these activities are accomplished, the adoption of measures that rely on data obtained directly from EHRs will enable us to expand the RHQDAPU program measure set with less cost and burden to hospitals.

In the FY 2009 IPPS final rule, we adopted nine AHRQ measures for the RHQDAPU program, one of which is now proposed for retirement for the FY 2011 payment determination and subsequent payment determinations in this proposed rule. We stated that we would initially calculate the measures using Medicare claims data (73 FR 48608). However, we also stated that we remained interested in using all-payer claims data to calculate them and that we might propose to collect such data in the future. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24169), we invited input and suggestions on how all-payer claims data can be collected and used by CMS to calculate these measures, as well as on additional AHRQ measures that we should consider adopting for future RHQDAPU program payment determinations.

In summary, we will continue to pursue goals regarding the expansion and updating of quality measures under the RHQDAPU program while minimizing burden. We will take into account the public comments we receive on the possible uses of EHRs, registries, and all-payer claims data in the RHQDAPU program. We also will consider the measure selection criteria suggested by various commenters in prioritizing and selecting quality measures for the future." In particular, we are concerned about the lack of progress in reducing the rates of healthcare associated infections that was recently reported in the 2009 National Healthcare Quality Report (*http://www.ahrq.gov/qual/nhqr09/nhqr09.pdf*). For example, the report found that rates of postoperative sepsis increased by 8 percent. It is evident that more attention needs to be paid to ensure health care does not result in avoidable harm and that patients are informed about hospitals' performance. We are soliciting comment on the option to include among our prioritization criteria quality measures that assess performance on healthcare associated infections. Also, while the current and proposed measures cover many aspects of healthcare associated infections, we are soliciting public comment on additional measures that could be added to those hospitals would

[7] A registry is a collection of clinical data for purposes of assessing clinical performance, quality of care, and opportunities for quality improvement.

report and that CMS would make available to the public in order promote improvement in healthcare associated infection rates.

In the past, we have proposed to add new RHQDAPU program measures for one year's payment determination in a given rulemaking cycle. Although in prior years we have identified various measures for future consideration, we have not proposed or finalized measures for the RHQDAPU program beyond those to be collected for the purpose of the next sequential payment determination. In this FY 2011 rulemaking cycle, we are proposing an expansion to the RHQDAPU program that will take place over three payment years, and are proposing to add measures not only for the FY 2012 payment determination, but also for the FY 2013 and FY 2014 payment determinations. To the extent we finalize some or all of these proposed measures this year, we believe that we will be providing greater certainty for hospitals to plan to meet future reporting requirements and implement related quality improvement efforts. We will also have more time to prepare, organize and implement the necessary infrastructure necessary to collect data on the measures and make payment determinations.

Finally, in section V.A.5.(2) of this proposed rule, we discuss a proposal to make RHQDAPU payment determinations beginning with FY 2013 using, in part, a consecutive calendar year of quality measure data. This proposed approach, of synchronizing the quarters for which data on these measures must be submitted during each year with the quarters we will use to make payment determinations, would apply beginning with January 1, 2011 discharges although it would not affect our payment determinations until FY 2013. We invite public comment on the measures and timeframe for their addition to the RHQDAPU program measure set.

b. Proposed RHQDAPU Program Quality Measures for the FY 2012 Payment Determination

(1) Proposed Retention of 45 Existing RHQDAPU Program Quality Measures for the FY 2012 Payment Determination

As noted above, we are proposing to retire the AHRQ Mortality for Selected Surgical Procedures Composite for the FY 2011 payment determination. We are proposing that the remaining 45 of the 46 quality measures for the FY 2011 RHQDAPU program payment determination will be used for the FY 2012 RHQDAPU program payment determination. Details regarding data submission requirements are discussed in section V.A.5. of this proposed rule. We invite comment on the proposal to include all FY 2011 measures except for the AHRQ Mortality for Selected Surgical Procedures Composite in the FY 2012 RHQDAPU measure set.

In proposing to retain 45 of the 46 FY 2011 measures, we recognize that we are not significantly reducing the burden for hospitals, since the one measure that we are proposing to remove is a measure that currently is calculated based on Medicare claims. At the same time, we are proposing to expand the measures for the FY 2012 and subsequent years' payment determinations, which may add additional reporting burdens and new focus areas for hospital quality improvement efforts. In view of our concern about the burden of reporting for hospitals, especially when it comes to reporting chart-abstracted measures, another option that we have considered to accommodate the expansion of the measure set is the retirement of additional measures. Specifically, we have considered retiring one or more of those measures suggested by various commenters that were listed in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43865). We noted in that final rule that 11 RHQDAPU program chart-abstracted measures were recommended for retirement by commenters. Seven of these 11 measures were recommended for retirement based on their performance being uniformly high nationwide, with little variability among hospitals. Information on the performance rates for hospitals reporting is available at: *http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalNationalLevelPerformance.pdf*. These measures are:

- AMI–1 Aspirin at arrival
- AMI–3 ACEI/ARB for left ventricular systolic dysfunction
- AMI–4 Adult smoking cessation advice/counseling
- AMI–5 Beta-blocker prescribed at discharge
- HF–4 Adult smoking cessation advice/counseling
- PN–4 Adult smoking cessation advice/counseling
- SCIP-Infection-6: Surgery patients with appropriate hair removal

In addition to these "topped out" measures, commenters recommended we retire four additional measures listed below for reasons unrelated to high unvarying performance. These measures are:

- HF–1 Discharge instructions
- PN–3b Blood culture performed before first antibiotic received in hospital
- SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
- SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

Reasons given by commenters included the following: (1) Care process measured has weak or no relationship to better outcomes; (2) Collection burden of measure negates or outweighs the benefit of reporting the measure; and (3) Measure perceived to be discordant with current guidelines.

We invite comments on the option to retire one or more of these 11 measures that were suggested for retirement by commenters to the FY 2010 IPPS proposed rule. We note that some of these measures were proposed for electronic reporting under the program for payment incentives for meaningful use of electronic health records (75 FR 1896).

In addition, we are considering an option under which if we propose and finalize measures that are specified to more broadly address a clinical topic, and thus would require hospitals to submit the same data that they are already submitting on more narrowly specified measures that we previously adopted for the RHQDAPU program, we would propose to retire the more narrowly specified measures from the RHQDAPU measure set. An example of this that we are considering would be to retire the current Influenza and Pneumoccocal vaccination measures that apply only to the Pneumonia admission inpatient population (PN–2 Pneumococcal vaccination status; and PN–7 Influenza vaccination status) if we proposed and finalized measures of Influenza and Pneumoccocal vaccination that apply to all inpatients. We invite comments on this option to retire narrowly specified measures in order to accommodate more broadly specified measures on a given topic.

(2) Proposed New Claims-Based Measures

We are proposing to add 10 claims-based measures to the RHQDAPU program measure set for the FY 2012 payment determination: 2 AHRQ Patient Safety Indicators and 8 Hospital Acquired Condition measures. These proposed measures would be calculated using up to three years' of Medicare claims for discharges prior to January 1, 2011. These measures are discussed below.

(A) Proposed AHRQ Patient Safety Indicators

In the FY 2009 IPPS final rule we adopted a number of AHRQ Patient Safety Indicators and Inpatient Quality Indicators for the RHQDAPU program to be calculated using Medicare claims. The addition of these measures to the RHQDAPU program allowed us to expand the RHQDAPU program measure set to include measures of patient safety, in-hospital mortality, adverse events and complications without increasing the data submission burden on hospitals. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we retained these measures for the FY 2011 payment determination. In this proposed rule, we are proposing to retire one of those measures (Mortality for Selected Surgical Procedures Composite) from the RHQDAPU program measure set for the FY 2011 payment determination. For the FY 2012 payment determination, we are proposing to adopt 2 additional Patient Safety Indicators developed by the AHRQ. These are: PSI–11: Post-Operative Respiratory Failure and PSI–12: Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT). Both measures address post-operative complications, a topic that is currently not well represented in the RHQDAPU program measure set. Both measures are NQF-endorsed, and have a Tier 1 evidence rating by AHRQ, the measure developer. Indicators given this level of evidentiary rating by AHRQ have the strongest evidence base, with established evidence in several or most evidentiary areas established by AHRQ, no substantial evidence suggesting that the indicators may not be useful for comparative reporting purposes, and in most cases the indicators have been NQF-endorsed.[8] The specific measures that we are proposing to add are NQF-endorsed, thus reflecting consensus among affected parties, and are deemed appropriate for comparative public reporting by the measure developer. Like the current AHRQ measures in the RHQDAPU program, these indicators are risk-adjusted outcome measures that can be calculated based on existing Medicare claims, placing no additional reporting burden on hospitals while allowing us to expand outcomes measurement in the RHQDAPU program. The specifications for these measures can be found at *http://www.qualityindicators.ahrq.gov/TechnicalSpecs41.htm#PSI41*. We invite comment on our proposal to adopt these two AHRQ Patient Safety Indicators for the FY 2012 payment determination.

(B) Proposed Hospital Acquired Condition (HAC) Measures

Section 1886(d)(4)(D) of the Act required the Secretary to select, in consultation with the Centers for Disease Control and Prevention (CDC), at least two conditions that: (a) Are high cost, high volume, or both; (b) are assigned to a higher paying MS–DRG when present as a secondary diagnosis (that is, conditions under the MS–DRG system that are CCs or MCCs); and (c) could reasonably have been prevented through the application of evidence based guidelines. We currently have 10 categories of Hospital Acquired Conditions (HACs). We refer readers to: section II.F. of the FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218); section II.F. of the FY 2009 IPPS final rule with comment period (73 FR 48474 through 48486); and section II.F. of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43782 through 43785) for detailed discussions regarding the selection of the current 10 HAC categories. We refer readers to section II.F. of this proposed rule for additional discussion and our proposals for HAC policy for FY 2011.

We have worked collaboratively with public health and infectious disease professionals from across HHS, including CDC, AHRQ, and the Office of Public Health and Science, to identify and select preventable HACs with input and comment from affected parties. CMS and CDC have also collaborated on the process for hospitals to submit a present on admission (POA) indicator for each diagnosis listed on IPPS hospital Medicare claims and on the payment implications for POA reporting (74 FR 43783).

CMS, CDC and AHRQ held jointly sponsored HAC and POA Listening Sessions (December 17, 2007 and December 18, 2008) to receive input from affected parties, individuals, and organizations regarding the selection and definition of HACs. The adoption of HACs were informed and continue to be informed by feedback received during the listening sessions, as well as through public comment received during the IPPS rulemaking process. In addition to receiving comments regarding the selection of conditions and POA indicator reporting, in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43785), commenters suggested that CMS consider making aggregate POA information publicly available, and providing comparative information as a means of facilitating improvements in preventing the incidence of HACs.

We are proposing to adopt as RHQDAPU measures for the FY 2012 payment determination eight (of 10) current HACs defined in section II.F. of this proposed rule, six of which have been identified by NQF as serious reportable events, and to publicly report these measures as we do other RHQDAPU program measures. These measures are:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing, Injury, Burn, Electric Shock)
- Vascular Catheter-Associated Infection
- Catheter-Associated Urinary Tract Infection (UTI)
- Manifestations of Poor Glycemic Control

We do not believe that it is necessary to propose to adopt the other two current HAC categories as RHQDAPU measures because the topics that they deal with would substantially overlap with other RHQDAPU program measures discussed below that we are proposing to adopt for future payment determinations as chart-abstracted measures (which allows us to collect data on all patients). By contrast, the eight proposed HAC measures are claims-based measures for which we can only (at this time) collect data only on Medicare beneficiaries.

We are proposing to utilize Medicare claims data to calculate measure rates for these eight HACs using the ICD–9–CM codes in conjunction with POA coding of "N" or "U," as defined in IPPS rulemaking. We refer readers to section II.F.6. of the FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218), section II.F.7. of the FY 2009 IPPS final rule (73 FR 48474 through 48486), section II.F.6. (74 FR 43782 through 43785) of the FY 2010 IPPS/RY 2010 LTCH PPS final rule, and section II.F. of this proposed rule for detailed discussions regarding the use of the POA indicator in conjunction with ICD–9–CM coding to determine the presence of HACs. We also refer readers to the current ICD–9–CM codes and proposed updates for these eight HAC categories in this proposed rule. We are proposing to use the ICD–9–CM codes in conjunction with the "N" and "U" POA indicators for the HAC categories that will be finalized in the FY 2011 IPPS/RY 2011 LTCH PPS final rule to

[8] *http://www.qualityindicators.ahrq.gov/downloads/publications/AHRQ%20QI%20Guide%20to%20Comparative%20Reporting%20v10.pdf.*

calculate the eight HAC measures for the RHQDAPU program.

We believe that these HAC measures reflect consensus among affected parties as required for RHQDAPU program measures by section 1886(b)(3)(B)(viii)(V) of the Act. In addition to meeting the consensus requirement through rulemaking and public comment, Vascular Catheter-Associated Infection and Catheter-Associated UTI are the subject of a quality measure which gained NQF endorsement in August 2009. The remaining six HAC categories have been identified as serious reportable events through the NQF consensus process and have also been selected as HACs through rulemaking and public comment. Data reporting requirements for these measures are provided in section V.A.5. of this proposed rule. We invite comment on our proposal to adopt these eight HAC measures for the FY 2012 payment determination.

(3) Proposed All-Patient Volume Data for Selected MS–DRGs

CMS currently displays volume data for 70 MS–DRGs, 55 of which relate to RHQDAPU program measures on the *Hospital Compare* Web site. However, the volume data currently shown on *Hospital Compare* is based on Medicare claims only. Although we do not consider volume alone to be a quality measure unless volume has been determined to be an indicator of quality, we believe that to the extent all-patient volume data are related to the measures, as they provide context for the quality measures in the inpatient hospital setting, and may assist *Hospital Compare* users in understanding the measure calculations. In general, in implementing RHQDAPU program measures, we have sought where currently possible to measure the care rendered to all patients within a hospital, and not just Medicare patients. For this reason, the chart-abstracted process of care measures we collect and display on *Hospital Compare* are based on the entire inpatient population for the hospital.

We are proposing that hospitals begin submitting as data on measures selected for the RHQDAPU program the all-patient data elements discussed in section V.A.5. of this proposed rule for 55 MS–DRGs displayed on *Hospital Compare* that relate to adopted RHQDAPU program measures. The specific MS–DRGs are listed below. As stated above, we believe that the addition of this data will enable us and Medicare beneficiaries to better understand and evaluate the quality of care provided by hospitals with respect to both the chart-abstracted and claims-based measures. We intend to publicly display this volume data along with the corresponding measure results on *Hospital Compare.* Hospitals would begin reporting these data once annually beginning with January 1, 2011 discharges by submitting the all-patient data elements needed to calculate MS–DRG volume to QualityNet so we can determine the volume of cases treated by a hospital for the 55 MS–DRGs currently displayed on *Hospital Compare.* Rather than require hospitals to group their all-patient claims data by MS–DRG category themselves, CMS would use the data to be submitted by hospitals to group the data.We invite comments on this proposal.

We also invite comment on an alternative that hospitals submit all-patient volume data based upon specific ICD–9–CM codes related to the proposed MS–DRGs rather than all data necessary to calculate the MS–DRGs.

The proposed RHQDAPU measure set for the FY 2012 payment determination is listed below:

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Topic	Proposed RHQDAPU Program Quality Measures for the FY 2012 Payment Determination
Acute Myocardial Infarction (AMI)	
	• AMI-1 Aspirin at arrival
	• AMI-2 Aspirin prescribed at discharge
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• AMI-4 Adult smoking cessation advice/counseling
	• AMI-5 Beta blocker prescribed at discharge
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
Heart Failure (HF)	
	• HF-1 Discharge instructions
	• HF-2 Left ventricular function assessment
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	• PN-2 Pneumococcal vaccination status
	• PN-3b Blood culture performed before first antibiotic received in hospital
	• PN-4 Adult smoking cessation advice/counseling
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival
	• PN-6 Appropriate initial antibiotic selection
	• PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2012 Payment Determination
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
	• SCIP-Infection-10: Perioperative Temperature Management
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS survey
Readmission Measure (Medicare Patients)	
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult
	• PSI 11: Post Operative Respiratory Failure *
	• PSI 12: Post Operative PE or DVT *
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care	
	• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2012 Payment Determination
Hospital Acquired Condition Measures *	
	• Foreign Object Retained After Surgery *
	• Air Embolism *
	• Blood Incompatibility *
	• Pressure Ulcer Stages III & IV *
	• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock)*
	• Vascular Catheter-Associated Infection*
	• Catheter-Associated Urinary Tract Infection (UTI)*
	• Manifestations of Poor Glycemic Control*
All-Patient Volume Data for Selected MS-DRGs *	
	MS-DRGs: 038; 039; 190; 191; 193; 219; 220; 221; 224; 226; 235; 236; 237; 243; 247; 280; 281; 282; 291; 292; 293; 328; 329; 330; 331; 353; 354; 417; 418; 459; 461; 462; 466; 467; 468; 469; 470; 471; 472; 477; 478; 490; 507; 515; 656; 657; 658; 659; 668; 673; 674; 675; 713; 743; 748 *

* Proposed for FY 2012 payment determination

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We invite comment on these proposed measures for the FY 2012 payment determination.

c. Proposed RHQDAPU Program Quality Measures for the FY 2013 Payment Determination

(1) Proposed Retention of FY 2012 Payment Determination Measures for the FY 2013 Payment Determination

We generally propose to retain RHQDAPU program measures from one year to the next. Consistent with this approach, we are proposing to retain all of the proposed measures for the FY 2012 RHQDAPU payment determination, if finalized, for the FY 2013 payment determination. We invite public comment on this proposal.

(2) Proposed New Chart-Abstracted Measure for the FY 2013 Payment Determination

We are proposing to add one new chart-abstracted measure for the FY 2013 payment determination—AMI-statin at discharge. This measure is similar to the NQF-endorsed stroke measure "Ischemic stroke patients with LDL >/= 100 mg/dL, or LDL not measured, or, who were on cholesterol reducing therapy prior to hospitalization are discharged on a statin medication" (NQF #0439), only specified for the AMI population. Current scientific evidence supports the continuation of statins more strongly for AMI patients than for stroke patients. Several randomized clinical trials have proven the benefits of statin drugs (also known as HMG Co-A reductase inhibitors) in reducing the risk of death and recurrent cardiovascular events in a broad range of patients with established cardiovascular disease, including those with prior myocardial infarction. Current ACC/AHA guidelines place a strong emphasis on the initiation or maintenance of statin drugs for patients hospitalized with AMI, particularly those with LDL-cholesterol levels at or above 100 mg/dL. As a result of the strength of the evidence and guideline support, the ACC/AHA has developed a performance measure to assess this aspect of care for AMI patients.

Because statins are generally well-tolerated, most AMI patients are appropriate candidates for this therapy. As a result of this clinical evidence, the NQF has been asked to review whether it should broaden the current endorsed measure specification to include the AMI population. This ad hoc review is occurring now and is expected to be completed prior to publication of the FY 2011 IPPS/LTCH PPS final rule. Information on this project can be found at: *http://www.qualityforum.org/Projects/a-b/Ad_Hoc_Reviews/Statin_Medication/Ad_Hoc_Review__Discharged_on_Statin.aspx.* We will decide whether to finalize this measure based on whether it achieves NQF endorsement and public comments. We believe that minimal additional burden would result from adoption of this measure into the RHQDAPU program because the AMI population that is the focus of this measure is already part of data collection efforts for RHQDAPU, and very few additional data elements would be needed to be abstracted for the proposed new measure on this existing measurement population. We proposed that hospitals would begin submission of data for the AMI-statin at discharge measure beginning with January 1, 2011 dischares for the RHQDAPU 2013 payment determination.

(3) Proposed New Healthcare Associated Infection (HAI) Measures for the FY 2013 Payment Determination

In the FY 2009 and FY 2010 IPPS rulemakings, we listed several Healthcare Associated Infection (HAI) measures as being under consideration for future adoption. Commenters to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule supported the HAI measures that were listed as being under consideration for the future and encouraged CMS to consider others as well (74 FR 43876). For the measure set to be used for the FY 2013 payment determination, we are proposing to adopt two new measures of Healthcare Acquired Infections that are currently being collected by the CDC via the National Healthcare Safety Network (NHSN). These measures are: (1) Central Line Associated Blood Stream Infection (NQF #0139) and (2) Surgical Site Infection (NQF #0299).

The NHSN is a secure, Internet-based surveillance system maintained and managed by the CDC, and can be

utilized by all types of healthcare facilities in the United States, including acute care hospitals, long term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long term care facilities. The NHSN enables healthcare facilities to collect and use data about HAIs, adherence to clinical practices known to prevent HAIs, the incidence or prevalence of multidrug-resistant organisms within their organizations, and other adverse events. Some States use NHSN as a means for healthcare facilities to submit data on HAIs mandated through their specific State legislation. Currently, 21 States require hospitals to report HAIs using NHSN, and CDC supports more than 2000 hospitals that are using NHSN.[9]

Both the Central Line Associated Blood Stream Infection measure and the Surgical Site Infection measure are NQF-endorsed, and therefore meet the statutory requirement for measure selection of reflecting consensus among affected parties. The measures address HAIs, a topic area widely acknowledged by the HHS, IOM, the National Priorities Partnership and others as a high priority requiring measurement and improvement. HAIs are among the leading causes of death in the United States. CDC estimates that as many as 2 million infections are acquired each year in hospitals and result in approximately 90,000 deaths per year.[10] It is estimated that more Americans die each year from HAIs than from auto accidents and homicides combined. HAIs not only put the patient at risk, but also increase the days of hospitalization required for patients and add considerable health care costs.

HAIs are largely preventable through interventions such as better hygiene and advanced scientifically tested techniques for surgical patients. Therefore, many health care consumers and organizations are calling for public disclosure of HAIs, arguing that public reporting of HAI rates provides the information health care consumers need to choose the safest hospitals, and gives hospitals an incentive to improve infection control efforts. Both of the measures we are proposing to add for the FY 2013 payment determination are NQF-endorsed, and are currently collected using the NHSN as part of State-mandated reporting and surveillance requirements for hospitals. NHSN data collection occurs via a Web-based tool hosted by CDC provided free of charge to hospitals. Additionally, data submission for these measures through EHRs may be possible in the near future.

(A) Central Line Associated Blood Stream Infection

This HAI measure assesses the rate of laboratory-confirmed cases of bloodstream infection or clinical sepsis among ICU patients. It was endorsed by the NQF in 2004 and was adopted by the HQA in 2007. The measure can be stratified by the type of ICU.

(B) Surgical Site Infection

This HAI measure assesses the number of NHSN-defined operative procedures with a surgical site infection (deep incisional or organ space) within 30 days, or 1 year if an implant is in place. Infections are identified on original admission or upon readmission to the facility of original operative procedure within the relevant time frame (30 days for no implants; within 1 year for implants). The measure can be stratified by procedure type or risk factors. This measure was NQF-endorsed in 2007 and was adopted by the HQA in 2008.

We invite comment on our proposal to adopt these two HAI measures into the RHQDAPU program for the FY 2013 payment determination. Collection of these measures would begin with January 1, 2011 discharges for the FY 2013 payment determination. We are proposing that hospitals use the NHSN infrastructure to report the measures for RHQDAPU program purposes. The proposed reporting mechanism for these HAI measures is discussed in greater detail in section V.A.5. of this proposed rule.

(4) Proposed New Registry-Based Measures

For the FY 2013 payment determination, we are proposing that hospitals choose one of the following four proposed measure topics: (1) Implantable Cardioverter Defibrillator (ICD) Complications; (2) Cardiac Surgery; (3) Stroke; or (4) Nursing-Sensitive Care. With respect to the proposed measure topic selected by a hospital, we are proposing that the hospital report data on the proposed measure(s) applicable to the measure topic (discussed below) to a qualified registry for the specific topic, and direct the registry to both calculate the measure results for the hospital and release those results (along with the numerator/denominator information and exclusion information) to CMS for the RHQDAPU program. We are proposing that hospitals begin submitting data to the qualified registry of its choosing for discharges on or after January 1, 2011, and we intend to release a list of qualified registries before that date. In section V.A.13. of this proposed rule, we specify the self-nomination process we are proposing to use to qualify registries for each proposed registry-based measure topic. Proposed procedural and submission requirements for the proposed registry-based measures are discussed in section V.A.5. of this proposed rule. Below is a discussion of the proposed registry-based measure topics and specific registry-based measures that fall within each topic that we are proposing to add to the RHQDAPU program for the FY 2013 payment determination.

(A) Proposed Implantable Cardioverter Defibrillator (ICD) Complications Registry-Based Topic and Measure

Implantable Cardioverter Defibrillators (ICDs) reduce the risk of sudden cardiac death for select high risk patients, and the number of patients undergoing ICD implantation increased from 5,600 in 1990 to 108,680 by 2005.[11] ICD implantation is an expensive procedure performed on patients with advanced cardiovascular disease and, often, significant comorbidities. Despite improvements in technology and increasing experience with device implantation, the procedure carries a significant risk of complications,[12] which in turn increases its cost, the patient's length of stay, and the patient's risk of mortality.[13] In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43873 through 43875), our list of potential future quality measures under consideration included a measure of ICD complications. This measure is a risk-adjusted complication and mortality rate following implantation of ICDs in Medicare Fee for Service (FFS) patients at least 65 years of age, with complication specific outcome time frames. The measure (NQF #OT1–007–09) is currently undergoing NQF review

[9] *http://www.cdc.gov/nhsn/.*

[10] McKibben L, Horan T Guidance on public reporting of healthcare-associated infections: recommendations of the Healthcare Infection Control Practices Advisory Committee. AJIC 2005;33:217–26.

[11] Brown, D.W., Croft, J.B., et al. (2008). "Trends in Hospitalizations for the Implantation of Cardioverter-Defibrillators in the United States, 1990–2005." *American Journal of Cardiology* 101 (12): 1753–1755.

[12] Hammill S and Curtis J. Publicly Reporting Implantable Cardioverter Defibrillator Outcomes—Grading the Report Card. Circ Arrhythmia Electrophysiol. 2008;1:235–237).

[13] Al-Khatib SM, Greiner MA, Peterson ED, Hernandez AF, Schulman KA, Curtis LH. Patient and Implanting Physician Factors Associated With Mortality and Complications After Implantable Cardioverter-Defibrillator Implantation, 2002–2005. Circ Arrhythmia Electrophysiol. 2008;1:240–249.

under Phase 1 of a call for Patient Outcome Measures initiated in Fall of 2009. We are proposing to add the ICD complications topic and measure to the RHQDAPU measure set for collection beginning with January 1, 2011 discharges for the FY 2013 RHQDAPU payment determination pending NQF endorsement. We anticipate that a final endorsement decision will occur in the fall of 2010, after publication of the FY 2011 IPPS/LTCH PPS final rule. Therefore, the decision whether to finalize this measure for the FY 2013 payment determination will be made in the CY 2011OPPS/ASC final rule with comment period.

The proposed ICD complications measure was developed based upon data submitted to the American College of Cardiology-National Cardiovascular Data Registry's (ACC–NCDR) ICD registry, and data from that registry has been linked with CMS administrative claims data used to identify procedural complications. For this proposed measure, the measured outcome for each ICD index admission is one or more complications or mortality within 30 or 90 days (depending on the complication) following ICD implantation. Complications are counted in the measure only if they occur during a hospital admission. Complications measured for 30 days include: (1) Pneumothorax or hemothorax plus a chest tube; (2) Hematoma plus a blood transfusion or evacuation; (3) Cardiac tamponade or pericardiocentesis; and (4) Death. Complications measured for 90 days include: (5) Mechanical complications requiring a system revision; (6) Device related infection; and (7) Additional ICD implantation.

To comply with a January 2005 National Coverage Determination for ICDs for primary prevention, all hospitals in which ICD procedures are performed are currently submitting to the ACC–NCDR ICD registry patient information needed for us to determine whether the procedure was reasonable and necessary. This requirement is documented in section 20.4 of the following Medicare National Coverage Determination Manual: *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf*. For purposes of the 2005 National Coverage Determination, we require that hospitals submit data to the ACC–NCDR ICD registry for primary prevention patients only but do not require hospitals to submit data on patients undergoing ICD implantation for secondary prevention. However, the ICD complication measure as submitted to the NQF for endorsement is specified such that it includes all ICD patients, regardless of whether they receive an ICD for the primary or secondary prevention of sudden cardiac death.

Therefore, hospitals that choose this registry-based measure topic for the RHQDAPU program would submit data on the ICD complications measure for both primary and secondary prevention patients to the qualified registry. For risk adjustment, data matching, and secondary prevention population identification purposes, we are proposing that hospitals also submit to the qualified ICD complications registry an additional 11 data elements not currently required under the NCD in order for the measure to be calculated for RHQDAPU program purposes.

In sum, we are proposing to add the ICD complications measure topic as one of four proposed measure topics that hospitals can choose from to submit required data elements to a qualified registry for the FY 2013 RHQDAPU payment determination. The only measure that we are proposing to include in this proposed topic at this time would be the ICD complications measure. Because the ICD complications measure is a risk-adjusted outcome measure, it is necessary that all data for the measure be collected by a single qualified registry in order for that registry to be able to accurately calculate the risk adjustment model and subsequent measure results. Therefore, we are proposing to qualify one registry for this topic. Proposed registry qualification criteria are discussed in section V.A.13. of this proposed rule. We note that the ACC–NCDR ICD registry has already been qualified to receive and transmit data to CMS for a Medicare National Coverage Determination, and is currently the only registry to which hospitals submit data for this NCD. However, this would not preclude another registry from self-nominating to become a qualified registry for this proposed topic for the RHQDAPU program. Because the ICD complication measure is a risk adjusted measure, it requires that all data be collected at a single repository for calculation of the measure. Therefore, we anticipate qualifying a single registry to collect all of the data for the proposed ICD complications registry-based topic.

(B) Proposed Stroke Registry-Based Topic and Measures

We proposed to add five stroke measures to the RHQDAPU measure set in the FY 2009 IPPS proposed rule (73 FR 23648). We indicated that we would again consider these measures once NQF reviewed and endorsed the measures. Since that time, eight stroke measures received NQF endorsement in July of 2008, and in the FY 2010 IPPS/RY 2010 LTCH PPS final rule we included these measures in the list of potential future measures. We also included these measures in the preview section of the Specifications Manual, and have worked with the Office of the National Coordinator for Health Information Technology (ONC) and its partners to create a set of electronic specifications for these measures to facilitate collection through EHRs.

We are also aware that a number of hospitals are already submitting these measures to registries, and in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we finalized a structural measure of participation in a systematic clinical database registry for stroke care. Stroke is a topic of great relevance to the Medicare population due to its impact on morbidity and mortality, and is an area of great potential improvement for hospitals. Commenters on the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule expressed support for these measures, indicating that they accurately measure evidence-based care of the stroke patient to minimize secondary strokes and other complications, are widely recognized, and have great potential for quality improvement (74 FR 43875).

Therefore, we are proposing to include the following eight measures in the Stroke registry-based topic:

PROPOSED MEASURES FOR STROKE REGISTRY-BASED TOPIC

STK–1: Venous Thromboembolism (VTE) Prophylaxis for patients with ischemic or hemorrhagic stroke (NQF #0434).	Patients with an ischemic stroke or a hemorrhagic stroke and who are non-ambulatory should start receiving DVT prophylaxis by end of hospital day two.
STK–2: Ischemic stroke patients discharged on antithrombotic therapy. (NQF #0435).	Patients with an ischemic stroke prescribed antithrombotic therapy at discharge.
STK–3: Anticoagulation therapy for atrial fibrillation/flutter. (NQF #0436).	Patients with an ischemic stroke with atrial fibrillation discharged on anticoagulation therapy.

PROPOSED MEASURES FOR STROKE REGISTRY-BASED TOPIC—Continued

STK–4: Thrombolytic Therapy for Acute ischemic stroke patients. (NQF #0437).	Acute ischemic stroke patients who arrive at the hospital within 120 minutes (2 hours) of time last known well and for whom IV t-PA was initiated at this hospital within 180 minutes (3 hours) of time last known well.
STK–5: Antithrombotic therapy by the end of hospital day two. (NQF #0438).	Patients with ischemic stroke who receive antithrombotic therapy by the end of hospital day two.
STK–6: Discharged on statin medication. (NQF #0439).	Ischemic stroke patients with LDL >/= 100 mg/dL, or LDL not measured, or, who were on cholesterol reducing therapy prior to hospitalization are discharged on a statin medication.
STK–8: Stroke education. (NQF #0440)	Patients with ischemic or hemorrhagic stroke or their caregivers who were given education or educational materials during the hospital stay addressing all of the following: personal risk factors for stroke, warning signs for stroke, activation of emergency.
STK–10: Assessed for rehabilitation services. (NQF #0441).	Patients with an ischemic stroke or hemorrhagic stroke who were assessed for rehabilitation services.

We are proposing to add the stroke registry-based topic, which would include these eight registry-based stroke measures, to the RHQDAPU program measure set as one of the four proposed measure topics that hospitals can choose from to submit data to a qualified registry for the FY 2013 payment determination beginning with January 1, 2011 discharges. We invite comment on the measures as well as the timing of their addition to the RHQDAPU measure set.

(C) Proposed Nursing Sensitive Care Registry-Based Topic and Measures

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we indicated that we were considering adopting a number of nursing-sensitive care measures for future RHQDAPU program payment determinations. Also in that rule, we adopted a structural measure of participation in a registry for nursing-sensitive care, under which hospitals submit data directly to the QIO Clinical Warehouse.

For the FY 2013 payment determination, we are proposing to add a nursing sensitive care registry-based topic to the RHQDAPU measure set, which would include the eight nursing-sensitive care measures listed below. All of the proposed nursing sensitive measures are NQF-endorsed. Hospitals selecting this topic would begin reporting data on the eight proposed nursing-sensitive care registry-based measures to a qualified nursing-sensitive care registry beginning with January 1, 2011 discharges. Hospitals would continue reporting the nursing-sensitive care structural measure previously adopted for the RHQDAPU program directly to the QIO Clinical Warehouse.

We invite comment on the proposed addition of a nursing sensitive care registry-based topic, which would include 8 proposed nursing sensitive care measures, as well as the timing of this addition to the RHQDAPU program for the FY 2013 payment determination.

PROPOSED MEASURES FOR NURSING SENSITIVE CARE REGISTRY-BASED TOPIC

Patient Falls: All documented falls with or without injury, experienced by patients on an eligible unit in a calendar month. (NQF #0141).
Falls with Injury: All documented patient falls with an injury level of minor or greater. (NQF #0202).
Pressure Ulcer Prevalence (NQF #0201).
Restraint Prevalence (vest and limb) (NQF #0203).
Skill Mix: Percentage of hours worked by: RN, LPN/LVN, UAP, Contract/Agency (NQF #0204).
Hours per patient day worked by RN, LPN, and UAP (NQF #0205).
Practice Environment Scale-Nursing Work Index (NQF #0206).
Voluntary turnover for RN, APN, LPN, UAP (NQF #0207).

(D) Proposed Cardiac Surgery Registry-Based Topic and Measures

We have previously proposed to add several measures on the topic of cardiac surgery to the RHQDAPU measure set (73 FR 48608), and have also listed a set of NQF-endorsed cardiac surgery measures in prior rules as being under consideration for future adoption (74 FR 43874). We also adopted a structural measure of cardiac surgery participation in the FY 2010 IPPS/RY 2010 LTCH PPS final rule. Cardiac surgery procedures carry a significant risk of morbidity and mortality. We believe that the nationwide public reporting of the 15 proposed cardiac surgery registry-based measures would provide highly meaningful information for Medicare beneficiaries because they address procedures widely performed on Medicare beneficiaries. Analysis of the structural measure data we have received from hospitals indicates that nearly 90 percent of hospitals performing these procedures already report these data to clinical registries. Therefore, if we adopt this proposed registry-based topic, a hospital would not face any additional data submission burden if it chooses this registry-based topic for purposes of the FY 2013 payment determination and the registry to which it already submits data is qualified for this proposed topic.

For the FY 2013 payment determination, we are proposing to include 15 cardiac surgery registry-based measures in the cardiac surgery registry-based measure topic. These proposed registry-based measures are listed below, and hospitals would submit data on these measures to a qualified registry for the cardiac surgery registry-based topic. Hospitals would continue submitting data for the cardiac surgery structural measure previously adopted for the RHQDAPU program directly to the QIO Clinical Warehouse.

PROPOSED MEASURES FOR PROPOSED CARDIAC SURGERY REGISTRY-BASED TOPIC

Post-operative Renal Failure (NQF# 0114).
Surgical Re-exploration (NQF# 0115).
Anti-Platelet Medication at Discharge (NQF# 0116).
Beta Blockade at Discharge (NQF# 0117).
Anti-Lipid Treatment Discharge (NQF# 0118).
Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft CABG (NQF# 0119)*.
Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR) (NQF# 0120)*.
Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair (MVR) (NQF# 0121)*.
Risk-Adjusted Operative Mortality MVR+CABG Surgery (NQF# 0122)*.
Risk-Adjusted Operative Mortality for AVR+CABG (NQF# 0123)*.
Pre-Operative Beta Blockade (NQF# 0127).
Duration of Prophylaxis for Cardiac Surgery Patients (NQF# 0128).
Prolonged Intubation (ventilation) (NQF# 0129).
Deep Sternal Wound Infection Rate (NQF# 0130).
Stroke/Cerebrovascular Accident (NQF# 0131).

* Requires risk adjustment.

Because these measures were endorsed by the NQF in May of 2007, they meet the statutory requirement of reflecting consensus among affected parties. Hospitals selecting this topic would begin submitting data on the proposed measures to a qualified cardiac surgery registry beginning with January 1, 2011 discharges. We note that five of these measures (indicated with an asterisk in the table above) must be risk-adjusted in order to be calculated properly. Therefore, the data needed to calculate these measures must be collected by a single registry. While the remaining measures do not require risk adjustment, we believe it may be overly burdensome for hospitals to submit data for this topic to more than one registry. For this reason, we anticipate qualifying a single registry to collect all of the data for the proposed cardiac surgery registry-based topic. We invite comment on this proposal.

Set out below are the RHQDAPU program topics and quality measures we are proposing to adopt for the FY 2013 payment determination:

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Topic	Proposed RHQDAPU Program Quality Measures for the FY 2013 Payment Determination
Acute Myocardial Infarction (AMI)	
	• AMI-1 Aspirin at arrival
	• AMI-2 Aspirin prescribed at discharge
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• AMI-4 Adult smoking cessation advice/counseling
	• AMI-5 Beta blocker prescribed at discharge
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
	• AMI-Statin at Discharge **
Heart Failure (HF)	
	• HF-1 Discharge instructions
	• HF-2 Left ventricular function assessment
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	• PN-2 Pneumococcal vaccination status
	• PN-3b Blood culture performed before first antibiotic received in hospital
	• PN-4 Adult smoking cessation advice/counseling
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival
	• PN-6 Appropriate initial antibiotic selection
	• PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
	• SCIP-Infection-10: Perioperative Temperature Management

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2013 Payment Determination
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality –Medicare patients
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS survey
Readmission Measure (Medicare Patients)	
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult
	• PSI -11: Post Operative Respiratory Failure *
	• PSI – 12: Post Operative PE or DVT *
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care	
	• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
Healthcare Associated Infections **	
	• Central Line Associated Bloodstream Infection **
	• Surgical Site Infection **
ICD Complications -- Registry Based **	
	• ICD Complications and Mortality **
Stroke -- Registry Based **	
	• STK-1: Venous Thromboembolism (VTE) Prophylaxis for patients with

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2013 Payment Determination
	ischemic or hemorrhagic stroke **
	• STK-2: Ischemic stroke patients discharged on antithrombotic therapy.**
	• STK-3: Anticoagulation therapy for atrial fibrillation/flutter.**
	• STK-4: Thrombolytic Therapy for Acute ischemic stroke patients.**
	• STK-5: Antithrombotic therapy by the end of hospital day two.**
	• STK-6: Discharged on statin medication.**
	• STK-8: Stroke education. **
	• STK-10: Assessed for rehabilitation services.**
Nursing Sensitive Care – Registry Based **	
	• Patient Falls: All documented falls with or without injury, experienced by patients on an eligible unit in a calendar month.**
	• Falls with Injury: All documented patient falls with an injury level of minor or greater.**
	• Pressure Ulcer Prevalence**
	• Restraint Prevalence (vest and limb)**
	• Skill Mix: Percentage of hours worked by: RN, LPN/LVN, UAP, Contract/Agency**
	• Hours per patient day worked by RN, LPN, and UAP**
	• Practice Environment Scale-Nursing Work Index**
	• Voluntary turnover for RN, APN, LPN, UAP**
Cardiac Surgery – Registry Based **	
	• Post-operative Renal Failure**
	• Surgical Re-exploration**
	• Anti-Platelet Medication at Discharge**
	• Beta Blockade at Discharge**
	• Anti-Lipid Treatment Discharge**
	• Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft CABG**
	• Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR)**
	• Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair (MVR)**
	• Risk-Adjusted Operative Mortality MVR+CABG Surgery**
	• Risk-Adjusted Operative Mortality for AVR+CABG**
	• Pre-Operative Beta Blockade**
	• Duration of Prophylaxis for Cardiac Surgery Patients**
	• Prolonged Intubation (ventilation)**
	• Deep Sternal Wound Infection Rate**
	• Stroke/Cerebrovascular Accident**
HAC Prevalence Measures *	
	• Foreign Object Retained After Surgery *
	• Air Embolism *

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2013 Payment Determination
	• Blood Incompatibility *
	• Pressure Ulcer Stages III & IV *
	• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock) *
	• Vascular Catheter-Associated Infections *
	• Catheter-Associated Urinary Tract Infection (UTI) *
	• Manifestations of Poor Glycemic Control *
All-Patient Volume Data for Selected MS-DRGs *	
	• **MS-DRGs:** 038; 039; 190; 191; 193; 219; 220; 221; 224; 226; 235; 236; 237; 243; 247; 280; 281; 282; 291; 292; 293; 328; 329; 330; 331; 353; 354; 417; 418; 459;461; 462; 466; 467; 468; 469; 470; 471; 472;477; 478;490;507;515;656; 657; 658; 659; 668; 673; 674; 675; 713;; 743; 748 *

* Proposed for FY 2012 payment determination.
** Proposed for FY 2013 payment determination.

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d. Proposed RHQDAPU Program Quality Measures for the FY 2014 Payment Determination

(1) Proposed Retention of FY 2013 Payment Determination Measures for the FY 2014 Payment Determination

We are proposing to retain all of the measures adopted for the FY 2013 payment determination for the FY 2014 payment determination. Collection of data for these measures would begin with January 1, 2012 discharges. We invite comment on this proposal.

(2) Proposed New Chart-Abstracted Measures for the FY 2014 Payment Determination

We also are proposing to add the following 4 new chart-abstracted measures to the RHQDAPU program measure set for the FY 2014 payment determination: (1) ED [Emergency Department]Throughput—Admit Decision Time to ED Departure Time for Admitted Patients (NQF #0497); (2) ED Throughput—Median time from emergency department arrival to ED departure for admitted patients (NQF #0495); (3) Global Flu Immunization; and (4) Global Pneumonia Immunization. In proposing to adopt these chart-abstracted measures, we recognize that we are proposing to increase the chart-abstraction burden on hospitals with respect to the RHQDAPU program. However, the burden associated with the proposed immunization measures for all inpatients could be counterbalanced by future retirement of the two current immunization measures that apply only to pneumonia inpatients. This measure retirement option is discussed earlier in section V.A.2. of this proposed rule. Furthermore, we note that the ED–Throughput measures have been specified for EHR-based collection, which may also serve to reduce burden associated with these measures in the future.

(A) Emergency Department (ED)-Throughput Measures

The two ED-Throughput measures we are proposing for the FY 2014 payment determination are: (1) Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status; and (2) Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.

The ED-Throughput measures reflect not only the processes of care that occur while the patient is in the emergency department, but also reflect the coordination of care, communication, and efficiency of service provision beyond the walls of the emergency department. These measures have been NQF-endorsed (NQF #0497 and #0495) and adopted by HQA. Specifications for these measures are available in the preview section of the current Specifications Manual available on QualityNet.

These measures also address ED overcrowding, which the IOM identified as a major quality issue. Reducing the time patients remain in the ED can improve access to treatment and increase the quality of care, and capability of the hospital to provide adequate treatment to patients. ED overcrowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of compromised emergency care. For patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. Finally, when EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.

(B) Global Immunization Measures

For the FY 2014 payment determination, we are proposing to adopt two global immunization measures: (1) Pneumoccocal Immunization; and (2) Influenza Immunization. Increasing influenza (flu) and pneumonia vaccination could reduce unnecessary hospitalizations and secondary complications particularly among high risk populations such as the elderly. About 36,000 adults die annually and over 200,000 are hospitalized for flu-related causes. Older adults are more vulnerable, and adults over 65 comprise about 90 percent of flu-related deaths. Vaccinations can significantly reduce the number of flu related illnesses and deaths. The measures we are proposing were endorsed by the NQF as part of a

consensus development project titled "National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations" which concluded in 2008. This project resulted in the endorsement of immunization measures that reflect current consensus among affected parties that standard measure specifications for influenza and pneumonia immunization should be broadly applicable across conditions, populations, and care settings. The technical specifications for these global measures will be available for preview in the Specifications Manual published in April 2010. The difference between these proposed immunization measures, and the two immunization measures that are currently part of the RHQDAPU program is that the current measures only apply to inpatients admitted for pneumonia, whereas the proposed measures apply to all inpatients regardless of admission diagnosis.

We are proposing to adopt these four chart-abstracted measures into the RHQDAPU program measure set for the FY 2014 payment determination. Data submission for these measures would begin with January 1, 2012 discharges. We invite comment on these proposed measures as well as the proposed timing of their addition to the RHQDAPU program for the FY 2014 payment determination. The complete list of proposed quality measures for the FY 2014 payment determination is set out below.

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Topic	Proposed RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
Acute Myocardial Infarction (AMI)	
	• AMI-1 Aspirin at arrival
	• AMI-2 Aspirin prescribed at discharge
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• AMI-4 Adult smoking cessation advice/counseling
	• AMI-5 Beta blocker prescribed at discharge
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)
	• AMI Statin at Discharge **
Heart Failure (HF)	
	• HF-1 Discharge instructions
	• HF-2 Left ventricular function assessment
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction
	• HF-4 Adult smoking cessation advice/counseling
Pneumonia (PN)	
	• PN-2 Pneumococcal vaccination status
	• PN-3b Blood culture performed before first antibiotic received in hospital
	• PN-4 Adult smoking cessation advice/counseling
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival
	• PN-6 Appropriate initial antibiotic selection
	• PN-7 Influenza vaccination status
Surgical Care Improvement Project (SCIP)	
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
	• SCIP-Infection-10: Perioperative Temperature Management
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality – Medicare patients
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients
Patients' Experience of Care	
	• HCAHPS survey
Readmission Measure (Medicare Patients)	
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI -06: Iatrogenic pneumothorax, adult
	• PSI -11: Post Operative Respiratory Failure *
	• PSI –12: Post Operative PE or DVT *
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ PSI and Nursing Sensitive Care	
	• Death among surgical inpatients with serious, treatable complications
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
Healthcare Associated Infections **	
	• Central Line Associated Bloodstream Infection **
	• Surgical Site Infection **
ICD Complications -- Registry–Based **	
	• ICD Complications and Mortality **
Stroke -- Registry-Based **	
	• STK-1: Venous Thromboembolism (VTE) Prophylaxis for patients with ischemic or hemorrhagic stroke. **
	• STK-2: Ischemic stroke patients discharged on antithrombotic therapy. **
	• STK-3: Anticoagulation therapy for atrial fibrillation/flutter. **
	• STK-4: Thrombolytic Therapy for Acute ischemic stroke patients. **
	• STK-5: Antithrombotic therapy by the end of hospital day two. **
	• STK-6: Discharged on statin medication. **
	• STK-8: Stroke education. **
	• STK-10: Assessed for rehabilitation services. **
Nursing Sensitive Care – Registry-Based **	
	• Patient Falls: All documented falls with or without injury, experienced by patients on an eligible unit in a calendar month **
	• Falls with Injury: All documented patient falls with an injury level of minor or greater **
	• Pressure Ulcer Prevalence **
	• Restraint Prevalence (vest and limb) **
	• Skill Mix: Percentage of hours worked by: RN, LPN/LVN, UAP, Contract/Agency **
	• Hours per patient day worked by RN, LPN, and UAP **
	• Practice Environment Scale-Nursing Work Index **
	• Voluntary turnover for RN, APN, LPN, UAP **
Cardiac Surgery – Registry–Based **	
	• Post-operative Renal Failure **
	• Surgical Re-exploration **
	• Anti-Platelet Medication at Discharge **
	• Beta Blockade at Discharge **
	• Anti-Lipid Treatment Discharge **
	• Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft CABG **
	• Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR) **
	• Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair (MVR) **
	• Risk-Adjusted Operative Mortality MVR+CABG Surgery **
	• Risk-Adjusted Operative Mortality for AVR+CABG **
	• Pre-Operative Beta Blockade **

Topic	Proposed RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
	• Duration of Prophylaxis for Cardiac Surgery Patients **
	• Prolonged Intubation (ventilation) **
	• Deep Sternal Wound Infection Rate **
	• Stroke/Cerebrovascular Accident **
HAC Prevalence Measures *	
	• Foreign Object Retained After Surgery *
	• Air Embolism *
	• Blood Incompatibility *
	• Pressure Ulcer Stages III & IV *
	• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock) *
	• Vascular Catheter-Associated Infection *
	• Catheter-Associated Urinary Tract Infection (UTI) *
	• Manifestations of Poor Glycemic Control *
All-Patient Volume Data for Selected MS-DRGs *	
	• **MS-DRGs:** 038; 039; 190; 191; 193; 219; 220; 221; 224; 226; 235; 236; 237; 243; 247; 280; 281; 282; 291; 292; 293; 328; 329; 330; 331; 353; 354; 417; 418; 459;461; 462; 466; 467; 468; 469; 470; 471; 472;477; 478;490;507;515;656; 657; 658; 659; 668; 673; 674; 675; 713; 743; 748 *
Emergency Department Throughput ***	
	• Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status. ***
	• Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department. ***
Global Immunization Measures ***	
	• Immunization for Influenza ***
	• Immunization for Pneumonia ***

*Proposed for FY 2012 payment determination.
**Proposed for FY 2013 payment determination.
*** Proposed for FY 2014 payment determination.

4. Possible New Quality Measures for Future Years

We are inviting public comment on the following quality measures and topics set out below that we are considering for the future. We also are seeking suggestions and rationales to support the adoption of measures and topics that are not included in this list for the RHQDAPU program.

Possible RHQDAPU Program Future Measures and Topics	
Measurement Topic	**Measure Title/ Description/Concept**
Surgical Safety	Surgical checklist use for surgical procedures
Complications	Lower Extremity Bypass Complications
PCI Readmission	30-day risk-standardized readmission rate following Percutaneous Coronary Intervention (PCI) among patients aged 18 years or older.
PCI Mortality	30-day risk-standardized mortality rate following PCI for STEMI/shock patients.
PCI Mortality	30-day risk-standardized mortality rate following PCI for non-STEMI/non-shock patients.
VTE	VTE-1: Venous Thromboembolism Prophylaxis
VTE	VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis
VTE	VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
VTE	VTE-4: Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol
VTE	VTE-5: Venous Thromboembolism Discharge Instructions
VTE	VTE-6: Incidence of Potentially-Preventable Venous Thromboembolism.
SCIP	Short Half-Life prophylactic administered preoperatively redosed within 4 hours after preoperative dose
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge ED Visit Measure
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge Evaluation and Management Service Measure
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge ED Visit Rate
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge Evaluation and Management Service Measure
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge Care Transition Composite Measure
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge ED Visit Rate
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge Evaluation and Management Service Measure

Possible RHQDAPU Program Future Measures and Topics	
Measurement Topic	**Measure Title/ Description/Concept**
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge Care Transition Composite Measure
Healthcare Associated Infections	Ventilator Associated Pneumonia
Healthcare Associated Infections	Multidrug-resistant organism (MDRO) infection
Healthcare Associated Infections	Clostridium Difficile Associated Diseases (CDAD)
Health Care Personnel Immunization	Influenza Vaccination for Healthcare Personnel
Cardiac Rehabilitation Referral	Cardiac Rehabilitation Referral for AMI, HF, Cardiac Surgery
End of Life Care	Appropriate Pain Management
Serious Reportable Events	NQF approved Serious Reportable Events

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5. Form, Manner, and Timing of Quality Data Submission

Sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year be reduced by 2.0 percentage points for any subsection (d) hospital that does not submit quality data in a form and manner, and at a time, specified by the Secretary. The data submission requirements, Specifications Manual, and submission deadlines are posted on the QualityNet Web site at: *http://www.QualityNet.org/*. CMS requires that hospitals submit data in accordance with the specifications for the appropriate discharge periods.

Hospitals submit quality data through the secure portion of the QualityNet Web site (formerly known as QualityNet Exchange) (*https://www.QualityNet.org*). This Web site meets or exceeds all current Health Insurance Portability and Accountability Act (HIPAA) requirements for security of protected health information.

a. Proposed RHQDAPU Program Requirements for FY 2012, FY 2013, and FY 2014

(1) Procedural Requirements for the FY 2012, FY 2013, and FY 2014 Payment Determinations

For the FY 2012, FY 2013, and FY 2014 payment determination, we are proposing that the following procedures would apply to hospitals participating in the RHQDAPU program. These procedures are, for the most part, the same as the procedures that apply to the FY 2011 payment determination. We identify below where we are proposing to modify a procedure.

- Register with QualityNet, before participating hospitals initially begin reporting data, regardless of the method used for submitting data.
- Identify a QualityNet Administrator who follows the registration process located on the QualityNet Web site (*http://www.QualityNet.org*).
- Complete a Notice of Participation. New subsection (d) hospitals and existing hospitals that wish to participate in the RHQDAPU program for the first time must complete a revised "Reporting Hospital Quality Data for Annual Payment Update Notice of Participation" form (Notice of Participation form) that includes the name and address of each hospital campus that shares the same CMS Certification Number (CCN). We will revise the Notice of Participation form as needed and will provide appropriate notification of any revisions to hospitals and QIOs through the routine RHQDAPU communication channels which include memo and e-mail notification and QualityNet Web site articles and postings.

We are proposing that, consistent with our policy for the FY 2011 payment determination, any hospital that receives a new CCN on or after October 15, 2009 (including new subsection (d) hospitals and hospitals that have merged) that wishes to participate in the RHQDAPU program and has not otherwise submitted a Notice of Participation form using the new CCN must submit a completed Notice of Participation form no later than 180 days from the date identified as the open date (that is, the Medicare acceptance date) on the approved CMS Online System Certification and Reporting (OSCAR) system to participate in the RHQDAPU program for FY 2012 and future years. We believe that this deadline will give these hospitals a sufficient amount of time to get their operations up and running while simultaneously providing CMS with clarity regarding whether they intend to participate in the RHQDAPU program for FY 2012.

(2) Synchronization of RHQDAPU Program Data Submission and Validation Quarters With Quarters Used To Make Payment Determinations

Currently we determine, in part, whether a hospital has met the RHQDAPU program requirements for a given fiscal year by looking at whether the hospital properly submitted data with respect to a number of quarterly discharge periods. However, the quarters that we look at for HCAHPS data, chart-abstracted RHQDAPU program measures, and structural measures may not be the same for a single payment determination. For example, for the FY 2011 payment

determination, we looked at discharge data submitted by hospitals from 4th quarter 2008 through 3rd quarter 2009 for AMI, HF, and PN chart-abstracted RHQDAPU program measures, 1st quarter 2010 for the newly added SCIP Infection 9 and 10 measures, April 2008 through March 2009 data for HCAHPS, and January 1, 2010 through June 30, 2010 data for structural measures.

This lack of synchronization has developed because we have generally made payment decisions using the four earliest occurring discharge quarters for each measure topic that we did not include in a previous year's payment determination, and we have not synchronized when hospitals must begin reporting data on new measures.

Starting with the FY 2013 payment determination, we are proposing to determine whether the hospital meets the data submission requirement for quality measure data by looking at whether the hospital properly submitted data on the applicable measures during the same quarterly discharge periods. Specifically, the quarterly discharge periods that will apply to a particular payment determination will be the four quarters that occur within a calendar year. In other words, beginning with the FY 2013 payment determination, we will look at whether the hospital properly submitted data for quality measure data for the four calendar year quarters of CY 2011.

With respect to our requirement that hospital data be successfully validated in order for the hospital to earn the full payment update for a given fiscal year, we are also proposing, beginning with the FY 2013 payment determination, to validate four discharge quarters, but the quarters will be the 4th calendar quarter of the calendar year that occurs two years before the payment determination and the first 3 calendar quarters of the following calendar year. Thus, for the FY 2013 payment determination, we will validate data from the 4th calendar quarter of 2010 through the 3rd calendar quarter of 2011. We believe this is appropriate given the time required for the validation abstraction and appeal process.

This proposed synchronization will give us a more complete picture of the quality of care provided by a hospital during a given time period, thus enabling us to link that quality of care to the applicable RHQDAPU payment determination. In addition, this proposal will provide clarity to hospitals regarding what data we will look at to make payment determinations for a given fiscal year. We believe that this synchronization will also assist us to more effectively implement the RHQDAPU program because we will be able to achieve operational consistency regarding what data applies to what payment determination. Further, we believe that this proposal may assist the agency in implementing Hospital Value-Based Purchasing as authorized by the Patient Protection and Affordable Care Act, Public Law 111–148, because it will improve the link between quality, as measured during a single period of time, and the payment amounts provided to hospitals. For example, under our proposal, the HCAHPS patient experience of care measure and chart-abstracted measures for a single set of discharge quarters will be used together for a single payment determination. Finally, we believe that this proposal will improve hospitals' ability to implement quality improvement strategies that affect RHQDAPU program measures and their quality of care.

We will post a table outlining the discharge quarters that will be used to make each fiscal year payment determination no later than September 15th annually on the QualityNet Web site (*http://www.QualityNet.org*). We welcome comments on this proposal.

(3) Proposed HCAHPS Requirements for the FY 2012, FY 2013 and FY 2014 Payment Determinations

We are proposing that, for the FY 2012, FY 2013 and FY 2014 payment determinations, except as noted below, the RHQDAPU program HCAHPS requirements we adopted for FY 2011 would continue to apply. Under these requirements, a hospital must continuously collect and submit HCAHPS data in accordance with the current HCAHPS *Quality Assurance Guidelines* and the quarterly data submission deadlines, both of which are posted at *http://www.hcahpsonline.org.* In order for a hospital to participate in the collection of HCAHPS data, a hospital must either: (1) Contract with an approved HCAHPS survey vendor that will conduct the survey and submit data on the hospital's behalf to the QIO Clinical Warehouse; or (2) self-administer the survey without using a survey vendor provided that the hospital attends HCAHPS training and meets Minimum Survey Requirements as specified on the Web site at: *http://www.hcahpsonline.org.* A current list of approved HCAHPS survey vendors can be found on the HCAHPS Web site at: *http://www.hcahpsonline.org.*

We are proposing that the FY 2012 payment determination for the RHQDAPU program for HCAHPS will be based on discharges from April 1, 2010 through December 31, 2010.

We are proposing that the FY 2013 payment determination for the RHQDAPU program for HCAHPS will be based on discharges from January 1, 2011 through December 31, 2011.

We are proposing that the FY 2014 payment determination for the RHQDAPU program for HCAHPS will be based on discharges from January 1, 2012 through December 31, 2012.

Every hospital choosing to contract with a survey vendor should provide the sample frame of HCAHPS-eligible discharges to its survey vendor with sufficient time to allow the survey vendor to begin contacting each sampled patient within 6 weeks of discharge from the hospital. (We refer readers to the *Quality Assurance Guidelines* located at *http://www.hcahpsonline.org* for details about HCAHPS eligibility and sample frame creation.) In addition, the hospital must authorize the survey vendor to submit data via My QualityNet, the secure part of the QualityNet Web site, on the hospital's behalf.

After the survey vendor submits the data to the QIO Clinical Warehouse, we strongly recommend that hospitals employing a survey vendor promptly review the two HCAHPS Feedback Reports (the Provider Survey Status Summary Report and the Data Submission Detail Report) that are available. These reports enable a hospital to ensure that its survey vendor has submitted the data on time and the data has been accepted into the QIO Clinical Warehouse.

Any hospital that has five or fewer HCAHPS-eligible discharges in any month is no longer required to submit HCAHPS surveys for that month, although the hospital may voluntarily choose to submit these data. However, the hospital still must submit its total number of HCAHPS-eligible cases for that month to the QIO Clinical Warehouse as part of its quarterly HCAHPS data submission.

In order to ensure compliance with HCAHPS survey and administration protocols, hospitals and survey vendors must participate in all oversight activities. As part of the oversight process, during the onsite visits or conference calls, the HCAHPS Project Team will review the hospital's or survey vendor's survey systems and assess protocols based upon the most recent HCAHPS *Quality Assurance Guidelines.* All materials relevant to survey administration will be subject to review. The systems and program review includes, but is not limited to: (a) Survey management and data systems; (b) printing and mailing materials and facilities; (c) telephone

and IVR materials and facilities; (d) data receipt, entry and storage facilities; and (e) written documentation of survey processes. Organizations will be given a defined time period in which to correct any problems and provide follow-up documentation of corrections for review. As needed, hospitals and survey vendors will be subject to follow-up site visits or conference calls. If CMS determines that a hospital is not compliant with HCAHPS program requirements, CMS may determine that the hospital is not submitting HCAHPS data that meet the requirements of the RHQDAPU program.

We continue to strongly recommend that each new hospital participate in an HCAHPS dry run, if feasible, prior to beginning to collect HCAHPS data on an ongoing basis to meet RHQDAPU program requirements. New hospitals can conduct a dry run in the last month of a calendar quarter. The dry run will give newly participating hospitals the opportunity to gain first-hand experience collecting and transmitting HCAHPS data without the public reporting of results. Using the official survey instrument and the approved modes of administration and data collection protocols, hospitals/survey vendors will collect HCAHPS dry-run data and submit the data to My QualityNet, the secure portion of QualityNet.

We are again encouraging hospitals to regularly check the HCAHPS Web site at *http://www.hcahpsonline.org* for program updates and information.

b. Additional Proposed RHQDAPU Program Procedural Requirements for the FY 2012, FY 2013 and FY 2014 Payment Determinations

(1) Chart-Abstracted Measures For Which Data Is Submitted Directly to CMS (via QualityNet)

Hospitals must begin submitting RHQDAPU program data starting with the first day of the quarter following the date when the hospital registers to participate in the program. For purposes of meeting this requirement, we interpret the registration date to be the date that the hospital submits a completed Notice of Participation form. As proposed previously in this section, hospitals must also register with QualityNet and identify a QualityNet Administrator who follows the QualityNet registration process before submitting RHQDAPU program data.

Hospitals must continuously collect and report data to CMS (via QualityNet) for each of the quality measures under the topic areas that require chart abstraction (and are not registry-based topic areas). For the FY 2012 and FY 2013 payment determinations, the proposed topic areas are AMI, HF, PN, and SCIP. For the FY 2014 payment determination, the proposed topic areas are AMI, HF, PN, SCIP, Emergency Department Throughput (EDT), and Global Immunization (GIM).

For FY 2012, we are proposing that hospitals must submit data for five calendar year discharge quarters as follows: 4Q CY 2009, 1Q CY 2010 (AMI, HF and PN only), 2Q CY 2010, 3Q CY 2010 and 4Q CY 2010. For the FY 2013 payment determination, we are proposing that hospitals must submit data for four consecutive calendar year discharge quarters as follows: 1Q CY 2011, 2Q CY 2011, 3Q CY 2011 and 4Q CY 2011. For the FY 2014 payment determination, hospitals must submit data for four consecutive calendar year discharge quarters as follows: 1Q CY 2012, 2Q CY 2012, 3Q CY 2012 and 4Q CY 2012. Hospitals must report these data by each quarterly deadline.

Hospitals must submit the data to the QIO Clinical Warehouse using the CMS Abstraction & Reporting Tool (CART), The Joint Commission ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that meets the measurement specification requirements for data transmission to QualityNet. All submissions will be executed through My QualityNet, the secure part of the QualityNet Web site. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR Part 480. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals.

Hospitals must submit complete data for each quality measure that requires chart abstraction in accordance with the joint CMS/The Joint Commission sampling requirements located on the QualityNet Web site. These requirements specify that hospitals must submit a random sample or complete population of cases for each of the topics covered by the quality measures. Hospitals must meet the sampling requirements for these quality measures for discharges in each quarter.

For the FY 2012 payment determination, we are proposing that hospitals must submit population and sampling data for three consecutive calendar year discharge quarters as follows: 2Q CY 2010, 3Q CY 2010 and 4Q CY 2010.

For the FY 2013 payment determination, we are proposing that hospitals must submit population and sampling data for four consecutive calendar year discharge quarters as follows: 1Q CY 2011, 2Q CY 2011, 3Q CY 2011 and 4Q CY 2011.

For the FY 2014 payment determination, we are proposing that hospitals must submit population and sampling data for four consecutive calendar year discharge quarters as follows: 1Q CY 2012, 2Q CY 2012, 3Q CY 2012 and 4Q CY 2012.

Hospitals must submit to CMS on a quarterly basis aggregate population and sample size counts for Medicare and non-Medicare discharges for the topic areas for which chart-abstracted data must be submitted (currently AMI, HF, PN, and SCIP). For clarification, we are proposing that hospitals are required to submit a numeric representation of their aggregate population and sample size count for each topic area even if the hospital has not treated patients in a specific topic area. For example, if a hospital has not treated AMI patients, the hospital is still required to submit a zero for its quarterly aggregate population and sample count for that topic in order to meet the requirement.

In order to reduce the burden on hospitals that treat a low number of patients in a RHQDAPU program topic area, a hospital that has five or fewer discharges (Medicare and non-Medicare combined) in a topic area during a quarter in which data must be submitted is not required to submit patient-level data for that topic area for the quarter. The hospital must still submit its aggregate population and sample size counts for Medicare and non-Medicare discharges for the topic areas each quarter. We also note that hospitals meeting the five or fewer patient discharge exception may voluntarily submit these data.

The quarterly data submission deadline for hospitals to submit patient level data for the proposed measures that require chart abstraction is 4½ months following the last discharge date in the calendar quarter. CMS will post the quarterly submission deadline schedule on the QualityNet Web site (*http://www.QualityNet.org*). Chart-abstracted measures have not been added for the FY 2012 payment determination. The collection of new chart-abstracted measures proposed for the FY 2013 payment determination would begin with the 1st calendar quarter 2011 discharges, for which the submission deadline would be August 15, 2011. The collection of new chart-abstracted measures proposed for the FY 2014 payment determination would begin with the 1st calendar quarter 2012 discharges, for which the submission deadline would be August 15, 2012. Hospitals must comply with the

discharge quarter submission deadlines in any fiscal year for each quarter for which data submission is required (Quarter 1—August 15th; Quarter 2—November 15th; Quarter 3—February 15th; Quarter 4—May 15th).

The data submission deadline for hospitals to submit aggregate population and sample size count data for the measures requiring chart abstraction is four months following the last discharge date in the calendar quarter. This requirement allows CMS to advise hospitals regarding their submission status in enough time for them to make appropriate revisions before the data submission deadline. We will post the aggregate population and sample size count data submission deadlines on the QualityNet Web site (*http://www.QualityNet.org*).

CMS strongly recommends that hospitals review the QIO Clinical Warehouse Feedback Reports and the RHQDAPU Program Provider Participation Reports that are available after patient level data are submitted to the QIO Clinical Warehouse. CMS generally updates these reports on a daily basis to provide accurate information to hospitals about their submissions. These reports enable hospitals to ensure that their data were submitted on time and accepted into the QIO Clinical Warehouse.

(2) Data Submission Requirements for HCAHPS

Hospitals must continuously collect and submit HCAHPS data in accordance with the current HCAHPS *Quality Assurance Guidelines,* which can be found on the HCAHPS Web site, *http://www.hcahpsonline.org.* The QIO Clinical Warehouse is able to accept submissions indicating zero HCAHPS-eligible discharges in a month. A hospital with zero HCAHPS-eligible discharges in a month must submit a zero as its total number of HCAHPS-eligible cases to the QIO Clinical Warehouse for that month as part of its quarterly HCAHPS data submission.

In order to reduce the burden on hospitals that treat a low number of patients that would be otherwise covered by the HCAHPS submission requirements, a hospital that has five or fewer HCAHPS-eligible discharges during a month is not required to submit HCAHPS surveys for that month. However, hospitals that meet this exception may voluntarily submit this data. A hospital with five or fewer HCAHPS-eligible discharges must submit its number of HCAHPS-eligible cases to the QIO Clinical Warehouse for the month(s) in which it had five or fewer HCAHPS-eligible discharges as part of its quarterly HCAHPS data submission.

(3) Procedures for Claims-Based Measures

Hospitals are encouraged to regularly check the QualityNet Web site, *http://www.QualityNet.org,* for program updates and information.

• The following RHQDAPU program claims-based measures would be calculated using Medicare claims:

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Topic	FY 2012 Payment Determination: Proposed Claims-Based Quality Measures (No Additional Hospital Data Submission Required)
Mortality Measures (Medicare Patients)	
	• MORT-30-AMI Acute Myocardial Infarction 30-day mortality –Medicare patients
	• MORT-30-HF Heart Failure 30-day mortality Medicare patients
	• MORT-30-PN Pneumonia 30-day mortality -Medicare patients
Readmission Measures (Medicare Patients)	
	• READ-30-HF Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-AMI Acute Myocardial Infarction (AMI) 30-Day Risk Standardized Readmission Measure (Medicare patients)
	• READ-30-PN Pneumonia (PN) 30-Day Risk Standardized Readmission Measure (Medicare patients)
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult
	• PSI -11: Post Operative Respiratory Failure *
	• PSI – 12: Post Operative PE or DVT *
	• PSI 14: Postoperative wound dehiscence
	• PSI 15: Accidental puncture or laceration
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
	• IQI 19: Hip fracture mortality rate
	• Complication/patient safety for selected indicators (composite)
	• Mortality for selected medical conditions (composite)
AHRQ Patient Safety Indicator (PSI) and Nursing Sensitive Care	
	• Death among surgical inpatients with serious, treatable complications
Hospital Acquired Condition Measures	
	• Foreign Object Retained After Surgery *
	• Air Embolism *
	• Blood Incompatibility *
	• Pressure Ulcer Stages III & IV *
	• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock)*
	• Vascular Catheter-Associated Infection*
	• Catheter-Associated Urinary Tract Infection (UTI) *
	• Manifestations of Poor Glycemic Control*

*New proposed measure

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For the claims-based RHQDAPU program measures listed above, hospitals are not required to submit the data to the QIO Clinical Warehouse. CMS uses the existing Medicare fee-for-service claims to calculate the measures. For the FY 2012 payment determination, CMS would use up to 3 years of discharges prior to January 1, 2011 (as appropriate for the measure), to calculate the 30-day mortality and 30-day readmission measures AHRQ PSI, IQI and Composite measures (including the AHRQ PSI and Nursing Sensitive Care measure, Death among surgical inpatients with serious, treatable complications), and the proposed new HAC Measures. For the FY 2013 and FY 2014 payment determinations, CMS would use up to 3 years of discharges (as appropriate for the measure) prior to January 1, 2012, and January 1, 2013 respectively. Hospitals are required to appropriately report the POA indicator in conjunction with ICD–9–CM coding to determine the presence of HACs so that the proposed HAC measures can be calculated for the RHQDAPU program using Medicare claims.

(4) Data Submission Requirements for Structural Measures

• We are proposing that for the FY 2012 payment determination, hospitals submit the required registry participation information once for the structural measures via a Web-based collection tool between July 1, 2011–August 15, 2011 with respect to the time period of July 1, 2010 through December 31, 2010.

Below is the list of structural measures we are proposing to adopt for the FY 2012 payment determination:

Topic	FY 2012 payment determination: Proposed structural measures
Cardiac Surgery	• Participation in a Systematic Database for Cardiac Surgery.
Stroke Care	• Participation in a Systematic Clinical Database Registry for Stroke Care.
Nursing Sensitive Care	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care.

(5) Data Submission of All-Patient Volume Data for Selected MS–DRGs Related to RHQDAPU Program Measures

For submission of the all-patient volume data for selected MS–DRGs, we are proposing that hospitals submit patient level information needed for CMS to apply the MS–DRG grouper software to calculate the all-patient MS–DRG volumes, the data elements for which would be defined in the Specifications Manual. Hospitals would begin submitting this data quarterly via QualityNet beginning with January 1, 2011 discharges.

We invite comment on an alternative that hospitals submit hospital-level all-patient volume data based upon specific ICD–9–CM codes that are related to the selected MS–DRGs (rather than the patient-level data) necessary for CMS to calculate the MS–DRGs. Hospitals would begin submitting this data quarterly via QualityNet beginning with January 1, 2011 discharges.

(6) Proposed Data Submission and Reporting Requirements for HAI Measures Reported via NHSN

We are proposing that hospitals participating in RHQDAPU submit the data elements needed to calculate the Central Line Associated Blood Stream Infection and Surgical Site Infection measures to the NHSN using the standard procedures that have been set forth by CDC for NHSN participation in general and for submission of these two measures to NHSN in particular. This would include NHSN participation forms and indications to CDC allowing CMS to access data for these two measures for RHQDAPU program purposes, adherence to training requirements, use of standard CDC measure specifications, data element definitions, data collection requirements and instructions, and data reporting timeframes. Detailed requirements for NHSN participation, measure specifications, and data collection can be found at *http://www.cdc.gov/nhsn/*. Hospitals must use the current specifications and data collection tools available on the CDC Web site to submit data for the Central Line Associated Bloodstream Infection and Surgical Site Infection measures. We are proposing that hospitals would submit data for these two measures to CDC's NHSN on a monthly basis for discharges occurring on or after January 1, 2011.

For the FY 2013 payment determination, we are proposing that hospitals must submit HAI data via the NHSN for four consecutive calendar year discharge quarters as follows: 1Q CY 2011, 2Q CY 2011, 3Q CY 2011 and 4Q CY 2011.

For the FY 2014 payment determination, hospitals must submit HAI data for four consecutive calendar year discharge quarters as follows: 1Q CY 2012, 2Q CY 2012, 3Q CY 2012 and 4Q CY 2012.

We are proposing that once quarterly each hospital would utilize an automated report function that will be made available to submitters in the NHSN, to generate a quarterly report containing hospital-level numerator, denominator, and exclusion counts for these two CDC measures specifically for the RHQDAPU program. The CDC will create this automated RHQDAPU report function and add it to NHSN's reporting functionalities in the next few months. While hospitals may be reporting other data elements to CDC for other reporting programs (that is: State mandated surveillance programs), the quarterly RHQDAPU report that would be generated within NHSN would only contain those data elements needed to calculate the two measures currently being proposed for the RHQDAPU program. CMS will access the reports in the NHSN and will compile the reports for RHQDAPU program and public reporting purposes.

We invite comment on the proposed mechanism for submitting data for the Central Line Associated Blood Stream Infection measure and the Surgical Site Infection measure for the RHQDAPU program beginning with the FY 2012 payment determination.

(7) Data Submission Requirements for Registry-Based Measures

We are proposing that hospitals participating in RHQDAPU would be required to choose at least one of four registry based measure topics (ICD Complications, Stroke, Nursing Sensitive Care, or Cardiac Surgery), and would submit the data needed to calculate the measures included in the chosen registry-based topic to a qualified registry in order to meet the requirements to receive the full FY 2013 annual payment update.

We are proposing that hospitals then would arrange to have the qualified registry calculate the measures and submit to the QIO Clinical Warehouse the results, as well as the numerator, denominator, and exclusions. Any arrangement reached between the hospital and the qualified registry must comply with HIPAA. The qualified registry would also submit registry-derived hospital-level measure calculations to the QIO Clinical Warehouse using a CMS-specified record layout and file format that we will make available.

Our program and its data system must maintain compliance with HIPAA requirements for requesting, processing, storing, and transmitting data. For the FY 2013 RHQDAPU payment determination, hospitals would need to submit data for the proposed registry-based measures to the qualified registry in the form and manner and by the deadline(s) specified by the registry.

CMS will begin qualifying registries for the four proposed registry-based topics so that hospitals may begin submitting data for discharges beginning January 1, 2011. Proposed registry qualification criteria are discussed in a section V.A.13. of this proposed rule. We are proposing to post on the RHQDAPU program section of the QualityNet Web site *http://www.qualitynet.org* a list of qualified registries for the FY 2013 RHQDAPU payment determination, including the registry name, contact information, and the measure(s) that the registry has been

qualified to collect and report for the RHQDAPU program.

We anticipate posting the list of qualified FY 2011 registries as soon as we have completed vetting the registries interested in participating in the FY 2013 RHQDAPU program payment determination and identified the qualified registries for the FY 2013 RHQDAPU program payment determination, which we anticipate will be completed by December 31, 2010. Specific data submission requirements for the registry-based measures are discussed below:

(A) Hospitals That Choose To Report the ICD Complications Measure

If the hospital chooses the ICD Complications measure, it would submit specified data elements for specified populations to the qualified ICD registry. We intend to establish criteria and begin qualifying registries for this topic so that hospitals can begin submitting data for discharges beginning January 1, 2011. The hospital would follow the standard participation and reporting procedures set by the registry regarding the submission of data elements for the particular measures we have specified for the topic. These data elements and population definitions will be listed in the Specifications Manual.

Hospitals must allow the qualified registry it is using to report the patient-level data to CMS in order to calculate the ICD complications measure.

(B) Hospitals That Choose To Report Either the Stroke, Nursing Sensitive Care, or Cardiac Surgery Measures

If a hospital chooses the Stroke, Nursing Sensitive Care, or Cardiac Surgery measure topics, it would submit data on the measures listed for these topics to a qualified registry for the topic. CMS intends to establish criteria and begin qualifying registries for these topics so that hospitals can begin submitting data for discharges beginning January 1, 2011. The hospital would follow the standard participation and reporting procedures set by the registry regarding the submission of data elements for the particular measures CMS has specified for the topic. Additionally, the hospital would agree to allow the registry to send calculations of the measures, numerator, denominator and exclusion counts to CMS for the RHQDAPU program.

6. RHQDAPU Program Disaster Extensions and Waivers

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24176), we solicited public comment about rules we could adopt that would enable hospitals to request either an extension or a waiver of various RHQDAPU program requirements in the event of a disaster (such as a hurricane that damages or destroys the hospital).

Specifically, we welcomed public comment on the following issues:

- Recommendations for rules that we could follow when considering whether to grant an extension or waiver of RHQDAPU program requirements in the event of a disaster, including suggested criteria that we should take into account (for example, specific hospital infrastructure damage, hospital closure time period, degree of destruction of medical records, impact on data vendors, and long-term evacuation of discharged patients impacting HCAHPS survey participation).
- The role that QIOs and QIO support contractors should play in the event of a disaster, including communicating with affected hospitals, communicating with State hospital associations, and collecting information directly from hospitals.
- How CMS extension or waiver decisions should be communicated to affected hospitals.
- Any other issues commenters deem relevant to a hospital's request for an extension or waiver of RHQDAPU program requirements in the event of a disaster.

We responded to public comments in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43881). We recognize that there are times when hospitals are unable to submit quality data due to extraordinary circumstances that are not within their control. It is our goal to not penalize hospitals for such circumstances and we do not want to unduly increase their burden during these times.

Therefore, we are proposing a process for hospitals to request and for CMS to grant extensions or waivers with respect to the reporting of required quality data when there are extraordinary circumstances beyond the control of the hospital. Under the proposed process, in the event of extraordinary circumstances not within the control of the hospital, for the hospital to receive consideration for an extension or waiver of the requirement to submit quality data for one or more quarters, a hospital must submit to the QIO in the hospital's State a request form that will be made available on the QualityNet Web site. The following information should be noted on the form:

- Hospital CCN;
- Hospital Name;
- CEO and any other designated personnel contact information, including name, e-mail address, telephone number, and mailing address (must include a physical address, a post office box address is not acceptable);
- Hospital's reason for requesting an extension or waiver;
- Evidence of the impact of the extraordinary circumstances, including but not limited to photographs, newspaper and other media articles; and
- A date when the hospital will again be able to submit RHQDAPU data, and a justification for the proposed date.

The request form must be signed by the hospital's CEO. A request form must be submitted within 45 days of the date that the extraordinary circumstance occurred. The QIO in the hospital's state will forward the request form to CMS. Following receipt of the request form, CMS will: (1) Provide a written acknowledgement using the contact information provided in the request, to the CEO and any additional designated hospital personnel, notifying them that the hospital's request has been received; and (2) provide a formal response to the CEO and any additional designated hospital personnel using the contact information provided in the request notifying them of our decision.

This proposal does not preclude CMS from granting waivers or extensions to hospitals that have not requested them when we determine that an extraordinary circumstance, such as an act of nature (for example, hurricane), affects an entire region or locale. If CMS makes the determination to grant a waiver or extension to hospitals in a region or locale, CMS will communicate this decision through routine communication channels to hospitals, vendors and QIOs, including but not limited to issuing memos, e-mails and notices on the QualityNet Web site. We invite comment on this proposal.

7. Proposed Chart Validation Requirements for Chart-Abstracted Measures

a. Chart Validation Requirements and Methods for the FY 2012 Payment Determination

For the FY 2012 payment determination, we will use the chart validation requirements and methods that we adopted for FY 2012 in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43884 through 43889). These requirements, as well as additional information on these requirements, will be posted on the QualityNet Web site after we issue the FY 2011 IPPS/RY 2011 LTCH PPS final rule.

Specifically, we will:

- Randomly select on an annual basis 800 participating hospitals that

submitted chart-abstracted data for at least 100 discharges combined in the measure topics to be validated. To determine whether a hospital meets this "100-case threshold," we will look to the discharge data submitted by the hospital during the calendar year three years prior to the fiscal year of the relevant payment determination. For example, if the 100-case threshold applied for the FY 2011 payment determination (which it will not), the applicable measure topics would be AMI, HF, PN, and SCIP, and we would choose 800 hospitals that submitted discharge data for at least 100 cases combined in these topics during calendar year 2008. If a hospital did not submit discharge data for at least 100 cases in these topics during CY 2008, we would not select the hospital for validation. We will announce the topic areas that apply for the FY 2012 payment determination at a later date, and we plan to select the first 800 hospitals in July 2010. We will select hospitals for the FY 2012 validation if they meet the 100-case threshold during CY 2009. We adopted this 100-case threshold because we believe that it strikes the appropriate balance between ensuring that the selected hospitals have a large enough patient population to be able to submit sufficient data to allow us to complete an accurate validation, while not requiring validation for hospitals with a low number of submitted quarterly cases and relatively unreliable measure estimates. Based on previously submitted data, we estimate that 98 percent of participating RHQDAPU program hospitals will meet this threshold and, thus, be eligible for validation. As noted below, we solicited comments and suggestions on how we might be able to target the remaining 2 percent of hospitals for validation.

- Validate for each of the 800 hospitals a randomly selected stratified sample for each quarter of the validation period. Each quarterly sample will include 12 cases, with at least one but no more than three cases per topic for which chart-abstracted data was submitted by the hospital. However, we recognize that some selected hospitals might not have enough cases in all of the applicable topics to submit data (for example, if they have 5 or fewer discharges in a topic area in a quarter). For those hospitals, we will validate measures in only those topic areas for which they have submitted data. For the FY 2012 payment determination, we will validate 1st calendar quarter 2010 through 3rd calendar quarter 2010 discharge data. We will validate 3 quarters of data for FY 2012 in order to provide hospitals with enough time to assess their medical record documentation and abstraction practices, and to take necessary corrective actions to improve these practices, before documenting their 1st calendar quarter 2010 discharges into medical records that may be sampled as part of this proposed validation process.

The CDAC contractor will, each quarter that applies to the validation, ask each of the 800 selected hospitals to submit 12 randomly selected medical charts from which data was abstracted and submitted by the hospital to the QIO Clinical Warehouse. We note that, under our current requirements, hospitals must begin submitting RHQDAPU program data starting with the first day of the quarter following the date when the hospital registers to participate in the program. For purposes of meeting this requirement, we interpret the registration date to be the date that the hospital submits a completed Notice of Participation form. As proposed previously in this section, hospitals must also register with QualityNet and identify a QualityNet Administrator who follows the QualityNet registration process before submitting RHQDAPU program data.

In addition, we will continue the following timeline with respect to CDAC contractor requests for paper medical records for the purpose of validating RHQDAPU program data. Beginning with CDAC contractor requests for second calendar quarter 2009 paper medical records, the CDAC contractor will request paper copies of the randomly selected medical charts from each hospital via certified mail (or other trackable method that requires a hospital representative to sign for the letter), and the hospital will have 45 days from the date of the request (as documented on the request letter) to submit the requested records to the CDAC contractor. If the hospital does not comply within 30 days, the CDAC contractor will send a second certified letter to the hospital, reminding the hospital that it must return paper copies of the requested medical records within 45 calendar days following the date of the initial CDAC contractor medical record request. If the hospital still does not comply, then the CDAC contractor will assign a "zero" score to each measure in each missing record. The letter from the CDAC contractor is addressed to the hospital's medical record staff identified by the hospital to their state Quality Improvement Organization (QIO). CMS recommends that hospitals routinely check with their State QIO to ensure the correct person is listed to receive the record request. If CMS has evidence from the CDAC contractor that the hospital received both letters requesting medical records (as determined by the tracking system used by the CDAC contractor), the hospital is responsible for not returning their charts and will not be able to submit charts as part of their reconsideration request.

Under the validation methodology, once the CDAC contractor receives the charts, it will re-abstract the same data submitted by the hospitals and calculate the percentage of matching RHQDAPU program measure numerators and denominators for each measure within each chart submitted by the hospital. Specifically, we will estimate the accuracy by calculating a match rate percent agreement for all of the variables submitted in all of the charts. For any selected record, a measure's numerator and denominator can have two possible states, included or excluded, depending on whether the hospital accurately included the cases in the measure numerator(s) and denominator(s). We will count each measure in a selected record as a match if the hospital-submitted measure numerator and denominator sets match the measure numerator and denominator states independently abstracted by our contractor. For example, one heart failure case from which data has been abstracted for four RHQDAPU program chart-abstracted measures (that is, HF–1, HF–2, HF–3, and HF–4) would receive a 75-percent match if three out of four of the hospital-reported heart failure measure numerator and denominator states matched the re-abstracted numerator and denominator states. This proposed scoring approach is the same as recommended in the CMS Hospital Value-Based Purchasing Report to Congress, and is illustrated in further detail using an example in pages 83–84 of the report which can be found on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf.* We believe that this approach is appropriate, and it was supported by many commenters when we requested comment in the FY 2009 and FY 2010 IPPS final rules for input about the RHQDAPU program validation process (73 FR 48622 and 48623, 74 FR 43886 and 43887).

Under the validation methodology, we will:

- Use, as we currently do, each selected case as a cluster comprising one or multiple measures utilized in a validation score estimate. Each selected case will have multiple measures included in the validation score (for example, for the FY 2011 payment

determination, a heart failure record will include 4 heart failure measures). Specifically, we will continue using the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a stratified single stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G.: Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12 (1977); and Kish, Leslie: Survey Sampling, John Wiley & Sons, New York, chapter 3, section 3.3 (1964).) Each quarter and clinical topic is treated as a stratum for variance estimation purposes.

We believe that the clustering approach is a statistically appropriate technique for calculating the annual validation confidence interval. Because we will not be validating all hospital records, we need to calculate a confidence interval that incorporates a potential sampling error. Our clustering approach incorporates the degree of correlation at the individual data record level, because our previous validation experience indicates that hospital data mismatch errors tend to be clustered in individual data records. We have used this clustering since the inception of the RHQDAPU program validation requirement to calculate variability estimates needed for calculating confidence intervals (70 FR 47423).

- Use the upper bound of a one-tailed 95 percent confidence interval to estimate the validation score; and
- Require all RHQDAPU program participating hospitals selected for validation to attain at least a 75 percent validation score per quarter to pass the validation requirement.

We believe that this modified validation methodology incorporates many of the principles supported by the vast majority of commenters in response to our solicitation for public comments in the FY 2009 and FY 2010 IPPS proposed rule (73 FR 23658 through 23659, 74 FR 43886 and 43887). Specifically, we believe that the increased annual sample size per hospital will provide more reliable estimates of validation accuracy. The sample size of 12 records per quarter would provide a total of 36 records across the three sampled quarters for the FY 2012 payment determination, and 48 records in subsequent years. This estimate would improve the reliability of our validation estimate, as compared to the current RHQDAPU program annual validation sample of 20 cases per year. We also believe that modifying the validation score to reflect measure numerator and denominator accuracy will ensure that accurate data are posted on the *Hospital Compare* Web site.

In addition, we believe that stratified quarterly samples by topic will improve the feedback provided to hospitals. CMS will provide validation feedback to hospitals about all sampled topics submitted by the hospitals each quarter. Because all relevant data elements submitted by the hospital must match the independently re-abstracted data elements to count as a match, we reduced the passing threshold from 80 percent to 75 percent. We will use a one-tail confidence interval to calculate the validation score because we strongly believe that a one-tail test most appropriately reflects the pass or fail dichotomous nature of the statistical test regarding whether the confidence interval includes or is completely above the 75 percent passing validation score.

We also will continue to allow hospitals that fail to meet the passing threshold for the quarterly validation an opportunity to appeal the validation results to their State QIO. QIOs are currently tasked by CMS to provide education and technical assistance about RHQDAPU program data abstraction and measures to hospitals, and the quarterly validation appeals process will provide hospitals with an opportunity to both appeal their quarterly results and receive education free of charge from their State QIO. This State QIO quarterly validation appeals process is independent of the proposed RHQDAPU program reconsideration procedures for hospital reconsideration requests involving validation for the FY 2010 payment update proposed in this proposed rule.

b. Proposed Supplements to the Chart Validation Process for the FY 2013 Payment Determination and Subsequent Years

For FY 2013 and future years, we are also proposing to adopt the same validation requirements that we adopted for the FY 2012 payment determination, except as set forth below.

For FY 2013 and future years, we are proposing to modify our FY 2012 criteria by adding a targeting criterion, refining our random sample approach, and changing our data discharge quarters validated as part of our proposed synchronization of RHQDAPU timelines. Specifically, we are proposing the following changes for FY 2013:

We are proposing to validate the data submitted by a hospital if the hospital failed the previous year's RHQDAPU program validation. We are proposing this targeting criterion to improve data accuracy for all hospitals failing our validation requirement in a previous year. We believe that this proposal is an appropriate method to ensure data accuracy, since it targets our resources on the hospitals with the least accurate data based on FY 2012 validation results. We also believe that these hospitals must correct the data inaccuracies identified in RHQDAPU validation for their internal quality improvement and RHQDAPU measures publicly reported on *Hospital Compare.* Our proposal allows CMS to assess the accuracy of these hospitals' data and provide feedback to hospitals until they comply with our RHQDAPU validation requirement.

Specifically, we are proposing that all hospitals selected for validation for the FY 2012 payment determination and that fail the validation will be selected for validation for the FY 2013 payment determination. Based on data analysis of past validation results, we estimate that targeting these hospitals would add about 20 to 40 hospitals to our list of validated hospitals to be selected in the FY 2013 validation sample.

For FY 2013, we also are proposing the following changes to the FY 2012 RHQDAPU validation random sample approach:

Starting in FY 2013, we are proposing to discontinue the 100 case minimum threshold for selection in the RHQDAPU 800 hospital random sample. We believe that discontinuing this requirement would improve the robustness of the RHQDAPU program validation sample by including the smallest hospitals participating in the RHQDAPU program in the sample. All hospitals successfully submitting at least one RHQDAPU case for the third calendar quarter of the year two years prior to the year to which the validation applies would be eligible to be selected for validation. For example, for the FY 2013 payment determination, we would select the sample in early 2011, and all hospitals that submitted at least one RHQDAPU case for third quarter 2010 discharges would be eligible to be selected. Starting in FY 2013, we are proposing this change to the RHQDAPU random validation sample, rather than including these hospitals in a targeted sample, to ensure that all RHQDAPU participating hospitals are equally likely to be selected in the random validation sample.

For the FY 2013 payment determination, we are proposing to modify the quarterly stratified sample selection by reallocating sample cases when a hospital has submitted fewer than three cases in a topic within a quarter. In these rare cases, we are proposing to randomly reallocate the extra sample cases to other topics with more than 3 submitted quarterly cases.

This proposed modification is designed to ensure that CMS selects 12 cases for all hospitals in a quarter, including those hospitals specializing in only one topic. For example, an orthopedic specialty surgery hospital submitting only SCIP measure cases in a given quarter would have only SCIP measure cases randomly selected in the validation sample for that quarter. This would provide a more reliable estimate of abstraction and measure accuracy by maintaining the same 12 case total quarterly validation sample.

For the FY 2013 payment determination, we also are proposing to validate data from the 4th calendar quarter of 2010 through the 3rd calendar quarter of 2011 in accordance with our proposed synchronization of RHQDAPU data as outlined in section V.A.5.a.(2) of this proposed rule. This lag between the time a hospital submits data and the time we can validate that data is necessary because data is not due to the QIO Clinical Warehouse until 4½ months after the end of each quarter, and we need additional time to select hospitals and complete the validation process.

We are also considering additional changes to our validation approach for future years. Beginning with the FY 2014 payment determination, we are considering adding two strata to the current RHQDAPU program validation sample of SCIP, AMI, HF, and PN cases. We are considering selecting 2 additional validation samples of 3 cases per selected hospital per quarter. One additional quarterly sample would enable us to validate the Central Line Associated Bloodstream Infection (CLABSI) and Surgical Site Infection (SSI) measures that we are proposing to add to the RHQDAPU measure set for the FY 2013 payment determination, and the second additional quarterly sample would enable us to validate the ED-Throughput and the Immunization for Influenza and Immunization for Pneumonia global measures that we are proposing to add to the RHQDAPU measure set for the FY 2014 payment determination. Thus, we would be validating a total of 18 records per quarter per validated hospital in six strata (1) SCIP, (2) AMI, (3) HF, (4) PN, (5) CLABSI/SSI, and (6) ED–Throughput/Immunization measures. We are also considering requiring hospitals to sign a written form explicitly granting CMS access to their patient level data submitted for the proposed Central Line Associated Blood Stream Infection measure and the Surgical Site Infection measure. We believe that the CLABSI/SSI stratum is necessary to validate the data in the reports that we will access from NHSN for the RHQDAPU program. We invite comment on our validation proposals and considerations.

We note that we are considering proposing, beginning with the FY 2015 payment determination, to add hospitals to our validation sample if they were open under their current CCNs in FY 2012 but not selected for validation in the three previous annual RHQDAPU validation samples. We are considering this addition to supplement our validation approach to ensure that all eligible RHQDAPU program hospitals are selected for validation at least once every 4 years. We are considering this addition beginning with the FY 2015 payment determination because FY 2015 would be the fourth year that we will be using the random validation approach.

8. Data Accuracy and Completeness Acknowledgement Requirements for the FY 2011 Payment Determination and Subsequent Years

For the FY 2011 payment determination and subsequent years, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24180), we proposed to require hospitals to electronically acknowledge on an annual basis the completeness and accuracy of the data submitted for the RHQDAPU program payment determination. Hospitals will be able to submit this acknowledgement on the same Web page that they use to submit data necessary to calculate the structural measures, and we believe that this Web page will provide a secure vehicle for hospitals to directly acknowledge that their information is complete and accurate to the best of their knowledge. A single annual electronic acknowledgement will provide us with explicit documentation acknowledging that the hospital's data is accurate and complete, but will not unduly burden hospitals. We noted that commenters generally supported the idea of electronic attestation in the FY 2009 IPPS final rule (73 FR 48625) at the point of data submission to the QIO Clinical Warehouse.

In addition, the Government Accountability Office (GAO) recommended in a 2006 report (GAO–06–54) that hospitals self-report that their data are complete and accurate. Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43890) for the FY 2010 payment determination, we required hospitals to electronically acknowledge their data accuracy and completeness once between July 1, 2009, and August 15, 2009. Hospitals will acknowledge that all information that is, or will be, submitted as required by the RHQDAPU program for the FY 2010 payment determination is complete and accurate to the best of their knowledge.

We are proposing to require hospitals to electronically acknowledge their data accuracy and completeness once between July 1, 2010 and August 15, 2010 for data to be used for the FY 2012 RHQDAPU program payment determination.

9. Proposed Public Display Requirements for the FY 2012 Payment Determination and Subsequent Years

Section 1886(b)(3)(B)(viii)(VII) of the Act provides that the Secretary shall establish procedures for making data submitted under the RHQDAPU program available to the public. As we noted in section V.A.1.c.(3) of this proposed rule, the RHQDAPU program quality measures are typically reported on the *Hospital Compare* Web site (*http://www.hospitalcompare.hhs.gov*), but on occasion are reported on other CMS Web sites. We require that hospitals sign a Notice of Participation form when they first register to participate in the RHQDAPU program. Once a hospital has submitted a form, the hospital is considered to be an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS (72 FR 47360). Hospitals signing this form agree that they will allow CMS to publicly report the quality measures included in the RHQDAPU program.

We will continue to display quality information for public viewing as required by section 1886(b)(3)(B)(viii)(VII) of the Act. Before we display this information, hospitals will be permitted to review their information as recorded in the QIO Clinical Warehouse.

10. Proposed Reconsideration and Appeal Procedures for the FY 2011 Payment Determination

The general deadline for submitting a request for reconsideration in connection with the FY 2011 payment determination is November 1, 2010. As discussed more fully below, we are proposing that all hospitals submit a request for reconsideration and receive a decision on that request before they can file an appeal with the Provider Reimbursement Review Board (PRRB).

For the FY 2011 payment determination, we are proposing to continue utilizing most of the same procedures that we utilized for the FY 2010 requests for reconsideration. Under these proposed procedures, the hospital must—

Submit to CMS, via QualityNet, a Reconsideration Request form (available on the *QualityNet* Web site) containing the following information:

—Hospital CMS Certification number (CCN).
—Hospital Name.
—CMS-identified reason for failure (as provided in the CMS notification of failure letter to the hospital).
—Hospital basis for requesting reconsideration. This must identify the hospital's specific reason(s) for believing it met the RHQDAPU program requirements and should receive the full FY 2011 IPPS annual payment update.
—CEO contact information, including name, e-mail address, telephone number, and mailing address (must include the physical address, not just the post office box). We no longer require that the hospital's CEO sign the RHQDAPU program reconsideration request. We have found that this requirement increases the burden for hospitals because it prevents them from electronically submitting the RHQDAPU program reconsideration request forms. In addition, to the extent that a hospital can submit a request for reconsideration on-line, the burden on our staff is reduced and, as a result, we can more quickly review the request.
—QualityNet System Administrator contact information, including name, e-mail address, telephone number, and mailing address (must include the physical address, not just the post office box).
—Paper medical record requirement for reconsideration requests involving validation. We are proposing that if a hospital asks us to reconsider an adverse RHQDAPU program payment decision made because the hospital failed the validation requirement, the hospital must submit paper copies of all the medical records that it submitted to the CDAC contractor each quarter for purposes of the validation. Hospitals must submit this documentation to a CMS contractor. The contractor will be a QIO support contractor, which has authority to review patient level information under 42 CFR part 480. We will post the address where hospitals can ship the paper charts on the QualityNet Web site after we issue the FY 2011 IPPS/LTCH PPS final rule. Hospitals submitting a RHQDAPU program validation reconsideration request will have all mismatched data reviewed by CMS, and not their State QIO. (As discussed in section V.A.6.b. of this proposed rule, the State QIO is available to conduct a quarterly validation appeal if so requested by a hospital.)

For the FY 2011 payment determination, the RHQDAPU program data that will be validated is 4th calendar quarter 2008 through 3rd quarter calendar year 2009 discharge data. Hospitals must provide a written justification for each appealed data element classified during the validation process as a mismatch. We will review the data elements that were labeled as mismatched, as well as the written justifications provided by the hospitals, and make a decision on the reconsideration request. As we mentioned above, we are proposing that all hospitals submit a reconsideration request to CMS and receive a decision on that request prior to submitting a PRRB appeal. We believe that the reconsideration process is less costly for both CMS and hospitals, and that this requirement will decrease the number of PRRB appeals by resolving issues earlier in the appeals process.

Following receipt of a request for reconsideration, we will—

• Provide an e-mail acknowledgement, using the contact information provided in the reconsideration request, to the CEO and the QualityNet Administrator that the request has been received.

• Provide written notification to the hospital CEO, using the contact information provided in the reconsideration request, regarding our decision. We expect the process to take approximately 90 days from the reconsideration request due date of November 1, 2010.

As we stated in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43892), the scope of our review when a hospital requests reconsideration because it failed our validation requirements will be as follows:

1. *Hospital requests reconsideration for CDAC contractor-abstracted data elements classified as mismatches affecting validation scores.* Hospitals must timely submit a copy of the entire requested medical record to the CDAC contractor during the quarterly validation process for the requested case to be eligible to be reconsidered on the basis of mismatched data elements.

2. *Hospital requests reconsideration for medical record copies submitted during the quarterly validation process and classified as invalid record selections.* Invalid record selections are defined as medical records submitted by hospitals during the quarterly validation process that do not match the patient's episode of care information as determined by the CDAC contractor (in other words, the contractor determines that the hospital returned a medical record that is different from that which was requested). If the CDAC contractor determines that the hospital has submitted an invalid record selection case, it awards a zero validation score for the case because the hospital did not submit the entire copy of the medical record for that requested case. During the reconsideration process, our review of invalid record selections will initially be limited to determining whether the record submitted to the CDAC contractor was actually an entire copy of the requested medical record. If we determine during reconsideration that the hospital did submit the entire copy of the requested medical record, then we would abstract data elements from the medical record submitted by the hospital.

3. *Hospital requests reconsideration for medical records not submitted to the CDAC contractor within the 45 calendar day deadline.* Our review will initially be limited to determining whether the CDAC contractor received the requested record within 45 calendar days, and whether the hospital received the initial medical record request and reminder notice. If we determine during reconsideration that the CDAC contractor did receive a paper copy of the requested medical record within 45 calendar days, then we would abstract data elements from the medical record submitted by the hospital. If we determine that the hospital received two letters requesting medical records and still did not submit the requested records within the 45 day period, CMS will not accept these records as part of the reconsideration. CMS will not abstract data from charts not received timely by the CDAC contractor.

In sum, we are initially limiting the scope of our reconsideration reviews involving validation to information already submitted by the hospital during the quarterly validation process, and we will not abstract medical records that were not submitted to the CDAC contractor during the quarterly validation process. We will expand the scope of our review only if we find during the initial review that the hospital correctly and timely submitted the requested medical records. In that case, then we would abstract data elements from the medical record submitted by the hospital as part of our review of its reconsideration request.

If a hospital is dissatisfied with the result of a RHQDAPU program reconsideration decision, the hospital may file a claim under 42 CFR part 405,

Subpart R (a PRRB appeal). We are again soliciting public comments on the extent to which these proposed procedures will be less costly for hospitals, and whether they will lead to fewer PRRB appeals.

11. Proposed RHQDAPU Program Withdrawal Deadlines

We are proposing to accept RHQDAPU program withdrawal forms for the FY 2012 payment determination from hospitals until August 15, 2011. We are proposing this deadline so that we would have sufficient time to update the FY 2012 payment to hospitals starting on October 1, 2011. If a hospital withdraws from the program for the FY 2012 payment determination, it will receive a 2.0 percentage point reduction in its FY 2012 annual payment update. We noted that once a hospital has submitted a Notice of Participation form, it is considered to be an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS.

12. Electronic Health Records (EHRs)

a. Background

Starting with the FY 2006 IPPS final rule, we have encouraged hospitals to take steps toward the adoption of EHRs (also referred to in previous rulemaking documents as electronic medical records) that will allow for reporting of clinical quality data from the EHRs directly to a CMS data repository (70 FR 47420 through 47421). We encouraged hospitals that are implementing, upgrading, or developing EHR systems to ensure that the technology obtained, upgraded, or developed conforms to standards adopted by HHS. We suggested that hospitals also take due care and diligence to ensure that the EHR systems accurately capture quality data and that, ideally, such systems provide point-of-care decision support that promotes optimal levels of clinical performance.

We also continue to work with standard setting organizations and other entities to explore processes through which EHRs could speed the collection of data and minimize the resources necessary for quality reporting as we have done in the past.

We note that we have initiated work directed toward enabling EHR submission of quality measures through EHR standards development and adoption. We have sponsored the creation of electronic specifications for quality measures that are currently proposed for the RHQDAPU program and measures under future consideration. We look to continue this activity in the future.

b. EHR Testing of Quality Measures Submission

As we have previously stated, we are interested in the reporting of quality measures using EHRs, and we continue to encourage hospitals to adopt and use EHRs that conform to the certification criteria as will be defined by the Office of the National Coordinator for Health Information Technology, HHS at 45 CFR part 170. We believe that the testing of EHR submission is an important and necessary step to establish the ability of EHRs to report clinical quality measures and the capacity of CMS to receive such data.

The electronic specifications and interoperability standards for EHR-based collection and transmission of the data elements for the ED Throughput, Stroke, and Venous Thromboembolism (VTE) measures have been finalized by the Health Information Technology Standards Panel (HITSP) and are available for review and testing at *http//www.HITSP.org*. We anticipate testing the components required for the submission of clinical quality data extracted from EHRs for these measures, and are exploring different mechanisms and formats that will aid the submission process, as well as ensure that the summary measure results extracted from the EHRs are reliable.

We anticipate moving forward with testing CMS' technical ability to accept data from EHRs for the ED, Stroke, and VTE measures as early as summer of 2011. We anticipate building upon the work completed by the HITSP in both the Connectathon and Health Information Management Systems Society (HIMSS) Interoperability Showcase. This testing will encompass an "end to end" view of data transmission. Pursuant to the Paperwork Reduction Act, we have previously published a **Federal Register** notice and information collection request for CMS–10296 (74 FR 44366) seeking public comments on the process we intended to follow to select EHR vendors/hospitals for testing CMS ability to accept EHR-based data submissions. We will notify interested parties of changes in the process and timeline for testing via the Inpatient EHR testing Web site at: *http://www.cms.hhs.gov/HospitalQualityInits/15_HospitalInpatientEHRTesting.asp.*

The test measures described above are not currently required under the RHQDAPU program. In addition, the posting of the electronic specifications for any particular measure should not be interpreted as a signal that we intend to select the measure for inclusion in the RHQDAPU program measure set.

c. HITECH Act EHR Provisions

The HITECH Act (Title IV of Division B of the ARRA, together with Title XIII of Division A of the ARRA) authorizes payment incentives under Medicare for the adoption and use of certified EHR technology beginning in FY 2011. Hospitals are eligible for these payment incentives if they meet requirements for meaningful use of certified EHR technology, which include reporting on quality measures using certified EHR technology. With respect to the selection of quality measures for this purpose, under section 1886(n)(3)(A)(ii) of the Act, as added by section 4102 of the HITECH Act, the Secretary shall select measures, including clinical quality measures, that hospitals must provide to CMS in order to be eligible for the EHR incentive payments. With respect to the clinical quality measures, section 1886(n)(3)(B)(i) of the Act requires the Secretary to give preference to those clinical quality measures that have been selected for the RHQDAPU program under section 1886(b)(3)(B)(viii) of the Act or that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act. Any measures must be proposed for public comment prior to their selection, except in the case of measures previously selected for the RHQDAPU program under section 1886(b)(3)(B)(viii) of the Act.

Thus, the RHQDAPU program and the HITECH Act have important areas of overlap and synergy with respect to the reporting of quality measures using EHRs. We believe the financial incentives under the HITECH Act for the adoption and meaningful use of certified EHR technology by hospitals will encourage the adoption and use of certified EHRs for the reporting of clinical quality measures under the RHQDAPU program. Further, these efforts to test the submission of quality data through EHRs may provide a foundation for establishing the capacity of hospitals to send, and for CMS to receive, quality measures via hospital EHRs for future RHQDAPU program measures.

We again note that the provisions in this proposed rule do not implicate or implement any HITECH statutory provisions. Those provisions are the subject of separate rulemaking and public comment.

13. Qualification of Registries for RHQDAPU Data Submission

In section V.A.3.c.(3) of this proposed rule, we proposed that hospitals would select at least one of four registry-based measure topics for which they will report data on proposed measures to a qualified registry beginning with January 1, 2011 discharges, and allow the registry to calculate and report measure data for the specified measures to CMS (via QualityNet) for RHQDAPU program purposes. The process and requirements that we are proposing to use to determine whether a registry is qualified to collect and submit quality measure data are described below. We will post on the RHQDAPU program section of the QualityNet Web site *http://www.qualitynet.org* no later than December 31, 2010 a list of qualified registries for the FY 2013 RHQDAPU payment determination, including the registry name, contact information, and the measure(s) for which the registry is qualified and will report for the FY 2013 RHQDAPU payment determination. We have proposed measures for inclusion in each of the four registry-based topics, and a registry seeking to be qualified for a particular topic would have to agree to collect and report the measures included in the topic. The proposed measures support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries (such as, prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; and effective management of acute and chronic episodes of care). We note, however, that none of the registries that we qualify for this purpose will be acting as a CMS contractor or agent. In other words, hospitals will still be responsible for making sure that the data it submits to the qualified registry is successfully processed and transmitted by the registry to CMS.

We are proposing to implement a self-nomination process for registries seeking to submit FY 2013 RHQDAPU program quality measures (including measure calculations, numerators, denominators, and exclusions) on behalf of hospitals beginning with January 1, 2011 discharges. A registry would be able to self-nominate if it meets the following requirements:

- The registry has been collecting data elements needed to calculate the particular measures that are being proposed for inclusion in the registry-based topic for which the registry is seeking qualification for at least 3 years prior to January 1, 2010.
- As of January 1, 2010, the registry has been collecting such data from at least 750 hospitals.
- The registry must have the capability to collect from hospitals all of the data elements which are included in the measure specifications and calculate the results for the specified measures. The measures are NQF-endorsed and will be listed in the Specifications Manual.
- The registry must agree to report the hospital level measure data to CMS (via QualityNet). During the registry qualification process, CMS will inform the registries of the specified reporting format which will include:
  - The volume of eligible cases (reporting denominator);
  - The volume of numerator events for the quality measure (reporting numerator);
  - The number of cases excluded from the measure;
  - The measure results
- The registry must agree to transmit quality measure data in a CMS-approved format. We expect that this CMS-specified record layout will be made available in late 2010;
- The registry must be able to perform data quality validation checks on the data received from hospitals to determine if the data submitted by the hospitals are accurate and agree to submit an acceptable "validation strategy" to CMS by December 15, 2011. A validation strategy ascertains whether hospitals have submitted data accurately to the registry. An acceptable validation strategy may include such provisions as the registry being able to verify the accuracy of hospital data through random sampling or through the hospital's adherence to a required sampling method;
- The registry must agree to enter into and maintain with its participating hospitals an appropriate Business Associate agreement that complies with HIPAA.
- The registry must obtain and keep on file signed documentation showing that each of its participating hospitals has authorized the registry to calculate and submit the quality measure hospital-level data specified by CMS to CMS. This documentation must be obtained at the time the hospital arranges to submit RHQDAPU program quality measure data to the registry;
- The registry must agree to provide CMS with access (if requested) to review the data that the hospital submitted to it for purposes of the RHQDAPU program;
- The registry must agree to indicate to CMS upon request whether a particular hospital has satisfied the registry's participation requirements;
- The registry must agree to provide CMS with a signed, written attestation statement via mail or e-mail which states that the quality measure data that the registry has submitted to CMS on behalf of its participating hospitals is accurate and complete.
- The registry must agree to provide at least 1 feedback report per year to participating hospitals;
- The registry must agree to provide on-going technical assistance to its participating hospitals with respect to the hospitals' submission of RHQDAPU data; and
- The registry must agree to participate in periodic RHQDAPU program support calls hosted by CMS.

To apply to be a qualified registry for any of the four proposed registry-based topics, a registry must submit a self-nomination letter by October 15, 2010 to *RHQDAPU_Registries@cms.hhs.gov* containing the registry name, point of contact, the proposed registry-based measure topic for which qualification is being sought, and detailed information regarding how the registry satisfies the criteria listed above.

B. Payment for Transfers of Cases From Medicare Participating Acute Care Hospitals to Nonparticipating Hospitals and CAHs (§ 412.4)

1. Background

Existing regulations at § 412.4(a) provide that an inpatient is considered discharged from a hospital paid under the IPPS when the patient is either formally released from the hospital or dies in the hospital. Under certain circumstances, a discharge is considered a transfer for purposes of payment under the IPPS. Section 412.4(b) defines acute care transfers, and § 412.4(c) identifies those discharges considered a postacute care transfer. In accordance with § 412.4(f), when a patient is transferred and his or her length of stay is less than the geometric mean length of stay for the MS–DRG to which the case is assigned, the transferring hospital is generally paid based on a graduated per diem rate for each day of the stay, not to exceed the full MS–DRG payment that would have been made if the patient had been discharged without being transferred. In the case of acute care transfers, the receiving hospital that ultimately discharges the transferred patient receives the full MS–DRG payment, regardless of whether the length of the patient's inpatient stay exceeds the geometric mean length of stay for the applicable MS–DRG.

The per diem rate paid to a transferring hospital is calculated by dividing the full MS–DRG payment by the geometric mean length of stay for the MS–DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 5804), our policy generally provides for payment that is double the per diem amount for the first day, with each subsequent day paid at the per diem amount up to the full DRG payment (§ 412.4(f)(1)). Transfer cases also are eligible for outlier payments. In general, the outlier threshold for transfer cases, as described in § 412.80(b) of the regulations, is equal to the fixed-loss outlier threshold for nontransfer cases (adjusted for geographic variations in costs), divided by the geometric mean length of stay for the MS–DRG, and multiplied by the length of stay for the case plus one day.

The transfer policy adjusts the payments of the transferring hospital to approximate the reduced costs of transfer cases. Medicare adopted its IPPS transfer policy because, if Medicare were to pay the full MS–DRG payment regardless of whether a patient is transferred or discharged, there would be a strong incentive for hospitals to transfer patients to another IPPS hospital early in their stay in order to minimize costs while still receiving the full MS–DRG payment.

b. Proposed Policy Change

The regulations at § 412.4(b) state that a discharge of a hospital inpatient is considered to be an acute care transfer when the patient is readmitted on the same day to another hospital that is paid under the IPPS, or to a hospital that is excluded from the IPPS because of participation in a statewide cost control program, unless the readmission is unrelated to the initial discharge. These regulations were developed under the authority granted in section 1886(d)(5)(I)(ii) of the Act. Because a discharge is only considered an acute care transfer if the receiving hospital either is paid under IPPS or participates in a statewide cost control program, the current acute care transfer policy only applies to transfers between acute care hospitals that participate in the Medicare program ("participating acute care hospitals"); it does not currently apply to acute care hospitals that would otherwise be eligible to be paid under the IPPS, but do not have an agreement to participate in the Medicare program ("nonparticipating acute care hospitals"). The acute care transfer policy also does not currently apply to IPPS acute care hospital transfers to CAHs.

The intent of the acute care transfer policy is to make payment to the transferring hospital commensurate with the resources it expends in treating Medicare beneficiaries. As stated above, a participating acute care hospital that admits a beneficiary from a transferring hospital receives a full MS–DRG payment, as long as the receiving hospital does not subsequently transfer the beneficiary prior to the geometric mean length of stay for that MS–DRG. The transferring hospital receives a reduced per diem payment amount. If the acute care transfer policy did not exist, Medicare would make separate full MS–DRG payments to each of the hospitals involved with the treatment of the beneficiary, even though the hospitals shared in one episode of care for the same beneficiary and neither provided the full spectrum of care for that beneficiary for that episode of care. Such a policy would inappropriately pay a "double" Medicare payment and would be inconsistent with the intent of the acute care transfer policy.

Although a nonparticipating acute care hospital is generally ineligible to receive payments under Medicare, such a hospital may still treat Medicare patients. In addition, acute care hospitals that do participate in the Medicare program are not precluded from transferring a Medicare patient to a nonparticipating acute care hospital. We note that a hospital that transfers a patient early in the patient's stay (that is, prior to the geometric mean length of stay of the patient's MS–DRG) incurs reduced costs for that case, regardless of whether the patient is transferred to a Medicare participating acute care hospital or a nonparticipating acute care hospital. A hospital that sends such a transfer to a CAH incurs similarly reduced costs, despite the fact that transfers to CAHs are not currently included under the Medicare acute care transfer policy.

These policy changes are also being proposed in order to avoid creating a financial incentive for an IPPS hospital to transfer cases to one type of provider versus another. A transfer decision should be made based on the clinical merits of the beneficiary's situation and the transferring hospital's capabilities. More pointedly, we want to avoid providing a Medicare participating acute care hospital with an incentive to transfer cases to a nonparticipating acute care hospital or a CAH. Without a policy change, these incentives still exists as payment issues relating to the IPPS transfer policy. With respect to nonparticipating acute care hospitals, it is frequently explained that the Medicare conditions of participation provide a certain minimum standard of care that beneficiaries can expect, and that Medicare does not make payments to nonparticipating acute care hospitals because these hospitals do not commit to adhering to these conditions of participation. As such, the lack of a policy with regard to transfers to nonparticipating acute care hospitals results in an inappropriate payment incentive.

Accordingly, in order to further align the IPPS regulations relating to transfer of cases under § 412.4(b) with its original intent (that is, that a hospital's payment should be commensurate with the resources it expends for the case), in this proposed rule, we are proposing to add a new paragraph (b)(3) to § 412.4 to specify that an acute care hospital "transfer case" includes a transfer to an acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program, and a new paragraph (b)(4) to state that an acute care hospital "transfer" also includes a transfer to a CAH.

Hospitals must use patient discharge status code "66" (Discharged/Transferred to a Critical Access Hospital) on IPPS claims to identify transfers to CAHs. For transfers to nonparticipating acute care hospitals, hospitals must continue to use patient status code "02" (Discharged/Transferred to a Short-Term General Hospital for Inpatient Care) on IPPS claims. We note that the National Uniform Billing Committee (NUBC) periodically updates or changes patient status codes; therefore, hospitals should check NUBC guidance periodically to determine whether there have been any changes to these codes.

C. Technical Change to Regulations

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43939 through 43940), in response to public comments we received on the FY 2010 proposed rule relating to the effects on CAH status arising from the redesignation by OMB of three Micropolitan Statistical Areas as MSAs, we amended our regulations at § 485.610 by adding a paragraph (b)(4) to provide for a transition period for the CAHs that are located in counties that are reclassified from rural to urban to obtain a rural redesignation. However, when we added the new paragraph (b)(4) to § 485.610, we inadvertently failed to make a conforming change to the introductory text of paragraph (b) to include a reference to paragraph (b)(4) as one of the requirements that the CAH must meet in order to satisfy the conditions of participation for CAHs.

We are proposing to make this confirming change.

D. Medicare-Dependent, Small Rural Hospitals (MDHs): Change to Criteria (§ 412.108)

1. Background

Under the IPPS, separate special payment protections are provided to a Medicare-dependent, small rural hospital (MDH). Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area, has not more than 100 beds, is not an SCH, and has a high percentage of Medicare discharges (that is, not less than 60 percent of its inpatient days or discharges either in its 1987 cost reporting year or in two of its most recent three settled Medicare cost reporting years). The regulations that set forth the criteria that a hospital must meet to be classified as an MDH are at 42 CFR 412.108.

Although MDHs are paid under an adjusted payment methodology, they are still IPPS hospitals paid under section 1886(d) of the Act. Like all IPPS hospitals paid under section 1886(d) of the Act, MDHs are paid for their discharges based on the DRG weights calculated under section 1886(d)(4) of the Act.

Through and including FY 2006, under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal rate or, if higher, the Federal rate plus 50 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rate based on the hospital's FY 1982 or FY 1987 costs per discharge, whichever of these hospital-specific rates is higher. Section 5003(b) of Public Law 109–171 (DRA 2005) amended section 1886(d)(5)(G) of the Act to provide that, for discharges occurring on or after October 1, 2006, MDHs are paid based on the Federal rate or, if higher, the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rate based on FY 1982, FY 1987, or FY 2002 costs per discharge, whichever of these hospital-specific rates is highest.

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

If a hospital disagrees with the fiscal intermediary's or the MAC's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the determination in accordance with the procedures set forth in 42 CFR Part 405, Subpart R, which govern provider payment determinations and appeals.

2. Medicare-Dependency: Counting Medicare Inpatients

Currently, in order for an IPPS hospital to qualify as an MDH, at least 60 percent of its inpatient days or discharges must be attributable to individuals receiving Medicare Part A benefits (§ 412.108(a)(1)(iii) of the regulations).

The MDH policy, as explained in the FY 1991 final rule (55 FR 35994 through 35998), does not include in the count of Medicare inpatients those Medicare beneficiaries who have exhausted their Medicare Part A inpatient benefits. Currently, for purposes of determining DSH payment adjustments under the IPPS, section 1886(d)(5)(F)(vi)(I) of the Act and our policy include, in the Medicare inpatient count, individuals entitled to Medicare Part A benefits, regardless of whether or not they have exhausted Medicare Part A coverage. This policy is discussed in the FY 2005 IPPS final rule (69 FR 49090 through 49099). In addition, section 1886(d)(5)(G)(iv)(IV) of the Act specifies that a hospital is Medicare-dependent if "not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A." The use of the word "entitled" in the statute would encompass individuals who are entitled to Medicare Part A even though they have exhausted their Part A hospital days. Individuals who have exhausted their Part A inpatient benefit coverage remain "entitled" to Medicare Part A because they retain the Medicare Part A insurance benefit coverage (for example, covered SNF days), and they continue to meet all statutory criteria for entitlement to Part A benefits under section 226 of the Act (Entitlement to Hospital Insurance Benefits).

Accordingly, we are proposing to revise the Medicare-dependency criterion at § 412.108(a)(1)(iii) of the regulations to replace the term "receiving" with the phrase "entitled to". As a result, we would include in the count of Medicare inpatient days or discharges all days or discharges attributable to individuals entitled to the Medicare Part A insurance benefit, including individuals who have exhausted their Medicare Part A inpatient hospital coverage benefit, as well as individuals enrolled in Medicare Advantage plans and section 1876 cost contracts, that is, health maintenance organizations (HMOs) and competitive medical plans (CMPs). We note that, for inpatient care provided to Medicare Part A beneficiaries enrolled with an HMO or a CMP, we provided that the days and discharges for those stays are counted for purposes of determining Medicare-dependency for MDH purposes (55 FR 35995). This was the case when HMOs and CMPs were included under Medicare Part A, and continues to be the case since 1997 when HMOs and CMPs were placed under Medicare Part C.

E. Rural Referral Centers (RRCs) (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as an RRC. For discharges that occurred before October 1, 1994, RRCs received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount (as discussed in the FY 1993 IPPS final rule (59 FR 45404 through 45409)). Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, RRCs continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Public Law 108–173 raised the DSH adjustment for RRCs such that they are not subject to the 12-percent cap on DSH payments that is applicable to other rural hospitals. RRCs are also not subject to the proximity criteria when applying for geographic reclassification. In addition, they do not have to meet the requirement that a hospital's average hourly wage must exceed, by a certain percentage, the average hourly wage of the labor market area where the hospital is located.

Section 4202(b) of Public Law 105–33 states, in part, "[a]ny hospital classified as an RRC by the Secretary * * * for fiscal year 1991 shall be classified as such an RRC for fiscal year 1998 and each subsequent year." In the August 29, 1997 IPPS final rule with comment period (62 FR 45999), CMS reinstated RRC status for all hospitals that lost the status due to triennial review or MGCRB reclassification. However, CMS did not reinstate the status of hospitals that lost RRC status because they were now urban for all purposes because of the OMB designation of their geographic area as urban. Subsequently, in the August 1, 2000 IPPS final rule (65 FR 47089), we indicated that we were revisiting that decision. Specifically, we stated that we would permit hospitals that previously qualified as an RRC and lost their status due to OMB redesignation of the county in which they are located from rural to urban, to be reinstated as an RRC. Otherwise, a hospital seeking RRC status must satisfy all of the other applicable criteria. We use the definitions of "urban" and "rural" specified in Subpart D of 42 CFR Part 412. One of the criteria under which a hospital may qualify as an RRC is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as an RRC if the hospital meets two mandatory prerequisites (a minimum CMI and a minimum number of discharges), and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). (We refer readers to § 412.96(c)(1) through (c)(5) and the September 30, 1988 **Federal Register** (53 FR 38513).) With respect to the two mandatory prerequisites, a hospital may be classified as an RRC if—

- The hospital's CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index (CMI)

Section 412.96(c)(1) provides that CMS establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining RRC status. The methodology we used to determine the national and regional CMI values is set forth in the regulations at § 412.96(c)(1)(ii). The proposed national median CMI value for FY 2011 includes data from all urban hospitals nationwide, and the proposed regional values for FY 2011 are the median CMI values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals that train residents in an approved GME program as provided in § 413.75). These proposed values are based on discharges occurring during FY 2009 (October 1, 2008 through September 30, 2009), and include bills posted to CMS' records through December 2009.

We are proposing that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2010, they must have a CMI value for FY 2009 that is at least—

- 1.5127; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The proposed median CMI values by region are set forth in the following table:

Region	Proposed Case-Mix Index Value
1. New England (CT, ME, MA, NH, RI, VT)	1.3010
2. Middle Atlantic (PA, NJ, NY)	1.3590
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.4559
4. East North Central (IL, IN, MI, OH, WI)	1.4262
5. East South Central (AL, KY, MS, TN)	1.3776
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.4404
7. West South Central (AR, LA, OK, TX)	1.5181
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.6004
9. Pacific (AK, CA, HI, OR, WA)	1.4826

The preceding numbers will be revised in the FY 2011 IPPS final rule to the extent required to reflect the updated FY 2009 MedPAR file, which will contain data from additional bills received through March 2010.

A hospital seeking to qualify as an RRC should obtain its hospital-specific CMI value (not transfer-adjusted) from its fiscal intermediary or MAC. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, the CMI values are computed based on all Medicare patient discharges subject to the IPPS MS–DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS set forth the national and regional

numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2008 (that is, October 1, 2007 through September 30, 2008), which are the latest cost report data available at the time this proposed rule was developed.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2010, must have, as the number of discharges for its cost reporting period that began during FY 2008, at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table.

Region	Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,701
2. Middle Atlantic (PA, NJ, NY)	11,346
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,905
4. East North Central (IL, IN, MI, OH, WI)	9,329
5. East South Central (AL, KY, MS, TN)	5,902
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	8,091
7. West South Central (AR, LA, OK, TX)	6,264
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,346
9. Pacific (AK, CA, HI, OR, WA)	8,464

These numbers will be revised in the FY 2011 IPPS final rule based on the latest available cost report data.

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that, if an osteopathic hospital is to qualify for RRC status for cost reporting periods beginning on or after October 1, 2010, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2008.

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

1. Background

Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the IPPS for hospitals that have residents in an approved graduate medical education (GME) program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

Public Law 105–33 (BBA 1987) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its full-time equivalent (FTE) resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997.

2. IME Adjustment Factor for FY 2011

The IME adjustment to the MS–DRG payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated by using a hospital's ratio of residents to beds, which is represented as r, and a formula multiplier, which is represented as c, in the following equation: $c \times [\{1 + r\}^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 502(a) of Public Law 108–173 modified the formula multiplier (c) to be used in the calculation of the IME adjustment. Prior to the enactment of Public Law 108–173, the formula multiplier was fixed at 1.35 for discharges occurring during FY 2003 and thereafter. In the FY 2005 IPPS final rule, we announced the schedule of formula multipliers to be used in the calculation of the IME adjustment and incorporated the schedule in our regulations at § 412.105(d)(3)(viii) through (d)(3)(xii). Section 502(a) modified the formula multiplier beginning midway through FY 2004 and provided for a new schedule of formula multipliers for FY 2005 and thereafter as follows:

- For discharges occurring on or after April 1, 2004, and before October 1, 2004, the formula multiplier is 1.47.
- For discharges occurring during FY 2005, the formula multiplier is 1.42.
- For discharges occurring during FY 2006, the formula multiplier is 1.37.
- For discharges occurring during FY 2007, the formula multiplier is 1.32.
- For discharges occurring during FY 2008 and fiscal years thereafter, the formula multiplier is 1.35.

Accordingly, for discharges occurring during FY 2011, the formula multiplier is 1.35. We estimate that application of

this formula multiplier for the FY 2011 IME adjustment will result in an increase in IPPS payment of 5.5 percent for every approximately 10-percent increase in the hospital's resident-to-bed ratio.

3. IME-Related Changes in Other Sections of This Proposed Rule

We refer readers to section IV.H.2. and IV.H.3. of the preamble of this proposed rule for a discussion of proposed changes to the policies for identifying "approved medical residency programs" and the electronic submission of Medicare GME affiliation agreements.

G. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs): Supplemental Security Income (SSI) Fraction (§ 412.106)

1. Background

Section 1886(d)(5)(F) of the Act provides for additional Medicare payments to subsection (d) hospitals that serve a significantly disproportionate number of low-income patients. The Act specifies two methods by which a hospital may qualify for the Medicare disproportionate share hospital (DSH) adjustment. Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a Medicare DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to needy patients with low incomes. This method is commonly referred to as the "Pickle method."

The second method for qualifying for the DSH payment adjustment, which is the most common, is based on a complex statutory formula under which the DSH payment adjustment is based on the hospital's geographic designation, the number of beds in the hospital, and the level of the hospital's disproportionate patient percentage (DPP). A hospital's DPP is the sum of two fractions: The "Supplemental Security Income (SSI) fraction" and the "Medicaid fraction." The SSI fraction (also known as the "SSI ratio" or the "Medicare fraction") is computed by dividing the number of the hospital's inpatient days that are furnished to patients who were entitled to both Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan) and SSI benefits by the hospital's total number of patient days furnished to patients entitled to benefits under Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan). The Medicaid fraction is computed by dividing the hospital's number of inpatient days furnished to patients who, for such days, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A, by the hospital's total number of inpatient days in the same period.

Because the DSH payment adjustment is part of the IPPS, the DSH statutory references (under section 1886(d)(5)(F) of the Act) to "days" apply only to hospital acute care inpatient days. Regulations located at 42 CFR 412.106 govern the Medicare DSH payment adjustment and specify how the DPP is calculated as well as how beds and patient days are counted in determining the DSH payment adjustment. Under § 412.106(a)(1)(i), the number of beds for the Medicare DSH payment adjustment is determined in accordance with bed counting rules for the IME adjustment under § 412.105(b).

2. CMS' Current Data Matching Process for the SSI Fraction

From the inception of the Medicare DSH adjustment in 1986, CMS (formerly HCFA) has calculated the SSI fraction for each acute care hospital paid under the IPPS. This fraction, in combination with the Medicaid fraction, is used to determine whether the provider qualifies for a DSH payment adjustment and the amount of any such payment (51 FR 16772, 16777, May 6, 1986 interim final rule). In determining the number of inpatient days for individuals entitled to both Medicare Part A and SSI, as required for calculation of the numerator of the SSI fraction, CMS matches the Medicare records and SSI eligibility records for each hospital's patients during the Federal fiscal year, unless the provider requests calculation of the SSI fraction on a cost reporting period basis (in which case the provider would receive its SSI fraction based on its own cost reporting period). The data underlying the match process are drawn from: (a) The Medicare Provider Analysis and Review (MedPAR) data file; and (b) SSI eligibility data provided by the Social Security Administration (SSA). CMS has matched Medicare and SSI eligibility records using Title II numbers (included in the SSI records) and Health Insurance Claims Account Numbers (HICANs) (contained in the MedPAR file). Below we provide a more detailed description of both a Title II number and a HICAN.

Title II Number: If a person qualifies for retirement or disability benefits under Title II of the Act (42 U.S.C. 401 *et seq.*), SSA assigns a "Title II number" to the individual. If the Title II beneficiary's own earnings history (or the individual's disability) were the basis for such benefits, the person's Social Security number (SSN) would constitute the "root" of the individual's Title II number. However, if the person's Title II benefits were based on the earnings history of another individual (for example, a spouse), that other person's SSN would provide the root for the beneficiary's Title II number. In addition to a root SSN, each Title II number ends with a Beneficiary Identification Code (BIC) that identifies the basis for an individual's entitlement to benefits. For example, a person who becomes eligible for benefits under his or her own account would be described by his or her SSN followed by the BIC "A" whereas a wife who becomes eligible for benefits under her husband's account would be described by his SSN followed by the BIC "B." Children who become eligible under a parent's account would be described by the parent's SSN followed by the BIC "C1," "C2," etc.

HICAN: When a person becomes entitled to Medicare benefits, he or she is assigned a HICAN for purposes of processing claims submitted on his or her behalf for Medicare services. A beneficiary's HICAN (which may not necessarily contain his or her SSN) is included on the Medicare inpatient hospital claim.

Each HICAN for a beneficiary should be identical, at the same point in time, to that individual's Title II number. This is because HICANs and Title II numbers are both assigned on the basis of the same data source, the SSA-maintained Master Beneficiary Record, and by using the same rules (that is, the rules for determining which person's SSN will serve as the root for an individual's HICAN and Title II number and for determining the BIC for both types of numbers).

We note that a person's Title II number and HICAN can change over time. For example, if the individual's entitlement to Title II and Medicare benefits was originally based on the earnings history of a first spouse, but the beneficiary later qualified for such benefits on the basis of a second spouse's earnings history, the beneficiary's HICAN and Title II number would change accordingly. Specifically, the first spouse's SSN would be the root of the beneficiary's original HICAN and Title II number; later, the second spouse's SSN would become the root of the beneficiary's second HICAN and Title II number.

The SSI eligibility data that CMS receives from SSA contain monthly

indicators to denote which month(s) each person was eligible for SSI benefits during a specific time period. The current matching process uses only one Title II number (which is included in the SSI file) and one HICAN (found in the MedPAR file) for each beneficiary. In the current matching process, CMS has used the HICAN because it is the patient identifier that is provided by hospitals on the Medicare claim. Because SSNs are not included on Medicare inpatient claims, CMS has not used SSNs in the match process.

For a given fiscal year, CMS determines the numerator of the hospital's SSI fraction (that is, the number of the hospital's inpatient days for all of its patients who were simultaneously entitled to Medicare Part A benefits and SSI benefits) by calculating the sum of the number of the hospital's inpatient days that are associated with all of the identical Title II numbers and HICANs for the hospital's claims that are found through the data matching process. In turn, CMS determines the denominator of the hospital's SSI fraction by calculating the sum of the number of the hospital's inpatient days for patients entitled to benefits under Medicare Part A (regardless of SSI eligibility) that are included in the hospital's inpatient claims for the period.

3. *Baystate Medical Center* v. *Leavitt Court Decision*

In *Baystate Medical Center* v. *Leavitt,* 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008), the district court concluded that, in certain respects, CMS' current matching process (as described above) did not use the "best available data" to match Medicare patient day information with SSI eligibility data when calculating the plaintiff's SSI fractions for FYs 1993 through 1996. Specifically, the court found that:

- Stale SSI Records and Forced Pay SSI Records. For the earliest years in question in *Baystate,* the SSI eligibility data did not include "stale" records—that is, records for individuals whose SSI records were no longer active from SSA's perspective. (We note that it is our understanding that, as of the year 2000, SSA no longer differentiates between inactive and active records and therefore, no longer uses the "stale record" indicator in its databases.) The court also found that the SSI data file only included SSI eligibility information for SSI payments that were automated (as opposed to manual), thereby excluding those people who, for whatever reason, received manual or "forced pay" payments. *Baystate,* 545 F. Supp. 2d at 44–46.
- Match Based on Only One Title II Number and One HICAN. The court found fault with CMS' use of only a single Title II number and one HICAN in the match process. As a beneficiary may receive SSI and Medicare Part A benefits under more than one Title II number and HICAN over a period of time, CMS would not have matched a beneficiary's records if there had been a change in the person's Title II number and HICAN between the time of an inpatient stay and when the match process was completed. *Baystate,* 545 F. Supp. 2d at 46–49.
- Retroactive SSI Eligibility Determinations and Lifting of Payment Suspensions. The court found that the match process did not appropriately account for retroactive eligibility determinations of SSI eligibility and the lifting of payment suspensions because the match process used SSI eligibility data that did not include more recent retroactive determinations of SSI eligibility and the lifting of SSI payment suspensions. By not using more recent SSI eligibility information that was available to CMS at the time of the hospital's cost report settlement, the court concluded that CMS did not use the "best available data" to calculate the provider's SSI fraction. *Baystate,* 545 F. Supp. 2d at 42–44.

CMS continues to believe that its current data matching process and the resultant SSI fraction and DSH payments were lawful. Nonetheless, the agency did not appeal the *Baystate* decision. Accordingly, CMS implemented the court's decision by recalculating the plaintiff's SSI fractions for 1993 through 1996. In recalculating the SSI fractions at issue in the *Baystate* case, we worked closely with SSA to ensure that stale and forced pay SSI records were included in the SSI eligibility data. Also, we used a revised data matching process (described in more detail below) that comports with the court's decision. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, we are proposing to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.

4. CMS' Proposed Process for Matching Medicare and SSI Eligibility Data

a. Inclusion of Stale Records and Forced Pay Records in the SSI Eligibility Data Files

In recalculating the SSI fractions at issue in the *Baystate* case, stale records and forced pay records were included in the SSI eligibility data files that CMS used in the revised data match for the four fiscal years at issue. All SSI payment records, whether the payments were automated or manual or were for an individual whose record was active or stale, are now included in the data files provided by SSA and will continue to be included in the future.

b. Use of SSNs in the Revised Match Process

As indicated above, the current matching process only uses one Title II number and one HICAN in the data match process. By contrast, our revised match process would make use of the Medicare Enrollment Database (EDB), which is CMS' system of records for all individuals who have ever been enrolled in Medicare. The EDB includes SSNs as well as all of an individual's HICANs. In our proposed revised match process, the individual's SSN, contained in the SSI eligibility data file, would be compared to the SSNs in the Medicare EDB, and each matched SSN would then be "cross-walked" within the EDB to find any and all HICANs associated with the individual's SSN. The resulting HICANs would then be matched against those HICANs contained in the MedPAR claims data files.

Before explaining our proposed revised match process in more detail, we believe it is appropriate to provide some background regarding SSNs and the three databases that would be used in our proposed match process. An individual should have only one SSN, which should be unique to that individual. The SSN may be assigned by SSA when the individual begins gainful employment (if not earlier). However, if an applicant for SSI benefits does not already have a SSN, SSA then assigns a SSN to the person. Thus, in the SSI eligibility data that SSA provides to CMS, each individual identified in those data should have a unique SSN.

The first database that we are proposing to use in our revised match process is the SSI eligibility data file, which contains a unique SSN for every SSI record and would include as many as 10 different historical Title II numbers for the records related to one individual. We are proposing to use 10 as the maximum number of Title II numbers for a beneficiary because that

is likewise the maximum number of HICANs that can be attributed to any one individual in our EDB. However, we note that as a practical matter, the greatest number of historical HICANs associated with any beneficiary appears to be 7. The SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI benefits.

The second relevant database, the Medicare EDB, contains a SSN for virtually every record in the EDB. Furthermore, the EDB has the capacity to hold up to 10 historical HICANs for a specific Medicare enrollee. (It is important to note that, of the more than 100 million records in the EDB, less than 0.07 percent (that is, fewer than 7 of every 10,000 records) relate to individuals for whom the EDB does not include a SSN for the person. The EDB might not include a SSN for an individual if, for example, the person lives in another country but is entitled to Medicare benefits through his or her spouse.)

The third relevant database that we are proposing to use in our revised match process is the MedPAR file. Hospitals submit claims to Medicare for inpatient services provided to Medicare beneficiaries. These claims are eventually accumulated in the MedPAR database. It is important to note that the MedPAR database does not contain SSNs. The MedPAR database contains one HICAN number for each and every record of services provided to a Medicare beneficiary who was admitted to a Medicare-certified hospital or skilled nursing facility. This database allows us to calculate the number of Medicare inpatient hospital days, which we use in determining each hospital's DSH SSI fraction.

Utilizing the steps set forth below, we are proposing to use these three databases in a revised match process for FY 2011 and subsequent fiscal years:

Step 1—Use SSNs to find any and all relevant HICANs. Using the SSI eligibility data file provided by SSA, we are proposing to compare the individual SSNs in that file to the SSNs contained in the Medicare EDB. Each matched SSN would then be "cross-walked" (within the EDB) to find any and all HICANs associated with the individual's SSN. The resulting HICANs would then be matched against those HICANs contained in the MedPAR claims data files. This process should identify all relevant SSI records in which a SSN is associated with an individual who is simultaneously enrolled in Medicare Part A and in the SSI program.

Step 2—Utilize any and all Title II numbers. In order to provide further assurance that all of the Title II numbers and HICANs for SSI-eligible individuals have been identified, next we are proposing to compare the complete list of Title II numbers from the SSI data file (up to 10 Title II numbers for any one individual) to the list of HICANs generated through Step 1 above. If the SSI data file includes any Title II numbers that were not already identified in Step 1, the Title II number will be included in our revised match process and compared to any and all HICANs in MedPAR. We note that by including this second step (that is, adding all Title II numbers not previously identified by Step 1), we are addressing the very small universe of individuals for whom the EDB does not include a SSN. If an individual is entitled to SSI benefits and Medicare benefits, the new format of the SSI eligibility file will contain up to 10 Title II numbers and, if they have not already been captured, each of those numbers will be included in our revised match process. Even if an individual does not have a SSN in the EDB, this second step should ensure that our revised match process will include that individual.

Step 3—Ensure consistency between the HICANs in the EDB, Title II numbers, and the HICANs in the MedPAR file. The EDB stores the beneficiary's record at the most specific level of detail. For example, if the beneficiary's Medicare eligibility was originally based on a spouse's earnings history and the spouse subsequently dies, the beneficiary would have two HICANs. Both HICANs, which would have the same root, but different BICs, would be stored in the EDB. However, the inpatient claim in the MedPAR file will only have the individual's HICAN at a more general level of detail; in the preceding example, the BIC would identify the beneficiary only as a spouse without specifying whether the spouse (that is, the "primary" beneficiary) was alive or deceased. This third step should ensure consistency between the HICANs from Step 1 and the Title II numbers from Step 2 by "equating" (or converting) the BIC identifiers to the identifiers that are on the inpatient claim that is included in the MedPAR file. In addition, we are proposing that, for any SSI-eligible beneficiary who is receiving Medicare benefits based on his or her own account but whose records have not been matched already, we will attempt to match the beneficiary's HICAN in the MedPAR file. Specifically, we are proposing to simply add an "A" to all the SSNs in the SSI eligibility data file so that, if that individual was not captured by Steps 1 and 2 above (for whatever unlikely reason) but MedPAR indicated that the person had received Medicare services, the individual would be included in the data match process by this third step.

Step 4—Calculate the SSI fraction. We are not proposing any changes with respect to the final step in determining the SSI fraction. To calculate the numerator of the SSI fraction, CMS would continue to sum a hospital's Medicare inpatient days in the acute care part of the hospital (excluding IPPS-exempt units such as rehabilitation and psychiatric units) where the Medicare beneficiary was simultaneously entitled to SSI benefits. To calculate the denominator, CMS would continue to sum a hospital's total Medicare inpatient days in the acute care part of the hospital.

c. Timing of the Match

One of the district court's findings in the *Baystate* decision was that CMS did not use the latest available SSI eligibility file to calculate the provider's SSI fractions. As a result, it might be possible that if a beneficiary treated at the hospital was later determined retroactively to be SSI eligible or if a suspension of the individual's SSI payments was later lifted, that inpatient stay might not be included in the numerator of the SSI fraction. We believe that, in our recalculation of the *Baystate* hospital's SSI fractions and DSH payments, retroactive SSI eligibility determinations and the lifting of SSI payment suspensions were not an issue due to the long period of time that elapsed between the provider's 1993 through 1996 fiscal years and our use of updated SSI eligibility data during our completion of the revised match process in 2009. However, we believe that further consideration of the timing of both the SSI eligibility information that SSA provides to CMS and our proposed revised match process for FY 2011 and subsequent fiscal years is warranted.

At present, SSA provides an annual file to CMS with SSI eligibility information that is current through March 31, or 6 months after the end of the prior Federal fiscal year on September 30 (70 FR 47278, 47440, August 12, 2005). Based on this date, for a hospital with an October 1 to September 30 cost reporting period, the SSI eligibility information we currently use contains 6 to 18 months worth of retroactive SSI eligibility determinations and payment suspension closures—6 months from September (that is, the end of the cost reporting period) and 18 months from October (that is, the

beginning of the cost reporting period). The time lag between the close of a hospital's cost reporting period and the date that CMS receives SSI eligibility information could actually be longer or shorter for some hospitals, depending on the hospital's specific cost reporting period. We note that SSI fractions are generally based on the Federal fiscal year. However, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.

As we stated in the FY 2006 final IPPS rule, we believe that administrative finality with respect to the calculation of a hospital's SSI fraction is important (70 FR 47440). We continue to believe that it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement. Further, we believe it is important to account for the time period in which hospitals are allowed to submit timely Medicare claims in order to ensure that the point in time that we perform the match process includes as many timely submitted inpatient hospital claims as are administratively practicable.

In accordance with the regulations at 42 CFR 424.44 and the Medicare Claims Processing Manual (Pub. L. 100–04), Chapter 1, Section 70, a hospital must generally file a claim by December 31 of the following year (for services furnished during the first 9 months of a calendar year) and by December 31 of the second following year (for services provided during the last 3 months of the calendar year). Therefore, Medicare claims for hospital services furnished in FY 2011 would have to be submitted no later than December 31, 2012. We note that section 6404 of the Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended, recently changed these deadlines to no more than "1 calendar year after the date of service" effective for services provided on or after January 1, 2010.

Generally speaking, providers have a financial incentive to submit fee-for-service claims as close as possible to the date of the patient's discharge, and providers have no incentive to wait until after the end of the fiscal year. Thus, while conducting a data match with MedPAR files that were updated 6 months after the end of the Federal fiscal year may not capture all of a provider's Medicare inpatient claims, we believe that, in large part, the provider's fee-for-service claims are included in that MedPAR file. The same may not be true for the "information only" or "no pay" claims that hospitals are required to submit to their fee-for-service contractor for Medicare Advantage (MA) beneficiaries. Because claims for MA beneficiaries are paid by MA plans and not the fee-for-service contractor, hospitals may not have the same incentive to file these claims as close as possible to the date of the patient's discharge.[14] However, in accordance with Transmittal 1396 (issued December 14, 2007) and Transmittal 1695 (issued March 6, 2009), which changed the instructions in the Medicare Claims Processing Manual (Pub. L. 100–04), all IPPS hospitals that do not qualify for IME payments, direct GME payments, or nursing and allied health (N&AH) payments are required to submit informational-only claims for all MA inpatients to ensure that data for MA beneficiaries is included in the SSI fraction. Accordingly, we also are considering changes to the timing of the data match process to ensure that all of a hospital's MA claims are included in the revised matching process given the lack of incentives that exist to submit these claims as soon as possible after the time of the patient's discharge.

In addition, in matching eligibility records for Medicare beneficiaries and SSI recipients to calculate the SSI fractions for FY 2011 and future fiscal years, we are also proposing to use more recent SSI eligibility information from SSA and a more updated version of MedPAR that is likely to contain more claims data. We currently use SSI eligibility data and MedPAR claims data that are updated 6 months after the close of the Federal fiscal year. We are proposing to use, for FY 2011 and subsequent years, SSI eligibility data files compiled by SSA and MedPAR claims information that are updated 15 months after the close of each Federal fiscal year. This proposal would more closely align the timing of the match process with the timing of our requirements (described above) for the timely submission of claims. For example, to calculate the FY 2011 SSI fractions, we would use the December 2012 update of the FY 2011 MedPAR file (containing claims information for patient discharges between October 1, 2010 and September 30, 2011), and a December 2012 SSI eligibility file (containing FY 2011 SSI eligibility data updated through December 2012, with a lag time relative to the Federal fiscal year of between 15 and 27 months). We expect that the FY 2011 SSI fractions would be published around March 2013 and would be used to settle cost reports for cost reporting periods that began in FY 2011. In addition, we would continue our practice of using each hospital's latest available SSI fraction in determining IPPS interim payments from the time that the SSI fractions are published until the SSI fractions for the next fiscal year are published.

Under current law as amended by section 6404 of Public Law 111–148, Medicare inpatient claims for FY 2011 can be submitted no later than 1 calendar year from the date of service or by September 30, 2012, for claims with a September 30, 2011 date of service. Therefore, we believe that using the version of MedPAR that is updated 15 months after the end of the fiscal year would contain more accurate and complete inpatient claims information, as we would be using claims data from 3 months after the filing deadline for claims with a date of service occurring on the last day of the second preceding fiscal year. Furthermore, a later update of the SSI eligibility file would contain more accurate eligibility information and would account for all retroactive changes in SSI eligibility and the lifting of SSI payment suspensions through that date.

The FY 2011 SSI fractions will be used to determine the hospitals' Medicare DSH payments for cost reporting periods beginning in FY 2011 (that is, October 1, 2010 through September 30, 2011). The proposed timing of the data match for the SSI fractions, effective for FY 2011, would result in FY 2011 SSI fractions being published around March 2013 and would generally coincide with the final settlement of cost reports for cost reporting periods beginning in FY 2011.

We believe that, by calculating SSI fractions on the basis of SSI eligibility data and MedPAR claims data that are

[14] Teaching hospitals have an incentive to submit these claims because they receive an indirect medical education payment. The claims are also used for a teaching hospital's direct medical education payments. Non-teaching DSH hospitals do not have the same direct incentives to submit these claims but to the extent that the MA beneficiary is also SSI eligible, it would be to the hospital's advantage to ensure these claims are included in the match process. However, nonteaching DSH hospitals are required to submit MA claims for all MA beneficiaries, regardless of whether the beneficiaries were eligible for SSI benefits.

updated 15 months after the end of the Federal fiscal year, we would be using the best data available to us, given the deadlines for the submission and final settlement of Medicare cost reports. Cost reports must be submitted to the Medicare fiscal intermediary or MAC no later than 5 months after the end of the provider's cost reporting period; the fiscal intermediary or MAC must make a determination of cost report acceptability within 30 days of receipt of the provider's cost report (42 CFR 413.24(f)(2)(i) and 413.24(f)(5)(iii)). In accordance with the Medicare Financial Manual (Pub. 100–06), Chapter 8, Section 90, the fiscal intermediary or MAC is expected to settle each cost report that is not scheduled for audit within 12 months of the contractor's acceptance of the cost report. We believe that our proposed timing of the data match would achieve an appropriate balance between accounting for additional retroactive SSI eligibility determinations and the lifting of SSI payment suspensions using all timely submitted Part A inpatient claims, and facilitating administrative finality through the timely final settlement of Medicare cost reports.

EXAMPLE OF TIMELINE TO CALCULATE FY 2011 SSI FRACTIONS UNDER CURRENT POLICY

Cost reports that use the FY 2011 SSI ratios	Deadline for timely filing of claims	MedPAR file used	SSI eligibility file used	Cost reports normally accepted	Cost report final settlement	SSI fraction available
Cost reports beginning October 1, 2010 through September 30, 2011.	December 2012	March 2012 update of FY 2011 MedPAR.	March 2012 update of FY 2011 SSI eligibility.	Generally between March 2012 and February 2013.	Generally between March 2013 and February 2014.	Summer 2012.

EXAMPLE OF TIMELINE TO CALCULATE FY 2011 SSI FRACTIONS UNDER PROPOSED RULE

Cost reports that use the FY 2011 SSI ratios	Deadline for timely filing of claims	MedPAR file used	SSI eligibility file used	Cost reports normally accepted	Cost report final settlement	SSI fraction available
Cost reports beginning October 1, 2010 through September 30, 2011.	December 2012	December 2012 update of FY 2011 MedPAR.	December 2012 update of FY 2011 SSI eligibility.	Generally between March 2012 and February 2013.	Generally between March 2013 and February 2014.	Spring 2013.

5. CMS Ruling

The CMS Administrator has prepared a CMS Ruling that addresses three Medicare DSH issues, including CMS' process for matching Medicare and SSI eligibility data and calculating hospitals' SSI fractions. With respect to the data matching process issue, the Ruling requires the Medicare administrative appeals tribunal (that is, the Administrator of CMS, the PRRB, the fiscal intermediary hearing officer, or the CMS reviewing official) to remand each qualifying appeal to the appropriate Medicare contractor. The Ruling also explains how, on remand, CMS and the contractor will recalculate the provider's DSH payment adjustment and make any payment deemed owing. The Ruling further provides that CMS and the Medicare contractors will apply the provisions of the Ruling, on the data matching process issue (and two other DSH issues, as applicable), in calculating the DSH payment adjustment for each hospital cost reporting period where the contractor has not yet final settled the provider's Medicare cost report through the issuance of an initial notice of program reimbursement (NPR) (42 CFR 405.1801(a) and 405.1803).

More specifically, the Ruling provides that, for qualifying appeals of the data matching issue and for cost reports not yet final settled by an initial NPR, CMS will apply any new data matching process that is adopted in the forthcoming FY 2011 IPPS final rule for each appeal that is subject to the Ruling. The data matching process provisions of the Ruling would apply to properly pending appeals and open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule).

The Ruling further states that, if a new data matching process is not adopted in the forthcoming FY 2011 IPPS final rule, CMS would apply to claims subject to the Ruling the same data matching process as the agency used to implement the Baystate decision by recalculating that provider's SSI fractions.

6. Clarification of Language on Inclusion of Medicare Advantage Days in the SSI Fraction of the Medicare DSH Calculation

In the FY 2005 IPPS final rule (69 FR 49099), we discussed in the preamble our policy change to reflect the inclusion of the days associated with Medicare + Choice (now Medicare Advantage (MA)) beneficiaries under Medicare Part C in the SSI fraction of the DSH calculation. In that rule, we indicated that we were revising the regulation text at § 412.106(b)(2)(i) to incorporate this policy. However, we inadvertently did not make a change in the regulation text to conform to the preamble language. We also inadvertently did not propose to change § 412.106(b)(2)(iii) in the FY 2005 final rule, although we intended to do so. Accordingly, in the FY 2007 IPPS rule (72 FR 47384), we made a technical correction to amend the regulations at § 412.106(b)(2)(i) and to § 412.106(b)(2)(iii) to make them consistent with the preamble language of the FY 2005 IPPS final rule and to conform to the policy implemented in that rule. Section 412.106(b)(2)(i) of the regulations discusses the numerator of the SSI fraction of the Medicare disproportionate patient percentage (DPP) calculation, while § 412.106(b)(2)(iii) of the regulations discusses the denominator of the SSI fraction of the Medicare DPP.

We are aware that there might be some confusion about our policy to include MA days in the SSI fraction, specifically regarding whether we have

implied that MA beneficiaries are not actually "entitled to receive benefits under Part A" by using the word "or" in § 412.106(b)(2)(i)(B) and § 412.106 (b)(2)(iii)(B) with respect to MA days. We note that in the FY 2005 final rule, we stated that we believed that Medicare + Choice (now MA) beneficiaries are patients who are entitled to benefits under Medicare Part A. With respect to the change to the regulatory text that we intended to make in the FY 2005 IPPS final rule, we stated "* * * we are adopting a policy to *include* patient days for M+C beneficiaries in the Medicare fraction" (69 FR 49099) (emphasis added). In order to further clarify our policy that patients days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word "or" with the word "including" in § 412.106(b)(2)(i)(B) and § 412.106 (b)(2)(iii)(B).

H. Payments for Direct Graduate Medical Education (GME) (§ 413.75)

1. Background

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of hospital inpatient services. Section 1886(h) of the Act, as implemented in regulations at § 413.75 through § 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved GME programs. Section 1886(h)(2) of the Act sets forth a methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable direct costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983, through September 30, 1984). Medicare direct GME payments are calculated by multiplying the PRA by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days. The base year PRA is updated annually for inflation.

Hospitals may receive direct GME and IME payments for residents in "approved medical residency training programs." Section 1886(h)(5)(A) of the Act defines an "approved medical residency training program" as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary." Section 1886(h)(4)(F) of the Act established a limit on the number of allopathic and osteopathic FTE residents that a hospital may include in its FTE resident count for purposes of calculating direct GME payments. For most hospitals, the limit, or cap, is the unweighted number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996.

2. Identifying "Approved Medical Residency Programs"

Despite the fact that current policies regarding the counting of FTE residents for IME and direct GME purposes have been in effect since October 1985, we continue to receive questions as to whether certain residents are training in approved medical residency programs, and whether these residents should be included in the Medicare direct GME and IME FTE counts. Although the fundamental rules defining an approved medical residency training program seem straightforward, some confusion apparently exists regarding whether certain trainees in a teaching hospital should be included in the FTE count for IME and direct GME purposes, or whether certain trainees should be treated as physicians and should instead bill for their services under Medicare Part B. These questions arise most often with regard to subspecialty training and "fellows." It is important for hospitals to understand when each of these types of payment applies.

a. Residents in Approved Medical Residency Programs

As stated earlier, section 1886(h)(5)(A) of the Act defines an "approved medical residency training program" as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary." The regulations at § 413.75(b) define an "approved medical residency program" as a program that meets *one* of the following criteria (emphasis added):

(1) Is approved by one of the national organizations listed in § 415.152 of the regulations.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

(3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

The regulations at § 415.152 define an "approved graduate medical education program" as a residency program approved by one of the following national organizations (or their predecessors): The Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association, the American Osteopathic Association (AOA), the Commission on Dental Accreditation (CODA) of the American Dental Association, and the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association. The statutory basis for this regulation is at section 1861(b)(6) of the Act, which cites these accrediting bodies for residency programs. Thus, in general, under § 413.75(b), an "approved" program can be a program that is accredited by one of these national organizations, or one that leads toward board certification by the American Board of Medical Specialties (ABMS). In the September 29, 1989 final rule (54 FR 40295), we explained that, in order to reconcile the two statutory definitions of approved programs at sections 1861(b)(6) and 1886(h)(5)(A) of the Act, we did not limit our regulatory definition of "approved medical residency program" to one that may count toward certification in a specialty, but added that a program is also "approved" for purposes of IME and direct GME if it is approved by one of the national accrediting bodies. Furthermore, we understood that, especially with respect to subspecialty training, there historically were some formal programs for which none of the listed national accrediting bodies had established standards. However, the ABMS had established a national board examination for some of those unaccredited programs and, consequently, those programs do count toward certification. Accordingly, such

programs also meet the definition of an "approved medical residency training program."

b. Determining Whether an Individual Is a Resident or a Physician

The statute and the regulations (in at least two places in the teaching context) define the term "resident." Section 1861(b)(6) of the Act refers to services provided in a hospital by an "intern or resident-in-training under a teaching program approved" by one of the listed accrediting bodies for residency programs. In addition, section 1886(h)(5)(I) of the Act states that the term "resident" includes "an intern or other participant in an approved medical residency training program." The regulations at § 413.75(b) state that the term resident means "an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board."

As discussed above, an "approved" program is one that is accredited by one of the listed national organizations, or one that may count towards board certification. Generally, residency programs today, whether they are core or subspecialty programs, are both accredited, and lead toward board certification through an explicit board examination for that field. Thus, in the typical instance, a resident is accepted into an accredited program in a particular specialty, completes that program over the course of what is typically 3 to 5 years, and then qualifies to take the board certifying examination in the particular specialty of that program. This resident may or may not train in an additional accredited subspecialty program, which would typically last for 1 to 3 years, and which would also lead to board certification through an additional board certifying examination which the individual would be qualified to take upon completion.

We receive questions from time to time regarding whether individuals are considered to be trainees in approved programs or whether they are considered to be physicians and should bill accordingly. These questions frequently involve programs of further training that certain senior and junior faculty at hospitals, typically at large academic medical centers, undertake on their own, not under the auspices of any accrediting body, and in an area of practice for which there is no board certification. Therefore, there is no actual standardized curriculum or formally organized "program" in which the individual trainee is participating. Another type of trainee about which we have received questions is one that has completed an accredited program in a certain specialty, but subsequently participates in additional training in that specialty that he or she could have participated in while still within the accredited program. Sometimes this individual may even train with residents who are actually still training in that accredited program (for example, an individual who has completed a dermatology residency may choose to do additional training with PGY4 dermatology residents). In these scenarios, in order to decide whether an individual is considered a resident or a physician for purposes of Medicare payment, the pertinent questions are whether—

(1) The individual actually needs the training in order to meet board certification requirements in that specialty; and

(2) Whether the individual is formally participating in an organized, standardized, structured course of study.

With regard to the junior faculty who are "training" with senior faculty to learn highly specialized skills, we believe that individuals participating in a course of training that one or more senior physicians creates absent the involvement and approval of an accrediting body, and for which there is no specific existing board certification examination, should not be considered "residents" or counted for IME and direct GME purposes. Similarly, individuals that already completed an accredited residency program, but subsequently participate in additional training in that same specialty that they could have participated in while still within that accredited program, should also not be considered "residents" or be included in the IME and direct GME count. This is because these individuals have already completed accredited residency programs in a particular specialty or subspecialty, and do not need to complete the additional training in order to meet board certification requirements in that field in which they continue to "train." The definition of "resident" at § 413.75(b) is "an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, *as required in order to become certified by the appropriate specialty board*" (emphasis added). Accordingly, the individuals described in the scenarios above do not meet the definition of "resident" at § 413.75(b) for IME and direct GME purposes. Instead, these individuals should be treated and receive payment as physicians.

As we explained in the September 29, 1989 **Federal Register** rule: "The costs relating to patient care services of licensed physicians who are classified as "fellows" but who are not in an identifiable formal program leading to certification as defined in section 1886(h)(5) of the Act but remain at a teaching hospital/medical school complex to enhance their expertise in a field of study are payable on a Part B reasonable charge basis [now under the Medicare physician fee schedule] as physicians' services" (54 FR 40295). Similarly, in the Provider Reimbursement Manual, Part I, section 2405.3.F.2, we state, "Intermediaries must not count an individual in the indirect medical education adjustment if * * * [A]n individual designated as a "fellow" has elected to remain at a teaching hospital/university complex for additional work to gain expertise in a particular field but is no longer in a formally organized program to *fulfill certification requirements.* The services of such an individual are generally covered as physicians' services payable on a reasonable charge basis" (emphasis added). (**Note:** Although we used the term "fellow," which is defined synonymously with "resident" in the regulations at § 413.75, in these paragraphs in the September 29, 1989 **Federal Register** and in the PRM–I, by stating that such "fellows" are not in identifiable, formally organized programs and their services should be billed under Part B as physician services, we clearly were indicating that these "fellows" are licensed physicians, not residents, and should not be included in the IME and direct GME FTE counts. Perhaps "junior faculty" would have been a more apt characterization of these individuals.)

The passage from the September 29, 1989 **Federal Register** also mentions an "identifiable formal program leading to certification as defined in section 1886(h)(5) of the Act" which refers to the statutory definition of "approved medical residency program." The word "approved" connotes formality; a planned, structured course of study with a curriculum based on national (rather than individual physician or hospital) standards with a standardized outcome based on standardized evaluations. Since the early days of Medicare, prior to the enactment of section 1886(h) of the Act, when hospitals received payment on a reasonable cost basis for "approved educational activities," we defined such activities as "*formally organized* or *planned* programs of study operated or

supported by an institution, *as distinguished from 'on-the-job,' 'inservice,' or similar work-learning programs*" (emphasis added) (PRM–I, section 402.1). We believe the education that junior faculty receive when working closely with senior faculty to gain highly specialized skills is more appropriately characterized as on-the-job, or inservice training, rather than training in an "approved medical residency program."

In order for the training to be considered an "approved medical residency program," the training must prepare the individual for certification in the particular specialty or subspecialty in which the individual is training. The mere possibility that the training could be construed as leading toward or counting toward certification in some existing board examination is insufficient. For example, an individual who is enrolled and participating in a two year accredited subspecialty program in allergy and immunology and, as part of that program, completes an elective in allergic reactions to insect stings is considered a resident during that elective, and may be included in the IME and direct GME FTE count (assuming all other requirements are met). However, if, after completion of the 2-year allergy and immunology subspecialty program, this individual decides to remain at the teaching hospital for a year to shadow a physician who has unique expertise in allergic reactions to insect stings, this individual would not be considered a resident, nor would this training be considered an approved program, because this individual is not formally enrolled in a planned, structured, standardized course of study, nor is this year of training required for any individual to qualify to take the board examination in allergy and immunology. This individual already completed the 2-year subspecialty program, and therefore, the extra year spent studying allergic reactions to insect stings is extraneous. Accordingly, this individual would not be viewed as a resident participating in an approved medical residency training program. Rather, this individual is considered a physician and should bill Medicare for services furnished under the physician fee schedule.

c. Formal Enrollment and Participation in a Program

We understand that the participation of individuals in an approved medical residency program under which they would be considered residents as defined at § 413.75 is marked by a formal application, acceptance, and enrollment process. We believe that in order for an individual to be considered a resident for purposes of inclusion in the IME and direct GME counts, whether the individual is a graduate of an allopathic medical school, an osteopathic medical school, or a school of podiatry or dentistry, the individual must be:

(1) Formally accepted and enrolled in the training program, and

(2) Fully participating in that training (unless there is a documented arrangement for the resident to work part time).

In general, we would expect formal acceptance to include an application process (for example, the national residency match process), and an enrollment process which would include letters or other official notifications from the hospital or program sponsor regarding the resident's acceptance to train in a particular program. We would also expect the resident to have an employment contract with the institution(s) sponsoring the program and/or the institution(s) in which he or she is training. A hospital must be able to document that the individual's participation in the particular course of training represents a definitive (not hypothetical) path for that individual's certification, and that satisfactory completion of such training would fulfill all required elements in order for the individual to qualify to take a specific board examination.

In order to make these rules clearer for the future, we are proposing to revise the definition of "resident" to specify that the trainee must be "formally accepted and enrolled" in the approved program in order to be considered a resident for IME and direct GME purposes. Specifically, we are proposing to revise the definition of "resident" at § 413.75(b) to mean "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board." We also are proposing to make a similar conforming change to the definition of "primary care resident" at § 413.75(b). This change in the definitions of "resident" and "primary care resident" would be effective for IME and direct GME for cost reporting periods beginning on or after October 1, 2010.

In summary, we are proposing to clarify that individuals participating in a specialized course of training created by a senior physician, and not under the auspices of a national accrediting body, and for which there is no explicit existing board certification examination, should not be counted for IME and direct GME purposes. Such individuals should be treated as physicians, and their services should be billed to Medicare for payment as physicians' services. If an individual has already successfully completed at least one residency program and has met the requirements to be board eligible in a specialty (regardless of whether the individual has passed the board examination for that specialty), and is engaged in subsequent training that will not provide additional knowledge or skills that could be applied for board certification in a subspecialty, the individual should be treated and bill for services provided as a physician. We also are proposing to revise the definition of "resident" at § 413.75(b) to mean "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board." We are proposing to make a conforming change to the definition of "primary care resident" to mean "a resident who is formally accepted, enrolled, and participating in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice." This change in the definitions of "resident" and "primary care resident" would be effective for IME and direct GME for cost reporting periods beginning on or after October 1, 2010.

3. Electronic Submission of Affiliation Agreements

Sections 1886(h)(4)(F) and 1886(d)(5)(B)(v) of the Act establish limits on the number of allopathic and osteopathic FTE residents that hospitals may count for purposes of calculating direct GME payments and the IME adjustment. In addition, under the authority granted by section 1886(h)(4)(H)(ii) of the Act, the Secretary issued regulations on May 12, 1998 (63 FR 26358) to allow institutions that are members of the same Medicare GME affiliated group to elect to apply their direct GME and IME FTE resident caps based on the aggregate cap of all hospitals that are part of a Medicare GME affiliation group. Under those regulations, specified at § 413.79(f) for direct GME and at § 412.105(f)(1)(vi) for IME, hospitals that are part of the same Medicare GME affiliated group are permitted to adjust each hospital's caps

to reflect the rotation of residents among affiliated hospitals during an academic year. Under § 413.75(b), a Medicare GME affiliated group may be formed by two or more hospitals if: (1) The hospitals are located in the same urban or rural area or in a contiguous area and have a shared rotational arrangement as specified at § 413.79(f)(2); (2) the hospitals are not located in the same or in a contiguous area, but have a shared rotational arrangement and they are jointly listed as the sponsor, primary clinical site, or major participating institution for one or more programs as these terms are used in the most recent publication of the *Graduate Medical Education Directory,* or as the sponsor or is listed under "affiliations and outside rotations" for one or more programs in *Opportunities, Directory of Osteopathic Post-Doctoral Education Programs;* or (3) effective beginning July 1, 2003, two or more hospitals are under common ownership and have a shared rotational arrangement under § 413.79(f)(2).

The existing regulations at § 413.79(f)(1) specify that each hospital in a Medicare GME affiliated group must submit a Medicare GME affiliation agreement (as defined under § 413.75(b)) to the CMS fiscal intermediary or MAC servicing the hospital and send a copy of the agreement to CMS' Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect. For example, in order for a hospital to receive a temporary adjustment to its FTE resident caps to reflect participation in a Medicare GME affiliated group for the academic year beginning July 1, 2009, through June 30, 2010, the hospital in the affiliated group had to submit a Medicare GME affiliation agreement to the fiscal intermediary or MAC servicing the hospital and send a copy of the agreement to CMS' Central Office no later than July 1, 2009.

Over the last several years, we have received numerous inquiries regarding the possibility of submitting the Medicare GME affiliation agreement electronically. To date, CMS has only accepted signed hard copies of Medicare GME affiliation agreements that are received through the mail. Facsimile (FAX) and other electronic submissions of affiliation agreements have not been acceptable means of transmission of affiliation agreements to CMS Central Office in order for a hospital to meet the requirements of §§ 413.79(f) and 412.105(f)(1)(vi).

The increasing frequency of these inquiries and our concerns regarding environmental and paperwork reduction have prompted us to reconsider our procedure for hospitals to submit Medicare GME affiliation agreements to the CMS Central Office. Accordingly, we are proposing to change our policy to provide for electronic submission of the affiliation agreement that is required to be sent to the CMS Central Office. This proposal would not affect the authority of the fiscal intermediary or MAC to continue to specify its requirements for submission for hospitals in its servicing area.

We are proposing an electronic submission process that would consist of either an e-mail mailbox or a Web site where hospitals would submit their Medicare GME affiliation agreements to the CMS Central Office. As part of this process, a copy of the Medicare GME affiliation agreement would need to be received through the electronic system no later than 11:59 p.m. on July 1 of each academic year. We are proposing that the electronic affiliation agreement would need to be submitted either as a scanned copy or a Printer-Friendly Display (PDF) version of that hard copy agreement; we are proposing not to accept an agreement in any electronic format that could be subject to manipulation. The scanned and/or PDF format will enable CMS to ensure that the agreements are signed and dated as required in the regulations at § 413.75.

We believe that allowing an electronic submission of the affiliation agreement to the CMS Central Office would assist us in more effectively tracking the groups of hospitals that affiliate as well as the numbers of FTE cap slots that are being transferred within those groups. In addition, we believe an electronic submission process would minimize the paperwork burden for hospitals.

I. Certified Registered Nurse Anesthetist (CRNA) Services Furnished in Rural Hospitals and CAHs

Section 2312 of the Deficit Reduction Act of 1984 (Pub. L. 98–369) provided for reimbursement to hospitals on a reasonable cost basis for the costs that hospitals incur in connection with the services of certified registered nurse anesthetists (CRNAs). Section 2312(c) provided that pass-through of CRNA costs was effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987. Section 9320 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (which established a fee schedule for the services of nurse anesthetists) amended section 2312(c) of Public Law 98–369 by extending the CRNA pass-through provision through cost reporting periods beginning before January 1, 1989. In addition, Public Law 99–509 amended section 1861 of the Act to add a new subsection (bb), which provides that CRNA services include anesthesia services and related care furnished by a CRNA. Section 608 of the Family Support Act of 1988 (Pub. L. 100–485) extended pass-through payments for CRNA services through 1991 and amended section 9320 of Public Law 99–509 by including language referring to eligibility for pass-through payments for CRNA services if the facility is "* * * a hospital located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act) * * *." Reasonable cost-based payment for CRNA services was extended indefinitely by section 6132 of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239).

Section 1886(d)(2)(D) of the Act defines "rural" as any area outside an urban area. This definition of "rural" was in effect when Public Law 100–485 was implemented. In 1999, the Balanced Budget Refinement Act (Pub. L. 106–113) amended section 1886(d)(8) of the Act by adding a new subparagraph (E), which permits a hospital physically located in an urban area to apply for reclassification to be treated as rural. In addition, Public Law 106–113 made a corresponding change to section 1820(c)(2)(B)(i) of the Act, which specifies the location requirements for CAH designation, by adding the phrase "or is treated as being located in a rural area pursuant to section 1886(d)(8)(E)."

The regulations implementing pass-through payments for anesthesia services and related care furnished by qualified nonphysician anesthetists employed by a hospital or CAH, including CRNAs, are located at § 412.113(c). Section 412.113(c)(2)(i)(A) specifies the location requirement for facilities that furnish these services and are eligible to be paid based on reasonable cost for the services. The regulations require that the hospital or CAH be located in a rural area as defined at § 412.62(f) and not be deemed to be located in an urban area under the provisions of § 412.64(b)(3). The regulations at § 412.62(f) mirror section 1886(d)(2)(D) of the Act and define a rural area as "* * * any area outside an urban area." The regulations at § 412.64(b)(3) implement section 1886(d)(8)(B) of the Act, also known as the "Lugar" provision, which requires a hospital located in a rural county adjacent to one or more urban areas to be treated as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute.

Under existing regulations, neither CAHs/hospitals that have reclassified

from urban to rural under the regulations at § 412.103 nor CAHs/hospitals located in Lugar counties are eligible to receive pass-through payments for anesthesia services and related care furnished by qualified nonphysician anesthetists. We believe that because the statute, as revised by section 608 of Public Law 100–485, allows for reasonable cost payments for CRNA services if the facility is a hospital located in a rural area as defined for purposes of section 1886(d) of the Act, it is appropriate for us to make the regulations consistent by permitting urban hospitals that have been reclassified as rural to qualify for these payments. Therefore, we are proposing to revise § 412.113(c)(2)(i)(A) to state that effective for cost reporting periods beginning on or after October 1, 2010, CAHs and hospitals that have reclassified pursuant to section 1886(d)(8)(E) of the Act and § 412.103 of the regulations are also rural for purposes of section 1886(d) of the Act and, therefore, are eligible to be paid based on reasonable cost for anesthesia services and related care furnished by a qualified nonphysician anesthetist.

We are not proposing to change our regulations to permit Lugar facilities to be paid based on reasonable cost for anesthesia services and related care furnished by qualified nonphysician anesthetists. As noted above, in order to be paid based on reasonable cost for anesthesia services and related care furnished by a qualified nonphysician anesthetist, a hospital or CAH must be considered rural for purposes of section 1886(d) of the Act. Lugar facilities (facilities that have been reclassified under §§ 412.63(b)(3) and 412.64(b)(3)) are considered urban for purposes of section 1886(d) of the Act. As a result, we do not believe it would be consistent with the statute and our regulations to permit these facilities to be paid on a reasonable cost basis for anesthesia services and related care furnished by qualified nonphysician anesthetists.

J. Rural Community Hospital Demonstration Program

Section 410A(a) of Public Law 108–173 required the Secretary to establish a demonstration program to test the feasibility and advisability of establishing "rural community hospitals" to furnish covered inpatient hospital services to Medicare beneficiaries. The demonstration pays rural community hospitals for such services under a cost-based methodology for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that—

- Is located in a rural area (as defined in section 1886(d)(2)(D) of the Act) or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act;
- Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;
- Provides 24-hour emergency care services; and
- Is not designated or eligible for designation as a CAH under section 1820 of the Act.

Section 410A(a)(4) of Public Law 108–173 (MMA) specified that the Secretary was to select for participation no more than 15 rural community hospitals in rural areas of States that the Secretary identified as having low population densities. Using 2002 data from the U.S. Census Bureau, we identified the 10 States with the lowest population density in which rural community hospitals were to be located in order to participate in the demonstration: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming. (Source: U.S. Census Bureau, Statistical Abstract of the United States: 2003).

CMS originally solicited applicants for the demonstration in May 2004; 13 hospitals began participation with cost report years beginning on or after October 1, 2004. (Four of these 13 hospitals withdrew from the program and became CAHs). In a notice published in the **Federal Register** on February 6, 2008 (73 FR 6971), we announced a solicitation for up to 6 additional hospitals to participate in the demonstration program. Four additional hospitals were selected to participate under this solicitation. These four additional hospitals began under the demonstration payment methodology with the hospital's first cost reporting period starting on or after July 1, 2008. Three hospitals (2 of the hospitals were among the 13 hospitals that originally participated in the demonstration and 1 of the hospitals was among the 4 hospitals that began the demonstration in 2008) withdrew from the demonstration during CY 2009. (Two of these hospitals indicated that they will be paid more for Medicare inpatient services under the rebasing allowed under the SCH methodology allowed by the Medicare Improvement for Patients and Providers Act of 2008 (Pub. L. 110–275). The other hospital restructured to become a CAH.) There are currently 10 hospitals participating in the demonstration.

Section 410A(a)(5) of Public Law 108–173 required a 5-year demonstration period of participation. For the seven currently participating hospitals that began the demonstration during FY 2005, the demonstration was scheduled to end for each of these hospitals on the last day of its cost reporting period that ends in FY 2010. The end of the participation for the three participating hospitals that began the demonstration in CY 2008 was scheduled to be September 30, 2010. A 5-year extension of the demonstration was mandated in the Patient Protection and Affordable Care Act (PPACA, Pub. L. 111–148). We note that this proposed rule does not address the relevant changes mandated by Public Law 111–148. Public Law 111–148 does affect our proposed FY 2011 policy with regard to the rural community hospital demonstration. However, we will address that provision of Public Law 111–148 and any revised policy proposals in a separate rulemaking document in the **Federal Register**.

Section 410A of Public Law 108–173 required that, "in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented." This requirement is commonly referred to as "budget neutrality."

Generally, when CMS implements a demonstration program on a budget neutral basis, the demonstration program is budget neutral in its own terms; in other words, the aggregate payments to the participating hospitals do not exceed the amount that would be paid to those same hospitals in the absence of the demonstration program. Typically, this form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration program may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration program's participants. These reduced expenditures offset increased payments elsewhere under the demonstration program, thus ensuring that the demonstration program as a whole is budget neutral or yields savings. However, the small scale of this demonstration program, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration program could be viable under the usual form of budget neutrality. Specifically, cost-based payments to participating small rural hospitals are likely to increase Medicare outlays without producing any

offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration program is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these same hospitals.

In the past six IPPS final regulations, spanning the period for which the demonstration has been implemented, we have adjusted the national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration program, thus applying budget neutrality across the payment system as a whole rather than merely across the participants in this demonstration program. As we discussed in the FY 2005, FY 2006, FY 2007, FY 2008, FY 2009, and FY 2010 IPPS final rules (69 FR 49183; 70 FR 47462; 71 FR 48100; 72 FR 47392; 73 FR 48670; and 74 FR 43922), we believe that the language of the statutory budget neutrality requirements permits the agency to implement the budget neutrality provision in this manner.

In this proposed rule, in order to ensure that the demonstration in FY 2007 is budget neutral, we are proposing to incorporate a component into the adjustment factor to the FY 2011 national IPPS rates that would offset the amount by which the costs of the demonstration program, as indicated by settled cost reports beginning in FY 2007 for hospitals participating in the demonstration during FY 2007, exceeded the amount that was identified in the FY 2007 final rule as the budget neutrality offset for FY 2007. Specifically, we are proposing the following methodology: (1) Calculate the FY 2007 costs of the demonstration program according to the settled cost reports that began in FY 2007 for the then participating hospitals (which represent the third year in the demonstration for each of the then participating hospitals); (2) Subtract the amount that was offset by the budget neutrality adjustment for FY 2007 ($9,197,870) from the costs of the demonstration in FY 2007 as calculated in step 1; and (3) Calculate an adjustment factor for the standardized amount for FY 2011 based on the dollar amount calculated in step 2 of this proposed methodology. This factor would represent the component of the proposed overall budget neutrality offset amount for FY 2011 that accounts for the difference between the cost of the demonstration in FY 2007 and the amount of the budget neutrality adjustment published in the FY 2007 final rule.

With respect to the first step of this proposed methodology, we note that we are proposing to use settled cost reports beginning in FY 2007 for hospitals participating in the demonstration during FY 2007 because we believe that these settled cost reports correspond most accurately to FY 2007 and because all such costs reports also began in FY 2007. Therefore, we believe they correctly represent FY 2007 inpatient costs for the demonstration during that period. In addition, in the process of making adjustments comparing the demonstration's costs to the amounts estimated annually for the budget neutrality offset over the demonstration's entire period of performance, the cost amounts from these hospitals' cost reports correspond most precisely to FY 2007. In addition, the settlement process for the demonstration hospitals' third year cost reports, that is, cost reporting periods starting in FY 2007, has experienced a delay. Therefore, for this FY 2011 IPPS proposed rule, we are unable to calculate the costs of the demonstration corresponding to FY 2007 and as a result are unable to propose the specific numeric adjustment that would be applied to the national IPPS rates. However, we expect cost reports beginning in FY 2007 for hospitals that participated in the demonstration during FY 2007 to be settled before the FY 2011 IPPS final rule is published. Therefore, for the FY 2011 IPPS final rule, we will be able to calculate the amount by which the costs corresponding to FY 2007 exceeded the amount offset by the budget neutrality adjustment for FY 2007.

V. Proposed Changes to the IPPS for Capital-Related Costs

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public L. 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate rulemaking documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and LTCH PPS, as well as the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and LTCH PPS.

A. Overview

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services "in accordance with a prospective payment system established by the Secretary." Under the statute, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs. We initially implemented the IPPS for capital-related costs in the Federal fiscal year (FY) 1992 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

FY 2001 was the last year of the 10-year transition period established to phase in the IPPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital IPPS payments are based solely on the Federal rate for almost all acute care hospitals (other than hospitals receiving certain exception payments and certain new hospitals). (We refer readers to the FY 2002 IPPS final rule (66 FR 39910 through 39914) for additional information on the methodology used to determine capital IPPS payments to hospitals both during and after the transition period.) The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312 of the regulations. For the purpose of calculating payments for each discharge, currently the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (COLA for hospitals located in Alaska and Hawaii) × (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable).

B. Exception Payments

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was

originally established for hospitals during the 10-year transition period, but as we discussed in the FY 2003 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). Additional information on the exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 49186).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of the hospital (§ 412.348(c)), but were available only during the 10-year transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, eligible hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital IPPS transition period. Hospitals eligible for special exceptions payments are required to submit documentation to the fiscal intermediary or MAC indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), we refer readers to the FY 2002 IPPS final rule (66 FR 39911 through 39914) and the FY 2003 IPPS final rule (67 FR 50102).)

C. New Hospitals

Under the IPPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years. For example, the following hospitals are not considered new hospitals: (1) A hospital that builds new or replacement facilities at the same or another location, even if coincidental with a change of ownership, a change in management, or a lease arrangement; (2) a hospital that closes and subsequently reopens; (3) a hospital that has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years; and (4) a hospital that changes its status from a hospital that is excluded from the IPPS to a hospital that is subject to the capital IPPS. For more detailed information, we refer readers to the FY 1992 IPPS final rule (56 FR 43418). During the 10-year transition period, a new hospital was exempt from the capital IPPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because, as discussed in the FY 2003 IPPS final rule (67 FR 50101), we believe that special protection to new hospitals is also appropriate even after the transition period, we revised the regulations at § 412.304(c)(2) to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its Medicare allowable capital-related costs through its first 2 years of operation, unless the new hospital elects to receive full prospective payment based on 100 percent of the Federal rate. (We refer readers to the FY 2003 IPPS final rule (67 FR 50101 through 50102) for a detailed discussion of the special payment provisions for new hospitals under the capital IPPS after the 10-year transition period.)

D. Hospitals Located in Puerto Rico

Section 412.374 of the regulations provides for the use of a blended payment amount for prospective payments for capital-related costs to hospitals located in Puerto Rico. Accordingly, under the capital IPPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In general, hospitals located in Puerto Rico are paid a blend of the applicable capital IPPS Puerto Rico rate and the applicable capital IPPS Federal rate.

Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital IPPS rate that consisted of 75 percent of the capital IPPS Puerto Rico specific rate and 25 percent of the capital IPPS Federal rate. However, effective October 1, 1997 (FY 1998), in conjunction with the change to the operating IPPS blend percentage for hospitals located in Puerto Rico required by section 4406 of Public Law 105–33, we revised the methodology for computing capital IPPS payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the capital IPPS Puerto Rico rate and 50 percent of the capital IPPS Federal rate. Similarly, in conjunction with the change in operating IPPS payments to hospitals located in Puerto Rico for FY 2005 required by section 504 of Public Law 108–173, we again revised the methodology for computing capital IPPS payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the capital IPPS Puerto Rico rate and 75 percent of the capital IPPS Federal rate effective for discharges occurring on or after October 1, 2004.

E. Proposed Changes for FY 2011: MS–DRG Documentation and Coding Adjustment

1. Background on the Prospective MS–DRG Documentation and Coding Adjustments for FY 2008 and FY 2009

In the FY 2008 IPPS final rule with comment period (72 FR 47175 through 47186), we adopted the MS–DRG patient classification system for the IPPS, effective October 1, 2007, to better recognize patients' severity of illness in Medicare payment rates. Adoption of the MS–DRGs resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. (Currently, there are 746 MS–DRGs, including one additional MS–DRG created in FY 2009. For FY 2011, there would be 747 DRGs with our proposals in this proposed rule to delete one MS- DRG and to create two new MS–DRGs.) By increasing the number of DRGs and more fully taking into account patients' severity of illness in Medicare payment rates, the MS–DRGs encourage hospitals to change their documentation and coding of patient diagnoses. In that same final rule with comment period (72 FR 47183), we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for changes in documentation and coding. Accordingly, we established adjustments to both the national operating standardized amount and the national capital Federal rate to eliminate the estimated effect of changes in documentation and coding resulting from the adoption of the MS–DRGs that do not reflect real changes in case-mix. Specifically, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent

for FY 2010. However, to comply with section 7(a) of Public Law 110–90, enacted on September 29, 2007, in a final rule published in the **Federal Register** on November 27, 2007 (72 FR 66886 through 66888), we modified the documentation and coding adjustment for FY 2008 to −0.6 percent, and consequently revised the FY 2008 IPPS operating and capital payment rates, factors, and thresholds accordingly, with these revisions effective October 1, 2007.

For FY 2009, section 7(a) of Public Law 110–90 required a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment established in the FY 2008 IPPS final rule with comment period. As discussed in the FY 2008 IPPS final rule with comment period (72 FR 48447 and 48733 through 48774), we applied a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amounts and the capital Federal rate. The documentation and coding adjustments established in the FY 2009 IPPS final rule, as amended by Public Law 110–90, are cumulative. As a result, the −0.9 percent documentation and coding adjustment in FY 2009 was in addition to the −0.6 percent adjustment in FY 2008, yielding a combined effect of −1.5 percent. (For additional details on the development and implementation of the documentation and coding adjustments for FY 2008 and FY 2009, we refer readers to section II.D. of this preamble and the following rules published in the **Federal Register**: August 22, 2007 (72 FR 47175 through 47186 and 47431 through 47432); November 27, 2007 (72 FR 66886 through 66888); and August 19, 2008 (73 FR 48447 through 48450 and 48773 through 48775).)

2. Retrospective Evaluation of FY 2008 Claims Data

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we presented the results of a retrospective evaluation of the FY 2008 data for claims paid through December 2008. Based on this evaluation, our actuaries determined that implementation of the MS–DRG system resulted in a 2.5 percent change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 (74 FR 24092 through 24101). We also sought public comment on our methodology and analysis and the proposed −1.9 percent prospective adjustment to address the effect of documentation and coding changes unrelated to changes in real case-mix in FY 2008 (that is, the estimated −2.5 percent documentation and coding effect for FY 2008 minus the −0.6 percent documentation and coding adjustment that was applied to the national capital Federal rate for FY 2008). In addition, we sought public comment on addressing in the FY 2011 rulemaking cycle any differences between the increase in FY 2009 case-mix due to documentation and coding changes that do not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied in determining the FY 2009 capital Federal rate established in the FY 2009 IPPS final rule. However, after consideration of the public comments received on the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, consistent with the application of the documentation and coding adjustment to the operating IPPS standardized amounts, we determined that it would be appropriate to postpone the adoption of any additional documentation and coding adjustments to the capital IPPS rates until a full analysis of FY 2009 case-mix changes could be completed. We stated that although we only proposed to make a −1.9 percent adjustment to account for the portion of the estimated 2.5 percent change in FY 2008 case-mix due to documentation and coding changes that exceeds the −0.6 percent prospective documentation and coding adjustment applied to the FY 2008 capital Federal rate (that is, −2.5 percent minus −0.6 percent = −1.9 percent), our then current estimate of the MS–DRG documentation and coding effect for FY 2009 was 2.3 percent (that is, the 4.8 percent total increase minus the 2.5 percent increase from FY 2008). We indicated that if the estimated documentation and coding effect determined based on a full analysis of FY 2009 claims data is more or less than our then current estimates, it would change the anticipated cumulative adjustments that we then estimated we would have to make for FY 2008 and FY 2009 combined. We indicated that, in future rulemaking, we would consider applying a prospective documentation and coding adjustment to the capital IPPS rates based on a complete analysis of FY 2008 and FY 2009 claims data (74 FR 43926 through 43928).

3. Retrospective Analysis of FY 2009 Claims Data

For this proposed rule, we have performed a thorough retrospective evaluation of the most recent available claims data, and the results of this evaluation were used by our actuaries to determine any necessary payment adjustments beyond the cumulative −1.5 percent adjustment that has already been applied to the national capital Federal rate to ensure budget neutrality for the implementation of MS–DRGs. Specifically, as discussed in greater detail in section II.D.5. of the preamble of this proposed rule, we performed a retrospective evaluation of the FY 2009 claims data updated through December 2009 using the same analysis methodology as we did for FY 2008 claims in the FY 2010 IPPS/RY 2010 LTCH PPS proposed and final rules. Based on this evaluation, our actuaries have determined that the implementation of the MS–DRG system resulted in a 5.4 percent change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009.

The 5.4 percent estimate of the cumulative effect of changes in documentation and coding under the MS–DRG system that did not reflect real changes in case-mix for FYs 2008 and 2009 exceeds the cumulative −1.5 percent prospective documentation and coding adjustment that has already been applied to the national capital Federal rate by 3.9 percentage points (5.4 percent minus 1.5 percent). An additional cumulative adjustment of −3.9 percent to the national capital Federal rate would be necessary to eliminate the full effect of the documentation and coding changes due to the adoption of the MS–DRGs on future payments. We intend to update our analysis with FY 2009 data on claims paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

4. Proposed Prospective MS–DRG Documentation and Coding Adjustment to the National Capital Federal Rate for FY 2011 and Subsequent Years

We continue to believe that it is appropriate to make adjustments to the capital IPPS rates to eliminate the effect of any documentation and coding changes as a result of the implementation of the MS–DRGs. These adjustments are intended to ensure that future annual aggregate IPPS payments are the same as payments that otherwise would have been made had the prospective adjustments for documentation and coding applied in FY 2008 and FY 2009 accurately reflected the change due to documentation and coding that occurred in those years. As noted in section V.A. of this preamble, under section 1886(g) of the Act, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs (that is, the capital IPPS). We have

consistently stated since the initial implementation of the MS–DRG system that we do not believe it is appropriate for Medicare expenditures under the capital IPPS to increase due to MS–DRG related changes in documentation and coding. Accordingly, we believe that it is appropriate under the Secretary's broad authority under section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, to make adjustments to the capital Federal rate to eliminate the full effect of the documentation and coding changes resulting from the adoption of the MS–DRGs. We believe that this is appropriate because, in absence of such adjustments, the effect of the documentation and coding changes resulting from the adoption of the MS–DRGs results in inappropriately high capital IPPS payments because that portion of the increase in aggregate payments is not due to an increase in patient severity of illness (and costs).

As discussed in greater detail in section II.D.7. of this preamble, we explain that we are proposing a −2.9 percent adjustment for FY 2011 under the authority of section 7(b)(1)(B) of Public Law 110–90. We refer readers to that section of the preamble for a detailed discussion of the issue. In section II.D.6. of this preamble, we also discuss our retrospective evaluation of the FY 2009 claims, and our actuaries' determination that implementation of the MS–DRG system resulted in a 5.4 percent change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009. The estimated 5.4 percent cumulative documentation and coding effect for FYs 2008 and 2009 exceeds the cumulative −1.5 percent prospective documentation and coding adjustment that has already been applied to the national capital Federal rate. Thus, an additional cumulative adjustment of −3.9 percent would be necessary to meet the requirements of section 7(b)(1)(A) of Public Law 110–90 to make an appropriate prospective adjustment to the IPPS operating average standardized amounts in order to eliminate the full effect of the documentation and coding changes on future payments. However, we are not proposing a prospective adjustment to the IPPS operating average standardized amounts under section 7(b)(1)(A) of Public Law 110–90 for FY 2011.

As discussed above in this section, given the increase in payments that we have determined is due to documentation and coding, we believe it is necessary and appropriate under the Secretary's broad authority under section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, to make further adjustments to the capital Federal rate to eliminate the full effect of the documentation and coding changes resulting from the adoption of the MS–DRGs.

It is often our practice to phase in rate adjustments over more than one year in order to moderate the effect on rates in any one year. Therefore, consistently with transitional policies we have adopted in many similar cases and in order to maintain consistency as far as possible with the adjustments that we are proposing to apply to IPPS hospitals, we are proposing an adjustment of −2.9 percent in FY 2011 to the national capital Federal rate. We believe that this proposed adjustment allows us to moderate the effects to hospitals in one year and to maintain equity between hospitals paid on the basis of different prospective rates. We are seeking public comment on the proposed −2.9 percent prospective adjustment to the national capital Federal rate for FY 2011 and our plans to address in future rulemaking cycles the cumulative effect of changes in case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008 and FY 2009, noting that our current estimates of the remaining adjustment to the national capital Federal rate is −1.0 percent. We intend to update our analysis with FY 2009 data on claim paid through March 2009 for the FY 2011 IPPS/LTCH PPS final rule.

Therefore, in this proposed rule, under the Secretary's broad authority under section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, we are proposing to reduce the capital Federal rate in FY 2011 by −2.9 percent to account for the cumulative effect of the estimated changes in documentation and coding changes under the MS–DRG system in FYs 2008 and 2009 that did not reflect real changes in case-mix. Furthermore, consistent with our proposal for the hospital-specific rates under the operating IPPS, we are proposing to leave that proposed −2.9 percent adjustment in place for subsequent fiscal years to account for the effect in FY 2011 and subsequent years. As noted above, we intend to address in future rulemaking cycles the remaining estimated adjustment to the national capital Federal rate of −1.0 percent (that is, the estimated cumulative effect of documentation and coding changes under the MS–DRG system for FYs 2008 and 2009 of −5.4 percent minus the existing −0.6 percent and −0.9 adjustments and the proposed FY 2011 of −2.9 percent adjustment).

5. Proposed Documentation and Coding Adjustment to the Puerto Rico-Specific Capital Rate

Under § 412.74, Puerto Rico hospitals are currently paid based on 75 percent of the national capital Federal rate and 25 percent of the Puerto Rico-specific capital rate. In the FY 2009 IPPS final rule (73 FR 48775), consistent with our development of the FY 2009 Puerto Rico-specific operating standardized amount, we did not apply the additional −0.9 percent documentation and coding adjustment (or the cumulative −1.5 percent adjustment) to the FY 2009 Puerto Rico-specific capital rate. However, the statute gives broad authority to the Secretary under section 1886(g) of the Act, with respect to the development of and adjustments to a capital PPS, and therefore we would not be outside the authority of section 1886(g) of the Act in applying the documentation and coding adjustment to the Puerto Rico-specific portion of the capital payment rate. To date, we had not applied a documentation and coding adjustment to the Puerto Rico-specific capital rate because we have historically made changes to the capital IPPS consistent with those changes made to the operating IPPS. We stated that we may propose to apply such an adjustment to the Puerto Rico capital rates in the future.

As discussed in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43928), when we performed a retrospective evaluation of the FY 2008 claims data of hospitals located in Puerto Rico using the same methodology discussed above, we found that the change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 from hospitals located in Puerto Rico was approximately 1.3 percent. Given this case-mix increase due to changes in documentation and coding under the MS–DRGs, we had proposed to adjust the Puerto Rico-specific capital rate by −1.3 percent in FY 2010 for the FY 2008 increase in case-mix due to changes in documentation and coding under the MS–DRGs. However, in that same final rule, postponed the adoption of any documentation and coding adjustments to the capital IPPS rates until a full analysis of FY 2009 case-mix changes could be completed. We indicated that any future documentation and coding adjustment to the capital

Puerto Rico-specific IPPS rates based on a complete analysis of FY 2008 and FY 2009 claims data for Puerto Rico hospitals would be established through the notice and comment rulemaking process.

As discussed in section II.D.9. of this preamble, when we performed a retrospective evaluation of the FY 2009 claims data of hospitals located in Puerto Rico using the same methodology discussed above, we found that the change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 from hospitals located in Puerto Rico was approximately 2.4 percent. Given this case-mix increase due to changes in documentation and coding under the MS–DRGs, consistent with our proposal to adjust the FY 2011 capital Federal rate presented above and consistent with our proposed adjustment to the FY 2011 Puerto Rico-specific standardized amount discussed in section II.D.9. of the preamble of this proposed rule, under the Secretary's broad authority under section 1886(g) of the Act, we are proposing to adjust the Puerto Rico-specific capital rate by −2.4 percent in FY 2011 for the cumulative increase in case-mix due to changes in documentation and coding under the MS–DRGs for FYs 2008 and 2009. In addition, consistent with our other proposals concerning prospective MS–DRG documentation and coding adjustments to the capital Federal rate and operating IPPS standardized amounts presented in this proposed rule, we are proposing to leave that proposed −2.4 percent adjustment in place for subsequent fiscal years in order to ensure that changes in documentation and coding resulting from the adoption of the MS–DRGs do not lead to an increase in aggregate payments not reflective of an increase in real case-mix. We are proposing that the proposed −2.4 percent documentation and coding adjustment would be applied to the capital Puerto Rico-specific rate that accounts for 25 percent of payments to hospitals located in Puerto Rico, with the remaining 75 percent based on the proposed national capital Federal rate, which we are proposing to adjust for documentation and coding as described above. Consequently, the proposed overall reduction to the FY 2011 payment rates for hospitals located in Puerto Rico to account for documentation and coding changes would be slightly less than the reduction for IPPS hospitals paid based on 100 percent of the national capital Federal rate. As noted above, the Puerto Rico-specific capital rate was not adjusted for the cumulative effects of documentation and coding changes in FY 2008 or FY 2009 as is the case with the national capital Federal rate.

F. Other Proposed Changes for FY 2011

The proposed annual update to the capital IPPS national and Puerto Rico-specific rates, as provided for at § 412.308(c), for FY 2011 is discussed in section III. of the Addendum to this proposed rule.

VI. Proposed Changes for Hospitals Excluded From the IPPS

A. Excluded Hospitals

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. A per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year, and updated annually by a rate-of-increase percentage. The updated target amount was multiplied by total Medicare discharges during that period and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers, which included rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals.

Payment to children's hospitals and cancer hospitals that are excluded from the IPPS continues to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a) of the regulations, RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

For FY 2011, we are proposing that the rate-of-increase percentage to be applied to the target amount for cancer and children's hospitals and RNHCIs would be the proposed FY 2011 percentage increase in the IPPS operating market basket. Beginning with FY 2006, we have used the percentage increase in the IPPS operating market basket to update the target amounts for children's and cancer hospitals. As explained in the FY 2006 IPPS final rule (70 FR 47396 through 47398), with IRFs, IPFs, and LTCHs being paid under their own PPS, the remaining number of providers being paid based on reasonable cost subject to a ceiling (that is, children's and cancer hospitals and RNHCIs) is too small and the cost report data are too limited to be able to create a market basket solely for these hospitals. We are proposing to continue to use the IPPS market basket to update the target amounts for children's and cancer hospitals and RNHCIs for the reasons discussed in the FY 2006 IPPS final rule.

We are proposing to use the revised and rebased FY 2006-based IPPS operating market baskets to update the target amounts for children's and cancer hospitals and RNHCIs for FY 2011. Based on IHS Global Insight, Inc.'s 2010 first quarter forecast, with historical data through the 2009 fourth quarter, we are estimating that the FY 2011 update to the IPPS operating market basket would be 2.4 percent (that is, the current estimate of the market basket rate-of-increase).

We calculated the proposed rate-of-increase in the IPPS operating market basket for FY 2011 using the most recent data available. However, if data that are more recent become available for the final rule, we will use them to calculate the IPPS operating market basket update for FY 2011. Therefore, consistent with our proposal that the rate-of-increase percentage for cancer and children's hospitals and RNHCIs would be the proposed percentage increase in the FY 2011 IPPS operating market basket, the proposed FY 2011 rate-of-increase percentage that would be applied to FY 2010 target amounts in order to calculate the FY 2011 target amounts for cancer and children's hospitals and RNHCIs would be 2.4 percent, in accordance with the applicable regulations in 42 CFR 413.40.

We note that IRFs, IPFs, and LTCHs, which were paid previously under the reasonable cost methodology, now receive payment under their own prospective payment systems, in accordance with changes made to the statute. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provided transition periods of varying lengths during which time a portion of the prospective payment was based on cost-based reimbursement rules under Part 413. (However, certain providers do not receive a transition period or may elect to bypass the transition period as applicable under 42 CFR Part 412, Subparts N, O, and P.) We note that the various transition periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended.

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We

refer readers to section IV. of the Addendum to this proposed rule for the specific proposed update changes to the Federal payment rates for LTCHs under the LTCH PPS for RY 2011. The annual updates for the IRF PPS and the IPF PPS are issued by the agency in separate **Federal Register** documents.

B. Critical Access Hospitals (CAHs)

1. Background

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs) under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and that meet the CAH conditions of participation under 42 CFR part 485, Subpart F, will be certified as CAHs by CMS. Regulations governing payments to CAHs for services to Medicare beneficiaries are located in 42 CFR part 413.

2. CAH Optional Method Election for Payment of Outpatient Services

Section 1834(g) of the Act establishes the payment rules for outpatient services furnished by a CAH. Section 403(d) of Public Law 106–113 (BBRA) amended section 1834(g) of the Act to provide for two methods of payment for outpatient services furnished by a CAH. Specifically, section 1834(g)(1) of the Act, as amended by Public Law 106–113, provided that the amount of payment for outpatient services furnished by a CAH is equal to the reasonable cost of providing such services, unless the CAH made an election, under section 1834(g)(2) of the Act, to receive amounts that were equal to the reasonable cost of the CAH for facility services plus, with respect to the professional services, the amount otherwise paid for professional services under Medicare, less the applicable Medicare deductible and coinsurance amount. The election made under section 1834(g)(2) of the Act is sometimes referred to as "method II." Throughout this section of this preamble, we refer to this election as the "optional method." Section 202 of Public Law 106–554 (BIPA) amended section 1834(g)(2)(B) of the Act to increase the payment for professional services under the optional method to 115 percent of the amount otherwise paid for professional services under Medicare. In addition, section 405(a)(1) of Public Law 108–173 (MMA) amended section 1834(g)(l) of the Act by inserting the phrase "equal to 101 percent of" before the phrase "the reasonable costs." However, the MMA made no changes to the amount of payment under the optional method at section 1834(g)(2)(A) of the Act. As stated earlier, the proposed policies and payment rates in this proposed rule do not reflect the provisions of the recently enacted Public Law 111–148, as amended by Public Law 111–152. We plan to address the provisions of Public Law 111–148, as amended, as they affect payments to CAHs in separate documents in the **Federal Register** or through further instructions.

Accordingly, section 1834(g) of the Act currently provides for two methods of payment for outpatient CAH services. Under the method specified at section 1834(g)(1) of the Act, facility services are paid at 101 percent of reasonable costs to the CAH through the Medicare fiscal intermediary or the Medicare Part A/B MAC, while payments for physician and other professional services are made to the physician or other practitioner under the Medicare Physician Fee Schedule (MPFS) through the Medicare carriers. Under section 1834(g)(2) of the Act (the optional method), a CAH submits bills for both the facility and the professional services to its Medicare fiscal intermediary or its Medicare Part A/B MAC. If a CAH chooses this optional method for outpatient services, the physician or other practitioner must reassign his or her billing rights to the CAH to bill the Medicare program for those services. In accordance with section 1834(g)(2) of the Act, under this optional method, the CAH receives reasonable cost payment for its facility costs and, with respect to the professional services, 115 percent of the amount otherwise paid for professional services under Medicare.

The existing regulations at § 413.70(b)(3)(i)(A) require that if a CAH wishes to elect the optional method, that election must be made in writing, made on an annual basis, and delivered to the fiscal intermediary servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made. The regulations at § 413.70(b)(3)(i)(B) specify that once an election is made for a cost reporting period, that election remains in effect for all of that period. Therefore, under the existing regulations, a CAH that is being paid under the optional method is required to submit an election on an annual basis if it wishes to continue to be paid under the optional method for a subsequent cost reporting period.

We have been informed that, in past years, some CAHs have submitted their elections several days late, which has caused these CAHs to lose their optional method election for the entire cost reporting year and has resulted in financial hardship for these providers. Such untimely submission of the optional method election may be due to staffing turnovers at the CAH as well as a change in fiscal intermediary or MAC assignments because, in the past, some CAHs received correspondence from their fiscal intermediaries or MACs reminding them to elect the optional method on an annual basis. Due to the significant consequences if a CAH fails to make a timely election, we are proposing to amend the regulations at § 413.70(b)(3)(i) to state that, effective for CAH cost reporting periods beginning on or after October 1, 2010, if a CAH has elected the optional method for its most recent cost reporting period beginning prior to October 1, 2010 or chooses to elect the optional method for its upcoming cost reporting period, that election will remain in place until it is terminated.

We believe that removing the annual election requirement will reduce any perceived burden associated with the election process and make it easier for CAHs to maintain their election if they experience administrative staffing changes. If a CAH is being paid under the traditional method and wishes to elect the optional method, it must submit its election in writing to its servicing fiscal intermediary or MAC at least 30 days prior to the first cost reporting period for which the election is effective. Once that initial election is made, it will remain in place until it is terminated.

We are proposing to revise the regulations to include a mechanism for CAHs that are being paid under the optional method to terminate that election. Specifically, we are proposing that if a CAH is being paid under the optional method and wishes to terminate that election, it must submit its termination request to the fiscal intermediary or MAC servicing the CAH at least 30 days prior to the start of the next cost reporting period. Because the proposed effective date for this provision is for cost reporting periods beginning on or after October 1, 2010, CAHs that have cost reporting periods beginning in October 2010 or November 2010 may not have sufficient time to terminate their optional method election at least 30 days prior to the start of the cost reporting period. Therefore, we are proposing that CAHs that have cost reporting periods beginning in October 2010 or November 2010 and elected the optional method in 2009 that wish to terminate that election will have until December 1, 2010, to terminate their prior year election. The termination will be effective for the entire FY 2011 cost reporting period. Thus, if a CAH with a cost reporting period beginning in

October 2010 or November 2010 terminates its optional method election after the beginning of its cost reporting period but before December 1, 2010, the fiscal intermediary or MAC would be instructed to reprocess any payments made under the optional method for services provided during that period as efficiently as possible.

Section 1834(g)(2)(B) of the Act provides that if a CAH elects the optional method, it is not required that each physician or other practitioner providing professional services in the CAH must reassign billing rights with respect to the services. Rather, the reassignment of billing rights is physician/practitioner specific. For this reason, the optional payment method should not apply to the computation of payments to the CAH for its facility services in conjunction with services furnished by physicians and practitioners who have not reassigned such billing rights. Accordingly, if a physician or practitioner has not reassigned his or her billing rights to the CAH, the CAH will be paid for its facility services at 101 percent of reasonable cost, as specified at § 413.70(b)(2)(i) of the regulations. If a CAH experiences changes in its physician or practitioner staffing, there may be a change in which physicians or practitioners choose to reassign their billing rights in order to permit the CAH to bill for their professional services. In order to ensure appropriate payments, and specifically, in order to ensure that there is no duplicate billing for a physician's or practitioner's professional services by the CAH to the fiscal intermediary or MAC and by the physician or practitioner providing the service to the carrier, a CAH must continue to notify its fiscal intermediary or MAC when changes in reassignment occur.

In summary, we are proposing to revise § 413.70(b)(3)(i) to specify, under paragraphs (A)(*1*) and (A)(*2*), that for CAH cost reporting periods beginning on or after October 1, 2010, once a CAH elects the optional method, including an election made for its most recent cost reporting period beginning prior to October 1, 2010, its election will remain in place until it is terminated. That is, CAHs would no longer be required to make an annual election in order to continue to be paid under the optional method in a subsequent year. If a CAH has not elected the optional method for its most recent cost reporting period beginning prior to October 1, 2010, and would like to be paid for outpatient services under the optional method for a cost reporting period beginning on or after October 1, 2010, consistent with our existing regulations, it would be required to provide its election in writing to its servicing fiscal intermediary or MAC at least 30 days prior to the start of the first cost reporting period for which the election is effective. In addition, we are proposing to revise the regulations to specify that if a CAH wishes to terminate its optional method election, it must submit its termination request to the fiscal intermediary or MAC servicing the CAH at least 30 days prior to the start of the next cost reporting period. We are proposing that CAHs that have cost reporting periods beginning in October 2010 or November 2010 and elected the optional method in 2009, that wish to terminate that election, will have until December 1, 2010, to terminate their prior year election. The termination would be effective for the entire FY 2011 cost reporting period. We also are proposing to make a conforming change to paragraph (b)(3)(i)(D).

3. Costs of Provider Taxes as Allowable Costs for CAHs

a. Background and Statutory Basis

Currently, certain taxes assessed against a provider may be allowable costs under Medicare to the extent that such taxes are related to the reasonable and necessary cost of providing patient care and represent costs actually incurred. Reasonable cost reimbursement is addressed in section 1861(v)(1)(A) of the Act. Section 1861(v)(1)(A) of the Act defines "reasonable cost," in part, as the cost actually incurred, excluding costs found to be unnecessary in the efficient delivery of needed health services and are determined in accordance with regulations establishing the method or methods to be used and the items to be included. Section 1861(v)(1)(A) of the Act does not specifically address the determination of reasonable costs, but authorizes the Secretary to promulgate regulations and principles to be applied in determining reasonable costs.

We have issued regulations implementing this provision of the Act, including 42 CFR 413.9(a) which provide that the determination of reasonable cost "must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries." In addition, § 413.9(c) requires that the provision for payment of reasonable cost of services is intended to meet the actual costs incurred in providing services. Therefore, in accordance with the statute, the regulations include two principles that help guide the determination of which expenses may be considered allowable reasonable costs that can be paid under Medicare; that is, such costs must be "related" to the care of Medicare beneficiaries, and such costs must actually be "incurred."

Consistent with these provisions, we also have issued policy instructions in the Provider Reimbursement Manual (PRM) for determining allowable reasonable costs under Medicare. Specifically, section 2122 of the PRM sets forth Medicare policy on determining when taxes levied on providers are allowable costs and provides a list of taxes that are considered unallowable costs. Specifically, section 2122.1 (General Rule) of the PRM states: "The general rule is that taxes assessed against the provider, in accordance with the levying enactments of the several States and lower levels of government and for which the provider is liable for payment, are allowable costs. Tax expenses should not include fines and penalties." Section 2122.2 (Taxes Not Allowable as Costs) of the PRM lists certain taxes that are levied on providers that are not allowable costs. The listed taxes are:

- Federal income and excess profit taxes, including any interest or penalties paid thereon (A).
- State or local income and excess profit taxes (B).
- Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense. (C)
- Taxes from which exemptions are available to the provider. (D)
- Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful lives. (E)
- Taxes on property which is not used in the rendition of covered services. (F)
- Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider. (G)
- Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, etc. (H)

b. Proposed Clarification of Payment Policy for Provider Taxes

We have learned that there is some confusion relating to the determination of whether a tax is an allowable cost. We believe that much of this confusion

has arisen because it may be possible to read sections 2122.1 and 2122.2 of the PRM as permitting all taxes assessed on a provider by a State that are not specifically listed in section 2122.2 to be treated as allowable costs. Section 2122 of the PRM was last updated in 1979 when States typically raised revenue only from income, sales, and property taxes. The list in section 2212.2 is incomplete now, as it does not reflect the variety of provider taxes imposed by States. In addition, we are concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, "incur" the entire amount of these assessed taxes. For example, in accordance with the Medicaid statute and regulations, some States levy tax assessments on hospitals. The assessed taxes may be paid by the hospitals into a fund that includes all taxes paid, all Federal matching monies, and any penalties for nonpayment. The State is then authorized to disburse monies from the fund to the hospitals. We believe that these types of subsequent disbursements to providers are associated with the assessed taxes and may, in fact, offset some, if not all, of the taxes originally paid by the hospitals.

We believe that the treatment of these types of payments on the Medicare cost report should be analogous to the adjustments described at § 413.98 of the regulations. Specifically, § 413.98(d) provides that the "true cost of the goods or services is the net amount actually paid for them." Section 413.98 specifically addresses the purchase of goods and services and reflects the statutory mandate that a provider's allowable costs are the net expenses it incurs for items and services. In situations in which payments that are associated with the assessed tax are made to providers specifically to make the provider whole or partly whole for the tax expenses, Medicare should similarly recognize only the net expense incurred by the provider. Thus, while a tax may be an allowable Medicare cost in that it is related to beneficiary care, the provider may only treat as a reasonable cost the net tax expense; that is, the tax paid by the provider, reduced by payments the provider *received* that are associated with the assessed tax. In addition, we do not believe that determinations made regarding whether the structure of specific taxes and subsequent reimbursements are consistent with Medicaid "hold harmless" provisions necessarily require the Medicare program to find that the same tax is an allowable cost. The Medicare statute and regulations set forth a different standard that requires a determination of how much of the allowable tax expense is actually "incurred" by the provider.

In this proposed rule, we are proposing to clarify our policy concerning when provider taxes may be considered allowable costs under Medicare. As stated above, section 2122 of the PRM was last updated in 1979, and it no longer reflects the variety of provider taxes that may be imposed by States. Although some of the more recently enacted provider taxes may be allowable costs, we are concerned that some of these taxes may not be "related to the care of beneficiaries" and that some, if not all, of the costs of these taxes might not be actually "incurred" by the providers. This payment policy may not directly affect providers that are paid under a Medicare prospective payment system unless a cost-based prospective payment system is rebased on more current reported reasonable costs. However, this policy clarification could impact certain providers that are paid on the basis of their incurred reasonable costs, such as CAHs.

Therefore, we are proposing to clarify the policy set forth in sections 2122.1 and 2122.2 of the PRM to reflect our concerns set forth above regarding when certain provider taxes may be allowable costs under the Medicare program. We will modify the PRM consistent with these principles. We believe that the proposed revision would clarify that our Medicare contractors will determine the allowability of provider taxes on a case-by-case basis, based on reasonable cost principles, and will determine if a reduction of the allowable tax expenses is proper to account for payments providers receive that are associated with the assessed tax.

VII. Proposed Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2011

A. Background of the LTCH PPS

1. Legislative and Regulatory Authority

Section 123 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) as amended by section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) provides for payment for both the operating and capital-related costs of hospital inpatient stays in long-term care hospitals (LTCHs) under Medicare Part A based on prospectively set rates. The Medicare prospective payment system (PPS) for LTCHs applies to hospitals that are described in section 1886(d)(1)(B)(iv) of the Social Security Act (the Act), effective for cost reporting periods beginning on or after October 1, 2002.

Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days." Section 1886(d)(1)(B)(iv)(II) of the Act also provides an alternative definition of LTCHs: Specifically, a hospital that first received payment under section 1886(d) of the Act in 1986 and has an average inpatient length of stay (LOS) (as determined by the Secretary of Health and Human Services (the Secretary)) of greater than 20 days and has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in FY 1997.

Section 123 of the BBRA requires the PPS for LTCHs to be a "per discharge" system with a diagnosis-related group (DRG) based patient classification system that reflects the differences in patient resources and costs in LTCHs.

Section 307(b)(1) of the BIPA, among other things, mandates that the Secretary shall examine, and may provide for, adjustments to payments under the LTCH PPS, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment.

In the August 30, 2002 **Federal Register**, we issued a final rule that implemented the LTCH PPS authorized under the BBRA and BIPA (67 FR 55954). This system currently uses information from LTCH patient records to classify patients into distinct MS-long-term care diagnosis-related groups (MS–LTC–DRGs) based on clinical characteristics and expected resource needs. Payments are calculated for each MS–LTC–DRG and provisions are made for appropriate payment adjustments. Payment rates under the LTCH PPS are updated annually and published in the **Federal Register**.

The LTCH PPS replaced the reasonable cost-based payment system under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) for payments for inpatient services provided by a LTCH with a cost reporting period beginning on or after October 1, 2002. (The regulations implementing the TEFRA reasonable cost-based payment provisions are located at 42 CFR Part 413.) With the implementation of the

PPS for acute care hospitals authorized by the Social Security Amendments of 1983 (Pub. L. 98–21), which added section 1886(d) to the Act, certain hospitals, including LTCHs, were excluded from the PPS for acute care hospitals and were paid their reasonable costs for inpatient services subject to a per discharge limitation or target amount under the TEFRA system. For each cost reporting period, a hospital-specific ceiling on payments was determined by multiplying the hospital's updated target amount by the number of total current year Medicare discharges. (Generally, in section VIII. of this preamble, when we refer to discharges, the intent is to describe Medicare discharges.) The August 30, 2002 final rule further details the payment policy under the TEFRA system (67 FR 55954).

In the August 30, 2002 final rule, we provided for a 5-year transition period. During this 5-year transition period, a LTCH's total payment under the PPS was based on an increasing percentage of the Federal rate with a corresponding decrease in the percentage of the LTCH PPS payment that is based on reasonable cost concepts. However, effective for cost reporting periods beginning on or after October 1, 2006, total LTCH PPS payments are based on 100 percent of the Federal rate.

In addition, in the August 30, 2002 final rule, we presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates, additional payments, and the budget neutrality requirements mandated by section 123 of the BBRA. The same final rule that established regulations for the LTCH PPS under 42 CFR part 412, Subpart O also contained LTCH provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements. We refer readers to the August 30, 2002 final rule for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS (67 FR 55954).

In the June 6, 2003 **Federal Register**, we published a final rule that set forth the FY 2004 annual update of the payment rates for the Medicare PPS for inpatient hospital services furnished by LTCHs (68 FR 34122). It also changed the annual period for which the payment rates were to be effective, such that the annual updated rates were effective from July 1 through June 30 instead of from October 1 through September 30. We referred to the July through June time period as a "long-term care hospital rate year" (LTCH PPS rate year). In addition, we changed the publication schedule for the annual update to allow for an effective date of July 1. The payment amounts and factors used to determine the annual update of the LTCH PPS Federal rate are based on a LTCH PPS rate year. In the past, while the LTCH payment rate updates were effective July 1, the annual update of the DRG classifications and relative weights for LTCHs continued to be linked to the annual adjustments of the acute care hospital inpatient DRGs and were effective each October 1.

As discussed in detail in section VIII.A.1. of the May 9, 2008 RY 2009 LTCH PPS final rule (73 FR 26788), we again changed the schedule for the annual updates of the LTCH PPS Federal payment rates beginning with RY 2010. We consolidated the rulemaking cycle for the annual update of the LTCH PPS Federal payment rates and description of the methodology and data used to calculate these payment rates with the annual update of the MS–LTC–DRG classifications and associated weighting factors for LTCHs so that the updates to the rates and the weights now occur on the same schedule and appear in the same publication. As a result, the updates to the rates and the weights are now effective on October 1 (on a Federal fiscal year schedule), and the annual updates to the LTCH PPS Federal rates are no longer published with a July 1 effective date (73 FR 26797 through 26798).

Public Law 110–173 (MMSEA), enacted on December 29, 2007, included provisions that have various effects on the LTCH PPS. In addition to amending section 1861 of the Act to add a subsection (ccc) which provided an additional definition of LTCHs, Public Law 110–173 also required the Secretary to submit, no later than 18 months after the date of enactment of the law, a report to Congress on a study of national long-term care hospital facility and patient criteria that included "recommendations for such legislation and administrative actions, including timelines for the implementation of LTCH patient criteria or other actions, as the Secretary determines appropriate." The payment policy provisions under sections 114(c)(1) and 114(c)(2) of Public Law 110–173 focused on providing 3 years of relief for certain LTCHs from the percentage threshold payment adjustment policy at 42 CFR 412.534 and 412.536. However, because of the original implementation schedule of those sections of the regulations, the payment provisions had varying timeframes of applicability (73 FR 29701 through 29704). In addition, section 114(c)(3) of Public Law 110–173 provided that the Secretary shall not apply, for the 3-year period beginning on the date of enactment of the Act the revision to the short-stay outlier (SSO) policy that was finalized in the RY 2008 LTCH PPS final rule (72 FR 26904 and 26992). In addition, section 114(c)(4) of Public Law 110–173 provided that the Secretary shall not, for the 3-year period beginning on the date of enactment of the Act, make the one-time adjustment to the payment rates provided for in § 412.523(d)(3) or any similar provision (73 FR 26800 through 26804). The statute also provided that the base rate for RY 2008 be the same as the base rate for RY 2007 (the revised base rate, however, does not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008) (73 FR 24875 through 24877). Section 114(d) of Public Law 110–173 established a 3-year moratorium (with specified exceptions) on the establishment and classification of new LTCHs, LTCH satellites, and on the increase in the number of LTCH beds in existing LTCHs or satellite facilities. Finally, section 114(f) of Public Law 110–173 provided for an expanded review of medical necessity for admission and continued stay at LTCHs.

In the RY 2009 LTCH PPS final rule (73 FR 26804 through 26812), we established the applicable Federal rates for RY 2009, consistent with section 1886(m)(2) of the Act as amended by Public Law 110–173. We also revised the regulations at § 412.523(d)(3) to change the methodology for the one-time budget neutrality adjustment and to comply with section 114(c)(4) of Public Law 110–173. Other policy revisions that were necessary as a result of the statutory changes of Public Law 110–173 were addressed in separate interim final rules with comment period (73 FR 24871 and 73 FR 29699). In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43976 through 43990), we address all of the public comments received and finalized these two interim final rules with comment period.

Section 4302 of the ARRA, Public Law 111–5, enacted on February 17, 2009, included several amendments to the provisions set forth in section 114 of Public Law 110–173. Specifically, section 4302(a) modified the effective dates of the provisions of section 114(c) of Public Law 110–173, described above, and added an additional category of LTCHs or satellite facilities that would not be subject to the percentage threshold payment adjustment at § 412.536 for a 3-year period. In

addition, section 4302(a)(2)(A) of Public Law 111–5 added "grandfathered" satellites (specified in § 412.22(h)(3)(i) of the regulations) to those "applicable" LTCHs (specified in § 412.534(g) of the regulations) originally granted relief under section 114(c) of Public Law 110–173. We issued instructions to the fiscal intermediaries and MACs interpreting the provisions of section 4302 of Public Law 111–5 (Change Request 6444). In addition, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (43990 through 43992), we implemented the provisions of section 4302 of Public Law 111–5 through an interim final rule with comment period. We received one piece of timely correspondence regarding the provisions of section 4302 of Public Law 111–5 that were implemented through the interim final rule with comment period that was included in the FY 2010 IPPS/RY 2010 LTCH PPS final rule. We plan to address this public comment and finalize the interim final rule with comment period in the FY 2011 IPPS/LTCH PPS final rule, which is scheduled to be issued by August l, 2010.

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public L. 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

2. Criteria for Classification as a LTCH

a. Classification as a LTCH

Under the existing regulations at § 412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Act, to qualify to be paid under the LTCH PPS, a hospital must have a provider agreement with Medicare and must have an average Medicare inpatient length of stay (LOS) of greater than 25 days. Alternatively, § 412.23(e)(2)(ii) states that for cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the PPS in 1986 and can demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease must have an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days.

b. Hospitals Excluded from the LTCH PPS

The following hospitals are paid under special payment provisions, as described in § 412.22(c), and therefore, are not subject to the LTCH PPS rules:

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR Part 403.
- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of the Social Security Amendments of 1967 (Pub. L. 90–248) (42 U.S.C. 1395b–1) or section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603) (42 U.S.C. 1395b–1 (note)) (Statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act).
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

3. Limitation on Charges to Beneficiaries

In the August 30, 2002 final rule, we presented an in-depth discussion of beneficiary liability under the LTCH PPS (67 FR 55974 through 55975). In the RY 2005 LTCH PPS final rule (69 FR 25676), we clarified that the discussion of beneficiary liability in the August 30, 2002 final rule was not meant to establish rates or payments for, or define Medicare-eligible expenses. Under § 412.507, if the Medicare payment to the LTCH is the full LTC–DRG payment amount, as consistent with other established hospital prospective payment systems, a LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts as specified under § 409.82, § 409.83, and § 409.87 and for items and services as specified under § 489.30(a). However, under the LTCH PPS, Medicare will only pay for days for which the beneficiary has coverage until the SSO threshold is exceeded. Therefore, if the Medicare payment was for a SSO case (§ 412.529) that was less than the full LTC–DRG payment amount because the beneficiary had insufficient remaining Medicare days, the LTCH could also charge the beneficiary for services delivered on those uncovered days (§ 412.507).

4. Administrative Simplification Compliance Act (ASCA) and Health Insurance Portability and Accountability Act (HIPAA) Compliance

Claims submitted to Medicare must comply with both the Administrative Simplification Compliance Act (ASCA) (Pub. L. 107–105), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191). Section 3 of the ASCA requires that the Medicare Program deny payment under Part A or Part B for any expenses incurred for items or services "for which a claim is submitted other than in an electronic form specified by the Secretary." Section 1862(h) of the Act (as added by section 3(a) of the ASCA) provides that the Secretary shall waive such denial in two specific types of cases and may also waive such denial "in such unusual cases as the Secretary finds appropriate" (68 FR 48805). Section 3 of the ASCA operates in the context of the HIPAA regulations, which include, among other provisions, the transactions and code sets standards requirements codified at 45 CFR parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered health care providers, to conduct certain electronic healthcare transactions according to the applicable transactions and code sets standards.

B. Proposed Medicare Severity Long-Term Care Diagnosis-Related Group (MS–LTC–DRG) Classifications and Relative Weights

1. Background

Section 123 of the BBRA requires that the Secretary implement a PPS for LTCHs (that is, a per discharge system with a diagnosis-related group (DRG)-based patient classification system reflecting the differences in patient resources and costs). Section 307(b)(1) of the BIPA modified the requirements of section 123 of the BBRA by requiring that the Secretary examine "the feasibility and the impact of basing payment under such a system [the long-term care hospital (LTCH) PPS] on the use of existing (or refined) hospital

DRGs that have been modified to account for different resource use of LTCH patients, as well as the use of the most recently available hospital discharge data."

When the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, we adopted the same DRG patient classification system (that is, the CMS DRGs) that was utilized at that time under the IPPS. As a component of the LTCH PPS, we refer to this patient classification system as the "long-term care diagnosis-related groups (LTC–DRGs). Although the patient classification systems used under both the LTCH PPS and the IPPS are the same, the relative weights are different. The established relative weight methodology and data used under the LTCH PPS result in relative weights under the LTCH PPS that reflect "the differences in patient resource use * * *" of LTCH patients (section 123(a)(1) of the BBRA (Pub. L. 106–113)).

As part of our efforts to better recognize severity of illness among patients, in the FY 2008 IPPS final rule with comment period (72 FR 47130), the MS–DRGs and the Medicare severity long-term care diagnosis-related groups (MS–LTC–DRGs) were adopted under the IPPS and the LTCH PPS, respectively, effective beginning October 1, 2007 (FY 2008). For a full description of the development and implementation and rationale for the use of the MS–DRGs and MS–LTC–DRGs, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175 and 47277 through 47299). (We note that, in that same final rule, we revised the regulations at § 412.503 to specify that for LTCH discharges occurring on or after October 1, 2007, when applying the provisions of 42 CFR part 412, Subpart O applicable to LTCHs for policy descriptions and payment calculations, all references to LTC–DRGs would be considered a reference to MS–LTC–DRGs. For the remainder of this section, we present the discussion in terms of the current MS–LTC–DRG patient classification system unless specifically referring to the previous LTC–DRG patient classification system that was in effect before October 1, 2007.) We believe the MS–DRGs (and by extension, the MS–LTC–DRGs) represent a substantial improvement over the previous CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption.

The MS–DRGs adopted in FY 2008 represent an increase in the number of DRGs by 207 (that is, from 538 to 745) (72 FR 47171). In FY 2009, an additional MS–DRG was adopted for a total of 746 distinct groupings (73 FR 48497). For FY 2011, we are proposing to delete one MS–DRG and create two new MS–DRGs, for a net gain of one MS–DRG, as noted in section II. of the preamble of this proposed rule. This would result in 747 distinct MS–DRG groupings for FY 2011. Consistent with section 123 of the BBRA, as amended by section 307(b)(1) of the BIPA, and § 412.515, we use information derived from LTCH PPS patient records to classify LTCH discharges into distinct MS–LTC–DRGs based on clinical characteristics and estimated resource needs. We then assign an appropriate weight to the MS–LTC–DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.

In a departure from the IPPS, and as discussed in greater detail below in section VII.B.3.f. of this preamble, we use low-volume MS–LTC–DRGs (that is, MS–LTC–DRGs with less than 25 LTCH cases) in determining the MS–LTC–DRG relative weights because LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. For purposes of determining the relative weights for the large number of low-volume MS–LTC–DRGs, we group all of the low-volume MS–LTC–DRGs into five quintiles based on average charge per discharge. (A detailed discussion of the initial development and application of the quintile methodology appears in the August 30, 2002 LTCH PPS final rule (67 FR 55978).) We also account for adjustments to payments for short-stay outlier (SSO) cases (that is, cases where the covered LOS at the LTCH is less than or equal to five-sixths of the geometric ALOS for the MS–LTC–DRG). Furthermore, we make adjustments to account for nonmonotonically increasing weights, when necessary. That is, theoretically, cases under the MS–LTC–DRG system that are more severe require greater expenditure of medical care resources and will result in higher average charges such that, in the severity levels within a base MS–LTC–DRG, the weights should increase monotonically with severity from the lowest to highest severity level. (We discuss nonmonotonicity in greater detail and our methodology to adjust the RY 2010 MS–LTC–DRG relative weights to account for nonmonotonically increasing relative weights in section VII.B.3.g. (Step 6) of this preamble.)

2. Patient Classifications Into MS–LTC–DRGs

a. Background

The MS–DRGs (used under the IPPS) and the MS–LTC–DRGs (used under the LTCH PPS) are based on the CMS DRG structure. As noted above in this section, we refer to the DRGs under the LTCH PPS as MS–LTC–DRGs although they are structurally identical to the MS–DRGs used under the IPPS.

The MS–DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are assigned based on a surgical hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. The GROUPER software program does not recognize all ICD–9–CM procedure codes as procedures affecting DRG assignment. That is, procedures that are not surgical (for example, EKG), or minor surgical procedures (for example, biopsy of skin and subcutaneous tissue (procedure code 86.11)) do not affect the MS–LTC–DRG assignment based on their presence on the claim.

Generally, under the LTCH PPS, a Medicare payment is made at a predetermined specific rate for each discharge and that payment varies by the MS–LTC–DRG to which a beneficiary's stay is assigned. Cases are classified into MS–LTC–DRGs for payment based on the following six data elements:

- Principal diagnosis;
- Additional or secondary diagnoses;
- Surgical procedures;
- Age;
- Sex; and
- Discharge status of the patient.

Through FY 2010, the number of secondary or additional diagnoses and the number of surgical procedures considered for MS–DRG assignment was limited to eight and six, respectively. Elsewhere in this proposed rule, however, we are proposing that, for claims submitted on the 5010 format beginning January 1, 2011, we would increase the capacity to process diagnosis and procedure codes up to 25 diagnoses and 25 procedures. This will include one principal diagnosis and up to 24 secondary diagnoses for severity of illness determinations. We refer readers to section II.G.11.c. of this preamble for a complete discussion of this proposed change.

Upon the discharge of the patient from a LTCH, the LTCH must assign

appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). HIPAA Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162 require that no later than October 16, 2003, all covered entities must comply with the applicable requirements of Subparts A and I through R of Part 162. Among other requirements, those provisions direct covered entities to use the ASC X12N 837 Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, and the applicable standard medical data code sets for the institutional health care claim or equivalent encounter information transaction (45 CFR 162.1002 and 45 CFR 162.1102). For additional information on the ICD–9–CM Coding System, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47241 through 47243 and 47277 through 47281). We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983). Additional coding instructions and examples are published in the *Coding Clinic for ICD–9–CM,* a product of the American Hospital Association. (We refer readers to section II.G.11. of this preamble for additional information on the annual revisions to the ICD–9–CM codes.)

With respect to the ICD–9–CM coding system, we have been discussing the conversion to the ICD–10–CM and the ICD–10–PCS coding systems for many years. As is discussed in detail in section II.G.11. of this preamble, the ICD–10 coding systems applicable to hospital inpatient services will be implemented on October 1, 2013. In order for the industry to make the necessary conversions from ICD–9–CM to ICD–10–CM and ICD–10–PCS, we proposed, through the ICD–9–CM Coordination and Maintenance Committee, to consider a moratorium on updates to the ICD–9–CM and ICD–10 coding sets. We refer readers to section II.G.11. of this preamble for additional information on the adoption of ICD–10–CM and ICD–10–PCS.

To create the MS–DRGs (and by extension, the MS–LTC–DRGs), individual DRGs were subdivided according to the presence of specific secondary diagnoses designated as complications or comorbidities (CCs) into three, two, or one level, depending on the impact of the CCs on resources used for those cases. Specifically, there are sets of MS–DRGs that are split into 2 or 3 subgroups based on the presence or absence of a CC or a major complication and comorbidity (MCC). We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a detailed discussion about the creation of MS–DRGs based on severity of illness levels (72 FR 47141 through 47175).

Medicare contractors (that is, fiscal intermediaries and MACs) enter the clinical and demographic information submitted by LTCHs into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a MS–LTC–DRG can be made. During this process, certain cases are selected for further development (74 FR 43949).

After screening through the MCE, each claim is classified into the appropriate MS–LTC–DRG by the Medicare LTCH GROUPER software on the basis of diagnosis and procedure codes and other demographic information (age, sex, and discharge status). The GROUPER software used under the LTCH PPS is the same GROUPER software program used under the IPPS. Following the MS–LTC–DRG assignment, the Medicare contractor determines the prospective payment amount by using the Medicare PRICER program, which accounts for hospital-specific adjustments. Under the LTCH PPS, we provide an opportunity for LTCHs to review the MS–LTC–DRG assignments made by the Medicare contractor and to submit additional information within a specified timeframe as provided in § 412.513(c).

The GROUPER software is used both to classify past cases to measure relative hospital resource consumption to establish the MS–LTC–DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible MS–DRG and MS–LTC–DRG classification changes and to recalibrate the MS–DRG and MS–LTC–DRG relative weights during our annual update under both the IPPS (§ 412.60(e)) and the LTCH PPS (§ 412.517), respectively.

b. Proposed Changes to the MS–LTC–DRGs for FY 2011

As specified by our regulations at § 412.517(a), which requires that the LTC–MS–DRG classifications and relative weights be updated annually and consistent with our historical practice of using the same patient classification system under the LTCH PPS as is used under the IPPS, in this proposed rule, we are proposing to modify and revise the MS–LTC–DRG classifications effective October 1, 2010, through September 30, 2011 (FY 2011) consistent with the proposed changes to specific MS–DRG classifications presented above in section II.G. of this proposed rule (that is, proposed GROUPER Version 28.0). Therefore, the MS–LTC–DRGs for FY 2011 presented in this proposed rule are the same as the proposed MS–DRGs that would be used under the IPPS for FY 2011. In addition, because the proposed MS–LTC–DRGs for FY 2011 are the same as the proposed MS–DRGs for FY 2011, the other changes that would affect MS–DRG (and by extension MS–LTC–DRG) assignments under Version 28.0 of the GROUPER discussed in section II.G. of the preamble of this proposed rule, including the proposed changes to the MCE software and proposed changes to the ICD–9–CM coding system, would also be applicable under the LTCH PPS for FY 2011.

3. Development of the Proposed FY 2011 MS–LTC–DRG Relative Weights

a. General Overview of the Development of the MS–LTC–DRG Relative Weights

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55984), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of medical care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we have annually adjusted the LTCH PPS standard Federal prospective payment system rate by the applicable relative weight in determining payment to LTCHs for each case.

Although the adoption of the MS–LTC–DRGs resulted in some modifications of existing procedures for assigning weights in cases of zero volume and/or nonmonotonicity (as discussed in the FY 2008 IPPS final rule with comment period (72 FR 47289 through 47295) and the FY 2009 IPPS final rule (73 FR 48542 through 48550)), the basic methodology for developing the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule continues to be determined in accordance with the general methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). Under the LTCH PPS, relative weights for each MS–LTC–DRG are a primary element used to

account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each MS–LTC–DRG that represents the resources needed by an average inpatient LTCH case in that MS–LTC–DRG. For example, cases in an MS–LTC–DRG with a relative weight of 2 will, on average, cost twice as much to treat as cases in an MS–LTC–DRG with a weight of 1.

b. Development of the Proposed MS–LTC–DRG Relative Weights for FY 2011

Beginning with the FY 2008 update, we established a budget neutral requirement for the annual update to the MS–LTC–DRG classifications and relative weights at 42 CFR 412.517(b) (in conjunction with § 412.503), such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the classification and relative weight changes (May 11, 2007 LTCH PPS final rule, 72 FR 26882 through 26884).

Consistent with § 412.517(b), we apply a two-step budget neutrality methodology, which is based on the current year MS–LTC–DRG classifications and relative weights. (For additional information on the established two-step budget neutrality methodology, we refer readers to the FY 2008 IPPS final rule (72 FR 47295 through 47296).) Thus, the proposed annual update to the MS–LTC–DRG classifications and relative weights for FY 2011 is based on the FY 2010 MS–LTC–DRG classifications and relative weights.

c. Data

In this proposed rule, to calculate the proposed MS–LTC–DRG relative weights for FY 2011, we are proposing to obtain total Medicare allowable charges from FY 2009 Medicare LTCH bill data from the December 2009 update of the MedPAR file, which are the best available data at this time, and to use the proposed Version 28.0 of the GROUPER to classify LTCH cases (as discussed above). We also are proposing that if more recent data become available, we would use those data and the finalized Version 28.0 of the GROUPER in establishing the FY 2011 MS–LTC–DRG relative weights in the final rule.

Consistent with our historical methodology, we excluded the data from LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 or section 222(a) of Public Law 92–603. In addition, as is the case with the IPPS, Medicare Advantage (Part C) claims are now included in the MedPAR files (74 FR 43808). Consistent with IPPS policy, we are proposing to exclude such claims in the calculations for the relative weights under the LTCH PPS that are used to determine payments for fee-for-service Medicare claims. Specifically, we have added an edit to the relative weight calculation to remove any claims from the MedPAR files that have a GHO Paid indicator value of "1," which effectively removes Medicare Advantage claims from the relative weight calculations (73 FR 48532). Accordingly, in the development of the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule, we excluded the data of 13 all-inclusive rate providers and the 2 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2009 MedPAR file, as well as any Medicare Advantage claims.

d. Hospital-Specific Relative Value (HSRV) Methodology

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. This nonrandom distribution of cases with relatively high (or low) charges in specific MS–LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, consistent with the methodology we have used since the implementation of the LTCH PPS, we are proposing to continue to use a hospital-specific relative value (HSRV) methodology to calculate the proposed MS–LTC–DRG relative weights. We believe this method removes this hospital-specific source of bias in measuring LTCH average charges (67 FR 55985). Specifically, we are reducing the impact of the variation in charges across providers on any particular proposed MS–LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the HSRV methodology, we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjust those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, average 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

In accordance with our established methodology, we continue to standardize charges for each case by first dividing the adjusted charge for the case (adjusted for SSOs under § 412.529 as described in section VII.B.3.g. (step 3) of the preamble of this proposed rule) by the average adjusted charge for all cases at the LTCH in which the case was treated. SSO cases are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the MS–LTC–DRG (§ 412.529 and § 412.503). The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case. (67 FR 55989)

Multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight at a LTCH with higher average costs than they would at a LTCH with low average costs, which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a $10,000 charge for a case at a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case at a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

e. Treatment of Severity Levels in Developing the Proposed MS–LTC–DRG Relative Weights

For purposes of determining the proposed MS–LTC–DRG relative weights, there are three different categories of DRGs based on volume of cases within specific MS–LTC–DRGs. MS–LTC–DRGs with at least 25 cases are each assigned a unique proposed relative weight; low-volume proposed MS–LTC–DRGs (that is, proposed MS–LTC–DRGs that contain between 1 and 24 cases based on a given year's claims data) are grouped into quintiles (as described below) and assigned the proposed relative weight of the quintile. No-volume proposed MS–LTC–DRGs (that is, no cases in the given year's claims data were assigned to those proposed MS–LTC–DRGs) are crosswalked to other proposed MS–LTC–DRGs based on the clinical similarities and assigned the relative weight of the crosswalked MS–LTC–DRG (as described in greater detail below). (We provide in-depth discussions of our policy regarding weight-setting for low-volume MS–LTC–DRGs in section VII.B.3.f. of the preamble of this proposed rule and for no-volume MS–LTC–DRGs, under Step 5 in section VII.B.3.g. of the preamble of this proposed rule.)

As also noted above, while the LTCH PPS and the IPPS use the same patient classification system, the methodology that is used to set the DRG relative weights for use in each payment system differs because the overall volume of cases in the LTCH PPS is much less than in the IPPS. In general, consistent with our existing methodology, we are proposing to determine the proposed FY 2011 relative weights for the proposed MS–LTC–DRGs using the following steps: (1) If a proposed MS–LTC–DRG has at least 25 cases, it is assigned its own proposed relative weight; (2) if a proposed MS–LTC–DRG has between 1 and 24 cases, it is assigned to a quintile for which we compute a proposed relative weight for all of the proposed MS–LTC–DRGs assigned to that quintile; and (3) if a proposed MS–LTC–DRG has no cases, it is crosswalked to another proposed MS–LTC–DRG based upon clinical similarities to assign an appropriate proposed relative weight (as described below in detail in Step 5 of section VII.B.3.g. of this preamble). Furthermore, in determining the proposed FY 2011 MS–LTC–DRG relative weights, when necessary, we are proposing to make adjustments to account for nonmonotonicity, as discussed in greater detail below in Step 6 of section VII.B.3.g. of this preamble. We refer readers to the discussion in the FY 2010 IPPS/RY LTCH PPS final rule for our rationale for including an adjustment for nonmonotonicity (74 FR 43953 through 43954).

f. Low-Volume MS–LTC–DRGs

In order to account for proposed MS–LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), consistent with our existing methodology, for purposes of determining the MS–LTC–DRG relative weights, we are proposing to continue to employ this quintile methodology for low-volume proposed MS–LTC–DRGs, such that we group those "low-volume MS–LTC–DRGs" (that is, MS–LTC–DRGs that contained between 1 and 24 cases annually) into one of five categories (quintiles) based on average charges (67 FR 55984 through 55995 and 72 FR 47283 through 47288). In determining the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule, in cases where the initial assignment of a low-volume proposed MS–LTC–DRG to quintiles results in nonmonotonicity within a base-DRG, in order to ensure appropriate Medicare payments, consistent with our historical methodology, we are proposing to make adjustments to the treatment of low-volume proposed MS–LTC–DRGs to preserve monotonicity, as discussed in detail below in section VII.B.3.g. (Step 6) in this preamble.

In this proposed rule, using LTCH cases from the December 2009 update of the FY 2009 MedPAR file, we identified 283 MS–LTC–DRGs that contained between 1 and 24 cases. This list of proposed MS–LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing a minimum of 56 proposed MS–LTC–DRGs (283/5 = 56 with 3 proposed MS–LTC–DRG as the remainder). We are proposing to assign a low-volume proposed MS–LTC–DRG to a specific low-volume quintile by sorting the low-volume proposed MS–LTC–DRGs in ascending order by average charge in accordance with our established methodology. Furthermore, because the number of proposed MS–LTC–DRGs with less than 25 cases was not evenly divisible by 5, the average charge of the low-volume quintile was used to determine which of the low-volume quintiles would contain the 3 additional low-volume proposed MS–LTC–DRGs. Specifically, after sorting the 283 low-volume proposed MS–LTC–DRGs by ascending order by average charge, we are proposing to assign the first fifth (1st through 56th) of low-volume proposed MS–LTC–DRGs (with the lowest average charge) into Quintile 1. The proposed MS–LTC–DRGs with the highest average charge cases would be assigned into Quintile 5. Because the average charge of the 113th low-volume proposed MS–LTC–DRG in the sorted list is closer to the average charge of the 112th low-volume proposed MS–LTC–DRG (assigned to Quintile 2) than to the average charge of the 114th low-volume MS–LTC–DRG (assigned to Quintile 3), we are proposing to place it into Quintile 2 (such that Quintile 2 would contain 57 low-volume proposed MS–LTC–DRGs before any adjustments for nonmonotonicity, as discussed below). This process was repeated through the remaining low-volume proposed MS–LTC–DRGs so that 2 of the 5 low-volume quintiles contain 56 MS–LTC–DRGs (Quintiles 1 and 4) and the other 3 low-volume quintiles contain 57 MS–LTC–DRGs (Quintiles 2, 3, and 5).

Accordingly, in order to determine the proposed FY 2011 relative weights for the proposed MS–LTC–DRGs with low volume, we are proposing to use the 5 low-volume quintiles described above. The composition of each of the 5 low-volume quintiles shown in the chart below was used in determining the proposed FY 2011 MS–LTC–DRG relative weights (as shown in Table 11 of the Addendum to this proposed rule). We determined a proposed relative weight and (geometric) average length of stay for each of the 5 low-volume quintiles using the methodology that we applied to the proposed MS–LTC–DRGs (25 or more cases), as described in section VII.B.3.g. of the preamble of this proposed rule. We are proposing to assign the same proposed relative weight and average length of stay to each of the low-volume proposed MS–LTC–DRGs that make up an individual low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of MS–LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume MS–LTC–DRGs and to calculate the proposed relative weights based on our methodology.

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Proposed Composition of Low-Volume Quintiles for FY 2011*

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
Quintile 1	
26	Craniotomy & endovascular intracranial procedures w CC
42	Periph & cranial nerve & other nerv syst proc w/o CC/MCC
60	Multiple sclerosis & cerebellar ataxia w/o CC/MCC
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC
68	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC
81	Nontraumatic stupor & coma w/o MCC
84	Traumatic stupor & coma, coma >1 hr w/o CC/MCC
87	Traumatic stupor & coma, coma <1 hr w/o CC/MCC
93	Other disorders of nervous system w/o CC/MCC
99	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC
122	Acute major eye infections w/o CC/MCC
148	Ear, nose, mouth & throat malignancy w/o CC/MCC
149	Dysequilibrium
151	Epistaxis w/o MCC
188	Pleural effusion w/o CC/MCC
198	Interstitial lung disease w/o CC/MCC
201	Pneumothorax w/o CC/MCC
244	Permanent cardiac pacemaker implant w/o CC/MCC
282	Circulatory disorders w AMI, discharged alive w/o CC/MCC
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC
354	Hernia procedures except inguinal & femoral w CC
376	Digestive malignancy w/o CC/MCC
379	G.I. hemorrhage w/o CC/MCC
383	Uncomplicated peptic ulcer w MCC
387	Inflammatory bowel disease w/o CC/MCC
390	G.I. obstruction w/o CC/MCC
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC
440	Disorders of pancreas except malignancy w/o CC/MCC
491	Back & neck procedures except spinal fusion w/o CC/MCC
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC
547	Connective tissue disorders w/o CC/MCC
553	Bone diseases & arthropathies w MCC
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
601	Non-malignant breast disorders w/o CC/MCC
645	Endocrine disorders w/o CC/MCC
656	Kidney & ureter procedures for neoplasm w MCC
694	Urinary stones w/ot esw lithotripsy w/o MCC
696	Kidney & urinary tract signs & symptoms w/o MCC
730	Other male reproductive system diagnoses w/o CC/MCC
759	Infections, female reproductive system w/o CC/MCC
781	Other antepartum diagnoses w medical complications
821	Lymphoma & leukemia w major O.R. procedure w CC
824	Lymphoma & non-acute leukemia w other O.R. proc w CC
842	Lymphoma & non-acute leukemia w/o CC/MCC
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC
864	Fever of unknown origin
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC
882	Neuroses except depressive
887	Other mental disorder diagnoses
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC
915	Allergic reactions w MCC
918	Poisoning & toxic effects of drugs w/o MCC
923	Other injury, poisoning & toxic effect diag w/o MCC
965	Other multiple significant trauma w/o CC/MCC
976	HIV w major related condition w/o CC/MCC
Quintile 2	
59	Multiple sclerosis & cerebellar ataxia w CC
83	Traumatic stupor & coma, coma >1 hr w CC
98	Non-bacterial infect of nervous sys exc viral meningitis w CC
121	Acute major eye infections w CC/MCC
158	Dental & Oral Diseases w CC
159	Dental & Oral Diseases w/o CC/MCC
182	Respiratory neoplasms w/o CC/MCC
200	Pneumothorax w CC
203	Bronchitis & asthma w/o CC/MCC
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC
236	Coronary bypass w/o cardiac cath w/o MCC
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC
254	Other vascular procedures w/o CC/MCC
262	Cardiac pacemaker revision except device replacement w/o CC/MCC
284	Circulatory disorders w AMI, expired w CC
305	Hypertension w/o MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
369	Major esophageal disorders w CC
384	Uncomplicated peptic ulcer w/o MCC
395	Other digestive system diagnoses w/o CC/MCC
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC
433	Cirrhosis & alcoholic hepatitis w CC
436	Malignancy of hepatobiliary system or pancreas w CC
446	Disorders of the biliary tract w/o CC/MCC
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC
487	Knee procedures w pdx of infection w/o CC/MCC
502	Soft tissue procedures w/o CC/MCC
536	Fractures of hip & pelvis w/o MCC
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC
554	Bone diseases & arthropathies w/o MCC
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC
584	Breast biopsy, local excision & other breast procedures w CC/MCC
598	Malignant breast disorders w CC
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC
625	Thyroid, parathyroid & thyroglossal procedures w MCC
643	Endocrine disorders w MCC
644	Endocrine disorders w CC
669	Transurethral procedures w CC
687	Kidney & urinary tract neoplasms w CC
700	Other kidney & urinary tract diagnoses w/o CC/MCC
710	Penis procedures w/o CC/MCC
723	Malignancy, male reproductive system w CC
755	Malignancy, female reproductive system w CC
760	Menstrual & other female reproductive system disorders w CC/MCC
776	Postpartum & post abortion diagnoses w/o O.R. procedure
809	Major hematol/immun diag exc sickle cell crisis & coagul w CC
815	Reticuloendothelial & immunity disorders w CC
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC
880	Acute adjustment reaction & psychosocial dysfunction
883	Disorders of personality & impulse control
903	Wound debridements for injuries w/o CC/MCC
906	Hand procedures for injuries
909	Other O.R. procedures for injuries w/o CC/MCC
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft
941	O.R. proc w diagnoses of other contact w health services w/o CC/MCC
957	Other O.R. procedures for multiple significant trauma w MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
983	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC
Quintile 3	
29	Spinal procedures w CC
75	Viral meningitis w CC/MCC
77	Hypertensive encephalopathy w MCC
78	Hypertensive encephalopathy w CC
82	Traumatic stupor & coma, coma >1 hr w MCC
90	Concussion w/o CC/MCC
96	Bacterial & tuberculous infections of nervous system w/o CC/MCC
102	Headaches w MCC
124	Other disorders of the eye w MCC
156	Nasal trauma & deformity w/o CC/MCC
243	Permanent cardiac pacemaker implant w CC
247	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC
258	Cardiac pacemaker device replacement w MCC
287	Circulatory disorders except AMI, w card cath w/o MCC
311	Angina pectoris
313	Chest pain
327	Stomach, esophageal & duodenal proc w CC
328	Stomach, esophageal & duodenal proc w/o CC/MCC
344	Minor small & large bowel procedures w MCC
348	Anal & stomal procedures w CC
370	Major esophageal disorders w/o CC/MCC
381	Complicated peptic ulcer w CC
382	Complicated peptic ulcer w/o CC/MCC
443	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC
467	Revision of hip or knee replacement w CC
494	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC
506	Major thumb or joint procedures
516	Other musculoskelet sys & conn tiss O.R. proc w CC
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC
581	Other skin, subcut tiss & breast proc w/o CC/MCC
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC
659	Kidney & ureter procedures for non-neoplasm w MCC
671	Urethral procedures w CC/MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
675	Other kidney & urinary tract procedures w/o CC/MCC
686	Kidney & urinary tract neoplasms w MCC
693	Urinary stones w/o esw lithotripsy w MCC
695	Kidney & urinary tract signs & symptoms w MCC
697	Urethral stricture
713	Transurethral prostatectomy w CC/MCC
726	Benign prostatic hypertrophy w/o MCC
808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC
834	Acute leukemia w/o major O.R. procedure w MCC
835	Acute leukemia w/o major O.R. procedure w CC
843	Other myeloprolif dis or poorly diff neopl diag w MCC
844	Other myeloprolif dis or poorly diff neopl diag w CC
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC
858	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC
866	Viral illness w/o MCC
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC
905	Skin grafts for injuries w/o CC/MCC
922	Other injury, poisoning & toxic effect diag w MCC
963	Other multiple significant trauma w MCC
970	HIV w extensive O.R. procedure w/o MCC
Quintile 4	
11	Tracheostomy for face,mouth & neck diagnoses w MCC
25	Craniotomy & endovascular intracranial procedures w MCC
28	Spinal procedures w MCC
31	Ventricular shunt procedures w MCC
37	Extracranial procedures w MCC
69	Transient ischemia
80	Nontraumatic stupor & coma w MCC
89	Concussion w CC
113	Orbital procedures w CC/MCC
125	Other disorders of the eye w/o MCC
157	Dental & Oral Diseases w MCC
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC
256	Upper limb & toe amputation for circ system disorders w CC
261	Cardiac pacemaker revision except device replacement w CC
336	Peritoneal adhesiolysis w CC
347	Anal & stomal procedures w MCC
353	Hernia procedures except inguinal & femoral w MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
358	Other digestive system O.R. procedures w/o CC/MCC
380	Complicated peptic ulcer w MCC
406	Pancreas, liver & shunt procedures w CC
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC
460	Spinal fusion except cervical w/o MCC
472	Cervical spinal fusion w CC
478	Biopsies of musculoskeletal system & connective tissue w CC
480	Hip & femur procedures except major joint w MCC
485	Knee procedures w pdx of infection w MCC
486	Knee procedures w pdx of infection w CC
490	Back & neck procedures except spinal fusion w CC/MCC or disc devices
496	Local excision & removal int fix devices exc hip & femur w CC
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC
504	Foot procedures w CC
505	Foot procedures w/o CC/MCC
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC
533	Fractures of femur w MCC
534	Fractures of femur w/o MCC
619	O.R. procedures for obesity w MCC
642	Inborn errors of metabolism
660	Kidney & ureter procedures for non-neoplasm w CC
663	Minor bladder procedures w CC
665	Prostatectomy w MCC
668	Transurethral procedures w MCC
685	Admit for renal dialysis
709	Penis procedures w CC/MCC
711	Testes procedures w CC/MCC
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC
722	Malignancy, male reproductive system w MCC
746	Vagina, cervix & vulva procedures w CC/MCC
749	Other female reproductive system O.R. procedures w CC/MCC
754	Malignancy, female reproductive system w MCC
802	Other O.R. proc of the blood & blood forming organs w MCC
917	Poisoning & toxic effects of drugs w MCC
928	Full thickness burn w skin graft or inhal inj w CC/MCC
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC
964	Other multiple significant trauma w CC
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
	Quintile 5
20	Intracranial vascular procedures w PDX hemorrhage w MCC
38	Extracranial procedures w CC
53	Spinal disorders & injuries w/o CC/MCC
58	Multiple sclerosis & cerebellar ataxia w MCC
72	Nonspecific cerebrovascular disorders w/o CC/MCC
131	Cranial/facial procedures w CC/MCC
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC
164	Major chest procedures w CC
168	Other resp system O.R. procedures w/o CC/MCC
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC
226	Cardiac defibrillator implant w/o cardiac cath w MCC
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC
237	Major cardiovascular procedures w MCC
242	Permanent cardiac pacemaker implant w MCC
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC
260	Cardiac pacemaker revision except device replacement w MCC
263	Vein ligation & stripping
286	Circulatory disorders except AMI, w card cath w MCC
294	Deep vein thrombophlebitis w CC/MCC
304	Hypertension w MCC
326	Stomach, esophageal & duodenal proc w MCC
330	Major small & large bowel procedures w CC
335	Peritoneal adhesiolysis w MCC
345	Minor small & large bowel procedures w CC
350	Inguinal & femoral hernia procedures w MCC
405	Pancreas, liver & shunt procedures w MCC
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC
411	Cholecystectomy w c.d.e. w MCC
416	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC
418	Laparoscopic cholecystectomy w/o c.d.e. w CC
423	Other hepatobiliary or pancreas O.R. procedures w MCC
424	Other hepatobiliary or pancreas O.R. procedures w CC
456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC
459	Spinal fusion except cervical w MCC
466	Revision of hip or knee replacement w MCC
469	Major joint replacement or reattachment of lower extremity w MCC
470	Major joint replacement or reattachment of lower extremity w/o MCC

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC
481	Hip & femur procedures except major joint w CC
482	Hip & femur procedures except major joint w/o CC/MCC
492	Lower extrem & humer proc except hip,foot,femur w MCC
493	Lower extrem & humer proc except hip,foot,femur w CC
498	Local excision & removal int fix devices of hip & femur w CC/MCC
507	Major shoulder or elbow joint procedures w CC/MCC
509	Arthroscopy
597	Malignant breast disorders w MCC
653	Major bladder procedures w MCC
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC
725	Benign prostatic hypertrophy w MCC
761	Menstrual & other female reproductive system disorders w/o CC/MCC
769	Postpartum & post abortion diagnoses w O.R. procedure
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC
876	O.R. procedure w principal diagnoses of mental illness
969	HIV w extensive O.R. procedure w MCC
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC

* Initial composition of proposed low-volume quintiles prior to adjusting for nonmonotonicity (as discussed in step 6 in section VII.B.3.g. of this preamble). Any adjustments to the proposed low volume quintile assignments to address nonmonotonicity are identified in Table 11 of the Addendum of this proposed rule.

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We note that we will continue to monitor the volume (that is, the number of LTCH cases) in the low-volume quintiles to ensure that our quintile assignments used in determining the proposed MS–LTC–DRG relative weights result in appropriate payment for such cases and do not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

g. Steps for Determining the Proposed FY 2011 MS–LTC–DRG Relative Weights

In general, we are proposing to determine the FY 2011 MS–LTC–DRG relative weights based on our existing methodology. For additional information on the original development of this methodology, and modifications to it since the adoption of the MS–LTC–DRGs, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55995) and the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43951 through 43966).

In summary, for FY 2011, to determine the proposed FY 2011 MS–LTC–DRG relative weights, we are proposing to group LTCH cases to the appropriate proposed MS–LTC–DRG, while taking into account the low-volume proposed MS–LTC–DRGs (as described above). After grouping the cases to the appropriate MS–LTC–DRG (or low-volume quintile), we calculate the proposed FY 2011 relative weights by first removing statistical outliers and cases with a length of stay of 7 days or less (as discussed in greater detail below). Next, we adjust the number of cases in each proposed MS–LTC–DRG (or low-volume quintile) for the effect of SSO cases (step 3 below). After removing statistical outliers (step 1 below) and cases with a length of stay of less than 8 days (step 2 below), the SSO adjusted discharges and corresponding charges are then used to calculate "relative adjusted weights" for each proposed MS–LTC–DRG (or low-volume quintile) using the HSRV method.

Below we discuss in detail the steps for calculating the proposed FY 2011 MS–LTC–DRG relative weights. We note that, as we stated in section VII.B.3.c. of this preamble, we excluded the data of all-inclusive rate LTCHs, LTCHs that are paid in accordance with demonstration projects, and any Medicare Advantage claims in the FY 2009 MedPAR file.

Step 1—Remove statistical outliers.

The first step in the calculation of the proposed FY 2011 MS–LTC–DRG relative weights is to remove statistical outlier cases. Consistent with our historical relative weight methodology, we are proposing to continue to define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each MS–LTC–DRG. These statistical outliers are removed prior to calculating the proposed relative weights because we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the proposed relative weights could result in an inaccurate

relative weight that does not truly reflect relative resource use among the MS–LTC–DRGs. (For additional information on this step of the relative weight methodology, we refer readers to 67 FR 55989 and 74 FR 43959.)

Step 2—Remove cases with a length of stay of 7 days or less.

The MS–LTC–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay of 7 days or less do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. If we were to include stays of 7 days or less in the computation of the proposed FY 2011 MS–LTC–DRG relative weights, the value of many proposed relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate. We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH by including data from these very short-stays. Therefore, consistent with our historical relative weight methodology, in determining the proposed FY 2011 MS–LTC–DRG relative weights, we are proposing to remove LTCH cases with a length of stay of 7 days or less. (For additional information on this step of the relative weight methodology, we refer readers to 67 FR 55989 and 74 FR 43959.)

Step 3—Adjust charges for the effects of SSOs.

After removing cases with a length of stay of 7 days or less, we are left with cases that have a length of stay of greater than or equal to 8 days. As the next step in the calculation of the proposed FY 2011 MS–LTC–DRG relative weights, consistent with our historical relative weight methodology, we are proposing to adjust each LTCH's charges per discharge for those remaining cases for the effects of SSOs (as defined in § 412.529(a) in conjunction with § 412.503).

We make this adjustment by counting an SSO case as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the MS–LTC–DRG for non-SSO cases. This has the effect of proportionately reducing the impact of the lower charges for the SSO cases in calculating the average charge for the MS–LTC–DRG. This process produces the same result as if the actual charges per discharge of an SSO case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the MS–LTC–DRG.

Counting SSO cases as full discharges with no adjustment in determining the proposed RY 2011 MS–LTC–DRG relative weights would lower the proposed FY 2011 MS–LTC–DRG relative weight for affected MS–LTC–DRGs because the relatively lower charges of the SSO cases would bring down the average charge for all cases within an MS–LTC–DRG. This would result in an "underpayment" for non-SSO cases and an "overpayment" for SSO cases. Therefore, we are proposing to adjust for SSO cases under § 412.529 in this manner because it results in more appropriate payments for all LTCH cases. (For additional information on this step of the relative weight methodology, we refer readers to 67 FR 55989 and 74 FR 43959.)

Step 4—Calculate the proposed FY 2011 MS–LTC–DRG relative weights on an iterative basis.

Consistent with our historical relative weight methodology, we are proposing to calculate the proposed FY 2011 MS–LTC–DRG relative weights using the HSRV methodology, which is an iterative process. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the SSO adjusted charge per discharge (see Step 3) of the LTCH case (after removing the statistical outliers (see Step 1)) and LTCH cases with a length of stay of 7 days or less (see Step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio is then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each proposed MS–LTC–DRG, the proposed FY 2011 relative weight was calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the proposed MS–LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated proposed MS–LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (that is, its case-mix) is calculated by dividing the sum of all the LTCH's proposed MS–LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above is multiplied by these hospital-specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values are then used to calculate a new set of proposed MS–LTC–DRG relative weights across all LTCHs. This iterative process was continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5—Determine a proposed FY 2011 relative weight for MS–LTC–DRGs with no LTCH cases.

As we stated above, we are proposing to determine the proposed FY 2011 relative weight for each proposed MS–LTC–DRG using total Medicare allowable charges reported in the best available LTCH claims data (that is, the December 2009 update of the FY 2009 MedPAR file for this proposed rule). Using these data, we identified a number of proposed MS–LTC–DRGs for which there were no LTCH cases in the database, such that no patients who would have been classified to those proposed MS–LTC–DRGs were treated in LTCHs during FY 2009 and, therefore, no charge data were available for these proposed MS–LTC–DRGs. Thus, in the process of determining the proposed MS–LTC–DRG relative weights, we were unable to calculate proposed relative weights for the proposed MS–LTC–DRGs with no LTCH cases using the methodology described in Steps 1 through 4 above. However, because patients with a number of the diagnoses under these proposed MS–LTC–DRGs may be treated at LTCHs, consistent with our historical methodology, we are proposing to assign a proposed relative weight to each of the no-volume proposed MS–LTC–DRGs based on clinical similarity and relative costliness (with the exception of "transplant" proposed MS–LTC–DRGs and "error" proposed MS–LTC–DRGs, as discussed below). (For additional information on this step of the relative weight methodology, we refer readers to 67 FR 55991 and 74 FR 43959 through 43960.)

In general, we determined proposed FY 2011 relative weights for the proposed MS–LTC–DRGs with no LTCH cases in the FY 2009 MedPAR file used in this proposed rule (that is, "no-volume" proposed MS–LTC–DRGs) by crosswalking each no-volume proposed MS–LTC–DRG to another proposed MS–LTC–DRG with a calculated proposed relative weight (determined in accordance with the methodology described above). Then, the "no-volume" proposed MS–LTC–DRG is assigned the same proposed relative weight (and average length of stay) of the proposed MS–LTC–DRG to which it was crosswalked (as described in greater detail below).

Of the 747 proposed MS–LTC–DRGs for FY 2011, we identified 223 proposed MS–LTC–DRGs for which there were no LTCH cases in the database (including

the 8 "transplant" proposed MS–LTC–DRGs and 2 "error" proposed MS–LTC–DRGs). As stated above, we are proposing to assign proposed relative weights for each of the 213 no-volume proposed MS–LTC–DRGs (with the exception of the 8 "transplant" proposed MS–LTC–DRGs and the 2 "error" proposed MS–LTC–DRGs, which are discussed below) based on clinical similarity and relative costliness to one of the remaining 524 (747—223 = 524) proposed MS–LTC–DRGs for which we were able to determine proposed relative weights based on FY 2009 LTCH claims data using the steps described above. (For the remainder of this discussion, we refer to the proposed "crosswalked" MS–LTC–DRGs as the proposed MS–LTC–DRGs to which we are proposing to crosswalk one of the 213 "no volume" proposed MS–LTC–DRGs for purposes of determining a proposed relative weight.) Then, we are proposing to assign the no-volume proposed MS–LTC–DRG the proposed relative weight of the proposed crosswalked MS–LTC–DRG. (As explained below in Step 6, when necessary, we made adjustments to account for nonmonotonicity.)

In this proposed rule, we are proposing to use the following methodology for determining the proposed FY 2011 relative weights for the no-volume proposed MS–LTC–DRGs: We crosswalk the no-volume proposed MS–LTC–DRG to a proposed MS–LTC–DRG for which there were LTCH cases in the FY 2009 MedPAR file and to which it is similar clinically in intensity of use of resources and relative costliness as determined by criteria such as care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. We evaluate the relative costliness in determining the applicable proposed MS–LTC–DRG to which a no-volume proposed MS–LTC–DRG was crosswalked in order to assign an appropriate proposed relative weight for the no-volume MS–LTC–DRGs in FY 2011. (For more detail on our process for evaluating relative costliness, we refer readers to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (73 FR 48543).) We believe in the rare event that there would be a few LTCH cases grouped to one of the no-volume proposed MS–LTC–DRGs in FY 2011, the proposed relative weights assigned based on the crosswalked proposed MS–LTC–DRGs would result in an appropriate LTCH PPS payment because the proposed crosswalks, which are based on similar clinical similarity and relative costliness, generally require equivalent relative resource use.

We then assign the proposed relative weight of the crosswalked proposed MS–LTC–DRG as the proposed relative weight for the no-volume proposed MS–LTC–DRG such that both of these MS–LTC–DRGs (that is, the no-volume proposed MS–LTC–DRG and the crosswalked proposed MS–LTC–DRG) would have the same proposed relative weight for FY 2011. We note that if the crosswalked proposed MS–LTC–DRG had 25 cases or more, its proposed relative weight, which is calculated using the methodology described in Steps 1 through 4 above, is assigned to the no-volume proposed MS–LTC–DRG as well. Similarly, if the MS–LTC–DRG to which the no-volume proposed MS–LTC–DRG is crosswalked has 24 or less cases and, therefore, is designated to one of the low-volume quintiles for purposes of determining the proposed relative weights, we assign the proposed relative weight of the applicable low-volume quintile to the no-volume proposed MS–LTC–DRG such that both of these proposed MS–LTC–DRGs (that is, the no-volume proposed MS–LTC–DRG and the crosswalked proposed MS–LTC–DRG) have the same proposed relative weight for FY 2011. (As we noted above, in the infrequent case where nonmonotonicity involving a no-volume proposed MS–LTC–DRG results, additional measures as described in Step 6 are required in order to maintain monotonically increasing proposed relative weights.)

For this proposed rule, a list of the no-volume MS–LTC–DRGs and the proposed MS–LTC–DRG to which it is crosswalked (that is, the crosswalked MS–LTC–DRG) for FY 2011 is shown in the chart below.

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Proposed No-Volume MS-LTC-DRG Crosswalk for FY 2011

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
12	Tracheostomy for face,mouth & neck diagnoses w CC	147
13	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	148
14	Allogeneic bone marrow transplant	812
15	Autologous bone marrow transplant	812
21	Intracranial vascular procedures w PDX hemorrhage w CC	65
22	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	66
23	Craniotomy w major device implant or acute complex CNS PDX w MCC	25
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC	26
27	Craniotomy & endovascular intracranial procedures w/o CC/MCC	26
30	Spinal procedures w/o CC/MCC	29
32	Ventricular shunt procedures w CC	31
33	Ventricular shunt procedures w/o CC/MCC	31
34	Carotid artery stent procedure w MCC	37
35	Carotid artery stent procedurew CC	38
36	Carotid artery stent procedure w/o CC/MCC	38
39	Extracranial procedures w/o CC/MCC	38
61	Acute ischemic stroke w use of thrombolytic agent w MCC	70
62	Acute ischemic stroke w use of thrombolytic agent w CC	71
63	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	72
67	Nonspecific cva & precerebral occlusion w/o infarct w MCC	68
76	Viral meningitis w/o CC/MCC	75
79	Hypertensive encephalopathy w/o CC/MCC	305
88	Concussion w MCC	89
103	Headaches w/o MCC	149
114	Orbital procedures w/o CC/MCC	125
115	Extraocular procedures except orbit	125
116	Intraocular procedures w CC/MCC	124
117	Intraocular procedures w/o CC/MCC	125
123	Neurological eye disorders	125
129	Major head & neck procedures w CC/MCC or major device	146
130	Major head & neck procedures w/o CC/MCC	148
132	Cranial/facial procedures w/o CC/MCC	156
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	148
135	Sinus & mastoid procedures w CC/MCC	133

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
136	Sinus & mastoid procedures w/o CC/MCC	148
137	Mouth procedures w CC/MCC	158
138	Mouth procedures w/o CC/MCC	159
139	Salivary gland procedures	159
150	Epistaxis w MCC	152
165	Major chest procedures w/o CC/MCC	168
183	Major chest trauma w MCC	163
184	Major chest trauma w CC	164
185	Major chest trauma w/o CC/MCC	168
215	Other heart assist system implant	254
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	237
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	253
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	254
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	237
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	254
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	242
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	243
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	242
228	Other cardiothoracic procedures w MCC	252
229	Other cardiothoracic procedures w CC	253
230	Other cardiothoracic procedures w/o CC/MCC	254
231	Coronary bypass w PTCA w MCC	237
232	Coronary bypass w PTCA w/o MCC	254
233	Coronary bypass w cardiac cath w MCC	237
234	Coronary bypass w cardiac cath w/o MCC	254
235	Coronary bypass w/o cardiac cath w MCC	237
238	Major cardiovascular procedures w/o MCC	254
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	254
245	AICD generator procedures	244
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC	252
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	250
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC	254
259	Cardiac pacemaker device replacement w/o MCC	262
265	AICD lead procedures	264
285	Circulatory disorders w AMI, expired w/o CC/MCC	284
295	Deep vein thrombophlebitis w/o CC/MCC	301
296	Cardiac arrest, unexplained w MCC	291

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
297	Cardiac arrest, unexplained w CC	292
298	Cardiac arrest, unexplained w/o CC/MCC	293
331	Major small & large bowel procedures w/o CC/MCC	358
332	Rectal resection w MCC	347
333	Rectal resection w CC	348
334	Rectal resection w/o CC/MCC	348
337	Peritoneal adhesiolysis w/o CC/MCC	336
338	Appendectomy w complicated principal diag w MCC	372
339	Appendectomy w complicated principal diag w CC	372
340	Appendectomy w complicated principal diag w/o CC/MCC	373
341	Appendectomy w/o complicated principal diag w MCC	371
342	Appendectomy w/o complicated principal diag w CC	372
343	Appendectomy w/o complicated principal diag w/o CC/MCC	373
346	Minor small & large bowel procedures w/o CC/MCC	344
349	Anal & stomal procedures w/o CC/MCC	348
351	Inguinal & femoral hernia procedures w CC	354
352	Inguinal & femoral hernia procedures w/o CC/MCC	354
355	Hernia procedures except inguinal & femoral w/o CC/MCC	354
407	Pancreas, liver & shunt procedures w/o CC/MCC	419
410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	419
412	Cholecystectomy w c.d.e. w CC	418
413	Cholecystectomy w c.d.e. w/o CC/MCC	419
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	417
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC	418
420	Hepatobiliary diagnostic procedures w MCC	423
421	Hepatobiliary diagnostic procedures w CC	424
422	Hepatobiliary diagnostic procedures w/o CC/MCC	424
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	424
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC	433
453	Combined anterior/posterior spinal fusion w MCC	459
454	Combined anterior/posterior spinal fusion w CC	459
455	Combined anterior/posterior spinal fusion w/o CC/MCC	460
457	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC	459
458	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC	460
461	Bilateral or multiple major joint procs of lower extremity w MCC	480
462	Bilateral or multiple major joint procs of lower extremity w/o MCC	482
468	Revision of hip or knee replacement w/o CC/MCC	467

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
471	Cervical spinal fusion w MCC	472
473	Cervical spinal fusion w/o CC/MCC	472
483	Major joint & limb reattachment proc of upper extremity w CC/MCC	480
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	482
488	Knee procedures w/o pdx of infection w CC/MCC	485
489	Knee procedures w/o pdx of infection w/o CC/MCC	487
508	Major shoulder or elbow joint procedures w/o CC/MCC	517
510	Shoulder,elbow or forearm proc,exc major joint proc w MCC	515
511	Shoulder,elbow or forearm proc,exc major joint proc w CC	516
512	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	517
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	517
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	537
582	Mastectomy for malignancy w CC/MCC	597
583	Mastectomy for malignancy w/o CC/MCC	596
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC	605
599	Malignant breast disorders w/o CC/MCC	601
614	Adrenal & pituitary procedures w CC/MCC	629
615	Adrenal & pituitary procedures w/o CC/MCC	630
618	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	617
620	O.R. procedures for obesity w CC	619
621	O.R. procedures for obesity w/o CC/MCC	619
626	Thyroid, parathyroid & thyroglossal procedures w CC	625
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	625
654	Major bladder procedures w CC	660
655	Major bladder procedures w/o CC/MCC	660
657	Kidney & ureter procedures forneoplasm w CC	656
658	Kidney & ureter procedures for neoplasm w/o CC/MCC	656
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	660
662	Minor bladder procedures w MCC	663
664	Minor bladder procedures w/o CC/MCC	663
666	Prostatectomy w CC	665
667	Prostatectomy w/o CC/MCC	665
670	Transurethral procedures w/o CC/MCC	669
672	Urethral procedures w/o CC/MCC	671
688	Kidney & urinary tract neoplasms w/o CC/MCC	687
691	Urinary stones w esw lithotripsy w CC/MCC	693
692	Urinary stones w esw lithotripsy w/o CC/MCC	694

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
707	Major male pelvic procedures w CC/MCC	659
708	Major male pelvic procedures w/o CC/MCC	660
712	Testes procedures w/o CC/MCC	711
714	Transurethral prostatectomy w/o CC/MCC	669
715	Other male reproductive system O.R. proc for malignancy w CC/MCC	717
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	718
724	Malignancy, male reproductive system w/o CC/MCC	723
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	749
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	749
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	749
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	755
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	755
739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	628
740	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	629
741	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	630
742	Uterine & adnexa proc for non-malignancy w CC/MCC	629
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	630
744	D&C, conization, laparascopy & tubal interruption w CC/MCC	749
745	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	749
747	Vagina, cervix & vulva procedures w/o CC/MCC	749
748	Female reproductive system reconstructive procedures	749
750	Other female reproductive system O.R. procedures w/o CC/MCC	749
756	Malignancy, female reproductive system w/o CC/MCC	755
765	Cesarean section w CC/MCC	749
766	Cesarean section w/o CC/MCC	749
767	Vaginal delivery w sterilization &/or D&C	749
768	Vaginal delivery w O.R. proc except steril &/or D&C	749
770	Abortion w D&C, aspiration curettage or hysterotomy	749
774	Vaginal delivery w complicating diagnoses	749
775	Vaginal delivery w/o complicating diagnoses	749
777	Ectopic pregnancy	776
778	Threatened abortion	776
779	Abortion w/o D&C	776
780	False labor	776
782	Other antepartum diagnoses w/o medical complications	781
789	Neonates, died or transferred to another acute care facility	781

Proposed MS-LTC-DRG	Proposed MS-LTC-DRG Description	Proposed Cross-Walked MS-LTC-DRG
790	Extreme immaturity or respiratory distress syndrome, neonate	781
791	Prematurity w major problems	781
792	Prematurity w/o major problems	781
793	Full term neonate w major problems	781
794	Neonate w other significant problems	781
795	Normal newborn	781
799	Splenectomy w MCC	802
800	Splenectomy w CC	802
801	Splenectomy w/o CC/MCC	802
803	Other O.R. proc of the blood & blood forming organs w CC	802
804	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	802
810	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	812
816	Reticuloendothelial & immunity disorders w/o CC/MCC	815
820	Lymphoma & leukemia w major O.R. procedure w MCC	821
822	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	821
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	824
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	827
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	827
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	829
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	846
838	Chemo w acute leukemia as sdx or w high dose chemo agent w CC	847
839	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC	847
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	847
894	Alcohol/drug abuse or dependence, left ama	897
895	Alcohol/drug abuse or dependence w rehabilitation therapy	897
916	Allergic reactions w/o MCC	915
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	928
955	Craniotomy for multiple significant trauma	25
956	Limb reattachment, hip & femur proc for multiple significant trauma	480
958	Other O.R. procedures for multiple significant trauma w CC	957
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC	957
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	985

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To illustrate this methodology for determining the proposed relative weights for the proposed FY 2011 MS–LTC–DRGs with no LTCH cases, we are providing the following example, which refers to the no-volume proposed MS–LTC–DRGs crosswalk information for FY 2011 provided in the chart above.

Example: There were no cases in the FY 2009 MedPAR file used for this proposed rule for MS–LTC–DRG 61 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC). We determined that proposed MS–LTC–DRG 70 (Nonspecific Cebrovascular Disorders with MCC) was similar clinically and based on resource use to MS–LTC–DRG 61. Therefore, we assigned the same proposed relative weight of MS–LTC–DRG 70 of 0.9204 for FY 2011 to MS–LTC–DRG 61 (Table 11 of the Addendum to this proposed rule).

Furthermore, for FY 2011, consistent with our historical relative weight methodology, we are proposing to establish MS–LTC–DRG relative weights of 0.0000 for the following transplant proposed MS–LTC–DRGs: Heart Transplant or Implant of Heart Assist System with MCC (proposed MS–LTC–DRG 1); Heart Transplant or Implant of Heart Assist System without MCC (proposed MS–LTC–DRG 2); Liver Transplant with MCC or Intestinal Transplant (proposed MS–LTC–DRG 5); Liver Transplant without MCC (proposed MS–LTC–DRG 6); Lung Transplant (proposed MS–LTC–DRG 7); Simultaneous Pancreas/Kidney Transplant (proposed MS–LTC–DRG 8); Pancreas Transplant (proposed MS–LTC–DRG 10); and Kidney Transplant (proposed MS–LTC–DRG 652). This is because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. At the present time, we only include these eight transplant MS–LTC–DRGs in the GROUPER program for administrative purposes only. Because we use the same GROUPER program for LTCHs as is used under the IPPS, removing these MS–LTC–DRGs would be administratively burdensome. (For additional information regarding our treatment of transplant MS–LTC–DRGs, we refer readers to the RY 2010 LTCH PPS final rule (74 FR 43964).) Again, we note that, as this system is dynamic, it is entirely possible that the number of MS–LTC–DRGs with no volume of LTCH cases based on the system will vary in the future. We used the most recent available claims data in the MedPAR file to identify no-volume MS–LTC–DRGs and to determine the proposed relative weights in this proposed rule.

Step 6—Adjust the proposed FY 2011 MS–LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As discussed earlier in this section, the MS–DRGs contain base DRGs that have been subdivided into one, two, or three severity of illness levels. Where there are three severity levels, the most severe level has at least one code that is referred to as an MCC (that is, major complication or comorbidity). The next lower severity level contains cases with at least one code that is a CC (that is, complication or comorbidity). Those cases without an MCC or a CC are referred to as "without CC/MCC." When data do not support the creation of three severity levels, the base DRG is subdivided into either two levels or the base DRG is not subdivided. The two-level subdivisions could consist of the with CC/MCC and the without CC/MCC. Alternatively, the other type of two-level subdivision may consist of the MCC and without MCC.

In those base MS–LTC–DRGs that are split into either two or three severity levels, cases classified into the "without CC/MCC" MS–LTC–DRG are expected to have a lower resource use (and lower costs) than the "with CC/MCC" MS–LTC–DRG (in the case of a two-level split) or both the "with CC" and the "with MCC" MS–LTC–DRGs (in the case of a three-level split). That is, theoretically, cases that are more severe typically require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, relative weights should increase by severity, from lowest to highest. If the relative weights decrease as severity decreased (that is, if within a base MS–LTC–DRG, an MS–LTC–DRG with CC has a higher relative weight than one with MCC, or the MS–LTC–DRG without CC/MCC has a higher relative weight than either of the others), they are nonmonotonic. We continue to believe that utilizing nonmonotonic relative weights to adjust Medicare payments would result in inappropriate payments because the payment for the cases in the higher severity level in a base MS–LTC–DRG (which are generally expected to have higher resource use and costs) would be lower than the payment for cases in a lower severity level within the same base MS–LTC–DRG (which are generally expected to have lower resource use and costs). Consequently, in determining the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule, consistent with our historical methodology, we are proposing to combine MS–LTC–DRG severity levels within a base MS–LTC–DRG for the purpose of computing a relative weight when necessary to ensure that monotonicity is maintained. For a comprehensive description of our existing methodology to adjust for nonmonotonicity, we refer readers to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43964 through 43966). Any adjustments for nonmonotonicity that were made in determining the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule by applying this methodology are denoted in Table 11 of the Addendum to this proposed rule.

Step 7— Calculate the proposed FY 2011 budget neutrality factor.

As we established in the RY 2008 LTCH PPS final rule (72 FR 26882), under the broad authority conferred upon the Secretary to develop the LTCH PPS under section 123 of Public Law 106–113, as amended by section 307(b) of Public Law 106–554, beginning with the MS–LTC–DRG update for FY 2008, the annual update to the MS–LTC–DRG classifications and relative weights is done in a budget neutral manner such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the MS–LTC–DRG classification and relative weight changes (§ 412.517(b) in conjunction with § 412.503). (For a detailed discussion on the establishment of the budget neutrality requirement to update the MS–LTC–DRG classifications and relative weights, we refer readers to the RY 2008 LTCH PPS final rule (72 FR 26881).)

The MS–LTC–DRG classifications and relative weights are updated annually based on the most recent available LTCH claims data to reflect changes in relative LTCH resource use (§ 412.517(a) in accordance with § 412.503). Under the budget neutrality requirement at § 412.517(b), for each annual update, the MS–LTC–DRG relative weights are uniformly adjusted to ensure that estimated aggregate payments under the LTCH PPS would not be affected (that is, decreased or increased). Consistent with that provision, we are proposing to update the proposed MS–LTC–DRG classifications and relative weights for FY 2011 based on the most recent available LTCH data, and to apply a budget neutrality adjustment in determining the proposed FY 2011 MS–LTC–DRG relative weights.

To ensure budget neutrality in the proposed update to the MS–LTC–DRG classifications and relative weights under § 412.517(b), we are proposing to continue to use our established two-step budget neutrality methodology. Specifically, in the first step of our MS–LTC–DRG budget neutrality methodology, we calculate and apply a normalization factor to the proposed recalibrated relative weights (the result of Steps 1 through 6 above) to ensure that estimated payments are not influenced by changes in the composition of case types or the changes to the classification system. That is, the normalization adjustment is intended to ensure that the recalibration of the proposed MS–LTC–DRG relative weights (that is, the process itself) neither increases nor decreases the average CMI.

To calculate the proposed normalization factor for FY 2011 (the first step of our budget neutrality methodology), we are proposing to use

the following three steps: (1.a.) We use the most recent available LTCH claims data (FY 2009) and group them using the proposed FY 2011 GROUPER (Version 28.0) and the proposed recalibrated FY 2011 MS–LTC–DRG relative weights (determined in steps 1 through 6 of the Steps for Determining the Proposed FY 2011 MS–LTC–DRG Relative Weights above) to calculate the average CMI; (1.b.) we group the same LTCH claims data (FY 2009) using the FY 2010 GROUPER (Version 27.0) and FY 2010 MS–LTC–DRG relative weights and calculate the average CMI; and (1.c.) we compute the ratio of these average CMIs by dividing the average CMI for FY 2010 (determined in Step 1.b.) by the average CMI for FY 2011 (determined in step 1.a.). In determining the proposed MS–LTC–DRG relative weights for FY 2011, each recalibrated MS–LTC–DRG relative weight is multiplied by 1.10362 in the first step of the budget neutrality methodology, which produces "normalized relative weights."

In the second step of our MS–LTC–DRG budget neutrality methodology, we determine a budget neutrality factor to ensure that estimated aggregate LTCH PPS payments (based on the most recent available LTCH claims data) after reclassification and recalibration (that is, the proposed FY 2011 MS–LTC–DRG classifications and relative weights) are equal to estimated aggregate LTCH PPS payments before reclassification and recalibration (that is, the FY 2010 MS–LTC–DRG classifications and relative weights). Accordingly, consistent with our existing methodology, we are proposing to use FY 2009 discharge data to simulate payments and compare estimated aggregate LTCH PPS payments using the FY 2010 MS–LTC–DRGs and relative weights to estimate aggregate LTCH PPS payments using the proposed FY 2011 MS–LTC–DRGs and relative weights. As noted above, the most recent available LTCH claims data for this proposed rule are from the December 2009 update of the FY 2009 MedPAR file. Consistent with our historical policy of using the best available data, we are proposing to use the most recently available claims data for determining the budget neutrality adjustment factor in the final rule.

For this proposed rule, we determined the proposed FY 2011 budget neutrality adjustment factor rule using the following three steps: (2.a.) we simulate estimated total LTCH PPS payments using the normalized proposed relative weights for FY 2011 and GROUPER Version 28.0 (as described above); (2.b.) we simulate estimated total LTCH PPS payments using the FY 2010 GROUPER (Version 27.0) and the FY 2010 MS–LTC–DRG relative weights shown in Table 11 of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44183 through 44192); and (2.c.) we calculate the ratio of these estimated total LTCH PPS payments by dividing the estimated total LTCH PPS payments using the FY 2010 GROUPER (Version 27.0) and the FY 2010 MS–LTC–DRG relative weights (determined in step 2.b.) by the estimated total LTCH PPS payments using the proposed FY 2011 GROUPER (Version 28.0) and the normalized proposed MS–LTC–DRG relative weights for FY 2011 (determined in Step 2.a.). In determining the proposed FY 2011 MS–LTC–DRG relative weights, each normalized proposed relative weight is multiplied by a budget neutrality factor of 0.987575 in the second step of the budget neutrality methodology to determine the proposed budget neutral FY 2011 relative weight for each MS–LTC–DRG.

Accordingly, in determining the proposed FY 2011 MS–LTC–DRG relative weights in this proposed rule, consistent with our existing methodology, we are proposing to apply a normalization factor of 1.10362 and a budget neutrality factor of 0.987575 (computed as described above).

Table 11 in the Addendum to this proposed rule lists the proposed MS–LTC–DRGs and their respective proposed relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used in determining SSO payments under § 412.529) for FY 2011. The proposed FY 2011 MS–LTC–DRG relative weights in Table 11 in the Addendum to this proposed rule reflect both the proposed normalization factor of 1.10362 and the proposed budget neutrality factor of 0.987575.

C. Proposed Changes to the LTCH Payment Rates and Other Changes to the FY 2011 LTCH PPS

1. Overview of Development of the LTCH Payment Rates

The LTCH PPS was effective beginning with a LTCH's first cost reporting period beginning on or after October 1, 2002. Effective beginning with that cost reporting period, LTCHs were paid, during a 5-year transition period, a total LTCH prospective payment that was comprised of an increasing proportion of the LTCH PPS Federal rate and a decreasing proportion based on reasonable cost-based principles, unless the hospital made a one-time election to receive payment based on 100 percent of the Federal rate, as specified in § 412.533. New LTCHs (as defined at § 412.23(e)(4)) are paid based on 100 percent of the Federal rate, with no phase-in transition payments.

The basic methodology for determining LTCH PPS Federal prospective payment rates is set forth at § 412.515 through § 412.536. In this section, we discuss the factors that would be used to update the LTCH PPS standard Federal rate for the FY 2011 that would be effective for LTCH discharges occurring on or after October 1, 2010 through September 30, 2011.

For further details on the development of the FY 2003 standard Federal rate, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037), and for subsequent updates to the LTCH PPS Federal rate, we refer readers to the following final rules: RY 2004 LTCH PPS final rule (68 FR 34134 through 34140), RY 2005 LTCH PPS final rule (69 FR 25682 through 25684), RY 2006 LTCH PPS final rule (70 FR 24179 through 24180), RY 2007 LTCH PPS final rule (71 FR 27819 through 27827), RY 2008 LTCH PPS final rule (72 FR 26870 through 27029), RY 2009 LTCH PPS final rule (73 FR 26800 through 26804), and RY 2010 LTCH PPS final rule (74 FR 44021 through 44030). The proposed update to the LTCH PPS standard Federal rate for FY 2011 is presented in section V.A. of the Addendum to this proposed rule. The two components of the proposed update to the LTCH PPS standard Federal rate for FY 2011 are discussed below.

2. Market Basket for LTCHs Reimbursed Under the LTCH PPS

a. Overview

Historically, the Medicare program has used a market basket to account for price increases in the services furnished by providers. The market basket used for the LTCH PPS includes both operating and capital-related costs of LTCHs because the LTCH PPS uses a single payment rate for both operating and capital-related costs. With the initial implementation of the LTCH PPS for FY 2003, we established the use of the excluded hospital with capital market basket as the LTCH PPS market basket (67 FR 56016 through 56017). The development of the initial LTCH PPS standard Federal rate for FY 2003, using the excluded hospital with capital market basket, is discussed in further detail in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56033). For further details on the development of the excluded hospital with capital market basket, we refer readers to the RY 2004 LTCH PPS final rule (68 FR 34134 through 34137).

Beginning in RY 2007, we adopted the rehabilitation, psychiatric, long-term care (RPL) hospital market basket based on FY 2002 data as the appropriate market basket of goods and services under the LTCH PPS for discharges occurring on or after July 1, 2006. As discussed in the RY 2007 LTCH PPS final rule (71 FR 27810), based on our research, we did not develop a market basket specific to LTCH services. We were unable to create a separate market basket specifically for LTCHs at that time due to the small number of facilities and the limited amount of data that was reported.

For further details on the development of the FY 2002-based RPL market basket, we refer readers to the RY 2007 LTCH PPS final rule (71 FR 27810 through 27817).

b. Market Basket Under the LTCH PPS for FY 2011

When we initially created the FY 2002-based RPL market basket, we were unable to create a separate market basket specifically for LTCHs due, in part, to the small number of facilities and the limited data that were provided in the Medicare cost reports. Over the last several years, however, the number of LTCH facilities submitting valid Medicare cost report data has increased. Based on this development, as well as our desire to move from one RPL market basket to three stand-alone and provider-specific market baskets (for IRFs, IPFs, and LTCHs, respectively), we plan to begin exploring the viability of creating these market baskets for future use. However, as we discussed in the RY 2010 LTCH PPS final rule (74 FR 43967 through 43968), we are conducting further research to assist us in understanding the reasons for the variations in costs and cost structure between freestanding IRFs and hospital-based IRFs. We also are researching the reasons for similar variations in costs and cost structure between freestanding IPFs and hospital-based IPFs. Therefore, as we continue to explore the development of stand-alone market baskets for LTCHs, IRFs and IPFs, respectively, we believe that it is appropriate to continue to use the FY 2002-based RPL market basket for LTCHs, IRFs and IPFs under their respective PPSs.

In addition, for the reasons discussed when we adopted the RPL market basket for use under the LTCH PPS in the RY 2007 LTCH PPS final rule (71 FR 27810 through 27817), we continue to believe that the RPL market basket appropriately reflect the cost structure of LTCHs. For the reasons explained above, in this proposed rule, we are proposing to continue to use the FY 2002-based RPL market basket under the LTCH PPS for FY 2011. We are hopeful that progress can be made in the near future with respect to creating stand-alone market baskets for LTCHs, IRFs, and IPFs and, as a result, may propose to rebase the appropriate market basket(s) for subsequent updates in the future.

c. Proposed Market Basket Update for LTCHs for FY 2011

Consistent with our historical practice, we estimate the RPL market basket update based on IHS Global Insight, Inc.'s forecast using the most recent available data. IHS Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the hospital market baskets. Based on IHS Global Insight Inc.'s first quarter 2010 forecast, the proposed FY 2011 market basket estimate for the LTCH PPS using the FY 2002-based RPL market basket is 2.4 percent. Consistent with our historical practice of using market basket estimates based on the most recent available data, we are proposing that if more recent data are available when we develop the final rule, we would use such data, if appropriate. (We note that in section V. of the Addendum to this proposed rule, for FY 2011, we are proposing to update the LTCH PPS standard Federal rate by -0.1 percent. This proposed update reflects an adjustment based on the most recent market basket estimate (currently 2.4 percent, as discussed above) and a proposed adjustment to account for the increase in case-mix in the prior periods (FYs 2008 through 2009) that resulted from changes in documentation and coding practices rather than increases in patients' severity of illness.)

d. Proposed Labor-Related Share Under the LTCH PPS for FY 2011

As discussed in section V.B. of the Addendum to this proposed rule, under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS payments to account for differences in LTCH area wage levels at § 412.525(c). The labor-related portion of the LTCH PPS Federal rate, hereafter referred to as the labor-related share, is adjusted to account for geographic differences in area wage levels by applying the applicable LTCH PPS wage index.

The labor-related share is determined by identifying the national average proportion of operating and capital costs that are related to, influenced by, or vary with the local labor market. We continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market. Consistent with our proposal to continue to use the FY 2002-based RPL market basket under the LTCH PPS for FY 2011 discussed above, we are proposing to continue to define the labor-related share as the national average proportion of operating costs that are attributable to wages and salaries, employee benefits, contract labor, professional fees, labor-intensive services, and a labor-related portion of capital based on the FY 2002-based RPL market basket. (Additional information on the development of the FY 2002-based RPL market basket used under the LTCH PPS can be found in the RY 2007 LTCH PPS final rule (71 FR 27809 through 27818).)

Furthermore, for FY 2011, we are proposing to continue to define the LTCH PPS labor-related share as the national average proportion of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and a labor-related portion of capital costs based on the FY 2002-based RPL market basket. Consistent with our historical practice of using the best available data, we are proposing to use IHS Global Insight, Inc.'s first quarter 2010 forecast of the FY 2002-based RPL market basket for FY 2011 to determine the proposed labor-related share for the LTCH PPS for FY 2011 that would be effective for discharges occurring on or after October 1, 2010, and through September 30, 2011, as these are the most recent available data.

The proposed labor-related share for FY 2011 would be the sum of the proposed FY 2011 relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2002) and FY 2011. The sum of the proposed relative importance for FY 2011 for operating costs (wages and salaries, employee benefits, professional fees, and all-other labor-intensive services) would be 71.537 percent, as shown in the chart below. The portion of capital that is influenced by the local labor market is estimated to be 46 percent. Because the relative importance for capital in FY 2011 would be 8.414 percent of the FY 2002-based RPL market basket, we are proposing to take 46 percent of 8.414 percent to determine the proposed labor-related share of capital for FY 2011. The result would be 3.870 percent, which we are proposing to add to 71.537 percent for the operating cost amount to determine the total proposed

labor-related share for FY 2011. Thus, the labor-related share that we are proposing to use for LTCH PPS in FY 2011 would be 75.407 percent.

The chart below shows the proposed FY 2011 relative importance labor-related share using the FY 2002-based RPL market basket.

PROPOSED FY 2011 LABOR-RELATED SHARE BASED ON THE FY 2002–BASED RPL MARKET BASKET

Cost category	FY 2011 relative importance (percent)
Wages and Salaries	52.590
Employee Benefits	13.987
Professional Fees	2.848
All Other Labor-Intensive Services	2.112
Subtotal	71.537
Labor-Related Share of Capital Costs (46 percent × 8.414)	3.870
Total Labor-Related Share	75.407

Accordingly, under the authority set forth in section 123 of the BBRA as amended by section 307(b) of the BIPA, we are proposing to establish a labor-related share of 75.407 percent under the LTCH PPS for the FY 2011. Furthermore, consistent with our historical practice of using the best data available, we also are proposing that if more recent data are available to determine the labor-related share used under the LTCH PPS for FY 2011, we would use these data for determining the FY 2011 LTCH PPS labor-related share in the final rule.

3. Proposed Adjustment for Changes in LTCHs' Case-Mix Due to Changes in Documentation and Coding Practices That Occurred in a Prior Period

a. Background

Beginning in RY 2007, in updating the standard Federal rate for the LTCH PPS, we have accounted for increases in payments from a past period that were due to changes in case-mix due to changes in documentation and coding practices. For additional information on the adjustments established for changes in LTCHs' case-mix due to changes in documentation and coding practices that occurred in a prior period, we refer readers to the following final rules published in the **Federal Register:** The RY 2007 LTCH PPS final rule (71 FR 27820); the RY 2008 LTCH PPS final rule (72 FR 26880 through 26890); the RY 2009 LTCH PPS final rule (73 FR 26805 through 26812); and the FY 2010IPPS/RY 2010 LTCH PPS final rule (74 FR 43969 through 43970).

For RY 2010, we performed an analysis of LTCHs' case-mix index (CMI) changes in the prior periods (FY 2007 and FY 2008) and established a methodology to determine if an adjustment to account for changes in documentation and coding practices was applicable (74 FR 43969 through 43970). This methodology is consistent with the methodology established for case-mix analysis under the IPPS. In general, under our established methodology, in order to isolate the documentation and coding effect, we divided the combined effect of the changes in documentation and coding and measurement by the measurement effect (74 FR 43970).

For the RY 2010 LTCH PPS proposed rule, we performed a retrospective evaluation of the FY 2007 and FY 2008 data for LTCH claims paid through December 2008. Based on this evaluation, our actuaries determined that case-mix increased 0.5 percent in FY 2007 and 1.3 percent in FY 2008 due to documentation and coding that did not reflect real changes in case-mix. In light of this analysis, in the RY 2010 LTCH PPS proposed rule, we proposed to apply a cumulative adjustment for changes in documentation and coding that do not reflect an increase in patients' severity of illness of −1.8 percent (that is, −0.5 percent for FY 2007 plus −1.3 percent for FY 2008). We also invited public comment on our proposed methodology and analysis. (For additional information on our methodology and the results of the retrospective evaluation, we refer reader to sections VIII.C.3. of the preamble of the FY 2010 IPPS/RY 2010 LTCH PPS proposed and final rules (74 FR 24229 through 24230 and 74 FR 43970 through 43972, respectively).)

In the FY 2010 IPPS/LTCH PPS final rule, we responded to comments on our methodology for the retrospective evaluation of FY 2007 and FY 2008 claims data, as well as our proposed −1.8 percent documentation and coding adjustment for RY 2010. In that same final rule, we finalized our proposal and established an adjustment of −0.5 percent to account for the documentation and coding increase that occurred in FY 2007. However, after consideration of public comments, and consistent with the decision to postpone the application of the prospective adjustment for estimated FY 2008 documentation and coding increases under the IPPS, we delayed the application of the FY 2008 documentation and coding adjustment of −1.3 percent that was proposed under the LTCH PPS for RY 2010. We also stated our intent to address any future documentation and coding adjustment to the LTCH PPS standard Federal rate based on our analysis of the FY 2008 LTCH claims data in the FY 2011 rulemaking cycle through the notice-and-comment rulemaking process. (74 FR 43970 through 43972)

b. Evaluation of FY 2009 Claims Data

For this proposed rule, we have performed a thorough retrospective evaluation of the most recent available claims data (that is, FY 2009 claims updated through December 2009) using the methodology that was adopted in the FY 2010 IPPS/RY 2010 LTCH PPS final rule and that was used to assess whether an adjustment for RY 2010 to account for changes in documentation and coding practices that occurred in a prior period was appropriate. (We refer readers to the explanation of our rationale for adopting this methodology as well as its intended purpose in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43970 through 43972).)

We performed this analysis by first dividing the CMI obtained by grouping the FY 2009 LTCH claims through the FY 2009 GROUPER (Version 26.0) by the CMI obtained by grouping these same FY 2009 LTCH claims through the FY 2007 GROUPER (Version 24.0). This resulted in a value of 1.0248. Because

this CMI analysis is based on the same FY 2009 cases grouped using the Versions 24.0 and 26.0 of the GROUPER, we attribute this increase in average CMI primarily to two factors: (1) The effect of changes in documentation and coding under the MS–DRG system; and (2) the measurement effect from the calibration of the GROUPER. Next, we estimated the measurement effect from the calibration of the GROUPER by dividing the CMI obtained by grouping the FY 2007 LTCH claims through the FY 2009 GROUPER (Version 26.0) by the CMI obtained by grouping these same LTCH claims through the FY 2007 GROUPER (Version 24.0). This resulted in a value of 0.9999. In order to isolate the documentation and coding effect, we then divided the combined effect of the changes in documentation and coding measurement (1.0248) by the measurement effect (0.9999) to yield 1.025. Therefore, based on the results of this analysis, we estimate that the cumulative effect of documentation and coding changes that occurred in FYs 2008 and 2009 was 2.5 percent. We note that, in applying the methodology we established for determining the effects of documentation and coding in the FY 2010 IPPS/RY 2010 LTCH PPS proposed and final rules, we applied such methodology separately to FY 2007 and FY 2008 LTCH claims data because those data were generated under different patient classification systems (that is, FY 2007 was the last year under the CMS LTC–DRGs and FY 2008 was the first year under the MS–LTC–DRGs). Because the same patient classification system was in effect for both FY 2008 and FY 2009 (that is, the MS–LTC–DRGs), consistent with the application of this methodology under the IPPS (discussed in section II.D.5. of this preamble), we believe it is appropriate to propose to apply our established methodology for determining the cumulative effects of documentation and coding for FYs 2008 and 2009, rather than proposing to applying the methodology separately to FY 2008 and FY 2009 LTCH claims data. We seek public comment on our proposal to determine the cumulative effects of documentation and coding in FYs 2008 and 2009. (We note that the FY 2007 and FY 2009 (as well as FY 2008) MedPAR files are available to the public to allow independent analysis of the documentation and coding effect in FYs 2008 and 2009.)

c. Proposed FY 2011 Documentation and Coding Adjustment

Based on analysis of the most recent available LTCH claims data as described above, we are proposing to apply a cumulative adjustment for changes in documentation and coding in a prior period (FYs 2008 and 2009) that do not reflect an increase in patients' severity of illness of −2.5 percent. Accordingly, as discussed in section V.A.2. of the Addendum to this proposed rule, we are proposing to update the proposed FY 2011 LTCH PPS standard Federal rate by −0.1 percent, which is based on the most recent estimate of the market basket increase (2.4 percent) and a proposed adjustment to account for changes in documentation and coding practices (−2.5 percent). We also are proposing that if more recent data are available for the final rule, we would use those data to establish a final update to the FY 2011 LTCH PPS standard Federal rate, if applicable.

D. Proposed Change in Terminology From "Rate Year" to "Fiscal Year" and Other Proposed Changes

Beginning with the annual update to the LTCH PPS that took effect on October 1, 2009, we consolidated the rulemaking cycle for the annual update of the LTCH PPS Federal payment rates with the annual update of the MS–LTC–DRG classifications and associated weighting factors for LTCHs so that the updates to the rates and the weights now occur on the same schedule and appear in the same **Federal Register** document. As a result, the updates to the LTCH standard Federal rates and the MS–LTC–DRG relative weights are now effective on October 1 (on a Federal fiscal year schedule), and the annual updates to the LTCH standard Federal rates are no longer published with a July 1 effective date. To reflect this change to the annual payment rate update cycle, we revised the regulations at § 412.503 to specify that, beginning on or after October 1, 2009, the LTCH PPS rate year is defined as October 1 through September 30 (73 FR 26797 through 26798 and 26838).

In this proposed rule, we are proposing to change the terminology used under the LTCH PPS to designate the annual payment update and MS–DRG relative weight recalibration cycle from "rate year" to "fiscal year," in order to conform with the standard definition of the Federal fiscal year (October 1 through September 30) used by the IPPS. We believe that this proposed change is appropriate because both the yearly update cycle of the LTCH standard Federal rates (and associated factors) and the annual reclassification and recalibration of the MS–LTC–DRG relative weights (which were always updated on October 1, consistent with the IPPS) are now concurrent with the IPPS update and implementation schedule of October 1 through September 30. Because the annual updates to both the LTCH standard Federal rates (and associated factors) and the MS–LTC–DRG relative weights now occur at the same time as the annual updates under the IPPS, we believe we would eliminate any possible confusion that may be caused by continuing to identify the LTCH PPS update cycle as a "rate year." We believe that changing the "fiscal year" terminology would provide important clarity for the LTCH provider community, particularly because both the proposed and final rules for the IPPS and the LTCH PPS are generally published in the same **Federal Register** document. Consequently, we are proposing to use the term "fiscal year" when referring to the annual updates for the LTCH standard Federal payment rates and MS–LTC–DRG relative weights as well as to the publication cycle for rulemaking for the LTCH PPS, consistent with the IPPS. We are proposing to revise our definition of "rate year" in the regulations at § 412.503 to reflect this proposed terminology change.

This proposed terminology revision from "rate year" to "fiscal year" would clarify the fact that since October 1, 2003, when we implemented the LTCH PPS, at different times, we have used the terms "rate year" and "fiscal year" when referring to the payment year under the LTCH PPS. In existing regulations at § 412.503, we specify the time periods during which each term was used. We also are proposing to add a definition of "long-term care hospital prospective payment system payment year" to § 412.503 in order to encompass both the long-term care hospital prospective payment system rate year and the long-term care hospital prospective payment system fiscal year. This proposed term would be used when describing ongoing policy features of the LTCH PPS for which, depending upon the time period, either the term "long-term care hospital prospective payment system rate year" or "long-term care hospital prospective payment system fiscal year" would be applicable. We believe that creating this term would minimize confusion by keeping the regulation text as simple as possible because this term would apply to the "long-term care hospital prospective payment system rate year" or to the "long-term care hospital prospective payment system fiscal year." In this respect, existing regulation text (for example, § 412.525(a)) would not need to be revised to address the specific time periods during which the terms "long-

term care hospital prospective payment system rate year" and "long-term care hospital prospective payment system fiscal year" are used.

In addition, as a conforming change, we are proposing to change the terminology in § 412.525(a)(1) and (a)(2), which describes the high-cost outlier policy (an ongoing feature of the LTCH PPS from its inception), from "long-term care hospital prospective payment system rate year" to "long-term care hospital prospective payment system payment year". We believe that this proposed change, which would reference the proposed new definition of the long-term care hospital prospective payment system payment year period at § 412.503, clearly reflects the application of the high-cost outlier policy for the period encompassed by both the current "rate year" terminology and the proposed change to "fiscal year" terminology, described above. We believe that these proposed changes present a straightforward way to provide additional clarity to our regulations in a circumstance that reflects changes in terminology but do not entail any change to the high-cost outlier policy. Furthermore, consistent with this proposal, for purposes of clarity, in this proposed rule, when discussing the annual update for the LTCH PPS, we employ "FY" rather than RY" because it is our intent that "FY" be used prospectively in all circumstances dealing with the LTCH PPS.

VIII. Effective Date of Provider Agreements and Supplier Approvals

A. Background

Section 1866 of the Act states that any provider of services as defined under section 1861(u) of the Act (except a fund designated for purposes of sections 1814(g) and 1835(e) of the Act) shall be qualified to participate in the Medicare program and shall be eligible for Medicare payments if it files with the Secretary a Medicare provider agreement and abides by the requirements applicable to Medicare provider agreements. These requirements are incorporated into our regulations in 42 CFR part 489, Subparts A and B. Section 1866(b)(2) of the Act provides that the Secretary may refuse to enter into, or may terminate, an agreement with a provider for various reasons, including the provider's failure to comply with the provisions of the agreement and if it has been determined that the provider fails to meet the applicable provisions of section 1861 of the Act, including health and safety standards. Certain suppliers are also required under the Act to meet health and safety standards specified by the Secretary: section 1861(aa)(2)(K), with respect to rural health clinics; section 1832(a)(2)(F)(i), with respect to ambulatory surgical centers; and section 1881(b)(1)(A), with respect to providers of renal dialysis services.

Under section 1864(a) of the Act, the Secretary enters into agreements with State agencies to determine if providers and suppliers meet the requisite Medicare requirements. Section 1865 of the Act permits CMS to "deem" facilities that have been accredited by a national accreditation organization under a CMS-approved accreditation program as having met the Medicare health and safety standards. Section 1871 of the Act authorizes the Secretary to adopt such regulations as may be necessary to carry out the requirements of Title XVIII of the Act.

On August 18, 1997, we adopted regulations, effective September 17, 1997 (1997 final rule), establishing uniform criteria for determining the effective dates of provider agreements and supplier approvals in the Medicare and Medicaid programs (62 FR 43931). Included in these regulations was 42 CFR 489.13, governing the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. Facilities subject to survey and certification are those that must comply with Medicare health and safety standards, that is, the conditions of participation (CoPs), long-term care requirements, conditions for coverage (CfC), or conditions for certification, depending on the type of facility. (The regulations exempt clinical laboratories, community mental health centers, and federally qualified health centers from its general provisions, establishing alternative requirements for these entities.) Compliance with the applicable health and safety standards is determined through an onsite survey by a State survey agency, CMS staff, or a CMS contractor, or, in accordance with section 1865 of the Act, CMS may "deem" an entity to have satisfied these requirements if it has been accredited by a national accreditation program approved by CMS. Currently, we have approved 15 accreditation programs offered by 7 national accreditation organizations for the following types of providers or suppliers: Hospitals, CAHs, HHAs, hospices, and ambulatory surgical centers.

Under § 489.13(b) of the regulations, the date the survey is completed is the effective date of the provider agreement or supplier approval, if all applicable Federal requirements have been met on that date. Similarly, § 489.13(d) provides that the effective date for a provider or supplier accredited by a national accreditation organization under a CMS-approved program, and which is subject to additional requirements not contained in the approved program, is the date on which all Federal requirements have been met, including the additional requirements. We have interpreted these provisions to mean not only that the survey/accreditation decision must show that the prospective provider or supplier is in compliance with all of the applicable health and safety standards, but also that all other Federal requirements related to the prospective provider's or supplier's participation in the Medicare program have been met.

Other Federal requirements include, but are not limited to, the submission of an application to enroll in the Medicare program that has been reviewed by our legacy fiscal intermediaries, legacy carriers, or MACs, as applicable, and has been found to meet the enrollment requirements established in 42 CFR part 424, Subpart P. Other Federal requirements also include, for providers, compliance with Office for Civil Rights requirements. There also are additional Federal requirements specific to certain provider types, such as IPPS exclusion requirements for certain types of hospitals, capitalization and surety bond requirements for home health agencies, among others.

Under our current process, section 2003B of the State Operations Manual (SOM) (Publication No. 100–07) states that: "The SA [State Survey agency] should not perform a survey of a new facility until it has received notice from the FI [fiscal intermediary] or carrier that the information provided on the enrollment application has been verified." Section 2005 of the SOM further states: "The MAC/legacy FI will process the Form CMS–855A and the MAC/legacy Carrier will process the Form CMS–855B, depending on which contractor is responsible for processing bills or claims for the provider/supplier. * * * The State Survey Agency will be responsible for surveying initial applicants *following the contractor's recommendation for approval,* and providing the initial certification package." (Emphasis added.)

In accordance with § 488.8(a)(2) of the regulations, one of the requirements for our approval of a national accreditation program is the comparability of its survey process to that of State survey agencies. Consistent with this requirement, in Survey and Certification Policy Memorandum S&C–09–08, dated October 17, 2008, we indicated that a

CMS-approved national accreditation organization also must not conduct a survey of a facility seeking a Medicare provider agreement or supplier approval until after the MAC, the legacy fiscal intermediary, or the legacy carrier has completed its review of the enrollment application and notified the applicant that its review has been completed and a recommendation has been made to CMS.

Therefore, historically, in the normal course of events, the health and safety survey (including the Life Safety Code survey, if applicable) of a prospective provider or supplier has usually occurred after it has demonstrated that it meets the Medicare enrollment requirements, and, as a result, the effective date of a provider agreement or supplier approval is generally later than the date when the contractor has verified that all enrollment requirements have been met. However, on occasion, a survey can take place before the CMS contractor has verified that enrollment requirements have been met. This has tended to happen more frequently in the case of facilities that seek to satisfy Medicare participation requirements through accreditation by a CMS-approved accreditation program, because the accreditation organization relies upon the facility to advise it when it has received notice of completion of the review of its enrollment application. This can result in the date of an accreditation decision preceding the date when the CMS contractor determination has occurred. In addition, in order to prevent fraud and abuse, there may be other situations in which the CMS contractor performs additional enrollment verification activities even after a health and safety survey has been performed.

In cases where the CMS contractor determines that the prospective provider's or supplier's compliance with enrollment requirements did not occur until after a survey by the State survey agency or after the accreditation survey and accreditation decision take place, it is our policy, consistent with our interpretation of § 489.13(b), to make the effective date of the provider agreement or supplier approval the date when the enrollment requirements are considered to have been met, that is, the date determined by the CMS contractor, pursuant to its review and verification activities, to be the date when the applicant is in compliance with all enrollment requirements and the CMS contractor is prepared to convey Medicare billing privileges to the provider or supplier, unless there are still other Federal requirements that remain to be satisfied, such as submission of required civil rights compliance documentation or satisfaction of the specialized requirements governing IPPS-excluded hospitals. If there are other unsatisfied requirements, the effective date would be the date when the last requirement has been satisfied, as determined by CMS.

B. Departmental Appeals Board Decision

In a decision dated September 28, 2009, the Appellate Division of the Departmental Appeals Board (DAB), in the case of *Renal CarePartners of Delray Beach, LLC* v. *Centers for Medicare and Medicaid Services* (DAB Decision No. 2271), rejected our longstanding interpretation of § 489.13(b). In this case, a State survey agency completed an initial certification survey on July 6, 2007, of an end-stage renal disease supplier, Renal CarePartners, prior to the CMS contractor's November 21, 2007 recommendation of approval of the supplier's enrollment application. The DAB concluded that there was no basis in regulation or policy issuances for our position that CMS contractor approval is a requirement a supplier must satisfy "before it may *furnish* services for which it will be reimbursed under Medicare once it is enrolled and obtains billing privileges" (DAB Decision No. 2271, page 2). The DAB further characterized the issue as "* * * not whether the effective date may be earlier than the date Renal CarePartners complied with a prerequisite it was required to meet in order to enroll, but whether the effective date must be delayed until the date the *Medicare contractor* notified CMS that the requirements were met" (DAB Decision No. 2271, page 5) (emphasis in original). The DAB agreed with Renal CarePartners that the requirement for the Medicare contractor to verify and determine whether an application should be approved is not a requirement for the supplier to meet, but a requirement for Medicare contractor action (DAB Decision No. 2271, page 5). The DAB further cited the provisions of § 489.13(d), concerning accredited facilities, as an example to bolster its contention that there is precedent for providers or suppliers to be retroactively reimbursed for services provided before the date of approval of the supplier or provider agreement (DAB Decision No. 2271, page 7).

We disagree with the DAB's reading of our existing regulations. We believe that the intent of the existing regulations is to require that all applicable Federal requirements, including a determination of whether the enrollment requirements have been satisfied, must be met before a provider agreement or supplier approval may be effective. Any other reading of the regulations could result in a provider or supplier being permitted to bill the Medicare program for services provided at a time when its compliance with Medicare's requirements is unknown and possibly deficient. For example, in the event a State survey precedes the CMS contractor's review of the enrollment application of a prospective provider or supplier, it might be possible that the application originally submitted to the CMS contractor is incomplete or incorrect, or both, and the applicant must provide additional information to the CMS contractor to demonstrate compliance with the enrollment requirements. It would not be consistent with our duty to protect the Medicare Trust Funds from unsupported claims against it to permit payment for services furnished by a health care facility after it has passed a State survey or been accredited, but before it has satisfied all other Medicare participation requirements, including enrollment requirements.

Such a reading also might undermine the incentives inherent in our longstanding policy, affirmed in the June 1, 1994 decision of the U.S. Court of Appeals for the Fifth Circuit in *U.S.* v. *Vernon Home Health, Inc.* (21 F.3d 693 (5th Cir. 1994), cert. denied, 115 S.Ct. 575 (1994)). Under that policy, a buyer of a Medicare-participating facility that chooses not to assume the provider agreement or supplier approval of the seller must be treated as an initial applicant to the Medicare program, with a necessary break in Medicare payments for services furnished to beneficiaries during the period between the effective date of the change of ownership, and the effective date of the new owner's provider agreement or supplier approval. Assumption of the seller's provider agreement or supplier approval includes assumption of the assets and liabilities associated with that agreement or approval, which has proven to be an important tool in protecting the Medicare Trust Funds through continuity in the ability to recover outstanding overpayments. Any requirement to make payments retroactive to the date of a State survey or accreditation decision, despite the fact that all other Federal requirements may not yet have been met, could provide an incentive for more buyers to refuse assumption of the seller's provider agreement or supplier approval, because there would potentially be no break in payments. Therefore, effectively, a buyer who does

not assume the seller's active provider agreement could begin receiving Medicare payments (assuming it meets all the requirements), but not be responsible for any existing liabilities of the provider agreement. This would also be an incentive for existing providers or suppliers with civil money penalties or overpayments to sell their facilities in order to escape any financial responsibility to the Medicare program.

C. Proposed Revisions to Regulations

We are proposing to amend § 489.13 and make a technical amendment to § 489.1 in order to clarify our policy. Specifically, we are proposing to revise § 489.13(a) to make it clearer that it is only CMS that determines whether health care facilities have satisfied the requirements for participation in the Medicare program, not State survey agencies or national accreditation organizations. We note that, although this CMS determination is sometimes referred to as a "certification," or "certification decision," § 488.1 defines "certification" as "a recommendation made by the State survey agency on the compliance of providers and suppliers with the conditions of participation, requirements (for SNFs and NFs), and conditions of coverage." Further, § 488.12 provides that CMS makes the determination on whether a provider or supplier is eligible to participate in or be covered by the Medicare program, based on the State survey agency's recommendation, or on the facility's accreditation.

We also are proposing to add language to § 489.13(a) in order to clarify that surveys of nonaccredited facilities may be conducted not only by State survey agencies, but also by CMS staff or contractors, as appropriate. We have used contractors to conduct certain types of surveys, such as life safety code, transplant program and psychiatric hospital special conditions surveys, and may continue to do so in the future. In addition, certain types of facilities, such as Indian Health Services (IHS) facilities and RNHCIs, have traditionally been surveyed by CMS employees rather than State survey agencies.

We are proposing to revise § 489.13(b) to make explicit that the effective date of a provider agreement or supplier approval may not be earlier than the latest of the dates on which each applicable Federal requirement is determined to be met. We also are proposing to state explicitly that "Federal requirements" include, but are not limited to, the enrollment requirements established in 42 CFR part 424, Subpart P, that have been determined by CMS to have been met. In addition, we are proposing to revise § 489.13(b) to include language concerning accredited facilities, to assure that accredited and nonaccredited facilities are treated in the same manner.

We wish to further explain the rationale behind the proposed change to § 489.13(b), particularly with respect to the requirements in the provider/supplier enrollment process.

A CMS contractor will review and conduct an initial assessment of a prospective provider's or supplier's enrollment. If the contractor finds that a prospective provider or supplier meets the basic enrollment requirements to participate in the Medicare program for its identified certified provider or supplier type, the contractor will notify the appropriate CMS Regional Office. Essentially, the contractor's initial assessment means that it has concluded its preliminary review of the application and has concluded that the survey and certification process can be initiated, and, consequently, it issues a recommendation of approval. In order to help ensure compliance with enrollment requirements throughout this process, the contractor may continue to perform a number of enrollment verification tasks even after it has issued a recommendation for approval. These include, but are not limited to, conducting onsite visits of the prospective provider or supplier to ensure that it is still operational; verifying an HHA applicant's compliance with the capitalization provisions in 42 CFR 489.28; and requesting the provider or supplier applicant to reaffirm the accuracy of the information it furnished on its initial enrollment application. Given the potentially significant length of time between when the contractor issues its recommendation of approval after its initial assessment and when the health and safety survey (or accreditation) and certification process is completed, we believe that it is essential for the contractor to verify that a provider or supplier applicant continues to meet enrollment requirements prior to the issuance of a Medicare provider agreement or supplier approval and the issuance of Medicare billing privileges.

To that end, we believe that the CMS contractor should verify that a provider or supplier is in compliance with all enrollment requirements when an enrollment application is submitted, during the period in which a provider or supplier is undergoing the health and safety survey and certification process and before the issuance of a Medicare provider agreement or supplier approval and billing privileges. If a provider or supplier is determined to be in compliance with all Medicare requirements, including the enrollment requirements, the enrollment process will be completed, and the Medicare provider agreement or supplier approval and billing privileges will be issued to the applicant. However, if a provider or supplier is determined to be out of compliance with Medicare enrollment requirements prior to the issuance of a Medicare provider agreement or supplier approval and billing privileges to the applicant, we believe that CMS must deny Medicare billing privileges using the applicable denial reason found in 42 CFR 424.530 and afford the applicant with the applicable Medicare appeal rights.

We are proposing to revise § 489.13(c) to make clear that this paragraph addresses those situations in which a facility has met all other Federal requirements but, upon survey, has been found to not meet all applicable CoPs, long-term care requirements, CfCs, or conditions for certification. We also are proposing to revise this paragraph to include language concerning accredited facilities, to assure that accredited and nonaccredited facilities are treated in the same manner.

We are proposing to remove § 489.13(d), concerning the determination of the effective date for accredited facilities. We see no reason for differential treatment of accredited and nonaccredited facilities with respect to the determination of their effective date, and, in practice, we have not treated them differentially. In particular, as a matter of policy, we have not exercised the discretion permitted under § 489.13(d)(2) to grant accredited facilities an effective date retroactive up to 1 year prior to what otherwise would be their effective date. Permitting such retroactive payment would provide accredited facilities an unwarranted advantage when compared to nonaccredited facilities. It would also seriously undermine our policy concerning change of ownership without assumption of the seller's provider agreement or supplier approval. However, the existence of this discretionary provision appears to cause confusion among accredited providers and suppliers who incorrectly believe they are entitled to a retroactive effective date.

This discretionary provision was included in the 1997 final rule as a result of public comments that concerned the Medicaid program. The commenters were concerned that the proposed rule would not have allowed for a retroactive agreement for a facility

that was already accredited and cited two Medicaid program scenarios to illustrate their concern. In one scenario, a facility participates in its own State's Medicaid program and provides services to a Medicaid recipient from another State. In the other scenario, a facility does not participate in Medicaid but provides services to a Medicaid recipient before learning of the individual's Medicaid status. Neither of these scenarios is pertinent to the Medicare program because Medicare enrollment is managed nationally. However, the stated intent of the 1997 final rule was to use a standard approach for both Medicare and Medicaid to determine the effective date of a provider agreement and a supplier approval, and, as a result, the provisions of § 489.13(d)(2) are identical to those at § 431.108(d)(2) for the Medicaid program.

Upon further consideration, we believe it is important to recognize the significant differences resulting from a State-based versus national system of beneficiary enrollment, and to ensure that the provisions of § 489.13 are tailored to the requirements of the Medicare program. As stated, as a matter of longstanding policy, reflected in issuances dating back at least as far as 1994, we have required new owners who do not accept the seller's Medicare provider agreement or supplier approval to be treated as initial applicants to the Medicare program. In a 1999 issuance, reaffirmed in several subsequent issuances, including the 2004 publication of the online version of the SOM and in Survey and Certification Memorandum S&C–09–08 issued on October 17, 2008, we explicitly state that this policy applies to accredited facilities as well. Therefore, we believe it is appropriate to remove § 489.13(d), and to instead make appropriate reference to the situation of accredited facilities in §§ 489.13(b) and (c).

Finally, we are proposing to make several technical amendments to § 489.1. Specifically, we are proposing to revise that section to add a reference to section 1865 of the Act, which permits CMS to "deem" facilities that have been accredited by a national accreditation organization under a CMS-approved accreditation program as having met the Medicare health and safety standards. We also are proposing to revise and renumber the existing provision of § 489.1 and to add references to "the Act" where the section refers to a provision of the Social Security Act.

IX. Proposed Changes to Medicare Conditions of Participation Affecting Hospital Rehabilitation Services and Respiratory Care Services

Recently, CMS received several public requests for clarification of the Medicare conditions of participation (CoPs) for hospitals relating to rehabilitation services at § 482.56 and respiratory care services at § 482.57. The questions concerning these conditions have been in the context of apparent inconsistencies between the two COPs themselves, and between the two CoPs and many State laws, regarding which practitioners are allowed to order rehabilitation and respiratory care services in the hospital setting.

Many States, under their scope-of-practice laws and other regulations, allow qualified, licensed practitioners (including nurse practitioners (NPs) and physician assistants (PAs)) to order rehabilitation services and respiratory care services, in addition to other common hospital services such as dietary and social work services. We also found that most States limit the types of practitioners allowed to order rehabilitation services, respiratory care services, and other hospital services to physicians and other qualified, licensed practitioners such as NPs and PAs.

However, the current standard at § 482.56(b) (Delivery of services) requires only that hospital rehabilitation services (for example, physical therapy, occupational therapy, audiology, and speech-pathology services) be ordered by "practitioners who are authorized by the medical staff to order the services." We believe that this requirement may be too open for interpretation and is not consistent with various State laws that limit the ordering of hospital services (including diagnostic tests, drugs and biologicals, and inpatient treatment modalities) to qualified, licensed practitioners who are responsible for the care of the patient and who are, most importantly, working within a State's delineated scope of practice for these types of practitioners. As this requirement is currently written, it would be conceivable for a hospital's medical staff to grant ordering privileges for rehabilitation services to personnel who are responsible for providing such services, that is, physical therapists, occupational therapists, audiologists, and speech-language pathologists. Such a situation would not only constitute a conflict of interest (for example, a physical therapists ordering physical therapy services for a patient for which medical necessity has not been established), but it would also potentially compromise coordination of care and patient safety if the practitioners who are responsible for the care of patients (that is, doctors of medicine, doctors of osteopathy, NPs, and PAs) are unaware of which services have been ordered for their patients.

Conversely, the current requirement for respiratory care services at § 482.57(b)(3) explicitly states that these services "must be provided only on, and in accordance with, the orders of a doctor of medicine or osteopathy." Similar to our finding that the requirement for the ordering of rehabilitation services is too broad in its parameters for determining which practitioners should be allowed to order those services, we find the parameters for the ordering of respiratory care services to be too narrow. While doctors of medicine or doctors of osteopathy have the option of delegating this task to NPs and PAs, this delegation requires physicians to countersign all orders by NPs or PAs for respiratory care services. We have not found any evidence that indicates that the ordering of respiratory care services should be kept to a different, and possibly higher, standard than rehabilitation and other hospital services. Nor have we found any documented studies indicating that qualified, licensed practitioners such as NPs and PAs should be restricted from ordering these necessary services for their patients. Further, we believe that the process of physician countersignature of orders written by qualified, licensed NPs and PAs, specifically for common hospital services such as rehabilitation and respiratory care services, is burdensome to practitioners (physicians as well as NPs and PAs) and the hospitals that they serve. In addition, we believe that this process also runs counter to what many States have already decided for NPs and PAs in their individual State regulations and scope-of-practice laws.

As a result of our analysis of the issues surrounding conflict of the Medicare CoPs with State laws, and conflict of the Medicare CoP with each other, we are proposing several revisions to the existing regulations. We are proposing to revise § 482.56 to clarify the types of practitioners who are allowed to order rehabilitation services. Further, we are proposing to limit those types of individuals to qualified, licensed practitioners who are responsible for the care of the patient and who are acting within the scope of practice under State law. We also are proposing that these practitioners would need to be authorized to order rehabilitation services by the hospital's medical staff, in accordance with both

hospital policies and procedures and State laws.

In addition, we are proposing changes to the existing requirements for the ordering of respiratory care services at § 482.57. Existing requirements only allow for services to be provided on the orders of a doctor of medicine or osteopathy. As stated above, we recently received several public requests (including requests from various hospitals as well as from The Joint Commission) for clarification of this requirement in the context of what is currently allowed under many State laws. Many States, under their scope-of-practice laws and other regulations, allow qualified, licensed practitioners (including NPs and PAs) to order respiratory care services. We are proposing to revise the existing requirements at § 482.57 to allow these practitioners, in addition to physicians as currently allowed, to order these services as long as such privileges are authorized by the medical staff and are in accordance with both hospital policies and procedures and State laws. As is required under the CoPs for all patient orders, the ordering practitioner must also be an individual who is responsible for the care of the patient.

In both of the CoPs for rehabilitation services and respiratory care services, we also are proposing that all orders for these services be documented in accordance with the requirements at § 482.24, Medical records.

X. Proposed Changes to the Accreditation Requirements for Medicaid Providers of Inpatient Psychiatric Services for Individuals Under Age 21

A. Background

Inpatient psychiatric services provided to individuals under the age of 21 were authorized as part of the Medicaid program by the Social Security Amendments of 1972 (Pub. L. 92–603). At that time, these services were only permitted to be provided by psychiatric hospitals accredited by the Joint Commission on Accreditation of Hospitals (later renamed as the Joint Commission on Accreditation of Healthcare Organizations and now named The Joint Commission). In 1984, Congress eliminated the requirement that such hospitals be accredited exclusively by The Joint Commission (section 2340(b) of Pub. L. 98–369).

Through statutory and regulatory amendments, inpatient psychiatric services provided to individuals under the age of 21 were also authorized to be provided in inpatient psychiatric programs within hospitals and in psychiatric facilities other than hospitals, called psychiatric residential treatment facilities (PRTFs). While PRTFs were given flexibility through rulemaking in 1998 to obtain accreditation from several specific accrediting organizations, or any other accrediting body with comparable standards recognized by the State, accreditation by The Joint Commission has remained a requirement for psychiatric hospitals and inpatient psychiatric programs within hospitals.

We have been contacted by several psychiatric hospitals and hospitals with inpatient psychiatric programs asking for relief of The Joint Commission accreditation requirement. In addition, The Joint Commission has previously expressed concern with the mandate for Joint Commission accreditation contained in existing regulation, as its policy is for facilities to seek accreditation voluntarily.

B. Proposed Revision of Policy and Regulations

In response to the concerns described above, we are proposing to remove the requirement that psychiatric hospitals and hospitals with inpatient psychiatric programs providing inpatient psychiatric services to individuals under age 21 must obtain accreditation from The Joint Commission in order to provide these services under the Medicaid program. Under our proposed policy change, psychiatric hospitals would have the choice of meeting the requirements to participate in Medicare as a psychiatric hospital under 42 CFR 482.60 or obtaining accreditation from a national accrediting organization whose psychiatric hospital accrediting program has been approved by CMS. Hospitals with inpatient psychiatric programs would have the choice of meeting the requirements for participation in Medicare as a hospital as specified in 42 CFR part 482 or obtaining accreditation from a national accrediting organization whose hospital accreditation program has been approved by CMS. These national accreditation bodies must provide reasonable assurance to CMS that their hospital accrediting programs require adherence to requirements that are at least as stringent as the Medicare requirements.

In addition, we are proposing to revise the accreditation requirements for PRTFs by removing any specific references to accreditation organizations to afford them flexibility in obtaining accreditation by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State. This proposed revision would remove specific reference to national accrediting bodies to provide appropriate administrative flexibility to account for any changes in qualifying accrediting organizations. Accrediting bodies approved by CMS must have accrediting requirements for an entity comparable to the CMS requirements for the same entity, and must have survey procedures comparable to those of State survey agencies.

The regulations at 42 CFR 488.4 describe the procedures to be followed by accrediting organizations applying or reapplying for approval of deeming authority for Medicare requirements. The regulations at 42 CFR 488.5(b) and 488.6(b) allow providers and suppliers deemed eligible for Medicare by these accrediting organizations to be also deemed eligible for Medicaid participation in the absence of Medicaid regulations requiring adherence to a different standard. In addition, the regulations at 42 CFR 488.8 detail the procedures that CMS will follow in reviewing and approving national accreditation organizations. Nothing in this proposed rule would alter the implementation of these regulatory provisions.

We believe this flexibility in obtaining accreditation would facilitate the provision of medically necessary, Medicaid-reimbursable psychiatric services to vulnerable children, while maintaining the high quality of care demanded by the Medicaid program. While services may be provided in different settings, the requirements of 42 CFR 441.150 through 441.182 must be adhered to by any provider of services. We are inviting public comments on our suggestions for improving current protections for children.

To incorporate the proposed changes described above in our regulations, we are proposing to revise § 440.160(b)(1) and § 441.151(a)(2)(i) by removing the requirement for accreditation by The Joint Commission of psychiatric hospitals and hospitals with inpatient psychiatric programs. Psychiatric hospitals would have the choice of meeting the requirements to participate in Medicare as a psychiatric hospital under 42 CFR 482.60 or obtaining accreditation from a national accrediting organization whose psychiatric hospital accrediting program has been approved by CMS. Hospitals with inpatient psychiatric programs would have the choice of meeting the requirements for participation in Medicare as a hospital as specified in 42 CFR part 482 or obtaining accreditation by a national accrediting organization whose hospital accrediting program has been approved

by CMS. We are proposing to revise § 440.160(b)(2) and § 441.151(a)(2)(ii) by removing an specific references to accreditation organizations to afford PRTFs the flexibility in obtaining accreditation by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State.

XI. MedPAC Recommendations

Under section 1886(e)(4)(B) of the Act, the Secretary must consider MedPAC's recommendations regarding hospital inpatient payments. Under section 1886(e)(5) of the Act, the Secretary must publish in the annual proposed and final IPPS rules the Secretary's recommendations regarding MedPAC's recommendations. We have reviewed MedPAC's March 2010 "Report to the Congress: Medicare Payment Policy" and have given the recommendations in the report careful consideration in conjunction with the policies set forth in this proposed rule.

MedPAC's Recommendation 2A–1 states that "The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2011 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program." This recommendation for the IPPS is discussed in Appendix B to this proposed rule.

MedPAC's Recommendation 2A–2 states that "To restore budget neutrality, the Congress should require the Secretary to fully offset increases in inpatient payments due to hospitals' documentation and coding improvements. To accomplish this goal, the Secretary must reduce payment rates in the inpatient prospective payment system by the same percentage (not to exceed 2 percentage points) each year in 2011, 2012, and 2013. The lower rates would remain in place until overpayments are fully recovered."

Response to Recommendation 2A–2: Beginning in FY 2008, CMS adopted the new MS–DRG patient classification system for the IPPS to better recognize severity of illness in Medicare payment rates. Adoption of the MS–DRGs resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The increase in the number of DRGs provides incentives for hospitals to change documentation and coding that can increase Medicare expenditures without any corresponding increase in underlying patient severity. Consistent with the statutory requirement to maintain budget neutrality, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 when the new MS–DRG system was implemented in FY 2008. Subsequent to issuance of the FY 2008 IPPS final rule, section 7 of the TMA of 2007 (Pub. L. 110–90) divided in half the documentation and coding adjustments for the MS–DRG system that we adopted in the FY 2008 IPPS final rule to −0.6 percent for FY 2008 and -0.9 percent for FY 2009. Section 7 requires that, if the implementation of the new MS–DRG payment system resulted in actual changes in documentation and coding in FY 2008 or FY 2009, or both years, that are different from those reflected in the −0.6 percent and −0.9 percent documentation and coding adjustments applied to payment rates in FY 2008 and FY 2009, respectively, the Secretary further adjust operating IPPS rates. This further adjustment must offset the estimated amount of the increase or decrease in aggregate payments for discharges occurring during FY 2008 and FY 2009, and must be made during FY 2010, FY 2011, and/or FY 2012. These adjustments are referred to as the recoupment adjustments and apply only to acute IPPS operating payments. In addition, the law requires that the Secretary eliminate the effect of all actual documentation and coding changes occurring in FY 2008 and FY 2009 incorporated into FY 2010 IPPS operating rates not already accounted for beyond the −0.6 and −0.9 percent adjustments. These adjustments are referred to as the prospective adjustments. As discussed in section II.D. of the preamble of this proposed rule, our current estimate is that an aggregate adjustment of 9.7 percent would be necessary to satisfy these requirements.

We discuss our proposed adjustments to correct for the effects of improved documentation and coding on Medicare payments to hospitals in section II.D. of the preamble of this proposed rule for IPPS operating payments, in section V.E. of the preamble of this proposed rule for IPPS capital payments, and in section VII.C.3. of the preamble of this proposed rule for LTCH PPS payments. In this context, we note that, in considering whether to adopt MedPAC's recommendation, we took into consideration the statutory requirement that the adjustment must offset the estimated amount of the increase or decrease in aggregate payments for discharges occurring during FY 2008 and FY 2009 must be made during FY 2010, FY 2011, and/or FY 2012.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653–7226, or visit MedPAC's Web site at: *http://www.medpac.gov.*

XII. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are now available on compact disc (CD) format. However, many of the files are available on the Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS*. Data files and the cost for each file, if applicable, are listed below. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to CMS–PUF) to cover the cost of the following address: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, MD 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. CMS Wage Data Public Use File

This file contains the hospital hours and salaries from Worksheet S–3, Parts II and III from FY 2007 Medicare cost reports used to create the proposed FY 2011 prospective payment system wage index. Multiple versions of this file are created each year. For a complete schedule on the release of different versions of this file, we refer readers to the wage index schedule in section III.K. of the preamble of this proposed rule.

Processing year	Wage data year	PPS Fiscal year
2010	2007	2011
2009	2006	2010
2008	2005	2009
2007	2004	2008

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

Periods Available: FY 2007 through FY 2011 IPPS Update.

2. CMS Occupational Mix Data Public Use File

This file contains the 2007–2008 occupational mix survey data to be used to compute the occupational mix adjustment wage indexes. Multiple versions of this file are created each

year. For a complete schedule on the release of different versions of this file, we refer readers to the wage index schedule in section III.K. of the preamble of this proposed rule.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

Period Available: FY 2011 IPPS Update.

3. Provider Occupational Mix Adjustment Factors for Each Occupational Category Public Use File

This file contains each hospital's occupational mix adjustment factors by occupational category. Two versions of these files are created each year. They support the following:

- Notice of proposed rulemaking published in the **Federal Register.**
- Final rule published in the **Federal Register.**

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

Period Available: FY 2011 IPPS Update.

4. Other Wage Index Files

CMS releases other wage index analysis files after each proposed and final rule.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

Periods Available: FY 2007 through FY 2011 IPPS Update.

5. FY 2011 IPPS SSA/FIPS CBSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a historical list of Metropolitan Statistical Areas (MSAs).

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*.

Period Available: FY 2011 IPPS Update.

6. HCRIS Cost Report Data

The data included in this file contain cost reports with fiscal years ending on or after September 30, 1996. These data files contain the highest level of cost report status.

Media: Internet at: *http://www.cms.hhs.gov/CostReports/02_HospitalCostReport.asp* and Compact Disc (CD).

File Cost: $100.00 per year.

7. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's or the MAC's system to compute DRG/MS–DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Internet at: *http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp*.

Period Available: FY 2011 IPPS Update.

8. CMS Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG/MS–DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:

- Notice of proposed rulemaking published in the **Federal Register.**
- Final rule published in the **Federal Register.**

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*.

Periods Available: FY 1985 through FY 2011.

9. MS–DRG Relative Weights (Also Table 5—MS–DRGs)

This file contains a listing of MS–DRGs, MS–DRG narrative descriptions, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register.** There are two versions of this file as published in the **Federal Register.**

- Notice of proposed rulemaking.
- Final rule.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*.

Periods Available: FY 2006 through 2011 IPPS Update.

10. IPPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register.**

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage* and *http://www.cms.hhs.gov/AcuteInpatientPPS/HIF/list.asp#TopOfPage*.

Periods Available: FY 1994 through FY 2011 IPPS Update.

11. AOR/BOR Tables

This file contains data used to develop the MS–DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by MS–DRG for length of stay and standardized charges. The BOR tables are "Before Outliers Removed" and the AOR is "After Outliers Removed." (Outliers refer to statistical outliers, not payment outliers.)

Two versions of this file are created each year. They support the following:

- Notice of proposed rulemaking published in the **Federal Register.**
- Final rule published in the **Federal Register.**

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*.

Periods Available: FY 2006 through FY 2011 IPPS Update.

12. Prospective Payment System (PPS) Standardizing File

This file contains information that standardizes the charges used to calculate relative weights to determine payments under the hospital inpatient operating and capital prospective payment systems. Variables include wage index, cost-of-living adjustment (COLA), case-mix index, indirect medical education (IME) adjustment, disproportionate share, and the Core-based Statistical Area (CBSA). The file supports the following:

- Notice of proposed rulemaking published in the **Federal Register.**
- Final rule published in the **Federal Register.**

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*.

Period Available: FY 2011 IPPS Update.

For further information concerning these data tapes, contact the CMS Public Use Files Hotline at (410) 786–3691.

Commenters interested in discussing any data used in constructing this proposed rule should contact Nisha Bhat at (410) 786–5320.

B. Collection of Information Requirements

1. Legislative Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs).

2. Requirements in Regulation Text

a. ICRs Regarding Withdrawing an Application, Terminating an Approved 3-Year Reclassification, or Canceling a Previous Withdrawal or Termination (Proposed Revised § 412.273)

Proposed revised § 412.273(b) states that the MGCRB allows a hospital, or group of hospitals, to withdraw its application or to terminate an already existing 3-year reclassification. Proposed revised § 412.273(c) further specifies the timing requirements for the withdrawal or termination requirements. Proposed § 412.273(c)(1) provides that a request for withdrawal must be received by the MGCRB at any time before the MGCRB issues a decision on the application; or after the MGCRB issues a decision, provided that the request for withdrawal is received by the MGCRB within 45 days of publication of CMS' annual notice of proposed rulemaking concerning changes to the IPPS and proposed payment rates for the fiscal year for which the application has been filed.

The burden associated with this requirement is the time and effort necessary for a hospital to submit a written withdrawal request to the MGCRB. While this requirement is subject to the PRA, we cannot accurately quantify the burden associated with this requirement. We currently review each request on a case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6).

Proposed revised § 412.273(c)(2) provides that a request for termination must be received by the MGCRB within 45 days of the publication of CMS' annual notice of proposed rulemaking concerning changes to the IPPS and proposed payment rates for the fiscal year for which the termination is to apply. The burden associated with this requirement is the time and effort necessary for a hospital to submit a written termination request to the MGCRB. While this requirement is subject to the PRA, we cannot accurately quantify the burden associated with this requirement. We currently review each request on a case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6).

Proposed revised § 412.273(d)(1) states that a hospital (or group of hospitals) may cancel a withdrawal or termination in a subsequent year and request the MGCRB to reinstate the wage index reclassification for the remaining fiscal year(s) of the 3-year period. Proposed revised § 412.273(d)(2) would require that cancellation requests be received in writing by the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year, as specified in § 412.256(a)(2). The burden associated with this requirement is the time and effort necessary for a hospital to submit a written request to the MGCRB, requesting that the current withdrawal or termination request be cancelled. While this requirement is subject to the PRA, we cannot accurately quantify the burden associated with this requirement. We currently review each request on a case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6).

Proposed § 412.273(d)(3) states that a hospital would be able to apply for reclassification to a different area (that is, an area different from the one to which it was originally reclassified for the 3-year period). If the application is approved, the reclassification will be effective for 3 years. Once a 3-year reclassification becomes effective, a hospital may no longer cancel a withdrawal or termination of another 3-year reclassification, regardless of whether the withdrawal or termination request is made within 3 years from the date of the withdrawal or termination. The burden associated with the reapplication requirement is the time and effort necessary for a hospital to submit a reclassification request to the MGCRB. While this requirement is subject to the PRA, the associated burden is approved under OMB control number 0938–0573, with an expiration date of December 31, 2011.

Proposed § 412.273(f)(1) states that a hospital may file an appeal of the MGCRB's denial of its request for withdrawal or termination, or of the MGCRB's denial of its request for a cancellation of such withdrawal or termination, to the Administrator. The appeal must be received within 15 days of the date of the notice of the denial. The burden associated with this requirement is the time and effort necessary for a hospital to file a written appeal of the MGCRB's denial. While this requirement is subject to the PRA, the associated burden is exempt under 5 CFR 1320.4. The burden associated with collection of information as part of or subsequent to an administrative action is not subject to the PRA.

b. ICRs Regarding Condition of Participation: Respiratory Care Services (§ 482.57)

Proposed § 482.57(b)(4) imposes a recordkeeping requirement. This section would require all respiratory care services orders to be documented in the patient's medical record according to the requirements at § 482.24. The burden associated with this requirement is the time and effort necessary for hospital staff to document and maintain the respiratory care services orders in a patient's medical record. While these requirements are subject to the PRA, the associated burden is exempt from the PRA under 5 CFR 1320.3(b)(2). We believe hospitals will not incur any burden above and beyond that associated with the usual and customary business practice of maintaining detailed patient medical records.

3. Additional Information Collection Requirements

This proposed rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this proposed rule also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

a. Present on Admission (POA) Indicator Reporting

Section II.F.6. of the preamble of this proposed rule discusses the POA

indicator reporting program. As stated earlier, collection of POA indicator data is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision and for broader public health uses of Medicare data. Through Change Request 5499 dated May 11, 2007, CMS issued instructions that require IPPS hospitals to submit POA indicator data for all diagnosis codes on Medicare claims.

The burden associated with this requirement is the time and effort necessary to place the appropriate POA indicator codes on Medicare claims. This requirement is subject to the PRA; however, the associated burden is currently approved under OMB control number 0938–0997, with an expiration date of October 31, 2012.

b. Add-On Payments for New Services and Technologies

Section II.I.1. of the preamble of this proposed rule discusses add-on payments for new services and technologies. Specifically, this section states that applicants for add-on payments for new medical services or technologies for FY 2011 must submit a formal request. A formal request includes a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement. In addition, the request must contain a significant sample of the data to demonstrate that the medical service or technology meets the high-cost threshold. We detailed the burden associated with this requirement in the September 7, 2001, IPPS final rule (66 FR 46902). As stated in that final rule, collection of the information for this requirement is conducted on an individual case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6). Similarly, we also believe the burden associated with this requirement is exempt from the PRA under 5 CFR 1320.3(c), which defines the agency collection of information subject to the requirements of the PRA as information collection imposed on 10 or more persons within any 12-month period. This information collection does not impact 10 or more entities in a 12-month period. In FYs 2008, 2009, 2010, and 2011 we received 1, 4, 5, and 3 applications, respectively.

c. Reporting of Hospital Quality Data for Annual Hospital Payment Update

As discussed in section V.A. of this proposed rule, the RHQDAPU program was originally established to implement section 501(b) of Public Law 108–173. The RHQDAPU program originally consisted of a "starter set" of 10 quality measures. OMB approved the collection of data associated with the original starter set of quality measures under OMB control number 0938–0918, with a current expiration date of January 31, 2011.

As part of our implementation of section 5001(a) of the DRA, we expanded the number of quality measures reported in the RHQDAPU program. Specifically, section 1886(b)(3)(B)(viii)(III) of the Act, added by section 5001(a) of the DRA, requires that the Secretary expand the "starter set" of 10 quality measures that were established by the Secretary as of November 1, 2003, to include measures "that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in inpatient settings." Under this provision, we established additional program measures to bring the total number of measures to 30. The burden associated with these reporting requirements is currently approved under OMB control number 0938–1022, with a current expiration date of June 30, 2011.

In the FY 2010 IPPS proposed rule (74 FR 24168), we solicited public comments on several considerations for expanding and updating quality measures. We responded to the public comments received in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43866 through 43868). We also expanded and finalized the RHQDAPU program measure set for the FY 2011 payment determination. As part of the expansion effort, we finalized 46 measures in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43872).

In this FY 2011 IPPS/LTCH PPS proposed rule, we are proposing to retire one measure for the FY 2011 payment determination. For the FY 2012 through FY 2014 payment determinations, we are proposing to retain the remaining 45 of the 46 current measures; and for FY 2012, to add 10 new measures and to require all-patient volume data for selected MS–DRGs that relate to RHQDAPU program measures; for FY 2013, to retain the FY 2012 measures and add 35 new measures; and for FY 2014, to retain the FY 2013 measures and to add 4 new measures. In addition, we have listed 28 new measures that are under consideration for adoption in future years. We are proposing that beginning with CY 2011 discharges, hospitals submit some of the new measure data to a qualified registry. We are also soliciting public comments on retiring one or more of the 11 additional measures suggested by commenters in the FY 2010 IPPS/RY 2010 LTCH PPS final rule based on topped out performance and other rationales.

In summary, we are proposing to retire one measure for the FY 2011 annual payment update and seeking comments on whether to retire 11 additional measures suggested by commenters in the FY 2010 IPPS/RY 2010 LTCH PPS final rule. In addition, we are proposing to expand the RHQDAPU program measure set to: 55 measures for the FY 2012 annual payment update (taking into account our proposal to retire one measure for the FY 2011 annual payment update); 90 measures for the FY 2013 annual payment update, and 94 measures for the FY 2014 annual payment update. We also list 28 additional measures under consideration for adoption in future years which may increase these numbers if we propose and adopt them in future IPPS rulemaking. Finally, we are proposing that, beginning with the FY 2012 annual payment update, hospitals that participate in the RHQDAPU program submit all-patient volume data for selected MS–DRGs that relate to RHQDAPU program measures. This proposal would require hospitals to report these data beginning with CY 2011 discharges.

We submitted a revised version of the information collection request approved under OMB control number 0938–1022, to obtain approval for the proposed new measures.

Section V.A.10. of this proposed rule addresses the reconsideration and appeal procedures for a hospital that we believe did not meet the RHQDAPU program requirements. If a hospital disagrees with our determination, it may submit a written request to CMS to reconsider our decision. The hospital's request for reconsideration must explain the reasons why it believes it satisfied the RHQDAPU program requirements. While this is a reporting requirement, the burden associated with it is not subject to the PRA under 5 CFR 1320.4(a)(2). The burden associated with information collection requirements imposed subsequent to an administrative action is not subject to the PRA.

d. Proposed Occupational Mix Adjustment to the FY 2011 Index (Hospital Wage Index Occupational Mix Survey)

Section II.D. of the preamble of this proposed rule discusses the proposed occupational mix adjustment to the FY

2011 wage index. While the preamble does not contain any new ICRs, it is important to note that there is an OMB approved information collection request associated with the hospital wage index.

Section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data at least once every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program in order to construct an occupational mix adjustment to the wage index. We collect the data via the occupational mix survey.

The burden associated with this information collection requirement is the time and effort required to collect and submit the data in the Hospital Wage Index Occupational Mix Survey to CMS. The aforementioned burden is subject to the PRA; however, it is currently approved under OMB control number 0938–0907, with an expiration date of February 28, 2013.

e. Hospital Applications for Geographic Reclassifications by the MGCRB

Section III.I.3. of the preamble of this proposed rule discusses revisions to the wage index based on hospital redesignations. As stated in that section, under section 1886(d)(10) of the Act, the MGCRB has the authority to accept short-term IPPS hospital applications requesting geographic reclassification for wage index or standardized payment amounts and to issue decisions on these requests by hospitals for geographic reclassification for purposes of payment under the IPPS.

The burden associated with this application process is the time and effort necessary for an IPPS hospital to complete and submit an application for reclassification to the MGCRB. While this requirement is subject to the PRA, the associated burden is currently approved under OMB control number 0938–0573, with an expiration date of December 31, 2011.

f. Direct GME Payments: General Requirements

Existing regulations at § 413.75(b) permit hospitals that share residents to elect to form a Medicare GME affiliated group if they are in the same or contiguous urban or rural areas, if they are under common ownership, or if they are jointly listed as program sponsors or major participating institutions in the same program. The purpose of a Medicare GME affiliated group is to provide flexibility to hospitals in structuring rotations under an aggregate FTE resident cap when they share residents. The existing regulations at § 413.79(f)(1) specify that each hospital in a Medicare GME affiliated group must submit a Medicare GME affiliation agreement (as defined under § 413.75(b)) to the Medicare fiscal intermediary or MAC servicing the hospital and send a copy to CMS' Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

In section V.H.3. of the preamble of this proposed rule, we are proposing to allow hospitals to electronically submit the copy of the affiliation agreement that is required to be sent to the CMS Central Office. As stated earlier in the preamble, the proposed electronic submission process would consist of either an e-mail mailbox or a Web site where hospitals would submit their Medicare GME affiliation agreements to the CMS Central Office to a designated online mailbox. We are proposing that a copy of the Medicare GME affiliation agreement would need to be received through the electronic system no later than 11:59 p.m. on July 1 of each academic year. We are proposing that the electronic affiliation agreement would need to be submitted either as a scanned copy or a Printer-Friendly Display (PDF) version of that hard copy agreement; we are proposing not to accept an agreement in any electronic format that could be subject to manipulation. The scanned and/or PDF format will enable CMS to ensure that the agreements are signed and dated as required in the regulations at § 413.75. Under this proposal, hospitals would have the option to continue to submit a hard copy of its affiliation agreement to the CMS Central Office. In addition, each fiscal intermediary or MAC would continue to have the authority to specify its requirements for submittal of the Medicare GME affiliation agreement by hospitals that are part of the affiliation.

The burden associated with this requirement is the time and effort it would take for the new hospital to develop and submit the Medicare GME affiliation agreement, to submit it the agreement to its fiscal intermediary or MAC, and to submit a copy to CMS. In the proposed and final rules that published on May 22, 2009 (74 FR 24080) and August 27, 2009 (74 FR 43754), we stated that it was difficult for us to estimate the annual burden associated with this requirement because we cannot estimate the additional number of hospitals that will be permitted to submit Medicare GME affiliation agreements in any given year as a result of the change. However, we now have better data available to quantify the burden associated with the existing requirement for hospitals to submit GME affiliation agreements to the fiscal intermediary or MAC servicing the hospital and new requirement for the electronic submission of a copy of the affiliation agreement to CMS. We are submitting a new information collection request to OMB for review and approval of the associated burden.

We anticipate receiving between 100 and 150 GME affiliation agreements annually. For the purposes of our information collection request, we estimate that we will receive 125 agreements annually. CMS provides a two-page sample agreement for hospitals; however, some facilities may submit additional information that is not required. We estimate that it will take 1 hour for a hospital to develop a GME affiliation agreement or to follow the format provided by CMS. Similarly, we estimate that it will take each hospital 15 minutes to submit a hard copy of the affiliation agreement to its fiscal intermediary or MAC. Finally, we estimate that it will take each hospital 5 minutes to submit an electronic copy of its GME affiliation agreement to CMS. The total annual burden associated with developing the affiliation agreement is 125 hours. The total annual burden associated with submitting a hard copy of the affiliation agreement is 31 hours. The total annual burden associated with submitting the agreement electronically is 10 hours. The total annual burden associated with all of the requirements in this section is 166 hours. The total cost associated with this requirement is $5,000 ($40.00 x 125 agreements).

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, CMS–1498–P; Fax: (202) 395–6974; or E-mail: *OIRA_submission@omb.eop.gov*.

C. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 440

Grant program-health, Medicaid.

42 CFR Part 441

Family planning, Grant program-health, Infants and children, Medicaid, Penalties, Prescription drugs, Reporting and recordkeeping requirements.

42 CFR Part 482

Grant program-health, Hospitals, Medicaid, Medicare, Reporting and rcordkeeping requirements.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Public Law 106–113 (113 Stat. 1501A–332).

2. Section 412.4 is amended by—

a. Republishing the introductory language of paragraph (b).

b. Removing the word "or" at the end of paragraph (b)(1).

c. Removing the period at the end of paragraph (b)(2) and adding in its place a semicolon.

d. Adding new paragraphs (b)(3) and (b)(4).

The additions read as follows:

§ 412.4 Discharges and transfers.

* * * * *

(b) *Acute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital that is—

* * * * *

(3) An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program; or

(4) A critical access hospital.

* * * * *

§ 412.106 [Amended]

3. Section 412.106 is amended by—

a. In paragraph (b)(2)(i)(B), removing the word "or" and adding in its place the word "including".

b. In paragraph (b)(2)(iii)(B), removing the word "or" and adding in its place the word "including".

§ 412.108 [Amended]

4. Amend § 412.108 (a)(1)(iii) introductory text by removing the word "receiving" and adding in its place the words "entitled to".

5. Section 412.113 is amended by revising paragraph (c)(2)(i)(A) to read as follows:

§ 412.113 Other payments.

* * * * *

(c) * * *

(2)(i) * * *

(A) The hospital or CAH is located in a rural area as defined in § 412.62(f) and is not deemed to be located in an urban area under the provisions of § 412.64(b)(3). For cost reporting periods beginning on or after October 1, 2010, the hospital or CAH is either located in a rural area as defined in § 412.62(f) and is not deemed to be located in an urban area under the provisions of § 412.64(b)(3) or the hospital or CAH has reclassified as rural under the provisions at § 412.103.

* * * * *

6. Section 412.273 is revised to read as follows:

§ 412.273 Withdrawing an application, terminating an approved 3-year reclassification, or canceling a previous withdrawal or termination.

(a) *Definitions.* For purposes of this section, the following definitions apply.

Termination refers to the termination of an already existing 3-year MGCRB reclassification where such reclassification has already been in effect for 1 or 2 years, and there are 1 or 2 years remaining on the 3-year reclassification. A termination is effective only for the full fiscal year(s) remaining in the 3-year period at the time the request is received. Requests for terminations for part of a fiscal year are not considered.

Withdrawal refers to the withdrawal of a 3-year MGCRB reclassification that has not yet gone into effect or where the MGCRB has not yet issued a decision on the application.

(b) *General rule.* The MGCRB allows a hospital, or group of hospitals, to withdraw its application or to terminate an already existing 3-year reclassification, in accordance with this section.

(c) *Timing.* (1) A request for withdrawal must be received by the MGCRB—

(i) At any time before the MGCRB issues a decision on the application; or

(ii) After the MGCRB issues a decision, provided that the request for withdrawal is received by the MGCRB within 45 days of publication of CMS' annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the application has been filed.

(2) A request for termination must be received by the MGCRB within 45 days of the publication of CMS' annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the termination is to apply.

(d) *Reapplication within the approved 3-year period, cancellations of terminations and withdrawals, and prohibition on overlapping reclassification approvals.*

(1) *Cancellation of terminations or withdrawals.* Subject to the provisions of this section, a hospital (or group of hospitals) may cancel a withdrawal or termination in a subsequent year and request the MGCRB to reinstate the wage index reclassification for the remaining fiscal year(s) of the 3-year period. (Withdrawals may be cancelled only in cases where the MGCRB issued a decision on the geographic reclassification request.)

(2) *Timing and process of cancellation request.* Cancellation requests must be received in writing by the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year, as specified in § 412.256(a)(2).

(3) *Reapplications.* A hospital may apply for reclassification to a different area (that is, an area different from the one to which it was originally reclassified for the 3-year period). If the application is approved, the reclassification will be effective for 3 years. Once a 3-year reclassification becomes effective, a hospital may no longer cancel a withdrawal or

termination of another 3-year reclassification, regardless of whether the withdrawal or termination request is made within 3 years from the date of the withdrawal or termination.

(4) *Termination of existing 3-year reclassification.* In a case in which a hospital with an existing 3-year wage index reclassification applies to be reclassified to another area, its existing 3-year reclassification will be terminated when a second 3-year wage index reclassification goes into effect for payments for discharges on or after the following October 1.

(e) *Written request only.* A request to withdraw an application must be made in writing to the MGCRB by all hospitals that are party to the application. A request to terminate an approved reclassification may be made in writing to the MGCRB by an individual hospital or by an individual hospital that is party to a group classification.

(f) *Appeal of the MGCRB's denial of a hospital's request for withdrawal or termination, or for cancellation of a withdrawal or termination.*

(1) A hospital may file an appeal of the MGCRB's denial of its request for withdrawal or termination, or of the MGCRB's denial of its request for a cancellation of such withdrawal or termination, to the Administrator. The appeal must be received within 15 days of the date of the notice of the denial.

(2) Within 20 days of receipt of the hospital's request for appeal, the Administrator affirms or reverses the denial.

7. Section 412.503 is amended by—

a. Adding a definition of "long-term care hospital prospective payment system fiscal year".

b. Adding a definition of "long-term care hospital prospective payment system payment year".

c. Revising paragraph (3) of the definition of "long-term care hospital prospective payment system rate year".

The additions and revision read as follows:

§ 412.503 Definitions.

* * * * *

Long-term care hospital prospective payment system fiscal year means, beginning October 1, 2010, the 12-month period of October 1 through September 30.

Long-term care hospital prospective payment system payment year means the general term that encompasses both the definition of "long-term care hospital prospective payment system rate year" and "long-term care hospital prospective payment system fiscal year" specified in this section.

Long-term care hospital prospective payment system rate year means—

* * * * *

(3) From October 1, 2009 through September 30, 2010, the 12-month period of October 1 through September 30.

* * * * *

8. Section 412.523 is amended by adding a new paragraph (c)(3)(vii) to read as follows:

§ 412.523 Methodology for calculating the Federal prospective payment rate.

* * * * *

(c) * * *

(3) * * *

(vii) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2010, and ending September 30, 2011.* The standard Federal rate for the long-term care hospital prospective payment system fiscal year beginning October 1, 2010, and ending September 30, 2011, is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by −0.1 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

* * * * *

9. Section 412.525 is amended by revising paragraphs (a)(1) and (a)(2) to read as follows:

§ 412.525 Adjustments to the Federal prospective payment.

(a) *Adjustments for high-cost outliers.* (1) CMS provides for an additional payment to a long-term care hospital if its estimated costs for a patient exceed the adjusted LTC–MS–DRG payment plus a fixed-loss amount. For each long-term care hospital prospective payment system payment year, as described in § 412.503, CMS determines a fixed-loss amount that is the maximum loss that a hospital can incur under the prospective payment system for a case with unusually high costs.

(2) The fixed-loss amount is determined for the long-term care hospital prospective payment system payment year, as defined in § 412.503, using the LTC–MS–DRG relative weights that are in effect at the start of the applicable long-term care hospital prospective payment system payment year, as defined in § 412.503.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

10. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106–133 (113 Stat. 1501A–332).

11. Section 413.70 is amended by—

a. Revising paragraph (b)(3)(i)(A).

b. Revising paragraph (b)(3)(i)(B).

c. Revising paragraph (b)(3)(i)(D).

The revisions read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(b) * * *

(3) * * *

(i) * * *

(A)(*1*) *For cost reporting periods beginning before October 1, 2010.* The election must be made in writing, made on an annual basis, and delivered to the fiscal intermediary or MAC servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made. An election, once made for a cost reporting period, remains in effect for all of that period.

(*2*) *For cost reporting periods beginning on or after October 1, 2010.* If a CAH had elected the method specified in paragraph (b)(3)(i) of this section in its most recent cost reporting period beginning prior to October 1, 2010, that election remains in effect for all of that period and for all subsequent cost reporting periods, unless the CAH submits a termination request to the fiscal intermediary or MAC servicing the CAH at least 30 days before the start of the next cost reporting period. If a CAH had not, in its most recent cost reporting period, elected the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section and chooses to elect this method on or after October 1, 2010, the election must be made in writing and delivered to the fiscal intermediary or MAC servicing the CAH at least 30 days before the start of the first cost reporting period for which the election is made. Once the election is made, it remains in effect for all of that period and for all subsequent cost reporting periods unless the CAH submits a termination request to the fiscal intermediary or MAC servicing

the CAH at least 30 days before the start of the next cost reporting period. For cost reporting periods beginning in October 2010 and November 2010, if a CAH wishes to terminate its election, the CAH must submit a termination request to the fiscal intermediary or MAC servicing the CAH prior to December 1, 2010.

(B) An election of the payment method specified under paragraph (b)(3)(i) of this section applies to all services furnished to outpatients by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with subpart F of Part 424 of this chapter. If a physician or other practitioner does not reassign his or her billing rights to the CAH in accordance with subpart F of Part 424 of this chapter, payment for the physician's or practitioner's services furnished to CAH outpatients will be made on a fee schedule or other applicable basis as specified in subpart B of Part 414 of this subchapter.

* * * * *

(D) An election made under paragraph (b)(3)(i) of this section is effective as provided for under paragraph (b)(3)(i)(A) or paragraph (b)(3)(i)(C) of this section and does not apply to an election that was terminated prior to the start of the cost reporting period for which it would otherwise apply.

* * * * *

12. Section 413.75 is amended by revising the definitions of "Primary care resident" and "Resident" under paragraph (b) to read as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

Primary care resident is a resident who is enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice. Effective for cost reporting periods beginning on or after October 1, 2010, *primary care resident* is a resident who is formally accepted, enrolled, and participating in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice.

* * * * *

Resident means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board. Effective for cost reporting periods beginning on or after October 1, 2010, *resident* means an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.

* * * * *

PART 440—SERVICES: GENERAL PROVISIONS

13. The authority citation for Part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

18. Section 440.160 is amended by revising paragraphs (b)(1) and (b)(2) to read as follows:

§ 440.160 Inpatient psychiatric services for individuals under age 21.

* * * * *

(b) * * *

(1) A psychiatric hospital that meets the requirements for participation in Medicare as a psychiatric hospital as specified in § 482.60 of this chapter, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS, or a hospital with an inpatient psychiatric program that meets the requirements for participation in Medicare as a hospital as specified in Part 482 of this chapter or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

(2) A psychiatric facility that is not a hospital and is accredited by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State.

* * * * *

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

14. The authority citation for Part 441 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

15. Section 441.151 is amended by revising paragraphs (a)(2)(i) and (a)(2)(ii) to read as follows:

§ 441.151 General requirements.

(a) * * *

(2) * * *

(i) A psychiatric hospital that meets the requirements for participation in Medicare as a psychiatric hospital as specified in § 482.60 of this chapter, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS, or a hospital with an inpatient psychiatric program that meets the requirements for participation in Medicare as a hospital as specified in Part 482 of this chapter or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

(ii) A psychiatric facility that is not a hospital and is accredited by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State.

* * * * *

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

16. The authority citation for Part 482 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

17. Section 482.56 is amended by revising paragraph (b) to read as follows:

§ 482.56 Condition of participation: Rehabilitation services.

* * * * *

(b) *Standard: Delivery of services.* Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.

(1) All rehabilitation services orders must be documented in the patient's medical record according to the requirements at § 482.24.

(2) The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of § 409.17 of this chapter.

18. Section 482.57 is amended by revising paragraph (b)(3) and adding paragraph (b)(4) to read as follows:

§ 482.57 Condition of participation: Respiratory care services.

* * * * *

(b) * * *

(3) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the

services in accordance with hospital policies and procedures and State laws.

(4) All respiratory care services orders must be documented in the patient's medical record according to the requirements at § 482.24.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

19. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

20. Section 485.610 is amended by revising the introductory text of paragraph (b) to read as follows:

§ 485.610 Condition of participation: Status and location.

* * * * *

(b) *Standard: Location in a rural area or treatment as rural.* The CAH meets the requirements of either paragraph (b)(1) or (b)(2) of this section or the requirements of either (b)(3) or (b)(4) of this section.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

21. The authority citation for Part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

22. Section 489.1 is revised to read as follows:

§ 489.1 Statutory basis.

(a) This part implements section 1866 of the Social Security Act (the Act). Section 1866 of the Act specifies the terms of provider agreements, the grounds for terminating a provider agreement, the circumstances under which payment for new admissions may be denied, and the circumstances under which payment may be withheld for failure to make timely utilization review. The sections of the Act specified in paragraphs (a)(1) through (a)(4) of this section are also pertinent.

(1) Section 1861 of the Act defines the services covered under Medicare and the providers that may be reimbursed for furnishing those services.

(2) Section 1864 of the Act provides for the use of State survey agencies to ascertain whether certain entities meet the conditions of participation.

(3) Section 1865(a)(1) of the Act provides that an entity accredited by a national accreditation body found by the Secretary to satisfy the Medicare conditions of participation, conditions for coverage, or conditions of certification or requirements for participation shall be treated as meeting those requirements. Section 1865(a)(2) of the Act requires the Secretary to consider when making such a finding, among other things, the national accreditation body's accreditation requirements and survey procedures.

(4) Section 1871 of the Act authorizes the Secretary to prescribe regulations for the administration of the Medicare program.

(b) Although section 1866 of the Act speaks only to providers and provider agreements, the effective date rules in this part are made applicable also to the approval of suppliers that meet the requirements specified in § 489.13.

(c) Section 1861(o)(7) of the Act requires each HHA to provide CMS with a surety bond.

23. Section 489.13 is revised to read as follows:

§ 489.13 Effective date of agreement or approval.

(a) *Applicability*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, this section applies to Medicare provider agreements with, and supplier approval of, entities that, as a basis for participation in Medicare are subject to a determination by CMS on the basis of—

(i) A survey conducted by the State survey agency or CMS staff surveyors; or

(ii) Accreditation by an accreditation organization whose program has CMS approval at the time of the accreditation survey and accreditation decision.

(2) *Exceptions.* (i) For an agreement with a community mental health center (CMHC) or a federally qualified health center (FQHC), the effective date is the date on which CMS accepts a signed agreement which assures that the CMHC or FQHC meets all Federal requirements.

(ii) A Medicare supplier approval of a laboratory is effective only while the laboratory has in effect a valid CLIA certificate issued under Part 493 of this chapter, and only for the specialty and subspecialty tests it is authorized to perform.

(b) *All health and safety standards are met on the date of survey.* The agreement or approval is effective on the date the State agency, CMS staff, or the CMS contractor survey (including the Life Safety Code survey, if applicable) is completed, or on the date of the accreditation decision, as applicable, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter. (If the agreement or approval is time-limited, the new agreement or approval is effective on the day following the expiration of the current agreement or approval.) However, the effective date of the agreement or approval may not be earlier than the latest of the dates on which CMS determines that each applicable Federal requirement is met. Federal requirements include, but are not limited to—

(1) Enrollment requirements established in Part 424, Subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met;

(2) The requirements identified in §§ 489.10 and 489.12; and

(3) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification.

(c) *All health and safety standards are not met on the date of survey.* If, on the date the survey is completed, the provider or supplier has failed to meet any one of the applicable health and safety standards, the following rules apply for determining the effective date of the provider agreement or supplier approval, assuming that no other Federal requirements remain to be satisfied. The effective date of the agreement or approval may not be earlier than the latest of the dates on which each applicable Federal requirement is met.

(1) For an agreement with an SNF, the effective date is the date on which—

(i) The SNF is in substantial compliance (as defined in § 488.301 of this chapter) with the requirements for participation; and

(ii) CMS or the State survey agency receives from the SNF, if applicable, an approvable waiver request.

(2) For an agreement with, or an approval of, any other provider or supplier, (except those specified in paragraph (a)(2) of this section), the effective date is the earlier of the following:

(i) The date on which the provider or supplier meets all applicable conditions of participation, conditions for coverage, or conditions for certification; or, if applicable, the date of a CMS-approved accreditation organization program's positive accreditation decision, issued after the accreditation organization has determined that the provider or supplier meets all applicable conditions.

(ii) The date on which a provider or supplier is found to meet all conditions of participation, conditions for coverage,

or conditions for certification, but has lower-level deficiencies, and—

(A) CMS or the State survey agency receives an acceptable plan of correction for the lower-level deficiencies (the date of receipt is the effective date regardless of when the plan of correction is approved); or, if applicable, a CMS-approved accreditation organization program issues a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies; or

(B) CMS receives an approvable waiver request (the date of receipt is the effective date regardless of when CMS approves the waiver request).

(C) For an agreement with any other provider or an approval of any other supplier (except those specified in paragraph (a)(2) of this section) that is found to meet all conditions of participation, conditions for coverage, or conditions for certification, but has lower-level deficiencies and has submitted both an approvable plan of correction/positive accreditation decision and an approvable waiver request, the effective date is the later of the dates that result when calculated in accordance with paragraph (c)(2)(ii)(A) or (c)(2)(ii)(B) of this section.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; Program No. 93.774, Medicare—Supplementary Medical Insurance Program; and Program No. 93.778, Medical Assistance)

Dated: April 6, 2010.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: April 16, 2010.

Kathleen Sebelius,

Secretary.

Editorial Note: The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amounts, Update Factors, and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning on or After October 1, 2010

I. Summary and Background

In this Addendum, we are setting forth a description of the methods and data we used to determine the proposed prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs for FY 2011 for acute care hospitals. We note that on March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111–148 was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public L. 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

We also are setting forth the proposed rate-of-increase percentages for updating the target amounts for certain hospitals excluded from the IPPS for FY 2011. We note that, because certain hospitals excluded from the IPPS are paid on a reasonable cost basis subject to a rate-of-increase ceiling (and not by the IPPS), these hospitals are not affected by the figures for the standardized amounts, offsets, and budget neutrality factors. Therefore, in this proposed rule, we are proposing to establish the rate-of-increase percentages for updating the target amounts for certain hospitals excluded from the IPPS that are effective for cost reporting periods beginning on or after October 1, 2010.

In addition, we are setting forth a description of the methods and data we used to determine the proposed standard Federal rate that will be applicable to Medicare LTCHs for FY 2011.

In general, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS is based on 100 percent of the Federal national rate, also known as the national adjusted standardized amount. This amount reflects the national average hospital cost per case from a base year, updated for inflation.

Currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on the FY 2006 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs historically have been paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever was higher. However, section 5003(a)(1) of Public Law 109–171 extended and modified the MDH special payment provision that was previously set to expire on October 1, 2006, to include discharges occurring on or after October 1, 2006, but before October 1, 2011. Under section 5003(b) of Public Law 109–171, if the change results in an increase to an MDH's target amount, we must rebase an MDH's hospital-specific rates based on its FY 2002 cost report. Section 5003(c) of Public Law 109–171 further required that MDHs be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate. Further, based on the provisions of section 5003(d) of Public Law 109–171, MDHs are no longer subject to the 12-percent cap on their DSH payment adjustment factor.

For hospitals located in Puerto Rico, the payment per discharge is based on the sum of 25 percent of an updated Puerto Rico-specific rate based on average costs per case of Puerto Rico hospitals for the base year and 75 percent of the Federal national rate. (We refer readers to section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for acute care hospitals for FY 2011. In section III. of this Addendum, we discuss our proposed policy changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2011. In section IV. of this Addendum, we are setting forth our proposed changes for determining the rate-of-increase limits for certain hospitals excluded from the IPPS for FY 2011. In section V. of this Addendum, we are proposing to make changes in the determination of the standard Federal rate for LTCHs under the LTCH PPS for FY 2011. The tables to which we refer in the preamble of this proposed rule are presented in section VI. of this Addendum.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for Acute Care Hospitals for FY 2011

The basic methodology for determining prospective payment rates for hospital inpatient operating costs for acute care hospitals for FY 2005 and subsequent fiscal years is set forth at § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico for FY 2005 and subsequent fiscal years is set forth at §§ 412.211 and 412.212. Below we discuss the factors used for determining the proposed prospective payment rates for FY 2011.

In summary, the proposed standardized amounts set forth in Tables 1A, 1B, and 1C of section VI. of this Addendum reflect—

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv)(II) of the Act, updated by the applicable percentage increase required under sections 1886(b)(3)(B)(i)(XX) and 1886(b)(3)(B)(viii) of the Act.
- The labor-related share that is applied to the standardized amounts and Puerto Rico-specific standardized amounts to give the hospital the highest payment, as provided for under sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act.
- Proposed updates of 2.4 percent for all areas (that is, the estimated full market basket percentage increase of 2.4 percent), as required by section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Public Law 109–171, and reflecting the requirements of section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Public Law 109–171, to reduce the applicable percentage increase by 2.0 percentage points for a hospital that fails to submit data, in a form and manner, and at the time specified by the Secretary, relating to the quality of inpatient care furnished by the hospital.
- A proposed update of 2.4 percent to the Puerto Rico-specific standardized amount (that is, the full estimated rate-of-increase in the hospital market basket for IPPS hospitals), as provided for under § 412.211(c), which states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1), or the percentage increase in the market basket index for prospective payment hospitals for all areas.
- An adjustment to the standardized amount to ensure budget neutrality for DRG recalibration and reclassification, as provided for under section 1886(d)(4)(C)(iii) of the Act.
- An adjustment to ensure the wage index changes are budget neutral, as provided for under section 1886(d)(3)(E)(i) of the Act. We note that section 1886(d)(3)(E)(i) of the Act requires that we do not consider the labor-related share of 62 percent to compute wage index budget neutrality.
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2010 budget neutrality factor and applying a revised factor.
- An adjustment to remove the FY 2010 outlier offset and apply an offset for FY 2011, as provided for in section 1886(d)(3)(B) of the Act.
- As discussed below and in section II.D. of the preamble to this proposed rule, an adjustment to meet the requirements of section 7(b)(1)(B) of Public Law 110–90 to adjust the standardized amounts to offset the estimated amount of the increase in aggregate payments (including interest) due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 and FY 2009.

For FY 2011 (in the absence of the provisions of Public Law 111–148 as amended by Pub. L. 111–152), the requirement under section 410A of Public Law 108–173 to conduct a rural community hospital demonstration program and under section 410A(c)(2) of Public Law 108–173 to adjust the standardized amount to ensure the effects of the rural community hospital demonstration are budget neutral has expired. Therefore, for this proposed rule, there is no adjustment applied to the standardized amount to ensure the effects of the rural community hospital demonstration are budget neutral.

We note that, beginning in FY 2008, we applied the budget neutrality adjustment for the rural floor to the hospital wage indices rather than the standardized amount. As we did for FY 2010, for FY 2011, we are proposing to continue to apply the rural floor budget neutrality adjustment to hospital wage indices rather than the standardized amount. In addition, instead of applying the budget neutrality adjustment for the imputed floor adopted under section 1886(d)(3)(E) of the Act to the standardized amount, for FY 2011, we are proposing to continue to apply the imputed floor budget neutrality adjustment to the wage indices. Consistent with the policy we established in the FY 2009 IPPS final rule (in absence of the provisions of Pub. L. 111–148, as amended by Pub. L. 111–152), we also are proposing to continue to apply the budget neutrality adjustments for the rural floor and imputed rural floor at the State level rather than the national level. For a complete discussion of the budget neutrality changes concerning the rural floor and the imputed floor, including the within-State budget neutrality adjustment, we refer readers to section III.B.2. of the preamble of the FY 2009 IPPS final rule and this proposed rule.

A. Calculation of the Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

In general, the national standardized amount is based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. For Puerto Rico hospitals, the Puerto Rico-specific standardized amount is based on per discharge averages of adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d)(9) of the Act. The September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established for urban and rural hospitals in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043 and 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and 1886(d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, IME costs, and costs to hospitals serving a disproportionate share of low-income patients.

In accordance with section 1886(d)(3)(E) of the Act, the Secretary estimates, from time-to-time, the proportion of hospitals' costs that are attributable to wages and wage-related costs. In general, the standardized

amount is divided into labor-related and nonlabor-related amounts; only the proportion considered to be the labor-related amount is adjusted by the wage index. Section 1886(d)(3)(E) of the Act requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made. (Section 1886(d)(9)(C)(iv)(II) of the Act extends this provision to the labor-related share for hospitals located in Puerto Rico.)

For FY 2011, we are proposing to continue to use a labor-related share of 68.8 percent for discharges occurring on or after October 1, 2010 for the national standardized amounts and 62.1 percent for the Puerto Rico-specific standardized amount. Consistent with section 1886(d)(3)(E) of the Act, we are applying the wage index to a labor-related share of 62 percent for all IPPS hospitals whose wage index values are less than or equal to 1.0000. For all IPPS hospitals whose wage indices are greater than 1.0000, we are applying the wage index to a labor-related share of 68.8 percent of the national standardized amount. For FY 2011, all Puerto Rico hospitals have a wage index less than 1.0. Therefore, the national labor-related share will always be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0.

For hospitals located in Puerto Rico, we are applying a labor-related share of 62.1 percent if its Puerto Rico-specific wage index is greater than 1.0000. For hospitals located in Puerto Rico whose Puerto-Rico specific wage index values are less than or equal to 1.0000, we are applying a labor share of 62 percent.

The proposed standardized amounts for operating costs appear in Table 1A, 1B, and 1C of the Addendum to this proposed rule.

2. Computing the Average Standardized Amount

Section 1886(d)(3)(A)(iv)(II) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Section 1886(d)(9)(A)(ii)(II) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we are proposing to calculate the FY 2011 national and Puerto Rico standardized amounts irrespective of whether a hospital is located in an urban or rural location.

3. Updating the Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv)(II) of the Act, we are proposing to update the equalized standardized amount for FY 2011 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Public Law 109–171. The percentage increase in the market basket reflects the average change in the price of goods and services comprising routine, ancillary, and special care unit hospital inpatient services. The most recent forecast of the hospital market basket increase for FY 2011 is 2.4 percent. Thus, for FY 2011, the proposed update to the average standardized amount is 2.4 percent for hospitals in all areas. The estimated market basket increase of 2.4 percent is based on IHS Global Insight, Inc.'s 2010 first quarter forecast of the hospital market basket increase (as discussed in Appendix B of this proposed rule).

Section 1886(b)(3)(B) of the Act specifies the mechanism to be used to update the standardized amount for payment for inpatient hospital operating costs. Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Public Law 109–171, provides for a reduction of 2.0 percentage points from the update percentage increase (also known as the market basket update) for FY 2007 and each subsequent fiscal year for any "subsection (d) hospital" that does not submit quality data, as discussed in section V.A. of the preamble of this final rule. The proposed standardized amounts in Tables 1A through 1C of section VI. of this Addendum reflect these differential amounts.

Section 412.211(c) states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1), or the percentage increase in the market basket index for prospective payment hospitals for all areas. We are proposing to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the proposed update to the Puerto Rico-specific standardized amount is 2.4 percent.

Although the update factors for FY 2011 are set by law, we are required by section 1886(e)(4) of the Act to recommend, taking into account MedPAC's recommendations, appropriate update factors for FY 2011 for both IPPS hospitals and hospitals and hospital units excluded from the IPPS. Section 1886(e)(5)(A) of the Act requires that we publish our proposed recommendations in the **Federal Register** for public comment. Our recommendation on the update factors is set forth in Appendix B of this proposed rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are proposing to adjust the FY 2011 standardized amount to remove the effects of the FY 2010 geographic reclassifications and outlier payments before applying the FY 2011 updates. We then apply budget neutrality offsets for outliers and geographic reclassifications to the standardized amount based on FY 2011 payment policies.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, estimated aggregate payments after updates in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year's adjustment, we would not satisfy these conditions.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (for example, changes to DRG classifications, recalibration of the DRG relative weights, updates to the wage index, and different geographic reclassifications). We include outlier payments in the simulations because they may be affected by changes in these parameters.

Similar to last year, because IME Medicare Advantage payments are made to IPPS hospitals under section 1886(d) of the Act, we believe these payments must be part of these budget neutrality calculations. However, we note that it is not necessary to include Medicare Advantage IME payments in the outlier threshold calculation or the outlier offset to the standardized amount because the statute requires that outlier payments be not less than 5 percent nor more than 6 percent of total "operating DRG payments," which does not include IME and DSH payments. In order to account for these Medicare Advantage IME payments in determining the budget neutrality adjustments for this proposed rule, we identified Medicare Advantage claims from IPPS teaching hospitals in the MedPAR data. The GHO Paid indicator with a value of "1" on the MedPAR file indicates that the claim was paid by a Medicare Advantage plan

(other than the IPPS IME payment specified at § 412.105(g)). For these Medicare Advantage claims from IPPS teaching hospitals, we computed a transfer-adjusted CMI by provider based on the FY 2009 MS–DRG GROUPER Version 27.0 assignment and relative weights. We also computed a transfer-adjusted CMI for these Medicare Advantage claims from IPPS teaching hospitals based on the FY 2010 MS–DRG GROUPER Version 28.0 assignments and relative weights. These transfer-adjusted CMIs (and corresponding case counts) were used to calculate an IME teaching add-on payment in accordance with § 412.105(g). The total Medicare Advantage IME payment amount was then added to the total Federal payment amount for each provider (where applicable) in order to account for the Medicare Advantage IME payment in determining the budget neutrality adjustments. We note that we did not include Medicare Advantage IME claims when estimating outlier payments for providers because Medicare Advantage claims are not eligible for outlier payments under the IPPS.

a. Proposed Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble of this proposed rule, we normalized the recalibrated DRG weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E)(i) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. Section 1886(d)(3)(E)(i) of the Act requires that we implement the wage index adjustment in a budget neutral manner. However, section 1886(d)(3)(E)(ii) of the Act sets the labor-related share at 62 percent for hospitals with a wage index less than or equal to 1.0, and section 1886(d)(3)(E)(i) of the Act provides that the Secretary shall calculate the budget neutrality adjustment for the adjustments or updates made under that provision as if section 1886(d)(3)(E)(ii) of the Act had not been enacted. In other words, this section of the statute requires that we implement the updates to the wage index in a budget neutral manner, but that our budget neutrality adjustment should not take into account the requirement that we set the labor-related share for hospitals with indices less than or equal to 1.0 at the more advantageous level of 62 percent. Therefore, for purposes of this budget neutrality adjustment, section 1886(d)(3)(E)(i) of the Act prohibits us from taking into account the fact that hospitals with a wage index less than or equal to 1.0 are paid using a labor-related share of 62 percent. Consistent with current policy, for FY 2011, we are proposing to adjust 100 percent of the wage index factor for occupational mix. We describe the proposed occupational mix adjustment in section III.D. of the preamble of this proposed rule.

For FY 2011, to comply with the requirement that DRG reclassification and recalibration of the relative weights be budget neutral for the Puerto Rico standardized amount and the hospital-specific rates, we used FY 2009 discharge data to simulate payments and compared aggregate payments using the FY 2010 labor-related share percentages, the FY 2010 relative weights, and the FY 2010 pre-reclassified wage data to aggregate payments using the FY 2010 labor-related share percentages, the proposed FY 2011 relative weights, and the FY 2010 pre-reclassified wage data. Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 0.996963. As discussed in section IV. of this Addendum, we would also apply the proposed DRG reclassification and recalibration budget neutrality factor of 0.996856 to the hospital-specific rates that are to be effective for cost reporting periods beginning on or after October 1, 2010.

In order to meet the statutory requirements that we do not take into account the labor-related share of 62 percent when computing wage index budget, it was necessary to use a three-step process to comply with the requirements that DRG reclassification and recalibration of the relative weights and the updated wage index and labor-related share have no effect on aggregate payments for IPPS hospitals. We first determined a proposed DRG reclassification and recalibration budget neutrality factor of 0.996856 by using the same methodology described above to determine the proposed DRG reclassification and recalibration budget neutrality factor for the Puerto Rico standardized amount and hospital-specific rates. Secondly, to compute a budget neutrality factor for wage index and labor-related share changes, we used FY 2009 discharge data to simulate payments and compared aggregate payments using proposed FY 2011 relative weights and FY 2010 pre-reclassified wage indices, and applied the FY 2010 labor-related share of 68.8 percent to all hospitals (regardless of whether the hospital's wage index was above or below 1.0) to aggregate payments using the proposed FY 2011 relative weights and the proposed FY 2011 pre-reclassified wage indices, and applied the labor-related share for FY 2011 of 68.8 percent to all hospitals (regardless of whether the hospital's wage index was above or below 1.0). In addition, we applied the proposed DRG reclassification and recalibration budget neutrality factor (derived in the first step) to the rates that were used to simulate payments for this comparison of aggregate payments from FY 2010 to FY 2011. By applying this methodology, we determined a proposed budget neutrality factor of 1.000107 for changes to the wage index. Finally, we multiplied the proposed DRG reclassification and recalibration budget neutrality factor of 0.996856 (derived in the first step) by the proposed budget neutrality factor of 1.000107 for changes to the wage index (derived in the second step) to determine the proposed DRG reclassification and recalibration and updated wage index budget neutrality factor of 0.996963.

b. Reclassified Hospitals—Proposed Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of

sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. We note that the wage index adjustments provided under section 1886(d)(13) of the Act are not budget neutral. Section 1886(d)(13)(H) of the Act provides that any increase in a wage index under section 1886(d)(13) shall not be taken into account "in applying any budget neutrality adjustment with respect to such index" under section 1886(d)(8)(D) of the Act. To calculate the proposed budget neutrality factor for FY 2011, we used FY 2009 discharge data to simulate payments and compared total IPPS payments with proposed FY 2011 relative weights, FY 2011 labor share percentages, and proposed FY 2011 wage data prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments with proposed FY 2011 relative weights, FY 2011 labor share percentages, and proposed FY 2011 wage data after such reclassifications. Based on these simulations, we calculated a proposed adjustment factor of 0.991756 to ensure that the effects of these provisions are budget neutral, consistent with the statute.

The proposed FY 2011 budget neutrality adjustment factor is applied to the standardized amount after removing the effects of the FY 2010 budget neutrality adjustment factor. We note that the proposed FY 2011 budget neutrality adjustment reflects proposed FY 2011 wage index reclassifications approved by the MGCRB or the Administrator. Furthermore, for this proposed rule, we note that the proposed FY 2011 wage index reclassifications approved by the MGCRB or the Administrator are in the absence of the provisions of Public Law 111–148, as amended by Public Law 111–152.

c. Proposed Rural Floor and Imputed Floor Budget Neutrality Adjustment

CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the BBA (Pub. L. 105–33) and the imputed floor under § 412.64(h)(4) of the regulations are made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section III.B. of the preamble of the FY 2009 IPPS final rule (73 FR 48570 through 48574), we adopted as final State-level budget neutrality for the rural and imputed floors, effective beginning with the FY 2009 wage index. In response to the public's concerns and taking into account the potentially significant payment cuts that could occur to hospitals in some States if we implemented this change with no transition, we decided to phase in, over a 3-year period, the transition from the national rural floor budget neutrality adjustment on the wage index to the State-level rural floor budget neutrality adjustment on the wage index. In FY 2009, hospitals received a blended wage index that was comprised of 20 percent of the wage index adjusted by applying the State-level rural and imputed floor budget neutrality adjustment and 80 percent of the wage index adjusted by applying the national budget neutrality adjustment. For FY 2010, the blended wage index was determined by adding 50 percent of the wage index adjusted by applying the State-level rural and imputed floor budget neutrality adjustment and 50 percent of the wage index adjusted by applying the national budget neutrality adjustment. In FY 2011 (in the absence of provisions of Pub. L. 111–148, as amended by Public Law 111–152), the proposed adjustment will be completely transitioned to the State-level methodology, such that the wage index will be determined by applying 100 percent of the State-level budget neutrality adjustment. As stated earlier, we note that the rural floor budget neutrality adjustment is applied to the wage index and not the standardized amount. However, because the 100 percent State-level rural and imputed floor budget neutrality adjustment is used in calculating the proposed FY 2011 outlier threshold (as discussed below), we are explaining our calculation of the proposed rural floor budget neutrality adjustments (in this section) below.

In order to compute a budget neutral wage index that is 100 percent of the wage index adjusted by the State-level rural and imputed floor budget neutrality adjustment, we used FY 2009 discharge data with proposed FY 2011 relative weights, proposed FY 2011 labor share percentages, and proposed FY 2011 post reclassified wage indices to simulate IPPS payments. To determine each State's rural or imputed floor budget neutrality adjustment, we compared each State's total simulated payments with and without the rural or imputed floor applied. These State-level rural and imputed floor budget neutrality factors were then applied to the wage indices to produce a State-level rural and imputed floor budget neutral wage index, which was used in determining the FY 2011 wage indices.

d. Proposed Case-Mix Budget Neutrality Adjustment

(1) Adjustment to the FY 2011 IPPS Standardized Amount

As stated earlier, beginning in FY 2008, we adopted the MS–DRG patient classification system for the IPPS to better recognize patients' severity of illness in Medicare payment rates. In the FY 2008 IPPS final rule with comment period (73 FR 47175 through 47186), we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for changes in documentation and coding. In that final rule, using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to maintain budget neutrality by adjusting the national standardized amounts to eliminate the effect of changes in documentation and coding that do not reflect real change in case-mix, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 (for a total adjustment of −4.8 percent). On September 29, 2007, Public Law 110–90 was enacted. Section 7 of Public Law 110–90 included a provision that reduces the documentation and coding adjustment for the MS–DRG system that we adopted in the FY 2008 IPPS final rule with comment period to −0.6 percent for FY 2008 and −0.9 percent for FY 2009. To comply with the provision of section 7(a) of Public Law 110–90, in a final rule that appeared in the **Federal Register** on November 27, 2007 (72 FR 66886), we changed the IPPS documentation and coding adjustment for FY 2008 to −0.6 percent, and revised the FY 2008 national standardized amounts (as well as other payment factors and thresholds) accordingly, with these revisions being effective as of October 1, 2007. For FY 2009, section 7(a) of Public Law 110–90 required a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment specified in the FY 2008 IPPS final rule with comment period. As required by statute, we applied a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amounts. The documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period are cumulative. As a result, the −0.9 percent documentation and coding adjustment in FY 2009 was in addition to the −0.6 percent adjustment

in FY 2008, yielding a combined effect of −1.5 percent.

In the FY 2010 IPPS proposed and final rules, we discussed our analysis of FY 2008 claims data which showed an increase in case-mix of 2.5 percent due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008. For FY 2010, we proposed to reduce the average standardized amounts under section 1886(d) of the Act in FY 2010 by −1.9 percent, which represents the difference between changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008 and the prospective adjustment applied under Public Law 110–90. As discussed in section II.D. of the preamble of the FY 2010 IPPS final rule, after consideration of the public comments we received on our analysis and proposals presented in the proposed rule, we decided to postpone adopting documentation and coding adjustments as authorized under section 7(a) of Public Law 110–90 and section 1886(d)(3)(A)(vi) of the Act until a full analysis of FY 2009 case-mix changes could be completed. Accordingly, in the FY 2010 IPPS final rule, for FY 2010, we did not apply any additional documentation and coding adjustments to the average standardized amounts under section 1886(d) of the Act.

As indicated in section II.D.in the preamble to this proposed rule, the change due to documentation and coding that did not reflect real changes in case mix for discharges occurring during FY 2008 and FY 2009 exceeded the −0.6 and −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 for those 2 years respectively by 1.9 percentage points in FY 2008 and 3.9 percentage points in FY 2009. In total, this change exceeded the cumulative prospective adjustments by 5.8 percentage points. Our actuaries currently estimate that this 5.8 percentage point increase resulted in an increase in aggregate payments of approximately $6.9 billion. Therefore, an aggregate adjustment of −5.8 percent in FYs 2011 and 2012, subject to actuarial adjustment to reflect accumulated interest, is necessary in order to meet the requirements of section 7(b)(1)(B) of Public Law 110–90 to adjust the standardized amounts for discharges occurring in FYs 2010, 2011, and/or 2012 to offset the estimated amount of the cumulative increase in aggregate payments (including interest) in FYs 2008 and 2009. We refer the reader to section II.D. of the preamble to this proposed rule for more discussion.

It is often our practice to phase in rate adjustments over more than one year in order to moderate the effect on rates in any one year. Therefore, we are proposing to make an adjustment to the standardized amount of −2.9 percent, representing half of the aggregate adjustment required under section 7(b)(1)(B) of Public Law 110–90, for FY 2011. As we have previously noted, unlike the prospective adjustment to the standardized amounts under section 7(b)(1)(A) of Public Law 110–90 described earlier, the recoupment or repayment adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90 is not cumulative, but would be removed for subsequent fiscal years once we have offset the increase in aggregate payments for discharges for FY 2008 expenditures and FY 2009 expenditures. We note that we are not making a formal proposal for the further implementation of section 7(b)(1)(B) of Public Law 110–90 in FY 2012 in this proposed rule.

(2) Proposed Adjustment to the FY 2011 Hospital-Specific Rates for SCHs and MDHs

As discussed in section II.D. of the preamble of this proposed rule, because hospitals (SCHs and MDHs) paid based in whole or in part on the hospital-specific rate use the same MS–DRG system as other hospitals, we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Under section 1886(d)(3)(A)(vi) of the Act, Congress stipulated that hospitals paid based on the standardized amount should not receive additional payments based on the effect of documentation and coding changes that do not reflect real changes in case-mix. Similarly, we believe that hospitals paid based on the hospital-specific rate should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. While we continue to believe that section 1886(d)(3)(A)(vi) of the Act does not provide explicit authority for application of the documentation and coding adjustment to the hospital-specific rates, we believe that we have the authority to apply the documentation and coding adjustment to the hospital-specific rates using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act.

As discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, based on our analysis of FY 2008 claims data, we found that, independently for both SCHs and MDHs, the change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 slightly exceeded the 2.5 percent result discussed earlier, but did not significantly differ from that result.

Therefore, in FY 2010, we proposed to use our authority under section 1886(d)(5)(I)(i) of the Act to prospectively adjust the hospital-specific rates by −2.5 percent in FY 2011 for our estimated documentation and coding effect in FY 2008 that does not reflect real changes in case-mix. We also noted that, unlike the national standardized rates, the FY 2010 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs.

Consistent with our approach for determining the national average standardized amounts discussed earlier, after consideration of the public comments we received on our analysis and proposals presented in the FY 2010 IPPS proposed rule, for FY 2010, we also postponed adoption of a documentation and coding adjustment to the hospital-specific rate until a full analysis of FY 2009 case-mix changes could be completed. Accordingly, for FY 2010, we did not apply a documentation and coding adjustment to the hospital-specific rates.

As we discuss in section II.D. of the preamble of this proposed rule, because SCHs and MDHs use the same DRG system as all other hospitals, we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Therefore, we believe they should be equally subject to a prospective budget neutrality adjustment that we are applying for adoption of the MS–DRGs to all other hospitals. While the findings of the effects documentation and coding are different for SCHs/MDHs and other IPPS hospitals, we continue to believe that the documentation and coding adjustments for all subsection (d) hospitals should be the same. We continue to believe that this is the appropriate policy so as to neither advantage nor disadvantage different types of providers.

As we have also discussed in section II.D. of the preamble to this proposed rule, our best estimate, based on the most recently available data, is that a cumulative adjustment of −5.4 percent

is required to eliminate the full effect of the documentation and coding changes on future payments. Unlike the case of standardized amounts paid to IPPS hospitals, we have not made any previous adjustments to the hospital specific rates paid to SCHs and MDHs to account for documentation and coding changes. Therefore, the entire −5.4 percent adjustment remains to be implemented. Therefore, in order to maintain consistency as far as possible with the adjustments applied to IPPS hospitals, we are proposing an adjustment of −2.9 percent in FY 2011 to the hospital-specific rates paid to SCHs and MDHs. We believe that this proposed adjustment is the most appropriate means to take into full account the effect of documentation and coding changes on payments, and to maintain equity between hospitals paid on the basis of different prospective rates.

(3) Proposed Adjustment to the FY 2011 Puerto Rico Standardized Amount

As stated in section II.D. of the preamble of this proposed rule, we believe that we have the authority to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. Similar to SCHs and MDHs that are paid based on the hospital-specific rate, we believe that Puerto Rico hospitals that are paid based on the Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. In the FY 2010 IPPS proposed rule, we discussed our analysis of FY 2008 claims data for Puerto Rico hospitals, which showed that, for Puerto Rico hospitals, the increase in payments for discharges occurring during FY 2008 due to documentation and coding changes that did not reflect real changes in case-mix for discharges occurring during FY 2008 was approximately 1.1 percent. We noted that, unlike the national standardized rates, the FY 2009 Puerto Rico-specific standardized amount was not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs. Therefore, for FY 2010, we proposed to use our authority under section 1886(d)(5)(I)(i) of the Act to adjust the Puerto Rico-specific standardized amount by −1.1 percent in FY 2010 to account for the FY 2008 documentation and coding changes that are not due to changes in real case-mix and to leave that adjustment in place for subsequent fiscal years.

Consistent with our approach for determining the national average standardized amounts and hospital-specific rates of SCHs and MDHs discussed above, after consideration of the public comments we received on our analysis and proposals presented in the FY 2010 IPPS proposed rule, for FY 2010, we also postponed adoption of a documentation and coding adjustment to the Puerto Rico-specific rates until a full analysis of FY 2009 case-mix changes can be completed. Accordingly, in the FY 2010 IPPS final rule, for FY 2010, we did not apply a documentation and coding adjustment to the Puerto Rico-specific rates.

As we have noted above, similar to SCHs and MDHs, hospitals in Puerto Rico use the same DRG system as all other hospitals and we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Therefore, we believe they should be equally subject to a prospective budget neutrality adjustment that we are applying for adoption of the MS–DRGs to all other hospitals.

As we have discussed in section II.D. of the preamble of this proposed rule, our best estimate, based on the most recently available data, is that a cumulative adjustment of −2.4 percent is required to eliminate the full effect of the documentation and coding changes on future payments from the Puerto Rico-specific rate. Unlike the case of standardized amounts paid to IPPS hospitals, we have not made any previous adjustments to the hospital-specific rates paid to Puerto Rico hospitals to account for documentation and coding changes. Therefore, the entire −2.4 percent adjustment remains to be implemented. In order to maintain consistency as far as possible with the adjustments applied to IPPS hospitals but to take into consideration the fact that the cumulative impact was smaller in Puerto Rico hospitals, we are therefore proposing an adjustment of −2.4 percent in FY 2011 to Puerto Rico-specific rate that accounts for 25 percent of payments to Puerto Rico hospitals, with the remaining 75 percent based on the national standardized amount, which are proposing to adjust as described above. Consequently, the overall reduction to rates for Puerto Rico hospitals to account for the documentation and coding changes will be slightly less than the reduction for IPPS hospitals based on 100 percent of the national standardized amount. We note that this proposed −2.4 percent prospective adjustment would eliminate the full effect of the documentation and coding changes on future payments from the Puerto Rico-specific rate. We believe that this proposed adjustment is the most appropriate means to take into full account the effect of documentation and coding changes on payments, and to maintain equity between hospitals paid on the basis of different prospective rates.

e. Proposed Outlier Payments

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for "outlier" cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the "outlier threshold" or "fixed-loss" amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). We refer to the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the outlier threshold as the outlier "fixed-loss cost threshold." To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to estimated costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the estimated costs above the fixed-loss cost threshold. The marginal cost factor for FY 2011 is 80 percent, the same marginal cost factor we have used since FY 1995 (59 FR 45367).

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. We note that the statute requires outlier payments to be not less than 5 percent nor more than 6 percent of total "operating DRG payments" (which does not include IME and DSH payments) plus outlier payments. When setting the outlier threshold, we compute the 5.1 percent target by dividing the total operating outlier payments by the total operating DRG payments plus outlier payments. We do not include any other payments such as IME and DSH within the outlier target amount. Therefore, it is not necessary to include Medicare Advantage IME payments in the outlier threshold calculation. Section

1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amount applicable to hospitals located in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage.*

(1) Proposed FY 2011 Outlier Fixed-Loss Cost Threshold

For FY 2011, we are proposing to continue to use the same methodology used for FY 2009 (73 FR 48763 through 48766) to calculate the outlier threshold. Similar to the methodology used in the FY 2009 IPPS final rule, for FY 2011, we are proposing to apply an adjustment factor to the CCRs to account for cost and charge inflation (as explained below). As we have done in the past, to calculate the proposed FY 2011 outlier threshold, we simulated payments by applying the proposed FY 2011 rates and policies using cases from the FY 2009 MedPAR files. Therefore, in order to determine the proposed FY 2011 outlier threshold, we inflated the charges on the MedPAR claims by 2 years, from FY 2009 to FY 2011.

We are proposing to continue to use a refined methodology that takes into account the lower inflation in hospital charges that are occurring as a result of the outlier final rule (68 FR 34494), which changed our methodology for determining outlier payments by implementing the use of more current CCRs. Our refined methodology uses more recent data that reflect the rate-of-change in hospital charges under the new outlier policy.

Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 2008 in combination with the first quarter of FY 2008 (July 1, 2008 through December 31, 2008) to the last quarter of FY 2009 in combination with the first quarter of FY 2010 (July 1, 2009 through December 31, 2009). This rate of change was 5.16 percent (1.0516) or 10.59 percent (1.1059) over 2 years.

As we have done in the past, we established the proposed FY 2011 outlier threshold using hospital CCRs from the December 2009 update to the Provider-Specific File (PSF)—the most recent available data at the time of this proposed rule. This file includes CCRs that reflect implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

As discussed in the FY 2007 IPPS final rule (71 FR 48150), we worked with the Office of Actuary to derive the methodology described below to develop the CCR adjustment factor. For FY 2011, we are proposing to continue to use the same methodology to calculate the CCR adjustment by using the FY 2009 operating cost per discharge increase in combination with the actual FY 2009 operating market basket percentage increase determined by IHS Global Insight, Inc., as well as the charge inflation factor described above to estimate the adjustment to the CCRs. (We note that the FY 2009 actual (otherwise referred to as "final") operating market basket percentage increase reflects historical data, whereas the published FY 2009 operating market basket update factor was based on IHS Global Insight, Inc.'s 2008 second quarter forecast with historical data through the first quarter of 2008. We also note that while the FY 2009 published operating market basket update was based on the FY 2002-based IPPS market basket, the actual or "final" market basket percentage increase is based on the FY 2006-based IPPS market basket. Similarly, the FY 2009 published capital market basket upate factor was based on the FY 2002-based capital market basket and the actual or "final" capital market basket percentage increase is based on the FY 2006-based capital market basket.) By using the operating market basket percentage increase and the increase in the average cost per discharge from hospital cost reports, we are using two different measures of cost inflation. For FY 2011, we determined the adjustment by taking the percentage increase in the operating costs per discharge from FY 2007 to FY 2008 (1.0513) from the cost report and dividing it by the final operating market basket percentage increase from FY 2008 (1.04). This operation removes the measure of pure price increase (the market basket) from the percentage increase in operating cost per discharge, leaving the nonprice factors in the cost increase (for example, quantity and changes in the mix of goods and services). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the operating market basket percentage increase and the increase in cost per case from the cost report (the FY 2005 to FY 2006 percentage increase of operating costs per discharge of 1.0577 divided by the FY 2006 final operating market basket percentage increase of 1.04, the FY 2006 to FY 2007 percentage increase of operating costs per discharge of 1.0466 divided by FY 2007 final operating market basket percentage increase of 1.0360). For FY 2011, we averaged the differentials calculated for FY 2006, FY 2007, and FY 2008, which resulted in a mean ratio of 1.0127. We multiplied the 3-year average of 1.0127 by the FY 2009 final operating market basket percentage increase of 1.027, which resulted in an operating cost inflation factor of 4.00 percent or 1.0400. We then divided the operating cost inflation factor by the 1-year average change in charges (1.0515) and applied an adjustment factor of 0.989016 to the operating CCRs from the PSF (calculation performed on unrounded numbers).

As stated in the FY 2009 IPPS final rule (73 FR 48763), we continue to believe it is appropriate to apply only a 1-year adjustment factor to the CCRs. On average, it takes approximately 9 months for a fiscal intermediary or MAC to tentatively settle a cost report from the fiscal year end of a hospital's cost reporting period. The average "age" of hospitals' CCRs from the time the fiscal intermediary or the MAC inserts the CCR in the PSF until the beginning of FY 2009 is approximately 1 year. Therefore, as stated above, we believe a 1-year adjustment factor to the CCRs is appropriate.

We used the same methodology for the capital CCRs and determined the adjustment by taking the percentage increase in the capital costs per discharge from FY 2007 to FY 2008 (1.0800) from the cost report and dividing it by the final capital market basket percentage increase from FY 2008 (1.015). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the capital market basket percentage increase and the increase in cost per case from the cost report (the FY 2005 to FY 2006 percentage increase of capital costs per discharge of 1.0464 divided by the FY 2006 final capital market basket percentage increase of 1.011, the FY 2006 to FY 2007 percentage increase of capital costs per discharge of 1.0512 divided by the FY 2007 final capital market basket percentage increase of 1.012). For FY 2011, we averaged the differentials calculated for FY 2006, FY 2007, and FY 2008, which resulted in a mean ratio of 1.0459. We multiplied the 3-year average of 1.0459 by the FY 2009 final capital market basket percentage increase of 1.014, which resulted in a

capital cost inflation factor of 6.06 percent or 1.0606. We then divided the capital cost inflation factor by the 1-year average change in charges (1.0516) and applied an adjustment factor of 1.008534 to the capital CCRs from the PSF (calculation performed on unrounded numbers). We are proposing to use the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges. Therefore, we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

As stated above, for FY 2011, we applied the proposed FY 2011 rates and policies using cases from the FY 2009 MedPAR files in calculating the proposed outlier threshold. In FY 2010, for purposes of estimating the proposed outlier threshold, we took into account the remaining projected case-mix growth when calculating the outlier threshold that results in outlier payments being 5.1 percent of total payments for FY 2010. As explained in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44008), for the FY 2010 analysis, we inflated the FY 2008 claims data by an additional 1.6 percent for the additional case-mix growth projected to have occurred since FY 2008. If we did not take into account the remaining 1.6 percent projected case-mix growth, our estimate of total FY 2010 payments would have been too low, and, as a result, the FY 2010 final outlier threshold would have been too high, such that estimated outlier payments would be less than our projected 5.1 percent of total payments. For this proposed rule, we are using the FY 2009 claims data to calculate the FY 2011 proposed outlier threshold. Our estimate of the cumulative effect of changes in documentation and coding due to the adoption of the MS–DRGs through FY 2009 is 5.4 percent, which is already included within the claims data (FY 2009 MedPAR files) used to calculate the proposed FY 2011 outlier threshold. Furthermore, we currently estimate that there will be no continued changes in documentation and coding in FYs 2010 and 2011. Therefore, the cumulative effect of documentation and coding that has occurred is already reflected within the FY 2009 MedPAR claims data, and we do not believe there is any need to inflate FY 2009 claims data for any additional case-mix growth projected to have occurred since FY 2009.

Using this methodology, we are proposing an outlier fixed-loss cost threshold for FY 2011 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $23,970.

As we did in establishing the FY 2009 outlier threshold (73 FR 57891), in our projection of FY 2011 outlier payments, we are not proposing to make any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We continue to believe that, due to the policy implemented in the June 9, 2003 outlier final rule (68 FR 34494), CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict the specific hospitals that will have CCRs and outlier payments reconciled in any given year. We also noted that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different than the interim CCRs used to calculate outlier payments when a bill is processed. Our simulations assume that CCRs accurately measure hospital costs based on information available to us at the time we set the outlier threshold. For these reasons, we are proposing not to make any assumptions about the effects of reconciliation on the outlier threshold calculation.

(2) Other Proposed Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2011 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.8 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are proposing to reduce the FY 2011 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The outlier adjustment factors that would be applied to the standardized amount for the proposed FY 2011 outlier threshold are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948999	0.942415
Puerto Rico	0.951686	0.924977

We are proposing to apply the outlier adjustment factors to the proposed FY 2011 rates after removing the effects of the FY 2010 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

Under our current policy at § 412.84, for hospitals for which the fiscal intermediary or MAC computes operating CCRs greater than 1.176 or capital CCRs greater than 0.154, or hospitals for whom the fiscal intermediary or MAC is unable to calculate a CCR (as described at § 412.84(i)(3) of our regulations), we still use statewide average CCRs to determine whether a hospital qualifies for outlier payments.[15] Table 8A in this Addendum contains the proposed statewide average operating CCRs for urban hospitals and for rural hospitals for which the fiscal intermediary or MAC is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2010, these statewide average ratios would replace the ratios published in the IPPS final rule for FY 2010 (74 FR 44159). Table 8B in this Addendum contains the proposed comparable statewide average capital CCRs. Again, the proposed CCRs in Tables 8A and 8B would be used during FY 2011 when hospital-specific CCRs based on the latest settled cost report are either not available or are outside the range noted above. Table 8C contains the proposed statewide average total

[15] These figures represent 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals.

CCRs used under the LTCH PPS as discussed in section V. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating and/or capital CCRs to work with their fiscal intermediary or MAC on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the fiscal intermediary or MAC can avoid possible overpayments or underpayments at cost report settlement, thus ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note that a hospital may request an alternative operating or capital CCR ratio at any time as long as the guidelines of Change Request 3966 are followed. To download and view the manual instructions on outlier and CCRs, we refer readers to CMS Web site: *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf*.

(3) FY 2009 and FY 2010 Outlier Payments

In the FY 2010 IPPS final rule (74 FR 44012), we stated that, based on available data, we estimated that actual FY 2009 outlier payments would be approximately 5.4 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2008 MedPAR file (discharge data for FY 2008 claims). That is, the estimate of actual outlier payments did not reflect actual FY 2009 claims, but instead reflected the application of FY 2009 rates and policies to available FY 2008 claims.

Our current estimate, using available FY 2009 claims data, is that actual outlier payments for FY 2009 were approximately 5.3 percent of actual total DRG payments. Thus, the data indicate that, for FY 2009, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2009. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2009 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2010 will be approximately 4.7 percent of actual total DRG payments, approximately 0.4 percentage points lower than the 5.1 percent we projected in setting the outlier policies for FY 2010. This estimate is based on simulations using the FY 2009 MedPAR file (discharge data for FY 2009 claims). We used these data to calculate an estimate of the actual outlier percentage for FY 2010 by applying FY 2010 rates and policies, including an outlier threshold of $23,140 to available FY 2009 claims.

5. Proposed FY 2011 Standardized Amount

The proposed adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B of this Addendum contain the national standardized amounts that we are proposing to apply to all hospitals, except hospitals located in Puerto Rico, for FY 2011. The proposed Puerto Rico-specific amounts are shown in Table 1C of this Addendum. The proposed amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is the labor-related share of 68.8 percent, and Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying a labor-related share of 62 percent, unless application of that percentage would result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we will apply a labor-related share of 62 percent for all hospitals (other than those in Puerto Rico) whose wage indices are less than or equal to 1.0000.

In addition, Tables 1A and 1B include proposed standardized amounts reflecting the proposed full 2.4 percent update for FY 2011, and the proposed standardized amounts reflecting the 2.0 percentage point reduction to the update (a 0.4 percent update) applicable for hospitals that fail to submit quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (this proposed amount is set forth in Table 1A). The proposed labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2011 are set forth in Table 1C of this Addendum. This table also includes the proposed Puerto Rico standardized amounts. The labor-related share applied to the Puerto Rico specific standardized amount is the proposed labor-related share of 62.1 percent, or 62 percent, depending on which provides higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals located in Puerto Rico be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

The following table illustrates the proposed changes from the FY 2010 national standardized amount. The second column shows the proposed changes from the FY 2010 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (2.4 percent). The third column shows the proposed changes for hospitals receiving the reduced update (0.4 percent). The first row of the table shows the proposed updated (through FY 2010) average standardized amount after restoring the FY 2010 offsets for outlier payments, demonstration budget neutrality and the geographic reclassification budget neutrality. The DRG reclassification and recalibration wage index budget neutrality factors are cumulative. Therefore, the FY 2010 factor is not removed from this table. Additionally, the documentation and coding adjustments for FY 2008 and FY 2009 are cumulative. Therefore, the FY 2008 and FY 2009 adjustment factors are not removed from this table. We also have added separate rows to this table to reflect the different labor-related shares that apply to hospitals.

COMPARISON OF FY 2010 STANDARDIZED AMOUNTS TO THE PROPOSED FY 2011 STANDARDIZED AMOUNT WITH FULL AND REDUCED UPDATE

	Full Update (2.4 percent); Wage index is greater than 1.0000	Full Update (2.4 percent); Wage index is less than or equal to 1.0000	Reduced Update (0.4 percent); Wage index is greater than 1.0000	Reduced Update (0.4 percent); Wage index is less than or equal to 1.0000
FY 2010 Base Rate, after removing geographic reclassification budget neutrality, demonstration budget neutrality, cumulative FY 2008 and FY 2009 documentation and coding adjustment and outlier offset (based on the labor-related share percentage for FY 2010)	Labor: $3,879.09 Nonlabor: $1,759.12	Labor: $3,459.69 Nonlabor: $2,142.52	Labor: $3,879.09 Nonlabor: $1,759.12	Labor: $3,459.69 Nonlabor: $2,142.52
Proposed FY 2011 Update Factor	1.024	1.024	1.004	1.004
Proposed FY 2011 DRG Recalibration and Wage Index Budget Neutrality Factor	0.996963	0.996963	0.996963	0.996963
Proposed FY 2011 Reclassification Budget Neutrality Factor	0.991756	0.991756	0.991756	0.991756
Proposed FY 2011 Outlier Factor	0.948999	0.948999	0.948999	0.948999
Proposed Cumulative Documentation and Coding Adjustment	0.957	0.957	0.957	0.957
Proposed Rate for FY 2011	Labor: $3,566.91 Nonlabor: $1,617.55	Labor: $3,214.37 Nonlabor:$1,970.09	Labor: $3,497.24 Nonlabor: $1,585.96	Labor: $3,151.58 Nonlabor: $1,931.62

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national standardized amount (as set forth in Table 1A of this Addendum). The labor-related and nonlabor-related portions of the proposed national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C of this Addendum. This table also includes the proposed Puerto Rico standardized amounts. The labor-related share applied to the proposed Puerto Rico standardized amount is 62.1 percent, or 62 percent, depending on which results in higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

B. Proposed Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as set forth in this Addendum, contain the labor-related and nonlabor-related shares that we are proposing to use to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2011. This section addresses two types of adjustments to the standardized amounts that are made in determining the proposed prospective payment rates as described in this Addendum.

1. Proposed Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble of this proposed rule, we discuss the data and methodology for the proposed FY 2011 wage index.

2. Proposed Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes the Secretary to make an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area

wages described above. For FY 2011, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the applicable adjustment factor contained in the table below. These proposed factors were obtained from the U.S. Office of Personnel Management (OPM) and are the same as the factors currently in use under the IPPS for FY 2010. In addition, we are proposing that if OPM releases revised COLA factors after publication of this proposed rule, we would use the revised factors for the development of IPPS payments for FY 2011 and publish those revised COLA factors in the final rule.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS

Area	Cost of living adjustment factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

The above factors are based on data obtained from the U.S. Office of Personnel Management Web site at: *http://www.opm.gov/oca/cola/rates.asp.*

C. Proposed MS–DRG Relative Weights

As discussed in section II.H. of the preamble of this proposed rule, we have developed proposed relative weights for each MS–DRG that reflect the resource utilization of cases in each MS–DRG relative to Medicare cases in other MS–DRGs. Table 5 of this Addendum contains the proposed relative weights that we would apply to discharges occurring in FY 2011. These factors have been recalibrated as explained in section II. of the preamble of this proposed rule.

D. Calculation of the Proposed Prospective Payment Rates

General Formula for Calculation of the Proposed Prospective Payment Rates for FY 2011

In general, the operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, for FY 2011 equals the Federal rate.

Currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on the FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

The prospective payment rate for SCHs for FY 2011 equals the higher of the applicable Federal rate, or the hospital-specific rate as described below. The prospective payment rate for MDHs for FY 2011 equals the higher of the Federal rate, or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate as described below. For MDHs, the updated hospital-specific rate is based on FY 1982, FY 1987 or FY 2002 costs per discharge, whichever yields the greatest aggregate payment.

The prospective payment rate for hospitals located in Puerto Rico for FY 2011 equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate.

1. Federal Rate

The Federal rate is determined as follows:

Step 1—Select the applicable average standardized amount depending on whether the hospital submitted qualifying quality data (full update for qualifying hospitals, update minus 2.0 percentage points for nonqualifying hospitals).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the applicable cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if applicable, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the applicable MS–DRG (see Table 5 of this Addendum).

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment. In addition, for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act and 42 CFR 412.101(b), the payment in Step 5 would be increased by 25 percent.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that currently SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on the FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

As discussed previously, currently MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the greater of the updated hospital-specific rates based on either FY 1982, FY 1987 or FY 2002 costs per discharge.

Hospital-specific rates have been determined for each of these hospitals based on the FY 1982 costs per discharge, the FY 1987 costs per discharge, or, for SCHs, the FY 1996 costs per discharge or the FY 2006 costs per discharge, and for MDHs, the FY 2002 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the FY 1984 IPPS interim final rule (48 FR 39772); the April 20, 1990 final rule with comment period (55 FR 15150); the FY 1991 IPPS final rule (55 FR 35994); and the FY 2001 IPPS final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor as discussed in section III. of this Addendum. The resulting rate will be used in determining the payment rate an SCH or MDH will receive for its discharges beginning on or after October 1, 2010.

b. Updating the FY 1982, FY 1987, FY 1996, FY 2002, and FY 2006 Hospital-Specific Rates for FY 2011

We are proposing to increase the hospital-specific rates by 2.4 percent (the hospital market basket percentage increase) for FY 2011 for those SCHs and MDHs that submit qualifying quality data and by 0.4 percent for SCHs and MDHs that fail to submit qualifying quality data. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2011, is the market basket percentage increase for hospitals that submit qualifying quality data and the market basket percentage increase minus 2 percentage points for hospitals that fail to submit qualifying quality data. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided for under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2011, is the market basket percentage increase for hospitals that submit qualifying quality data and the market basket percentage increase minus 2 percentage points for hospitals that fail to submit qualifying quality data.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning on or After October 1, 2010, and Before October 1, 2011

Section 1886(d)(9)(E)(iv) of the Act provides that, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount considering the applicable wage index (Table 1C of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable Puerto Rico-specific wage index.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (Table 5 of this Addendum).

Step 5—Multiply the result in Step 4 by 25 percent.

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount.

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the national average standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (Table 5 of this Addendum).

Step 5—Multiply the result in Step 4 by 75 percent.

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate would then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2011

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in the regulations at 42 CFR 412.308 through 412.352. Below we discuss the factors that we are proposing to use to determine the capital Federal rate for FY 2011, which would be effective for discharges occurring on or after October 1, 2010.

The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except "new" hospitals under § 412.304(c)(2)) are paid based on the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provide that the capital Federal rate be adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor (GAF) are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the respective fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital Federal rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital Federal rate made in FY 1996 as a result of the revised policy for paying for transfers. In FY 1998, we implemented section 4402 of Public Law 105–33, which required that, for discharges occurring on or after October 1, 1997, the budget neutrality adjustment factor in effect as of September 30, 1995, be applied to the unadjusted capital standard Federal rate and the unadjusted hospital-specific rate. That factor was 0.8432, which was equivalent to a 15.68 percent reduction to the unadjusted capital payment rates. An additional 2.1 percent reduction to the rates was effective from October 1, 1997 through September 30, 2002, making the total reduction 17.78 percent. As we discussed in the FY 2003 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6), the 2.1 percent reduction was restored to the unadjusted capital payment rates effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related

costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the FY 2002 IPPS final rule (66 FR 39911), beginning in FY 2002, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because payments are no longer made under the regular exception policy effective with cost reporting periods beginning in FY 2002, we discontinued use of the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099).

Section 412.374 provides for blended payments to hospitals located in Puerto Rico under the IPPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals located in Puerto Rico were paid a blended operating rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. Similarly, prior to FY 1998, hospitals located in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable capital Puerto Rico-specific rate and 25 percent of the applicable capital Federal rate. However, effective October 1, 1997, in accordance with section 4406 of Public Law 105–33, the methodology for operating payments made to hospitals located in Puerto Rico under the IPPS was revised to make payments based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges occurring on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the national capital Federal rate.

As we discussed in the FY 2005 IPPS final rule (69 FR 49185), section 504 of Public Law 108–173 increased the national portion of the operating IPPS payments for hospitals located in Puerto Rico from 50 percent to 62.5 percent and decreased the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004 through September 30, 2004 (refer to the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Public Law 108–173 provided that the national portion of operating IPPS payments for hospitals located in Puerto Rico is equal to 75 percent and the Puerto Rico-specific portion of operating IPPS payments is equal to 25 percent for discharges occurring on or after October 1, 2004. Consistent with that change in operating IPPS payments to hospitals located in Puerto Rico, for FY 2005 (as we discussed in the FY 2005 IPPS final rule), we revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the Puerto Rico-specific capital rate and 75 percent of the national capital Federal rate for discharges occurring on or after October 1, 2004.

A. Determination of Proposed Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the correction notice to the FY 2010 IPPS/RY 2010 LTCH PPS final rule published on October 7, 2009 (74 FR 51499), we established the final capital Federal rate of $429.26 for FY 2010. In the discussion that follows, we explain the factors that we are proposing to use to determine the capital Federal rate for FY 2011. In particular, we explain why the proposed FY 2011 capital Federal rate would decrease approximately 1.9 percent, compared to the FY 2010 capital Federal rate. As discussed in the impact analysis, we estimate capital payments per discharge would decrease 0.2 percent during that same period. Because capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about a 0.1 percent change in actual payments to hospitals.

We note that on March 23, 2010, the Patient Protection and Affordable Care Act, Public Law 111–148, was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the providers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to implement those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this section do not reflect the new legislation. We plan to issue separate rulemaking documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and LTCH PPS, as well as the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we adjust the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2011 under that framework is 1.5 percent based on the best data available at this time. The proposed update factor under that framework is based on a projected 1.2 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2009 DRG reclassification and recalibration, and a forecast error correction of 0.3 percent. As discussed below in section III.C. of this Addendum, we continue to believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2011 CIPI projection in that same section of this Addendum. We note, as discussed in section VI.E.1. of the preamble of this proposed rule, we are proposing to apply a −2.9 percent adjustment to the capital rate in FY 2011 to account for the cumulative effect of changes in documentation and coding under the MS–DRGs that do not correspond to changes in real increases in patients' severity of illness. Below we describe the policy adjustments that we are proposing to apply in the update framework for FY 2011.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes ("real" case-mix change);
- Changes in hospital documentation and coding of patient records result in higher weight DRG assignments ("coding effects"); and
- The annual DRG reclassification and recalibration changes may not be budget neutral ("reclassification effect").

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in documentation and coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2004 IPPS proposed rule for FY 2005 (69 FR 28816)). (We no longer use an update framework to make a recommendation for updating the operating IPPS standardized amounts as discussed in section II. of Appendix B in the FY 2006 IPPS final rule (70 FR 47707).)

Absent any increase in case-mix resulting from changes in documentation and coding due to the adoption of the MS–DRGs, for FY 2011, we are projecting a 1.0 percent total increase in the case-mix index. We estimated that the real case-mix increase will also equal 1.0 percent for FY 2011. The net adjustment for change in case-mix is the difference between the projected real increase in case-mix and the projected total increase in case-mix. Therefore, the proposed net adjustment for case-mix change in FY 2011 is 0.0 percentage points.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year's changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we have data available to evaluate the effects of the FY 2009 DRG reclassification and recalibration as part of our proposed update for FY 2011. To adjust for reclassification and recalibration effects, under our historical methodology, we run the FY 2009 cases through the FY 2008 GROUPER and through the FY 2009 GROUPER. The resulting ratio of the case-mix indices should equate to 1.0. If not, under our historical methodology, in the update framework for FY 2011, we would make an adjustment to adjust for the reclassification and recalibration effects in FY 2009. As discussed in detail in section II.B. of the preamble of this proposed rule, however, when we adopted the MS–DRGs beginning in FY 2008 to better recognize severity of illness in Medicare payment rates, we also recognized that changes in documentation and coding could potentially lead to increases in aggregate payments without a corresponding increase in patients' severity of illness (that is, increased case-mix index other than real case-mix index increase). To maintain budget neutrality for the adoption of the MS–DRGs, as discussed in greater detail in section V.E. of the preamble of this proposed rule, we are proposing to make an adjustment to the proposed capital Federal rate in FY 2011 based on actuarial estimates of the cumulative effects of documentation and coding changes that occurred in FYs 2008 and 2009 (based on FYs 2008 and 2009 claims data). Therefore, we are not adjusting for reclassification and recalibration effects from FY 2009 in the update framework for FY 2011 because it is already accounted for in the proposed documentation and coding adjustment to the capital Federal rates for FY 2011. Consequently, we are proposing a 0.0 percent adjustment for DRG reclassification and recalibration in the proposed FY 2011 update framework.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the availability of data to develop a measurement of the forecast error. A forecast error of 0.3 percentage point was calculated for the FY 2011 update. That is, current historical data indicate that the forecasted FY 2009 CIPI (1.4 percent) used in calculating the FY 2009 update factor slightly understated the actual realized price increases (1.7 percent) by 0.3 percentage point. This is due to the prices associated with both the depreciation and interest cost categories growing faster than anticipated. Historically, when the estimation of the change in the CIPI is greater than 0.25 percentage points, it is reflected in the update recommended under this framework. Therefore, we are proposing to make a 0.3 percent adjustment for forecast error in the update for FY 2011.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. Historically, we have calculated this adjustment using the same methodology and data that were used in the past under the framework for operating IPPS. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes within DRG severity, and for expected modification of practice patterns to remove noncost-effective services. Our intensity measure is based on a 5-year average.

Historically, we have calculated case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CIPI for hospital and related services) and changes in real case-mix. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and the combination of quality-enhancing new technologies and complexity within the DRG system, we assume that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for increases within DRG severity and the adoption of quality-enhancing technology.

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (*Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988* by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on

total change, but was usually a fairly steady increase of 1.0 to 1.5 percent per year. However, we used 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining, and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2002 and 2003, we found that case-mix constant intensity was increasing, and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively. For FYs 2004 and 2005, we found that the charge data appeared to be skewed as a result of hospitals attempting to maximize outlier payments, while lessening costs, and we established a 0.0 percent adjustment in each of those years. Furthermore, we stated that we would continue to apply a 0.0 percent adjustment for intensity until any increase in charges can be tied to intensity rather than attempts to maximize outlier payments. For FYs 2006 through 2010, we continued to apply a 0.0 percent adjustment for intensity in the capital update framework.

In an effort to further refine the intensity adjustment and more accurately reflect allowable changes in hospital intensity, we are proposing to use changes in hospital *costs* per discharge over a 5-year average rather than changes in hospital charges, which have been the basis of the intensity adjustment in prior years. The unique nature of capital—how and when it is purchased, its longevity, and how it is financed—creates a greater degree of variance in capital cost among hospitals than does operating cost. We believe that using changes in capital costs per discharge as the basis for the intensity adjustment in lieu of changes in charges will decrease some of the variability of this adjustment. A case in point is the charge data over much of the last decade— the annual change in hospital charges has fluctuated erratically from as little as 3 percent to as large as 16 percent. As we have discussed for several years in past rulemaking, we believe the effects of hospitals' charge practices prior to the implementation of the outlier policy revisions established in the June 9, 2003 final rule were the main cause of the variability and large annual increases in hospital charges for much of the past decade. However, even after the outlier policy was implemented, we continued to see evidence of these charge practices in the data, as it may have taken hospitals some time to adopt changes in their behavior in response to the new outlier policy. Thus, we believe that the charge data for much of the past decade was skewed because if hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, we would expect hospitals' case-mix to increase proportionally, and it did not.

Therefore, in this proposed rule, for the reasons discussed above, we believe it would be more appropriate to use our intensity adjustment based on the change in capital cost per discharge. To determine the proposed intensity adjustment for FY 2011, we have replaced charge data with capital cost per discharge data. As expected, there are significantly smaller increases in cost per discharge over this time period and less fluctuation from year to year. As we did when using charge data, we are basing the intensity measure on a 5-year average. Therefore, the proposed intensity measure for FY 2011 is based on an average of cost per discharge data from the 5-year period beginning with FY 2004 and extending through FY 2008. Based on these data, we estimate that case-mix constant intensity declined during FYs 2004 through 2008. In the past (FYs 1996 through 2001) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Because we estimate intensity declined during that 5-year period, we believe that it is appropriate to continue apply a zero intensity adjustment for FY 2011. Therefore, we are proposing to make a 0.0 percent adjustment for intensity in the update for FY 2011.

Above, we described the basis of the components used to develop the proposed 1.5 percent capital update factor under the capital update framework for FY 2011 as shown in the table below.

CMS FY 2011 PROPOSED UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index Intensity:	1.2
	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	−1.0
Projected Case-Mix Change	1.0
Subtotal	1.2
Effect of FY 2009 Reclassification and Recalibration	0.0
Forecast Error Correction	0.3
Total Update	1.5

b. Comparison of CMS and MedPAC Update Recommendation

In its March 2010 Report to Congress, MedPAC did not make a specific update recommendation for capital IPPS payments for FY 2011. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2010, Section 2A.)

2. Proposed Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier payment methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating IPPS DRG payments.

For FY 2010, we estimated that outlier payments for capital would equal 5.35 percent of inpatient capital-related payments based on the capital Federal rate in FY 2010. Based on the thresholds as set forth in section II.A. of this Addendum, we estimate that outlier payments for capital-related costs would equal 5.76 percent for inpatient capital-related payments based on the proposed capital Federal rate in FY 2011. Therefore, we are proposing to apply an outlier adjustment factor of 0.9424 in determining the capital Federal rate. Thus, we estimate that the percentage of capital outlier payments to total capital standard payments for FY 2011 would be higher than the percentage for FY 2010. This increase in capital outlier payments is primarily due to the estimated decrease in capital IPPS payments per discharge. That is, because capital payments per discharge are projected to be slightly lower in FY 2011 compared to FY 2010, as shown in Table III. in section VIII. of Appendix A

to this proposed rule, more cases would qualify for outlier payments.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The proposed FY 2011 outlier adjustment of 0.9424 is a -0.54 percent change from the FY 2010 outlier adjustment of 0.9475. Therefore, the net change in the outlier adjustment to the proposed capital Federal rate for FY 2011 is 0.9946 (0.9424/0.9475). Thus, the proposed outlier adjustment decreases the proposed FY 2011 capital Federal rate by 0.54 percent compared with the FY 2010 outlier adjustment.

3. Proposed Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we no longer use the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the proposed factors for FY 2011, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2010 MS–DRG classifications and relative weights and the FY 2010 GAF to estimated aggregate capital Federal rate payments based on the FY 2010 MS–DRG classifications and relative weights and the proposed FY 2011 GAFs. In making the comparison, we set the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national GAFs, based on calculations using updated data, we are proposing to apply an incremental budget neutrality adjustment of 1.0007 for FY 2011 to the previous cumulative FY 2010 adjustment of 0.9907, yielding an adjustment of 0.9915, through FY 2011 (calculated with unrounded numbers). For the Puerto Rico GAFs, we are proposing to apply an incremental budget neutrality adjustment of 1.0004 for FY 2011 to the previous cumulative FY 2010 adjustment of 0.9969, yielding a cumulative adjustment of 0.9973 through FY 2011.

We then compared estimated aggregate capital Federal rate payments based on the FY 2010 DRG relative weights and the proposed FY 2011 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the proposed FY 2011 MS–DRG classifications and relative weights and the proposed FY 2011 GAFs. The proposed incremental adjustment for DRG classifications and proposed changes in relative weights is 0.9992 both nationally and for Puerto Rico. The proposed cumulative adjustments for MS–DRG classifications and proposed changes in relative weights and for proposed changes in the GAFs through FY 2011 are 0.9907 nationally and 0.9965 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

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BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal Year	National				Puerto Rico			
	Incremental Adjustment			Cumulative	Incremental Adjustment			Cumulative
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined		Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	
1992	—	—	—	1.00000	—	—	—	—
1993	—	—	0.99800	0.99800	—	—	—	—
1994	—	—	1.00531	1.00330	—	—	—	—
1995	—	—	0.99980	1.00310	—	—	—	—
1996	—	—	0.99940	1.00250	—	—	—	—
1997	—	—	0.99873	1.00123	—	—	—	—
1998	—	—	0.99892	1.00015	—	—	—	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809	0.99662	1.00468	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028	1.00081	1.00109	0.99736
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028	1.00081	1.00109	0.99736
2005[11]	0.99967[12]	1.00094	1.00061[12]	0.99137	0.99115	1.00094	0.99208	0.98946
2005[13]	0.99946[12]	1.00094	1.00040[12]	0.99117	0.99115	1.00094	0.99208	0.98946
2006	1.00185[14]	0.99892	1.00076[14]	0.99198	1.00762	0.99892	1.00653	0.99592
2007	1.00000	0.99858	0.99858	0.99057	1.00234	0.99858	1.00092	0.99683
2008	1.00172	0.99792	0.99963	0.99021	1.00079	0.99792	0.99870	0.99554
2009[15]	1.00206	0.99945	1.00150	0.99170	1.00097	0.99945	1.00041	0.99595
2010[16]	0.99950	0.99953	0.99902	0.99073	1.00141	0.99953	1.00094	0.99688
2011[17]	1.00074	0.99922	0.99997	0.99070	1.00036	0.99922	0.99959	0.99647

[1]Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2]Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3]Incremental factors are applied to FY 2000 cumulative factors.
[4]Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5]Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6]Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7]Incremental factors are applied to FY 2002 cumulative factors.
[8]Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9]Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10]Factors effective for the second half of FY 2004 (April 2004 through September 2004).
[11]Factors effective for the first quarter of FY 2005 (September 2004 through December 2004).
[12]Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.
[13]Factors effective for the last three quarters of FY 2005 (January 2005 through September 2005).
[14]Incremental factors are applied to average of the cumulative factors for 2005.
[15]Final factors for FY 2009, including the implementation of section 124 of Pub. L. 110-275, which affects wage indices and GAFs for FY 2009,
[16]Final factors for FY 2010.
[17]Proposed factors for FY 2011

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The methodology used to determine the recalibration and geographic adjustment factor (DRG/GAF) budget neutrality adjustment is similar to the methodology used in establishing budget neutrality adjustments under the IPPS for operating costs. One difference is that, under the operating IPPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital IPPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined

separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for DSH or IME.

For FY 2010, we calculated a final GAF/DRG budget neutrality factor of 0.9990 (74 FR 44019). For FY 2011, we are proposing to establish a GAF/DRG budget neutrality factor of 1.0000. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs. The incremental change in the proposed adjustment from FY 2010 to FY 2011 is 1.0000. The cumulative change in the proposed capital Federal rate due to this adjustment is 0.9907 (the product of the incremental factors for FYs 1995 though 2010 and the proposed incremental factor of 1.0000 for FY 2011). (We note that averages of the incremental factors that were in effect during FYs 2005 and 2006, respectively, were used in the calculation of the cumulative adjustment of 0.9907 for FY 2011.)

The proposed factor accounts for the proposed MS–DRG reclassifications and recalibration and for proposed changes in the GAFs. It also incorporates the effects on the proposed GAFs of FY 2011 geographic reclassification decisions made by the MGCRB compared to FY 2010 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) of our regulations requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the proposed FY 2011 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the FY 2002 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments are made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the proposed exceptions adjustment used in calculating the FY 2011 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets the following criteria: (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries and MACs, six hospitals have qualified for special exceptions payments under § 412.348(g). One of these hospitals closed in May 2005. Because we have cost reports ending in FY 2008 for four of these five hospitals, we calculated the adjustment based on actual cost experience. (We note that the one hospital for which we do not have FY 2008 cost report data has had zero special exception payments for all available past cost reports. Consequently, we expect that this hospital would not have any special exceptions payments in FY 2008, and the lack of this hospital's FY 2008 cost report data would not distort the calculation of the adjustment.) Using data from cost reports ending in FY 2008 from the December 2009 update of the HCRIS data, we divided the capital special exceptions payment amounts for the four available hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2008, this ratio is rounded to 0.0003, and we are proposing to make an adjustment of 0.0003. Because special exceptions are budget neutral, we are proposing to offset the capital Federal rate by 0.03 percent for special exceptions payments for FY 2011. Therefore, the proposed exceptions adjustment factor is equal to 0.9997 (1 − 0.0003) to account for estimated special exceptions payments in FY 2011.

In the FY 2010 IPPS final rule (74 FR 44019), we estimated that total (special) exceptions payments for FY 2010 would equal 0.02 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9998 (1 − 0.0002) to determine the FY 2010 capital Federal rate. As we stated above, we are proposing to apply an exceptions payment adjustment factor of 0.9997 to the proposed capital Federal rate for FY 2011 based on our estimate that exceptions payments in FY 2011 would equal 0.03 percent of aggregate payments based on the proposed FY 2011 capital Federal rate. The proposed exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the proposed exceptions adjustment factor used in determining the proposed FY 2011 capital Federal rate is 0.9999 (0.9997/0.9998).

5. Proposed Capital Standard Federal Rate for FY 2011

For FY 2010, we established a final capital Federal rate of $429.26 (74 FR 51499). We are proposing to establish an update of 1.5 percent in determining the proposed FY 2011 capital Federal rate for all hospitals. However, as discussed in greater detail in section V.E. of the preamble of this proposed rule, under the statutory authority at section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, we are proposing an additional 2.9 percent reduction to the national capital Federal payment rate in FY 2011. The proposed −2.9 percent adjustment is based on our actuary's analysis of the effect of changes in case-mix resulting from documentation and coding changes that do not reflect real changes in the case-mix in light of the adoption of MS–DRGs. Accordingly, we are proposing to apply a cumulative documentation and coding adjustment factor of 0.957 in determining the proposed FY 2011 capital Federal rate percent (that is, the

existing −0.6 percent adjustment in FY 2008 plus the −0.9 percent adjustment in FY 2009 plus the proposed additional −2.9 percent adjustment, computed as 1 divided by (1.006 × 1.009 × 1.029). (We note that we did not apply a documentation and coding adjustment to the capital Federal rate in FY 2010 (74 FR 43927).) As a result of the proposed 1.5 percent update and other proposed budget neutrality factors discussed above, we are proposing to establish a national capital Federal rate of $420.99 for FY 2011. The proposed national capital Federal rate for FY 2011 was calculated as follows:

- The proposed FY 2011 update factor is 1.015, that is, the update is 1.5 percent.
- The proposed FY 2011 budget neutrality adjustment factor that is applied to the proposed capital standard Federal payment rate for proposed changes in the MS–DRG classifications and relative weights and proposed changes in the GAFs is 1.0000.
- The proposed FY 2011 outlier adjustment factor is 0.9424.
- The proposed FY 2011 (special) exceptions payment adjustment factor is 0.9997.
- The proposed cumulative adjustment factor for FY 2011 applied to the national capital Federal rate for changes in documentation and coding under the MS–DRGs is 0.957.

Because the proposed capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not proposing to make additional adjustments in the proposed capital standard Federal rate for these factors, other than the proposed budget neutrality factor for proposed changes in the MS–DRG classifications and relative weights and for proposed changes in the GAFs.

We are providing the following chart that shows how each of the proposed factors and adjustments for FY 2011 affects the computation of the proposed FY 2011 national capital Federal rate in comparison to the FY 2010 national capital Federal rate. The proposed FY 2011 update factor has the effect of increasing the proposed capital Federal rate by 1.5 percent compared to the FY 2010 capital Federal rate. The proposed GAF/DRG budget neutrality factor of 1.000 has no net effect on the proposed capital Federal rate. The proposed FY 2011 outlier adjustment factor has the effect of decreasing the proposed capital Federal rate by 0.54 percent compared to the FY 2010 capital Federal rate. The proposed FY 2011 exceptions payment adjustment factor has the effect of decreasing the proposed capital Federal rate by 0.01 percent compared to the FY 2010 capital Federal rate. Furthermore, as shown in the chart below, the resulting cumulative adjustment for changes in documentation and coding that do not reflect real changes in patients' severity of illness (that is, the proposed cumulative adjustment factor of 0.957 has the net effect of decreasing the proposed FY 2011 national capital Federal rate by 2.8 percent as compared to the FY 2010 national capital Federal rate. (As discussed in section VI.E.1. of the preamble of this proposed rule, a cumulative adjustment of −1.5 percent (that is, the −0.6 percent in FY 2008 and −0.9 percent in FY 2009) or a cumulative adjustment factor of 0.985 has already been applied to the FY 2010 capital Federal rate for changes in documentation and coding that do not reflect real changes in patients' severity of illness. We did not apply any additional documentation and coding adjustment to the capital Federal rate in FY 2010). The combined effect of all the proposed changes would decrease the proposed national capital Federal rate by approximately 1.93 percent compared to the FY 2010 national capital Federal rate.

Comparison of Factors and Adjustments: FY 2010 Capital Federal Rate and Proposed FY 2011 Capital Federal Rate

	FY 2010	Proposed FY 2011	Change	Percent Change
Update Factor[1]	1.0120	1.0150	1.0150	1.50
GAF/DRG Adjustment Factor[1]	0.9990	1.0000	1.0000	0.00
Outlier Adjustment Factor[2]	0.9475	0.9424	0.9946	-0.54
Exceptions Adjustment Factor[2]	0.9998	0.9997	0.9999	-0.01
MS-DRG Documentation and Coding Adjustment Factor	0.9850[3]	0.9570[4]	0.9716[5]	-2.84
Capital Federal Rate	$429.26	$420.99	0.9807	-1.93

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2010 to FY 2011 resulting from the application of the proposed 1.000 GAF/DRG budget neutrality factor for FY 2011 is a net change of 1.00 (zero percent).

[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the proposed net change resulting from the application of the proposed FY 2011 outlier adjustment factor is 0.9475/0.9424, or 0.9946.

[3] The documentation and coding adjustment factor includes the -0.6 percent in FY 2008, -0.9 percent in FY 2009, and no additional reduction in FY 2010.

[4] The documentation and coding adjustment factor includes the -0.6 percent in FY 2008, -0.9 percent in FY 2009, no additional reduction in FY 2010 and the proposed -2.9 percent reduction in FY 2011.

[5] The change is measured from the FY 2009 cumulative factor of 0.9850.

6. Proposed Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments to hospitals located in Puerto Rico under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. Under the broad authority of section 1886(g) of the Act, as discussed in section V. of the preamble of this proposed rule, beginning with discharges occurring on or after October 1, 2004, capital payments to hospitals located in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index, and varies depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. The proposed national GAF budget neutrality factor is 1.0004 and the proposed DRG adjustment is 0.9992, for a combined cumulative adjustment of 0.9965.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (25 percent) is multiplied by the Puerto Rico-specific GAF for the labor market area in which the hospital is located, and the national portion of the capital rate (75 percent) is multiplied by the national GAF for the labor market area in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Public Law 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2010, the special capital rate for hospitals located in Puerto Rico was $203.56 (74 FR 51499). Consistent with our development of the FY 2010 Puerto Rico-specific operating standardized amount, we have not applied the −0.6 percent adjustment in FY 2008 or the −0.9 percent documentation and coding adjustment in FY 2009 (that is, the cumulative −1.5 percent adjustment) that was applied to the national capital Federal rate to the Puerto Rico-specific capital rate. However, we noted in the FY 2009 IPPS final rule (73 FR 48449 through 48550) that we may propose to apply such an adjustment to the Puerto Rico operating and capital rates in the future.

As noted above and discussed in greater detail in section V.E.4. of the preamble of this proposed rule, consistent with our development of the Puerto Rico-specific operating standardized amount, we are proposing to apply a −2.4 percent adjustment to account for changes in documentation and coding that resulted from the adoption of the MS–DRGs in determining the proposed FY 2011 Puerto Rico-specific capital rate. With the changes we are proposing to make to the other factors used to determine the capital rate, the proposed FY 2011 special capital rate for hospitals in Puerto Rico is $199.43.

B. Calculation of the Proposed Inpatient Capital-Related Prospective Payments for FY 2011

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except "new" hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2011.

For purposes of calculating payments for each discharge during FY 2011, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) x (DRG weight) x (GAF) x (COLA for hospitals located in Alaska and Hawaii) x (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The proposed outlier thresholds for FY 2011 are in section II.A. of this Addendum. For FY 2011, a case would qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments is greater than the prospective payment rate for the MS–DRG plus the fixed-loss amount of $23,970.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) up through the 10th year beyond the end of the capital transition period if it meets the following criteria: (1) A project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) Any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals. We note that this was a 10-year provision. Therefore, FY 2012 is the final year hospitals will be eligible for the special exceptions payment.

Currently, as provided in § 412.304(c)(2), we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a

fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input price indexes to reflect the changing composition of inputs for operating and capital expenses. In the FY 2010 IPPS final rule (74 FR44021), we rebased and revised the CIPI to a FY 2006 base year to reflect the more current structure of capital costs in hospitals. A complete discussion of this rebasing is provided in section IV. of the preamble of that final rule.

2. Forecast of the CIPI for FY 2011

Based on the latest forecast by IHS Global Insight, Inc. (first quarter of 2010), we are forecasting the FY 2006-based CIPI to increase 1.2 percent in FY 2011. This reflects a projected 1.8 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a 1.9 percent increase in other capital expense prices in FY 2011, partially offset by 1.9 percent decline in vintage-weighted interest expenses in FY 2011. The weighted average of these three factors produces the 1.2 percent increase for the FY 2006-based CIPI as a whole in FY 2011.

IV. Proposed Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year, and updated annually by a rate-of-increase percentage. The updated target amount for that period was multiplied by the Medicare discharges during that period and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers (rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals).

Payments for services furnished in children's hospitals and cancer hospitals that are excluded from the IPPS continue to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a), RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

We are proposing that the FY 2011 rate-of-increase percentage for updating the target amounts for cancer and children's hospitals and RNHCIs be the estimated percentage increase in the FY 2011 IPPS operating market basket, estimated to be 2.4 percent, using the most recent data available based on IHS Global Insight, Inc.'s first quarter 2010 forecast, with historical data through the 2009 fourth quarter. (We are proposing to use more recent data when determining the estimated percentage increase for the FY 2011 IPPS operating market basket for the final rule, to the extent these data are available.)

IRFs, IPFs, and LTCHs were previously paid under the reasonable cost methodology. However, the statute was amended to provide for the implementation of prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provide transitioning periods of varying lengths of time during which a portion of the prospective payment is based on cost-based reimbursement rules under 42 CFR Part 413 (certain providers do not receive a transitioning period or may elect to bypass the transition as applicable under 42 CFR part 412, Subparts N, O, and P.) We note that all of the various transitioning periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended.

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We refer readers to section VII. of the preamble and section V. of the Addendum to this proposed rule for the proposed update changes to the Federal payment rates for LTCHs under the LTCH PPS for RY 2011. The annual updates for the IRF PPS and the IPF PPS are issued by the agency in separate **Federal Register** documents.

V. Proposed Changes to the Payment Rates for the LTCH PPS for FY 2011

A. Proposed LTCH PPS Standard Federal Rate for FY 2011

1. Background

In section VII. of the preamble of this proposed rule, we discuss our proposed changes to the payment rates, factors, and specific policies under the LTCH PPS for FY 2011. We note that on March 23, 2010, the Patient Protection and Affordable Care Act, Public Law 111–148, was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

At § 412.523(c)(3)(ii) of the regulations, for LTCH PPS rate years beginning RY 2004 through RY 2006, we updated the standard Federal rate by a factor to adjust for the most recent estimate of the increases in prices of an appropriate market basket of goods and services for LTCHs. We established that policy of annually updating the standard Federal rate because, at that time, we believed that was the most appropriate method for updating the LTCH PPS standard Federal rate annually for years after the initial implementation of the LTCH PPS in FY 2003. Under § 412.523(c)(3)(ii), for RYs 2004 through 2006, the annual update to the LTCH PPS standard Federal rate was equal to the previous rate year's Federal rate updated by the most recent estimate of increases in the appropriate market basket of goods and services included in covered inpatient LTCH services.

In determining the annual update to the standard Federal rate for RY 2007, based on our ongoing monitoring activity, we believed that, rather than solely using the most recent estimate of the LTCH PPS market basket as the basis of the update factor, it was appropriate to adjust the standard Federal rate to account for the changes in documentation and coding practices in a prior period that were unrelated to patient severity of illness (71 FR 27818). Accordingly, we established regulations at § 412.523(c)(3)(iii) to specify that the update to the standard Federal rate for RY 2007 is zero percent based on the most recent estimate of the LTCH PPS market basket at the time, offset by an adjustment to account for changes in case-mix in prior periods due to changes in documentation and coding that were unrelated to patient severity of illness in FY 2004. For RYs 2008 through 2010, we also considered changes in documentation and coding practices that were unrelated to patient severity of illness in establishing the annual update to the standard Federal rate as set forth in the regulations at §§ 412.523(c)(3)(iv) through (c)(3)(vi). (We note that section 114(e)(1) of Public Law 110–173 provided that the standard Federal rate for RY 2008 shall be the same as the standard Federal rate for RY 2007. In addition, section 114(e)(2) of Public Law 110–173 specified that the revised standard Federal rate provided for under section 114(e)(1) "shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008," effectively resulting in a delay of the application of the updated standard Federal rate for RY 2007 established in the RY 2008 LTCH PPS final rule (72 FR 26890).) Consistent with our historical practice, in the RY 2010 LTCH PPS final rule, we established an annual update to the standard Federal rate for RY 2010 based on the most recent estimate of the increase in the LTCH PPS market basket at that time (2.5 percent and an adjustment of −0.5 percent to account for the increase in case-mix in a prior period (FY 2007) due to changes in documentation and coding practices unrelated to an increase in patient severity of illness (74 FR 44022)). Accordingly, we established regulations at § 412.523(c)(3)(vi) to specify that the update to the standard Federal rate for RY 2010 is 2.0 percent.

2. Development of the Proposed FY 2011 LTCH PPS Standard Federal Rate

While we continue to believe that an update to the LTCH PPS standard Federal rate should be based on the most recent estimate of the increase in the LTCH PPS market basket, we also believe it is appropriate that the standard Federal rate be offset by an adjustment to account for any changes in documentation and coding practices that do not reflect increased patient severity of illness. Such an adjustment protects the integrity of the Medicare Trust Funds by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients. Furthermore, as we discussed most recently in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44022), we did not establish a case-mix budget neutrality factor (that is, a documentation and coding adjustment for changes in case-mix that are not due to changes in patient severity of illness) for the adoption of the severity adjusted MS–LTC–DRG patient classification system. Rather, we noted that, consistent with past LTCH payment policy, we would continue to monitor LTCH data and we could propose to make adjustments when updating the LTCH PPS standard Federal rate in the future to account for changes in documentation and coding that do not reflect any real changes in case-mix during these years that we are implementing MS–LTC–DRGs. As noted above, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule, we applied a −0.5 percent adjustment to account for the effect of changes in documentation and coding on the increase in case-mix in FY 2007. Although we proposed a −1.3 percent adjustment to account for the effect of changes in documentation and coding on the increase in case-mix in FY 2008, in the final rule after consideration of public comments and consistent with IPPS policy, we delayed the application of that adjustment (74 FR 43970 through 43972).

For FY 2011, for this proposed rule as discussed in greater detail in section VII.C.3. of the preamble of this proposed rule, we performed a CMI analysis using the most recent available LTCH claims data (FY 2009) under both the current MS–LTC–DRG and the former CMS LTC–DRG patient classification systems. Based on this evaluation, we determined that there was a cumulative increase in LTCH CMI of 2.5 percent due to changes in documentation and coding that did not reflect real changes in patient severity of illness for LTCH discharges occurring in FY 2008 and FY 2009. At this time, the most recent estimate of the increase in the proposed LTCH PPS market basket (that is, the FY 2002-based RPL market basket) for FY 2011 is 2.4 percent, as discussed in section VII.B.2. of the preamble of this proposed rule. Consistent with our historical practice, in this proposed rule, we are proposing to update the LTCH PPS standard Federal rate for FY 2011 based on the full proposed LTCH PPS market basket increase estimate of 2.4 percent and an adjustment to account for the increase in case-mix in a prior period (FYs 2008 and 2009) that resulted from changes in documentation and coding practices of −2.5 percent. The proposed update factor to the standard Federal rate for FY 2011 is −0.1 percent (that is, we are proposing to apply a factor of 0.999 in determining the LTCH PPS standard Federal rate for FY 2011, calculated as 1.024×1 divided by 1.025 = 0.999 or −0.1 percent). Therefore, in this proposed rule, under the broad authority conferred upon the Secretary under the BBRA and the BIPA to determine appropriate updates under the LTCH PPS, we are proposing to amend § 412.523 to add a new paragraph (c)(3)(vii) to specify that the standard Federal rate for discharges occurring on or after October 1, 2010, through September 30, 2011, is the standard Federal rate for the previous rate year updated by −0.1 percent. In determining the proposed standard Federal rate for FY 2011, we are applying the proposed 0.999 update factor to the RY 2010 Federal rate of $39,896.65 (as established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44022)). Consequently, the proposed standard Federal rate for FY 2011 is $39,856.75. We also are proposing that if more recent data become available, we would use those data, if appropriate, to determine the update to the standard Federal rate for FY 2011 in the final rule, and, thus, the standard Federal rate update specified in the proposed regulation text at § 412.523(c)(3)(vii) could change accordingly.

B. Proposed Adjustment for Area Wage Levels Under the LTCH PPS for FY 2011

1. Background

Under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS standard Federal rate to account for differences in LTCH area wage levels at § 412.525(c). The labor-related share of the LTCH PPS standard Federal rate is adjusted to account for geographic differences in area wage levels by applying the applicable LTCH PPS wage index. The applicable LTCH PPS wage index is computed using wage data from inpatient acute care hospitals without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act.

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56015), when we implemented the LTCH PPS, we established a 5-year transition to the full wage index adjustment. The wage index adjustment was completely phased in for cost reporting periods beginning in FY 2007. Therefore, for cost reporting periods beginning on or after October 1, 2006, the applicable LTCH wage index values are the full (five-fifths) LTCH PPS wage index values calculated based on acute care hospital inpatient wage index data without taking into account geographic reclassification under section 1886(d)(8) and section 1886(d)(10) of the Act. For additional information on the phase-in of the wage index adjustment under the LTCH PPS, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56017 through 56019) and the RY 2008 LTCH PPS final rule (72 FR 26891).

2. Proposed Updates to the Geographic Classifications/Labor Market Area Definitions

a. Background

As discussed in the August 30, 2002 LTCH PPS final rule, which implemented the LTCH PPS (67 FR 56015 through 56019), in establishing an adjustment for area wage levels, the labor-related portion of a LTCH's Federal prospective payment is adjusted by using an appropriate wage index based on the labor market area in which the LTCH is located. Specifically, the application of the LTCH PPS wage index adjustment at § 412.525(c) is made on the basis of the location of the LTCH in either an urban area or a rural area as defined in § 412.503. Currently under the LTCH PPS at § 412.503, an "urban area" is defined as a Metropolitan Statistical Area (which would include a metropolitan division, where applicable) as defined by the Executive OMB and a "rural area" is defined as any area outside of an urban area.

In the RY 2006 LTCH PPS final rule (70 FR 24184 through 24185), in regulations at § 412.525(c), we revised the labor market area definitions used under the LTCH PPS effective for discharges occurring on or after July 1, 2005, based on the Executive OMB's CBSA designations, which are based on 2000 Census data. We made this revision because we believe that the CBSA-based labor market area definitions will ensure that the LTCH PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. We note that these are the same CBSA-based designations implemented for acute care hospitals under the IPPS at § 412.64(b), effective October 1, 2004 (69 FR 49026 through 49034). (For further discussion of the CBSA-based labor market area (geographic classification) definitions currently used under the LTCH PPS, we refer readers to the RY 2006 LTCH PPS final rule (70 FR 24182 through 24191).) We have updated the LTCH PPS CBSA-based labor market area definitions annually since they were adopted for RY 2006 (73 FR 26812 through 26814, and 74 FR 44023 through 44204).

b. Update to the CBSA-Based Labor Market Area Titles and Principal Cities

On December 1, 2009, the Executive OMB announced changes to the principal cities and titles of a number of CBSAs and Metropolitan Divisions (OMB Bulletin No. 10–02). Under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, we update our titles and definitions using the Executive OMB's bulletin. These changes are effective for discharges occurring on or after October 1, 2010.

Specifically, for FY 2011, the following CBSAs have new titles and new principal cities:

- San Marcos, TX qualifies as a new principal city of the Austin-Round Rock, TX CBSA. The new title is Austin-Round Rock-San Marcos, TX CBSA (CBSA Code 12420).
- Delano, CA qualifies as a new principal city of the Bakersfield, CA CBSA. The new title: Bakersfield-Delano, CA CBSA (CBSA Code 12540).
- Conroe, TX qualifies as a new principal city of the Houston-Sugar Land-Baytown, TX CBSA (CBSA Code 26420). The CBSA title is unchanged.
- North Port, FL qualifies as a new principal city of the Bradenton-Sarasota-Venice, FL CBSA (currently CBSA Code 14600). The new title is North Port-Bradenton-Sarasota, FL CBSA. The new code is CBSA 35840.
- Sanford, FL qualifies as a new principal city of the Orlando-Kissimmee, FL CBSA (CBSA Code 36740). The new title is Orlando-Kissimmee-Sanford, FL CBSA.
- Glendale, AZ qualifies as a new principal city of the Phoenix-Mesa-Scottsdale, AZ CBSA. The new title is Phoenix-Mesa-Glendale, AZ CBSA (CBSA Code 38060).
- Palm Desert, CA qualifies as a new principal city of the Riverside-San Bernardino-Ontario, CA CBSA (CBSA Code 40140). The CBSA title is unchanged.
- New Braunfels, TX qualifies as a new principal city of the San Antonio, TX CBSA. The new title is San Antonio-New Braunfels, TX CBSA (CBSA Code 41700).
- Auburn, WA qualifies as a new principal city of the Seattle-Tacoma-Bellevue, WA CBSA (CBSA Code 42644). The CBSA title is unchanged.

In addition, the following CBSAs have new titles as a result of changes to the order of principal cities based on population:

- Rockville, MD replaces Frederick, MD as the second most populous principal city in the Bethesda-Frederick-Rockville, MD Metropolitan Division. The new title is Bethesda-Rockville-Frederick, MD Metropolitan Division (CBSA Code 13644).
- Rock Hill, SC replaces Concord, NC as the third most populous principal city in the Charlotte-Gastonia-Concord, NC-SC CBSA. The new title is Charlotte-Gastonia-Rock Hill, NC-SC CBSA (CBSA Code 16740).
- Joliet, IL replaces Naperville, IL as the second most populous principal city in the Chicago-Naperville-Joliet, IL Metropolitan Division. The new title is Chicago-Joliet-Naperville, IL Metropolitan Division (CBSA Code 16974).
- Crestview, FL replaces Fort Walton Beach, FL as the most populous principal city in the Fort Walton Beach-Crestview-Destin, FL CBSA (currently CBSA Code 23020). The new title is Crestview-Fort Walton Beach-Destin, FL CBSA. The new code is 18880.
- Hillsboro, OR replaces Beaverton, OR as the third most populous principal city in the Portland-Vancouver-Beaverton, OR-WA CBSA. The new title is Portland-Vancouver-Hillsboro, OR-WA CBSA (CBSA Code 38900).
- Steubenville, OH replaces Weirton, WV as the most populous principal city in the Weirton-Steubenville, WV-OH CBSA (currently CBSA Code 48260). The new title is Steubenville-Weirton, OH-WV CBSA. The new CBSA code is 44600.

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The proposed FY 2011 LTCH PPS wage index values presented in Tables 12A and 12B in the Addendum of this proposed rule reflect the revisions to the CBSA-based labor market area titles and codes described above.

3. Proposed LTCH PPS Labor-Related Share

As noted above in this section, under the adjustment for difference in area wage levels at § 412.525(c), the labor-related share of a LTCH's PPS Federal prospective payment is adjusted by the applicable wage index for the labor market area in which the LTCH is located. The LTCH PPS labor-related share represents the sum of the labor-related portion of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and a labor-related portion of capital costs using the applicable LTCH PPS market basket. Currently, as established in the RY 2007 LTCH PPS final rule (71 FR 27829 through 27830), the LTCH PPS labor-related share is based on the relative importance of the labor-related share of operating costs and capital costs of the rehabilitation psychiatric long-term care (hospital) (RPL) market basket based on FY 2002 data, as they are the best available data that reflect the cost structure of LTCHs. For the past 3 years (RYs 2008, 2009, and 2010), we updated the LTCH PPS labor-related share annually based on the latest available data for the RPL market basket. For RY 2010, the labor-related share is 75.779 percent, as established in the RY 2010 LTCH PPS final rule (74 FR 43968 and 44024). (Additional background information on the historical development of the labor-related share under the LTCH PPS and the development of the RPL market basket can be found in the RY 2007 LTCH PPS final rule (71 FR 27810 through 27817 and 27829 through 27830) and the RY 2010 LTCH PPS final rule (74 FR 43968).)

As discussed in greater detail in section VII.C.2.d. of the preamble of this proposed rule, we are proposing to use IHS Global Insight, Inc.'s first quarter 2010 forecast of the FY 2002-based RPL market basket for FY 2011 to determine the proposed labor-related share for the LTCH PPS for FY 2011 that would be effective for discharges occurring on or after October 1, 2010, and through September 30, 2011, as these are the most recent available data. The proposed labor-related share for FY 2011 would be the sum of the proposed FY 2011 relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2002) and FY 2011. The sum of the proposed relative importance for FY 2011 for operating costs (wages and salaries, employee benefits, professional fees, and all-other labor-intensive services) would be 71.537 percent and the labor-related share of capital costs would be 3.870 percent. Thus, the labor-related share that we are proposing to use for LTCH PPS in FY 2011 would be 75.407 percent (71.537 percent + 3.870 percent), as shown in the chart in section VII.C.2.d. of the preamble of this proposed rule.

Accordingly, under the authority set forth in section 123 of the BBRA as amended by section 307(b) of the BIPA, we are proposing to establish a labor-related share of 75.407 percent under the LTCH PPS for the FY 2011. Furthermore, consistent with our historical practice of using the best data available, we also are proposing that if more recent data are available to determine the labor-related share used under the LTCH PPS for FY 2011, we would use these data for determining the FY 2011 LTCH PPS labor-related share in the final rule.

4. Proposed LTCH PPS Wage Index for FY 2011

Historically, under the LTCH PPS, we have established LTCH PPS wage index values calculated from acute care IPPS hospital wage data without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act (67 FR 56019). The wage adjustment established under the LTCH PPS is based on a LTCH's actual location without regard to the urban or rural designation of any related or affiliated provider.

In the RY 2010 LTCH PPS final rule (74 FR 44024 through 44026), we calculated the LTCH PPS wage indices using the same data used for the FY 2010 acute care hospital IPPS (that is, data from cost reporting periods beginning during FY 2006), without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act.

To determine the applicable wage index values under the LTCH PPS for FY 2011, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, consistent with our historical methodology, we are proposing to use wage data collected from cost reports submitted by IPPS hospitals for cost reporting periods beginning during FY 2007, without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act, because these data (FY 2007) are the most recent complete data available at this time. These are the same data used to compute the proposed FY 2011 acute care hospital inpatient wage index, as discussed in section III. of the preamble of this proposed rule. For our rationale for using IPPS hospital wage data as a proxy for determining the wage index values used under the LTCH PPS, we refer readers to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44024 through 44025).

The proposed FY 2011 LTCH PPS wage index values are computed consistent with the urban and rural geographic classifications (labor market areas) discussed above in section V.B.2. of the Addendum of this proposed rule and consistent with the pre-reclassified IPPS wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS). We also note that, as with the IPPS wage data, wage data for multicampus hospitals with campuses located in different labor market areas (CBSAs) are apportioned to each CBSA where the campus or campuses are located (discussed in section III.C. of the preamble of this proposed rule). We also would continue to use our existing policy for determining wage index values in areas where there are no IPPS wage data.

We established a methodology for determining a LTCH PPS wage index values for areas that have no IPPS wage data in the RY 2009 LTCH PPS final rule, and we are proposing to use this methodology for FY 2011. (We refer readers to 73 FR 26817 through 26818 for an explanation of and rationale for our policy.) Under this methodology, the LTCH PPS wage index value for urban CBSAs with no IPPS wage data is determined by using an average of all of the urban areas within the State. As was the case in RY 2010, there are currently no LTCHs located in labor areas without IPPS hospital wage data (or IPPS hospitals) for FY 2011. However, we calculate LTCH PPS wage index values for these areas using our established methodology in the event that, in the future, a LTCH should open in one of those areas.

Based on the current FY 2007 IPPS wage data that we are proposing to use to determine the proposed FY 2011 LTCH PPS wage index values, there are no IPPS wage data for the urban area of Anderson, SC (CBSA 11340) and Hinesville-Fort Stewart, GA (CBSA 25980). Consistent with the methodology discussed above, we calculated the proposed FY 2011 wage index value for CBSA 11340 as the average of the proposed wage index values for all of the other urban areas within the State of South Carolina (that

is, CBSAs 12260, 16700, 16740, 17900, 22500, 24860, 34820, 43900 and 44940) (reflected in Table 12A of the Addendum of this proposed rule). Similarly, for CBSA 25980 as the average of the proposed wage index values for all of the other urban areas within the State of Georgia (that is, CBSAs 10500, 12020, 12060, 12260, 15260, 16860, 17980, 19140, 23580, 31420, 40660, 42340, 46660 and 47580) (reflected in Table 12A of the Addendum of this proposed rule). (As noted above, there are currently no LTCHs located in CBSA 11340 or CBSA 25980.) As discussed in the RY 2009 final rule (73 FR 26817), as IPPS wage data are dynamic, it is possible that urban areas without IPPS wage data will vary in the future.

For FY 2011, using our established methodology, we calculated a LTCH PPS wage index value for rural areas with no IPPS wage data using the unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties of the State (for an explanation of this policy, we refer readers to 73 FR 26818). For this purpose, we define "contiguous" as sharing a border.

Based on the FY 2007 IPPS wage data, there are no IPPS wage data for the rural area of Massachusetts (CBSA code 22). Consistent with the methodology discussed above, the proposed FY 2011 wage index value for rural Massachusetts is computed using the unweighted average of the wage indices from all of the CBSAs contiguous to the rural counties in that State. Specifically, the entire Massachusetts rural area consists of Dukes and Nantucket counties. The borders of Dukes and Nantucket counties are "contiguous" with Barnstable County, MA, and Bristol County, MA. Therefore, the proposed FY 2011 LTCH PPS wage index value for rural Massachusetts is computed as the unweighted average of the proposed FY 2011 wage indexes for Barnstable County and Bristol County (reflected in Tables 12A and 12B in the Addendum of this proposed rule). (There are currently no LTCHs located in rural Massachusetts.) As discussed in the RY 2009 final rule (73 FR 26817), as IPPS wage data are dynamic, it is possible that rural areas without IPPS wage data will vary in the future.

The proposed FY 2011 LTCH wage index values that would be applicable for LTCH discharges occurring on or after October 1, 2010, through September 30, 2011, are presented in Table 12A (for urban areas) and Table 12B (for rural areas) in the Addendum of this proposed rule.

5. Proposed LTCH PPS Cost-of-Living Adjustment for LTCHs Located in Alaska and Hawaii

In the August 30, 2002 final rule (67 FR 56022), we established, under § 412.525(b), a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. In the RY 2010 LTCH PPS final rule (74 FR 44026) (under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS), for RY 2010, we applied a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the factors listed in Table III of that same rule.

For FY 2011, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, we are proposing to apply a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the proposed standard Federal payment rate by the factors listed in the chart below because they are the most recent available data at this time. These proposed factors were obtained from the U.S. Office of Personnel Management (OPM) and are also proposed to be used under the IPPS effective October 1, 2010 (section II.B.2. of the Addendum of this proposed rule). We note that there has been no change in the COLA factors since the current factors were established in the RY 2010 LTCH PPS final rule. In addition, we are proposing that if OPM releases revised COLA factors before publication of the final rule, we would use the revised factors for the development of LTCH PPS payments for FY 2011 and publish those revised COLA factors in the final rule.

PROPOSED COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE LTCH PPS FOR FY 2011

Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
All other areas of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

C. Proposed Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases

1. Background

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA, in the regulations at § 412.525(a), we established an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. We refer to these cases as high cost outliers (HCOs). Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level. These additional payments reduce the financial losses that would otherwise be incurred when treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients. We set the outlier threshold before the beginning of the applicable rate year so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS.

Under § 412.525(a) in the regulations (in conjunction with § 412.503), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted LTCH PPS payment for the MS–LTC–DRG plus a fixed-loss amount. Specifically, in accordance with § 412.525(a)(3) (in conjunction with § 412.503), we pay outlier cases 80 percent of the difference between the estimated cost of the patient case and the outlier threshold, which is the sum of the adjusted Federal prospective payment for the MS–LTC–DRG and the fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that a hospital will incur under the outlier policy for a case with unusually high costs. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. Under the LTCH PPS HCO policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the outlier threshold (MS–LTC–DRG payment plus the fixed-loss amount). The fixed percentage of costs is called the marginal cost factor. We calculate the estimated cost of a case by multiplying the Medicare allowable

covered charge by the hospital's overall hospital cost-to-charge ratio (CCR).

Under the LTCH PPS, we determine a fixed-loss amount, that is, the maximum loss that a LTCH can incur under the LTCH PPS for a case with unusually high costs before the LTCH will receive any additional payments. We calculate the fixed-loss amount by estimating aggregate payments with and without an outlier policy. The fixed-loss amount results in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments. Currently, MedPAR claims data and CCRs based on data from the most recent provider specific file (PSF) (or from the applicable statewide average CCR if a LTCH's CCR data are faulty or unavailable) are used to establish a fixed-loss threshold amount under the LTCH PPS.

2. Determining LTCH CCRs Under the LTCH PPS

a. Background

The following is a discussion of CCRs that are used in determining payments for HCO and SSO cases under the LTCH PPS, at § 412.525(a) and § 412.529, respectively. Although this section is specific to HCO cases, because CCRs and the policies and methodologies pertaining to them are used in determining payments for both HCO and SSO cases (to determine the estimated cost of the case at § 412.529(d)(2)), we are discussing the determination of CCRs under the LTCH PPS for both of these types of cases simultaneously.

In determining both HCO payments (at § 412.525(a)) and SSO payments (at § 412.529), we calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. In general, we use the LTCH's overall CCR, which is computed based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period, in accordance with § 412.525(a)(4)(iv)(B) and § 412.529(f)(4)(ii) for HCOs and SSOs, respectively. (We note that, in some instances, we use an alternative CCR, such as the statewide average CCR in accordance with the regulations at § 412.525(a)(4)(iv)(C) and § 412.529(f)(4)(iii), or a CCR that is specified by CMS or that is requested by the hospital under the provisions of the regulations at § 412.525(a)(4)(iv)(A) and § 412.529(f)(4)(i).) Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs. Therefore, we compute a single "overall" or "total" LTCH-specific CCR based on the sum of LTCH operating and capital costs (as described in Section 150.24, Chapter 3, of the Medicare Claims Processing Manual (Pub. 100–4)) as compared to total charges. Specifically, a LTCH's CCR is calculated by dividing a LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges).

b. LTCH Total CCR Ceiling

Generally, a LTCH is assigned the applicable statewide average CCR if, among other things, a LTCH's CCR is found to be in excess of the applicable maximum CCR threshold (that is, the LTCH CCR ceiling). This is because CCRs above this threshold are most likely due to faulty data reporting or entry, and, therefore, CCRs based on erroneous data should not be used to identify and make payments for outlier cases. Thus, under our established policy, generally, if a LTCH's calculated CCR is above the applicable ceiling, the applicable LTCH PPS statewide average CCR is assigned to the LTCH instead of the CCR computed from its most recent (settled or tentatively settled) cost report data.

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44027), in accordance with § 412.525(a)(4)(iv)(C)(*2*) for HCOs and § 412.529(f)(4)(iii)(B) for SSOs, using our established methodology for determining the LTCH total CCR ceiling, based on IPPS total CCR data from the March 2009 update of the Provider Specific File (PSF), we established a total CCR ceiling of 1.232 under the LTCH PPS, effective October 1, 2009, through September 30, 2010. (For further detail on our current methodology for annually determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121).)

In this proposed rule, in accordance with § 412.525(a)(4)(iv)(C)(*2*) for HCOs and § 412.529(f)(4)(iii)(B) for SSOs, using our established methodology for determining the LTCH total CCR ceiling (described above), based on IPPS total CCR data from the December 2009 update of the PSF, we are proposing to establish a total CCR ceiling of 1.230 under the LTCH PPS that would be effective for discharges occurring on or after October 1, 2010, through September 30, 2011.

c. LTCH Statewide Average CCRs

Our general methodology established for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling (described above) because it is based on "total" IPPS CCR data. Under the LTCH PPS HCO policy at § 412.525(a)(4)(iv)(C) and the SSO policy at § 412.529(f)(4)(iii), the fiscal intermediary may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following circumstances: (1) new LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the fiscal intermediary may consider in determining a LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

In Table 8C of the Addendum to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44160 through 44161), in accordance with the regulations at § 412.525(a)(4)(iv)(C) for HCOs and § 412.529(f)(4)(iii) for SSOs, using our established methodology for determining the LTCH statewide average CCRs, based on using the most recent complete IPPS total CCR data from the March 2009 update of the PSF, we established the LTCH PPS statewide average total CCRs for urban and rural hospitals effective for discharges occurring on or after October 1, 2009, through September 30, 2010. (For further detail on our current methodology for annually determining the LTCH statewide average CCRs, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121).)

In this proposed rule, using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS total CCR data from the December 2009 update of the PSF, we are proposing to establish LTCH PPS statewide average total CCRs for urban and rural hospitals that would be effective for discharges occurring on or after October 1, 2010, through

September 30, 2011, in Table 8C of the Addendum to this proposed rule.

We also note that all areas in the District of Columbia, New Jersey, Puerto Rico, and Rhode Island are classified as urban; therefore, there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C of the Addendum to this proposed rule. This policy is consistent with the policy that we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121) and is the same as the policy applied under the IPPS. In addition, although Massachusetts has areas that are designated as rural, there are no short-term acute care IPPS hospitals or LTCHs located in those areas as of December 2009. Therefore, for this proposed rule, there is no rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum of this proposed rule.

In addition, as we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48120 through 48121), in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, in this proposed rule, we use, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We use this proxy because we believe that the CCR data on the PSF for Maryland hospitals may not be entirely accurate (as discussed in greater detail in that same final rule (71 FR 48120)).

d. Reconciliation of LTCH HCO and SSO Payments

We note that under the LTCH PPS HCO policy at § 412.525(a)(4)(iv)(D) and the LTCH PPS SSO policy at § 412.529(f)(4)(iv), the payments for HCO and SSO cases, respectively, are subject to reconciliation. Specifically, any reconciliation of outlier payments is based on the CCR that is calculated based on a ratio of CCRs computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. For additional information, we refer readers to the RY 2009 LTCH PPS final rule (73 FR 26820 through 26821).

3. Establishment of the Proposed LTCH PPS Fixed-Loss Amount for FY 2011

When we implemented the LTCH PPS, as discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56026), under the broad authority of section 123 of the BBRA as amended by section 307(b) of BIPA, we established a fixed-loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS. To determine the fixed-loss amount, we estimate outlier payments and total LTCH PPS payments for each case using claims data from the MedPAR files. Specifically, to determine the outlier payment for each case, we estimate the cost of the case by multiplying the Medicare covered charges from the claim by the applicable CCR. Under § 412.525(a)(3) (in conjunction with § 412.503), if the estimated cost of the case exceeds the outlier threshold (the sum of the adjusted Federal prospective payment for the MS–LTC–DRG and the fixed-loss amount), we pay an outlier payment equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal prospective payment for the MS–LTC–DRG and the fixed-loss amount).

In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44028), we used our existing methodology to calculate the fixed-loss amount for RY 2010 in order to maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments. Specifically, we used LTCH claims data from the March 2009 update of the FY 2008 MedPAR files and CCRs from the March 2009 update of the PSF to determine a fixed-loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments in RY 2010 because those data were the most recent complete LTCH data available at that time. In that same final rule, we established a fixed-loss amount of $18,425 for RY 2010.

In this proposed rule, we are proposing to continue to use our existing methodology to calculate the proposed fixed-loss amount for FY 2011 (based on updated data and the proposed rates and policies presented in this proposed rule) in order to maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments. (For an explanation of our rationale for establishing an HCO payment "target" of 8 percent of total estimated LTCH payments, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56024).) Consistent with our historical practice of using the best data available, in determining the proposed fixed-loss amount for FY 2011, we use the most recent available LTCH claims data and CCR data. Specifically, for this proposed rule, we used LTCH claims data from the December 2009 update of the FY 2009 MedPAR files and CCRs from the December 2009 update of the PSF to determine a fixed-loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments in FY 2011 because these data are the most recent complete LTCH data currently available. Consistent with the historical practice of using the best available data, we are proposing that if more recent LTCH claims data become available, we will use them for determining the fixed-loss amount for FY 2011 in the final rule. Furthermore, we are proposing to determine the proposed FY 2011 fixed-loss amount based on the MS–LTC–DRG classifications and relative weights from the version of the GROUPER that will be in effect as of the beginning of FY 2011, that is, proposed Version 28.0 of the GROUPER (discussed in section VII.B. of the preamble of this proposed rule).

In this proposed rule, under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we are proposing to establish a fixed-loss amount of $18,692 for FY 2011. Thus, we would pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the MS–LTC–DRG and the fixed-loss amount of $18,692).

The proposed fixed-loss amount for FY 2011 of $18,692 is slightly higher than the RY 2010 fixed-loss amount of $18,425. Based on our payment simulations using the most recent available data, the proposed slight increase in the fixed-loss amount for FY 2011 would be necessary to maintain the existing requirement that estimated outlier payments would equal 8 percent of estimated total LTCH PPS payments. (For further information on the existing 8 percent HCO "target" requirement, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56024.) Maintaining the fixed-loss amount at the current level would result in HCO payments that are greater than the current regulatory requirement 8 percent requirement because a higher fixed-loss amount would result in fewer cases qualifying as outlier cases as well as decreases the amount of the additional payment for a HCO case because the maximum loss that a LTCH must incur before receiving an HCO payment (that is, the fixed-loss amount) would be larger. For these reasons, we believe that proposing to raise the fixed-loss amount is appropriate and necessary to maintain that estimated outlier payments would equal 8 percent

of estimated total LTCH PPS payments as required under § 412.525(a).

4. Application of Outlier Policy to SSO Cases

As we discussed in the August 30, 2002 final rule (67 FR 56026), under some rare circumstances, a LTCH discharge could qualify as a SSO case (as defined in the regulations at § 412.529 in conjunction with § 412.503) and also as a HCO case. In this scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific MS–LTC–DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the HCO threshold (that is, the SSO payment plus the fixed-loss amount), the discharge is eligible for payment as a HCO. Thus, for a SSO case in FY 2011, the HCO payment would be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed fixed-loss amount of $18,692 and the amount paid under the SSO policy as specified in § 412.529).

D. Computing the Proposed Adjusted LTCH PPS Federal Prospective Payments for FY 2011

In accordance with § 412.525, the proposed standard Federal rate is adjusted to account for differences in area wages by multiplying the proposed labor-related share of the proposed standard Federal rate by the appropriate proposed LTCH PPS wage index (as shown in Tables 12A and 12B of the Addendum of this proposed rule). The proposed standard Federal rate is also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the proposed nonlabor-related share of the proposed standard Federal rate by the appropriate cost-of-living factor (shown in the chart in section V.C.5. of the Addendum of this proposed rule). In this proposed rule, we are proposing to establish a standard Federal rate for FY 2011 of $39,856.75, as discussed in section V.A.2. of the Addendum of this proposed rule. We illustrate the methodology to adjust the proposed LTCH PPS Federal rate for FY 2011 in the following example:

Example: During FY 2011, a Medicare patient is in a LTCH located in Chicago, Illinois (CBSA 16974). The proposed FY 2011 LTCH PPS wage index value for CBSA 16974 is 1.0573 (Table 12A of the Addendum of this proposed rule). The Medicare patient is classified into MS–LTC–DRG 28 (Spinal Procedures with MCC), which has a proposed relative weight for FY 2011 of 1.0834 (Table 11 of the Addendum of this proposed rule).

To calculate the LTCH's total adjusted Federal prospective payment for this Medicare patient, we compute the wage-adjusted proposed Federal prospective payment amount by multiplying the unadjusted proposed standard Federal rate ($39,856.75) by the proposed labor-related share (75.407 percent) and the proposed wage index value (1.0573). This wage-adjusted amount is then added to the proposed nonlabor-related portion of the unadjusted proposed standard Federal rate (24.593 percent; adjusted for cost of living, if applicable) to determine the adjusted proposed Federal rate, which is then multiplied by the proposed MS–LTC–DRG relative weight (1.0834) to calculate the total adjusted proposed Federal LTCH PPS prospective payment for FY 2011 ($45,046.57). The table below illustrates the components of the calculations in this example.

Unadjusted Proposed Standard Federal Prospective Payment Rate	$39,856.75
Proposed Labor-Related Share	x 0.75407
Labor-Related Portion of the Proposed Federal Rate	= $30,054.78
Proposed Wage Index (CBSA 16974)	x 1.0573
Proposed Wage-Adjusted Labor Share of Federal Rate	= $31,776.92
Proposed Nonlabor-Related Portion of the Federal Rate ($39,856.75 x 0.24593)	+ $9,801.97
Adjusted Proposed Federal Rate Amount	= $41,578.89
Proposed MS-LTC-DRG 28 Relative Weight	x 1.0834
Total Adjusted Federal Prospective Payment	= $45,046.57

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 1E, 2, 3A, 3B, 4A, 4B, 4C, 4D–1, 4D–2, 4E, 4F, 4J, 5, 7A, 7B, 8A, 8B, 8C, 9A, 9C, 10, 11, 12A, and 12B are presented below. Table 6G.—Additions to the CC Exclusions List, Table 6H.—Deletions from the CC Exclusions List, Table 6I.—Complete List of Complication and Comorbidity (CC) Exclusions, Table 6J.—Major Complication and Comorbidity (MCC) List, and Table 6K.—Complications and Comorbidity (CC) List are available only through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/.*

We note that, because of the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS, as well as the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS, tables 1A, 1B, 1C, 1D, 1E, 2, 4A, 4B, 4C, 4D–1, 4D–2, 4J, 9A, 10, and 11 will need to be updated to reflect these provisions. We plan to issue separate documents in the **Federal Register** and instructions to address these changes and to issue new tables that reflect these provisions.

The tables presented below are as follows:

Table 1A.—Proposed National Adjusted Operating Standardized Amounts, Labor/Nonlabor (68.8 Percent Labor Share/31.2 Percent Nonlabor Share If Wage Index Is Greater Than 1)

Table 1B.—Proposed National Adjusted Operating Standardized Amounts,

Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1)
Table 1C.—Proposed Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D.—Proposed Capital Standard Federal Payment Rate
Table 1E.—Proposed LTCH Standard Federal Prospective Payment Rate
Table 2.—Acute Care Hospitals Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2009; Proposed Hospital Wage Indexes for Federal Fiscal Year 2011; Hospital Average Hourly Wages for Federal Fiscal Years 2009 (2005 Wage Data), 2010 (2006 Wage Data), and 2011 (2007 Wage Data); and 3-Year Average of Hospital Average Hourly Wages
Table 3A.—FY 2011 and 3-Year Average Hourly Wage for Acute Care Hospitals in Urban Areas by CBSA
Table 3B.—FY 2011 and 3-Year Average Hourly Wage for Acute Care Hospitals in Rural Areas by CBSA
Table 4A.—Proposed Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals in Urban Areas by CBSA and by State—FY 2011
Table 4B.—Proposed Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals in Rural Areas by CBSA and by State—FY 2011
Table 4C.—Proposed Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals That Are Reclassified by CBSA and by State—FY 2011
Table 4D–1.—Proposed Rural Floor Budget Neutrality Factors for Acute Care Hospitals—FY 2011
Table 4D–2.—Urban Areas with Acute Care Hospitals Receiving the Statewide Rural Floor or Imputed Floor Wage Index—FY 2011
Table 4E.—Urban CBSAs and Constituent Counties for Acute Care Hospitals—FY 2011
Table 4F.—Proposed Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals by CBSA—FY 2011
Table 4J.—Proposed Out-Migration Adjustment for Acute Care Hospitals—FY 2011
Table 5.—List of Medicare Severity Diagnosis-Related Groups (MS–DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay
Table 6A.—New Diagnosis Codes
Table 6B.—New Procedure Codes
Table 6C.—Invalid Diagnosis Codes
Table 6D.—Invalid Procedure Codes
Table 6E.—Revised Diagnosis Code Titles
Table 6F.—Revised Procedure Code Titles
Table 7A.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2009 MedPAR Update—December 2009 GROUPER V27.0 MS–DRGs
Table 7B.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2009 MedPAR Update—December 2009 GROUPER V28.0 MS–DRGs
Table 8A.—Proposed Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—March 2009
Table 8B.—Proposed Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—March 2009
Table 8C.—Proposed Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs—March 2009
Table 9A.—Hospital Reclassifications and Redesignations—FY 2011
Table 9C.—Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the Act—FY 2011
Table 10.—Geometric Mean Plus the Lesser of .75 of the National Adjusted Operating Standardized Payment Amount (Increased to Reflect the Difference Between Costs and Charges) or .75 of One Standard Deviation of Mean Charges by Medicare Severity Diagnosis-Related Group (MS–DRG) —March 2009
Table 11.—Proposed MS–LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for Discharges Occurring from October 1, 2010 through September 30, 2011 under the LTCH PPS
Table 12A.—Proposed LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2010 through September 30, 2011
Table 12B.—Proposed LTCH PPS Wage Index for Rural Areas for Discharges Occurring From October 1, 2010 through September 20, 2011

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TABLE 1A.—PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (68.8 PERCENT LABOR SHARE/31.2 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)

Full Update (2.4 Percent)		Reduced Update (0.4 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,566.91	$1,617.55	$3,497.24	$1,585.96

TABLE 1B.—PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)

Full Update (2.4 Percent)		Reduced Update (0.4 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,214.37	$1,970.09	$3,151.58	$1,931.62

TABLE 1C.—PROPODSED ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if Wage Index is Greater Than 1		Rates if Wage Index is Less Than or Equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,566.91	$1,617.55	$3,214.37	1,970.09
Puerto Rico	$1,530.25	$933.92	$1,527.79	$936.38

TABLE 1D.—PROPOSED CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$420.99
Puerto Rico	$199.43

TABLE 1E.—PROPOSED LTCH STANDARD FEDERAL PROSPECTIVE PAYMENT RATE

	Rate
Standard Federal Rate	$39,856.75

TABLE 2.--HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2009; PROPOSED HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2011; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2009 (2005 WAGE DATA), 2010 (2006 WAGE DATA), AND 2011 (2007 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage[**] (3 years)
010001	1.6908	0.8539	25.0592	24.8712	27.6011	25.8542
010005	1.2841	0.8427	25.7771	24.9052	26.7660	25.7876
010006	1.4782	0.8028	25.1401	26.7013	27.1899	26.3024
010007	1.0377	0.7448	22.0185	20.0565	21.0524	21.0330
010008	1.1123	0.7622	23.2572	22.8443	24.6733	23.5882
010009	0.9990	0.8646	25.8420	26.1396	27.7497	26.5428
010010	1.2246	0.7744	24.8390	26.2416	27.1969	26.0938
010011	1.5830	0.8614	27.1997	28.6140	33.0361	29.6023
010012	1.1634	0.7634	26.4989	24.8944	25.4141	25.5688
010015	0.9011	0.7494	23.6821	22.9857	22.2077	22.9349
010016	1.5802	0.8614	28.9724	28.7392	30.3170	29.3596
010018	1.1555	0.8614	26.9514	26.7633	28.8087	27.5186
010019	1.3603	0.8028	25.0170	26.0567	29.0622	26.7038
010021	1.3329	0.7571	21.7601	24.3385	25.0343	23.6912
010022	0.9217	0.9563	28.7529	26.5348	30.6579	28.6538
010023	1.7864	0.8506	28.2135	30.0684	31.4256	29.9233
010024	1.6738	0.8506	26.6636	28.1766	29.2979	28.1013
010025	1.4344	0.8613	23.8617	20.1873	29.5803	23.9653
010027	0.7496	0.7510	18.2508	19.7740	22.3038	20.2061
010029	1.6510	0.8613	24.3622	28.3184	26.2864	26.2272
010032	0.8693	0.7773	20.8458	24.7706	22.5607	22.8612
010033	2.2117	0.8614	29.2036	29.3762	30.8243	29.8385
010034	1.1730	0.8506	21.3728	21.0565	23.7513	22.0213
010035	1.3475	0.8427	26.5299	28.0534	28.4993	27.6832
010036	1.1875	0.7448	23.3876	25.0011	25.7199	24.7026
010038	1.3776	0.7945	28.9646	29.7948	32.5231	30.4750
010039	1.8330	0.8994	29.8034	30.6619	31.7063	30.7533
010040	1.6522	0.7561	25.9856	25.2840	27.2842	26.1688
010043	1.2776	0.8614	25.3633	27.3636	26.3517	26.3192
010044	1.0295	0.7448	23.4020	27.3403	28.2131	26.2653
010045	1.0535	0.7670	24.2450	25.1108	27.0851	25.4649

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
010046	1.5582	0.8427	25.4465	33.3112	21.9429	26.0994
010047	0.8765	0.7575	21.7349	17.0984	24.5251	21.0332
010049	1.0744	0.7510	23.1194	25.4446	27.0625	25.1500
010050	1.0266	0.8614	25.3678	27.0365	29.5491	27.2877
010051	0.8615	0.8225	20.0765	21.4140	20.9159	20.8071
010052	0.9419	0.8506	22.7571	22.1386	21.8148	22.2484
010054	1.0674	0.8646	25.4209	24.6126	24.5639	24.8520
010055	1.5928	0.8002	25.3306	26.4706	26.7456	26.1757
010056	1.6143	0.8614	25.7290	28.5668	31.1851	28.4494
010058	0.9816	0.8614	31.1865	23.6860	24.6105	25.8253
010059	1.0664	0.8646	27.8613	29.5434	26.7428	27.9872
010061	0.9602	0.8594	25.7048	26.5035	26.1463	26.1214
010062	1.0748	0.7743	22.9491	20.8224	23.0559	22.2543
010064	1.6120	0.8614	26.6333	*	23.3954	24.8292
010065	1.4982	0.8427	24.4454	25.9433	27.7120	26.0207
010066	0.8151	0.7448	25.6052	25.9301	26.7367	26.0555
010069	0.9679	0.7448	27.3438	29.4662	25.8964	27.5684
010073	0.9744	0.7448	20.7833	19.9743	21.0063	20.5785
010078	1.7376	0.7945	25.2897	24.5429	26.5654	25.4734
010079	1.3594	0.8994	23.1025	25.4118	27.2463	25.2397
010083	1.1948	0.7899	25.0422	25.2405	25.2017	25.1655
010084	***	*	27.5069	*	*	27.5069
010085	1.4769	0.8646	24.0475	25.6072	26.5909	25.3882
010086	1.1077	0.7448	26.9753	24.9468	27.4146	26.3789
010087	2.4471	0.7899	27.4929	27.2725	26.8954	27.1988
010089	1.3862	0.8614	25.9719	26.9357	27.9079	26.8958
010090	1.8308	0.7899	25.6110	26.8029	28.3744	26.9471
010091	0.8685	0.7494	23.6555	27.8571	25.1201	25.3701
010092	1.5529	0.8225	28.8433	30.3263	28.7948	29.3311
010095	0.7991	0.8225	17.8248	21.6551	23.5564	21.0352
010097	0.8060	0.8506	18.4218	19.5147	21.2996	19.7766
010099	0.9382	0.7448	22.3686	20.8632	23.5835	22.2682
010100	1.7378	0.8144	25.4357	25.8178	26.8181	26.0446
010101	1.1605	0.8427	26.2744	25.0955	26.5747	25.9872
010102	0.9608	0.8506	26.6943	22.6883	22.4398	23.9594
010103	1.9636	0.8614	30.4032	27.9049	29.7010	29.3261
010104	1.6984	0.8614	30.4963	29.1001	30.1353	29.9264

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
010108	1.0545	0.8506	26.8900	27.7601	29.5101	28.1758
010109	1.0134	0.7757	21.9300	19.3990	23.0918	21.4719
010110	0.8328	0.7663	22.1175	17.9438	25.5691	21.8242
010112	0.9041	0.7448	21.3904	22.0927	20.9602	21.4581
010113	1.6548	0.7899	25.0704	25.7852	28.0528	26.3173
010114	1.5070	0.8614	25.3666	25.8015	25.6005	25.5885
010118	1.3294	0.8015	25.3689	25.7663	27.7362	26.2760
010120	0.9119	0.7448	22.8177	22.0809	*	22.4473
010125	1.1026	0.7924	23.6549	24.1942	25.4328	24.3975
010126	1.0242	0.8506	25.7254	28.8995	27.0770	27.1824
010128	0.9834	0.7494	25.9421	25.1022	25.7453	25.6021
010129	1.1598	0.7582	24.4816	25.2104	27.6767	25.7944
010130	1.0145	0.8614	25.2790	23.8895	31.2319	26.5261
010131	1.4270	0.8994	28.0487	28.6759	32.2481	29.7152
010137	1.5361	0.8614	30.4361	30.7312	33.4983	31.5313
010138	0.6398	0.7514	15.0815	16.7541	16.6144	16.1902
010139	1.6830	0.8614	29.3560	29.3626	30.7489	29.8142
010143	1.1691	0.8646	25.0871	25.1522	25.9745	25.3833
010144	1.7207	0.7899	23.8601	25.4614	26.4008	25.1949
010145	1.5795	0.8225	27.3296	30.2093	29.5558	29.0313
010146	0.9412	0.7945	23.8076	24.6572	25.2484	24.5514
010148	0.9563	0.7448	25.0960	24.8409	24.3699	24.7693
010149	1.3663	0.8506	26.8920	28.1328	29.5254	28.2683
010150	1.0187	0.7575	25.0070	26.3342	25.9401	25.7372
010152	1.3718	0.7899	26.0793	23.0248	26.8322	25.2347
010157	1.1568	0.8028	27.1793	27.5674	27.3487	27.3636
010158	1.3394	0.7583	26.2363	26.8821	27.7665	26.9653
010164	1.1777	0.8427	25.6759	24.4625	23.9304	24.6859
010167	1.5767	0.8614	*	24.7643	29.1631	26.8653
010168	1.6115	0.9111	*	30.2040	27.0185	28.8600
010169	1.0410	*	*	*	*	*
020001	1.8974	1.1919	38.1784	39.2651	40.8325	39.4363
020006	1.3723	1.1919	37.2853	40.5422	42.4838	40.2757
020008	1.2207	1.1919	40.6783	42.8075	44.8291	42.8366
020012	1.4672	1.1919	36.1911	37.0181	38.4880	37.2462
020014	***	*	30.6343	*	*	30.6343
020017	2.2168	1.1919	38.2157	41.2448	42.1762	40.5573

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
020018	0.9117	1.8246	*	*	*	*
020024	1.1323	1.1919	39.9943	35.9358	43.5298	39.9069
020026	1.5829	1.8246	*	*	*	*
020027	0.8544	1.8246	*	*	*	*
020028	***	*	*	*	42.1568	42.1568
030001	1.5123	1.0519	35.9083	38.1204	36.9465	37.0095
030002	2.1395	1.0519	32.9094	34.2998	35.5406	34.2817
030006	1.7866	0.9692	29.1248	32.1646	32.4565	31.2997
030007	1.5010	1.2318	35.5226	38.1199	40.1726	38.0212
030010	1.6899	0.9692	31.8640	33.3049	33.9522	33.0660
030011	1.6799	0.9692	30.2096	31.8532	32.9183	31.7320
030012	1.6785	1.2318	31.3068	33.4818	50.8525	36.5891
030013	1.5846	0.9455	31.9162	31.1767	33.0103	32.0532
030014	1.6003	1.0519	30.6308	31.8529	33.7100	32.1295
030016	1.3364	1.0519	31.1878	30.6196	34.0540	31.8987
030017	***	*	34.8488	34.9499	37.4893	35.7433
030018	***	*	31.7240	34.2870	35.7209	33.8731
030019	***	*	33.6553	36.3298	36.3760	35.4444
030022	1.6387	1.0519	35.0772	34.3377	34.4050	34.5355
030023	2.0211	1.2457	37.5523	41.8098	43.4901	40.9837
030024	2.1783	1.0519	35.3556	38.5575	40.6081	38.3107
030030	1.6996	1.0519	36.4772	38.9056	37.5980	37.7197
030033	1.3578	1.0519	32.0362	33.9716	35.7840	33.9594
030036	1.6971	1.0519	35.7464	37.1271	40.4842	37.7767
030037	1.9779	1.0519	35.1342	35.8129	37.1935	36.2152
030038	1.6840	1.0519	31.2928	33.8052	36.9266	34.1148
030043	1.3149	0.9120	28.3158	29.0816	31.0593	29.4840
030055	1.5838	1.0287	31.0806	37.2632	37.4315	35.3174
030061	1.7125	1.0519	33.0847	34.2000	35.3864	34.2660
030062	1.4495	0.9120	29.9359	30.3859	33.1874	31.2110
030064	2.1061	0.9692	31.6632	33.1535	35.0230	33.3240
030065	1.8343	1.0519	31.4602	33.8941	36.2534	33.8318
030067	1.0416	0.9418	27.0784	27.4410	31.2478	28.5865
030068	1.1142	0.9120	26.0296	26.8369	28.7966	27.2639
030069	1.5878	1.1429	30.7723	35.1793	35.6421	33.9927
030071	1.0518	1.4448	*	*	*	*
030073	1.2775	1.4448	*	*	*	*

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
030074	0.9561	1.4448	*	*	*	*
030077	0.9180	1.4448	*	*	*	*
030078	1.2123	1.4448	*	*	*	*
030080	***	*	30.7682	34.2723	*	32.4902
030083	1.5477	1.0519	35.8521	39.0888	39.9707	38.3254
030084	1.0830	1.4448	*	*	*	*
030085	1.6913	0.9692	29.0774	30.7160	33.4062	31.0315
030087	1.7697	1.0519	31.1094	33.0362	37.2751	33.9611
030088	1.4335	1.0519	30.5738	33.5408	34.6877	33.0355
030089	1.7404	1.0519	31.3179	32.8874	34.7343	33.0017
030092	1.6022	1.0519	30.4394	31.6471	33.8309	32.0855
030093	1.4573	1.0519	33.0720	33.5029	34.3015	33.6746
030094	1.6808	1.0519	34.2040	35.9213	36.9133	35.7448
030099	0.7231	*	24.9127	*	*	24.9127
030100	2.2953	0.9692	35.0981	36.9783	39.5385	37.2928
030101	1.4411	1.1811	33.2139	34.1060	33.6260	33.6535
030102	2.8130	1.0519	36.9539	39.4617	36.4149	37.5421
030103	1.8002	1.0519	34.2770	41.6469	41.1210	39.1558
030105	2.2878	1.0519	33.9875	37.6952	38.6741	36.8267
030106	***	*	40.1657	43.9022	*	41.9807
030107	2.1093	1.0519	35.4562	35.9171	37.6288	36.3377
030108	2.4034	1.0519	34.8507	33.2799	34.5124	34.1536
030110	1.7329	1.0519	36.2158	38.0468	39.0340	37.8801
030111	1.1668	0.9692	28.5146	33.3314	37.0123	33.6486
030112	2.0671	1.0519	33.4810	36.1513	40.1301	36.8711
030113	0.9505	1.4448	*	*	*	*
030114	1.4510	0.9692	28.8466	30.2128	30.3754	29.8451
030115	1.5083	1.0519	32.5885	34.8409	36.8225	35.0086
030117	1.3318	1.0287	*	34.5349	36.6725	35.7305
030118	1.3327	1.2318	*	28.2945	32.6116	30.4114
030119	1.6200	1.0519	*	38.2362	40.7172	39.6384
030120	0.8520	1.0519	*	39.7676	47.5037	43.8726
030121	1.6902	1.0519	*	*	36.6999	36.6999
030122	1.4640	1.0519	*	*	35.1781	35.1781
030123	1.4739	1.0519	*	*	*	*
030124	1.8948	1.0519	*	*	*	*
030125	2.0742	1.0519	*	*	*	*

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
030126	1.8635	1.0519	*	*	*	*
040001	1.0932	0.8648	24.4962	25.0147	25.5841	25.0463
040002	1.1071	0.7517	24.0487	26.2100	24.0639	24.7422
040004	1.7351	0.8648	29.2714	30.1320	31.6130	30.3580
040007	1.7451	0.8675	28.3305	29.3146	30.2051	29.2717
040010	1.4698	0.8648	28.2375	28.1618	29.2017	28.5990
040011	0.9266	0.7517	22.6327	25.6224	25.9642	24.7357
040014	1.3689	0.8490	34.8279	24.1271	24.6941	25.6001
040015	1.0662	0.7517	22.3148	23.2134	23.7403	23.0850
040016	1.7601	0.8675	26.4806	27.6568	28.6501	27.6411
040017	1.0990	0.8127	24.3772	25.3390	26.2509	25.3116
040018	1.2191	0.7742	26.2521	25.3362	26.6851	26.0819
040019	0.9918	0.7775	26.4932	25.5468	25.0491	25.6618
040020	1.6272	0.7833	26.1529	25.9754	26.6049	26.2463
040021	***	*	27.6799	28.7690	28.8903	28.4564
040022	1.4167	0.8648	30.0250	29.5992	29.4604	29.6905
040026	1.6410	0.9296	31.8588	32.2814	34.6944	32.9479
040027	1.5093	0.8413	25.7935	27.2441	28.4743	27.1878
040029	1.4958	0.8675	27.8882	27.8412	29.1988	28.3053
040036	1.6856	0.8675	30.4906	32.0772	33.1236	31.9038
040039	1.1753	0.8127	22.9807	23.4456	23.0760	23.1655
040041	1.1592	0.8490	26.4435	27.8594	27.4448	27.2474
040042	1.3566	0.9213	23.1661	23.5768	28.3874	25.0294
040047	0.9113	0.7634	23.3557	25.0102	27.5142	25.1265
040050	1.1590	0.7517	19.6946	21.0178	22.0146	20.9063
040051	0.9936	0.7517	22.1981	23.4783	24.9308	23.5416
040055	1.7558	0.7742	26.0150	26.3370	26.5702	26.3163
040062	1.6827	0.7742	25.6554	28.5888	28.4309	27.5460
040067	1.0555	0.7524	20.9700	21.3492	22.1772	21.5146
040069	0.9730	0.8127	23.3117	23.0880	22.6987	23.0306
040071	1.5474	0.8490	26.6645	25.0185	28.7130	26.7537
040072	1.1859	0.7517	22.9671	23.3205	24.0488	23.4429
040074	1.1781	0.8675	27.3897	27.4614	27.7915	27.5518
040076	1.0157	0.9071	24.7903	25.7464	25.0274	25.1722
040078	1.7507	0.9296	25.6886	27.9394	28.4481	27.3094
040080	1.0416	0.7833	26.5905	26.9354	26.1224	26.5524
040081	0.8641	0.7874	18.4759	18.5265	17.3969	18.1445

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
040084	1.3107	0.8675	28.1570	28.7379	29.9634	29.0185
040085	0.9358	0.8981	26.6987	25.4981	26.7545	26.3201
040088	1.5419	0.8122	24.7119	26.7050	28.8877	26.7762
040091	1.1940	0.7517	22.3311	27.7747	29.9029	26.3939
040100	***	*	24.5458	24.7712	*	24.6638
040114	1.9109	0.8675	28.5702	29.1200	30.6358	29.4351
040118	1.6136	0.7517	26.5783	27.3360	30.6065	28.2493
040119	1.5157	0.8490	25.6779	26.9632	28.2765	27.0150
040132	0.8021	0.9296	21.8140	*	22.6953	22.2510
040134	2.2362	0.8675	34.9673	35.2045	36.1627	35.4829
040137	1.3325	0.8675	27.7638	28.2123	31.3247	29.2690
040138	***	*	33.0073	31.1138	32.6001	32.2159
040141	***	*	33.8791	34.8500	*	34.4114
040142	1.5826	0.9296	23.1302	24.4876	27.5086	25.1151
040145	1.9580	0.7833	20.3878	22.1731	22.3687	21.7125
040147	1.9130	0.8675	35.7669	33.6215	30.4256	32.7938
040148	***	*	*	*	35.6031	35.6031
040149	***	*	*	*	29.0721	29.0721
040152	2.5966	0.8648	*	*	*	*
050002	1.5159	1.5855	43.1760	42.3825	45.4953	43.6748
050006	1.8102	1.3277	41.7714	43.8923	45.0094	43.5856
050007	1.5598	1.5182	49.5271	55.1636	52.2245	52.2511
050008	1.6354	1.5036	50.9569	50.4751	52.7669	51.4050
050009	1.7626	1.5173	49.7177	51.5510	53.0588	51.5292
050013	1.9184	1.5173	43.4906	46.3422	49.5453	46.5172
050014	1.2657	1.3217	42.2044	42.7255	41.0206	41.9545
050016	1.4193	1.2121	34.3863	36.3674	39.4584	36.8709
050017	2.1061	1.3217	44.4857	46.6209	48.7220	46.6321
050018	1.3007	1.2002	34.0338	34.7941	36.0324	34.9615
050022	1.7904	1.2002	36.6360	38.9203	41.5471	39.0977
050024	1.2891	1.2002	33.5247	34.6921	37.1807	34.9055
050025	1.9538	1.2002	36.9233	39.5330	42.5246	39.7669
050026	1.6191	1.2002	35.0306	36.3315	37.3290	36.2935
050028	1.2261	1.2002	28.1584	28.5839	*	28.3806
050030	1.2680	1.2002	33.5654	33.2455	34.4700	33.7632
050036	1.7457	1.2002	37.4298	39.2616	41.5393	39.4707
050038	1.7728	1.6059	55.2197	58.4851	61.3276	58.4346

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050039	1.5400	1.2002	34.9262	37.8559	40.9213	37.8428
050040	1.3721	1.2002	38.1665	41.9767	44.2571	41.5266
050042	1.5785	1.3277	40.5791	45.6660	50.9908	45.8022
050043	1.7576	1.5855	51.9529	55.4677	53.5411	53.6961
050045	1.3696	1.2002	28.5952	27.8903	31.4860	29.3287
050046	1.2182	1.2002	34.2529	34.0106	37.1982	35.1676
050047	1.8545	1.5036	48.5961	51.4298	53.1141	51.0350
050054	1.2411	1.2002	27.1320	27.9082	32.4947	29.1694
050055	1.4904	1.5036	48.2796	51.9993	52.9342	51.0882
050056	1.5972	1.2002	34.7964	33.2655	39.4954	35.7797
050057	1.6940	1.2002	33.7574	35.6340	38.6138	36.0669
050058	1.8187	1.2002	38.9843	41.4811	43.4764	41.3510
050060	1.6287	1.2002	34.1183	35.3108	36.7750	35.4314
050063	1.6524	1.2002	36.6301	40.9558	43.3599	40.2753
050065	***	*	42.0085	*	*	42.0085
050067	1.3773	1.2002	41.8988	41.1549	34.0218	39.0746
050069	2.0169	1.2002	38.1339	40.0498	44.2637	40.8835
050070	1.4481	1.5182	48.9362	53.8300	55.6284	52.8293
050071	1.7718	1.6059	52.0696	55.3995	54.9153	54.1707
050072	1.5282	1.5536	51.4538	54.7774	55.8299	54.0528
050073	1.5376	1.5428	50.6523	54.2296	55.8359	53.6371
050075	1.6153	1.5855	51.1187	54.8332	56.6372	54.2184
050076	1.8135	1.5036	50.5761	53.8043	55.1835	53.2013
050077	1.6624	1.2002	37.4989	38.5242	38.0509	38.0339
050078	1.3299	1.2002	37.1940	38.9256	38.8489	38.3347
050079	1.5469	1.5536	48.3017	50.6578	65.1440	53.7676
050082	1.8234	1.2002	42.0181	41.8861	44.1069	42.6942
050084	1.6992	1.3217	41.1276	42.4418	46.0253	43.2693
050089	1.4757	1.2002	39.6297	39.9711	42.3990	40.7121
050090	1.4461	1.5428	41.6026	44.0838	44.4628	43.3851
050091	0.9802	1.2002	40.1063	34.8170	33.6732	36.0063
050093	1.5991	1.2002	37.7244	38.5686	41.6205	39.3792
050095	***	*	44.2400	*	*	44.2400
050096	1.4571	1.2002	33.3803	27.6236	33.2850	31.4278
050099	1.6444	1.2002	34.3507	35.4717	37.9297	35.9486
050100	1.8716	1.2002	34.2839	37.1606	39.4312	36.9821
050101	1.6391	1.5428	48.7495	54.5185	56.2550	53.2934

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050102	1.4707	1.2002	33.2837	35.4740	35.1267	34.5871
050103	1.6949	1.2002	37.3608	38.8446	38.1720	38.1428
050104	1.5783	1.2002	37.4417	39.1121	41.8962	39.5439
050107	1.6748	1.2002	36.5843	40.5315	41.9627	39.7421
050108	2.0166	1.3217	45.3460	48.8199	53.1654	48.7805
050110	1.2043	1.2002	30.9054	32.3171	33.5933	32.2754
050111	1.0887	1.2002	31.9394	31.1160	32.2597	31.7697
050112	1.5483	1.2002	39.9951	41.8195	41.5924	41.1912
050113	1.4076	1.5182	46.3471	45.1998	42.4778	44.6111
050114	***	*	37.5924	36.6541	*	37.1115
050115	1.5983	1.2002	33.3013	37.7614	40.4397	37.1497
050116	1.7304	1.2002	45.7510	40.6863	42.7961	43.0779
050118	1.2522	1.2002	41.8191	43.4432	46.9088	44.0974
050121	1.2757	1.2002	35.1135	36.9069	41.8043	38.1805
050122	1.7509	1.2384	36.8821	40.4510	41.5112	39.6349
050124	1.3527	1.2002	31.7690	33.3080	34.6304	33.2610
050125	1.6861	1.6059	53.6300	57.6242	60.2474	57.1280
050126	1.6064	1.2002	35.1909	34.9807	36.0294	35.4292
050127	1.5461	1.3217	42.5226	46.9648	48.0928	46.1911
050128	1.6196	1.2002	34.2364	36.6986	39.3773	36.7615
050129	1.9659	1.2002	40.3786	41.4256	44.5762	42.1957
050131	1.4681	1.5428	52.8228	56.6586	53.6221	54.3340
050132	1.6276	1.2002	43.6747	42.8187	45.1737	43.9116
050133	1.4848	1.2180	35.2433	36.8254	37.6504	36.6555
050135	1.0726	1.2002	25.4431	28.5118	30.6553	28.0980
050136	1.4481	1.5428	51.8508	52.5398	57.3918	53.8780
050137	1.3773	1.2002	43.5305	45.2088	49.1420	45.8667
050138	1.9128	1.2002	45.1011	47.3839	51.2980	47.9183
050139	1.4368	1.2002	43.0734	44.5753	48.6963	45.4255
050140	1.4087	1.2002	42.7590	44.8911	46.8652	44.8787
050144	***	*	40.4760	*	*	40.4760
050145	1.6332	1.5512	49.4479	54.8909	58.5220	54.4145
050146	1.8322	*	*	*	*	*
050149	1.5052	1.2002	43.1926	42.8003	45.3498	43.7950
050150	1.3011	1.3217	43.5937	44.3354	48.0733	45.3350
050152	1.6955	1.5428	54.7176	55.9738	57.1905	55.9904
050153	1.5690	1.6059	50.4884	53.5925	57.8841	54.0652

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050158	1.5055	1.2002	42.7874	42.9454	44.0747	43.2830
050159	1.3444	1.2002	35.0153	40.4701	42.5924	39.5664
050167	1.4923	1.2384	38.0742	39.9946	41.8816	40.0050
050168	1.6873	1.2002	40.8362	37.9746	43.4951	40.7650
050169	1.6805	1.2002	33.1130	35.4836	41.1246	36.5888
050173	1.3930	1.2002	32.3265	31.5434	32.8423	32.2554
050174	1.7399	1.5428	53.7113	54.7960	59.7549	56.0844
050179	1.2738	1.2002	34.6558	36.2060	33.9197	34.8615
050180	1.7149	1.5536	48.7425	51.1836	53.5567	51.2533
050188	1.4966	1.6059	45.8501	49.6669	54.1865	49.5983
050189	0.9575	1.5512	31.5805	27.5311	29.3459	29.4661
050191	1.6765	1.2002	41.7185	40.0694	41.5164	41.0746
050192	0.9069	1.2002	27.4611	29.4203	33.2102	30.1271
050193	1.2942	1.2002	36.7240	39.0111	43.0282	39.5133
050194	1.3701	1.6059	49.8539	49.9857	55.1169	51.6953
050195	1.6650	1.5855	57.6563	61.8312	65.0039	61.5445
050196	1.2008	1.2002	41.1300	43.7415	41.0270	41.9842
050197	1.9331	1.5855	55.3173	59.0280	63.2066	59.2051
050204	1.5451	1.2002	38.8689	37.5591	41.0566	39.2215
050205	1.5945	1.2002	30.6117	30.2818	31.5240	30.7776
050211	1.3252	1.5855	42.9254	44.8773	46.1770	44.5820
050219	1.3542	1.2002	26.7061	26.9022	26.0523	26.5448
050222	1.7729	1.2002	35.4045	36.0221	37.6975	36.4283
050224	1.7191	1.2002	37.3442	39.7119	41.8790	39.6769
050225	1.5650	1.2002	37.5252	38.9288	42.8450	39.8661
050226	1.5718	1.2002	36.5354	38.4952	39.4194	38.1228
050228	1.4239	1.5036	49.9063	54.5580	57.3422	54.0697
050230	1.7061	1.2002	38.8901	39.8582	42.1567	40.3322
050231	1.8460	1.2002	37.0245	38.7280	40.2191	38.7139
050232	1.7131	1.2121	35.4055	39.4290	42.5544	39.2518
050234	1.5381	1.2002	37.7125	37.6811	38.9602	38.1603
050235	1.7383	1.2002	39.1744	40.0962	40.2265	39.8347
050236	1.5208	1.2002	34.4257	42.5939	44.3842	40.4072
050238	1.7269	1.2002	35.1268	36.4272	37.0926	36.2576
050239	1.6695	1.2002	36.3257	37.2939	38.5937	37.4489
050242	1.4892	1.6059	53.8385	58.5684	59.7332	57.3859
050243	1.6103	1.2002	37.8538	40.0490	42.5305	40.1509

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050245	1.3766	1.2002	34.7153	36.9270	37.1180	36.2906
050248	1.1998	1.5512	46.0329	47.7637	51.0500	48.2742
050254	1.3843	1.3217	33.5069	34.8262	39.7976	36.0829
050256	***	*	32.6841	*	*	32.6841
050257	0.8947	1.2002	29.2651	30.7766	29.8486	29.9463
050261	1.3026	1.2002	33.7196	34.8188	39.3041	36.0518
050262	2.3736	1.2002	43.7709	40.8071	44.0453	42.8188
050264	1.4655	1.5855	50.1691	54.4052	57.0188	53.7398
050272	1.5454	1.2002	32.2584	35.0624	37.3015	34.8914
050276	1.1140	1.5536	47.2432	53.7552	55.4715	52.2517
050277	1.2258	1.2002	*	48.9698	47.5707	48.2343
050278	1.7099	1.2002	38.5689	39.5929	42.8799	40.4121
050279	1.3099	1.2002	32.1695	31.0888	31.6803	31.6436
050280	1.8248	1.3277	43.6243	46.2628	50.0266	46.6861
050281	1.5342	1.2002	31.0706	31.4166	32.8623	31.7857
050283	1.7021	1.5855	45.1132	50.3066	51.3746	48.9680
050289	1.6807	1.5182	52.0918	53.8571	58.3774	54.8745
050290	1.7520	1.2002	42.0099	42.2249	42.6314	42.2987
050291	2.0918	1.5428	44.6102	49.6427	52.1353	48.7155
050292	1.1648	1.2002	35.0372	34.6404	39.9841	36.7557
050295	1.5834	1.2002	39.7399	39.3961	42.9356	40.7188
050296	1.1416	1.6044	44.8135	48.2583	50.4082	47.9062
050298	1.2079	1.2002	33.6947	31.7374	34.0150	33.1345
050300	1.4557	1.2002	37.1275	39.2722	43.0474	40.0013
050301	1.3483	1.2002	36.3681	36.7568	39.9485	37.7770
050305	1.5667	1.5855	56.9756	55.7229	54.6309	55.7281
050308	1.5864	1.6059	49.0132	51.0183	54.0475	51.4737
050309	1.5729	1.3217	42.9280	46.6901	47.4734	45.7112
050313	1.2453	1.2384	39.0663	42.3998	43.8913	41.8600
050315	1.4388	1.2002	37.3560	40.3132	47.1318	41.7255
050320	1.2324	1.5855	50.6708	50.9692	55.3663	52.3385
050324	1.8098	1.2002	37.1883	38.9511	41.1149	39.1426
050325	0.7767	1.2035	34.0343	*	47.6656	36.0502
050327	1.8597	1.2002	36.9550	37.7681	39.6815	38.2025
050329	1.3249	1.2002	36.7669	37.6975	37.0324	37.1628
050334	1.7820	1.5855	50.9834	54.9338	59.6727	55.2808
050335	1.4895	1.2002	37.2347	37.1670	39.1873	37.9135

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050336	1.2295	1.2384	33.0325	35.3658	38.7257	35.7910
050342	1.2591	1.2002	29.8389	31.6852	33.8443	31.8494
050348	1.7579	1.2002	33.5276	35.1080	37.4660	35.3772
050349	0.7643	1.2002	23.1095	23.5190	24.5969	23.7436
050350	1.5328	1.2002	34.6747	36.1856	37.1989	35.9750
050351	1.5646	1.2002	35.0042	35.6083	34.8470	35.1393
050352	1.4182	1.3217	38.6265	41.5370	41.4294	40.5216
050353	1.5266	1.2002	37.1716	37.4560	38.3124	37.6445
050357	1.4556	1.2002	38.9244	40.9999	41.8008	40.6080
050359	1.1943	1.2002	30.3988	30.9732	33.5096	31.6303
050360	1.6360	1.5428	55.3738	59.2147	57.2879	57.3315
050366	1.1199	1.3217	41.8324	43.0169	43.1165	42.6581
050367	1.6146	1.5428	40.0453	41.1059	44.3506	41.9320
050369	***	*	33.3357	34.7337	37.3679	35.1733
050373	1.4497	1.2002	37.6695	40.8506	43.5055	40.7260
050376	1.6492	1.2002	36.7270	40.0354	42.4754	39.8599
050378	1.1137	1.2002	42.0480	50.0875	51.5092	47.5470
050380	1.8224	1.6059	52.5804	58.6395	60.9625	57.5372
050382	1.6019	1.2002	32.9248	34.3636	36.6641	34.7208
050385	1.4871	1.5428	36.5644	38.9773	44.3026	40.0228
050390	1.2847	1.2002	33.0463	31.4134	33.7927	32.7377
050393	1.4304	1.2002	35.1887	35.5678	38.9873	36.6236
050394	1.7929	1.2002	32.9572	37.2557	40.0176	36.7479
050396	1.5923	1.2002	38.9944	41.2602	41.6933	40.7032
050397	0.8415	1.2002	31.1621	32.3700	36.0861	33.4783
050407	1.2178	1.5036	47.5591	47.7943	48.9123	48.1149
050411	1.4376	1.2002	42.9884	44.3404	47.5402	44.9714
050414	1.3420	1.3217	45.1621	48.5863	51.1532	48.4113
050417	1.3322	1.2002	37.9951	38.8418	38.4087	38.4269
050423	1.0535	1.2002	32.4108	41.3130	43.7795	38.6501
050424	1.9481	1.2002	37.5246	39.8802	42.7414	40.2044
050425	1.4308	1.3217	45.3743	52.0378	53.7887	50.3034
050426	1.7182	1.2002	37.6505	*	37.1444	37.3893
050430	1.0514	*	25.9368	28.7102	*	27.6338
050433	***	*	23.0949	*	*	23.0949
050434	0.9730	1.2002	35.4807	34.4698	36.3651	35.4609
050435	1.2470	1.2002	35.7427	35.3040	36.3716	35.8152

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050438	1.6093	1.2002	38.2855	36.8507	37.7652	37.6241
050441	2.0773	1.6059	49.2129	50.0652	56.1662	51.9914
050444	1.4821	1.2235	39.3947	39.4231	41.6899	40.2059
050447	***	*	27.1271	*	*	27.1271
050448	1.2055	1.2002	32.6682	32.9244	35.5744	33.7517
050454	2.1384	1.5036	43.5230	46.9602	50.6105	47.1838
050455	1.5674	1.2002	35.0232	38.9871	39.4869	37.8773
050456	***	*	27.9702	28.1444	*	28.0651
050457	1.7524	1.5036	53.3175	54.6802	57.1259	55.0565
050464	1.8533	1.2002	42.6699	44.9128	46.6301	44.6843
050468	1.5593	1.2002	37.3416	35.7136	37.0600	36.6946
050470	***	*	32.5041	*	*	32.5041
050471	1.6569	1.2002	36.8185	37.6641	40.5399	38.3240
050476	***	*	41.7566	*	*	41.7566
050478	0.9581	1.2002	41.5635	44.3775	46.6521	44.3460
050481	1.6201	1.2002	42.8536	47.2326	50.1977	46.8143
050485	1.7165	1.2002	34.7078	37.4203	39.3266	37.2228
050488	1.5157	1.5855	49.3604	53.8013	53.3366	52.2027
050492	1.4172	1.2002	32.6609	35.6838	39.4538	36.0641
050496	1.8243	1.5536	56.7446	57.1030	61.4808	58.5059
050498	1.4628	1.3217	45.3508	46.6560	47.6863	46.5454
050502	1.7474	1.2002	32.9791	40.2876	37.2580	36.7036
050503	1.5401	1.2002	37.7210	40.7324	43.1770	40.6385
050506	1.5155	1.2121	40.6534	42.3670	45.0204	42.6481
050510	1.4186	1.5428	51.3143	54.8690	55.9873	54.0800
050512	1.4447	1.5855	50.1470	53.9292	55.7732	53.3348
050515	1.4010	1.2002	42.0106	45.0972	48.0118	45.0227
050516	1.6158	1.3217	45.6228	48.5267	48.0618	47.4427
050517	1.4708	1.2002	29.3694	29.8385	27.5129	28.8628
050523	1.3871	1.5536	46.9870	49.5029	53.7305	50.2368
050526	1.4939	1.2002	35.5457	*	36.5894	36.0188
050528	1.1577	1.2002	38.3051	41.9922	43.2318	41.2013
050531	1.1682	1.2002	28.4890	28.4921	31.0366	29.3122
050534	1.6008	1.2002	38.1892	39.7655	42.3047	40.1251
050537	1.6440	1.3217	41.5275	43.1765	45.7187	43.4999
050541	1.6420	1.5855	51.4545	55.2594	56.3321	54.3652
050543	0.7871	1.2002	32.8367	29.0470	31.0801	30.9554

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050545	0.9027	1.2002	*	27.4889	*	27.4889
050547	1.0068	1.5428	*	*	*	*
050548	0.7480	1.2002	*	*	*	*
050549	1.6820	1.2002	40.6796	44.6715	46.9107	44.1208
050550	***	*	39.2163	*	*	39.2163
050551	1.3889	1.2002	37.6223	39.4047	42.2041	39.7598
050552	0.9442	1.2002	35.3468	38.6658	41.1173	38.3633
050557	1.6479	1.2002	39.2224	41.9292	43.9916	41.7837
050561	1.3989	1.2002	40.1567	43.1147	46.9113	43.3701
050567	1.5237	1.2002	39.0114	41.7247	46.3879	42.4571
050568	1.1903	1.2002	26.7733	28.7691	30.1104	28.6056
050570	1.7113	1.2002	40.6761	40.3411	42.9671	41.3473
050573	1.6162	1.2002	36.8561	38.0175	41.0463	38.7328
050575	1.5692	1.2002	22.1018	32.1046	33.5745	29.0057
050578	***	*	43.4917	*	*	43.4917
050580	1.3315	1.2002	35.0966	36.7968	33.1767	35.0893
050581	1.6333	1.2002	40.0909	41.9698	45.2924	42.4394
050583	***	*	40.5845	41.3920	*	40.9835
050584	***	*	31.9910	30.8650	*	31.4271
050586	1.6278	1.2002	31.1932	32.7348	32.8095	32.2361
050588	1.4763	1.2002	39.4251	39.0347	41.0641	39.8351
050589	1.2827	1.2002	37.2056	39.2646	40.8842	39.1776
050590	1.4972	1.3217	44.3382	50.0371	49.7328	48.1461
050592	***	*	32.2376	*	*	32.2376
050597	1.4581	1.2002	32.8987	35.6567	37.5208	35.3960
050599	2.0012	1.3217	36.6146	38.9877	39.8105	38.5379
050601	***	*	43.2404	43.3329	46.0784	44.2186
050603	1.5047	1.2002	35.4809	37.4348	38.3834	37.1447
050604	1.6291	1.6059	49.6068	54.1687	55.6773	53.0805
050608	1.3872	1.2002	30.7280	28.3794	30.7212	29.9386
050609	1.4301	1.2002	43.4555	45.2475	49.1701	45.9890
050616	1.4949	1.2002	40.7388	45.2614	43.3018	43.0759
050618	0.9683	1.2002	34.9177	34.0584	35.2789	34.7493
050624	1.5075	1.2002	39.2553	40.2253	41.9206	40.5628
050625	1.8425	1.2002	44.8482	48.1826	46.7270	46.6153
050633	1.2030	1.2121	40.7383	41.1786	44.7463	42.2532
050636	1.4438	1.2002	35.4565	38.8844	39.6096	38.0088

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050641	1.3049	1.2002	32.0508	33.1417	34.1849	33.1406
050644	1.0475	1.2002	33.2777	32.1513	32.5153	32.6132
050660	1.6423	*	*	*	*	*
050662	1.1129	1.6059	*	*	*	*
050663	1.3695	1.2002	17.7252	30.4117	33.0151	26.4022
050667	0.8006	1.4010	25.8460	30.1039	32.0624	28.9596
050668	1.0786	1.5428	52.7011	62.7714	65.4231	60.6295
050674	1.4993	1.3217	48.6880	51.3517	53.4854	51.2273
050677	1.5581	1.2002	41.8130	44.4567	47.7267	44.6382
050678	1.4527	1.2002	35.8411	38.3361	39.9167	38.1597
050680	1.4613	1.5428	39.0389	40.7514	44.0282	41.3411
050682	0.6944	1.2002	22.3903	22.4419	*	22.4133
050684	1.2570	1.2002	33.5915	33.0982	35.4682	34.0341
050686	1.3750	1.2002	42.1444	45.2231	48.0040	45.1124
050688	1.3358	1.6059	53.2741	54.5423	56.6466	54.9010
050689	1.5695	1.5536	48.9935	50.2942	53.7493	51.0590
050690	1.3287	1.5428	51.6179	55.1002	55.3847	54.0619
050693	1.4804	1.2002	42.8266	41.9594	44.4380	43.0972
050694	1.2375	1.2002	34.8486	33.8553	35.2422	34.6536
050696	2.5549	1.2002	39.4353	41.2315	44.0844	41.4935
050697	1.1148	1.3277	26.7600	29.0854	30.2726	28.7053
050701	1.3546	1.2002	37.2839	38.4382	42.7575	39.6135
050704	1.1342	1.2002	32.2017	31.7051	32.1670	32.0293
050707	***	*	44.0254	49.4684	*	46.9800
050708	1.8358	1.2002	28.3074	34.4063	34.8907	31.9717
050709	1.6404	1.2002	29.5364	30.4570	28.8514	29.5817
050710	1.4205	1.2002	46.2533	51.1460	52.8041	50.0857
050714	1.5922	1.6059	42.9797	45.2746	47.4228	45.3980
050717	1.5965	1.2002	37.0875	42.2736	41.8557	40.5623
050720	***	*	32.1173	33.8712	34.7221	33.4577
050722	0.9563	1.2002	35.6741	35.2177	37.3302	36.1210
050723	1.5436	1.2002	42.1571	43.3875	47.0388	44.1779
050724	1.9468	1.2002	35.1020	35.5224	39.0539	36.5017
050725	0.9517	1.2002	28.8389	27.8565	*	28.3307
050726	1.6175	1.2002	30.6105	35.3964	36.4404	34.1918
050727	1.3740	1.2002	33.0932	29.0789	35.3258	32.5219
050732	2.3923	1.2002	34.3475	37.4333	37.9684	36.6936

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
050733	1.7727	1.3277	40.6320	44.7509	44.5719	43.2177
050735	1.4534	1.2002	36.6081	34.3859	34.2886	35.0721
050736	1.3576	1.2002	41.8938	38.0913	36.6220	38.8361
050737	1.7443	1.2002	38.0424	36.4535	38.0483	37.5164
050738	1.6053	1.2002	43.9259	40.3081	39.1266	41.0361
050739	1.6999	1.2002	57.2480	44.0540	40.0074	45.3865
050740	1.7415	1.2002	54.0370	44.8439	37.0976	43.5160
050741	***	*	51.1526	44.0305	*	47.5915
050742	1.6473	1.2002	39.2532	41.0036	44.3972	41.4615
050744	1.7380	1.2002	48.4951	56.5911	54.9148	53.1646
050745	1.4481	1.2002	42.5523	48.2903	48.8922	46.5732
050746	1.8123	1.2002	43.2015	46.3622	45.1988	44.9325
050747	1.8632	1.2002	44.5887	47.8242	47.3968	46.5482
050748	1.2527	1.2002	43.1008	50.6390	54.1242	49.3277
050749	1.3796	1.2002	28.2000	39.6030	41.4811	35.7689
050750	***	*	33.9915	*	*	33.9915
050751	3.5931	1.2002	29.5488	34.0436	36.5150	33.0527
050752	1.4901	1.2002	39.8035	41.3783	42.4687	41.1950
050754	1.2220	1.5182	*	56.3628	*	56.3628
050755	1.6182	1.2002	*	36.5212	36.5251	36.5232
050756	***	*	*	33.4951	*	33.4951
050757	1.7470	1.2002	*	*	42.3546	42.3546
050758	1.5779	1.2002	*	17.6509	27.8366	21.8706
050759	***	*	*	*	36.7495	36.7495
050760	1.3958	1.5536	*	*	*	*
050761	1.6126	1.2002	*	*	*	*
050762	1.4125	1.2002	*	*	*	*
050763	0.9992	1.2002	*	*	*	*
050764	1.6615	1.3277	*	*	*	*
050765	1.1291	1.2002	*	*	*	*
050766	1.5412	1.2002	*	*	*	*
060001	1.4318	1.0303	32.4226	32.5239	33.5009	32.8211
060003	1.5346	1.0303	31.8637	33.6264	34.9819	33.5098
060004	1.2485	1.0485	34.8428	34.5727	36.3214	35.2917
060006	1.2988	0.9581	27.6453	30.5664	30.7361	29.6331
060008	1.5166	0.9581	27.2071	26.0851	28.6913	27.3573
060009	1.6004	1.0485	34.0151	35.8398	36.9037	35.5950

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
060010	1.5399	0.9581	30.6424	33.5549	32.9241	32.3981
060011	1.5301	1.0485	34.4171	34.6239	36.6800	35.2356
060012	1.5328	0.9581	29.4365	29.6957	31.4807	30.2506
060013	1.6156	0.9581	28.0800	29.5100	30.9706	29.5285
060014	2.0318	1.0485	33.0366	35.6231	36.9360	35.1981
060015	2.1471	1.0485	36.3296	36.6824	38.2231	37.1141
060016	1.1827	0.9581	28.3055	30.0601	30.4208	29.6098
060018	1.0992	*	26.5788	*	*	26.5788
060020	1.6397	0.9581	26.7362	27.3823	29.0073	27.7438
060022	1.6431	0.9581	31.9376	32.0594	31.6915	31.8828
060023	1.6909	1.0303	32.7922	33.4798	34.9894	33.7723
060024	1.9110	1.0485	32.8206	36.1736	37.9233	35.6626
060027	1.5428	1.0303	31.6134	33.4869	33.6616	32.8750
060028	1.6913	1.0485	33.4966	35.8222	37.1167	35.5436
060030	1.4475	0.9581	31.2932	31.2752	32.9330	31.8568
060031	1.5069	1.0303	30.7381	32.0153	33.2299	32.0027
060032	1.6656	1.0485	34.6447	35.6500	37.4582	35.9181
060034	1.8224	1.0485	33.3656	34.6615	36.1706	34.7283
060036	1.1704	0.9581	20.9370	24.8220	25.3568	23.6418
060041	***	*	31.4739	*	*	31.4739
060043	0.8976	0.9581	23.3908	19.9611	20.3282	21.2601
060044	1.2481	0.9581	28.9200	32.0455	32.7653	31.1835
060049	1.4153	0.9581	32.1589	34.5262	35.5353	34.0821
060054	1.4909	1.0051	24.6721	29.2998	32.8197	29.3593
060064	1.8838	1.0485	37.2407	34.7448	36.3099	36.0591
060065	1.4593	1.0485	34.9205	36.2377	37.7892	36.3163
060071	1.1608	0.9581	31.5388	32.1367	32.4497	32.0600
060075	1.4614	1.0051	35.8081	37.3019	40.1016	37.8404
060076	1.3290	0.9581	31.6044	31.5032	31.8373	31.6524
060096	1.8302	1.0303	38.2249	39.9302	42.6189	40.4330
060100	1.7950	1.0485	33.5356	35.7861	36.6803	35.3368
060103	1.4229	1.0303	33.7542	34.9964	36.7528	35.2095
060104	1.5478	1.0485	37.1434	37.4598	39.0604	37.9751
060107	2.0677	1.0485	30.3991	30.0308	30.5898	30.3552
060112	1.7503	1.0485	35.1308	36.4093	37.9928	36.6034
060113	1.5005	1.0485	35.2097	36.0794	38.0309	36.4956
060114	1.6645	1.0485	35.3056	37.1394	37.6554	36.8077

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
060115	0.9083	0.9581	*	*	*	*
060116	1.4913	1.0303	33.1547	36.3560	36.9071	35.6457
060117	1.3581	0.9581	28.3112	31.6734	31.3013	30.6152
060118	1.4926	1.0303	*	40.2136	39.9922	40.0904
060119	1.9646	0.9581	*	*	34.0822	34.0822
060121	2.1298	1.0303	*	*	38.3284	38.3284
060123	1.8589	1.0485	*	*	*	*
070001	1.6363	1.2234	37.9438	38.4864	39.3014	38.5781
070002	1.7996	1.1251	36.4269	36.6624	39.3490	37.4818
070003	1.1819	1.1251	36.0524	36.6553	37.6699	36.7817
070004	1.1875	1.1251	31.2115	34.3803	35.1037	33.5419
070005	1.6586	1.2234	36.5502	37.3430	38.3363	37.4209
070006	1.6560	1.2817	41.2165	41.9550	43.2602	42.1481
070007	1.4209	1.1353	37.0984	38.9830	40.3319	38.8215
070008	1.3351	1.1251	35.4969	34.0603	35.8161	35.1073
070009	***	*	36.6382	38.1380	*	37.4141
070010	1.6960	1.2817	38.6114	38.7345	41.3102	39.5949
070011	1.4801	1.1251	32.6835	33.7313	36.9466	34.4150
070012	1.4730	1.1251	33.2477	35.4738	37.5683	35.3833
070015	1.5810	1.2817	39.9249	42.4738	43.1481	41.8469
070016	1.5918	1.2234	34.1266	34.5418	36.2707	34.9884
070017	1.4503	1.2234	37.5855	38.1713	41.0077	38.9339
070018	1.4031	1.2817	42.4771	44.1370	45.8974	44.2078
070019	1.5997	1.2234	35.8618	37.0666	39.8743	37.6317
070020	1.3867	1.1352	35.6542	40.4989	40.6182	39.0618
070021	1.1794	1.1251	39.7793	41.9076	43.8622	41.8599
070022	1.7333	1.2234	41.4721	41.5553	43.2394	42.1299
070024	1.5050	1.1353	36.8997	38.6301	39.2511	38.2737
070025	1.7003	1.1251	36.1322	38.7067	38.9328	37.9080
070027	1.5868	1.1251	33.5979	35.7677	36.5223	35.3536
070028	1.5644	1.2817	40.9645	41.2950	42.0488	41.4517
070029	1.3443	1.1251	32.8504	35.4716	36.0406	34.8141
070031	1.3419	1.2234	30.5924	33.2618	33.5139	32.4882
070033	1.4782	1.2817	44.6717	46.5982	47.7688	46.3583
070034	1.5225	1.2817	42.4111	45.7694	44.0374	44.0855
070035	1.4095	1.1251	33.4047	38.2298	35.3357	35.6697
070036	1.7475	1.1654	43.6374	44.0756	46.4609	44.7773

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
070038	0.9441	1.2234	29.9516	33.5109	31.4454	31.4773
070039	1.0971	1.2234	32.7153	35.9137	36.2927	35.1271
070040	1.0743	1.1251	*	26.3824	30.5486	28.3408
080001	1.6907	1.0802	34.9507	37.4441	39.1835	37.2540
080002	***	*	33.0404	33.3472	35.2276	33.8892
080003	1.5403	1.0802	30.5132	29.0166	31.5225	30.4059
080004	1.6748	1.0690	34.3854	33.6190	35.0266	34.3423
080006	1.5520	1.0090	31.0327	30.7985	29.2411	30.3636
080007	1.7565	1.0903	33.4782	35.5425	37.5631	35.5927
090001	1.7104	1.0561	40.1658	38.3876	39.8134	39.3691
090003	1.3090	1.0561	34.4430	37.2088	37.3982	36.3730
090004	2.0589	1.0573	38.5681	39.9027	40.6216	39.7496
090005	1.3805	1.0561	35.2884	35.1327	36.9545	35.7927
090006	1.4341	1.0561	32.3654	32.5988	34.9946	33.3147
090008	1.5880	1.0561	36.6633	40.3260	41.7318	39.2644
090011	2.1681	1.0561	39.0111	39.5389	41.3036	39.9493
100001	1.6225	0.8902	27.8526	30.5213	30.2446	29.5877
100002	1.5581	1.0364	30.6668	33.1103	34.4039	32.7223
100006	1.6837	0.9178	28.9769	29.2697	31.1090	29.8250
100007	1.6560	0.9178	30.3379	30.6689	32.7648	31.2751
100008	1.6404	1.0222	32.1679	32.3397	34.9341	33.1587
100009	1.6764	1.0222	30.0492	32.0145	33.5623	31.8710
100012	1.6726	0.9167	30.8626	30.2066	32.0081	31.0290
100014	1.5567	0.9178	27.4064	28.8679	32.2443	29.5972
100015	***	*	28.6825	29.9757	31.5936	30.0347
100017	1.6037	0.9178	29.8705	31.2313	32.0601	31.0930
100018	1.7857	0.9809	32.8642	34.2077	34.9524	34.0313
100019	1.7306	0.9332	31.4549	32.2496	34.2627	32.6917
100022	1.7695	1.0364	36.3355	40.4664	42.4881	39.7952
100023	1.6827	0.9094	27.1032	27.7860	27.8953	27.6060
100024	1.2216	1.0222	29.8918	31.5160	30.5545	30.6338
100025	1.8056	0.8458	27.1665	28.7604	29.6928	28.5823
100026	1.6151	0.8458	27.3044	28.5877	27.8367	27.9162
100028	1.4448	0.9332	28.7801	28.1509	31.9846	29.6732
100029	1.3707	1.0222	31.6006	33.2920	34.8161	33.2424
100030	1.4694	0.9178	26.3113	27.0977	30.8824	28.0853
100032	1.7391	0.9094	27.8942	29.3641	30.3253	29.1887

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
100034	1.8674	1.0222	28.9387	29.8997	29.6114	29.4885
100035	1.5772	0.9265	32.5593	31.2325	31.4578	31.7203
100038	1.6264	1.0364	32.8392	37.0928	37.1884	35.7516
100039	1.9693	1.0364	29.0236	32.6863	32.2419	31.3704
100040	1.7070	0.8902	28.3366	29.8029	29.6297	29.2510
100043	1.4166	0.9094	26.8417	29.1014	31.1972	28.9417
100044	1.5653	1.0762	34.3920	34.4743	41.7922	37.0061
100045	1.3103	0.9178	25.5621	27.8526	28.1643	27.2127
100046	1.5558	0.9094	27.7878	29.7844	30.9730	29.5992
100047	1.6811	0.9265	31.4072	31.8998	32.2047	31.8452
100048	0.9614	0.8458	21.7693	22.7260	23.5379	22.6813
100049	1.3320	0.8628	27.6316	26.9145	27.7020	27.4184
100050	1.2458	1.0222	23.5222	23.7419	24.5868	23.9540
100051	1.4875	0.9178	30.1492	28.7367	30.6461	29.8530
100052	1.4003	0.8628	25.1110	27.6591	28.4807	27.1112
100053	1.4162	1.0222	31.9268	33.6936	35.2550	33.5895
100054	1.4027	0.8762	30.9840	33.2237	36.2168	33.5037
100055	1.4759	0.9094	29.7027	28.5830	30.4298	29.5982
100057	1.4780	0.9178	27.7045	30.4258	30.5235	29.5810
100061	1.5789	1.0222	31.9174	33.9803	34.8482	33.5811
100062	1.7148	0.8578	26.3067	28.0821	29.2949	27.9112
100063	1.4087	0.9094	27.0769	29.5864	31.2488	29.3363
100067	1.5488	0.9094	27.5501	30.0555	31.5618	29.6772
100068	1.7784	0.9178	27.7707	28.5177	28.0307	28.1041
100069	1.8450	0.9094	29.0486	33.4008	32.7796	31.7251
100070	1.6892	0.9265	29.1117	27.1313	27.9973	28.0427
100071	1.3529	0.9094	25.1883	25.6870	27.8655	26.2748
100072	1.4518	0.9178	27.6947	28.6435	29.6882	28.7088
100073	1.7399	1.0364	31.0395	33.8783	33.7457	32.8947
100075	1.5788	0.9094	26.7571	29.2992	31.2004	29.0714
100076	1.2234	1.0222	24.0280	23.7078	26.3433	24.4935
100077	1.3992	0.9265	27.9783	28.0178	29.5962	28.5634
100079	1.5106	*	*	*	*	*
100080	1.6204	1.0364	31.0516	33.2091	35.4485	33.2130
100081	1.0281	0.8565	19.7406	17.2548	17.7222	18.2774
100084	1.6551	0.9178	30.6301	30.7165	35.1858	32.1812
100086	1.5751	1.0364	31.3187	33.0726	33.7048	32.7154

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
100087	1.8405	0.9265	32.1314	33.4104	33.2328	32.9255
100088	1.7052	0.8902	29.4952	30.3481	30.9148	30.2877
100090	1.4563	0.8902	28.9581	27.4996	28.2012	28.2140
100092	1.5558	0.9332	28.6782	29.1433	29.6087	29.1462
100093	1.7452	0.8458	23.4847	24.9505	25.8345	24.7522
100099	1.1448	0.8628	28.0688	28.2871	30.0337	28.8423
100102	1.0551	0.8458	29.0396	30.0754	28.5248	29.1936
100105	1.5943	1.0283	30.8936	31.5294	33.0707	31.8950
100106	1.0979	0.8458	25.6288	20.6449	26.2560	24.0768
100107	1.2712	0.9167	31.2954	30.9662	32.4297	31.5714
100108	***	*	22.8153	17.9561	17.5426	19.1444
100109	1.3854	0.9178	26.7380	29.1403	29.2478	28.3934
100110	1.6147	0.9178	30.3758	32.4083	32.8616	31.9067
100113	2.0648	0.9406	30.6037	30.9741	33.2418	31.6327
100114	***	*	32.3956	34.3630	*	33.3214
100117	1.1720	0.8902	30.0281	30.6894	31.4492	30.7465
100118	1.4486	0.8458	28.3201	31.3833	28.6480	29.3969
100121	1.1958	0.8628	25.0320	20.0814	27.6294	24.2372
100122	1.2388	0.8762	27.6178	27.9970	28.5222	28.0534
100124	1.1993	0.8458	26.2329	28.2667	28.9298	27.8069
100125	1.2299	1.0222	33.3499	35.2588	37.2705	35.4531
100126	1.3809	0.9094	28.9164	30.3912	31.2105	30.1653
100127	1.6431	0.9094	27.0686	29.3856	31.1177	29.1793
100128	2.2037	0.9094	30.6202	29.6793	31.2298	30.5186
100130	1.3212	1.0364	29.5763	29.9727	29.8339	29.7970
100131	1.3800	1.0222	30.9614	32.2086	33.9594	32.3908
100132	1.3499	0.9094	27.6632	29.3380	30.9567	29.3475
100134	0.8526	0.8458	22.9635	24.7863	23.0684	23.5589
100135	1.6829	0.8981	29.8452	30.2093	34.2492	31.4439
100137	1.4023	0.8628	28.3000	27.8783	28.6777	28.2947
100139	0.9036	0.9406	21.4418	22.1683	21.4572	21.6824
100140	1.1241	0.8902	28.5485	29.7482	30.7155	29.6963
100142	1.2138	0.8458	26.8995	26.8829	25.1309	26.3144
100150	1.2062	1.0222	29.3711	33.0132	32.5785	31.6449
100151	1.9703	0.8902	31.3846	33.1725	34.9557	33.1543
100154	1.7005	1.0222	31.3640	32.3793	34.9899	32.9507
100156	1.1212	0.8458	28.3060	29.9029	31.1552	29.8254

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
100157	1.5825	0.9094	30.3359	30.4870	31.8594	30.8981
100160	1.1017	1.0222	32.3136	33.8433	35.2448	33.8503
100161	1.6418	0.9178	30.8984	32.6427	33.0240	32.1874
100166	1.6290	0.9265	31.9072	33.0019	34.8424	33.2088
100167	1.5548	1.0364	32.4740	34.8085	36.1348	34.4179
100168	1.7112	1.0364	28.0543	31.1427	32.5053	30.6385
100172	***	*	20.5518	*	*	20.5518
100173	1.7179	0.9094	30.2491	30.3599	30.9982	30.5313
100175	1.0188	0.8458	26.1723	26.8828	30.6970	27.8555
100176	1.7599	1.0364	35.5849	35.7433	37.0046	36.1156
100177	1.4618	0.9332	31.0085	31.3830	32.8491	31.7568
100179	1.7363	0.8902	30.5439	31.8790	33.3430	31.9272
100180	1.4792	0.9094	31.5485	32.3796	34.6817	32.8425
100181	1.4002	1.0222	26.0682	26.0880	26.4568	26.2189
100183	1.3902	1.0222	32.9893	31.6760	33.2466	32.6280
100187	1.4893	1.0222	31.6660	31.8020	34.2328	32.5967
100189	1.4419	1.0364	30.5516	32.8847	34.2447	32.5432
100191	1.3645	0.9094	30.9212	31.6024	33.7871	32.0675
100200	1.5295	1.0364	29.0731	32.5611	33.7050	31.7495
100204	1.6164	0.9406	29.9334	30.6252	31.4765	30.6899
100206	1.3259	0.9094	28.8625	30.4576	31.2653	30.2061
100209	1.6863	1.0222	29.0462	30.5582	32.8523	30.8033
100210	1.6173	1.0364	32.4566	33.3016	34.2993	33.3096
100211	1.2867	0.9094	28.8328	30.5902	31.6079	30.3679
100212	1.5679	0.8578	29.2500	30.5141	31.1368	30.3163
100213	1.5727	0.9265	30.2271	31.4309	33.1230	31.5995
100217	1.2905	1.0283	30.3325	33.5767	30.5641	31.4346
100220	1.6269	0.9167	30.8292	31.8393	33.1625	32.0038
100223	1.6223	0.8762	27.6775	28.6449	30.3741	28.8695
100224	1.3813	1.0364	29.2008	31.0307	33.6361	31.2128
100225	***	*	32.6906	31.8048	*	32.2587
100226	1.3734	0.8902	30.2857	30.8904	31.4361	30.8818
100228	1.4519	1.0364	31.0222	32.2672	34.6713	32.6412
100230	1.4348	1.0364	34.6133	35.9319	36.1673	35.6194
100231	1.6148	0.8458	28.3652	28.8912	29.8895	29.0352
100232	1.4309	0.9406	29.3797	30.3768	30.7940	30.1690
100234	1.3292	1.0364	29.7818	33.1508	35.3677	32.6857

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
100236	1.4897	0.9265	30.5719	31.4385	33.2992	31.8165
100237	***	*	33.9626	33.9696	34.7138	34.1878
100238	1.6561	0.9094	31.6353	32.8745	35.1867	33.2711
100239	1.5075	0.9094	30.3234	32.7150	33.9579	32.2861
100240	1.1030	1.0222	31.0951	35.3888	36.6032	34.5027
100242	1.5952	0.8458	27.8169	28.5034	29.7347	28.6980
100243	1.5542	0.9094	29.8323	31.4863	32.5227	31.3056
100244	1.4331	0.9167	29.8287	29.1611	30.3453	29.7743
100246	1.5614	1.0762	30.0467	32.5063	33.5469	32.0515
100248	1.5668	0.9094	32.4725	33.7659	36.0601	34.0862
100249	1.3514	0.9094	28.5117	29.7981	30.5240	29.6388
100252	1.2169	1.0283	29.1448	31.5631	33.8245	31.4852
100253	1.4998	1.0364	28.5617	29.4959	31.3059	29.8138
100254	1.5108	0.8981	28.5262	28.9095	30.8142	29.4282
100255	1.3545	0.9094	29.5172	30.0466	31.9271	30.4950
100256	1.6224	0.9094	33.3936	34.6637	34.8304	34.2928
100258	1.6613	1.0364	35.2225	34.2862	36.3146	35.2877
100259	1.2922	0.9094	29.9294	32.2273	33.8210	31.9723
100260	1.5192	1.0762	29.4907	31.5667	33.8328	31.6747
100264	1.5444	0.9094	30.1980	31.5050	33.9279	31.9530
100265	1.4504	0.9094	26.6940	28.6915	30.9790	28.8513
100266	1.4224	0.8458	25.6382	26.4488	27.7418	26.6590
100267	1.2849	0.9265	30.6051	32.3955	33.7231	32.2103
100268	1.2089	1.0364	33.6225	33.5314	34.5858	33.9080
100269	1.4107	1.0364	28.3745	30.9572	33.5064	30.8897
100271	2.2229	*	*	*	*	*
100275	1.3264	1.0364	31.0487	31.5424	33.3199	32.0064
100276	1.3326	1.0364	31.7067	32.3992	34.3287	32.8345
100277	1.3799	1.0222	25.5926	27.0942	28.4949	27.0616
100279	***	*	31.1951	31.6691	33.9735	32.3443
100281	1.4063	1.0364	32.8840	36.3173	36.3681	35.2827
100284	1.1512	1.0222	21.4420	24.4155	25.5819	23.7595
100285	1.2393	1.0364	34.7999	36.2107	37.2874	36.2349
100286	1.6176	0.9809	26.5809	26.1494	32.3293	29.0001
100287	1.4754	1.0364	30.3085	32.3704	34.0899	32.1810
100288	1.7381	1.0364	32.9587	35.3363	36.0630	34.7728
100289	1.5892	1.0364	31.4727	31.7699	33.2012	32.2125

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
100290	1.2699	0.9178	29.7588	31.7110	32.8039	31.5893
100291	1.2805	0.9332	28.3780	28.3455	28.7323	28.4870
100292	1.4540	0.8565	28.5807	29.8156	30.8473	29.8365
100296	1.4038	1.0222	31.1475	31.8730	34.2725	32.5067
100298	0.8558	0.8981	21.9247	17.8678	19.4952	19.4589
100299	1.4576	0.9265	31.6840	31.5048	31.4297	31.5278
100300	***	*	33.1693	*	*	33.1693
100301	***	*	*	33.6261	*	33.6261
100302	1.1221	0.9178	*	27.9362	29.7289	28.8052
100303	***	*	*	*	24.9650	24.9650
100307	1.5052	0.8902	*	*	*	*
100308	1.8792	0.9094	*	*	*	*
100309	2.7432	0.9824	*	*	*	*
100310	3.4842	0.9824	*	*	*	*
100311	2.4626	0.9094	*	*	*	*
110001	1.4636	0.8602	27.6480	28.5465	29.5684	28.6101
110002	1.3129	0.8970	28.9013	32.2910	31.4618	30.8489
110003	1.3324	0.7782	25.0089	26.0330	25.4762	25.5083
110004	1.3418	0.8794	27.2528	26.8828	29.0667	27.7197
110005	1.4382	0.9572	29.6009	30.4924	30.9276	30.4128
110006	1.6178	0.9348	30.8495	32.2597	34.4102	32.5400
110007	1.7505	0.9098	28.0684	29.8618	31.7901	29.9011
110008	1.4810	0.9572	31.8387	33.5616	31.8787	32.4273
110010	2.4555	0.9572	33.9848	33.7073	37.5179	35.0462
110011	1.4340	0.9572	30.3534	32.2028	34.6167	32.4547
110015	1.0789	0.9572	30.5016	31.7245	32.9437	31.7570
110016	1.3214	0.8621	25.9209	26.3449	27.9587	26.7064
110018	1.4095	0.9572	30.9422	30.8295	32.9879	31.5762
110020	***	*	29.4641	30.4725	31.6465	30.4885
110023	1.4384	0.9572	29.2018	31.1890	31.5376	30.6943
110024	1.5142	0.8858	28.5660	30.7207	31.0718	30.1390
110025	1.4691	0.9352	31.8968	31.0532	32.4958	31.8053
110026	1.1774	0.7782	24.3863	25.6943	25.5958	25.1969
110027	1.0792	0.7782	25.6532	26.2689	26.5342	26.1268
110028	1.8270	0.9571	32.8706	34.0699	34.0976	33.6914
110029	1.8427	0.9572	30.1146	31.6425	33.8978	31.8764
110030	1.4738	0.9572	32.0275	33.2158	35.3984	33.6145

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
110031	1.2980	0.9572	30.7462	30.4811	31.6496	30.9694
110032	1.2257	0.7782	24.4968	23.1156	25.3848	24.3265
110033	***	*	32.7039	31.9373	*	32.3312
110034	1.8212	0.9571	29.6819	30.4053	34.1394	31.4559
110035	1.6957	0.9572	31.5737	31.8545	33.7827	32.4229
110036	1.9192	0.8858	28.4041	29.4915	30.6530	29.5209
110038	1.6353	0.7840	23.3669	24.2742	26.0470	24.6113
110039	1.3610	0.9571	28.4376	28.9594	29.2688	28.9113
110040	1.0861	0.9572	21.5762	21.1939	23.4093	22.0778
110041	1.4490	0.9348	27.6609	29.2068	29.6983	28.8467
110042	1.0433	0.9572	34.5137	34.0568	35.6003	34.7521
110043	1.8463	0.8858	30.3728	31.1628	31.4697	31.0207
110044	1.1492	0.7782	27.0431	25.0449	25.2725	25.8029
110045	1.0749	0.9572	28.2232	31.6766	31.6090	30.4800
110046	1.1860	0.9572	28.6286	28.4212	30.3845	29.1786
110050	1.0846	0.8483	27.1533	29.2759	30.0217	28.7933
110051	1.1636	0.7782	22.1491	23.3866	25.5805	23.8633
110054	1.5235	0.9572	31.5798	27.9775	28.7220	29.3745
110059	1.1670	0.7782	24.9271	24.4436	25.3086	24.8831
110064	1.7636	0.9119	28.7296	30.0182	33.6996	30.7770
110069	1.4012	0.8970	30.6465	31.0168	29.2608	30.2522
110071	1.0603	0.7782	23.6499	22.6384	22.8137	23.0100
110073	1.1093	0.7782	23.0072	23.4570	24.6046	23.6849
110074	1.6250	0.9348	29.0310	30.4310	32.0070	30.5025
110075	1.3248	0.8858	26.1089	26.7302	27.8478	26.9319
110076	1.6273	0.9572	31.0661	30.4815	31.6821	31.0859
110078	2.1377	0.9572	32.0516	35.8457	34.2909	34.0297
110079	1.5730	0.9572	29.0905	28.9872	29.4495	29.1738
110082	2.0493	0.9572	31.1478	33.1144	35.7031	33.2771
110083	2.0957	0.9572	34.5798	34.7446	35.7676	35.0417
110086	1.3316	0.7782	23.4772	23.1298	23.4255	23.3429
110087	1.6146	0.9572	32.8029	33.9036	33.1508	33.2981
110089	1.0939	0.7782	26.0116	25.4960	27.7584	26.4217
110091	1.4186	0.9572	28.0637	29.4898	30.4058	29.2918
110092	1.1014	0.7782	22.8602	24.5262	28.2182	24.9164
110095	1.4911	0.8547	28.0480	31.2298	30.8338	30.0970
110100	0.9291	0.8572	20.0638	22.9014	22.3608	21.8873

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
110101	1.0901	0.7849	23.8601	25.5998	27.0115	25.5015
110104	1.2299	0.7782	22.2596	22.3707	22.3377	22.3206
110105	1.3045	0.8547	23.7752	24.6128	25.9808	24.8167
110107	1.9862	0.9368	31.5783	34.3508	31.8817	32.6134
110109	0.9841	0.7782	21.6019	22.5719	24.1377	22.7275
110111	1.2997	0.9571	27.6501	25.7188	26.1218	26.4751
110112	1.0053	0.8547	24.2935	23.2426	23.9046	23.7940
110113	0.9056	0.9571	22.0472	24.2980	23.8703	23.3793
110115	1.8784	0.9572	33.3902	34.4864	35.7096	34.5483
110121	1.0235	0.7782	24.5653	27.4406	28.0044	26.6723
110122	1.5890	0.8795	26.3071	28.0334	29.0791	27.8028
110124	0.9766	0.7782	24.8552	28.7544	30.2200	27.9406
110125	1.3181	0.8970	26.5006	29.4103	30.8516	28.8615
110128	1.3499	0.7782	24.5284	27.1987	29.1767	26.8886
110129	1.6241	0.9119	29.7332	26.8229	29.6690	28.7891
110130	0.8616	0.7782	21.7089	21.0352	21.7302	21.5091
110132	0.9942	0.7782	21.6039	22.3816	23.0261	22.3425
110135	1.4233	0.7782	25.1027	25.6594	25.4541	25.3958
110142	0.9519	0.7967	22.2164	21.2836	23.4220	22.2520
110143	1.4910	0.9572	30.9621	31.3623	33.8251	32.0572
110146	0.9949	0.9352	30.1181	32.7307	33.2928	32.0816
110150	1.3556	0.8970	27.7920	28.7549	25.9718	27.3903
110153	1.2669	0.8970	30.5108	30.2843	29.0378	29.9181
110161	1.6539	0.9572	32.0002	32.9894	34.2402	33.1043
110163	1.5743	0.9098	29.5693	30.7798	31.5968	30.6951
110164	1.7796	0.9368	31.2830	32.7865	34.6876	32.9571
110165	1.5814	0.9572	28.7925	28.4324	29.6512	28.9468
110168	1.8987	0.9572	30.8750	31.8921	32.9718	31.9136
110172	***	*	33.0452	34.0243	*	33.5073
110177	1.9707	0.9571	30.5526	31.9338	34.1139	32.1851
110183	1.3243	0.9572	29.6622	32.0200	32.3945	31.3716
110184	1.2816	0.9572	30.2920	30.8380	33.5282	31.6112
110186	1.3175	0.9119	29.6503	32.0599	32.7164	31.3889
110187	1.2145	0.9572	31.0164	27.6729	30.2062	29.5462
110189	1.0743	0.9572	27.4207	28.9465	30.6935	29.0587
110190	1.0617	0.8470	29.4198	28.7747	35.0710	30.9664
110191	1.4803	0.9572	28.7505	30.0142	32.1599	30.3011

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
110192	1.5471	0.9572	31.6627	32.6403	33.8949	32.7867
110194	0.8287	0.7782	20.5267	23.2382	22.8941	22.2276
110198	1.4509	0.9572	34.0050	33.2450	34.3576	33.8700
110200	2.3051	0.9119	29.4633	29.6256	31.9920	30.3302
110201	1.5909	0.9368	33.4292	35.8335	37.5429	35.6404
110203	1.0033	0.9572	32.0594	33.0119	39.2026	34.2394
110205	1.1254	0.8289	26.1973	25.5319	25.5795	25.7616
110209	0.8544	0.7782	22.4549	21.6681	24.1927	22.7937
110212	1.1580	0.8131	*	23.4398	24.7805	24.1197
110215	1.5772	0.9572	30.1793	31.2779	34.0438	31.9379
110219	1.5092	0.9572	33.4481	34.8875	35.5795	34.5964
110225	1.4407	0.9572	28.9773	29.6272	31.3111	30.0865
110226	1.2984	0.9572	32.1840	30.2150	31.1969	31.1849
110229	1.5914	0.9572	*	*	30.3562	30.3562
110230	1.4559	0.9572	*	*	35.0804	35.0804
110231	2.6459	0.9348	*	*	*	*
120001	1.9654	1.1635	39.0371	39.2838	41.7842	40.0704
120002	1.3903	1.1292	37.7287	38.3420	40.8461	39.0696
120004	1.4516	1.1635	32.5164	33.3874	34.8788	33.5345
120005	1.4037	1.1292	35.1996	38.2915	39.9388	37.8326
120006	1.3827	1.1635	35.7089	37.6360	38.8087	37.4368
120007	1.6959	1.1635	35.0193	34.8231	35.1439	34.9953
120010	2.0707	1.1635	34.3371	37.3680	38.3032	36.3762
120011	1.6395	1.1635	43.7527	45.9848	46.1156	45.3395
120014	1.3862	1.1292	34.2127	38.1372	37.5329	36.5854
120019	1.1857	1.1292	36.1879	37.4564	39.5249	37.7583
120022	1.8805	1.1635	34.9048	35.3877	38.3908	36.2596
120026	1.4967	1.1635	35.8413	38.2128	40.8061	38.3647
120027	1.4876	1.1635	31.8177	32.7112	36.4792	33.4996
120028	1.3976	1.1292	34.6354	34.7783	35.3970	34.9858
130002	1.4862	0.9068	24.3501	26.4728	25.9204	25.6067
130003	1.7141	0.9659	29.8793	31.4275	32.0498	31.1265
130006	1.7583	0.9305	29.0504	30.0002	31.6998	30.3256
130007	1.8904	0.9305	31.2268	33.4536	33.5741	32.8364
130013	1.4315	0.9305	33.8928	33.6160	34.7966	34.1028
130014	1.2836	0.9305	28.2831	29.1200	31.1589	29.5140
130018	1.7913	0.9676	30.2047	31.8735	34.0700	32.0682

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
130024	1.2438	0.8262	25.3197	24.4757	27.9247	25.9223
130025	1.2892	0.7587	23.8592	24.2424	25.4832	24.5583
130028	1.7322	0.9379	29.3374	30.5090	32.7435	30.8806
130049	1.6650	1.0384	29.7211	30.8293	32.3219	31.0108
130062	***	*	28.3419	38.1416	38.2016	35.1513
130063	1.5471	0.9305	27.7697	28.8897	30.6360	29.0590
130065	2.0187	0.9676	25.8998	29.4957	31.7109	28.7350
130066	2.3072	0.9535	28.1502	29.3049	30.2156	29.2289
130067	3.0407	0.9676	26.8285	28.6474	*	27.6699
130068	***	*	*	25.8399	*	25.8399
130069	2.8776	0.9305	*	*	*	*
130070	2.9727	0.9305	*	*	*	*
140001	1.2495	0.8749	23.2233	23.7481	24.5618	23.9087
140002	1.5362	0.9060	29.1097	29.6312	30.7187	29.8279
140007	1.5429	1.0503	32.4449	34.2607	34.4024	33.7444
140008	1.5089	1.0515	32.7618	33.2563	33.8475	33.2685
140010[3]	1.5525	1.0515	39.3727	39.7245	41.6706	40.3259
140B10[3]	***	*	39.3727	39.7245	41.6706	40.3212
140011	1.1871	0.8380	26.2135	27.0019	27.8999	27.0776
140012	1.1826	1.0370	31.9613	33.0198	33.9621	33.0388
140013	1.3956	0.9289	26.4199	28.2787	29.7601	28.1742
140015	1.3818	0.8955	25.2504	25.8304	27.2800	26.1224
140018	1.4659	1.0515	31.5624	31.2535	32.8781	31.9237
140019	0.9025	0.8380	22.2907	22.9179	22.1774	22.4623
140026	1.2390	0.8695	28.1718	28.5497	28.8965	28.5453
140029	1.6147	1.0503	34.8938	37.7285	39.2923	37.4109
140030	1.6091	1.0503	32.1135	32.8927	34.5324	33.1540
140032	1.2724	0.8955	28.5242	28.4605	28.8062	28.6026
140033	0.8477	1.0736	31.4347	32.3417	37.3159	32.3454
140034	1.2373	0.8955	26.7250	27.6121	29.4226	27.8956
140040	1.2933	0.9179	28.5016	30.5814	29.5659	29.5161
140043	1.2977	0.8658	31.3754	34.4429	36.6352	34.1714
140046	1.5473	0.8955	25.7925	26.8384	27.7909	26.8011
140048	1.3808	1.0515	31.6290	34.4373	35.6153	33.9229
140049	1.5889	1.0515	32.0239	33.6104	35.1305	33.5575
140051	1.6022	1.0515	32.6517	32.7898	35.9661	33.8131
140052	1.4729	0.9060	26.7916	27.7932	28.3571	27.6322

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
140053	1.8431	0.8948	29.9487	32.7126	32.7073	31.7542
140054	1.5563	1.0515	34.5369	36.9786	37.5300	36.3814
140058	1.2163	0.8948	26.5671	28.6945	29.4589	28.2825
140059	1.1060	0.9060	22.8597	24.6248	27.1293	24.8684
140062	1.4327	1.0515	36.6718	38.3407	40.0353	38.3865
140063	1.5742	1.0515	31.1266	34.4732	34.2888	33.3236
140064	1.2440	0.9179	26.6249	28.5964	28.7175	28.0100
140065	1.5255	1.0515	32.4661	34.3988	34.8576	33.9264
140066	0.8358	0.9060	23.6304	24.3856	25.8813	24.6266
140067	1.8100	0.9289	30.6911	31.9470	33.6485	32.1175
140068	1.3473	1.0515	31.3463	32.8724	34.3346	32.8242
140075	***	*	33.6872	34.9376	37.0601	35.1205
140077	1.1765	0.9060	22.5074	24.2006	27.9915	24.7807
140080	1.6004	1.0515	30.3788	33.0275	33.9568	32.4504
140082	1.6828	1.0515	32.0562	33.4686	33.5580	33.0486
140083	1.0840	1.0515	26.1639	29.5034	26.0278	27.1377
140084	1.4066	1.0736	31.3307	32.1286	34.0802	32.4884
140088	2.0925	1.0515	34.4137	36.6991	39.5656	36.8355
140089	1.1697	0.8380	26.6955	27.5295	28.0437	27.4281
140091	1.7821	1.0161	29.7381	33.7851	35.7416	33.1415
140093	1.3604	0.9722	31.2973	29.3377	33.9418	31.5446
140094	0.7328	1.0515	28.8621	28.0819	31.7652	29.3420
140095	1.3861	1.0515	29.9626	35.7876	34.5168	33.4434
140100	1.5029	1.0736	37.3044	39.0405	53.2763	43.9761
140101	1.2867	1.0503	31.0070	32.4260	33.9464	32.5018
140103	1.1752	1.0515	25.3630	26.4236	27.1901	26.3291
140105	***	*	30.7154	*	*	30.7154
140110	1.0816	1.0370	31.3486	33.7263	37.0537	34.0414
140113	1.5438	1.0161	31.6191	33.2262	34.9622	33.3322
140114	1.5369	1.0515	31.1412	31.7038	31.4289	31.4242
140115	1.1726	1.0515	26.2606	30.2062	33.4032	29.8398
140116	1.4871	1.0515	34.2519	35.6726	37.3731	35.8074
140117	1.6529	1.0515	28.5809	34.6766	33.8389	32.2626
140118	1.5189	1.0515	33.8168	34.9352	35.7829	34.8477
140119	1.9388	1.0515	34.6543	35.5146	39.1814	36.4476
140120	1.2850	0.9289	26.2418	27.0681	28.1509	27.1802
140122	1.6620	1.0503	32.4750	34.2512	35.7240	34.1638

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
140124	1.2545	1.0515	38.8976	39.9267	42.6211	40.3601
140125	1.1748	0.9060	27.6352	28.3533	30.1443	28.6668
140127	1.5604	0.9567	29.3352	30.9124	32.7929	30.9550
140130	1.3285	1.0736	34.9907	35.8275	36.5321	35.7850
140133	1.3550	1.0515	32.8941	34.0222	33.5193	33.4793
140135	1.4489	0.9154	25.9057	26.6854	27.2912	26.6118
140137	1.0866	0.9060	*	27.0616	26.9569	27.0094
140143	1.1048	0.8380	27.0312	27.2878	28.8821	27.7646
140145	1.3204	0.9060	26.9344	28.3622	29.2121	28.2021
140147	1.0814	0.8380	22.1035	22.6508	23.5511	22.7827
140148	1.7060	0.8948	28.9471	30.1467	30.0605	29.7419
140150	1.6603	1.0515	39.0316	41.6125	42.0035	40.9013
140151	0.9472	1.0515	27.3552	28.0758	27.9212	27.7895
140152	***	*	32.2803	*	*	32.2803
140155	1.3206	1.0370	35.0825	36.2360	42.9342	38.0739
140158	1.4480	1.0515	32.0137	31.7570	32.5513	32.1276
140160	1.3230	0.9874	28.9043	30.0100	29.7281	29.5556
140161	1.4829	1.0370	28.8150	33.5158	34.2463	32.1524
140162	1.6404	0.9567	33.0995	33.2372	34.3289	33.5598
140164	1.7410	0.8380	27.3133	27.5981	28.8827	27.9483
140166	1.2438	0.9154	27.6725	27.5406	28.8318	28.0436
140167	1.1637	0.8380	24.2749	21.2479	26.4163	23.8760
140172	1.4264	1.0515	33.4616	36.8394	37.7898	35.9979
140174	1.6817	1.0503	33.9382	35.1535	37.2213	35.4862
140176	1.2563	1.0515	33.2235	34.3901	35.2474	34.3194
140177	1.0534	1.0515	26.0727	28.0720	30.3713	28.2119
140179	1.4032	1.0515	31.3624	30.6997	31.6593	31.2406
140180	1.4341	1.0515	29.8009	31.4683	33.1831	31.5677
140181	1.2767	1.0515	27.5414	29.0862	28.5827	28.4001
140182	1.5270	1.0515	26.4103	34.4971	35.0847	31.5371
140184	1.4579	0.8380	27.5858	28.2155	30.8810	28.8696
140185	1.4880	0.9060	27.9433	29.7742	31.1163	29.6209
140186	1.5823	1.0370	32.8063	32.5128	33.6497	32.9984
140187	1.5586	0.9060	26.9265	29.2345	29.0150	28.4359
140189	1.2512	0.8380	29.1371	25.9192	29.7443	28.2279
140191	1.4166	1.0515	29.7684	31.4076	32.4757	31.2541
140197	1.0537	1.0515	24.8715	26.9930	26.0614	25.9598

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
140200	1.5345	1.0503	31.3712	33.2897	34.0868	32.9105
140202	1.4834	1.0736	34.3789	38.4323	37.4214	36.7750
140206	1.1584	1.0515	31.1406	31.5212	27.6427	29.9651
140207	1.2953	1.0515	31.6818	25.8073	32.4874	29.9202
140208	1.8222	1.0515	26.1749	26.2434	36.5625	29.1083
140209	1.6452	0.9289	28.8774	31.5349	31.8673	30.7293
140210	1.0405	0.8380	22.2512	24.1193	24.7376	23.7498
140211	1.4102	1.0503	34.5917	36.0400	37.0954	35.9438
140213	1.2807	1.0503	33.3932	33.6351	35.2016	34.1074
140217	1.5985	1.0503	33.2172	34.8475	36.7916	35.0335
140223	1.6066	1.0515	34.6997	36.6437	38.4099	36.5719
140224	1.4303	1.0515	30.2241	34.4001	32.1594	32.1531
140228	1.4921	1.0052	28.7462	30.7381	33.1724	30.9914
140231	1.5719	1.0503	35.6724	36.3601	38.3032	36.8493
140233	1.7853	1.0052	32.3376	35.7752	36.3886	34.8790
140234	1.0863	0.8695	25.7660	26.9670	27.9382	26.9002
140239	1.7231	1.0052	33.7264	35.6391	35.7029	35.0237
140240	1.4344	1.0515	28.0986	32.9491	34.4714	31.9066
140242	1.6355	1.0503	36.8032	40.7474	41.8148	39.8954
140250	1.2990	1.0515	32.9414	33.7382	35.9552	34.1583
140251	1.4663	1.0515	29.5941	31.5378	33.9137	31.6519
140252	1.5144	1.0515	36.1531	37.6031	38.6010	37.4880
140258	1.7431	1.0515	34.5696	34.9198	36.5007	35.3489
140275	1.4119	0.8658	26.7394	26.7114	28.4089	27.3093
140276	2.0654	1.0515	32.7073	33.1620	35.5860	33.8463
140280	1.4890	0.8658	26.9835	28.0388	28.9833	28.0224
140281	1.7722	1.0515	37.5700	38.6663	40.3035	38.8921
140286	1.2278	1.0503	32.2246	38.2039	37.1421	35.9395
140288	1.6334	1.0503	32.5472	34.1167	37.2937	34.6391
140289	1.3772	0.9060	26.0872	26.7573	27.9748	26.9787
140290	1.5455	1.0515	35.9679	34.5766	36.0910	35.5293
140291	1.6451	1.0736	32.7884	34.2987	37.6820	34.9828
140292	1.3397	1.0503	32.4496	32.9675	34.8169	33.4335
140294	1.2039	0.8380	26.9789	27.4105	29.1291	27.8159
140300	1.0783	1.0515	37.4508	35.5837	50.8399	41.0132
140301	0.9779	1.0515	35.9742	*	25.6069	29.8693
140303	2.2113	1.0515	33.0359	31.4718	27.9269	30.4360

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
140304	1.4263	1.0503	*	*	*	*
150001	1.2764	0.9555	32.9804	32.5348	32.6297	32.7148
150002	1.6234	1.0370	28.1076	28.3271	29.6905	28.6820
150003	1.7222	0.9253	29.3660	30.1317	33.7073	30.8984
150004	1.5661	1.0370	31.7867	34.4889	35.7071	34.0029
150005	1.3511	0.9555	31.6090	32.6541	33.1179	32.4681
150006	1.4802	0.9488	28.3403	29.7289	30.6306	29.5973
150007	1.5994	0.9010	31.0384	32.4836	32.2298	31.9370
150008	1.4456	1.0370	29.1492	30.9426	33.9870	31.5695
150009	1.5710	0.8850	26.1517	25.9625	26.7891	26.3075
150010	1.6352	0.9010	28.2616	32.8116	30.3873	30.4161
150011	1.3841	0.9555	27.7870	27.8089	29.9431	28.4970
150012	1.5535	0.9889	31.6762	32.0116	33.6506	32.4574
150015	1.4932	0.9069	30.2516	32.6995	36.4154	32.8813
150017	1.7290	0.9245	27.1262	27.4538	30.5938	28.4044
150018	1.6443	0.9488	30.0928	30.9511	32.3280	31.1271
150021	1.7703	0.9245	31.1158	33.1505	34.1233	32.7891
150022	1.0676	0.8557	26.9525	29.7752	29.6975	28.8110
150023	1.5976	0.9555	30.3667	30.8457	32.8854	31.3908
150024	1.6680	0.9555	30.6154	32.1844	32.4374	31.8086
150026	1.2688	0.9488	31.9397	33.1225	34.1049	33.0885
150029	***	*	31.0692	32.1154	34.7470	32.5698
150030	1.1399	0.9555	31.1986	34.5137	33.5357	33.0658
150033	1.4780	0.9555	32.9469	31.7314	32.8768	32.5228
150034	1.5129	1.0370	30.0048	30.9961	32.0665	31.0341
150035	1.4857	0.9069	29.2039	27.9432	28.4279	28.5206
150037	1.4116	0.9555	30.4640	32.2960	34.2666	32.3692
150038	1.2551	0.9555	31.9552	32.2545	32.5543	32.2583
150042	1.3233	0.8757	25.2456	25.2218	26.7161	25.7175
150044	1.5944	0.8850	25.9284	26.6389	28.1622	26.9147
150045	0.9713	0.8399	29.4323	30.0052	30.9207	30.1025
150046	1.5593	0.9254	27.6228	29.7184	30.9654	29.3854
150047	1.6689	0.9245	27.1847	27.9365	31.6507	28.8997
150048	1.5145	0.9637	29.5588	30.5008	32.3958	30.8298
150051	1.6271	0.9555	30.3764	31.2746	32.2657	31.3278
150056	2.0215	0.9555	30.5777	30.8461	32.4031	31.2946
150057	1.8617	0.9555	29.2358	30.4490	32.1298	30.5843

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
150058	1.6714	0.9889	31.7558	32.4036	35.0250	33.0649
150059	1.4935	0.9555	36.2570	30.4189	32.7391	32.9236
150061	1.1637	0.8399	23.2427	24.7808	25.5354	24.5382
150064	1.1633	0.9555	28.9430	29.7898	31.2189	29.8692
150065	1.2812	0.9555	30.7970	31.7556	30.5764	31.0263
150069	1.1856	0.9637	27.0740	28.6514	29.6637	28.4852
150072	1.1231	0.8504	23.0619	24.6596	25.9259	24.5284
150074	1.4197	0.9555	29.4135	31.6043	32.2693	31.1351
150075	1.1147	0.9245	26.5987	27.1412	29.3253	27.5816
150076	1.3188	0.9488	30.2972	29.4643	30.9772	30.2388
150082	1.5964	0.8399	28.1302	28.0003	28.9121	28.3718
150084	1.8928	0.9555	35.0288	35.4818	35.6641	35.4130
150086	1.1942	0.9637	27.2580	28.8279	29.7408	28.6114
150088	1.3132	0.9555	30.2396	31.9171	33.4869	31.8591
150089	1.7163	0.8736	26.7290	28.0389	28.6143	27.7655
150090	1.4939	1.0370	30.9274	33.6812	32.6472	32.3780
150091	1.1504	0.9245	33.0421	32.9027	32.9069	32.9497
150097	1.2299	0.9555	29.4797	29.9967	31.3599	30.2962
150100	1.6908	0.8399	27.6339	30.0246	30.5792	29.4364
150101	1.0091	0.9245	31.6031	32.5860	33.5799	32.5996
150102	1.0478	0.9069	25.4717	30.4952	30.6858	28.7323
150104	1.2531	0.9555	30.8984	31.2245	32.6367	31.6520
150109	1.6020	0.9253	29.0076	31.0757	31.1542	30.3473
150112	1.5048	0.9555	31.7966	32.0659	33.0833	32.3322
150113	1.2748	0.9555	26.9098	29.0485	31.1284	29.0331
150115	1.3849	0.8399	22.3571	25.0221	22.3911	23.2176
150125	1.5510	1.0370	30.7113	31.6959	31.3249	31.2479
150126	1.3388	1.0370	32.6488	34.5086	34.8705	34.0137
150128	1.4381	0.9555	31.1071	30.7549	33.5421	31.8223
150129	1.4581	0.9555	32.9629	36.4709	35.4468	35.0559
150133	1.1372	0.9488	23.0662	25.1415	27.9662	25.3965
150134	***	*	27.3983	30.4440	*	28.8978
150146	1.1222	0.9457	31.8757	32.9491	33.5246	32.8186
150147	***	*	28.9269	28.9204	25.8261	28.0014
150149	0.9508	0.8399	25.3350	26.4595	28.5387	26.8755
150150	1.3103	0.9245	26.5984	26.5020	30.8735	28.0119
150153	2.2954	0.9555	37.3948	38.6948	40.7215	38.9628

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
150154	2.2826	0.9555	30.5775	32.3383	33.4212	32.1347
150157	1.7623	0.9555	32.9167	35.4134	36.4550	34.9919
150158	1.3123	0.9555	30.4355	31.5245	33.9116	32.0793
150159	***	*	27.5595	*	*	27.5595
150160	2.0703	0.9555	27.6375	31.2957	35.6878	31.9424
150161	1.6991	0.9555	*	32.3409	32.7880	32.5716
150162	1.8807	0.9555	*	32.2317	34.3034	33.2490
150163	1.0317	0.8850	*	26.0437	25.0146	25.4847
150164	1.2919	0.9287	*	*	34.3607	34.3607
150165	1.4820	1.0370	*	*	29.3019	29.3019
150166	0.9623	1.0370	*	*	22.9271	22.9271
150167	2.3686	0.9245	*	*	*	*
150168	2.1247	0.9245	*	*	*	*
150169	1.6356	0.9555	*	*	*	*
150170	1.3876	1.0370	*	*	*	*
150172	1.6329	0.8850	*	*	*	*
150173	1.6384	0.9253	*	*	*	*
150174	0.9714	0.9069	*	*	*	*
150175	2.3255	0.8399	*	*	*	*
150176	2.7334	0.8850	*	*	*	*
160001	1.3311	0.9525	25.8686	27.4207	28.7099	27.3326
160005	1.2769	0.8533	24.8597	25.6204	27.4917	26.1096
160008	0.9769	0.8533	24.1282	24.3704	24.4497	24.3155
160013	1.2219	0.8712	25.5162	26.6913	28.1891	26.7376
160016	1.5478	0.9273	26.6537	27.9879	28.8021	27.8144
160024	1.5796	0.9525	32.4253	32.7762	34.4365	33.1992
160028	1.4350	0.9550	29.8343	32.4639	33.7785	32.0904
160029	1.5442	0.9550	32.2035	33.7679	34.1917	33.3869
160030	1.3905	1.0044	30.4779	32.0333	35.0846	32.5833
160032	0.9942	0.8768	28.5645	29.0326	31.8085	29.8300
160033	1.6046	0.8654	27.4810	27.6537	29.9665	28.3732
160040	1.4565	0.8533	28.2982	27.9810	28.9805	28.4165
160045	1.7963	0.8799	28.1681	30.0063	30.1557	29.4747
160047	1.2816	0.9550	29.4286	31.2897	32.5410	31.0812
160057	1.5524	0.9422	27.7969	28.3640	29.9080	28.7095
160058	2.0933	0.9550	29.8975	31.2742	33.2320	31.5155
160064	1.4740	0.9142	33.6082	32.7787	33.3370	33.2334

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
160067	1.4190	0.8533	26.7679	27.2055	27.9863	27.3213
160069	1.5388	0.8562	28.4081	29.0981	30.1739	29.2235
160079	1.5326	0.8799	28.5034	29.8338	31.5836	30.0015
160080	1.2455	0.8654	27.8745	27.4136	29.4683	28.2508
160082	1.8108	0.9525	31.7508	34.0609	34.3141	33.3856
160083	1.7250	0.9525	29.9489	31.0514	33.2497	31.4494
160089	1.3913	0.8533	23.9194	25.0810	26.2942	25.0591
160101	1.1089	0.9525	26.8515	27.1889	27.7523	27.2723
160104	1.6136	0.8654	27.0538	27.8486	29.6187	28.2439
160110	1.5439	0.8533	29.9094	30.8876	32.2713	31.0216
160112	1.2738	0.8533	26.1721	26.7136	28.5427	27.1637
160117	1.4386	0.8562	24.3326	28.8434	29.5419	27.4138
160122	1.1901	0.8533	25.3192	26.6212	27.6209	26.5321
160124	1.0341	0.8533	25.5048	27.2937	27.7842	26.8757
160146	1.5275	0.8964	25.1834	27.1213	27.6992	26.6860
160147	1.1959	0.9273	33.6394	37.2058	33.7922	34.8361
160153	1.7431	0.8964	30.4356	32.1357	33.9188	32.1398
160155	***	*	*	30.2301	*	30.2301
160156	1.6040	0.8799	*	*	*	*
170001	1.1336	0.8027	24.5942	26.2914	27.4924	26.1347
170006	1.3107	0.8448	28.3527	30.5591	29.7039	29.5405
170009	1.1982	0.9558	32.2847	29.3342	35.8139	32.4214
170010	1.2280	0.8027	28.1802	28.6734	28.0225	28.2857
170012	1.6238	0.8027	28.7878	30.0388	31.3285	30.0679
170013	1.8476	0.8886	28.3051	29.6511	29.3136	29.1030
170014	1.0892	0.9558	25.8165	27.2909	28.6642	27.2564
170016	1.7045	0.9138	28.6817	31.9998	32.2154	30.9367
170017	1.1853	0.8860	29.1463	29.5447	30.5545	29.7618
170020	1.5234	0.8756	25.0561	26.1258	27.5267	26.2659
170023	1.4396	0.8027	24.8827	24.9932	23.5945	24.4631
170027	1.4459	0.8027	24.1133	24.6748	28.0618	25.5280
170033	1.2736	0.8756	25.0404	26.9830	28.5416	26.8290
170039	1.0418	0.8860	23.5975	24.1339	25.9946	24.6007
170040	1.9930	0.9558	30.0828	33.3813	34.7542	32.6359
170049	1.5816	0.9558	31.8595	34.8212	36.0453	34.2790
170058	1.0032	0.9558	28.1330	28.6239	28.3939	28.3847
170068	1.1495	0.8438	23.8509	25.6803	26.5991	25.3770

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
170074	1.1194	0.8027	24.8871	26.7280	27.0989	26.2418
170075	0.8374	0.8027	21.1965	20.9091	23.3361	21.8104
170086	1.5306	0.9138	28.5260	30.0102	31.6797	30.1229
170094	0.9016	0.8027	17.1719	26.4808	26.5182	22.5983
170103	1.4110	0.8860	25.5671	26.2628	27.2927	26.3968
170104	1.5054	0.9558	29.7793	31.7058	33.9851	31.8232
170105	1.0539	0.8027	23.4332	24.4249	25.3842	24.4229
170109	1.2001	0.9558	29.0197	33.0257	35.5902	32.6026
170110	0.9742	0.8027	24.7927	26.7359	27.8054	26.4654
170120	1.5992	0.8027	23.5287	24.9819	25.5442	24.7148
170122	1.7938	0.8860	29.6337	31.0839	31.6953	30.8189
170123	1.8214	0.8860	28.7627	29.1591	30.2106	29.3841
170133	1.0783	0.9558	25.7129	27.6138	29.6857	27.6809
170137	1.5460	0.8027	26.8029	28.6556	29.7218	28.4175
170142	1.4422	0.8948	25.5567	26.4060	27.8156	26.6242
170145	1.2223	0.8027	25.3745	26.5981	26.7895	26.2826
170146	1.6495	0.9558	31.7023	31.6451	33.8549	32.3707
170147	***	*	21.4581	*	*	21.4581
170150	1.1460	0.8193	22.0265	22.2379	22.4168	22.2250
170166	0.9627	0.8027	24.1079	24.4570	25.1569	24.5747
170175	1.2714	0.8756	31.7600	30.1456	32.3747	31.4397
170176	1.6710	0.9558	30.1135	31.4048	32.9892	31.5099
170182	1.4837	0.9558	30.3805	32.3903	32.5488	31.7971
170183	2.0144	0.8860	27.7207	27.5559	27.2280	27.4870
170185	1.3885	0.9558	29.3226	31.0813	31.8944	30.8239
170186	2.5662	0.8860	30.7673	36.3546	37.5555	34.8719
170187	1.8179	0.8027	24.6419	26.2236	27.0072	25.9990
170188	2.0192	0.9558	33.7247	34.0134	35.3969	34.4593
170190	1.0539	0.8027	27.3041	28.7392	29.4546	28.5196
170191	1.6762	0.8027	26.0305	26.2347	26.3239	26.2056
170192	1.8218	0.8860	30.9230	31.7531	31.2301	31.3156
170193	***	*	24.4131	21.9349	*	23.1732
170194	1.3210	0.9558	28.2004	29.8055	35.7190	31.0251
170195	2.6049	0.9558	29.1787	31.0187	31.1434	30.5894
170196	2.4657	0.8860	29.9671	29.9241	30.4796	30.1295
170197	2.3696	0.8860	*	*	33.5871	33.5871
170198	1.9628	0.8027	*	*	21.2698	21.2698

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
180001	1.3332	0.9634	29.9674	29.7832	30.9838	30.2388
180002	1.0159	0.8060	27.3344	28.4044	31.5452	29.0298
180004	1.1704	0.7992	22.0626	25.7454	24.9532	24.2670
180005	1.1872	0.7992	27.4317	27.9687	27.9438	27.7826
180007	***	*	26.9440	29.3465	27.5457	27.8795
180009	1.7787	0.8919	28.7048	28.9804	29.4309	29.0610
180010	2.0260	0.8798	28.2168	29.8818	30.7775	29.6381
180011	1.7841	0.8798	25.0372	26.6072	27.6650	26.5198
180012	1.5168	0.8848	27.2851	27.8386	29.2425	28.1376
180013	1.5078	0.9320	26.8108	28.6307	30.5698	28.7209
180016	1.3865	0.7992	26.9539	28.2975	29.3722	28.1740
180017	1.3206	0.8347	25.4174	26.0927	26.1053	25.8753
180018	1.4264	0.7992	24.9874	25.0082	26.1033	25.3849
180019	1.1841	0.7992	27.6801	27.5969	28.3775	27.8968
180020	1.0587	0.8060	26.8865	29.8100	32.2271	29.5397
180021	0.9701	0.7992	22.3768	24.2127	25.2066	23.9245
180024	1.2076	0.8389	26.9553	27.8181	29.6250	28.1394
180025	1.4648	0.8848	28.4172	30.2576	30.4293	29.7381
180027	1.1926	0.7992	23.3881	24.0032	25.5862	24.3439
180029	1.3851	0.8798	26.3907	29.1400	33.4416	29.5244
180035	1.5342	0.9634	34.0370	36.6577	38.6645	36.4402
180036	1.4322	0.8919	30.2643	31.9987	31.3634	31.1868
180037	***	*	33.1897	28.5734	*	30.8765
180038	1.6881	0.7992	28.2430	28.5219	29.7930	28.8753
180040	1.8998	0.8848	30.2471	28.9562	29.2132	29.3762
180043	1.0208	0.7992	24.0582	25.0444	25.3256	24.8642
180044	1.7655	0.8767	25.7990	27.7934	29.8308	27.8637
180045	1.4112	0.9634	29.9366	29.9395	30.5356	30.1379
180046	1.1858	0.8798	28.5568	30.0536	32.2894	30.3563
180048	1.3799	0.8848	24.6800	25.3490	26.8313	25.6487
180049	1.5640	0.8480	23.5756	25.8921	26.3445	25.2345
180050	1.0789	0.7992	26.7726	29.9911	31.6423	29.3799
180051	1.3473	0.7992	25.2369	26.2560	27.0283	26.1992
180053	0.9345	0.7992	23.0302	24.6694	23.9194	23.8815
180056	1.1784	0.8393	26.3973	26.6223	27.8825	26.9638
180064	1.3127	0.8306	21.9517	22.5090	22.7958	22.4385
180066	1.0981	0.8431	24.9542	27.2184	27.9417	26.6868

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
180067	2.0349	0.8798	29.6053	28.9896	30.0550	29.5697
180069	1.0562	0.8767	27.6785	29.9406	32.9994	30.0147
180070	1.3985	0.8232	21.3707	22.8450	24.2407	22.8589
180078	1.1477	0.8767	29.2136	27.4672	28.5438	28.3969
180079	1.1129	0.8251	24.9911	27.2710	26.6427	26.2944
180080	1.2983	0.7992	25.3013	27.2402	28.8798	27.1688
180087	1.3935	0.7992	22.1063	23.2617	24.6628	23.3436
180088	1.8784	0.8848	30.7954	31.8151	32.8838	31.8430
180092	1.2199	0.8798	25.2900	27.0330	26.1035	26.1598
180093	1.6163	0.7992	22.3330	23.5805	24.2302	23.4008
180095	0.9817	0.7992	21.2162	23.9869	25.2742	23.4675
180101	1.3075	0.8798	28.8772	29.6176	31.3685	30.0013
180102	1.5096	0.8361	27.3901	28.3445	26.8886	27.5244
180103	1.8987	0.8798	29.7648	31.7171	33.5024	31.6641
180104	1.5028	0.8361	27.1292	28.7669	29.7545	28.5731
180105	0.9798	0.7992	24.3663	22.9902	23.8783	23.7503
180106	0.8418	0.7992	21.2271	20.1899	21.6369	21.0328
180115	0.9093	0.7992	22.7095	24.9627	24.7222	24.1589
180116	1.3811	0.8361	26.8850	26.9052	28.8350	27.5313
180117	0.8909	0.7992	24.9571	25.9593	32.4322	27.4620
180124	1.4443	0.9320	27.1359	28.2511	30.0346	28.4149
180127	1.3104	0.9634	28.3635	29.8610	30.7333	29.6661
180128	0.9465	0.7992	23.7778	23.9098	25.5746	24.4176
180130	1.6650	0.8848	29.6751	31.2746	32.7395	31.2576
180132	1.3644	0.8798	29.0563	29.5884	29.0754	29.2355
180138	1.2014	0.8848	29.2603	30.7144	32.5413	30.8691
180139	1.0292	0.7992	26.2450	28.3450	28.6303	27.6831
180141	1.9520	0.8848	28.7329	29.5347	30.4173	29.5803
180143	1.7482	0.8798	28.0780	29.0323	30.9817	29.3864
180149	1.0602	0.7992	16.4918	16.3670	21.0293	17.8136
180150	***	*	*	27.9388	*	27.9388
180151	***	*	*	*	30.5548	30.5548
190001	1.2286	0.7946	22.5331	25.3862	29.4366	25.9390
190002	1.6804	0.8473	25.9387	27.1770	27.9755	27.0325
190003	1.4192	0.8473	28.0899	30.5381	32.3943	30.3019
190004	1.5130	0.7992	24.6563	27.0776	27.9541	26.6299
190005	1.6165	0.9005	28.3308	32.9927	37.7220	33.1294

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
190006	1.3802	0.8473	25.4826	28.9179	29.0341	27.9150
190007	1.1745	0.7946	24.0538	24.6117	25.6561	24.7757
190008	1.7700	0.7992	27.2683	28.1194	28.2325	27.8874
190009	1.0153	0.8164	25.0269	24.8263	26.5888	25.4978
190011	1.0472	0.8122	21.9174	24.2068	26.6802	24.1700
190013	1.5009	0.8202	22.8380	25.2468	25.4352	24.5312
190014	1.1793	0.7946	24.5410	25.6064	40.7501	28.3699
190015	1.4420	0.9005	26.9591	29.5241	30.0800	28.8947
190017	1.4652	0.8473	25.5477	26.9640	25.4720	25.9802
190019	1.7524	0.8164	27.6057	28.6311	28.7429	28.3536
190020	1.3278	0.8726	24.2361	25.9262	28.0273	26.1642
190025	1.3326	0.7946	26.5949	26.6296	28.3544	27.1661
190026	1.7583	0.8164	25.3752	27.0875	28.8897	27.0946
190027	1.6967	0.8202	31.5047	29.4789	30.4014	30.3905
190034	1.1283	0.8135	22.9920	24.3969	26.3116	24.6129
190036	1.7818	0.9005	29.1818	27.7969	28.4731	28.4470
190037	0.7254	0.8202	28.0463	19.5982	18.7972	23.3675
190039	1.6259	0.9005	24.6848	29.0738	29.9665	27.9939
190040	1.4743	0.9005	28.2444	29.0914	29.9696	29.1339
190041	1.5169	0.8651	28.7702	29.3296	30.0940	29.3847
190044	1.2801	0.8207	22.2462	23.1701	24.3770	23.2873
190045	1.5746	0.9005	27.5873	29.2569	30.1234	29.0388
190046	1.6328	0.9005	25.1890	30.9760	30.5410	29.0312
190050	1.2653	0.7990	22.7962	23.6921	25.5258	24.0045
190053	1.2074	0.8047	20.6289	22.1404	23.5988	22.1805
190054	1.3179	0.8031	23.5137	26.5586	26.1148	25.4390
190060	1.4983	0.8202	19.8911	25.1496	27.7720	23.8818
190064	1.7058	0.8726	26.9960	28.6273	31.9836	29.2661
190065	1.7366	0.8726	22.9861	24.3651	27.9398	25.1110
190078	1.1497	0.8133	25.6943	26.0185	29.3271	27.0437
190079	1.1235	0.9005	25.3344	28.0268	29.1127	27.5269
190081	0.8388	0.7946	20.4111	21.2224	19.7228	20.4547
190086	1.3020	0.8122	22.2852	24.2040	26.9719	24.3187
190088	1.0754	0.8333	24.7450	29.5999	28.2045	27.5180
190090	0.9838	0.7946	25.8610	25.0681	27.3204	26.0691
190098	1.7167	0.8651	27.5058	27.8846	30.6530	28.7025
190099	1.0253	0.8135	25.7488	25.7136	28.4919	26.6705

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
190102	1.5099	0.8473	28.3090	28.6165	29.3771	28.7633
190106	1.1005	0.8164	24.2759	25.5188	28.9361	26.2131
190111	1.7590	0.8651	27.3192	28.8406	30.5678	28.9640
190114	1.0703	0.7946	20.3651	21.1463	21.6231	21.0606
190115	***	*	26.0285	25.7014	26.8130	26.0523
190116	1.0753	0.8031	24.2154	24.4439	24.8437	24.4763
190118	1.0876	0.8651	22.6572	22.3386	23.2836	22.7652
190122	1.0958	0.8726	22.8681	24.5686	31.3913	26.4871
190124	***	*	28.6713	*	*	28.6713
190125	1.6466	0.8122	26.6269	26.9761	28.3593	27.4096
190128	1.0737	0.8726	31.1819	32.2095	33.7971	32.4200
190131	1.0333	0.8726	28.5946	29.9837	*	29.2828
190133	0.9268	0.8048	23.9550	27.2643	30.2477	27.1223
190135	1.4976	0.9005	35.0547	43.3956	30.1783	34.5478
190140	0.9443	0.7981	23.6713	23.2346	24.0204	23.6404
190144	1.3143	0.8651	24.8866	25.8501	28.3036	26.4021
190145	0.9783	0.8036	21.3988	22.1298	23.2156	22.2666
190146	1.5988	0.9005	28.5984	29.8336	31.9250	30.1773
190151	0.8796	0.7946	20.6970	23.0032	23.1695	22.2541
190152	***	*	34.6508	34.6962	*	34.6751
190158	***	*	21.5594	*	*	21.5594
190160	1.5857	0.8122	25.8646	26.4460	30.4379	27.3739
190161	1.1145	0.8202	23.8073	24.8249	29.2908	26.0454
190164	1.1621	0.8022	27.7265	28.2630	29.1501	28.3895
190167	1.1858	0.8473	27.1981	29.3971	31.7116	29.4476
190175	1.4156	0.9005	30.5948	31.4039	32.4181	31.4544
190176	1.8915	0.9005	28.2192	32.2906	33.3670	31.0851
190177	1.8394	0.9005	29.7252	30.9158	33.1157	31.2414
190182	***	*	30.7058	*	*	30.7058
190183	1.3719	0.7992	23.3462	25.0395	27.3509	25.2419
190184	0.9910	0.7993	22.6144	22.5006	23.5652	22.8901
190185	***	*	36.7317	*	*	36.7317
190190	0.9500	0.8122	27.5051	27.5875	28.9875	28.1199
190191	1.2692	0.8133	26.9656	28.1116	32.0257	28.8862
190196	0.8810	0.8473	27.7824	28.4697	30.6579	29.0035
190197	***	*	28.7044	29.4072	*	29.0218
190199	1.0401	0.8726	36.7128	29.8286	28.2996	31.3500

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
190201	1.1431	0.8202	26.8550	27.8244	29.9264	28.1877
190202	1.6103	0.8726	27.6463	27.8790	27.6445	27.7278
190204	1.5181	0.9005	32.9140	31.9034	33.9644	32.9173
190205	1.7463	0.8473	30.1687	31.6103	32.4248	31.3896
190206	***	*	32.0180	30.4228	*	31.2019
190208	0.8027	0.7946	24.9405	27.5238	30.0154	27.5723
190218	0.8614	0.8651	26.5251	26.9305	28.1252	27.1844
190236	1.4843	0.8651	26.9059	28.6472	30.3119	28.6612
190241	1.3729	0.7992	26.5320	27.5130	28.2954	27.5238
190242	1.3789	0.8726	26.9729	28.7307	28.2808	28.0344
190245	1.4118	0.8122	26.4166	26.6403	28.0180	26.9888
190246	2.1718	0.7993	31.7158	31.5003	31.9438	31.7321
190249	***	*	27.0975	28.3211	25.9997	26.9704
190250	2.2150	0.9005	32.8381	35.2699	34.8604	34.3606
190251	1.3719	0.8726	25.1594	27.3657	22.3853	24.6260
190253	***	*	22.2227	*	*	22.2227
190255	0.8263	0.8473	23.8035	27.8066	29.2058	26.9371
190256	1.0879	0.9005	25.9365	28.7148	28.7915	27.9122
190257	1.7222	0.8122	22.7512	24.2936	25.5176	24.1258
190258	1.8369	0.8651	25.1993	27.7948	22.8748	24.8290
190259	2.1986	0.8473	27.5518	28.9188	32.6301	29.7424
190260	***	*	33.6227	*	*	33.6227
190261	1.5307	0.8122	25.4757	28.7987	29.7560	28.0746
190263	2.3305	0.8473	29.7063	36.3082	35.0861	33.5957
190265	***	*	30.9260	*	*	30.9260
190266	2.9075	0.8726	24.3809	32.3423	32.8535	29.9624
190267	1.4667	0.9005	24.2794	27.6254	30.2475	27.6505
190268	1.5022	0.8473	29.1425	25.8619	27.3050	27.2594
190270	1.8564	0.9005	*	28.5382	29.0574	28.8214
190272	1.3915	0.8473	28.4558	28.4184	23.0702	27.0083
190273	1.8338	0.8726	*	22.7627	21.7837	22.2231
190274	1.8427	0.9005	*	*	28.1128	28.1128
190275	***	*	*	*	29.8209	29.8209
190278	2.3634	0.8651	*	*	23.8972	23.8972
190297	1.1631	0.7946	*	*	*	*
200001	1.3741	0.9695	28.1145	28.9839	29.1670	28.7667
200002	1.2267	0.9509	33.2695	30.4965	27.7502	29.9690

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
200008	1.4018	0.9930	29.3538	32.3955	34.1427	32.0121
200009	1.9252	0.9930	35.0743	36.9995	36.6216	36.2321
200018	1.3541	0.8589	24.6790	25.4228	25.7060	25.2725
200019	1.4200	0.9930	28.3413	30.1233	30.4156	29.6126
200020	1.2880	1.0218	34.5762	36.9185	40.2167	37.3309
200021	1.2139	0.9930	28.7614	31.8322	32.8539	31.2416
200024	1.6897	0.9509	31.0799	31.6913	31.9731	31.6024
200025	1.0822	0.9930	29.3607	30.2866	27.5904	29.0492
200031	1.2922	0.8589	23.7553	25.5973	25.9030	25.1172
200032	1.0966	0.8920	27.2276	27.8426	29.5270	28.2308
200033	1.8148	0.9695	33.6293	34.8017	34.8344	34.4346
200034	1.5798	0.9509	28.0417	28.5612	29.9180	28.9063
200037	1.1561	0.8589	26.7815	27.9167	29.6936	28.2024
200039	1.3319	0.9509	28.8043	29.9958	31.1083	30.0137
200040	1.0262	0.9930	25.5519	29.6104	29.7535	28.2949
200041	1.2990	0.8589	27.5067	28.7604	34.7992	30.1914
200050	1.1681	0.9695	30.1473	32.0363	34.1295	32.1599
200052	1.0602	0.8589	25.6238	24.4545	27.8885	25.8956
200063	1.1945	0.8589	28.2203	29.6832	30.0507	29.3664
210001	1.5177	0.9692	31.2355	30.9218	34.1438	32.0935
210002	2.0643	1.0198	36.0252	36.8782	37.3977	36.7890
210003	1.5893	1.0561	28.2566	34.4117	33.3073	31.8002
210004	1.4458	1.0573	33.9037	32.4548	34.4088	33.6063
210005	1.4195	1.0573	32.4081	32.2224	36.0013	33.5795
210006	1.1291	1.0198	27.9859	31.8510	33.3367	31.1101
210007	1.7980	1.0198	31.4125	35.3019	40.3645	35.4047
210008	1.4858	1.0198	31.8535	33.0343	33.6017	32.8716
210009	1.8265	1.0198	31.8273	34.4385	37.6659	34.7016
210011	1.4747	1.0198	30.7547	29.7694	28.5986	29.6638
210012	1.7244	1.0198	32.5327	33.8099	34.9535	33.8058
210013	1.3276	1.0198	32.1180	35.6347	35.7358	34.5777
210015	1.3298	1.0198	31.6903	34.7961	35.0662	33.9077
210016	1.8075	1.0573	35.3253	37.1478	38.1774	36.9059
210017	1.1984	0.9305	26.6208	27.9652	27.6553	27.4194
210018	1.2329	1.0573	31.5460	33.7284	36.4156	33.9785
210019	1.7439	0.9305	30.5485	30.8121	31.7957	31.0539
210022	1.5465	1.0573	36.1833	35.8394	37.6708	36.5871

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
210023	1.5697	1.0277	34.1664	35.8243	37.3156	35.8033
210024	1.7983	1.0198	34.5548	36.7920	36.9018	36.1089
210025	1.3682	0.9305	23.5175	28.3956	29.8053	27.1446
210027	1.4746	0.9305	25.2143	25.6339	27.5980	26.1526
210028	0.9952	0.9559	28.5214	31.7636	34.3131	31.6983
210029	1.3475	1.0198	32.9100	33.9139	34.5075	33.8223
210030	1.1460	0.9305	29.1790	33.8729	34.4330	32.5402
210032	1.2840	1.0802	29.2785	31.6516	32.2034	31.0732
210033	1.2494	1.0198	28.4350	33.0982	34.9230	32.1677
210034	1.3548	1.0198	33.0407	35.1533	36.2172	34.8437
210035	1.3316	1.0561	30.6692	28.7165	34.0007	31.1344
210037	1.2971	0.9305	28.8708	31.0096	32.7661	30.9387
210038	1.3568	1.0198	31.1563	32.7411	36.1404	33.3841
210039	1.1580	1.0561	35.1172	33.7557	36.9817	35.3260
210040	1.2899	1.0198	31.0882	30.5834	32.5361	31.4068
210043	1.3938	1.0277	29.2762	31.9196	36.7035	32.5832
210044	1.3943	1.0198	31.5463	31.9067	33.9671	32.5153
210045	0.9460	0.9305	19.6112	23.8454	23.8643	22.3580
210048	1.4049	1.0198	29.2464	30.6650	32.7111	30.9342
210049	1.3689	1.0198	28.5970	31.5740	32.8713	31.1060
210051	1.3877	1.0561	30.7954	33.0355	33.8704	32.6204
210054	1.3042	1.0561	28.6905	32.3079	30.9544	30.6912
210055	1.3146	1.0561	30.2010	36.7615	34.9377	33.7047
210056	1.4309	1.0198	33.2271	35.5593	36.1736	34.9799
210057	1.4422	1.0573	33.7287	34.3643	36.7381	34.9642
210058	1.3962	1.0198	32.0669	32.9569	31.3100	32.0828
210060	1.1535	1.0561	32.5141	34.1974	35.0184	33.9386
210061	1.3663	0.9305	26.6842	28.6561	29.3158	28.2516
220001	1.3129	1.1613	32.0843	34.3993	36.2517	34.3061
220002	1.3674	1.1613	35.9765	37.9204	41.2350	38.3812
220008	1.3871	1.1613	35.8680	37.3794	38.4715	37.2430
220010	1.2534	1.1613	33.7392	36.1759	37.2035	35.7194
220011	1.1936	1.1613	39.1234	41.0183	43.4600	41.2510
220012	1.4849	1.2825	41.7080	43.0551	45.5643	43.4397
220015	1.2957	1.0361	35.2373	36.6427	36.3548	36.1085
220016	1.1444	1.0361	33.1424	34.9714	36.4237	34.8489
220017	1.3175	1.2342	34.6575	38.0626	37.7006	36.8223

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
220019	1.1234	1.1613	26.3018	28.0084	29.0921	27.8076
220020	1.2029	1.1613	32.1528	33.6332	35.4990	33.7696
220024	1.3423	1.0361	33.0415	33.8692	34.5389	33.8318
220025	0.9616	1.1613	27.6973	26.6082	29.5458	27.9060
220029	1.2117	1.1613	32.6792	34.8311	36.1946	34.5999
220030	1.0618	1.0361	29.3714	28.8797	29.5814	29.2776
220031	1.5941	1.2342	39.4214	43.7983	46.0432	43.1210
220033	1.2423	1.1613	34.7005	36.1938	40.1729	37.0696
220035	1.4532	1.1613	36.1799	37.2879	39.7370	37.7407
220036	1.5744	1.2342	37.7301	37.0998	37.8321	37.5495
220046	1.5340	1.0483	33.8604	36.3356	37.2026	35.8565
220049	1.2222	1.1613	35.1134	35.7550	37.2433	36.0618
220050	1.1147	1.0361	30.3176	32.4636	33.3155	32.0704
220051	1.4962	0.9671	32.8693	34.7850	33.7650	33.7771
220052	1.2183	1.2342	34.9151	34.9505	36.2809	35.4000
220058	0.9958	1.1613	30.0344	31.9532	34.4760	32.1059
220060	1.1949	1.2342	36.8668	39.1180	41.3006	39.2150
220062	0.7353	1.1613	27.4755	27.3983	28.6128	27.8434
220063	1.3010	1.1613	32.2442	34.6004	35.5788	34.2281
220065	1.2968	1.0361	32.3814	33.6328	34.7541	33.5673
220066	1.4186	1.0361	*	32.6289	35.0834	33.8457
220067	1.2573	1.2342	33.9836	35.7611	37.4704	35.7586
220070	1.1469	1.1613	35.6271	37.4036	39.9838	37.7577
220071	1.8988	1.2342	40.0313	44.2752	46.1244	43.5120
220073	1.2200	1.1613	37.4249	38.9942	39.6789	38.7046
220074[4]	1.3861	1.1613	33.2081	34.5531	36.8098	34.8867
220B74[4]	***	*	33.2082	34.5530	36.8098	34.8283
220075	1.6785	1.2342	33.3578	33.9698	34.7027	34.0072
220077	1.7243	1.1117	34.7345	36.4382	37.4924	36.2651
220080	1.2906	1.1613	33.1640	36.8086	36.4484	35.4648
220082	1.4119	1.1613	32.2124	33.0780	34.8104	33.3699
220083	1.1280	1.2342	35.2758	37.6415	40.5366	37.8780
220084	1.3987	1.1613	34.6275	36.1148	37.5379	36.1306
220086	1.8041	1.2342	36.2385	38.7853	41.1551	38.7907
220088	2.0559	1.2342	37.0840	37.3891	39.2279	37.9115
220090	1.2951	1.1613	35.8969	36.8628	39.5926	37.5164
220095	1.1067	1.1613	31.1644	34.1504	35.3675	33.6005

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
220098	1.1646	1.1613	31.1288	32.1864	33.5413	32.2804
220100	1.3340	1.2342	35.7309	36.5606	38.7440	37.0351
220101	1.4456	1.1613	37.7292	39.3939	41.7554	39.6905
220105	1.2292	1.1613	35.8179	36.6444	39.1029	37.2192
220108	1.2101	1.2342	35.7009	37.1981	38.4718	37.1647
220110	2.0616	1.2342	43.8444	45.3683	47.3232	45.5499
220111	1.2935	1.2342	35.6223	36.8788	39.2865	37.3009
220116	1.8798	1.2342	40.0982	44.6345	47.0582	43.9023
220119	1.1259	1.2342	33.7200	36.2751	37.4673	35.8320
220126	1.2307	1.2342	35.6278	40.5321	38.0733	38.0049
220135	1.4968	1.2825	39.0296	40.3011	42.8827	40.7443
220153	***	*	20.5063	17.4773	19.0273	19.2029
220154	***	*	*	*	43.7359	43.7359
220162	1.7710	*	*	*	*	*
220163	1.6759	1.1613	39.4893	41.6485	42.2659	41.1896
220171	1.6535	1.1613	36.4567	39.7385	38.8272	38.4029
220174	1.2280	1.1613	32.9140	35.8880	34.9007	34.5714
220175	1.3204	1.1613	34.1572	36.6376	38.0801	36.2674
220176	1.5591	1.1613	31.4220	36.2759	38.1158	35.1359
220177	0.9796	0.9671	*	*	*	*
230002	1.4172	0.9849	33.9708	34.2904	35.4085	34.5484
230003	1.4546	0.9386	28.9886	28.5041	30.5808	29.4057
230004	1.7665	0.9829	33.4644	33.1555	34.1260	33.5840
230005	1.3107	0.9078	29.0634	30.5550	31.3029	30.3037
230013	1.3464	1.0134	28.6430	29.9019	31.7651	29.9529
230015	1.1276	0.8900	28.9601	29.8884	32.5133	30.4506
230017	1.7269	1.0313	36.8045	35.5276	37.9122	36.7658
230019	1.6780	1.0134	35.1440	34.8302	36.2716	35.4350
230020	1.7393	0.9849	29.9492	30.4302	31.1906	30.5265
230021	1.6302	0.9979	29.5414	30.4315	31.6153	30.5478
230022	1.1397	0.9759	25.7846	29.5713	32.6757	29.2761
230024	1.7276	0.9849	34.5278	35.1416	35.9913	35.2122
230029	1.7576	1.0134	33.1482	35.5257	33.5106	34.0740
230030	1.3448	0.9102	25.1929	27.8555	29.6479	27.5704
230031	1.5302	0.9725	30.8870	30.9321	31.8722	31.2241
230034	1.3190	0.8605	29.1098	29.8711	29.1077	29.3790
230035	1.3229	0.9315	25.7099	27.0372	27.3075	26.6792

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
230036	1.4412	0.8891	31.0938	31.9872	32.2768	31.7900
230037	1.2616	0.9849	28.8547	31.4423	32.0467	30.7793
230038	1.7841	0.9386	30.1040	31.5536	32.5264	31.4308
230040	1.1548	0.9315	27.2850	27.6894	27.5684	27.5177
230041	1.6226	0.9481	30.3082	31.7229	32.9174	31.6784
230046	1.9829	1.0107	33.5304	34.3952	35.9760	34.6925
230047	1.6075	0.9776	32.0248	33.2300	33.7264	32.9936
230053	1.7703	0.9849	33.5440	34.1884	35.6490	34.5004
230054	1.8298	0.9249	28.1229	28.5274	28.7117	28.4479
230055	1.3352	0.8605	28.1881	28.2657	29.6910	28.7240
230058	1.2321	0.8605	27.9643	29.2185	29.8956	29.0455
230059	1.6857	0.9386	28.3602	30.3935	32.7833	30.4889
230060	1.2298	*	28.7760	30.7515	*	29.7837
230066	1.2837	0.9829	32.3582	32.8383	34.5386	33.2625
230069	1.2686	0.9849	31.9675	33.3136	33.1722	32.8338
230070	1.6133	0.9210	28.0366	32.2151	31.6902	30.6210
230071	1.2460	1.0134	28.8879	29.6172	29.7855	29.4320
230072	1.4884	0.9386	28.8024	29.3214	30.4713	29.5569
230075	1.5124	0.9806	32.1166	33.2981	33.0856	32.8458
230077	1.8634	1.0134	31.0123	32.2274	33.2565	32.1576
230078	1.1159	0.8605	27.0069	27.7143	28.9163	27.8714
230080	1.1863	0.8605	25.6204	25.9082	27.1896	26.2395
230081	1.3269	0.8605	27.8106	27.9649	28.8068	28.1980
230085	1.1525	1.0313	27.6474	28.1395	28.6603	28.1833
230089	1.4386	0.9849	32.2311	34.4092	*	33.3212
230092	1.4241	0.9483	30.5417	29.5262	32.3303	30.8026
230093	1.1780	0.8663	27.0572	27.7275	27.1808	27.3255
230095	1.1846	0.8891	25.9210	25.9787	26.7295	26.2107
230096	1.1720	0.9979	29.7225	30.9326	35.3084	32.0067
230097	1.6800	0.9315	31.5174	32.2990	31.8133	31.8763
230099	1.2400	0.9849	29.0975	30.7388	31.3316	30.3938
230100	1.4065	0.8605	25.6594	25.9480	27.1021	26.2240
230101	1.1279	0.8605	28.8608	29.4146	30.2722	29.5256
230104[5]	1.7305	0.9849	34.0195	34.0176	35.3943	34.4648
230B04[5]	***	*	34.0195	34.0176	35.3943	34.4605
230105	1.7055	0.9315	32.1124	33.0444	32.7701	32.6587
230106	1.1686	0.9386	30.0223	29.0344	31.2500	30.1013

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
230108	1.2433	0.8605	25.7477	25.4728	26.0197	25.7525
230110	1.3362	0.8605	27.0280	29.0921	30.1801	28.7817
230117	1.8114	1.0313	33.9176	33.6962	34.2863	33.9717
230118	1.2950	0.8605	24.8638	27.1359	28.4445	26.8191
230119	***	*	33.2050	33.6503	*	33.4472
230121	1.3766	1.0144	27.7512	28.9511	30.8615	29.1524
230130	1.7250	1.0134	32.5613	33.6704	34.9198	33.7273
230132	1.6023	1.1382	38.2454	39.2894	39.7151	39.0892
230133	1.3475	0.8605	25.8537	26.1806	25.7151	25.9203
230135	1.0031	0.9849	31.5194	32.6527	*	32.0720
230141	1.6878	1.1382	36.3124	36.2647	40.7648	37.7993
230142	1.4114	0.9849	29.9911	30.2157	31.2257	30.4794
230146	1.4359	0.9849	29.0218	29.3346	30.5060	29.6420
230151	1.4202	1.0134	28.6724	28.6413	30.4839	29.2693
230156	1.7070	1.0107	34.7865	35.1696	34.0537	34.6666
230165	1.6917	0.9849	32.2855	31.9887	33.4514	32.6026
230167	1.6598	1.0269	32.8092	35.8019	36.9076	35.1687
230174	1.4021	0.9386	31.2469	31.6387	31.5781	31.4917
230176	1.4667	0.9849	29.2688	29.5281	30.9173	29.9026
230180	1.2683	0.8605	24.6007	28.1401	29.3516	27.1906
230190	***	*	33.6724	30.7924	36.7558	33.6260
230193	1.4023	0.9725	28.4641	29.1474	31.5897	29.7561
230195	1.5647	0.9776	32.5549	33.4975	33.4337	33.2184
230197	1.7706	1.1382	34.8066	36.4129	39.0787	36.8022
230204	1.4815	0.9776	30.1982	31.5389	34.3475	31.9741
230207	1.4333	1.0134	26.8231	27.2054	27.4081	27.1461
230208	1.2571	0.9315	25.2481	25.8892	27.8814	26.3666
230212	1.0316	1.0107	33.4379	34.3917	34.3170	34.0488
230216	1.5184	0.9725	28.9586	30.7478	30.8494	30.1826
230217	1.5091	0.9806	33.0839	35.4957	36.9025	35.2407
230222	1.6616	0.8891	32.4404	30.6277	29.6522	30.8343
230223	***	*	31.8146	34.2971	*	33.0613
230227	1.5877	0.9776	34.2762	35.4364	37.2215	35.5888
230230	1.4717	1.0269	31.4953	31.2614	35.4132	32.7682
230236	1.5236	0.9386	31.9100	32.1973	33.9442	32.7342
230239	1.4068	0.8605	23.5461	26.8301	25.7446	25.3678
230241	1.2282	0.9725	30.0248	28.4771	28.1985	28.8297

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
230244	1.4335	0.9849	32.5586	33.0082	34.3841	33.3260
230254	1.5845	1.0134	31.6332	33.3035	35.0125	33.2978
230257	0.9982	0.9776	30.0674	32.6298	33.3636	32.2062
230259	1.4407	1.0107	27.9572	28 7672	29.1866	28.6444
230264	2.1717	0.9776	29.2202	35.0990	32.8671	32.3761
230269	1.4542	1.0134	34.2694	34.4514	35.2440	34.6832
230270	1.4328	0.9849	29.2408	29.0416	30.1197	29.4618
230273	1.5702	0.9849	32.5730	32.6874	34.8800	33.4102
230275	0.5916	0.9210	22.3740	*	22.6311	22.5224
230277	1.6115	1.0134	32.2545	33.8036	33.9308	33.3444
230279	0.6904	0.9849	26.8552	26.8567	28.8581	27.5609
230297	1.8559	0.9849	*	35.4246	38.9109	37.1670
230300	***	*	*	40.1731	*	40.1731
230301	1.2227	1.0134	*	*	29.1394	29.1394
230302	1.4906	1.0134	*	*	*	*
240001	1.5641	1.1027	37.2211	38.3979	41.1376	38.9343
240002	1.8190	1.0682	34.6368	36.8748	39.2785	37.0047
240004	1.8454	1.1027	33.4596	36.5476	38.0780	36.0985
240006	1.2478	1.0759	32.8229	29.6609	33.3951	31.7330
240010	2.0987	1.0759	35.9131	37.5473	37.9757	37.1825
240014	1.0711	1.1027	33.4492	35.0675	34.9155	34.4959
240018	1.3136	0.9951	30.5645	32.3271	33.2201	32.0521
240019	1.1884	1.0682	34.2547	36.7033	37.3681	36.1294
240020	1.1431	1.1027	34.5703	34.6135	36.6782	35.2976
240022	1.0184	0.9146	28.5905	29.9313	31.1852	29.9071
240030	1.5777	0.9146	27.6596	29.4253	30.4810	29.1808
240036	1.5881	1.1027	37.2207	39.2407	40.6853	39.1270
240038	1.5960	1.1027	34.7357	35.8365	37.8663	36.2048
240040	1.0412	1.0682	30.0255	31.3287	34.0437	31.7765
240043	1.2674	0.9146	25.7424	27.1539	28.4042	27.1230
240044	1.0396	0.9771	28.5705	29.8375	29.2879	29.2433
240047	1.5709	1.0682	35.6763	36.7122	36.2255	36.2136
240050	1.2531	1.1027	33.7964	34.6160	36.3370	34.9328
240052	1.2601	0.9146	31.0934	33.1438	33.8454	32.7273
240053	1.6040	1.1027	34.4210	35.4738	36.3414	35.4352
240056	1.3478	1.1027	35.8603	36.1085	32.7052	34.7799
240057	1.9154	1.1027	34.8374	35.4436	38.0303	36.0623

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
240059	1.1327	1.1027	32.5958	33.5784	33.2499	33.1597
240061	1.8971	1.0759	34.6031	36.2545	37.5561	36.1385
240063	1.6747	1.1027	36.9822	38.3735	38.3869	37.9467
240064	1.2584	0.9280	29.9917	34.2284	35.6462	33.1970
240066	1.6077	1.1027	39.6609	38.4941	39.9654	39.3787
240069	1.2417	1.1027	31.1673	31.6325	35.5345	32.8398
240071	1.1899	1.1027	32.5460	33.1094	35.2567	33.6586
240075	1.2925	0.9146	30.3230	31.5984	32.9126	31.6235
240076	1.1549	1.1027	33.7950	35.4135	37.1723	35.5183
240078	1.7615	1.1027	36.2276	37.3608	39.4962	37.7013
240080	2.0360	1.1027	36.5390	37.7353	39.9460	38.0844
240084	1.1431	1.0682	29.0275	30.3789	32.3263	30.5812
240088	1.2605	0.9146	30.7240	31.4165	32.7525	31.5969
240093	1.5139	0.9270	30.4744	31.3517	32.3639	31.4358
240100	1.3557	0.9146	30.9481	32.5307	33.0821	32.1908
240101	1.1930	0.9146	28.5503	28.7121	29.5095	28.9269
240104	1.3000	1.1027	35.8839	36.0711	40.4033	37.5188
240106	1.6415	1.1027	33.9984	36.8942	39.4450	36.7952
240115	1.5182	1.1027	36.2788	37.5802	38.9388	37.6716
240117	1.2305	0.9673	29.0894	30.4437	29.6594	29.7231
240132	1.4186	1.1027	36.4252	37.0941	37.9072	37.1624
240141	1.1176	1.1027	34.2473	35.8696	37.1809	35.6971
240166	1.2510	0.9146	26.1732	27.3184	28.1765	27.2416
240187	1.2545	1.1027	30.9646	33.5186	33.4717	32.6497
240196	0.8864	1.1027	35.0345	35.4472	38.7978	36.4399
240206	0.8428	1.4448	*	*	*	*
240207	1.3525	1.1027	36.4569	37.7179	39.4085	37.8940
240210	1.3728	1.1027	36.5950	37.7064	38.2195	37.5323
240211	0.6922	0.9958	16.6158	16.1460	16.5163	16.4219
240213	1.4249	1.1027	37.4608	38.4222	39.6158	38.5555
250001	2.1543	0.8125	24.3404	26.7079	28.0700	26.4339
250002	0.9292	0.8035	25.0342	31.2353	32.6776	29.5266
250004	1.8180	0.8981	24.8086	29.1096	30.0764	27.9177
250006	1.1385	0.8981	27.0511	26.9193	29.3899	27.7903
250007	1.1775	0.8923	29.3479	32.6672	31.9040	31.2803
250009	1.4344	0.8379	24.9118	25.9247	27.4133	26.1295
250010	1.0254	0.7738	22.7988	23.8749	24.5667	23.7460

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
250012	0.9436	0.9213	26.4110	29.8873	27.8154	28.0019
250015	1.3891	0.7738	22.3685	22.7775	24.6835	23.2714
250017	0.9972	0.7738	25.7404	25.5007	22.3075	24.4789
250018	0.7464	0.7738	19.1108	19.5527	20.4538	19.7094
250019	1.6160	0.8923	27.7230	28.4743	30.6079	28.9597
250020	0.9777	0.7738	23.1521	26.9602	27.3319	25.8108
250023	0.8903	0.8350	19.5081	22.2932	17.2321	19.5475
250025	1.1249	0.7738	23.0555	26.0579	25.2972	24.7574
250027	0.9255	0.7738	32.5451	26.7593	26.0044	28.1387
250031	1.3465	0.8125	26.7507	28.6356	29.2948	28.1906
250034	1.6373	0.8981	27.9279	29.3365	30.0088	29.1234
250035	0.7907	0.7738	20.5251	24.0653	21.6802	22.1592
250036	0.9473	0.8182	22.5676	22.6781	24.7319	23.3935
250038	0.8901	0.8125	30.7960	27.1958	27.6152	28.2419
250040	1.6037	0.8350	26.2268	28.4423	29.0586	27.8924
250042	1.2263	0.8981	27.4610	25.8791	30.3623	27.9247
250043	1.0488	0.7738	21.1265	22.4618	22.6912	22.0994
250044	0.9899	0.7738	26.1732	26.9451	27.9188	27.0217
250048	1.5964	0.8125	27.6339	27.4186	27.6442	27.5667
250049	0.9434	0.7738	24.2227	24.2129	21.5835	23.2761
250050	1.2840	0.7738	22.4429	22.6843	23.7790	23.0068
250051	0.7692	0.7738	14.1662	15.6982	15.7373	15.2520
250057	1.2695	0.7738	22.9683	22.5524	25.9738	23.8179
250058	1.2848	0.7738	19.6720	20.4748	22.1248	20.7697
250059	0.9412	0.7738	25.5982	24.8145	23.7995	24.7437
250060	0.8138	0.7738	27.0354	31.0689	32.3114	29.8012
250061	0.8353	0.7738	25.1495	23.3006	22.9622	23.7108
250067	1.1274	0.7738	23.8027	28.2894	27.2284	26.3793
250069	1.6226	0.8022	23.4495	25.8456	27.7173	25.6762
250072	1.7556	0.8125	27.5791	30.5382	33.2443	30.4790
250077	0.9612	0.7738	19.6333	19.3962	20.7217	19.9362
250078	1.7165	0.8350	23.9598	26.5481	27.5440	26.0252
250079	0.8236	0.8125	46.0349	32.3758	33.2547	37.9283
250081	1.4366	0.8022	24.8281	23.1385	25.6748	24.4935
250082	1.5383	0.8311	25.6218	27.8096	29.4889	27.6785
250084	1.1549	0.7738	19.5694	20.1192	21.2261	20.3028
250085	0.9389	0.7738	24.6757	24.5765	25.8783	25.0289

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
250093	1.2675	0.7738	26.4351	27.0937	28.9844	27.5340
250094	1.6566	0.8350	25.4232	26.1331	28.4550	26.7033
250095	1.1011	0.8125	25.9021	30.7505	25.2111	27.0637
250096	1.2779	0.8125	27.7291	27.5206	29.1993	28.1437
250097	1.5766	0.8580	22.7916	23.6607	24.1451	23.5520
250099	1.4358	0.8125	27.5757	25.0076	26.7877	26.4479
250100	1.4971	0.8022	27.5484	28.2019	29.4874	28.4283
250102	1.5878	0.8125	25.5327	27.8758	27.2188	26.8670
250104	1.4298	0.8022	25.4008	26.3140	25.7731	25.8274
250112	0.9397	0.7738	27.4162	29.6978	23.5300	26.6029
250117	1.0807	0.8350	24.5706	26.0965	24.8866	25.2046
250122	1.1551	0.7738	23.4908	27.3606	31.2642	27.3826
250123	1.3700	0.8923	29.8299	29.5520	32.4487	30.5969
250124	0.8592	0.8125	21.9420	22.4247	23.9262	22.8076
250125	***	*	32.7411	29.0819	31.9629	31.3858
250126	1.0391	0.9213	25.2581	26.8712	26.7811	26.3514
250127	0.8051	1.4448	*	*	*	*
250128	1.0195	0.8184	23.5918	24.7051	26.7124	25.1932
250134	0.9778	0.8125	22.0846	40.7995	30.5066	30.6943
250136	1.0796	0.8125	27.1479	27.8270	30.6565	28.5419
250138	1.3635	0.8125	27.3132	27.0688	29.2021	27.8594
250141	1.5961	0.9213	33.4413	32.1496	31.6915	32.3561
250149	0.8744	0.7738	17.0964	17.2423	20.1488	18.0903
250151	0.6315	0.7738	*	17.3962	25.0894	22.4010
250152	0.9097	0.8125	28.5526	29.8216	30.9016	29.7410
250161	***	*	*	26.0070	*	26.0070
250162	1.0038	0.8937	*	*	31.4828	31.4828
260001	1.7887	0.8448	31.1866	28.6690	30.0120	29.9052
260004	0.9453	0.8127	23.9584	24.1764	25.5508	24.5784
260005	1.6662	0.9060	31.1050	33.1020	35.2618	33.2207
260006	1.5176	0.8127	33.8253	34.3548	36.2278	34.8344
260009	1.1928	0.8605	26.6685	26.2248	26.1705	26.3503
260011	1.6596	0.8605	31.2612	31.4415	31.7034	31.4717
260015	1.1557	0.8127	25.0250	25.1585	26.2721	25.5036
260017	1.3354	0.8605	26.2621	27.4586	29.5743	27.7703
260020	1.7611	0.9060	30.9599	32.0889	31.9904	31.7069
260021	1.4447	0.9060	19.5810	19.3770	32.4283	21.7242

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
260022	1.4859	0.8261	25.9391	25.6866	26.7028	26.0941
260023	1.5492	0.9060	25.5899	26.7586	27.4201	26.6186
260024	1.1778	0.8127	20.7136	22.4347	22.9479	22.0397
260025	1.4225	0.8955	24.5042	24.4959	24.4546	24.4847
260027	1.8912	0.9558	31.0236	32.3066	33.7779	32.3722
260032	1.9415	0.9060	28.7183	29.8257	30.8428	29.7999
260034	0.9685	0.8127	28.7736	29.7821	29.4705	29.3435
260040	1.7603	0.8413	27.3680	28.5035	29.9909	28.6335
260047	1.4981	0.8127	27.2667	27.1986	27.8259	27.4384
260048	1.2788	0.9558	29.6969	30.1691	30.8650	30.2475
260050	1.0775	0.8127	27.8065	27.6085	33.8795	29.6615
260052	1.3299	0.9060	29.6998	31.5722	32.2076	31.2112
260057	1.0671	0.9558	23.8181	27.0128	27.1389	26.1324
260059	1.2757	0.8204	25.3025	26.9521	27.3419	26.5876
260061	1.1228	0.8127	23.6717	24.7824	27.0467	25.1434
260062	1.3726	0.9558	29.6156	30.7159	32.0976	30.8722
260064	1.4339	0.8216	21.4932	23.6002	25.8393	23.6092
260065	1.7126	0.8413	28.3411	29.9325	29.6384	29.3273
260068	1.7723	0.8261	28.1246	29.3972	29.5631	29.0347
260070	0.8779	0.8127	25.2997	26.2370	25.8550	25.8217
260074	1.2943	0.8261	28.6216	28.4171	29.3367	28.7901
260077	1.7066	0.9060	28.7204	28.9940	29.4958	29.0802
260078	1.2849	0.8127	23.1785	24.7794	25.1259	24.3417
260080	1.0588	0.8127	18.6813	19.0041	19.1541	18.9629
260081	1.6605	0.9060	32.0799	34.8761	40.1198	35.5606
260085	1.6239	0.9558	29.6514	30.4727	31.6239	30.5668
260091	1.5674	0.9060	30.2636	32.9623	33.9609	32.4273
260094	1.6223	0.8413	25.1491	27.0127	27.2078	26.4777
260095	1.5411	0.9558	29.9090	30.9142	30.5602	30.4766
260096	1.6341	0.9558	32.9383	33.1804	34.9570	33.7008
260097	1.1617	0.8427	27.3129	28.2444	28.5379	28.0218
260102	1.0526	0.9558	30.7678	29.1467	30.1752	29.9874
260104	1.7078	0.9060	29.5891	32.0122	33.6904	31.7812
260105	1.8595	0.9060	32.4292	33.4278	35.1672	33.6282
260107	***	*	29.7775	38.3668	*	33.8526
260108	1.8751	0.9060	28.5654	30.1064	31.5495	30.0747
260110	1.6558	0.8810	28.0381	28.5364	30.1062	28.9080

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
260113	1.2656	0.8380	23.0826	23.6758	25.6538	24.1544
260115	1.2365	0.9060	25.5658	26.5268	27.1964	26.4347
260116	1.0191	0.8380	22.5536	25.1758	27.7471	24.8978
260119	1.3362	0.8363	31.5003	26.4382	26.5894	27.9902
260137	1.7978	0.8448	31.4091	28.3521	29.0069	29.4979
260138	2.0048	0.9558	31.7582	33.4156	34.9809	33.4163
260141	2.0499	0.8261	26.6684	28.3492	28.1099	27.7524
260142	1.2469	0.8127	22.8205	25.0940	24.1327	24.0438
260147	0.8251	0.8127	22.9689	22.8326	25.3191	23.5737
260159	***	*	24.3027	25.5039	26.0684	25.2758
260160	1.0383	0.8271	26.6715	27.9585	25.0259	26.6874
260162	1.4325	0.9060	30.5761	32.3673	33.0717	32.0297
260163	1.2350	0.8214	23.8644	25.0443	26.1076	25.0496
260166	***	*	29.5259	30.6020	*	30.0575
260175	1.0460	0.9558	25.7069	26.5767	28.1661	26.8058
260176	1.7475	0.9060	30.6205	32.4957	33.1495	32.1198
260177	1.3018	0.9558	29.0815	31.1662	33.9925	31.4147
260178	1.9849	0.8261	26.9902	28.9170	29.8616	28.6265
260179	1.5711	0.9060	29.6316	30.3276	30.8119	30.2731
260180	1.7531	0.9060	30.7336	31.4721	32.7989	31.6539
260183	1.6167	0.8810	31.4916	32.2621	31.3742	31.7100
260186	1.5186	0.8605	29.1874	30.8706	32.4493	30.8711
260190	1.3538	0.9558	30.9003	32.2069	34.1815	32.3839
260191	1.5869	0.9060	27.8648	28.7185	29.0100	28.5516
260193	1.3548	0.9558	29.5436	30.5190	31.7196	30.5601
260195	1.4152	0.8127	25.0294	25.6697	26.6828	25.8073
260198	***	*	27.9093	31.4660	*	29.5529
260200	1.4152	0.9060	30.5032	32.0910	35.5276	32.9288
260207	1.1898	0.8413	23.6392	22.8308	22.7884	23.0797
260209	1.0738	0.8605	26.4203	33.7185	32.9213	30.8380
260210	1.2999	0.9060	36.4055	33.5701	35.4741	35.1652
260211	1.3016	0.9558	37.1557	42.4297	36.1850	38.3836
260214	1.3113	0.9558	31.0175	31.7957	34.1199	32.2663
260216	1.3206	0.9558	*	32.4039	33.4387	32.9968
260217	***	*	*	12.2879	*	12.2879
260219	1.3400	0.9060	*	*	30.7118	30.7118
260220	***	*	*	*	28.4885	28.4885

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
260221	2.0760	0.8413	*	*	*	*
260222	3.1344	0.9558	*	*	*	*
260223	2.1186	1.0377	*	*	*	*
270002	1.1098	0.8439	28.3379	26.9419	28.2480	27.8202
270003	1.2908	0.8439	28.0543	28.5127	29.8638	28.8333
270004	1.7281	0.8944	28.5869	29.4694	31.2252	29.8125
270012	1.6404	0.8618	28.0672	27.9087	28.8521	28.2738
270014	2.0243	0.8811	28.2582	30.1101	30.2981	29.5713
270017	1.3880	0.8618	29.3542	29.4260	31.2231	30.0045
270023	1.6600	0.8811	28.1896	30.9908	31.5012	30.2124
270032	1.0183	0.8439	21.6360	21.5106	23.5705	22.2266
270049	1.8451	0.8944	29.8891	31.3941	31.2349	30.8507
270051	1.4506	0.8618	29.3941	29.1163	30.1070	29.5459
270057	1.4282	0.8439	28.3627	29.5317	31.6476	29.8918
270074	0.9307	1.4446	*	*	*	*
270086	1.4090	0.8439	21.9017	27.3995	29.1257	26.4704
270087	1.5197	0.8439	24.9197	24.2168	24.9946	24.6957
280003	1.8427	0.9490	32.3780	33.7700	34.2000	33.4257
280009	1.8904	0.9490	28.1559	31.9280	33.6269	31.2504
280013	1.7682	0.9554	30.3120	31.9793	32.8493	31.7431
280020	1.6813	0.9490	29.4831	30.3731	32.3597	30.7314
280023	1.4338	0.9490	30.0717	31.9420	31.3884	31.1400
280030	1.8814	0.9554	31.8758	33.4544	34.0104	33.0874
280032	1.4305	0.8886	25.6549	25.8707	27.6089	26.3994
280040	1.6949	0.9554	30.7406	32.1005	32.7707	31.9093
280060	1.7924	0.9554	30.4625	32.0607	33.5256	32.0484
280061	1.4381	0.8886	28.9591	29.2231	30.8542	29.7095
280065	1.2973	0.9418	29.5470	30.1143	30.8900	30.1783
280077	1.3795	0.9490	29.9223	29.7362	31.3194	30.3231
280081	1.6286	0.9554	28.9696	31.0768	35.8382	31.9389
280105	1.2687	0.9554	30.0472	33.3196	33.1407	32.1834
280111	1.1463	0.8886	28.3541	29.0865	29.9691	29.1189
280119	0.8685	1.4448	*	*	*	*
280123	***	*	20.2741	20.6384	29.1514	22.7020
280125	1.5076	0.8968	24.7466	25.1212	30.7311	26.8386
280127	1.9295	0.9490	26.5659	28.4607	27.8198	27.6863
280128	2.7835	0.9490	27.1024	19.2781	30.1879	25.4888

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
280129	2.0282	0.9554	27.9511	30.4258	30.9589	29.8728
280130	1.4549	0.9554	29.9645	32.4243	33.1336	31.9744
280131	2.1542	0.9554	*	*	*	*
290001	1.7980	1.0439	33.3318	32.3610	34.3377	33.3434
290002	0.8656	0.9960	22.7362	25.4458	22.9980	23.6418
290003	1.8020	1.1811	34.6433	36.8494	40.5365	37.2945
290005	1.5573	1.1811	34.2373	34.2514	36.3971	34.9747
290006	1.1041	1.0439	33.3243	32.9232	35.2729	33.8405
290007	1.8733	1.1811	41.2395	44.0851	42.0134	42.4287
290008	1.2259	0.9555	33.2473	36.1620	38.0995	35.8471
290009	1.8183	1.0439	34.2103	38.6692	40.9685	37.9159
290012	1.3732	1.1811	38.3731	38.1494	39.8936	38.8324
290019	1.6158	1.0439	32.2817	34.3215	35.6893	34.1535
290020	0.9789	0.9555	27.2908	25.3592	28.1710	26.9891
290021	1.6573	1.1811	36.8728	39.5976	41.5629	39.3340
290022	1.7355	1.1811	38.8262	40.9896	41.3493	40.4278
290027	0.8303	0.9555	29.1123	25.1315	17.5194	22.5706
290032	1.4270	1.0439	36.9175	38.9632	37.5999	37.8103
290039	1.6578	1.1811	34.6359	37.5722	41.3057	37.8449
290041	1.4861	1.1811	38.4445	40.0602	42.8383	40.5654
290045	1.7861	1.1811	38.2560	38.5440	40.6077	39.1861
290046	1.5403	1.1811	38.3112	41.5550	42.1303	40.8035
290047	1.7100	1.1811	35.6381	38.6892	41.6528	38.6969
290049	1.4003	1.0439	33.4278	33.2014	34.9166	33.8543
290051	2.0280	1.0282	32.5277	37.2727	37.4812	35.6526
290053	1.7043	1.1811	*	*	41.7596	41.7596
290054	1.3973	1.1811	*	*	*	*
290055	1.5038	1.0282	*	*	*	*
300001	1.4814	1.0054	31.0122	31.4533	31.9222	31.4790
300003	2.0987	1.0054	37.7246	37.3007	37.8482	37.6390
300005	1.4367	1.0054	28.8402	29.4927	32.0379	30.1494
300011	1.3554	1.0990	33.0785	32.7459	35.9010	33.9466
300012	1.4793	1.0990	33.0569	34.8519	34.3089	34.0963
300014	1.2376	1.0218	30.7735	32.8211	33.7545	32.5359
300017	1.4332	1.1021	33.4164	35.2028	37.5444	35.3995
300018	1.3748	1.0218	31.5028	32.7008	33.9529	32.7460
300019	1.3351	1.0258	28.3114	30.5332	31.7382	30.2375

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
300020	1.4207	1.0990	32.4655	34.7678	36.3083	34.5838
300023	1.4607	1.0054	32.3202	34.2636	35.1291	33.9582
300029	1.8966	1.1021	32.0033	35.3112	36.0190	34.4466
300034	1.8501	1.0990	33.5537	33.7397	32.8443	33.3569
310001	1.8394	1.2884	41.4946	44.8619	50.6238	45.4383
310002	1.8317	1.2619	37.9484	39.7599	41.2456	39.6858
310003	1.3084	1.2884	40.1543	39.8679	42.8065	40.9664
310005	1.3923	1.1099	34.7657	34.4087	36.0844	35.0992
310006	1.4947	1.2884	30.4296	29.1025	36.9201	33.0307
310008	1.4134	1.2884	34.3268	36.2903	37.2702	35.9673
310009	1.4910	1.2619	35.4624	37.9098	37.8328	37.0580
310010	1.3390	1.1069	36.0823	34.1071	34.7174	34.9269
310011	1.3734	1.1069	37.4855	34.0850	38.0642	36.5086
310012	1.5578	1.2884	41.9630	41.3814	44.1956	42.5328
310013	***	*	32.9488	*	*	32.9488
310014	1.9878	1.1069	35.0124	39.7527	42.5981	39.1445
310015	1.9757	1.2619	40.8229	39.5076	41.0862	40.4747
310016	1.3519	1.2884	41.0363	39.7563	42.6321	41.1071
310017	1.3342	1.2619	35.9806	34.8881	36.6814	35.8577
310018	***	*	32.6956	33.5069	33.6869	33.3032
310019	1.5578	1.2884	31.8930	34.6618	36.9116	34.4783
310020	***	*	38.4266	34.8440	33.1591	35.6399
310021	1.5817	1.1069	32.2064	33.2554	32.9745	32.8103
310022	1.3683	1.1069	32.8079	32.8154	35.0037	33.5940
310024	1.4947	1.1099	36.8666	34.7011	38.7731	36.8133
310025	1.4049	1.2884	32.1481	35.2564	40.8475	35.5411
310026	***	*	30.1321	31.9905	*	31.0489
310027	1.5531	1.1099	34.6471	34.1653	35.4202	34.7452
310028	1.2605	1.1099	34.8332	37.2987	38.5629	36.9482
310029	1.7816	1.1069	35.2084	36.5179	37.3225	36.3377
310031	2.6733	1.1069	39.5911	38.2643	39.1387	39.0033
310032	1.4461	1.1069	35.2402	35.8019	38.1019	36.3949
310034	1.4950	1.1069	36.8614	37.1191	38.7316	37.5645
310037	***	*	40.4642	44.3134	40.6768	41.8620
310038	1.8962	1.2619	39.8707	40.7395	41.0737	40.5745
310039	1.3494	1.2619	32.6425	33.4253	37.6948	34.5052
310040	1.2885	1.2884	41.2246	38.3232	42.0647	40.5945

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
310041	1.3677	1.1069	35.2009	34.4308	35.9905	35.2159
310044	1.4058	1.1069	33.5868	35.9981	36.7851	35.4384
310045	1.6751	1.2884	39.2097	40.3222	39.4667	39.6718
310047	1.3605	1.1069	37.7220	38.1213	38.6544	38.1625
310048	1.3744	1.1099	34.5256	33.9641	35.1089	34.5372
310050	1.3717	1.2619	37.9214	32.5213	36.1607	35.4032
310051	1.5361	1.1099	39.7671	37.9104	41.4326	39.7291
310052	1.4235	1.1069	36.5494	36.2042	36.6736	36.4774
310054	1.3353	1.2619	38.2432	37.2851	38.6073	38.0262
310057	1.4774	1.1069	34.2052	32.8649	33.3760	33.4433
310058	1.0417	1.2884	30.4436	32.1349	27.4856	30.0784
310060	1.4272	1.1069	27.9134	30.4626	31.0602	29.7917
310061	1.3306	1.1069	33.5586	33.6084	36.9685	34.7294
310063	***	*	38.1481	36.7131	40.5744	38.4253
310064	1.6138	1.1069	39.8091	39.9456	39.4518	39.7314
310069	1.2782	1.1069	35.1376	36.9367	38.6358	36.8960
310070	1.4374	1.2619	36.9999	36.8951	38.3936	37.4045
310073	1.8090	1.1069	36.9249	37.5317	38.0676	37.5047
310074	1.3788	1.2884	39.0729	35.9044	36.5051	37.2159
310075	1.3708	1.1069	33.5253	33.8979	36.8738	34.7688
310076	1.7422	1.2619	38.1671	39.0325	41.7283	39.6466
310081	1.4281	1.1069	31.7981	32.1241	34.1491	32.7041
310083	1.5302	1.2619	28.3406	28.2875	32.3793	29.6429
310084	1.2977	1.1069	34.9626	34.3130	35.9514	35.1066
310086	1.2760	1.1069	30.9467	31.4837	32.6634	31.7177
310088	1.1089	1.1069	31.2437	28.1703	30.2907	29.8993
310090	***	*	33.9174	36.2502	39.0484	36.2524
310091	1.2160	1.1069	35.2913	34.8679	36.3009	35.4738
310092	1.5401	1.1069	32.8431	34.8028	35.8723	34.4902
310093	***	*	32.3860	33.4460	31.7831	32.5380
310096	1.7501	1.2619	34.2014	36.3201	35.9746	35.5053
310105	***	*	32.0277	31.3423	38.1225	33.7325
310108	1.5387	1.2619	36.2848	38.3403	40.4235	38.3602
310110	1.3629	1.1069	35.6825	36.5227	34.9354	35.6895
310111	1.3887	1.1069	36.0748	38.3519	38.6478	37.7170
310112	1.3763	1.1069	34.5337	33.6207	34.5131	34.2210
310113	1.3519	1.1069	35.0245	38.0066	38.4702	37.2154

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
310115	1.4081	1.1069	32.1197	33.7061	34.3696	33.4228
310116	1.3231	1.2884	27.8677	35.3805	35.7518	32.7295
310118	1.3491	1.2884	32.8286	33.2234	33.7344	33.2605
310119	1.9233	1.2619	41.2997	46.1339	47.1035	44.7858
310120	1.0481	1.1099	35.1661	36.3365	37.6331	36.3759
310126	***	*	34.3189	*	*	34.3189
310127	***	*	*	40.1255	*	40.1255
320001	1.8271	0.9638	31.4193	33.6433	35.9775	33.8378
320002	1.5849	1.0788	34.1610	35.6036	37.4477	35.7737
320003	1.0965	1.0400	31.5792	31.4445	34.6790	32.5200
320004	1.3353	0.9030	28.2407	30.5543	31.0096	29.9078
320005	1.6317	0.9505	25.2168	26.4658	27.9464	26.5665
320006	1.2566	0.9505	28.5177	31.6888	35.2623	31.7638
320009	1.7026	0.9638	31.3296	31.7240	33.1269	32.2269
320011	1.1092	0.9374	28.9951	30.6151	31.5915	30.3549
320013	1.2176	1.0400	31.2890	31.7159	31.8550	31.6268
320014	1.0148	0.9183	30.4803	29.8578	33.1461	31.2305
320016	1.1858	0.9030	26.6392	27.7121	27.8593	27.4337
320017	1.3865	0.9638	30.5787	30.9261	28.3807	29.6659
320018	1.5868	0.9207	28.3465	29.9038	32.8908	30.3587
320019	***	*	28.7067	31.8205	34.4963	30.4182
320021	1.5923	0.9638	29.6464	31.3577	32.8369	31.4496
320022	1.1128	0.9030	27.5152	28.7195	30.9229	28.9228
320030	0.9864	0.9030	25.5267	28.5145	29.5507	27.9621
320033	1.2665	1.0400	30.1846	32.8631	36.8262	33.1229
320037	1.1970	0.9638	27.8982	28.6968	29.0394	28.5512
320038	1.2537	0.9030	31.6526	33.2147	34.1644	33.0257
320057	0.8901	1.4448	*	*	*	*
320058	0.7912	1.4448	*	*	*	*
320059	1.0293	1.4448	*	*	*	*
320060	1.0719	1.4448	*	*	*	*
320061	1.0731	1.4448	*	*	*	*
320062	0.8817	1.4448	*	*	*	*
320063	1.2855	0.9315	27.4946	30.2997	31.3336	29.7847
320065	1.2319	0.9030	26.9130	27.9999	31.2804	28.6457
320067	0.8536	0.9030	25.4121	23.6677	26.3413	25.1468
320069	1.0613	0.9030	25.3151	26.5521	25.6533	25.8355

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
320070	0.9578	1.4448	*	*	*	*
320074	1.3254	0.9638	28.8088	29.8317	31.0548	30.0014
320079	***	*	31.5661	30.3600	*	30.9560
320083	2.2519	0.9638	32.9476	35.1125	33.6069	33.8474
320084	0.8797	0.9030	24.2902	25.9161	27.1350	25.8609
320085	1.7238	0.9207	28.4537	28.7114	30.1280	29.0969
320086	1.3497	0.9030	*	*	25.1198	25.1198
320087	1.6719	1.0788	*	*	42.5428	42.5428
320088	2.4348	0.9207	*	*	34.8348	34.8348
330002	1.7166	1.3154	34.7270	35.3553	37.0389	35.6963
330003	1.4425	0.8708	26.8363	27.7173	28.8520	27.8126
330004	1.3751	0.9785	30.3221	30.8305	31.6848	30.9524
330005	1.6498	0.9628	33.2851	34.1763	35.4979	34.3373
330006	1.4087	1.3154	36.3305	38.6645	38.8190	37.9639
330008	1.1596	0.9628	26.2141	26.7882	28.4993	27.1558
330009	1.4682	1.3154	41.3797	42.4137	43.3382	42.4122
330010	1.1603	0.8487	20.5805	24.3033	*	22.4266
330011	1.2668	0.8932	26.8269	29.2672	30.3716	28.8455
330013	1.9518	0.8708	28.8039	29.2399	30.3522	29.4870
330014	1.4172	1.3154	46.3170	48.1054	48.9173	47.8284
330019	1.2184	1.3154	44.5669	46.8153	47.5751	46.3311
330023	1.5195	1.2884	37.5135	40.9595	42.7458	40.4809
330024	1.8856	1.3154	44.8070	46.2954	46.9066	46.0301
330025	1.1126	0.9628	24.2702	26.5550	27.7959	26.2089
330027	1.3420	1.2884	45.9571	49.0573	51.4887	48.8103
330028	1.5496	1.3154	38.0149	38.7770	44.2973	40.0572
330029	0.6085	0.9628	22.9332	23.7555	23.2845	23.3244
330030	1.2366	0.8708	25.5089	27.4344	29.0646	27.3460
330033	1.1516	0.8643	25.0215	26.7551	25.6393	25.7911
330036	1.2446	1.3154	30.4659	31.2701	33.0839	31.6283
330037	1.1595	0.8708	23.4915	24.4428	25.1766	24.3854
330041	1.3783	1.3154	37.1651	41.2299	45.4010	40.9876
330043	1.5215	1.2591	40.6094	42.4560	43.3176	42.1465
330044	1.3451	0.8737	28.2638	29.4872	31.0628	29.6090
330045	1.5074	1.2591	41.6565	44.7551	43.4805	43.2898
330046	1.5094	1.3154	52.2397	53.4532	55.0516	53.5982
330047	1.3009	0.8487	22.9948	27.4392	27.9776	26.2104

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
330049	1.6219	1.1418	34.9740	38.0110	39.1050	37.4092
330053	1.0453	0.8708	20.1303	21.4837	22.9142	21.4899
330055	1.6466	1.3154	44.2343	44.6905	45.0891	44.6857
330056	1.5790	1.3154	39.9662	40.5499	43.3731	41.2870
330057	1.8056	0.8708	30.1821	30.5006	31.3091	30.6714
330058	1.4159	0.8708	23.6296	25.3712	26.6416	25.2427
330059	1.6093	1.3154	45.3691	47.7115	48.5102	47.2325
330061	1.2404	1.3154	37.8649	38.8790	38.2257	38.3275
330064	1.4200	1.3154	41.5737	39.5994	39.7532	40.3486
330065	1.1305	0.9628	26.2288	28.6809	29.2490	28.0535
330066	***	*	27.2085	30.7011	31.6665	29.8079
330067	1.4686	1.1418	30.7537	31.5572	33.4719	31.8968
330072	***	*	41.4605	40.5965	41.2397	41.0975
330073	1.1842	0.8708	25.1392	24.8055	27.0827	25.6766
330074	1.1789	0.8708	23.1016	24.6973	24.5262	24.0899
330075	1.1415	0.9710	23.7522	27.5360	29.7333	26.9519
330078	1.4769	0.9628	27.6682	30.8157	31.7996	30.0981
330079	1.4095	0.9328	27.9479	28.7349	30.3415	29.0021
330080	1.2278	1.3154	40.2067	47.4529	47.6661	45.2191
330084	1.0795	0.8420	27.3434	28.8661	32.3490	29.4885
330085	1.1543	0.8420	27.1707	27.7050	29.8188	28.2639
330086	1.4037	1.3154	40.9768	44.0362	43.8907	42.9617
330088	1.0424	1.2591	37.4716	41.8635	40.8115	40.0302
330090	1.5852	0.9187	27.7306	29.5626	31.1822	29.4923
330091	1.3864	0.9628	28.3034	30.9457	31.7515	30.3752
330094	1.2966	1.0158	28.6213	33.0706	34.7858	32.0911
330096	1.2839	0.8420	24.7895	24.8667	25.8292	25.1613
330100	1.0060	1.3154	39.3170	38.6625	42.2645	40.0975
330101	1.9953	1.3154	45.5412	49.6431	49.8588	48.3746
330102	1.5567	0.9628	27.2543	31.6270	31.8101	30.2074
330103	1.2588	0.8551	25.4919	26.1064	27.2392	26.3017
330104	1.4546	1.3154	36.5894	38.4254	39.2321	38.0457
330106	1.7129	1.2884	48.2903	47.2240	50.3199	48.5977
330107	1.2256	1.2591	38.0262	40.2541	42.4304	40.1994
330108	1.1028	0.8540	25.3023	25.5480	26.9810	25.9259
330111	0.9381	0.9628	23.2134	25.1572	26.0179	24.6747
330115	1.1378	0.9710	24.3898	27.0362	25.4507	25.6316

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
330119	1.8188	1.3154	41.2365	43.8894	44.0249	43.0193
330125	1.7757	0.8708	29.4817	30.4389	30.4103	30.1168
330126	1.3867	1.2884	37.7807	40.0542	41.7981	39.8971
330127	1.4712	1.3154	45.2554	51.8817	48.5274	48.5452
330128	1.2873	1.3154	43.3437	41.7875	46.9809	44.0332
330132	1.0753	0.8551	22.1452	23.4437	23.9298	23.1468
330133	***	*	39.9025	*	*	39.9025
330135	1.2525	1.2060	33.2314	35.3624	39.4523	36.0995
330136	1.6306	0.8708	25.4198	27.9525	28.3358	27.2668
330140	1.8705	0.9710	31.1333	32.7905	33.3826	32.4461
330141	1.3455	1.2591	39.1733	41.4127	44.4198	41.7713
330144	0.9644	0.8454	24.9304	26.0623	28.4224	26.4223
330151	1.2456	0.8454	21.6339	23.4664	23.7227	22.9394
330152	1.4485	1.3154	39.5754	45.9310	54.7885	46.5567
330153	1.7004	0.8708	28.9944	31.7611	31.6854	30.8216
330154	1.5936	*	*	*	*	*
330157	1.3987	0.9710	29.7622	30.2745	31.5462	30.5482
330158	1.8465	1.3154	39.5946	41.6800	45.4100	42.4088
330159	1.3174	0.9710	33.8484	35.6944	36.1910	35.2789
330160	1.5849	1.3154	39.0970	42.1789	42.6001	41.2794
330162	1.2954	1.3154	38.7638	39.3460	39.3481	39.1620
330163	1.0935	0.9628	28.6252	26.3050	28.3979	27.7803
330164	1.5397	0.8708	29.8458	30.3023	31.3949	30.5335
330166	0.8986	0.8420	22.8506	23.2773	24.1281	23.4282
330167	1.6650	1.2884	39.2421	40.8753	40.4764	40.2069
330169	1.4020	1.3154	47.5404	49.7924	52.6481	49.9729
330175	1.1395	0.8680	26.7883	28.2085	29.0736	28.0498
330177	0.9519	0.8420	23.4299	26.0397	26.3552	25.2331
330180	1.3073	0.8708	26.8658	28.0975	28.8360	27.9626
330181	1.4442	1.2884	46.2181	47.2523	47.5998	47.0087
330182	2.3077	1.2884	42.7962	46.6346	47.1719	45.5399
330184	1.4461	1.3154	39.7242	41.3935	44.1215	41.7428
330185	1.3245	1.2591	39.6724	41.3543	42.6846	41.2528
330188	1.3394	0.9628	29.7318	30.7222	31.9349	30.8079
330189	0.9639	0.8708	25.8125	26.4233	27.1290	26.4668
330191	1.3966	0.8708	28.2949	29.3753	30.8219	29.5362
330193	1.5971	1.3154	40.0280	40.7257	41.4653	40.7612

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
330194	1.7160	1.3154	49.8886	49.9208	51.5125	50.4577
330195	1.6426	1.3154	43.3213	46.0878	46.8783	45.3774
330196	1.3574	1.3154	38.6949	42.8106	47.1254	42.9572
330197	1.1361	0.8420	26.5525	27.6437	28.8743	27.7160
330198	1.5031	1.2884	35.8715	37.9641	39.0864	37.7000
330199	1.1339	1.3154	39.4076	47.5059	46.3505	44.4308
330201	1.8227	1.3154	46.5114	51.2179	54.5822	50.6852
330202	1.3722	1.3154	38.7624	42.1074	46.7852	42.6301
330203	1.5060	0.9710	34.6525	33.9161	34.8968	34.4914
330204	1.3905	1.3154	39.5324	44.8153	45.9057	43.4038
330205	1.3126	1.2060	35.3792	37.0171	39.7040	37.4547
330208	1.2411	1.3154	37.1735	38.7279	40.4900	38.7610
330211	1.2386	0.8420	24.9432	25.6929	25.1977	25.2864
330213	1.0549	0.8737	28.5370	30.0957	30.7737	29.8133
330214	1.9522	1.3154	43.3229	43.6872	45.3214	44.1777
330215	1.3738	0.8420	26.3978	28.0026	29.8652	28.0726
330218	1.1081	0.9710	28.4113	28.4369	28.6896	28.5177
330219	1.7911	0.9628	33.2147	38.3321	35.2787	35.5523
330221	1.6164	1.3154	42.5486	40.5201	40.5359	41.2446
330222	1.4126	0.8724	28.7858	30.5142	30.9231	30.1149
330223	0.9881	0.8420	27.1970	28.2638	29.7060	28.4078
330224	1.3051	1.1246	30.4784	32.4518	32.2402	31.7207
330225	1.2507	1.2884	32.9036	33.7052	32.9394	33.1790
330226	1.5413	0.8708	26.3685	25.7981	25.8056	25.9824
330229	1.2515	0.8420	23.9243	24.9977	25.8926	24.9413
330230	***	*	39.3863	39.5043	38.2724	39.1655
330231	1.1081	1.3154	48.9021	49.1983	55.0629	51.0168
330232	1.3400	0.8708	27.9615	28.7263	30.4424	29.0437
330233	1.7151	1.3154	40.8539	43.4873	45.0313	43.1279
330234	2.3642	1.3154	49.8804	55.2159	52.8431	52.7054
330235	1.1918	0.8420	30.8034	31.2218	32.2728	31.3938
330236	1.5342	1.3154	42.6205	45.0321	46.2233	44.6274
330238	1.1263	0.8708	23.3953	24.7086	25.0088	24.3863
330239	1.2644	0.8420	24.6391	24.7255	25.3756	24.9143
330240	1.2759	1.3154	41.6132	42.5871	39.9681	41.3705
330241	1.8864	0.9710	32.9275	34.7013	35.6452	34.4408
330242	***	*	38.7875	40.2224	38.6084	39.2370

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
330245	1.7049	0.8737	28.6698	29.3183	29.9976	29.3388
330246	1.4001	1.2591	35.9577	39.4705	37.8934	37.7571
330247	***	*	41.3465	39.8390	41.3991	40.8503
330249	1.3877	0.9710	26.9856	29.4003	31.3898	29.2579
330250	1.4215	1.0071	29.6186	32.1740	32.6642	31.4918
330259	1.4278	1.2884	39.0213	38.5914	37.9733	38.5494
330261	1.2872	1.3154	38.0216	37.9563	43.0206	39.7053
330263	0.9364	0.8420	24.2125	25.5991	27.1890	25.6737
330264	1.4015	1.2060	32.5050	35.1876	37.0730	34.9405
330265	1.2783	0.8708	22.7433	22.8141	23.4393	23.0082
330267	1.5186	1.3154	35.3907	38.1619	39.3105	37.7127
330268	0.9270	0.8420	23.9135	25.7738	27.2044	25.6557
330270	2.1604	1.3154	52.3154	55.7360	54.4915	54.2881
330273	1.4195	1.3154	39.7880	41.3568	43.8576	41.7263
330276	1.0974	0.8456	27.0445	28.5781	29.1322	28.2518
330277	1.3453	0.9187	30.8156	30.8543	30.9283	30.8668
330279	1.6990	0.9628	31.2393	33.7210	34.1573	33.0755
330285	1.9158	0.8708	31.8987	33.0830	34.8538	33.3318
330286	1.3682	1.2591	38.8556	40.3250	42.5791	40.6255
330290	1.6635	1.3154	39.8036	43.2989	45.9549	43.0520
330304	1.3128	1.3154	39.4632	39.7987	39.8891	39.7160
330306	1.5933	1.3154	39.0409	40.3216	43.4869	40.9711
330307	1.3162	0.9777	30.8121	33.6277	34.1345	32.8690
330314	***	*	22.6885	38.7241	*	24.3594
330316	1.3911	1.3154	37.9357	40.3783	41.6082	39.9746
330331	1.3669	1.2884	44.1734	44.3947	46.9048	45.1731
330332	1.3212	1.2884	38.6932	40.8557	43.4228	41.0514
330339	***	*	25.0057	26.8982	28.5075	26.7655
330340	1.2054	1.2591	38.4726	38.4180	42.2175	39.7075
330350	1.5307	1.3154	44.2389	47.8575	48.0009	46.7458
330353	1.4414	1.3154	46.0215	45.8432	49.5882	47.1722
330354	1.9646	*	*	*	*	*
330357	1.5294	1.3154	40.2132	45.4617	46.6428	43.1989
330372	1.3511	1.2884	37.0323	40.3348	43.4028	40.1441
330385	1.1384	1.3154	47.4017	51.5393	45.1489	48.1275
330386	1.3008	1.1332	32.9990	35.2560	36.5454	34.8018
330389	***	*	37.5908	39.3586	*	38.5126

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
330390	1.5026	1.3154	38.7652	35.4546	38.7532	37.4670
330393	1.7670	1.2591	38.9324	40.1511	41.2486	40.1584
330394	1.6358	0.8932	28.8074	30.5684	31.6244	30.3603
330395	1.3609	1.3154	50.1316	41.6484	45.4826	45.3889
330396	1.5484	1.3154	39.1956	41.6293	44.4691	41.8352
330397	1.4662	1.3154	41.1682	41.0651	42.6933	41.6049
330399	1.2742	1.3154	39.8023	41.7487	43.7557	41.7446
330401	1.3844	1.2591	41.7839	47.0780	45.2281	44.6412
330403	0.8761	0.8708	28.7282	26.7473	23.7571	26.0020
330404	1.1578	1.3154	36.1069	36.8792	36.7400	36.5676
330405	1.1290	1.3154	35.2720	38.6588	39.7124	37.3537
330406	1.1795	0.8708	28.2733	28.0950	29.0800	28.3975
330407	***	*	*	*	22.8305	22.8305
340001	1.5740	0.9299	29.9718	30.6910	31.4272	30.7359
340002	1.8308	0.9055	30.7403	31.6973	32.7669	31.7640
340003	1.4893	0.8476	26.6831	28.0732	28.5497	27.8127
340004	1.5876	0.8974	27.9200	30.6110	31.1689	29.9152
340008	1.2878	0.8768	29.0661	30.7569	34.1051	31.2995
340010	1.4897	0.8476	29.5232	31.0327	32.4035	31.0271
340011	1.1201	0.8476	22.5152	23.6040	24.0602	23.4067
340012	1.2071	*	24.9271	*	*	24.9271
340013	1.2699	0.9162	26.9152	29.2509	27.6445	27.9355
340014	1.6864	0.8974	29.5350	29.4771	30.8373	29.9760
340015	1.4756	0.9162	30.0979	30.7573	28.8959	29.8838
340016	1.4468	0.8476	27.9651	27.2226	28.5561	27.9443
340017	1.4517	0.9055	28.4866	28.4785	30.0523	29.0201
340020	1.2373	0.8632	28.3461	30.5510	32.0755	30.2875
340021	1.5313	0.9162	31.3630	32.5625	31.4752	31.8018
340023	1.4538	0.9127	27.6921	29.5911	30.1104	29.1815
340024	1.3148	0.8653	26.9001	27.4770	28.5059	27.6241
340025	***	*	25.2846	25.8195	27.0389	26.0605
340027	1.2773	0.9192	26.6528	27.2788	27.9469	27.2947
340028	1.5908	0.9453	31.9872	31.7634	33.0069	32.2702
340030	2.1669	0.9662	31.2051	31.5786	33.0418	31.9615
340032	1.5602	0.9299	29.2080	29.3927	31.1516	29.9329
340035	1.0454	0.8476	26.0846	26.8821	28.5418	27.1710
340036	1.1481	0.9713	29.0646	29.9160	32.2510	30.4372

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
340037	1.3488	0.9162	30.5362	32.0484	32.2585	31.6367
340038	1.2142	0.8729	26.2600	26.9487	27.5626	26.9249
340039	1.3643	0.8974	29.5069	30.2952	30.5891	30.1244
340040	1.9443	0.9343	30.1280	31.3866	32.6226	31.4428
340041	1.5949	0.8650	27.1285	27.8408	26.9709	27.3113
340042	1.2562	0.8476	27.0597	27.0729	27.4651	27.2070
340047	1.8790	0.8974	28.7620	30.6701	31.8492	30.4241
340049	1.9406	0.9662	31.5555	35.4171	37.3166	34.8797
340050	1.3906	0.9238	29.2290	30.4447	30.6267	30.1189
340051	1.3116	0.8537	25.4981	25.4162	27.3196	26.0657
340053	1.6844	0.9299	30.8342	30.9274	32.3100	31.3844
340055	1.3835	0.8650	29.0116	29.5040	29.9587	29.5167
340060	1.1756	0.8996	26.8387	27.3403	27.6220	27.2840
340061	1.8918	0.9662	31.2910	33.4821	35.0126	33.3710
340064	1.3481	0.8476	25.0814	27.2184	23.8863	25.2967
340068	1.3615	0.8680	24.7409	27.3499	29.9975	27.4065
340069	1.8686	0.9662	32.2171	32.5361	34.5413	33.1296
340070	1.3306	0.8996	27.7679	29.0391	30.6796	29.1889
340071	1.1590	0.9713	29.7343	31.3756	33.3407	31.6507
340073	1.8342	0.9662	33.1054	33.2705	35.0550	33.8504
340075	1.4189	0.8650	26.8315	29.1504	29.2000	28.3921
340084	1.2918	0.9299	25.6885	27.4289	28.6175	27.2158
340085	1.3401	0.8996	29.1095	29.9176	30.6564	29.9103
340087	1.2638	0.8476	23.8360	25.0091	24.8627	24.5696
340090	1.4562	0.9713	28.3615	28.6805	30.2246	29.1062
340091	1.6471	0.8974	30.4371	31.2643	32.1069	31.2828
340096	1.2936	0.8996	26.5814	26.8103	28.8274	27.3932
340097	1.2417	0.8476	27.9810	29.8702	31.1005	29.7098
340098	1.6521	0.9299	31.3916	31.8472	32.6891	31.9928
340099	1.3129	0.8476	26.0077	28.1143	27.2332	27.0988
340104	***	*	19.9492	20.2901	22.6845	20.9674
340106	1.1483	0.8476	24.5154	24.4254	24.4668	24.4681
340107	1.1997	0.9123	27.3565	28.5859	31.3986	29.1909
340109	1.3875	0.8954	26.6479	28.6310	29.6145	28.2997
340113	2.0509	0.9299	32.3786	32.4983	33.7477	32.8917
340114	1.6329	0.9662	30.1207	32.3730	33.9019	32.1940
340115	1.6196	0.9662	28.0974	28.9265	30.1329	29.0563

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
340116	1.6601	0.8650	29.9447	30.8834	31.7109	30.8405
340119	1.5385	0.9299	27.2938	28.1090	27.5712	27.6658
340120	1.1905	0.8476	26.1465	26.6358	25.4889	26.0896
340121	1.2056	0.8476	25.1577	25.7488	27.4932	26.1656
340123	1.4033	0.8996	28.7150	29.9077	30.2556	29.6505
340124	***	*	25.7294	25.2498	*	25.5286
340126	1.4018	0.9713	30.6902	31.7266	32.8511	31.7775
340127	1.3442	0.9662	28.8675	30.8152	29.2765	29.6601
340129	1.4724	0.9162	31.7863	27.7470	28.6231	29.2827
340130	1.3943	0.9299	29.5294	30.4887	31.5667	30.5985
340131	1.5012	0.9192	29.6571	32.1743	32.7180	31.5487
340132	1.2123	0.8476	25.3264	25.9153	27.9450	26.4203
340133	1.0352	0.8795	26.8850	27.2630	27.7506	27.3138
340137	***	*	27.0874	28.8723	*	27.9808
340138	0.7851	0.9662	*	*	*	*
340141	1.7657	0.9264	29.3372	30.8628	32.7734	31.0073
340142	1.3540	0.8476	28.2413	28.4951	28.8034	28.5181
340143	1.6608	0.8650	29.3861	30.7162	30.7369	30.3039
340144	1.3389	0.9162	27.6548	26.5581	28.9693	27.6935
340145	1.3578	0.9162	28.0647	28.4230	30.2759	28.9487
340147	1.4283	0.9713	29.6960	30.2620	31.9805	30.6482
340148	1.5162	0.8974	27.9136	28.6607	29.4141	28.6790
340151	1.2488	0.8528	24.5782	25.9633	27.4868	26.0151
340153	2.2501	0.9299	29.8278	30.9065	31.9428	30.9177
340155	1.5111	0.9662	31.7570	31.6719	33.3228	32.2613
340156	0.9566	1.4446	*	*	*	*
340158	1.2800	0.9264	29.4110	29.2570	30.5810	29.7971
340159	1.2531	0.9662	28.1706	27.8427	28.4492	28.1630
340160	1.3305	0.8476	24.2016	24.9127	26.6329	25.2921
340166	1.4619	0.9299	29.9122	31.0779	32.0934	31.0482
340168	0.6198	0.9264	*	*	*	*
340171	1.2836	0.9299	31.1954	31.7831	32.9707	32.0444
340173	1.3664	0.9662	30.9843	30.9025	33.6286	31.9191
340183	1.4456	0.9299	30.1261	31.4691	33.8741	32.0540
340184	1.2205	0.9055	*	*	*	*
350002	1.9786	0.7641	23.6051	25.2966	25.6152	24.8333
350003	1.3396	*	24.5812	27.3546	*	25.9392

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
350006	1.5896	0.7451	23.4343	26.6508	24.5023	24.8210
350009	1.1530	*	23.9795	*	*	23.9795
350011	1.9178	0.8102	26.0201	27.3884	28.6631	27.4053
350015	1.7512	0.7641	22.9120	27.6960	27.5676	26.0667
350017	***	*	24.0968	*	*	24.0968
350019	1.7575	0.8034	24.9890	27.0960	28.0496	26.7628
350030	***	*	23.1023	*	*	23.1023
350063	0.9324	1.4448	*	*	*	*
350064	0.7461	1.4448	*	*	*	*
350070	1.7884	0.8102	26.2871	28.1430	27.2743	27.2399
360001	1.6025	0.9624	30.1038	31.8522	32.7842	31.5960
360002	1.4501	0.8696	25.2209	26.7549	28.6674	26.8773
360003	1.8677	0.9624	31.8976	31.9294	33.1679	32.3384
360006	1.9087	1.0163	31.8814	35.3579	37.9929	35.0514
360008	1.5052	0.8757	28.0202	28.5988	29.5464	28.7459
360009	1.6126	0.9254	28.2423	30.2452	30.8841	29.8023
360010	1.3386	0.8612	26.6040	27.3194	29.0985	27.6697
360011	1.4401	1.0025	29.9882	31.3142	31.2797	30.8745
360012	1.4610	1.0163	31.9837	32.9127	33.7117	32.8731
360013	1.1783	0.9254	30.2406	30.9331	32.0183	31.0838
360014	1.2374	1.0025	28.1811	28.9635	31.9691	29.7242
360016	1.5885	0.9624	30.2190	30.5892	31.9656	30.9288
360017	1.8785	1.0163	32.6006	34.8774	37.9269	35.0847
360019	1.3519	0.9082	28.8568	29.3536	29.9006	29.3780
360020	1.5714	0.9082	27.8079	29.5312	30.6901	29.3408
360025	1.4669	0.9246	28.4761	29.5329	30.0999	29.3797
360026	1.6064	0.9172	27.5757	27.3618	26.3380	27.0570
360027	1.5697	0.9082	29.9449	30.8898	32.5281	31.0972
360029	1.1553	0.9374	28.0191	29.0633	29.4172	28.8392
360032	1.3121	0.8555	27.2636	27.4896	29.0836	27.9439
360035	1.7082	1.0163	32.0858	32.5622	33.7737	32.7945
360036	1.2891	0.8917	29.9410	31.5027	32.2558	31.2400
360037	1.6216	0.9082	30.6552	31.5221	32.0751	31.4189
360038	1.7378	0.9624	31.3776	32.3095	34.0962	32.4982
360039	1.5460	0.8555	25.8216	27.3636	28.7284	27.2681
360040	1.2153	0.8942	26.7450	28.4404	29.8190	28.4196
360041	1.3782	0.9082	28.4439	29.3331	29.9816	29.2239

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
360044	1.2307	0.8682	24.7698	25.7011	25.6594	25.3785
360046	1.3090	0.9624	28.2972	28.5624	28.9068	28.5940
360048	1.8571	0.9374	30.0390	33.3273	39.7450	34.2489
360051	1.7630	0.9172	29.4434	30.5937	31.1421	30.4107
360052	1.6740	0.9172	28.4731	29.8072	31.5097	29.8835
360054	1.5310	0.8757	23.6606	26.8828	27.5188	25.9621
360055	1.4571	0.9082	31.4794	31.2738	32.8952	31.8741
360056	1.5298	0.9624	31.3936	31.8378	33.3691	32.2230
360058	1.1411	0.8555	25.9295	27.7073	27.9521	27.1876
360059	1.7410	0.9082	30.6294	31.3956	32.6539	31.5860
360062	***	*	32.9025	35.2065	*	34.0497
360064	1.6958	0.8628	28.6101	28.5325	29.7002	28.9332
360065	1.2957	0.9082	31.5066	31.6781	32.9311	32.0490
360066	1.4780	0.9254	30.9652	32.1991	33.3925	32.2022
360068	1.9074	0.9374	28.6335	30.0212	30.0149	29.5525
360070	1.7211	0.8650	28.8739	30.0192	30.7774	29.8917
360071	1.1589	0.8590	25.7956	26.6139	29.0698	27.1686
360072	1.4371	1.0163	29.1514	29.8851	29.9298	29.6482
360074	1.4181	0.9374	28.0283	30.1333	30.4801	29.5360
360075	1.3041	0.9082	28.3930	29.8181	31.5315	29.9856
360076	1.6207	0.9624	29.5342	28.8462	39.7210	32.3956
360077	1.6129	0.9082	28.3022	26.2961	29.4388	28.0016
360078	1.3461	0.9082	27.3652	28.2973	29.8163	28.5296
360079	1.9369	0.9172	31.3132	32.0935	34.0345	32.4653
360080	1.2318	0.8555	21.8806	22.9825	23.4889	22.7871
360081	1.3978	0.9374	31.4293	33.2532	33.2079	32.6352
360082	1.3923	0.9082	30.5837	29.7447	31.0704	30.4761
360084	1.6721	0.8650	29.2489	29.2527	30.7559	29.7670
360085	1.9801	1.0163	33.1295	35.9664	36.9965	35.5221
360086	1.6162	0.9172	29.1579	31.9690	31.4898	30.8314
360087	1.5016	0.9082	28.6336	30.0084	31.6840	30.0619
360089	1.1498	0.8555	28.0779	28.5192	31.2561	29.2567
360090	1.4048	0.9374	29.2662	30.3175	30.9528	30.1599
360091	1.3254	0.9082	28.2009	29.6324	30.4266	29.4199
360092	1.3143	1.0163	28.0813	28.3576	30.1497	28.8462
360095	1.5618	0.9246	30.2138	30.0996	29.4352	29.8848
360096	1.1693	0.8626	27.9514	29.8687	30.9621	29.5853

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
360098	1.4382	0.9082	26.5839	27.6752	29.8125	28.0156
360100	***	*	25.8143	25.9628	25.6754	25.8206
360101	1.4306	0.9082	30.6650	29.4661	30.1728	30.0962
360107	1.0926	0.8674	26.8180	29.9869	30.3832	29.1302
360109	1.1223	1.0025	30.4643	30.7873	32.3056	31.1780
360112	1.8127	0.9653	32.4403	34.6063	34.7090	33.9241
360113	1.3049	0.9624	30.3914	33.3293	33.4370	32.4622
360115	1.4149	0.9082	27.9711	29.0971	30.1635	29.1065
360116	1.2562	0.9624	26.8632	29.3122	29.7886	28.5973
360118	1.5008	0.8917	29.9823	30.1189	30.7835	30.3015
360121	1.3059	0.9246	31.6766	22.1967	32.9106	28.0639
360123	1.5042	0.9082	28.5435	30.0862	31.5149	30.0236
360125	1.2614	0.8555	27.1776	28.8237	28.0379	28.0071
360130	1.3605	0.9082	28.1811	28.5433	29.7395	28.7979
360131	1.4918	0.8650	27.3426	28.3618	28.7700	28.1660
360132	1.4508	0.9624	29.8411	29.5751	31.5629	30.3076
360133	1.7092	0.9624	33.1812	33.9534	34.8154	33.9938
360134	1.7893	0.9624	29.9198	31.9438	32.3503	31.4241
360137	1.8571	0.9082	30.3116	32.2727	33.2378	32.0143
360141	1.7533	0.8628	31.9397	32.0733	32.7782	32.2474
360143	1.4331	0.9082	28.0693	27.0053	28.0817	27.7280
360144	1.4492	0.9082	29.6547	29.5081	31.0418	30.0723
360145	1.5767	0.9082	29.3271	29.8688	30.7653	29.9946
360147	1.4745	0.8555	29.2371	28.0794	29.5821	28.9716
360148	1.2665	0.8555	25.7460	28.4538	29.4819	27.8748
360150	1.4450	0.9082	27.8840	27.8860	28.7383	28.1724
360151	1.3858	0.8650	26.9672	28.3917	29.2479	28.3557
360152	1.6437	1.0163	33.1017	35.3636	38.6208	35.6295
360153	1.0408	0.8555	21.8416	22.3028	22.2992	22.1453
360155	1.5129	0.9082	29.1711	30.0263	31.6318	30.2212
360156	1.2161	0.8674	26.2268	27.4185	28.7732	27.4930
360159	1.5048	1.0025	29.0187	29.1683	31.7186	29.9873
360161	1.4352	0.8639	27.7423	29.4713	29.7974	29.0175
360163	1.8520	0.9624	31.2087	31.1214	35.9313	32.7672
360170	1.3566	1.0163	30.0688	30.9891	30.4758	30.5174
360172	1.4106	0.9082	30.2330	31.2620	33.1946	31.5024
360174	1.4016	0.9172	28.3769	29.2419	29.6556	29.0991

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
360175	1.3096	1.0025	29.7499	31.8340	31.7026	31.1036
360179	1.6158	0.9624	31.3540	30.6820	31.6922	31.2533
360180	2.5220	0.9082	32.0225	30.3025	32.9705	31.8017
360185	1.4175	0.8555	26.4210	27.4008	27.6522	27.1534
360187	***	*	27.3745	28.2630	31.4188	28.8678
360189	1.1225	1.0163	28.3738	28.8931	29.4708	28.9364
360192	1.4530	0.9082	29.1999	31.7957	32.2091	31.1258
360195	1.1421	0.9082	27.2630	28.4907	29.0980	28.3002
360197	1.3514	0.8555	28.5267	30.3316	31.0116	29.9915
360203	1.1956	0.8555	27.7569	28.7975	29.7199	28.7550
360210	1.4152	1.0163	31.8182	35.1678	37.5771	34.9693
360211	1.6242	0.8555	27.5081	26.9504	26.8677	27.1117
360212	1.4042	0.9082	28.5882	28.8865	31.1956	29.5446
360218	1.3838	1.0163	31.1641	31.4458	31.3310	31.3170
360230	1.5862	0.9082	30.5995	29.9181	31.6669	30.7266
360234	1.4362	0.9624	30.7926	29.5412	33.3664	31.1901
360236	1.4186	0.9624	29.9367	31.7585	32.1567	31.3134
360239	1.4331	0.9172	31.7938	32.3401	33.2718	32.5127
360241	***	*	25.8137	28.0304	29.5279	27.8946
360242	1.9199	*	*	*	*	*
360245	0.8463	0.9082	20.4589	20.8560	21.7637	21.1049
360247	0.6198	1.0163	*	*	20.0037	20.0037
360253	***	*	34.6887	33.3121	37.3905	35.0706
360259	1.3694	0.9374	28.0886	29.3681	31.0669	29.4823
360261	1.2686	0.8909	26.6262	28.2317	32.7931	29.2218
360262	1.3275	0.9374	31.5637	33.1908	34.1099	32.9417
360263	1.9512	0.9254	28.1671	25.5127	26.8628	26.7667
360266	2.2686	1.0163	29.8385	31.3706	33.4559	31.8486
360269	1.9619	0.9624	25.5191	26.3965	34.8464	29.0819
360270	1.1560	0.8555	28.8677	30.0580	32.1049	30.6384
360271	1.4738	0.9624	28.4353	30.8070	32.9727	30.7694
360272	***	*	38.1014	*	*	38.1014
360273	***	*	37.6645	*	*	37.6645
360274	1.6329	0.9172	*	*	41.5894	41.5894
360275	***	*	*	*	35.3416	35.3416
360276	1.3571	0.8628	*	*	30.8602	30.8602
360347	1.2052	1.0163	*	*	*	*

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
360348	1.6182	1.0163	*	*	*	*
360349	1.4026	0.9374	*	*	*	*
360350	1.8062	0.9624	*	*	*	*
360351	1.9867	0.8850	*	*	*	*
360352	1.0842	0.8628	*	*	*	*
360354	1.4011	0.9624	*	*	*	*
360355	1.5439	0.9183	*	*	*	*
370001	1.6993	0.8903	28.4907	27.2881	29.2907	28.3843
370002	1.2418	0.8052	26.2486	26.5804	28.5178	27.1335
370004	1.1751	0.8446	28.2804	27.2378	29.4714	28.3160
370006	1.2115	0.8798	25.2307	27.5299	28.6399	27.1064
370007	0.9619	0.8052	21.1260	25.7680	29.2831	25.4572
370008	1.4129	0.8900	27.9944	29.1467	29.2458	28.8413
370011	0.9562	0.8900	23.1761	24.5886	26.7301	24.8297
370013	1.4968	0.8900	28.3502	29.7899	32.8050	30.3615
370014	1.2150	0.8445	28.8962	29.3407	28.8058	29.0123
370015	0.9979	0.8798	27.8061	27.6086	27.9015	27.7724
370016	1.5857	0.8900	30.4672	29.6737	30.9822	30.3796
370018	1.5379	0.8798	31.2335	29.3285	29.9348	30.1154
370019	1.1741	0.8052	26.7613	30.4599	30.9046	29.3782
370020	1.5729	0.8900	24.7520	24.7484	26.5784	25.3619
370022	1.3858	0.8306	26.4836	24.4735	26.1508	25.6663
370023	1.3323	0.8142	24.9580	27.4272	27.9018	26.8583
370025	1.3829	0.8798	24.8336	27.0211	27.6951	26.4528
370026	1.4507	0.8900	26.0203	26.8057	28.1146	26.9937
370028	2.0270	0.8900	29.9849	31.9029	33.9521	31.9991
370029	1.1511	0.8052	30.0134	30.3712	31.0013	30.4602
370030	0.9910	0.8798	26.0831	26.5853	27.9552	26.8681
370032	1.4856	0.8900	28.0739	30.2497	29.6486	29.2901
370034	1.2867	0.8052	23.2192	23.9679	29.5364	25.5443
370036	1.0370	0.8052	21.1544	22.1686	21.3785	21.5609
370037	1.8563	0.8900	26.8992	28.9215	30.8721	28.8559
370039	1.1530	0.8903	25.3422	26.7579	27.7301	26.6250
370040	0.9917	0.8052	19.7644	21.6739	23.4331	21.6824
370041	0.8609	0.8903	29.5074	26.4346	25.4871	27.1154
370047	1.4945	0.8900	27.8937	29.6739	32.3165	30.0356
370048	0.9653	0.8052	23.4848	24.2668	24.1343	23.9599

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
370049	1.4371	0.8052	24.2099	22.8526	28.2783	25.0600
370051	1.0771	0.8052	21.8716	22.8411	25.2437	23.3375
370054	1.2593	0.8052	23.4644	25.4821	31.2786	26.7359
370056	1.7795	0.8616	27.6178	26.9562	31.0225	28.6018
370057	0.9892	0.8903	23.1814	21.0790	21.6866	21.9676
370060	***	*	25.5571	29.0333	*	27.1132
370065	1.0374	0.8148	24.0062	23.7889	27.6147	25.2679
370072	0.7840	0.8310	22.8598	17.3061	22.6081	20.6800
370078	1.6690	0.8903	30.4837	28.7496	30.0395	29.7756
370080	0.9537	0.8052	23.7231	22.4258	20.5624	22.2160
370083	0.8441	0.8103	21.9162	21.3677	19.0707	20.7313
370084	1.0783	0.8052	17.4202	17.7119	16.9006	17.3311
370089	1.5651	0.8052	22.0607	23.8318	25.9159	24.0554
370091	1.7197	0.8903	28.0487	28.3945	29.9801	28.8357
370093	1.9314	0.8900	26.7272	29.0161	30.3405	28.6784
370094	1.4661	0.8900	28.3512	29.5931	29.7407	29.2592
370097	1.3617	0.8616	28.0911	28.1234	28.0485	28.0899
370099	1.0863	0.8900	30.5437	28.8908	29.8196	29.7121
370100	0.8879	0.8152	20.6298	18.2493	20.4983	19.7870
370103	1.0503	0.8052	22.2675	23.4746	23.9559	23.2347
370105	2.1142	0.8900	30.5438	30.9068	36.1174	32.0645
370106	1.5245	0.8900	29.6797	31.4433	32.4747	31.2193
370112	1.0149	0.8052	19.0130	20.2239	20.4699	19.9447
370113	1.1529	0.8646	30.0061	28.3511	28.2888	28.8884
370114	1.7327	0.8903	27.1348	32.9928	34.7611	31.4511
370138	1.0298	0.8052	23.6348	24.7631	28.4293	25.7195
370139	0.9194	0.8052	21.0759	19.3691	22.7663	21.0194
370148	1.5057	0.8900	29.3447	30.8781	32.6383	30.9688
370149	1.3740	0.8354	23.0764	25.0025	27.3475	25.0933
370153	1.0947	0.8052	25.9238	30.0891	28.8427	28.2741
370156	1.0078	0.8173	22.7140	22.3940	23.9498	23.0193
370158	0.9116	0.8900	22.0056	22.2823	23.6271	22.6383
370166	0.9198	0.8903	26.3420	22.9735	24.2071	24.5055
370169	0.7920	0.8215	24.5389	20.5348	20.0430	21.8109
370170	0.9052	1.4444	*	*	*	*
370171	1.0000	1.4444	*	*	*	*
370172	0.8044	1.4702	*	*	*	*

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
370173	1.0007	1.4444	*	*	*	*
370176	***	*	26.6687	27.2899	*	26.9843
370178	0.9180	0.8052	15.6720	17.3536	21.1275	17.9568
370180	1.2523	1.4444	*	*	*	*
370183	0.9346	0.8903	30.3850	25.4218	25.6096	27.0506
370190	1.6477	0.8903	32.5635	35.6046	42.6067	37.1583
370192	1.9251	0.8900	19.1346	28.9574	32.6197	27.3274
370196	***	*	24.6984	*	*	24.6984
370199	0.9552	0.8900	23.9376	25.9775	26.7845	25.6708
370200	***	*	19.7060	27.9940	35.8719	26.8170
370201	1.5046	0.8900	25.5882	30.4213	30.9026	28.9180
370202	1.4666	0.8903	25.8261	29.3845	30.9936	28.8532
370203	1.8920	0.8900	30.3641	31.6266	32.1871	31.6717
370206	1.9178	0.8900	30.8151	28.9491	30.0585	29.9057
370210	1.9062	0.8903	25.7905	29.4082	29.9079	28.4566
370211	1.1934	0.8900	30.9656	32.7888	34.6101	32.9440
370212	1.9722	0.8900	20.0919	23.4166	27.1375	23.5295
370214	0.8377	0.8173	20.1495	22.3796	25.0447	22.5261
370215	2.2825	0.8900	32.0950	32.7257	33.2373	32.7263
370216	2.1658	0.8903	29.6658	29.1189	26.1707	28.1248
370218	1.4156	0.8903	23.7517	29.6378	28.7572	27.2714
370219	***	*	41.4392	*	*	41.4392
370220	2.2137	0.8900	21.3168	22.2077	20.9298	21.4203
370222	1.9360	0.8900	26.9175	28.6123	28.3453	27.9656
370223	***	*	24.0154	*	19.6604	21.4670
370224	***	*	*	21.5542	*	21.5542
370225	1.1413	0.8900	*	*	*	*
370226	***	*	*	*	37.1390	37.1390
370227	1.0250	0.8903	*	*	25.9830	25.9830
370228	1.1823	0.8903	*	*	29.2557	29.2557
370229	1.0257	0.8052	*	*	*	*
370231	0.9969	0.8903	*	*	*	*
370232	1.1109	0.8052	*	*	*	*
380001	1.2530	1.1221	33.8490	36.3316	37.7584	36.0275
380002	1.3507	1.0089	32.6830	32.7006	33.7907	33.0702
380004	1.6902	1.1221	36.1021	37.7310	38.7848	37.5392
380005	1.4128	1.0089	33.5765	33.5424	36.4765	34.5241

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
380007	1.9680	1.1221	36.4222	37.9358	39.2842	37.8818
380009	2.1862	1.1221	36.5688	36.8442	39.1393	37.5615
380014	1.9778	1.0340	35.7101	36.4373	36.1111	36.0952
380017	1.7902	1.1221	36.8103	37.5098	38.6492	37.6722
380018	2.0193	1.0089	32.4884	32.3945	33.4301	32.7883
380020	1.4677	1.1331	35.7392	37.4343	42.4903	38.6506
380021	1.5246	1.1221	33.0628	33.3855	35.2942	33.9333
380022	1.4159	1.0149	30.9181	32.6138	34.0849	32.6081
380025	1.2343	1.1221	38.1507	38.7401	40.2542	39.0981
380027	1.4336	1.1032	31.4398	33.7027	35.3681	33.5331
380029	1.3160	1.1119	33.3368	34.4907	36.3780	34.8151
380033	1.1325	1.1331	36.0798	36.6589	38.9026	37.2572
380037	1.4089	1.1221	34.0321	36.0715	37.8397	36.1223
380038	1.3228	1.1221	35.0350	36.3586	37.3367	36.2465
380040	1.5283	1.0089	34.4500	37.3200	39.0280	37.0491
380047	1.8942	1.1032	35.8165	37.9901	39.2864	37.8086
380050	1.4662	1.0089	31.3088	32.4377	35.5034	33.1746
380051	1.8579	1.1221	35.0114	37.3363	39.5771	37.3333
380052	1.2455	1.0089	27.7656	29.1449	30.5763	29.1627
380056	1.2401	1.1119	31.0210	31.9034	32.2946	31.7201
380060	1.5979	1.1221	35.1106	36.9581	37.6168	36.6196
380061	1.6961	1.1221	35.8922	37.9554	39.8524	37.8861
380071	1.5130	1.1221	31.6821	32.7466	36.1630	33.5296
380075	1.4781	1.0089	34.0197	36.0119	37.8963	35.9417
380082	1.3415	1.1221	37.7268	38.8914	40.5892	39.0683
380089	1.3650	1.1221	37.0017	37.7878	39.3331	38.0936
380090	1.3301	1.1032	41.4540	41.3541	36.1957	39.4825
380091	1.6124	1.1221	39.7431	47.7003	43.5979	43.8371
380100	***	*	45.3882	*	*	45.3882
380102	1.8467	1.1331	*	*	*	*
390001	1.5928	0.8521	25.4188	27.9772	27.1369	26.8091
390002	1.4560	0.8579	25.9827	26.9670	28.0217	26.9883
390003	1.1897	0.8521	26.2872	26.6558	28.5550	27.1598
390004	1.7151	0.9172	26.5054	29.3249	30.1116	28.6336
390006	1.9048	0.9172	30.9914	32.8108	34.0319	32.6975
390008	1.1052	0.8581	22.9417	25.0200	23.3722	23.7761
390009	1.7909	0.8521	29.0286	29.4416	29.4788	29.3179

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
390010	***	*	26.0966	27.8944	*	26.9767
390012	1.2900	1.0780	34.2004	35.6251	36.5075	35.4492
390013	1.4998	0.9172	28.3039	26.8792	28.6128	27.9375
390016	1.3710	0.8521	26.1802	25.6660	28.0791	26.6336
390019	1.2656	0.9418	25.3185	25.2047	27.4886	25.9672
390023	1.2198	1.0780	36.2618	37.9254	40.0307	38.0623
390024	***	*	37.4815	*	*	37.4815
390025	0.5715	1.0780	*	*	*	*
390026	1.2953	1.0780	36.0608	36.6927	37.8982	36.8748
390027	1.8176	1.0780	40.9110	42.5592	43.2863	42.2614
390028	1.7616	0.8579	29.6218	31.3868	29.7659	30.2416
390030	1.1774	0.8856	26.5678	26.9684	29.2589	27.6203
390031	1.2218	0.8856	26.1258	27.5747	30.8796	28.1344
390032	1.3312	0.8579	25.3756	27.3294	28.0123	26.9158
390035	1.2342	1.0780	27.2130	27.6331	30.9600	28.6617
390036	1.5866	0.8579	26.1956	30.1286	32.9773	29.7227
390037	1.4602	0.8579	27.0788	31.6832	31.5443	30.0435
390039	1.3655	0.8558	22.1531	23.3456	24.9694	23.4740
390041	1.2656	0.8579	25.1190	26.4415	26.5753	26.0714
390042	1.5148	0.8579	29.6213	30.6691	30.9971	30.4337
390043	1.2296	0.8521	24.3590	26.4451	27.6266	26.1527
390044	1.6128	0.9047	29.9959	30.6946	30.4850	30.4001
390045	1.4760	0.8521	25.8800	26.4450	25.4029	25.8954
390046	1.8301	0.9760	32.5273	32.1156	34.3559	33.0452
390048	1.1692	0.9172	28.4563	29.0278	30.0870	29.1884
390049	1.5518	0.9418	31.0290	32.7809	33.9546	32.6141
390050	2.1229	0.8579	29.6715	32.0935	32.6719	31.5014
390052	1.1984	0.8568	26.3700	27.4028	28.0662	27.3003
390054	***	*	27.5696	*	*	27.5696
390056	1.1238	0.8557	24.7038	25.5903	26.0944	25.4676
390057	1.3731	1.0780	31.0279	33.9576	34.1227	33.0166
390058	1.4268	0.9172	29.6620	29.4647	31.4346	30.2160
390061	1.5125	0.9760	30.9208	30.2319	33.2839	31.3678
390062	1.1590	0.8529	22.8856	37.2849	24.7403	28.3031
390063	1.9432	0.8521	28.3987	30.3687	29.6085	29.4599
390065	1.3869	1.0539	31.8841	31.2628	34.1509	32.4868
390066	1.4935	0.9172	29.0033	28.3747	28.4545	28.6018

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
390067	1.8047	0.9760	32.2891	30.5601	32.7009	31.8523
390068	1.2866	0.9760	29.6984	28.2183	31.3686	29.7350
390070	1.3814	1.0780	34.5501	33.4969	34.5022	34.1840
390071	1.0479	0.8521	26.3830	27.8695	29.4067	27.8637
390072	1.0365	0.8521	28.8145	28.0714	29.3008	28.7479
390073	1.7549	0.8529	27.0876	28.8519	30.4073	28.7640
390076	1.3590	1.0780	33.9908	34.0355	36.0337	34.6436
390079	1.8713	0.8762	26.0199	26.9676	29.0245	27.3480
390080	1.4522	1.0780	31.6210	33.0003	34.7963	33.0758
390081	1.3314	1.0780	36.4788	37.7643	37.7381	37.3396
390084	1.2793	0.8521	24.3191	24.8010	26.7795	25.2800
390086	1.5945	0.8521	24.7454	25.3096	25.8212	25.3007
390090	1.8764	0.8579	30.1256	31.9282	33.7323	31.8674
390091	1.2620	0.8521	23.2118	23.9434	24.9895	24.0598
390093	1.2290	0.8521	23.8846	23.5291	23.4916	23.6341
390095	1.2005	0.8521	25.3859	25.9594	25.8271	25.7150
390096	1.6264	0.9047	30.3910	31.7443	32.9599	31.7312
390097	1.2966	1.0780	28.1285	30.4946	31.2933	29.9565
390100	1.6541	0.9760	32.7836	32.8949	33.8098	33.1901
390101	1.3191	0.9539	25.9850	28.6622	30.5652	28.4498
390102	1.4762	0.8579	25.5336	26.3716	27.4078	26.4615
390104	1.0256	0.8521	20.4552	26.8407	25.5500	24.5842
390107	1.7718	0.8579	25.6790	26.6305	27.5113	26.6481
390108	1.3264	1.0780	34.3066	33.3017	33.0812	33.5657
390110	1.6616	0.8521	25.7159	28.5314	29.2114	27.8372
390111	2.3297	1.0780	37.7322	34.5571	37.4034	36.5385
390112	1.1114	0.8558	18.4185	19.5361	21.7618	19.8898
390113	1.3636	0.8521	24.8669	25.9952	27.3239	26.1026
390114	1.5335	0.8579	28.5336	28.2039	31.1727	29.3417
390115	1.4010	1.0780	32.5058	32.8427	32.4906	32.6138
390116	1.4090	1.0780	33.9295	34.5119	35.8124	34.7722
390117	1.2284	0.8523	22.2327	26.0642	29.4532	25.9021
390118	1.2756	0.8521	23.6535	23.7128	24.9150	24.0866
390119	1.3599	0.8521	25.3907	25.9784	27.7668	26.4246
390122	1.0543	0.8574	24.6434	24.0424	25.6753	24.7750
390123	1.2379	1.0780	35.1244	34.1121	36.2907	35.1769
390125	1.2563	0.8543	24.0199	24.4654	28.2329	25.5409

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
390127	1.5706	1.0780	33.1227	34.6488	37.2911	35.0077
390128	1.2760	0.8579	25.1858	26.0441	26.6048	25.9610
390130	1.2073	0.8521	30.7083	26.7324	27.8831	28.3944
390131	1.4113	0.8579	27.7146	26.9190	27.7765	27.4675
390132	1.6245	1.0780	30.0751	33.1853	34.6686	32.6204
390133	1.8571	1.0663	33.0604	35.0046	33.5858	33.8932
390137	1.5065	0.8521	26.9156	27.9033	28.8768	27.9121
390138	1.3244	0.9172	27.7565	29.0224	31.9340	29.6092
390139	1.3858	1.0780	36.5001	36.8337	38.9715	37.4666
390142	1.5812	1.0780	33.3509	38.1793	41.7965	37.8882
390145	1.4739	0.8579	26.9212	27.6510	28.4472	27.7026
390146	1.1970	0.8543	23.9878	27.5267	28.5944	26.6700
390147	1.4098	0.8579	29.0995	30.4797	29.9003	29.8258
390150	1.1325	0.8552	22.6483	27.2922	29.5097	26.6124
390151	1.4533	1.0539	31.8967	35.0627	36.1838	34.4568
390153	1.3662	1.0780	36.0287	37.0995	38.6509	37.2968
390154	1.2217	0.8521	23.9785	24.6857	26.5297	25.0858
390156	1.3617	1.0780	33.7057	34.9903	37.3076	35.3187
390157	1.2496	0.8579	23.0989	23.7167	25.3304	24.0528
390160	1.4641	0.8579	25.2043	27.5196	28.6869	27.1706
390162	1.5709	1.1296	35.1844	36.7008	37.4703	36.4185
390163	1.3306	0.8579	24.8761	25.4594	26.9809	25.7955
390164	2.2789	0.8579	29.7778	29.0556	30.3482	29.7279
390166	***	*	28.2178	*	*	28.2178
390168	1.6857	0.8579	27.3674	28.2578	30.9235	28.8822
390169	1.1762	0.8521	26.6063	28.4619	28.7411	27.9870
390173	1.3215	0.8558	27.6039	28.0999	29.4695	28.4211
390174	1.8138	1.0780	35.1118	36.5352	38.5670	36.7628
390176	1.0420	0.8579	*	27.5270	32.1051	29.5889
390178	1.4445	0.8612	23.9166	25.2325	26.0853	25.0756
390179	1.4701	1.0780	31.5498	33.9916	35.7591	33.8296
390180	1.4303	1.0780	38.2997	37.8677	39.2901	38.4851
390181	***	*	27.8833	*	*	27.8833
390183	1.1887	0.8521	28.2211	28.8361	29.9287	29.0390
390184	1.0458	0.8579	23.9973	24.1461	24.6116	24.2542
390185	1.3942	0.9418	25.5318	28.1346	29.5155	27.8683
390189	1.0954	0.8521	23.4902	25.3686	26.8189	25.2753

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
390192	1.0196	0.8521	23.7958	24.7427	25.0085	24.5203
390194	1.2336	0.9418	23.7367	27.8231	27.5260	26.2940
390195	1.6061	1.0780	37.2504	36.8626	39.5226	37.8846
390196	1.5301	*	*	*	*	*
390197	1.3716	0.9418	27.7303	28.1999	28.4855	28.1347
390198	1.0016	0.8521	21.0861	21.3574	23.6249	22.0336
390199	1.1525	0.8521	24.5469	24.9642	25.6275	25.0628
390201	1.5511	0.9691	28.5668	28.7755	33.2321	30.2676
390203	1.5230	1.0780	30.7244	33.0056	39.2667	34.4792
390204	1.3951	1.0780	32.0242	33.8120	31.6920	32.4668
390211	1.4122	0.8612	27.7875	28.0796	29.5567	28.4769
390217	1.2688	0.8579	26.2706	25.6917	27.0886	26.3518
390219	1.3817	0.8579	26.3263	27.2812	28.9463	27.5217
390220	1.2574	1.0780	32.0891	33.0323	34.0933	33.0447
390222	1.4380	1.0780	32.7077	34.5835	35.0162	34.1313
390223	2.1413	1.0780	36.5784	35.8030	36.4686	36.2827
390225	1.3671	0.9760	26.3642	*	37.2003	31.3972
390226	1.7682	1.0780	35.4683	35.5564	37.7252	36.2815
390228	1.5300	0.8579	25.5120	28.4321	28.7341	27.5570
390231	1.4535	1.0780	35.2312	35.0675	35.2479	35.1832
390233	1.4332	0.8521	28.3660	29.5938	31.2920	29.7908
390236	1.0294	0.8524	24.5574	25.1866	26.6442	25.4333
390237	1.6878	0.8521	29.9748	29.6917	29.3123	29.6520
390256	1.9907	0.9172	28.5887	31.6455	32.5650	30.9753
390258	1.4564	1.0780	32.0551	33.7330	37.1156	34.3523
390263	1.6615	0.9418	30.2069	31.1718	31.3913	30.9524
390265	1.6237	0.8579	27.7795	27.8241	30.8343	28.8119
390266	1.1383	0.8612	23.0142	23.5248	24.2255	23.5948
390267	1.5021	0.8579	25.7571	28.4250	30.7224	28.2795
390268	1.4705	0.8640	28.4200	30.0652	30.2637	29.6045
390270	1.7441	0.8521	27.0301	29.3622	31.2862	29.3404
390272	0.6330	1.0780	32.9918	29.4836	28.9815	30.3399
390278	0.7864	1.0780	28.8318	33.9596	32.6176	31.7776
390285	***	*	38.4703	43.0793	42.6411	41.2248
390286	***	*	31.7337	32.6998	34.3467	32.9330
390290	1.8432	1.0780	47.7663	41.9121	45.5855	45.0203
390304	1.4348	1.0780	33.4134	35.0741	31.4118	33.2717

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
390307	1.9281	0.8612	22.9474	27.2053	28.6025	26.1219
390311	***	*	49.9027	*	*	49.9027
390312	1.4452	1.0780	51.3372	42.3481	47.4912	46.6973
390313	1.1402	0.8856	*	27.3018	28.2730	27.7674
390314	1.9104	0.9418	*	*	31.2627	31.2627
390315	***	*	*	*	33.7886	33.7886
390316	2.1098	0.9047	*	*	27.5474	27.5474
390317	0.8038	1.0780	*	*	40.0462	40.0462
390318	1.4192	0.9418	*	*	28.8744	28.8744
390319	0.9481	0.8579	*	*	*	*
390320	2.7965	1.0780	*	*	*	*
390321	1.7804	0.9418	*	*	*	*
400001	1.3274	0.4302	15.4249	15.9192	16.7467	16.0408
400002	***	*	12.9793	14.2946	*	13.6163
400003	1.4027	0.4278	14.6859	15.8816	16.1022	15.5378
400004	1.1337	0.4302	13.5197	14.5542	15.6128	14.5649
400005	1.1494	0.4302	11.7590	12.6516	13.5902	12.6912
400006	1.2753	0.4302	*	*	11.3150	11.3150
400007	1.3194	0.4302	10.4934	10.7767	12.4403	11.1611
400009	1.0496	0.3577	10.1212	14.0016	12.1371	11.8594
400010	0.8029	0.3384	10.4206	12.8584	9.9686	10.7816
400011	1.2081	0.4302	9.4068	10.7620	11.2889	10.4922
400012	1.6634	0.4302	*	11.1553	12.3642	11.7247
400013	1.3877	0.4302	12.3073	12.7900	13.8665	13.0128
400014	1.4610	0.3612	12.3301	11.0722	11.8099	11.7048
400015	1.2566	0.4302	21.9225	17.6943	20.6014	19.9015
400016	1.5854	0.4302	17.9107	19.1577	18.3119	18.4599
400017	***	*	10.0590	*	*	10.0590
400018	1.3636	0.4302	13.1572	13.6091	14.0267	13.6205
400019	1.5566	0.4302	15.2364	15.0604	15.9353	15.3872
400021	1.5607	0.4570	14.9779	16.3677	16.9832	16.1033
400022	1.4793	0.4278	15.2124	15.3660	16.3760	15.6441
400024	0.7732	0.3612	13.7215	14.2708	12.9549	13.5783
400026	1.2407	0.3577	8.9064	9.8155	10.7169	9.7988
400028	***	*	9.6941	11.1923	10.2934	10.3638
400032	1.1343	0.4302	10.7844	11.9013	12.2669	11.6859
400044	1.7300	0.4278	12.1393	13.4579	14.6579	13.6085

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
400048	1.2979	0.3577	10.5176	11.5766	13.1850	11.7959
400061	2.1704	0.4302	17.4504	18.5327	20.5087	18.8372
400079	1.5588	0.3384	10.6127	11.3550	11.9824	11.3404
400087	1.2640	0.4302	12.0034	12.6233	13.4288	12.6871
400098	1.2431	0.4302	12.8756	13.2365	13.3671	13.1717
400102	1.2316	0.4302	12.1257	12.6314	10.9542	11.7721
400103	2.0761	0.3612	11.3314	12.7285	11.9853	12.0090
400104	1.3358	0.4302	12.6934	12.9616	11.8195	12.5011
400105	1.0711	0.4302	17.0463	25.3823	19.6129	19.9057
400106	1.1191	0.4302	14.8544	14.1766	15.1456	14.7145
400109	1.4847	0.4302	14.5713	15.4910	16.2304	15.4433
400110	1.2368	0.3544	10.8214	11.2311	12.3738	11.4462
400111	1.2060	0.3384	10.7892	11.0467	12.0683	11.3123
400112	1.2379	0.4302	11.2303	9.6181	13.0534	11.1342
400113	1.3390	0.4278	11.5948	11.9672	12.8788	12.1619
400114	1.2113	0.4302	11.6872	11.5514	12.7842	12.0298
400115	1.0598	0.4302	10.6809	12.0201	10.9564	11.2441
400117	1.0324	0.4302	12.1540	12.2159	13.0609	12.4850
400118	1.3323	0.4302	12.6199	13.3983	14.0618	13.3770
400120	1.4734	0.4302	14.5205	14.6591	15.3683	14.8571
400121	1.0669	0.4302	9.9713	11.7462	11.7441	11.2726
400122	2.2443	0.4302	10.0966	13.1851	13.6602	12.0852
400123	1.2369	0.3612	13.8601	13.4317	14.3030	13.8583
400124	2.8599	0.4302	19.1704	21.9082	22.0619	21.0750
400125	1.2425	0.3892	13.1078	12.7141	13.5864	13.1629
400126	1.2276	0.4570	*	14.2108	13.0372	13.5539
400127	2.2024	0.4302	*	12.0796	10.6621	11.1995
400128	1.0442	0.4302	*	23.6366	14.1088	17.2092
410001	1.3296	1.1613	30.5865	30.8038	33.6421	31.6567
410004	1.3994	1.1613	35.2384	33.7118	35.8403	34.9238
410005	1.2979	1.1613	34.2846	38.2842	38.0619	36.9368
410006	1.4558	1.0751	33.9961	35.4462	36.1985	35.2228
410007	1.7064	1.1613	34.4774	37.0287	38.3867	36.7006
410008	1.3757	1.0751	33.6384	34.6138	35.3809	34.5644
410009	1.3355	1.0751	34.3427	36.0892	36.4091	35.6362
410010	1.1199	1.1613	34.9330	38.4603	39.9638	37.7769
410011	1.4645	1.1613	36.7668	38.5007	37.6589	37.6665

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
410012	1.6248	1.1613	36.5207	37.5223	38.6851	37.5744
410013	1.2620	1.1412	39.8659	38.2253	38.6414	38.8940
420002	1.6629	0.9300	31.2247	32.3569	33.2952	32.2569
420004	2.1010	0.9295	30.0764	31.8610	34.1012	32.1498
420005	1.2940	0.8450	26.5044	28.0173	29.8412	28.1181
420006	2.1518	*	29.1404	31.5368	32.2965	30.9655
420007	1.7111	0.9128	28.9557	31.1080	31.3033	30.4861
420009	1.4017	0.9128	28.6648	29.1084	29.6808	29.1549
420010	1.1694	0.8478	26.5523	27.0435	27.8709	27.1665
420011	1.1720	0.9357	26.0585	25.9484	25.1689	25.7394
420015	1.3418	0.9357	27.4929	27.9759	29.5582	28.3316
420016	1.0027	0.8438	23.4323	23.2125	23.4618	23.3687
420018	1.9284	0.8799	29.0923	28.9660	30.2579	29.4553
420019	1.1621	0.8596	25.8119	23.7910	26.9977	25.5119
420020	1.3033	0.9295	29.2935	28.9093	30.9488	29.7089
420023	1.8241	0.9357	30.4492	31.2602	32.2488	31.4072
420026	1.9124	0.8799	29.5066	31.2504	32.5572	31.1347
420027	1.6300	0.9128	31.3797	30.6779	*	31.0258
420030	1.4921	0.9295	30.3424	31.3260	33.0987	31.5744
420033	1.3463	0.9357	32.4287	33.8157	33.5699	33.2702
420036	1.2688	0.8695	26.3480	27.1715	28.0250	27.1767
420037	1.4064	0.9357	32.7124	33.5291	34.1076	33.4635
420038	1.2847	0.9357	27.1524	29.5673	31.5388	29.4623
420039	1.0619	0.8970	26.3127	24.5270	26.0489	25.6075
420043	1.1861	0.8595	25.8366	24.2727	25.6018	25.2202
420048	1.3049	0.8799	27.4353	29.9094	30.5167	29.3111
420049	1.3260	0.8681	28.0920	28.4801	29.1163	28.5669
420051	1.8299	0.8478	27.6130	28.0711	29.6261	28.4477
420053	1.2963	0.8473	25.4820	26.4997	27.1081	26.3512
420054	1.1210	0.8446	26.7900	27.1580	28.2725	27.4120
420055	1.1416	0.8467	25.3144	25.9899	26.0255	25.7592
420056	1.3094	0.8438	29.7774	27.8175	29.3188	28.9542
420057	1.2963	0.8478	27.7137	29.5662	29.8897	29.0709
420062	1.0833	0.8563	27.2263	28.3129	29.4726	28.3826
420064	1.5616	0.8681	25.0654	26.4352	28.3216	26.6452
420065	1.5441	0.9295	28.1896	28.2922	28.9626	28.4895
420066	0.9570	0.8478	20.5743	26.0307	27.0504	24.3154

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
420067	1.4142	0.8858	27.7167	29.0379	29.2066	28.6526
420068	1.5378	0.9571	28.0316	28.1555	30.0666	28.7169
420069	1.2850	0.8438	24.4656	25.1993	25.9447	25.2155
420070	1.4122	0.8695	27.6431	28.4000	28.5579	28.2053
420071	1.5208	0.9128	28.1099	28.6098	30.2531	29.0105
420072	1.1647	0.8438	20.7716	24.4951	25.2077	23.5012
420073	1.4865	0.8799	28.2671	29.5999	30.4941	29.4818
420078	1.9867	0.9357	32.8731	34.3181	33.3691	33.5209
420079	1.5363	0.9295	30.5981	31.7686	32.4626	31.6252
420080	1.4096	0.8858	32.8712	33.8785	35.2949	34.0334
420082	1.5126	0.9571	34.8864	33.5290	33.6670	33.9910
420083	1.4791	0.9128	29.6587	29.2264	33.5329	30.7160
420085	1.5196	0.9265	29.9085	31.3391	32.5361	31.2837
420086	1.5308	0.8799	29.6349	30.1406	30.5884	30.1347
420087	1.8321	0.9295	28.4632	28.8860	29.6136	29.0043
420089	1.6898	0.9295	31.7367	33.0906	35.2407	33.3707
420091	1.5567	0.8478	27.9062	28.0471	30.7482	28.8706
420098	1.1976	0.8462	27.6722	28.2058	29.6500	28.5992
420100	***	*	29.2979	*	*	29.2979
420101	1.0052	0.8858	33.1995	33.5957	33.0451	33.2696
420102	1.8906	0.9357	*	*	34.3207	34.3207
420103	1.2387	0.9357	*	*	*	*
430005	1.4208	0.8435	25.4385	27.1759	29.2386	27.2448
430008	1.1323	0.8970	27.2275	27.2961	28.1278	27.5654
430012	1.3663	0.9388	27.0195	28.5808	28.9595	28.1941
430013	1.2067	0.8435	28.4962	28.3679	29.7388	28.8759
430014	1.5187	0.8435	28.9295	29.2921	30.3630	29.5359
430015	1.3611	0.8435	28.0414	28.0093	28.9296	28.3270
430016	1.6144	0.9388	31.1336	31.5894	34.2610	32.4635
430027	1.7295	0.9388	29.2617	29.2432	31.1835	29.9366
430048	1.2480	0.8564	25.6428	26.9537	28.6697	27.1026
430060	0.9026	0.8435	*	11.7801	*	11.7801
430064	0.9703	*	17.7334	*	*	17.7334
430077	1.7929	1.0990	31.1945	35.3480	39.6547	35.4000
430081	1.0199	1.4448	*	*	*	*
430082	0.7513	1.4448	*	*	*	*
430083	1.0550	1.4448	*	*	*	*

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
430084	0.8832	1.4448	*	*	*	*
430089	2.2827	0.8968	24.9060	28.3217	28.7338	27.4480
430090	2.0301	0.9388	32.7395	33.8350	34.0212	33.5658
430091	2.0885	1.0990	26.7258	28.3496	29.0916	28.0819
430092	2.0494	0.8435	23.2527	26.6750	28.3015	26.0017
430093	0.9808	1.0990	24.7426	30.7398	30.2337	28.4605
430094	1.7420	0.8564	23.6624	23.9005	24.9804	24.2133
430095	2.3107	0.9388	32.5881	31.8141	38.2085	34.0836
430096	2.3728	0.8435	24.9623	28.0608	28.3796	27.0773
440001	1.1423	0.7919	25.4855	23.9380	25.8019	25.0735
440002	1.7402	0.8907	26.9133	28.4828	28.7976	28.0851
440003	1.3257	0.9246	26.0115	31.4162	31.1666	29.3051
440006	1.6645	0.9246	31.7394	32.6924	33.2995	32.6609
440007	1.1248	0.8138	22.7571	23.4825	23.6870	23.3271
440008	1.0281	0.8368	26.8857	26.2003	28.2870	27.1392
440009	1.1708	0.7919	24.4423	25.1184	26.0040	25.1835
440010	0.9243	0.7919	20.2497	23.8087	24.9022	22.8411
440011	1.4425	0.7919	24.8300	25.7912	27.1600	25.9502
440012	1.5952	0.7919	24.9261	26.2076	26.5953	25.9396
440015	1.9977	0.7919	27.1603	28.1389	28.4467	27.9223
440016	1.0765	0.8063	25.2512	25.4197	27.4924	26.0451
440017	1.8177	0.7919	26.1820	28.6110	27.1081	27.3237
440018	1.1740	0.7919	24.8568	26.0748	26.3363	25.7740
440019	***	*	26.2464	28.0387	30.1931	28.0787
440020	1.0657	0.7919	27.5626	28.0269	28.6636	28.0709
440024	***	*	26.2534	25.4398	*	25.8750
440025	1.2561	0.8407	24.0289	25.5605	26.7642	25.4762
440026	***	*	28.4615	26.5911	29.9514	28.3617
440029	1.4714	0.9246	31.4652	31.8872	32.1072	31.8356
440030	1.3554	0.7919	22.3144	23.1116	23.2575	22.8992
440031	1.2845	0.7938	22.0711	23.0937	24.1851	23.1142
440032	1.2903	0.7919	23.8030	25.4122	25.3202	24.8770
440033	1.1176	0.7946	23.9792	24.3197	24.4996	24.2751
440034	1.7491	0.7919	25.9138	26.7987	27.0736	26.5997
440035	1.3762	0.9246	27.9217	26.8725	27.7533	27.5134
440039	2.2785	0.9246	30.1918	32.4190	32.3384	31.6681
440040	0.8602	0.7919	21.1288	21.3795	23.0134	21.8153

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
440046	1.5007	0.9246	30.7334	31.5146	32.8764	31.6731
440047	0.9783	0.8257	25.2150	26.8032	28.6702	26.9106
440048	1.8888	0.9137	30.6725	31.5584	32.5404	31.5872
440049	1.7063	0.9137	29.8623	31.7148	32.6356	31.4058
440050	1.4510	0.7919	26.3825	27.1284	29.3303	27.5657
440051	0.9297	0.8001	23.6560	23.1773	24.8037	23.8861
440052	1.0648	*	24.4071	28.1868	*	26.2378
440053	1.3950	0.9246	30.3907	31.3189	32.4503	31.4080
440054	1.2435	0.7919	21.9641	25.7785	25.9377	24.4630
440056	1.2204	0.7919	24.0635	25.2050	25.9743	25.0917
440057	1.1740	0.7940	19.3546	25.1519	22.9222	22.2785
440058	1.1492	0.8582	29.1184	28.5093	28.0299	28.5506
440059	1.5321	0.9246	29.4532	30.4489	30.5995	30.1903
440060	1.3363	0.8257	26.5867	26.5518	27.3024	26.8209
440061	1.1152	0.7919	25.4134	25.9969	26.5212	25.9931
440063	1.7344	0.7952	26.0763	25.4344	24.7803	25.4192
440064	0.9734	0.8721	26.7957	26.9014	28.9331	27.5492
440065	1.4389	0.9246	25.6111	27.3501	27.6328	26.8707
440067	1.0879	0.7919	26.0866	26.5062	27.4606	26.6924
440068	1.1836	0.8531	27.9082	27.2646	28.3925	27.8565
440070	0.9667	0.8028	23.2228	24.4477	23.7568	23.8061
440072	1.1077	0.7919	26.1661	27.6990	29.4625	27.8065
440073	1.4586	0.9246	27.5133	28.3950	33.8232	29.7943
440081	1.3267	0.7971	21.9681	23.3000	24.5259	23.2799
440082	1.9820	0.9246	32.8941	34.4535	34.2270	33.8164
440083	0.9678	0.7919	25.7074	25.5397	31.8133	27.4028
440084	1.1913	0.7944	19.8950	21.3873	22.1562	21.1576
440091	1.8112	0.8721	28.9697	30.0650	31.3375	30.1465
440102	1.0781	0.7919	22.1114	23.5525	24.5121	23.3354
440104	2.0266	0.8721	28.0905	29.7326	30.2301	29.3691
440105	0.9050	0.7952	23.7154	24.6039	25.1558	24.4882
440109	1.0319	0.7989	22.5878	23.8465	25.0329	23.8752
440110	1.2059	0.7919	23.6275	23.8010	25.2412	24.2401
440111	1.3708	0.9246	29.7461	33.0828	34.8033	32.5048
440115	1.0246	0.8257	24.9778	25.2508	26.5072	25.5829
440120	1.5835	0.7919	26.0621	28.0271	29.3067	27.8170
440125	1.7354	0.7919	24.0934	24.7908	25.9494	24.9465

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
440130	1.1307	0.7919	26.3192	27.5525	29.7509	27.8864
440131	1.1097	0.9137	28.3162	29.0546	29.2776	28.8882
440132	1.2404	0.7919	29.3377	26.1823	26.0031	27.0744
440133	1.7764	0.9246	32.5726	33.2319	32.4641	32.7486
440135	***	*	27.2094	28.7658	*	27.7843
440137	1.1024	0.8657	24.6143	25.6931	26.9374	25.7242
440141	1.0666	0.7919	24.8737	24.3575	26.3678	25.1500
440144	1.2612	0.8531	26.3225	26.6282	28.1527	27.0256
440147	***	*	36.6978	33.5900	37.8346	36.1793
440148	1.2607	0.8215	28.0708	26.2483	26.9352	27.0789
440150	1.5299	0.9246	30.5513	32.9854	32.8334	32.1424
440151	1.2054	0.9246	28.6585	28.8412	29.7082	29.0660
440152	2.5625	0.9137	29.0588	28.7357	30.1779	29.3307
440153	1.0707	0.7919	23.3790	23.8797	25.5049	24.2283
440156	1.6720	0.8721	30.5161	31.0506	31.6017	31.0718
440159	1.4664	0.9137	27.2785	26.2728	29.3516	27.6174
440161	2.1078	0.9246	31.0667	32.2343	33.4813	32.2916
440162	***	*	24.6425	27.8605	32.8708	28.2006
440168	0.9044	0.9137	31.3316	37.0865	35.6076	34.6194
440173	1.5174	0.7919	23.1370	23.5486	24.5617	23.7711
440174	0.9085	0.8907	27.4579	27.4578	29.2147	28.0222
440175	1.0307	0.7919	26.7705	29.2713	28.1637	28.0598
440176	1.4968	0.7919	24.9420	26.1477	25.8830	25.6676
440180	1.1625	0.7946	24.3376	26.9310	28.0126	26.4469
440181	1.1717	0.8284	26.4763	26.2247	26.8006	26.5057
440182	0.9173	0.8063	24.9899	24.4173	26.1132	25.1673
440183	1.5613	0.9137	30.9923	31.9159	33.2870	32.0523
440184	1.1262	0.7952	26.9086	25.3287	23.3322	25.0223
440185	1.2332	0.8531	26.3974	25.6005	27.2121	26.4383
440186	0.9656	0.9246	28.2840	30.0775	29.4231	29.3781
440187	1.1201	0.7919	27.4034	27.2669	29.4492	28.0330
440189	1.3670	0.8310	30.5786	29.9065	32.4791	31.0665
440192	1.1026	0.9246	30.6533	32.0772	30.4030	31.0183
440193	1.4241	0.9246	25.9726	27.8132	29.2015	27.6576
440194	1.3855	0.9246	32.3020	32.1073	33.3464	32.6095
440197	1.5649	0.9246	31.4317	32.3241	33.1604	32.2961
440200	1.1684	0.9246	23.8288	23.3049	25.6800	24.2881

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
440217	***	*	31.6650	33.8684	33.5264	33.0112
440218	2.3018	0.9246	36.9273	31.7847	34.8600	34.3070
440222	***	*	30.5148	32.4230	33.4779	32.1341
440225	0.8351	0.7919	26.9687	29.8273	31.2189	29.5476
440226	1.8051	0.7919	28.3199	28.4491	31.2423	29.3511
440227	1.4445	0.9246	31.9119	32.1862	33.3005	32.4840
440228	1.5313	0.9137	29.5372	31.2049	32.7230	31.2589
450002	1.5584	0.8594	29.7180	30.0562	31.6279	30.4327
450005	1.2589	0.8456	27.3473	27.9825	28.6433	28.0242
450007	1.2745	0.9071	24.4630	26.2568	27.9008	26.2410
450008	1.3007	0.8775	24.4372	26.1215	28.5492	26.3295
450010	1.6966	0.9929	30.1034	32.9053	35.9573	32.9324
450011	1.6446	0.9244	29.9302	30.9903	32.9877	31.3013
450015	1.7472	0.9734	30.3168	30.3228	30.4911	30.3779
450018	1.7997	0.9946	31.3131	32.9922	35.5712	33.2965
450021	2.0024	0.9734	31.7360	34.5462	35.7307	34.0291
450023	1.3908	0.8038	25.1683	25.6361	27.9984	26.2980
450024	1.7757	0.8594	27.3814	27.8816	27.1925	27.4827
450028	1.6425	0.9486	29.5689	29.8049	34.0997	31.2123
450029	1.5534	0.8312	28.6465	27.2662	28.3780	28.0928
450031	***	*	29.2141	28.8891	34.0104	30.5763
450032	1.3782	0.8593	26.3159	25.7989	24.7722	25.5859
450033	1.6415	0.9486	29.7668	31.6557	32.7706	31.4322
450034	1.5659	0.8456	29.6309	28.2761	30.5057	29.4205
450035	1.7041	0.9946	30.3369	30.8574	*	30.5883
450037	1.5611	0.8593	28.2622	26.8661	31.6332	28.8487
450039	1.6804	0.9584	29.8145	29.5097	31.1550	30.1911
450040	1.7943	0.8940	28.5469	30.0844	31.7878	30.1162
450042	1.7837	0.8648	27.6131	28.3649	29.9591	28.7245
450044	1.7955	0.9734	32.9921	36.3786	36.8350	35.4324
450046	1.6799	0.8576	27.2439	28.4297	29.1115	28.2783
450047	***	*	24.9670	24.6290	*	24.8091
450051	2.0476	0.9734	30.3976	31.0740	32.5581	31.3450
450052	1.1232	0.8018	24.3964	25.8142	26.8780	25.6896
450054	1.8685	0.8775	30.2211	30.7196	31.8152	30.9786
450055	0.9581	0.8018	24.1418	24.6436	24.1331	24.3059
450056	1.7335	0.9523	32.0902	33.7634	35.1758	33.7275

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
450058	1.6760	0.9071	27.7318	27.8963	29.3038	28.3582
450059	***	*	28.5645	29.9336	30.4251	29.6617
450064	1.6215	0.9584	29.0495	30.6704	31.2918	30.3637
450068	2.2983	0.9946	32.0372	34.9179	36.0902	34.3951
450072	1.2590	0.9946	28.0921	28.7063	30.1911	29.0674
450073	0.8084	0.8018	22.2322	23.1471	27.3607	24.1130
450076	1.7389	*	*	*	*	*
450078	0.9125	0.8018	20.7800	21.0876	22.8792	21.5781
450079	1.5567	0.9734	36.8936	34.1533	35.0924	35.3302
450080	1.2802	0.9584	26.8111	28.6334	28.2834	27.9102
450082	1.2045	0.8018	25.5654	27.1314	28.0686	26.8222
450083	1.8349	0.8259	30.2054	28.6628	27.8743	28.9055
450085	1.1963	0.8018	26.3610	28.1669	28.9441	27.8191
450087	1.5252	0.9584	32.6556	34.2493	35.5922	34.2084
450090	1.3411	0.8668	22.7822	22.2148	21.7004	22.2188
450092	1.4103	0.8312	28.2278	28.3891	30.5314	29.0936
450097	1.5643	0.9946	31.9782	33.8910	34.3604	33.4331
450099	1.3224	0.8434	29.8491	25.5799	25.4382	26.8735
450101	1.6811	0.8648	28.4220	29.3777	30.4843	29.3988
450102	1.7949	0.8259	27.3364	27.5145	28.5283	27.8122
450104	1.2249	0.9071	27.7851	30.4631	31.5834	29.9121
450107	1.7114	0.8594	29.0328	29.6790	31.5472	30.1274
450108	1.1643	0.9071	22.4293	21.7619	23.4651	22.5508
450119	1.6775	0.8888	34.4161	31.0699	34.4231	33.3604
450123	1.0012	0.8456	24.0433	27.6445	25.6415	25.8683
450124	1.8454	0.9523	31.9797	32.9774	34.3913	33.0155
450126	***	*	32.0370	32.9729	33.9635	33.0184
450128	1.3469	0.8888	28.3171	28.9733	25.6071	27.5150
450130	1.2316	0.9071	26.9208	28.3786	29.5020	28.2589
450132	1.6455	0.9426	31.1361	34.8719	33.2761	33.1083
450133	1.6806	0.9554	30.9622	31.3911	33.3058	31.9181
450135	1.7157	0.9584	30.7909	30.8734	32.1719	31.2968
450137	1.6678	0.9584	35.7775	33.8235	36.3832	35.3104
450143	1.0086	0.9523	24.4346	25.1702	26.2306	25.2759
450144	0.8810	0.9554	31.1552	31.4041	33.9298	32.1350
450147	1.4830	0.8576	26.3032	27.3607	28.1864	27.2675
450148	1.3368	0.9584	30.0542	29.9522	32.0315	30.7189

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
450151	***	*	22.8768	*	*	22.8768
450152	1.2507	0.8775	24.3442	25.7523	27.2981	25.8872
450154	1.3577	0.8018	24.2582	23.2210	26.8036	24.6426
450155	0.9518	0.8018	24.8773	25.2546	27.0261	25.7426
450162	1.1826	0.8940	33.7823	27.1453	27.1885	29.3979
450163	1.0821	0.8072	27.0967	27.6273	28.6735	27.8002
450165	1.1390	0.9071	30.2236	30.3796	31.6216	30.7510
450176	1.6011	0.8888	25.8587	28.4561	29.1369	27.9379
450177	1.1127	0.8018	26.0895	27.7791	28.5027	27.4708
450178	0.9348	0.9311	28.5990	27.5779	28.9534	28.3711
450184	1.7708	0.9946	30.9726	32.7090	34.0933	32.6058
450187	1.1680	0.9946	29.2749	29.3048	32.4972	30.4075
450188	0.9030	0.8018	24.6823	23.0844	23.5026	23.7701
450191	1.2449	0.9523	31.1339	30.0686	32.6122	31.2546
450192	1.0167	0.8289	26.9884	27.5539	29.0941	27.8974
450193	2.2410	0.9946	37.1906	38.2891	38.8688	38.1249
450194	1.2453	0.8231	30.4381	28.6816	28.5747	29.3155
450196	1.4787	0.8018	25.4842	29.8107	34.5610	29.7868
450200	1.5357	0.8018	27.9843	27.5112	27.4356	27.6508
450201	***	*	22.5464	*	*	22.5464
450203	1.3080	0.9427	28.0986	29.4706	30.6946	29.4199
450209	1.8635	0.8574	31.9882	30.4150	32.0113	31.4497
450210	1.0230	0.8169	22.9055	23.7777	24.1082	23.5571
450211	1.4423	0.8593	28.8485	27.7427	28.6208	28.3857
450213	1.9743	0.9071	28.0307	29.2061	31.8766	29.7730
450214	1.2952	0.9946	28.2261	27.0761	29.7013	28.2460
450219	0.9672	0.8018	24.7274	28.0584	26.5426	26.4061
450221	1.0166	0.8018	20.7118	23.9462	26.0548	23.4307
450222	1.8038	0.9946	31.9255	33.2164	35.4314	33.5503
450224	1.3332	0.8259	28.7931	29.8428	34.2896	30.7490
450229	1.6776	0.8416	26.8039	27.2189	28.6814	27.5782
450231	1.7396	0.8574	27.0545	27.7289	29.0463	27.9560
450234	1.1803	0.8018	21.6799	23.2715	24.5744	23.0923
450235	0.9372	0.8018	23.8001	24.3335	26.5480	24.8876
450236	1.2391	0.8407	24.5942	24.1409	24.7381	24.4954
450237	1.6644	0.9071	31.2197	36.8412	38.6993	35.7648
450239	0.9838	0.8775	18.4234	19.1203	20.1484	19.2749

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450241	1.0529	0.8018	28.4948	24.3518	23.6473	25.3644
450243	1.0338	0.8018	19.0180	19.9804	19.3327	19.4422
450253	0.8658	0.9946	22.9918	24.3618	24.8454	24.0810
450270	1.2977	0.8289	12.9999	19.0341	23.1601	17.6868
450271	1.3816	0.9427	23.9534	27.4614	27.2326	26.3228
450272	1.2457	0.9523	29.0917	29.5124	30.9357	29.8687
450280	1.6447	0.9734	34.9349	33.8297	36.7763	35.1896
450283	1.1064	0.9584	28.2094	24.3428	26.0914	26.1061
450289	1.5582	0.9946	32.6137	32.4591	33.0717	32.7210
450292	1.2182	0.9734	29.0243	29.2485	29.9357	29.4213
450293	0.7961	0.8018	24.1556	23.7577	24.0607	23.9932
450296	1.0761	0.9946	33.4545	34.1708	36.4604	34.6820
450299	1.6942	0.9244	29.4593	30.3493	31.1239	30.4022
450306	0.8749	0.8416	22.6818	25.9877	26.8169	25.0749
450315	2.1271	0.9734	31.4227	32.3840	33.7842	32.7212
450324	1.6326	0.9584	27.9899	26.8023	29.4539	28.0902
450330	1.3508	0.9946	27.7419	29.4471	30.3251	29.1461
450340	1.4176	0.8479	29.6617	28.7672	30.5815	29.6840
450346	1.5986	0.8456	24.8434	26.7809	28.3085	26.7155
450347	1.2930	0.9946	28.5789	30.0644	39.0879	31.7620
450348	0.8857	0.8018	22.6828	23.1190	24.9786	23.5721
450351	1.1747	0.9427	29.9598	30.3441	31.5335	30.6264
450352	1.1455	0.9734	27.6480	29.3516	30.7631	29.2850
450358	2.1150	0.9946	33.9103	36.9859	37.7186	36.2668
450369	0.8990	0.8018	24.1953	22.7433	26.2247	24.2072
450370	1.1848	0.9946	29.0816	28.8348	29.9689	29.2856
450372	1.3896	0.9734	30.9345	33.7023	35.7078	33.4644
450373	0.8488	0.8018	27.4251	25.3691	24.2932	25.7191
450378	***	*	33.0583	33.9891	36.4075	34.4205
450379	1.4175	0.9734	35.0637	35.9067	32.6271	34.4741
450388	1.7639	0.9071	29.5386	30.3720	31.6070	30.5182
450389	1.2142	0.9584	26.8499	24.6733	25.7364	25.7517
450393	***	*	39.0266	12.9286	27.1107	24.0530
450395	1.1582	0.8459	28.4272	27.2714	29.8846	28.5726
450399	0.8847	0.8018	20.6307	23.2716	22.6787	22.2015
450400	1.0362	0.9244	29.5020	29.8965	30.9996	30.1497
450403	1.5366	0.9734	31.7065	33.1710	35.4782	33.5113

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450411	1.0111	0.8018	21.7877	20.9108	22.4110	21.7020
450419	1.3410	0.9584	34.9972	33.6834	34.9747	34.5445
450422	1.2762	0.9734	32.4669	36.7309	34.1134	34.3580
450424	1.5450	0.9946	29.8290	32.4674	34.5569	32.3014
450431	1.7403	0.9523	28.5289	29.6446	30.6654	29.6328
450438	1.3139	0.9946	27.7734	25.1006	25.4692	26.1366
450446	0.8334	0.9946	15.4641	12.4405	15.5216	14.4421
450447	1.1936	0.9584	28.3724	29.9936	31.8935	29.9931
450451	1.0730	0.8554	25.8836	26.5422	31.4824	27.8675
450460	0.8984	0.8071	25.2165	27.6224	25.4765	26.1120
450462	1.7382	0.9734	30.6516	31.7311	33.7989	32.0439
450465	1.2421	0.9946	28.1853	28.0105	30.1955	28.8001
450469	1.5261	0.9584	31.1348	29.2172	29.6203	29.9824
450475	1.1705	0.8593	24.7037	25.0642	25.7533	25.1909
450484	1.5134	0.8593	27.7792	29.4306	31.9711	29.7496
450488	1.1850	0.8593	24.9109	26.6089	19.2414	24.1030
450489	1.0148	0.8018	26.9543	25.3695	27.9844	26.7321
450497	1.0021	0.8393	23.0712	24.6056	25.5912	24.4315
450498	0.9124	0.8018	20.6873	19.3077	20.7519	20.2120
450508	1.4192	0.8593	29.1519	30.4829	31.5816	30.4268
450514	***	*	26.4196	*	*	26.4196
450518	1.4458	0.8456	27.5880	28.9969	30.5901	29.0765
450530	1.3988	0.9946	30.7745	31.5033	33.7675	32.0278
450537	1.6268	0.9734	30.9167	33.1500	33.2793	32.4461
450539	1.2570	0.8085	25.0191	25.5268	27.9134	26.1684
450547	0.9127	0.9584	25.4140	24.6575	25.2773	25.1206
450558	1.7520	0.8416	28.7747	30.9433	32.3359	30.6894
450563	1.5978	0.9584	32.6875	35.8856	35.5273	34.6996
450565	1.3413	0.9427	27.4774	28.0400	20.2604	24.6775
450571	1.6736	0.8479	26.5313	26.2046	29.0276	27.1996
450573	1.0624	0.8144	24.6750	28.8508	27.5686	27.0771
450578	0.9388	0.8018	25.2478	25.7938	24.6928	25.2301
450580	0.9863	0.8018	25.9881	23.7932	24.3360	24.7329
450584	1.0404	0.8018	23.6044	23.7329	23.9279	23.7525
450586	1.0322	0.8018	18.3289	19.8656	21.2418	19.8421
450587	1.1286	0.8018	25.9364	27.1505	29.0095	27.3368
450591	1.2132	0.9946	27.9867	26.8802	27.3228	27.3932

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
450596	1.3215	0.9427	31.6590	30.9701	32.6451	31.7682
450597	0.9543	0.8021	24.8443	26.3300	28.5346	26.5850
450604	1.5282	0.9071	29.1543	27.9983	29.6711	28.9317
450605	1.0389	0.8576	14.8039	23.3169	25.9294	19.8604
450610	1.6708	0.9946	30.5977	32.1314	33.4177	32.0231
450615	0.9227	0.8018	22.6331	25.1269	24.9073	24.2185
450617	1.6748	0.9946	30.2923	31.5691	32.8524	31.6194
450620	0.8835	0.8018	21.2535	21.7871	21.8114	21.6178
450630	1.5995	0.9946	31.8014	32.3195	33.9731	32.6640
450634	1.6926	0.9734	31.8008	31.9667	35.0494	32.9472
450638	1.7216	0.9946	33.3237	34.1802	33.8596	33.7803
450639	1.5533	0.9584	34.3754	33.3962	35.2238	34.3245
450641	0.9255	0.8393	21.7292	20.0231	21.9208	21.2237
450643	1.4481	0.8312	27.2538	28.7747	28.9744	28.3464
450644	1.6896	0.9946	31.6874	33.5265	34.8463	33.3746
450646	1.6538	0.8594	27.4631	27.8352	29.9319	28.4242
450647	1.9676	0.9734	34.1016	35.2696	36.5367	35.3425
450651	1.6423	0.9734	33.6498	34.9917	35.6621	34.7071
450653	1.1352	0.8018	26.5361	27.8569	30.2644	28.1938
450654	0.9530	0.8018	25.0755	23.5856	24.5622	24.3772
450656	1.4433	0.8593	29.7290	30.0651	32.2787	30.6407
450658	1.0226	0.8018	22.7090	21.8183	23.5451	22.6654
450659	1.6318	0.9946	34.2657	35.0007	37.4041	35.4287
450661	1.6239	0.9426	29.2381	29.1701	32.8505	30.5685
450662	1.7067	0.9486	30.9630	32.8936	34.5875	32.8475
450668	1.5975	0.8594	30.2083	30.7673	32.0366	30.9613
450669	1.2140	0.9734	32.1244	32.6777	35.4345	33.3993
450670	1.6341	0.9946	26.2954	28.8285	30.3037	28.5168
450672	1.8489	0.9584	33.0858	34.5171	35.3309	34.3346
450674	0.9275	0.9946	31.9316	33.4719	34.3708	33.2937
450675	1.5462	0.9584	32.6380	34.4049	35.3618	34.1567
450677	1.3956	0.9584	27.1603	29.5819	31.0723	29.3313
450678	1.6140	0.9734	33.5513	33.6167	35.4020	34.2062
450683	1.2254	0.9734	24.8440	28.7984	29.3788	27.6756
450684	1.5209	0.9946	31.2765	31.8794	35.0768	32.7040
450686	1.7733	0.8940	26.4871	28.8211	30.3945	28.6469
450688	1.5690	0.9734	29.4393	30.4156	39.5212	33.4935

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450690	1.4264	0.8259	30.0577	31.8607	33.2142	31.5431
450694	1.1250	0.8018	27.0862	28.3456	29.6365	28.3309
450697	1.6210	0.9071	28.3002	29.0148	30.4461	29.3085
450698	0.9036	0.8145	23.3062	21.5450	22.3625	22.2982
450702	1.6646	0.8593	27.1318	26.9753	30.2610	28.1063
450709	1.5374	0.9946	31.3239	31.0331	32.2101	31.5528
450711	1.6479	0.8888	28.1040	29.2934	31.1833	29.5133
450713	1.7474	0.9523	30.4933	31.3274	32.4793	31.4789
450715	***	*	*	27.0982	*	27.0982
450716	1.4846	0.9946	33.9926	33.4960	35.7265	34.4031
450718	1.6829	0.9523	29.7609	30.6623	32.6777	31.1373
450723	1.5586	0.9734	31.0481	32.1316	32.6655	31.9568
450730	1.5137	0.9734	32.8920	34.9137	33.1903	33.6228
450742	1.2662	0.9734	30.4204	31.4270	33.0463	31.6358
450743	1.4816	0.9734	29.5098	30.3302	31.3249	30.4344
450746	1.1292	0.8018	23.3484	22.7535	25.0694	23.7092
450747	1.2515	0.8259	28.3935	27.1975	28.8858	28.1491
450749	0.9107	0.8018	23.9269	23.0265	23.2733	23.4142
450754	0.9768	0.8018	22.8572	23.4607	24.3117	23.5585
450755	1.0767	0.8294	24.7428	22.4195	31.3204	25.7528
450758	***	*	28.3305	29.5013	28.2010	28.6514
450760	***	*	23.7157	24.0691	25.7775	24.3542
450766	1.9556	0.9734	31.2084	33.3435	35.1683	33.2474
450770	1.3684	0.9523	23.6093	25.5863	18.0459	22.2518
450771	1.6045	0.9734	32.5014	32.6206	33.7565	32.9584
450774	1.6654	0.9946	27.5065	29.1151	*	28.3542
450775	1.5260	0.9946	31.6656	33.1582	34.3654	33.1091
450779	1.4365	0.9584	32.0770	31.4350	31.9592	31.8179
450780	2.1639	0.9071	28.5560	29.4960	31.6556	29.8709
450788	1.6154	0.8576	29.7667	31.5593	32.7687	31.3701
450795	1.1190	0.9946	43.8574	31.1871	28.4802	34.7233
450796	2.6228	0.8574	39.4762	31.6590	33.6154	34.7499
450797	1.7663	0.9946	26.0302	29.7074	31.7739	29.3070
450801	1.6105	0.8018	25.6379	27.2635	26.6634	26.5192
450803	1.3194	0.9946	28.7041	28.4345	33.0146	29.9070
450804	2.0163	0.9946	31.1891	33.2767	34.1951	32.9236
450808	2.3057	0.9523	29.6476	27.4132	29.9055	29.0173

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450809	1.7258	0.9523	29.4696	30.4031	31.4588	30.4836
450811	***	*	31.3007	32.5513	31.9859	31.9444
450813	1.1372	0.8144	26.5803	24.0804	20.6715	23.5616
450820	1.7477	0.9946	34.7445	36.4796	38.2108	36.6079
450822	1.3504	0.9734	34.4060	34.7760	36.6675	35.3212
450824	2.6197	0.9523	31.8413	34.8301	39.0190	35.1987
450825	1.6530	0.8888	25.8006	23.6674	24.3308	24.5730
450827	1.4304	0.9929	24.3659	23.6628	23.9496	23.9877
450828	1.3734	0.8018	26.9553	26.3231	28.2632	27.1681
450830	0.9681	*	28.4007	*	*	28.4007
450831	1.7089	0.9946	24.4141	24.2732	29.1549	25.8378
450832	1.5453	0.9946	28.1389	31.2830	32.4824	30.7550
450833	1.1420	0.9734	29.0256	30.3604	32.5010	30.7618
450834	1.7933	0.9244	26.7253	28.1564	29.1031	27.9224
450838	***	*	19.2949	20.3039	19.0487	19.5634
450839	1.0081	0.8018	27.5330	28.0060	28.5894	28.0255
450840	1.2748	0.9734	32.4162	34.1412	35.8725	34.2963
450841	1.6187	0.9486	24.4389	24.6321	23.9682	24.3370
450844	1.4764	0.9946	33.0758	34.7070	36.5371	34.8354
450845	1.8367	0.8594	28.5039	30.9556	31.2402	30.2207
450847	1.3939	0.9946	30.7431	31.6028	32.1869	31.6098
450848	1.4727	0.9946	31.1476	32.0471	33.4153	32.3022
450850	***	*	27.2653	*	*	27.2653
450851	2.0867	0.9734	32.8377	35.2085	38.8802	35.5622
450853	2.0083	0.9734	38.3600	37.5237	36.5101	37.2120
450855	1.8608	0.9486	30.7353	33.0196	32.9107	32.1835
450856	2.5479	0.9071	35.5006	35.5221	33.9274	34.9300
450860	1.8566	0.9946	33.3404	36.0060	39.5352	36.4526
450862	1.8415	0.9946	33.7962	34.2163	35.3982	34.5218
450864	2.6098	0.8259	25.3535	26.6579	27.1210	26.4353
450865	1.1060	0.9523	31.9200	34.6338	35.8513	34.1920
450867	1.2922	0.9523	31.4953	33.8712	34.7654	33.3974
450868	***	*	27.7501	28.4524	30.9119	29.0597
450869	1.9926	0.8888	28.7422	27.9532	33.2135	30.1400
450871	1.9451	0.9523	32.3990	35.2470	37.9738	35.1792
450872	1.3983	0.9584	31.7345	30.7510	30.9726	31.1239
450874	1.8676	0.9734	35.6839	37.4432	36.9974	36.7518

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
450875	1.9516	0.8574	23.2962	26.9904	20.1676	22.8117
450876	1.7122	0.8940	30.3515	30.7721	30.9806	30.7060
450877	1.5299	0.8594	29.2353	28.0504	28.0186	28.4103
450878	2.5973	0.9071	33.6269	33.5225	36.1310	34.4610
450879	***	*	36.4874	31.1510	33.9546	33.6692
450880	1.9228	0.9584	32.6713	32.1245	34.4319	33.1600
450883	1.9373	0.9734	37.1525	38.5954	37.3049	37.6847
450884	1.0402	0.8642	23.5799	25.0230	25.7645	24.7956
450885	1.5264	0.9734	36.0954	33.7612	36.0679	35.3127
450886	2.1922	0.9584	30.1571	33.2011	34.2513	32.5780
450887	***	*	25.5590	*	*	25.5590
450888	1.9205	0.9451	28.5995	26.3027	33.6718	29.5947
450889	1.3218	0.9734	35.6151	29.1149	37.7768	33.7885
450890	1.6403	0.9734	32.2000	33.9068	30.5718	32.1704
450891	1.8038	0.9734	39.0890	29.7832	28.6689	31.5429
450892	***	*	39.5333	*	*	39.5333
450893	1.6541	0.9734	36.2660	37.8279	38.4890	37.6102
450894	2.5125	0.9734	25.9441	34.3388	30.1201	30.2587
460001	2.0520	0.9273	30.7040	32.3262	33.1209	32.1021
460003	1.6576	0.9362	29.6450	31.8128	33.2304	31.5395
460004	1.8788	0.9362	29.8773	32.2759	33.1810	31.8222
460005	1.5680	0.9362	29.4188	29.6947	32.5526	30.5747
460006	1.7333	0.9362	28.9653	30.3798	31.5156	30.3358
460007	1.3358	0.9311	29.1191	30.8583	31.3963	30.5244
460008	***	*	27.6906	30.5351	31.2708	29.8198
460009	2.0509	0.9362	29.4705	31.5120	32.4915	31.2060
460010	2.0371	0.9362	30.9813	32.8157	33.5686	32.4990
460011	1.3290	0.8714	26.5486	27.0189	29.7484	27.7675
460013	1.5423	0.9273	29.7252	31.2945	33.2639	31.4115
460014	1.1697	0.9362	30.6450	30.0229	31.5876	30.7603
460015	1.4935	0.8843	28.8014	30.7369	31.4843	30.3806
460017	1.3823	0.9097	28.7126	29.8556	32.9922	30.5250
460018	1.0014	*	22.0935	24.7761	*	23.4535
460019	1.1788	0.8714	25.1615	24.9579	29.0338	26.4222
460021	1.9540	0.9311	29.7397	31.5207	32.5066	31.3092
460023	1.4134	0.9273	28.9473	30.5888	31.3338	30.3465
460026	0.9596	0.9272	29.2775	31.3552	32.2647	30.9963

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
460030	1.1661	0.8714	26.8979	30.0714	29.9269	28.9836
460033	0.9059	0.8714	27.9108	29.0346	30.0615	29.0242
460035	0.9434	0.8714	23.8682	23.4736	25.1957	24.1858
460039	1.1592	0.9354	30.0677	32.8010	35.0008	32.6853
460041	1.4984	0.9362	26.7356	29.4568	30.8887	29.0180
460042	1.5807	0.9362	36.2903	35.5686	32.3029	34.4949
460043	0.8631	0.9273	29.5660	31.2717	32.7481	31.2613
460044	1.4132	0.9362	29.5079	31.4469	32.6644	31.2589
460047	1.7647	0.9362	31.0020	33.0291	35.1263	33.0272
460049	2.1169	0.9362	28.6267	32.0329	32.9633	31.2669
460051	1.5507	0.9362	28.1140	28.6559	29.4759	28.9591
460052	1.7033	0.9273	28.7455	30.2613	31.8515	30.3626
460054	1.5710	0.8843	26.3939	28.1478	28.0120	27.5238
460055	***	*	*	*	23.1431	23.1431
460056	0.8224	0.8714	*	*	*	*
470001	1.3548	1.0071	32.2887	34.5891	33.5241	33.3804
470003	1.7940	1.0340	30.0535	35.8753	36.7362	34.6784
470005	1.3682	0.9465	33.9969	32.1087	32.9379	33.0059
470011	1.2239	0.9465	30.8742	32.1668	33.3394	32.1525
470012	1.2953	1.0158	29.8259	30.9839	32.7025	31.2202
470024	1.3785	1.0340	27.3106	28.9203	29.2657	28.4919
490001	1.1846	0.8060	24.6883	25.2705	26.8850	25.6328
490002	0.9564	0.8063	24.0672	26.2533	27.6367	26.0235
490004	1.4283	0.9243	28.8660	30.6657	32.4538	30.6807
490005	1.7029	1.0559	31.4909	32.7159	34.9053	33.0668
490007	2.0623	0.8953	30.7411	31.5954	32.4614	31.6048
490009	2.0440	0.9243	31.4260	30.5748	31.9496	31.3136
490011	1.7060	0.8953	28.8780	30.5522	31.9508	30.4122
490012	1.1797	0.8060	21.8322	22.3339	24.4301	22.9678
490013	1.3615	0.9661	27.3486	27.4108	28.5324	27.7697
490017	1.6019	0.8953	29.6784	29.5853	30.9047	30.0811
490018	1.3937	0.9243	27.8682	28.8491	29.5589	28.7713
490019	1.3345	0.9243	29.8891	33.5636	33.7765	32.4062
490020	1.3546	0.9536	30.6013	32.5621	33.3461	32.1198
490021	1.4713	0.8527	28.1254	28.1343	30.0869	28.7596
490022	1.5783	1.0559	31.7985	34.5366	33.3639	33.2694
490023	1.4038	1.0559	32.6308	33.4561	35.6316	33.9527

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
490024	1.7367	0.9020	29.0407	29.9188	31.4854	30.2069
490027	1.4257	0.8060	24.3834	23.6876	25.1699	24.4425
490032	2.0641	0.9536	28.0120	30.0331	32.8661	30.3741
490033	1.2418	1.0559	30.9910	32.1854	35.3543	32.8355
490037	1.1921	0.8060	26.2951	28.9020	27.7807	27.6377
490038	1.1365	0.8063	24.0852	25.7219	26.5823	25.5525
490040	1.6870	1.0559	35.6822	36.5546	38.2247	36.8591
490041	1.7419	0.8953	29.1244	30.4198	31.6506	30.4422
490042	1.3852	0.8864	26.6078	28.1989	28.6351	27.8261
490043	1.4528	1.0571	36.5982	33.4364	35.4380	35.1246
490044	1.5021	0.8953	24.1763	30.3606	31.1639	28.6723
490045	1.4362	1.0559	32.8774	34.0289	33.2301	33.3822
490046	1.5611	0.8953	29.3882	30.5445	32.0244	30.6581
490048	1.5181	0.9020	28.0320	29.1952	32.3457	29.8101
490050	1.6932	1.0559	31.1370	33.3979	35.3441	33.2738
490052	1.7570	0.8953	25.4179	26.5858	27.5800	26.5238
490053	1.2123	0.8060	24.6206	25.5300	27.6516	26.0148
490057	1.6341	0.8953	29.0700	30.5163	31.4342	30.3581
490059	1.7476	0.9536	32.1031	32.7894	33.7315	32.8906
490060	1.0988	0.8060	25.7765	26.2620	26.8764	26.2885
490063	1.9288	1.0571	34.1179	35.7722	36.5676	35.5145
490066	1.3993	0.9536	31.4298	31.1949	32.8018	31.8232
490067	1.3116	0.9536	26.7802	27.5172	28.6635	27.6322
490069	1.7572	0.9536	30.1482	33.1140	33.7580	32.4106
490071	***	*	33.7118	36.1311	37.5474	35.7436
490073	***	*	46.4210	*	*	46.4210
490075	1.4728	0.8168	27.3424	27.8663	28.5221	27.8788
490077	1.4245	0.9243	31.0016	33.5266	33.9868	32.8758
490079	1.2258	0.8973	24.2066	25.3814	26.8381	25.4605
490084	1.1514	0.8247	26.3234	28.0861	29.2001	27.8967
490088	1.0343	0.8527	26.0285	26.5138	27.3105	26.6200
490089	1.0904	0.9020	27.4587	28.7200	28.6746	28.3003
490090	1.1170	0.8060	27.0760	28.1280	30.1159	28.4491
490092	1.0905	0.8060	27.5277	26.9546	27.9480	27.4786
490093	1.5805	0.8953	28.7122	29.2159	30.8707	29.6194
490094	1.0446	0.9536	29.7990	33.4960	35.2427	32.9163
490097	1.1213	0.8060	27.4608	27.3832	30.3702	28.3815

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
490098	1.2490	0.8060	26.7152	29.1195	30.2724	28.7604
490101	1.5529	1.0571	32.9516	36.2501	37.1100	35.5137
490104	0.8635	0.9536	19.0056	21.5140	25.4797	21.5647
490105	0.7752	0.8063	*	*	*	*
490106	0.7217	*	26.2318	28.0073	29.6648	27.8955
490107	1.5612	1.0571	35.0272	36.5156	37.8948	36.4952
490108	0.9350	0.8527	27.8717	26.8474	28.1422	27.6252
490109	0.8360	0.8953	21.6711	26.3100	35.3956	26.6243
490110	1.4981	0.8478	26.3089	28.6114	30.4140	28.4403
490111	1.3002	0.8060	26.4297	25.9801	25.5933	26.0180
490112	1.8616	0.9536	31.2549	32.6940	34.4483	32.7850
490113	1.3453	1.0559	34.7841	34.3609	35.7020	34.9658
490114	1.2877	0.8060	23.0533	23.6217	24.3756	23.7176
490115	1.1261	0.8060	23.2118	24.2056	24.5732	24.0079
490116	1.1200	0.8060	25.0351	26.8981	27.6062	26.5245
490117	1.1400	0.8060	20.3038	19.0627	21.2554	20.2023
490118	1.7126	0.9536	31.2407	32.7697	34.4087	32.7699
490119	1.3791	0.8953	29.5222	30.2401	31.8001	30.5988
490120	1.5447	0.8953	27.1990	29.8199	31.3588	29.5073
490122	1.6804	1.0571	35.2234	36.8356	37.2409	36.4506
490123	1.1733	0.8060	24.6011	25.9018	26.5759	25.6908
490126	1.2835	0.8060	25.3294	26.4277	28.1112	26.5960
490127	1.1572	0.8060	23.1399	23.5161	25.8521	24.1618
490130	1.3539	0.8953	25.9782	27.8912	28.5506	27.5060
490134	0.8484	0.8060	31.1495	36.6290	38.4799	35.3431
490135	0.8329	0.9020	27.2795	29.4817	30.6983	29.1252
490136	1.5986	0.9536	31.2911	33.2256	33.6199	32.9138
490137	***	*	*	33.7203	*	33.7203
490138	***	*	*	*	29.6062	29.6062
490140	1.1707	1.0559	*	*	*	*
500001	1.6920	1.1393	37.5323	34.4057	36.7516	36.1864
500002	1.4064	1.0107	30.1872	32.8317	34.4481	32.6052
500003	1.3883	1.1272	32.7983	34.5869	35.4284	34.3657
500005	1.9139	1.1393	36.0918	36.7598	34.3832	35.6947
500007	1.3046	1.1272	31.0313	32.8189	34.5520	32.8250
500008	2.0942	1.1393	34.7810	37.6578	39.2151	37.2339
500011	1.5112	1.1393	38.3979	35.9571	39.3411	37.8813

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
500012	1.6682	1.0107	33.1685	34.1650	36.8979	34.8623
500014	1.7774	1.1393	37.2698	36.3915	39.1505	37.5950
500015	1.4145	1.1393	40.8683	41.8914	37.7765	39.9793
500016	1.7006	1.1272	34.2828	35.1946	36.9961	35.5244
500019	1.2954	1.0238	33.8882	33.3151	33.7113	33.6367
500021	1.2735	1.1272	33.5610	34.1696	35.5039	34.4442
500024	1.6970	1.1080	37.4529	38.1144	38.4388	38.0019
500025	2.0660	1.1393	44.7105	45.7929	46.4667	45.6979
500026	1.5246	1.1393	35.5080	38.9294	39.8935	38.0803
500027	1.5514	1.1393	42.4974	43.3521	46.0534	43.9702
500030	1.6107	1.1302	36.9489	37.8938	39.5003	38.1941
500031	1.3816	1.1015	34.1651	37.1418	39.3882	37.0143
500033	1.3025	1.0107	32.6753	33.5611	34.6180	33.6561
500036	1.3062	1.0107	31.9164	33.0937	34.4581	33.2430
500037	1.0522	1.0107	29.1773	31.5221	33.5698	31.4598
500039	1.6290	1.1272	34.5739	35.7525	36.9804	35.8188
500041	1.4539	1.1212	36.9273	37.1754	37.2841	37.1483
500044	1.8709	1.0588	32.0743	32.9066	37.2547	34.2357
500049	1.3589	1.0107	30.8135	32.9904	35.3710	33.0668
500050	1.6841	1.1212	35.7254	35.8576	38.7771	36.8297
500051	1.7983	1.1393	36.4764	38.1805	40.4444	38.4149
500052	0.5257	1.1393	*	*	*	*
500053	1.2927	1.0107	28.5664	35.5776	32.3889	32.3866
500054	2.0439	1.0588	34.8114	36.0163	37.0037	35.9970
500058	1.7819	1.0107	32.6843	33.9116	35.3683	34.0086
500060	1.3839	1.1393	40.3040	33.4139	36.1561	36.3222
500064	2.1038	1.1393	34.7925	36.5889	38.6388	36.7061
500072	1.2795	1.0399	33.1148	33.7689	34.6614	33.8664
500077	1.6554	1.0588	34.3114	35.6352	36.5941	35.5623
500079	1.4615	1.1272	34.2420	35.0285	39.6971	36.2958
500084	1.2299	1.1393	33.3072	35.9603	37.4223	35.5895
500088	1.5216	1.1393	38.5194	39.5328	42.2213	40.1754
500108	1.7135	1.1272	35.8918	36.9874	38.4486	37.1566
500119	1.3965	1.0588	31.7125	33.2862	37.1560	34.2985
500124	1.5615	1.1393	36.3338	36.2555	38.4951	37.0807
500129	1.7301	1.1272	37.3189	39.0479	40.9416	39.1501
500134	***	*	28.9759	27.6000	*	28.2473

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
500139	1.5940	1.1080	37.5709	37.3065	40.1626	38.3039
500141	1.3018	1.1393	34.2384	35.0996	36.5770	35.3417
500143	0.8345	1.1080	26.3893	27.6976	27.0786	27.0516
500148	1.2582	1.0107	24.6347	29.1435	29.3580	27.8028
500150	1.3469	1.1212	34.8480	37.1238	39.5124	37.2763
500151	1.2724	1.1264	*	*	*	*
510001	1.9015	0.8266	26.7924	27.6648	28.5579	27.6991
510002	1.3699	0.8820	24.8846	25.3769	26.9879	25.7394
510006	1.3756	0.8266	26.6421	27.5033	28.3986	27.5167
510007	1.7093	0.8875	28.5783	29.7125	31.3109	29.8649
510008	1.4922	0.9455	27.4709	30.6397	31.5292	29.9314
510012	0.9949	0.7660	22.9038	23.9222	23.9062	23.5707
510013	1.1575	0.7536	22.9612	22.1864	22.8779	22.6690
510018	1.1130	0.8093	23.7736	22.6582	24.2196	23.5313
510022	1.8567	0.8093	27.6119	28.4911	28.9389	28.3550
510023	1.1934	0.7536	23.1461	21.1483	23.2098	22.4635
510024	1.6521	0.8266	31.1327	32.3022	29.9740	31.1328
510026	1.0087	*	17.8275	18.6662	*	18.2486
510029	1.4261	0.8093	25.3925	24.6743	25.6860	25.2487
510030	1.1745	0.7536	25.5600	26.0174	26.6707	26.0891
510031	1.6207	0.8093	26.7872	29.5993	29.4024	28.5765
510033	1.5597	0.7536	24.2839	24.4150	24.9115	24.5148
510038	1.1536	0.7536	21.7545	21.1103	22.4112	21.7748
510039	1.3776	0.7536	21.3819	21.7158	22.0335	21.7116
510046	1.4481	0.8020	24.7187	23.2634	24.7177	24.2383
510047	1.2916	0.8266	28.8794	30.0461	31.1243	30.0454
510048	1.3054	0.7536	23.6396	25.0987	26.5418	25.1357
510050	1.8089	0.8441	23.5794	24.3081	24.5207	24.1225
510053	1.0042	0.7536	22.6288	24.3853	25.0147	24.0222
510055	1.6973	0.8875	30.7382	32.3284	33.3163	32.1773
510058	1.3980	0.7536	24.8770	24.9360	23.8781	24.5564
510059	***	*	21.9053	20.5651	23.5300	22.1135
510062	1.2221	0.8093	27.7971	30.4515	32.4834	30.2773
510067	***	*	25.2248	25.4499	*	25.3238
510070	1.3121	0.8093	25.4981	26.1227	28.1871	26.6091
510071	1.3504	0.7746	23.4553	21.7085	23.4390	22.8860
510072	1.0600	0.7536	20.2387	20.1981	21.4895	20.6336

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
510077	1.0537	0.8723	27.1611	24.7849	27.0319	26.3370
510082	1.2339	0.7536	21.1665	24.7558	22.7658	22.9281
510085	1.4818	0.8093	26.8133	27.6206	24.4240	26.3575
510086	1.1482	0.7536	20.1965	21.2628	20.3576	20.5850
510090	***	*	39.0787	*	*	39.0787
520002	1.3482	0.9113	28.3413	28.2765	26.7116	27.7254
520004	1.4996	0.9864	30.9212	32.9848	34.1865	32.6654
520008	1.6075	1.0226	33.6774	36.6697	38.2815	36.3308
520009	1.8579	0.9375	29.6290	31.0683	31.6106	30.8052
520011	1.3433	0.9019	29.5024	31.8421	33.2873	31.5935
520013	1.6336	1.1027	32.1721	33.9209	34.9944	33.6882
520017	1.2107	0.9600	31.0537	31.8512	33.6624	32.2031
520019	1.2522	0.9019	30.2189	28.8256	25.1409	27.9904
520021	1.3391	1.0370	29.7809	29.0525	30.3673	29.7460
520027	1.4301	1.0226	33.5836	33.5264	35.9033	34.3676
520028	1.3940	1.1096	29.4694	28.1055	30.4362	29.3795
520030	1.7246	0.9581	31.6807	32.0646	34.2167	32.6070
520033	1.3879	0.9019	30.2631	29.5690	31.1389	30.3366
520034	1.3078	0.9019	28.1819	30.4913	31.6386	30.1603
520035	1.5330	0.9375	29.4076	31.0972	32.7626	31.1082
520037	1.7279	0.9113	32.2206	33.1606	33.0449	32.8212
520038	1.2914	1.0226	30.5267	32.6502	32.9167	32.0875
520040	***	*	35.9652	*	*	35.9652
520041	1.0128	1.1316	26.1586	28.3889	30.2068	28.2350
520044	1.5130	0.9375	28.6620	*	31.9599	30.2726
520045	1.7890	0.9536	30.0856	29.6250	33.3652	30.9444
520048	1.6586	0.9536	30.1483	31.8604	33.1944	31.7313
520049	1.9727	0.9443	29.4238	29.8707	30.8224	30.0316
520051	1.5852	1.0226	32.4131	32.5510	35.4345	33.4292
520057	1.2057	0.9212	29.1597	31.7777	34.0671	31.7455
520059	1.4262	1.0226	31.1798	32.1905	33.6526	32.3663
520062	1.3557	1.0226	32.7015	37.5630	37.0520	35.8645
520063	1.2023	1.0226	31.5200	32.6383	34.1781	32.7561
520064	1.6643	1.0226	33.1269	34.1899	36.0924	34.4301
520066	1.4525	0.9694	31.6793	31.2257	33.7033	32.1994
520070	1.8311	0.9600	30.0475	30.2454	32.1644	30.8209
520071	1.2720	1.0226	31.5452	32.9974	33.3852	32.6894

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
520075	1.8243	0.9443	32.2773	33.5393	34.0973	33.3083
520076	1.2579	1.0226	26.8943	28.0857	30.1903	28.4165
520078	1.6147	1.0226	32.0200	32.8377	33.6214	32.8336
520083	1.6732	1.1316	34.7230	36.8165	38.2281	36.6451
520087	1.6998	0.9864	31.9771	33.5759	34.5519	33.3848
520088	1.3791	0.9470	30.7482	32.9061	32.7670	32.1576
520089	1.5783	1.1316	34.9357	36.3819	38.0516	36.4973
520091	1.3243	0.9019	28.7180	29.9318	31.2611	29.9703
520095	1.2864	1.1096	33.2426	33.3298	35.6079	34.0578
520096	1.4255	1.0226	29.2895	31.5023	37.8499	32.7151
520097	1.4507	0.9443	30.5442	32.2225	34.3493	32.3376
520098	2.0458	1.1316	38.0993	39.1444	41.0919	39.4919
520100	1.3212	0.9694	31.7772	32.4038	34.0159	32.7405
520102	1.2714	1.0226	31.5756	31.9275	34.1568	32.5763
520103	1.5487	1.0226	34.5640	35.3825	36.9411	35.6386
520107	1.3724	0.9178	30.0354	31.6500	31.1976	30.9724
520109	1.0287	0.9019	25.9740	27.2739	28.4742	27.2711
520113	1.4088	0.9249	33.3040	34.9718	35.6843	34.6401
520116	1.2781	1.0226	31.6702	32.7105	34.6508	33.0184
520136	1.8091	1.0226	32.3504	32.8906	33.7189	32.9955
520138	1.9849	1.0226	32.5677	33.5487	36.0676	34.0683
520139	1.4138	1.0226	31.7086	32.9369	34.1039	32.9713
520160	1.7449	0.9375	30.3052	31.0392	33.4129	31.5467
520170	1.6326	1.0226	31.7610	35.2627	33.8589	33.5756
520177	1.7357	1.0226	33.1243	34.6960	35.6005	34.5408
520189	1.3474	1.0370	29.2229	29.0333	31.6752	29.9942
520193	1.7818	0.9443	29.4737	30.8077	32.6949	31.0673
520194	1.7194	1.0226	31.0015	36.9520	35.9064	34.6592
520195	***	*	41.6120	37.8891	*	39.7179
520196	1.7921	0.9600	33.4890	32.0197	35.9711	33.8028
520198	1.4018	0.9536	29.9803	30.6303	32.9887	31.2354
520199	2.1323	1.0226	37.0128	45.5967	46.6518	43.7293
520202	1.7481	0.9581	*	33.6427	30.8076	32.2276
520203	***	*	*	*	44.8123	44.8123
520204	1.0509	1.0226	*	*	*	*
520205	2.1096	1.0226	*	*	*	*
530002	1.1686	0.9392	29.2418	32.5654	34.0190	32.0426

Provider Number	Case-Mix Index[2]	FY 2011 Wage Index	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010	Average Hourly Wage FY 2011[1]	Average Hourly Wage** (3 years)
530006	1.2785	0.9392	30.3724	32.8615	33.0523	32.1254
530008	1.1051	0.9392	30.6010	30.6600	30.9960	30.7519
530009	0.8427	0.9392	27.0555	27.3359	30.2467	28.1948
530010	1.2811	0.9392	28.5534	30.1134	32.0732	30.2646
530011	1.1057	0.9392	31.1329	31.8923	31.4146	31.4720
530012	1.6294	0.9444	30.6109	31.1738	32.9710	31.6237
530014	1.4706	0.9418	29.6724	31.2573	32.7666	31.2186
530015	1.2800	0.9392	33.4903	36.0871	37.1114	35.5281
530017	1.1557	*	25.8183	24.0911	*	24.8262
530025	1.2173	0.9392	28.8963	31.4614	30.9906	30.4574
530032	1.1632	0.9392	25.4267	26.7025	31.0922	27.6747
530033	2.0646	0.9444	*	*	*	*
640001	0.8536	*	*	*	*	*
650001	1.4006	*	*	*	*	*
660001	1.0796	*	*	*	*	*
670002	1.0505	0.9734	29.1376	29.9545	30.5438	29.8867
670003	***	*	33.8986	33.4713	33.2183	33.4927
670004	1.1660	0.8018	25.3706	25.5671	26.9631	25.9396
670005	1.7721	0.9946	31.9464	41.2085	29.7605	33.4908
670006	1.9552	0.9523	27.1064	34.6785	36.8199	32.5839
670007	***	*	*	29.5985	30.3445	30.0121
670008	1.5966	0.9946	*	30.3978	30.7957	30.6253
670009	***	*	*	31.8096	29.0715	30.1581
670010	0.8338	0.9734	*	35.6620	29.6612	31.5941
670011	1.0270	0.9523	*	32.1855	30.2158	30.9733
670012	2.2140	0.9946	*	24.1597	24.2305	24.1941
670013	***	*	*	29.4886	*	29.4886
670014	***	*	*	34.6108	*	34.6108
670015	***	*	*	35.3054	*	35.3054
670016	***	*	*	*	30.9543	30.9543
670017	***	*	*	*	30.4743	30.4743
670018	0.9687	0.9946	*	*	34.7939	34.7939
670019	1.5202	0.9946	*	*	42.1599	42.1599
670020	***	*	*	*	39.6181	39.6181
670022	***	*	*	32.9889	34.0570	33.5229
670023	1.4036	0.9427	*	*	32.5158	32.5158
670024	1.6178	0.9946	*	*	30.0165	30.0165
670025	3.0845	0.9734	*	*	39.9558	39.9558
670026	***	*	*	*	21.8681	21.8681
670027	1.9240	0.9946	*	*	19.3451	19.3451
670028	***	*	*	*	43.4052	43.4052
670029	1.7447	0.9946	*	*	24.7438	24.7438
670030	***	*	*	*	32.0527	32.0527
670031	1.3908	0.9946	*	*	32.9130	32.9130
670033	1.1449	0.9734	*	*	*	*
670034	1.4385	0.9523	*	*	31.7770	31.7770
670040	0.8256	0.9946	*	*	20.5126	20.5126
670041	1.5612	0.9523	*	*	*	*
670042	1.7645	0.9427	*	*	*	*
670043	1.2712	0.9523	*	*	*	*
670044	1.2345	0.9734	*	*	*	*
670046	1.2291	0.9427	*	*	*	*
670047	1.4178	0.8594	*	*	*	*
670048	1.2701	0.9946	*	*	*	*
670049	1.4828	0.9734	*	*	*	*
670050	1.2258	0.8940	*	*	*	*
670051	1.7132	0.9244	*	*	*	*
670052	0.9734	0.9427	*	*	*	*
670053	1.5075	0.9946	*	*	*	*
670054	2.1510	0.9071	*	*	*	*
670055	1.4073	0.9071	*	*	*	*

1. Based on salaries adjusted for occupational mix, according to the calculation in section III.H. of this proposed rule.
2. The case-mix index is based on the billed MS-DRGs in the FY 2009 MedPAR file. It is not transfer-adjusted.
3. Provider 140010 is part of a multi-campus provider (MCH) that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 140B10, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 29404; provider number 140010 indicates the portion of wages and hours of the MCH that is allocated to CBSA 16974.
4. Provider 220074 is part of a MCH that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 220B74, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 14484; provider number 220074 indicates the portion of wages and hours of the MCH that is allocated to CBSA 39300.
5. Provider 230104 is part of a MCH that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 230B04, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 47644; provider number 230104 indicates the portion of wages and hours of the MCH that is allocated to CBSA 19804.

Notes:

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2009, 2010, and 2011.
*** Denotes MedPAR data not available for the provider for FY 2009.

TABLE 3A.--FY 2011 and 3-YEAR* AVERAGE HOURLY WAGE FOR ACUTE CARE HOSPITALS IN URBAN AREAS BY CBSA

[*Based on the salaries and hours computed for Federal FYs 2009, 2010, and 2011.]

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
10180	Abilene, TX	29.3949	28.1776
10380	Aguadilla-Isabela-San Sebastián, PR	11.8160	11.2855
10420	Akron, OH	30.9394	29.7268
10500	Albany, GA	31.7616	30.0124
10580	Albany-Schenectady-Troy, NY	30.4027	29.4970
10740	Albuquerque, NM	33.6484	32.1367
10780	Alexandria, LA	28.4818	27.3679
10900	Allentown-Bethlehem-Easton, PA-NJ	32.9853	32.3982
11020	Altoona, PA	29.8723	28.7214
11100	Amarillo, TX	29.9470	29.2820
11180	Ames, IA	35.0846	32.5833
11260	Anchorage, AK	41.3142	39.7621
11300	Anderson, IN	32.4243	30.5946
11340	[1]Anderson, SC	----	31.0258
11460	Ann Arbor, MI	35.2875	34.4775
11500	Anniston-Oxford, AL	27.5967	26.3204
11540	Appleton, WI	32.6349	31.2420
11700	Asheville, NC	31.6157	30.6097
12020	Athens-Clarke County, GA	32.6369	31.0325
12060	Atlanta-Sandy Springs-Marietta, GA	33.4176	32.3815
12100	Atlantic City-Hammonton, NJ	38.5037	38.3789
12220	Auburn-Opelika, AL	26.2864	26.2272
12260	Augusta-Richmond County, GA-SC	33.4130	32.0531
12420	Austin-Round Rock-San Marcos, TX	33.2627	31.9957
12540	Bakersfield-Delano, CA	41.2731	38.7144
12580	Baltimore-Towson, MD	35.6052	33.9776
12620	Bangor, ME	33.8045	33.3702
12700	Barnstable Town, MA	44.7757	42.6501
12940	Baton Rouge, LA	30.4662	28.2098
12980	Battle Creek, MI	34.0719	33.4413
13020	Bay City, MI	32.9174	31.6784
13140	Beaumont-Port Arthur, TX	29.5372	28.3888
13380	Bellingham, WA	39.5003	38.1941
13460	Bend, OR	39.2471	37.6920
13644	Bethesda-Rockville-Frederick, MD	36.3603	34.8330
13740	Billings, MT	31.2292	30.2506
13780	Binghamton, NY	31.1847	29.8256
13820	Birmingham-Hoover, AL	30.1026	29.0144
13900	Bismarck, ND	26.6755	25.4947
13980	Blacksburg-Christiansburg-Radford, VA	28.9603	27.7355
14020	Bloomington, IN	32.4229	31.4114
14060	Bloomington-Normal, IL	33.4002	31.9474
14260	Boise City-Nampa, ID	32.4846	31.3466
14484	Boston-Quincy, MA	43.0901	41.0488
14500	Boulder, CO	35.3221	34.0847
14540	Bowling Green, KY	30.4559	28.6498
14740	Bremerton-Silverdale, WA	36.9804	35.8188
14860	Bridgeport-Stamford-Norwalk, CT	44.1289	43.0332
15180	Brownsville-Harlingen, TX	33.1329	31.3922
15260	Brunswick, GA	32.4958	31.8053
15380	Buffalo-Niagara Falls, NY	33.6124	32.5065
15500	Burlington, NC	30.6796	29.1889
15540	Burlington-South Burlington, VT	36.0988	34.0281
15764	Cambridge-Newton-Framingham, MA	39.4299	37.7800
15804	Camden, NJ	36.2670	34.9790
15940	Canton-Massillon, OH	30.1085	29.2640
15980	Cape Coral-Fort Myers, FL	32.0534	31.0627
16020	Cape Girardeau-Jackson, MO-IL	30.7590	30.1921
16180	Carson City, NV	35.8985	34.3321
16220	Casper, WY	32.9710	31.6237
16300	Cedar Rapids, IA	30.7335	29.6900
16580	Champaign-Urbana, IL	35.4749	33.2063
16620	Charleston, WV	28.2186	27.7498
16700	Charleston-North Charleston-Summerville, SC	32.4496	31.0970
16740	Charlotte-Gastonia-Rock Hill, NC-SC	32.4685	31.5651
16820	Charlottesville, VA	32.2777	31.5688
16860	Chattanooga, TN-GA	30.7014	29.7023
16940	Cheyenne, WY	32.7666	31.2186

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
16974	Chicago-Joliet-Naperville, IL	36.6687	34.9381
17020	Chico, CA	39.7055	37.2221
17140	Cincinnati-Middletown, OH-KY-IN	33.6443	32.0501
17300	Clarksville, TN-KY	27.4198	26.9255
17420	Cleveland, TN	27.2121	26.2003
17460	Cleveland-Elyria-Mentor, OH	31.7487	30.5792
17660	Coeur d'Alene, ID	32.1766	30.7795
17780	College Station-Bryan, TX	32.2874	30.8937
17820	Colorado Springs, CO	32.2511	31.9296
17860	Columbia, MO	28.8423	28.3106
17900	Columbia, SC	30.7179	29.8385
17980	Columbus, GA-AL	31.8363	30.1940
18020	Columbus, IN	33.0833	32.3322
18140	Columbus, OH	35.5317	33.8232
18580	Corpus Christi, TX	29.9543	28.8144
18700	Corvallis, OR	36.1111	36.0952
18880	[2]Crestview-Fort Walton Beach-Destin, FL	30.6368	29.2681
19060	Cumberland, MD-WV	28.7642	26.6875
19124	Dallas-Plano-Irving, TX	33.9994	32.8345
19140	Dalton, GA	29.6173	28.6311
19180	Danville, IL	33.9418	31.5446
19260	Danville, VA	28.5221	27.8788
19340	Davenport-Moline-Rock Island, IA-IL	29.4290	28.1402
19380	Dayton, OH	32.0635	31.0431
19460	Decatur, AL	26.2777	25.6527
19500	Decatur, IL	27.8420	27.0898
19660	Deltona-Daytona Beach-Ormond Beach, FL	30.6744	29.6824
19740	Denver-Aurora-Broomfield, CO	37.0948	35.6553
19780	Des Moines-West Des Moines, IA	33.2680	31.9747
19804	Detroit-Livonia-Dearborn, MI	34.0881	33.1008
20020	Dothan, AL	27.0561	25.7662
20100	Dover, DE	35.0266	34.3423
20220	Dubuque, IA	29.9069	28.4340
20260	Duluth, MN-WI	37.2948	35.6803
20500	Durham-Chapel Hill, NC	33.7364	32.4388
20740	Eau Claire, WI	33.5152	32.1516

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
20764	Edison-New Brunswick, NJ	38.0887	36.9892
20940	El Centro, CA	32.5187	30.4057
21060	Elizabethtown, KY	29.2425	28.1376
21140	Elkhart-Goshen, IN	32.9702	31.8127
21300	Elmira, NY	29.8159	28.3066
21340	El Paso, TX	30.0169	29.1999
21500	Erie, PA	29.1769	28.9316
21660	Eugene-Springfield, OR	39.5694	37.5142
21780	Evansville, IN-KY	29.3081	28.4396
21820	Fairbanks, AK	38.4880	37.2462
21940	Fajardo, PR	13.5864	13.1629
22020	Fargo, ND-MN	28.2861	27.3617
22140	Farmington, NM	27.9464	26.5665
22180	Fayetteville, NC	33.0069	32.2702
22220	Fayetteville-Springdale-Rogers, AR-MO	30.1927	29.7252
22380	Flagstaff, AZ	43.4901	40.9837
22420	Flint, MI	39.7366	37.7705
22500	Florence, SC	29.6001	28.2550
22520	Florence-Muscle Shoals, AL	27.7915	26.5477
22540	Fond du Lac, WI	32.7670	32.1576
22660	Fort Collins-Loveland, CO	33.2168	32.4365
22744	Fort Lauderdale-Pompano Beach-Deerfield	34.9003	33.5974
22900	Fort Smith, AR-OK	27.0278	26.3924
23060	Fort Wayne, IN	32.2565	30.3718
23104	Fort Worth-Arlington, TX	32.9268	31.9797
23420	Fresno, CA	39.9087	37.8308
23460	Gadsden, AL	24.8236	26.1400
23540	Gainesville, FL	32.8864	31.4434
23580	Gainesville, GA	33.8978	31.8764
23844	Gary, IN	31.4542	30.7534
24020	Glens Falls, NY	30.8219	29.5362
24140	Goldsboro, NC	32.4035	31.0271
24220	Grand Forks, ND-MN	28.0496	26.7628
24300	Grand Junction, CO	34.4738	32.8228
24340	Grand Rapids-Wyoming, MI	32.5225	31.2449
24500	Great Falls, MT	28.8603	28.2315

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
24540	Greeley, CO	33.5991	32.8595
24580	Green Bay, WI	32.9660	31.7777
24660	Greensboro-High Point, NC	31.4115	30.5532
24780	Greenville, NC	32.6226	31.4428
24860	Greenville-Mauldin-Easley, SC	32.6686	32.3059
25020	Guayama, PR	12.4886	11.4528
25060	Gulfport-Biloxi, MS	31.1513	29.7538
25180	Hagerstown-Martinsburg, MD-WV	33.1846	31.3132
25260	Hanford-Corcoran, CA	40.0252	37.9890
25420	Harrisburg-Carlisle, PA	32.1215	30.8066
25500	Harrisonburg, VA	32.4538	30.6807
25540	Hartford-West Hartford-East Hartford, C	38.8127	37.6851
25620	Hattiesburg, MS	27.7551	26.1804
25860	Hickory-Lenoir-Morganton, NC	30.2030	29.6952
25980	[1]Hinesville-Fort Stewart, GA	----	----
26100	Holland-Grand Haven, MI	30.7086	29.9212
26180	Honolulu, HI	40.6203	38.8534
26300	Hot Springs, AR	32.4533	30.8422
26380	Houma-Bayou Cane-Thibodaux, LA	27.9003	26.7495
26420	Houston-Sugar Land-Baytown, TX	34.7363	33.3876
26580	Huntington-Ashland, WV-KY-OH	31.1470	30.3284
26620	Huntsville, AL	31.4293	30.1542
26820	Idaho Falls, ID	33.7810	31.5660
26900	Indianapolis-Carmel, IN	33.3588	32.4485
26980	Iowa City, IA	33.3562	31.7675
27060	Ithaca, NY	34.1345	32.8690
27100	Jackson, MI	32.3303	30.8026
27140	Jackson, MS	28.3657	27.2938
27180	Jackson, TN	29.2532	28.4242
27260	Jacksonville, FL	31.1293	30.3737
27340	Jacksonville, NC	27.4651	27.2070
27500	Janesville, WI	33.8440	32.4434
27620	Jefferson City, MO	30.0429	29.6671
27740	Johnson City, TN	24.9085	25.3818
27780	Johnstown, PA	29.1342	27.8673
27860	Jonesboro, AR	27.3474	26.4977

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
27900	Joplin, MO	29.4636	29.6834
28020	Kalamazoo-Portage, MI	36.0038	35.2099
28100	Kankakee-Bradley, IL	36.9046	34.8205
28140	Kansas City, MO-KS	33.3682	31.9790
28420	Kennewick-Pasco-Richland, WA	34.3233	33.4579
28660	Killeen-Temple-Fort Hood, TX	30.6493	29.6099
28700	Kingsport-Bristol-Bristol, TN-VA	26.7971	26.4513
28740	Kingston, NY	31.9507	31.3235
28940	Knoxville, TN	27.4247	26.4301
29020	Kokomo, IN	31.4563	31.3022
29100	La Crosse, WI-MN	34.4391	33.1590
29140	Lafayette, IN	32.3043	30.6089
29180	Lafayette, LA	29.5826	28.5502
29340	Lake Charles, LA	28.6346	26.6076
29404	Lake County-Kenosha County, IL-WI	37.4834	35.3301
29420	Lake Havasu City-Kingman, AZ	35.9129	34.5415
29460	Lakeland-Winter Haven, FL	30.1679	29.0320
29540	Lancaster, PA	34.1814	32.6061
29620	Lansing-East Lansing, MI	35.8522	33.4940
29700	Laredo, TX	28.7425	28.4271
29740	Las Cruces, NM	31.8991	29.9182
29820	Las Vegas-Paradise, NV	41.2359	39.5656
29940	Lawrence, KS	29.7218	28.4175
30020	Lawton, OK	30.0871	28.4155
30140	Lebanon, PA	28.4545	28.6018
30300	Lewiston, ID-WA	32.0498	31.1265
30340	Lewiston-Auburn, ME	31.2669	30.6891
30460	Lexington-Fayette, KY	30.7246	29.8100
30620	Lima, OH	32.3533	31.2513
30700	Lincoln, NE	33.1312	31.8977
30780	Little Rock-N.Little Rock-Conway,AR	30.2877	29.2865
30860	Logan, UT-ID	30.8717	29.8653
30980	Longview, TX	30.0153	27.9402
31020	Longview, WA	37.2841	37.1483
31084	Los Angeles-Long Beach-Santa Ana, CA	41.8223	40.3432
31140	Louisville-Jefferson County, KY-IN	30.8966	30.1980

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
31180	Lubbock, TX	31.2259	29.6499
31340	Lynchburg, VA	29.7754	28.5576
31420	Macon, GA	32.7055	32.8408
31460	Madera-Chowchilla, CA	30.1104	28.6056
31540	Madison, WI	39.5054	37.8696
31700	Manchester-Nashua, NH	34.5930	33.9822
31740	Manhattan, KS	27.6635	26.5957
31860	Mankato-North Mankato, MN	32.3639	31.4358
31900	Mansfield, OH	30.7835	30.3015
32420	Mayagüez, PR	12.6118	12.4907
32580	McAllen-Edinburg-Mission, TX	31.0449	30.1056
32780	Medford, OR	35.0103	33.9125
32820	Memphis, TN-MS-AR	32.1641	31.1231
32900	Merced, CA	42.0265	40.4262
33124	Miami-Fort Lauderdale-Pompano Beach, FL	35.7435	33.7683
33140	Michigan City-La Porte, IN	32.8129	30.9515
33260	Midland, TX	33.3058	31.8597
33340	Milwaukee-Waukesha-West Allis, WI	35.6954	34.2353
33460	Minneapolis-St. Paul-Bloomington, MN-WI	38.4952	36.9220
33540	Missoula, MT	30.7656	29.8216
33660	Mobile, AL	27.6019	26.3141
33700	Modesto, CA	42.0519	41.0061
33740	Monroe, LA	28.3557	26.8341
33780	Monroe, MI	31.3315	30.3938
33860	Montgomery, AL	29.7248	28.3780
34060	Morgantown, WV	28.9024	28.5485
34100	Morristown, TN	24.8315	24.2612
34580	Mount Vernon-Anacortes, WA	35.1691	33.8802
34620	Muncie, IN	28.6143	27.7649
34740	Muskegon-Norton Shores, MI	34.3151	33.4379
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	30.3085	29.1823
34900	Napa, CA	50.6166	48.0443
34940	Naples-Marco Island, FL	34.2982	32.9979
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	32.5483	31.7724

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
35004	Nassau-Suffolk, NY	43.9572	42.5759
35084	Newark-Union, NJ-PA	39.5622	38.2213
35300	New Haven-Milford, CT	40.3584	39.1449
35380	New Orleans-Metairie-Kenner, LA	31.4388	30.2046
35644	New York-White Plains-Wayne, NY-NJ	45.9252	44.0840
35660	Niles-Benton Harbor, MI	31.3865	30.3136
35840	[2]North Port-Bradenton-Sarasota, FL	32.3943	31.9392
35980	Norwich-New London, CT	39.8427	38.5763
36084	Oakland-Fremont-Hayward, CA	55.5972	53.3129
36100	Ocala, FL	29.9935	28.8386
36140	Ocean City, NJ	38.0642	36.5086
36220	Odessa, TX	32.9220	32.1340
36260	Ogden-Clearfield, UT	32.6211	31.3730
36420	Oklahoma City, OK	31.0777	29.6784
36500	Olympia, WA	38.2620	37.6059
36540	Omaha-Council Bluffs, NE-IA	33.3566	31.9233
36740	Orlando-Kissimmee-Sanford, FL	32.0901	30.6557
36780	Oshkosh-Neenah, WI	33.2157	31.2415
36980	Owensboro, KY	29.7930	28.8753
37100	Oxnard-Thousand Oaks-Ventura, CA	43.2233	40.5774
37340	Palm Bay-Melbourne-Titusville, FL	32.6298	31.2779
37380	Palm Coast, FL	28.6480	29.3969
37460	Panama City-Lynn Haven-Panama City Beach, FL	28.4491	28.1718
37620	Parkersburg-Marietta-Vienna, WV-OH	25.9479	25.8732
37700	Pascagoula, MS	28.5637	27.4171
37764	Peabody, MA	38.4760	36.5635
37860	Pensacola-Ferry Pass-Brent, FL	28.4556	27.3708
37900	Peoria, IL	32.4315	31.0327
37964	Philadelphia, PA	37.7549	36.4016
38060	Phoenix-Mesa-Glendale, AZ	36.7246	35.1010
38220	Pine Bluff, AR	28.7130	26.7537
38300	Pittsburgh, PA	30.0448	28.9335
38340	Pittsfield, MA	36.5974	35.4692
38540	Pocatello, ID	32.7435	30.8807
38660	Ponce, PR	14.9358	14.1175

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
38860	Portland-South Portland-Biddeford, ME	34.6681	33.6576
38900	Portland-Vancouver-Hillsboro, OR-WA	39.1861	37.7069
38940	Port St. Lucie, FL	37.6301	34.3690
39100	Poughkeepsie-Newburgh-Middletown, NY	39.8644	37.7073
39140	Prescott, AZ	43.0057	36.4216
39300	Providence-New Bedford-Fall River, RI-M	37.5354	36.1121
39340	Provo-Orem, UT	32.3723	31.4543
39380	Pueblo, CO	30.0091	28.7443
39460	Punta Gorda, FL	31.7131	30.7467
39540	Racine, WI	37.1869	32.6652
39580	Raleigh-Cary, NC	33.9133	32.4239
39660	Rapid City, SD	38.3671	34.5099
39740	Reading, PA	31.0160	30.6990
39820	Redding, CA	47.5125	44.9345
39900	Reno-Sparks, NV	36.4465	34.9208
40060	Richmond, VA	33.2980	31.4929
40140	Riverside-San Bernardino-Ontario, CA	39.9014	37.9847
40220	Roanoke, VA	31.4982	29.9865
40340	Rochester, MN	37.5616	36.5729
40380	Rochester, NY	30.4032	29.5889
40420	Rockford, IL	35.0956	33.6906
40484	Rockingham County, NH	35.0486	33.6796
40580	Rocky Mount, NC	31.8553	30.3489
40660	Rome, GA	30.5837	30.5032
40900	Sacramento--Arden-Arcade--Roseville, CA	47.2994	45.2291
40980	Saginaw-Saginaw Township North, MI	32.1555	31.1518
41060	St. Cloud, MN	40.6853	39.1270
41100	St. George, UT	32.5066	31.3092
41140	St. Joseph, MO-KS	36.2278	34.8344
41180	St. Louis, MO-IL	31.6290	30.3438
41420	Salem, OR	38.8312	36.7534
41500	Salinas, CA	55.5109	51.7900
41540	Salisbury, MD	31.1946	30.3645
41620	Salt Lake City, UT	32.6863	31.4867
41660	San Angelo, TX	29.6151	28.0559
41700	San Antonio-New Braunfels, TX	31.6824	30.2027

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
41740	San Diego-Carlsbad-San Marcos, CA	40.5279	38.5285
41780	Sandusky, OH	30.0999	29.3797
41884	San Francisco-San Mateo-Redwood City, CA	53.8091	51.6664
41900	San Germán-Cabo Rojo, PR	15.9545	15.6643
41940	San Jose-Sunnyvale-Santa Clara, CA	57.4157	54.3198
41980	San Juan-Caguas-Guaynabo, PR	15.0192	14.6360
42020	San Luis Obispo-Paso Robles, CA	43.3776	40.8126
42044	Santa Ana-Anaheim-Irvine, CA	41.9435	39.8926
42060	Santa Barbara-Santa Maria-Goleta, CA	41.2648	39.8280
42100	Santa Cruz-Watsonville, CA	56.9566	54.4353
42140	Santa Fe, NM	37.6618	35.8749
42220	Santa Rosa-Petaluma, CA	55.3076	52.3185
42340	Savannah, GA	30.9240	29.9675
42540	Scranton--Wilkes-Barre, PA	28.7281	27.7860
42644	Seattle-Bellevue-Everett, WA	39.8184	38.4963
42680	Sebastian-Vero Beach, FL	32.4326	31.7794
43100	Sheboygan, WI	32.4662	30.8688
43300	Sherman-Denison, TX	29.4908	28.9887
43340	Shreveport-Bossier City, LA	30.2022	28.7466
43580	Sioux City, IA-NE-SD	31.3111	29.8813
43620	Sioux Falls, SD	32.7745	31.1879
43780	South Bend-Mishawaka, IN-MI	34.5236	32.8075
43900	Spartanburg, SC	31.7207	30.5331
44060	Spokane, WA	37.0084	35.4231
44100	Springfield, IL	31.2379	30.6699
44140	Springfield, MA	36.1737	35.1312
44180	Springfield, MO	29.3703	28.6119
44220	Springfield, OH	31.4540	29.8060
44300	State College, PA	30.2637	29.6045
44600	[2]Steubenville-Weirton, OH-WV	25.4395	25.3407
44700	Stockton, CA	43.8475	41.3450
44940	Sumter, SC	28.5579	28.2053
45060	Syracuse, NY	33.9000	32.9463
45104	Tacoma, WA	39.3681	37.5711
45220	Tallahassee, FL	31.4039	29.7448
45300	Tampa-St. Petersburg-Clearwater, FL	31.7974	30.3381

CBSA Code	Urban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
45460	Terre Haute, IN	32.3071	30.7568
45500	Texarkana, TX-Texarkana, AR	26.8927	26.8786
45780	Toledo, OH	32.7715	31.4781
45820	Topeka, KS	31.9034	30.4681
45940	Trenton-Ewing, NJ	35.1805	34.8810
46060	Tucson, AZ	33.8370	32.2980
46140	Tulsa, OK	31.0910	29.4632
46220	Tuscaloosa, AL	28.7402	29.0146
46340	Tyler, TX	28.7095	28.5924
46540	Utica-Rome, NY	30.4893	29.2712
46660	Valdosta, GA	28.3875	27.3859
46700	Vallejo-Fairfield, CA	50.8429	48.5255
47020	Victoria, TX	28.0779	26.7203
47220	Vineland-Millville-Bridgeton, NJ	38.1019	36.3949
47260	Virginia Beach-Norfolk-Newport News, VA	31.2647	29.9721
47300	Visalia-Porterville, CA	38.0071	35.3637
47380	Waco, TX	30.2079	29.0730
47580	Warner Robins, GA	29.2281	30.2010
47644	Warren-Troy-Farmington-Hills, MI	33.9524	33.0850
47894	Washington-Arlington-Alexandria DC-VA	36.8726	35.7731
47940	Waterloo-Cedar Falls, IA	29.6525	28.7768
48140	Wausau, WI	33.4493	32.5485
48300	Wenatchee-East Wenatchee, WA	33.8234	32.3786
48424	West Palm Beach-Boca Raton-Boynton FL	34.3519	32.7302
48540	Wheeling, WV-OH	23.4746	23.0898
48620	Wichita, KS	30.9307	30.0110
48660	Wichita Falls, TX	34.6795	32.0396
48700	Williamsport, PA	25.4029	25.8954
48864	Wilmington, DE-MD-NJ	37.7128	36.0069
48900	Wilmington, NC	32.2983	30.6626
49020	Winchester, VA-WV	34.9053	33.0668
49180	Winston-Salem, NC	31.3330	30.1817
49340	Worcester, MA	39.1354	37.4410
49420	Yakima, WA	35.0663	33.5431
49500	Yauco, PR	12.3738	11.4462
49620	York-Hanover, PA	33.4110	31.9488
49660	Youngstown-Warren-Boardman, OH-PA	30.1643	29.3613
49700	Yuba City, CA	37.6504	36.6555
49740	Yuma, AZ	33.0103	32.0532

[1] This area has no average hourly wage because there are no short-term, acute care hospital wage data for the area.
[2] This is a new CBSA for FY 2011. To calculate the 3-year average hourly wage for this new area, we included the hospitals' data from their previous geographic location for FY 2009 and FY 2010.

TABLE 3B.--FY 2011 AND 3-YEAR* AVERAGE HOURLY WAGE FOR ACUTE CARE HOSPITLAS IN RURAL AREAS BY CBSA

(*Based on the sum of the salaries and hours computed for Federal FYs 2009, 2010, and 2011.)

CBSA Code	Nonurban Area	FY 2011 Average Hourly Wage	3-Year Average Hourly Wage
01	Alabama	26.0264	25.1568
02	Alaska	44.1146	40.4763
03	Arizona	31.8393	29.9784
04	Arkansas	25.9685	25.2920
05	California	42.9541	40.4802
06	Colorado	33.8979	32.2217
07	Connecticut	39.4836	37.7398
08	Delaware	34.5676	33.5989
10	Florida	29.5728	28.7958
11	Georgia	27.1671	26.2403
12	Hawaii	39.4229	37.8491
13	Idaho	26.1426	25.4397
14	Illinois	29.2557	28.1409
15	Indiana	29.3235	28.4347
16	Iowa	29.8030	28.9280
17	Kansas	27.8665	27.0309
18	Kentucky	27.6898	26.5212
19	Louisiana	27.7399	26.2678
20	Maine	29.9878	28.8613
21	Maryland	32.4848	30.6740
22	Massachusetts[1]	----	----
23	Michigan	30.0405	29.4059
24	Minnesota	31.6251	30.5376
25	Mississippi	27.0138	25.8819
26	Missouri	27.2630	26.6216
27	Montana	29.4658	28.4050
28	Nebraska	31.0214	29.3825
29	Nevada	32.7810	32.3514
30	New Hampshire	34.6904	33.8700
31	New Jersey[2]	----	----
32	New Mexico	31.5263	30.1115
33	New York	29.0517	27.9458
34	North Carolina	29.5268	28.7455
35	North Dakota	24.5023	24.8120
36	Ohio	29.9108	28.7616
37	Oklahoma	28.0420	26.6656
38	Oregon	34.9774	34.1391
39	Pennsylvania	29.7971	28.2813
40	Puerto Rico[2]	----	----
41	Rhode Island[2]	----	----
42	South Carolina	29.4603	28.4856
43	South Dakota	29.3712	28.1981
44	Tennessee	27.8764	26.6861
45	Texas	27.9871	26.9747
46	Utah	30.4214	28.6155
47	Vermont	33.0189	32.4250
49	Virginia	28.1471	27.0795
50	Washington	35.3253	34.0250
51	West Virginia	26.4462	25.3997
52	Wisconsin	31.4858	30.9851
53	Wyoming	32.7909	31.3477

[1]Massachusetts has area(s) designated as rural. However, no short term, acute care hospitals are located in the area(s) for FY 2011.
[2]All counties within the State or territory are classified as urban.

TABLE 4A.—PROPOSED WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS IN URBAN AREAS BY CBSA AND BY STATE--FY 2011

[Constituent counties are listed in Table 4E.]

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
10180	Abilene, TX	TX	0.8416	0.8886
10380	Aguadilla-Isabela-San Sebastián, PR	PR	0.3384	0.4762
10420	Akron, OH	OH	0.8850	0.9197
10500	Albany, GA	GA	0.9098	0.9373
10580	Albany-Schenectady-Troy, NY	NY	0.8708	0.9096
10740	Albuquerque, NM	NM	0.9638	0.9751
10780	Alexandria, LA	LA	0.8164	0.8703
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1069	1.0720
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9418	0.9598
11020	Altoona, PA	PA	0.8529	0.8968
11100	Amarillo, TX	TX	0.8574	0.9000
11180	Ames, IA	IA	1.0044	1.0030
11260	Anchorage, AK	AK	1.1919	1.1277
11300	Anderson, IN	IN	0.9287	0.9506
11340	Anderson, SC	SC	0.8438	0.8902
11460	Ann Arbor, MI	MI	1.0107	1.0073
11500	Anniston-Oxford, AL	AL	0.7898	0.8508
11540	Appleton, WI	WI	0.9348	0.9549
11700	Asheville, NC	NC	0.9055	0.9343
12020	Athens-Clarke County, GA	GA	0.9348	0.9549
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9572	0.9705
12100	Atlantic City-Hammonton, NJ	NJ	1.1069	1.0720
12220	Auburn-Opelika, AL	AL	0.7522	0.8228
12260	Augusta-Richmond County, GA-SC	GA	0.9571	0.9704
12260	Augusta-Richmond County, GA-SC	SC	0.9571	0.9704
12420	Austin-Round Rock-San Marcos, TX	TX	0.9523	0.9671
12540	Bakersfield-Delano, CA	CA	1.2002	1.1331
12580	Baltimore-Towson, MD	MD	1.0198	1.0135
12620	Bangor, ME	ME	0.9695	0.9790
12700	Barnstable Town, MA	MA	1.2825	1.1858
12940	Baton Rouge, LA	LA	0.8726	0.9109
12980	Battle Creek, MI	MI	0.9759	0.9834
13020	Bay City, MI	MI	0.9429	0.9605
13140	Beaumont-Port Arthur, TX	TX	0.8456	0.8915
13380	Bellingham, WA	WA	1.1302	1.0874
13460	Bend, OR	OR	1.1239	1.0833
13644	Bethesda-Rockville-Frederick, MD	MD	1.0573	1.0389
13740	Billings, MT	MT	0.8944	0.9264
13780	Binghamton, NY	NY	0.8932	0.9256
13820	Birmingham-Hoover, AL	AL	0.8614	0.9029
13900	Bismarck, ND	ND	0.7641	0.8317
13980	Blacksburg-Christiansburg-Radford, VA	VA	0.8293	0.8797
14020	Bloomington, IN	IN	0.9287	0.9506
14060	Bloomington-Normal, IL	IL	0.9567	0.9701
14260	Boise City-Nampa, ID	ID	0.9305	0.9519
14484	Boston-Quincy, MA	MA	1.2342	1.1550
14500	Boulder, CO	CO	0.9983	0.9988
14540	Bowling Green, KY	KY	0.8722	0.9106
14740	Bremerton-Silverdale, WA	WA	1.0580	1.0394
14860	Bridgeport-Stamford-Norwalk, CT	CT	1.2575	1.1699
15180	Brownsville-Harlingen, TX	TX	0.9486	0.9645
15260	Brunswick, GA	GA	0.9352	0.9552
15380	Buffalo-Niagara Falls, NY	NY	0.9628	0.9744
15500	Burlington, NC	NC	0.8787	0.9153
15540	Burlington-South Burlington, VT	VT	1.0340	1.0232
15764	Cambridge-Newton-Framingham, MA	MA	1.1294	1.0869
15804	Camden, NJ	NJ	1.1069	1.0720
15940	Canton-Massillon, OH	OH	0.8612	0.9027
15980	Cape Coral-Fort Myers, FL	FL	0.9167	0.9422
16020	Cape Girardeau-Jackson, MO-IL	IL	0.8810	0.9169
16020	Cape Girardeau-Jackson, MO-IL	MO	0.8810	0.9169
16180	Carson City, NV	NV	1.0282	1.0192
16220	Casper, WY	WY	0.9444	0.9616
16300	Cedar Rapids, IA	IA	0.8799	0.9161
16580	Champaign-Urbana, IL	IL	1.0161	1.0110
16620	Charleston, WV	WV	0.8093	0.8651
16700	Charleston-North Charleston-Summerville, SC	SC	0.9295	0.9512
16740	Charlotte-Gastonia-Rock Hill, NC-SC	NC	0.9299	0.9514
16740	Charlotte-Gastonia-Rock Hill, NC-SC	SC	0.9300	0.9515
16820	Charlottesville, VA	VA	0.9243	0.9475
16860	Chattanooga, TN-GA	GA	0.8794	0.9158
16860	Chattanooga, TN-GA	TN	0.8721	0.9105
16940	Cheyenne, WY	WY	0.9392	0.9580
16974	Chicago-Joliet-Naperville, IL	IL	1.0503	1.0342
17020	Chico, CA	CA	1.2002	1.1331
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9637	0.9750
17140	Cincinnati-Middletown, OH-KY-IN	KY	0.9634	0.9748
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9624	0.9741

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17300	Clarksville, TN-KY	KY	0.7992	0.8577
17300	Clarksville, TN-KY	TN	0.7919	0.8523
17420	Cleveland, TN	TN	0.7919	0.8523
17460	Cleveland-Elyria-Mentor, OH	OH	0.9082	0.9362
17660	Coeur d'Alene, ID	ID	0.9216	0.9456
17780	College Station-Bryan, TX	TX	0.9244	0.9476
17820	Colorado Springs, CO	CO	0.9581	0.9711
17860	Columbia, MO	MO	0.8261	0.8774
17900	Columbia, SC	SC	0.8799	0.9161
17980	Columbus, GA-AL	AL	0.9111	0.9382
17980	Columbus, GA-AL	GA	0.9119	0.9388
18020	Columbus, IN	IN	0.9476	0.9638
18140	Columbus, OH	OH	1.0163	1.0111
18580	Corpus Christi, TX	TX	0.8576	0.9001
18700	Corvallis, OR	OR	1.0340	1.0232
18880	Crestview-Fort Walton Beach-Destin, FL	FL	0.8762	0.9135
19060	Cumberland, MD-WV	MD	0.9305	0.9519
19060	Cumberland, MD-WV	WV	0.8196	0.8726
19124	Dallas-Plano-Irving, TX	TX	0.9734	0.9817
19140	Dalton, GA	GA	0.8483	0.8935
19180	Danville, IL	IL	0.9722	0.9809
19260	Danville, VA	VA	0.8168	0.8706
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8658	0.9060
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8654	0.9057
19380	Dayton, OH	OH	0.9172	0.9425
19460	Decatur, AL	AL	0.7583	0.8274
19500	Decatur, IL	IL	0.8380	0.8860
19660	Deltona-Daytona Beach-Ormond Beach, FL	FL	0.8773	0.9143
19740	Denver-Aurora-Broomfield, CO	CO	1.0485	1.0330
19780	Des Moines-West Des Moines, IA	IA	0.9525	0.9672
19804	Detroit-Livonia-Dearborn, MI	MI	0.9776	0.9846
20020	Dothan, AL	AL	0.7743	0.8393
20100	Dover, DE	DE	1.0090	1.0062
20220	Dubuque, IA	IA	0.8562	0.8991
20260	Duluth, MN-WI	MN	1.0682	1.0462
20260	Duluth, MN-WI	WI	1.0682	1.0462
20500	Durham-Chapel Hill, NC	NC	0.9662	0.9767
20740	Eau Claire, WI	WI	0.9600	0.9724
20764	Edison-New Brunswick, NJ	NJ	1.1069	1.0720
20940	El Centro, CA	CA	1.2002	1.1331
21060	Elizabethtown, KY	KY	0.8389	0.8867
21140	Elkhart-Goshen, IN	IN	0.9457	0.9625

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21300	Elmira, NY	NY	0.8540	0.8976
21340	El Paso, TX	TX	0.8594	0.9014
21500	Erie, PA	PA	0.8521	0.8962
21660	Eugene-Springfield, OR	OR	1.1331	1.0893
21780	Evansville, IN-KY	IN	0.8399	0.8874
21780	Evansville, IN-KY	KY	0.8393	0.8869
21820	Fairbanks, AK	AK	1.1919	1.1277
21940	Fajardo, PR	PR	0.3892	0.5240
22020	Fargo, ND-MN	MN	0.9146	0.9407
22020	Fargo, ND-MN	ND	0.8102	0.8658
22140	Farmington, NM	NM	0.9030	0.9325
22180	Fayetteville, NC	NC	0.9453	0.9622
22220	Fayetteville-Springdale-Rogers, AR-MO	AR	0.8648	0.9053
22220	Fayetteville-Springdale-Rogers, AR-MO	MO	0.8648	0.9053
22380	Flagstaff, AZ	AZ	1.2457	1.1624
22420	Flint, MI	MI	1.1382	1.0927
22500	Florence, SC	SC	0.8478	0.8931
22520	Florence-Muscle Shoals, AL	AL	0.8028	0.8603
22540	Fond du Lac, WI	WI	0.9386	0.9575
22660	Fort Collins-Loveland, CO	CO	0.9581	0.9711
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0364	1.0248
22900	Fort Smith, AR-OK	AR	0.7742	0.8392
22900	Fort Smith, AR-OK	OK	0.8052	0.8621
23060	Fort Wayne, IN	IN	0.9245	0.9477
23104	Fort Worth-Arlington, TX	TX	0.9427	0.9604
23420	Fresno, CA	CA	1.2002	1.1331
23460	Gadsden, AL	AL	0.7448	0.8173
23540	Gainesville, FL	FL	0.9406	0.9589
23580	Gainesville, GA	GA	0.9709	0.9800
23844	Gary, IN	IN	0.9069	0.9353
24020	Glens Falls, NY	NY	0.8828	0.9182
24140	Goldsboro, NC	NC	0.9280	0.9501
24220	Grand Forks, ND-MN	MN	0.9146	0.9407
24220	Grand Forks, ND-MN	ND	0.8034	0.8608
24300	Grand Junction, CO	CO	1.0051	1.0035
24340	Grand Rapids-Wyoming, MI	MI	0.9315	0.9526
24500	Great Falls, MT	MT	0.8439	0.8903
24540	Greeley, CO	CO	0.9581	0.9711
24580	Green Bay, WI	WI	0.9443	0.9615
24660	Greensboro-High Point, NC	NC	0.8996	0.9301
24780	Greenville, NC	NC	0.9343	0.9545

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24860	Greenville-Mauldin-Easley, SC	SC	0.9357	0.9555
25020	Guayama, PR	PR	0.3577	0.4946
25060	Gulfport-Biloxi, MS	MS	0.8923	0.9249
25180	Hagerstown-Martinsburg, MD-WV	MD	0.9505	0.9658
25180	Hagerstown-Martinsburg, MD-WV	WV	0.9455	0.9623
25260	Hanford-Corcoran, CA	CA	1.2002	1.1331
25420	Harrisburg-Carlisle, PA	PA	0.9172	0.9425
25500	Harrisonburg, VA	VA	0.9294	0.9511
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1251	1.0841
25620	Hattiesburg, MS	MS	0.7950	0.8546
25860	Hickory-Lenoir-Morganton, NC	NC	0.8650	0.9055
26100	Holland-Grand Haven, MI	MI	0.8796	0.9159
26180	Honolulu, HI	HI	1.1635	1.1093
26300	Hot Springs, AR	AR	0.9296	0.9512
26380	Houma-Bayou Cane-Thibodaux, LA	LA	0.7992	0.8577
26420	Houston-Sugar Land-Baytown, TX	TX	0.9946	0.9963
26580	Huntington-Ashland, WV-KY-OH	KY	0.8919	0.9246
26580	Huntington-Ashland, WV-KY-OH	OH	0.8909	0.9239
26580	Huntington-Ashland, WV-KY-OH	WV	0.8875	0.9215
26620	Huntsville, AL	AL	0.8994	0.9300
26820	Idaho Falls, ID	ID	0.9676	0.9777
26900	Indianapolis-Carmel, IN	IN	0.9555	0.9693
26980	Iowa City, IA	IA	0.9550	0.9690
27060	Ithaca, NY	NY	0.9777	0.9847
27100	Jackson, MI	MI	0.9260	0.9487
27140	Jackson, MS	MS	0.8125	0.8675
27180	Jackson, TN	TN	0.8310	0.8809
27260	Jacksonville, FL	FL	0.8902	0.9234
27340	Jacksonville, NC	NC	0.8476	0.8929
27500	Janesville, WI	WI	0.9694	0.9789
27620	Jefferson City, MO	MO	0.8605	0.9022
27740	Johnson City, TN	TN	0.7919	0.8523
27780	Johnstown, PA	PA	0.8521	0.8962
27860	Jonesboro, AR	AR	0.7833	0.8460
27900	Joplin, MO	MO	0.8448	0.8909
28020	Kalamazoo-Portage, MI	MI	1.0313	1.0213
28100	Kankakee-Bradley, IL	IL	1.0571	1.0388
28140	Kansas City, MO-KS	KS	0.9558	0.9695
28140	Kansas City, MO-KS	MO	0.9558	0.9695
28420	Kennewick-Pasco-Richland, WA	WA	1.0107	1.0073
28660	Killeen-Temple-Fort Hood, TX	TX	0.8775	0.9144
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7919	0.8523
28700	Kingsport-Bristol-Bristol, TN-VA	VA	0.8060	0.8627
28740	Kingston, NY	NY	0.9152	0.9411
28940	Knoxville, TN	TN	0.7919	0.8523
29020	Kokomo, IN	IN	0.9010	0.9311
29100	La Crosse, WI-MN	MN	0.9864	0.9907
29100	La Crosse, WI-MN	WI	0.9864	0.9907
29140	Lafayette, IN	IN	0.9253	0.9482
29180	Lafayette, LA	LA	0.8473	0.8927
29340	Lake Charles, LA	LA	0.8202	0.8731
29404	Lake County-Kenosha County, IL-WI	IL	1.0736	1.0498
29404	Lake County-Kenosha County, IL-WI	WI	1.0736	1.0498
29420	Lake Havasu City-Kingman, AZ	AZ	1.0287	1.0196
29460	Lakeland-Winter Haven, FL	FL	0.8628	0.9039
29540	Lancaster, PA	PA	0.9760	0.9835
29620	Lansing-East Lansing, MI	MI	1.0269	1.0183
29700	Laredo, TX	TX	0.8312	0.8811
29740	Las Cruces, NM	NM	0.9183	0.9433
29820	Las Vegas-Paradise, NV	NV	1.1811	1.1207
29940	Lawrence, KS	KS	0.8513	0.8956
30020	Lawton, OK	OK	0.8616	0.9030
30140	Lebanon, PA	PA	0.8521	0.8962
30300	Lewiston, ID-WA	ID	0.9180	0.9431
30300	Lewiston, ID-WA	WA	1.0107	1.0073
30340	Lewiston-Auburn, ME	ME	0.8956	0.9273
30460	Lexington-Fayette, KY	KY	0.8798	0.9160
30620	Lima, OH	OH	0.9254	0.9483
30700	Lincoln, NE	NE	0.9490	0.9648
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8675	0.9072
30860	Logan, UT-ID	ID	0.8843	0.9192
30860	Logan, UT-ID	UT	0.8843	0.9192
30980	Longview, TX	TX	0.8593	0.9014
31020	Longview, WA	WA	1.0667	1.0452
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.2002	1.1331
31140	Louisville-Jefferson County, KY-IN	IN	0.8850	0.9197
31140	Louisville-Jefferson County, KY-IN	KY	0.8848	0.9196
31180	Lubbock, TX	TX	0.8940	0.9261
31340	Lynchburg, VA	VA	0.8527	0.8966
31420	Macon, GA	GA	0.9368	0.9563
31460	Madera-Chowchilla, CA	CA	1.2002	1.1331
31540	Madison, WI	WI	1.1316	1.0884
31700	Manchester-Nashua, NH	NH	1.0054	1.0037
31740	Manhattan, KS	KS	0.8027	0.8603

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31860	Mankato-North Mankato, MN	MN	0.9270	0.9494
31900	Mansfield, OH	OH	0.8917	0.9245
32420	Mayagüez, PR	PR	0.3612	0.4979
32580	McAllen-Edinburg-Mission, TX	TX	0.8888	0.9224
32780	Medford, OR	OR	1.0089	1.0061
32820	Memphis, TN-MS-AR	AR	0.9213	0.9454
32820	Memphis, TN-MS-AR	MS	0.9213	0.9454
32820	Memphis, TN-MS-AR	TN	0.9137	0.9401
32900	Merced, CA	CA	1.2002	1.1331
33124	Miami-Miami Beach-Kendall, FL	FL	1.0222	1.0151
33140	Michigan City-La Porte, IN	IN	0.9399	0.9584
33260	Midland, TX	TX	0.9554	0.9692
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0226	1.0154
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.1027	1.0692
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.1027	1.0692
33540	Missoula, MT	MT	0.8811	0.9170
33660	Mobile, AL	AL	0.7899	0.8509
33700	Modesto, CA	CA	1.2002	1.1331
33740	Monroe, LA	LA	0.8122	0.8672
33780	Monroe, MI	MI	0.9666	0.9770
33860	Montgomery, AL	AL	0.8506	0.8951
34060	Morgantown, WV	WV	0.8266	0.8777
34100	Morristown, TN	TN	0.7919	0.8523
34580	Mount Vernon-Anacortes, WA	WA	1.0107	1.0073
34620	Muncie, IN	IN	0.8399	0.8874
34740	Muskegon-Norton Shores, MI	MI	0.9829	0.9883
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	SC	0.8681	0.9077
34900	Napa, CA	CA	1.4144	1.2680
34940	Naples-Marco Island, FL	FL	0.9809	0.9869
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9246	0.9477
35004	Nassau-Suffolk, NY	NY	1.2591	1.1709
35084	Newark-Union, NJ-PA	NJ	1.1099	1.0740
35084	Newark-Union, NJ-PA	PA	1.1296	1.0870
35300	New Haven-Milford, CT	CT	1.1654	1.1105
35380	New Orleans-Metairie-Kenner, LA	LA	0.9005	0.9307
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.2884	1.1895
35644	New York-White Plains-Wayne, NY-NJ	NY	1.3154	1.2065
35660	Niles-Benton Harbor, MI	MI	0.8990	0.9297
35840	North Port-Bradenton-Sarasota-Venice, FL	FL	0.9265	0.9491
35980	Norwich-New London, CT	CT	1.1353	1.0908
36084	Oakland-Fremont-Hayward, CA	CA	1.5536	1.3522
36100	Ocala, FL	FL	0.8578	0.9003

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36140	Ocean City, NJ	NJ	1.1069	1.0720
36220	Odessa, TX	TX	0.9426	0.9603
36260	Ogden-Clearfield, UT	UT	0.9354	0.9553
36420	Oklahoma City, OK	OK	0.8900	0.9233
36500	Olympia, WA	WA	1.1015	1.0684
36540	Omaha-Council Bluffs, NE-IA	IA	0.9550	0.9690
36540	Omaha-Council Bluffs, NE-IA	NE	0.9554	0.9692
36740	Orlando-Kissimmee-Sanford, FL	FL	0.9178	0.9430
36780	Oshkosh-Neenah, WI	WI	0.9514	0.9665
36980	Owensboro, KY	KY	0.8532	0.8970
37100	Oxnard-Thousand Oaks-Ventura, CA	CA	1.2078	1.1380
37340	Palm Bay-Melbourne-Titusville, FL	FL	0.9332	0.9538
37380	Palm Coast, FL	FL	0.8458	0.8916
37460	Panama City-Lynn Haven-Panama City Beach, FL	FL	0.8458	0.8916
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8555	0.8986
37620	Parkersburg-Marietta-Vienna, WV-OH	WV	0.7536	0.8239
37700	Pascagoula, MS	MS	0.8182	0.8716
37764	Peabody, MA	MA	1.1021	1.0688
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8458	0.8916
37900	Peoria, IL	IL	0.9289	0.9507
37964	Philadelphia, PA	PA	1.0780	1.0528
38060	Phoenix-Mesa-Glendale, AZ	AZ	1.0519	1.0353
38220	Pine Bluff, AR	AR	0.8311	0.8810
38300	Pittsburgh, PA	PA	0.8579	0.9004
38340	Pittsfield, MA	MA	1.0483	1.0328
38540	Pocatello, ID	ID	0.9379	0.9570
38660	Ponce, PR	PR	0.4278	0.5591
38860	Portland-South Portland-Biddeford, ME	ME	0.9930	0.9952
38900	Portland-Vancouver-Hillsboro, OR-WA	OR	1.1221	1.0821
38900	Portland-Vancouver-Hillsboro, OR-WA	WA	1.1212	1.0815
38940	Port St. Lucie, FL	FL	1.0762	1.0516
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.1418	1.0951
39140	Prescott, AZ	AZ	1.2318	1.1535
39300	Providence-New Bedford-Fall River, RI-MA	MA	1.0751	1.0508
39300	Providence-New Bedford-Fall River, RI-MA	RI	1.0751	1.0508
39340	Provo-Orem, UT	UT	0.9272	0.9496
39380	Pueblo, CO	CO	0.9581	0.9711
39460	Punta Gorda, FL	FL	0.9070	0.9353
39540	Racine, WI	WI	1.0651	1.0441
39580	Raleigh-Cary, NC	NC	0.9713	0.9803
39660	Rapid City, SD	SD	1.0990	1.0668
39740	Reading, PA	PA	0.8856	0.9202

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39820	Redding, CA	CA	1.3277	1.2142
39900	Reno-Sparks, NV	NV	1.0439	1.0299
40060	Richmond, VA	VA	0.9536	0.9680
40140	Riverside-San Bernardino-Ontario, CA	CA	1.2002	1.1331
40220	Roanoke, VA	VA	0.9020	0.9318
40340	Rochester, MN	MN	1.0759	1.0514
40380	Rochester, NY	NY	0.8708	0.9096
40420	Rockford, IL	IL	1.0052	1.0036
40484	Rockingham County-Strafford County, NH	NH	1.0218	1.0149
40580	Rocky Mount, NC	NC	0.9123	0.9391
40660	Rome, GA	GA	0.8760	0.9133
40900	Sacramento--Arden-Arcade--Roseville, CA	CA	1.3217	1.2105
40980	Saginaw-Saginaw Township North, MI	MI	0.9210	0.9452
41060	St. Cloud, MN	MN	1.1654	1.1105
41100	St. George, UT	UT	0.9311	0.9523
41140	St. Joseph, MO-KS	KS	1.0377	1.0257
41140	St. Joseph, MO-KS	MO	1.0377	1.0257
41180	St. Louis, MO-IL	IL	0.9060	0.9346
41180	St. Louis, MO-IL	MO	0.9060	0.9346
41420	Salem, OR	OR	1.1119	1.0753
41500	Salinas, CA	CA	1.5512	1.3507
41540	Salisbury, MD	MD	0.9305	0.9519
41620	Salt Lake City, UT	UT	0.9362	0.9559
41660	San Angelo, TX	TX	0.8479	0.8932
41700	San Antonio-New Braunfels, TX	TX	0.9071	0.9354
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.2002	1.1331
41780	Sandusky, OH	OH	0.8610	0.9026
41884	San Francisco-San Mateo-Redwood City, CA	CA	1.5036	1.3222
41900	San Germán-Cabo Rojo, PR	PR	0.4570	0.5849
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.6044	1.3823
41980	San Juan-Caguas-Guaynabo, PR	PR	0.4302	0.5612
42020	San Luis Obispo-Paso Robles, CA	CA	1.2121	1.1408
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.2002	1.1331
42060	Santa Barbara-Santa Maria-Goleta, CA	CA	1.2002	1.1331
42100	Santa Cruz-Watsonville, CA	CA	1.6059	1.3832
42140	Santa Fe, NM	NM	1.0788	1.0533
42220	Santa Rosa-Petaluma, CA	CA	1.5455	1.3473
42340	Savannah, GA	GA	0.8858	0.9203
42540	Scranton--Wilkes-Barre, PA	PA	0.8521	0.8962
42644	Seattle-Bellevue-Everett, WA	WA	1.1393	1.0934
42680	Sebastian-Vero Beach, FL	FL	0.9276	0.9498
43100	Sheboygan, WI	WI	0.9299	0.9514

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43300	Sherman-Denison, TX	TX	0.8443	0.8906
43340	Shreveport-Bossier City, LA	LA	0.8651	0.9055
43580	Sioux City, IA-NE-SD	IA	0.8964	0.9278
43580	Sioux City, IA-NE-SD	NE	0.8968	0.9281
43580	Sioux City, IA-NE-SD	SD	0.8968	0.9281
43620	Sioux Falls, SD	SD	0.9388	0.9577
43780	South Bend-Mishawaka, IN-MI	IN	0.9889	0.9924
43780	South Bend-Mishawaka, IN-MI	MI	0.9889	0.9924
43900	Spartanburg, SC	SC	0.9086	0.9365
44060	Spokane, WA	WA	1.0588	1.0399
44100	Springfield, IL	IL	0.8948	0.9267
44140	Springfield, MA	MA	1.0361	1.0246
44180	Springfield, MO	MO	0.8413	0.8884
44220	Springfield, OH	OH	0.8997	0.9302
44300	State College, PA	PA	0.8640	0.9047
44600	Steubenville-Weirton, OH-WV	OH	0.8555	0.8986
44600	Steubenville-Weirton, OH-WV	WV	0.7536	0.8239
44700	Stockton, CA	CA	1.2252	1.1492
44940	Sumter, SC	SC	0.8438	0.8902
45060	Syracuse, NY	NY	0.9710	0.9800
45104	Tacoma, WA	WA	1.1264	1.0849
45220	Tallahassee, FL	FL	0.8981	0.9290
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.9094	0.9370
45460	Terre Haute, IN	IN	0.9254	0.9483
45500	Texarkana, TX-Texarkana, AR	AR	0.7703	0.8363
45500	Texarkana, TX-Texarkana, AR	TX	0.8018	0.8596
45780	Toledo, OH	OH	0.9374	0.9567
45820	Topeka, KS	KS	0.9138	0.9401
45940	Trenton-Ewing, NJ	NJ	1.1069	1.0720
46060	Tucson, AZ	AZ	0.9692	0.9788
46140	Tulsa, OK	OK	0.8903	0.9235
46220	Tuscaloosa, AL	AL	0.8225	0.8748
46340	Tyler, TX	TX	0.8259	0.8772
46540	Utica-Rome, NY	NY	0.8737	0.9117
46660	Valdosta, GA	GA	0.8131	0.8679
46700	Vallejo-Fairfield, CA	CA	1.4207	1.2718
47020	Victoria, TX	TX	0.8038	0.8611
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1069	1.0720
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8954	0.9271
47260	Virginia Beach-Norfolk-Newport News, VA	VA	0.8953	0.9271
47300	Visalia-Porterville, CA	CA	1.2002	1.1331
47380	Waco, TX	TX	0.8648	0.9053

CBSA Code	Urban Area	State	Proposed Wage Index	Proposed GAF
47580	Warner Robins, GA	GA	0.8470	0.8925
47644	Warren-Troy-Farmington-Hills, MI	MI	0.9725	0.9811
47894	Washington-Arlington-Alexandria, DC-VA	DC	1.0561	1.0381
47894	Washington-Arlington-Alexandria, DC-VA	MD	1.0561	1.0381
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0559	1.0380
47894	Washington-Arlington-Alexandria, DC-VA	WV	1.0506	1.0344
47940	Waterloo-Cedar Falls, IA	IA	0.8533	0.8971
48140	Wausau, WI	WI	0.9581	0.9711
48300	Wenatchee-East Wenatchee, WA	WA	1.0107	1.0073
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	FL	0.9824	0.9879
48540	Wheeling, WV-OH	OH	0.8555	0.8986
48540	Wheeling, WV-OH	WV	0.7536	0.8239
48620	Wichita, KS	KS	0.8860	0.9205
48660	Wichita Falls, TX	TX	0.9929	0.9951
48700	Williamsport, PA	PA	0.8521	0.8962
48864	Wilmington, DE-MD-NJ	DE	1.0802	1.0543
48864	Wilmington, DE-MD-NJ	MD	1.0802	1.0543
48864	Wilmington, DE-MD-NJ	NJ	1.1069	1.0720
48900	Wilmington, NC	NC	0.9264	0.9490
49020	Winchester, VA-WV	VA	0.9996	0.9997
49020	Winchester, VA-WV	WV	0.9946	0.9963
49180	Winston-Salem, NC	NC	0.8974	0.9285
49340	Worcester, MA	MA	1.1210	1.0814
49420	Yakima, WA	WA	1.0107	1.0073
49500	Yauco, PR	PR	0.3544	0.4915
49620	York-Hanover, PA	PA	0.9539	0.9682
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8628	0.9039
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8612	0.9027
49700	Yuba City, CA	CA	1.2002	1.1331
49740	Yuma, AZ	AZ	0.9455	0.9623

TABLE 4B.—PROPOSED WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS IN RURAL AREAS BY CBSA AND BY STATE--FY 2011

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Rural Area	State	Proposed Wage Index	Proposed GAF
01	Alabama	AL	0.7448	0.8173
02	Alaska	AK	1.1919	1.1277
03	Arizona	AZ	0.9120	0.9389
04	Arkansas	AR	0.7517	0.8225
05	California	CA	1.2002	1.1331
06	Colorado	CO	0.9581	0.9711
07	Connecticut	CT	1.1251	1.0841
08	Delaware	DE	1.0090	1.0062
10	Florida	FL	0.8458	0.8916
11	Georgia	GA	0.7782	0.8422
12	Hawaii	HI	1.1292	1.0868
13	Idaho	ID	0.7587	0.8277
14	Illinois	IL	0.8380	0.8860
15	Indiana	IN	0.8399	0.8874
16	Iowa	IA	0.8533	0.8971
17	Kansas	KS	0.8027	0.8603
18	Kentucky	KY	0.7992	0.8577
19	Louisiana	LA	0.7946	0.8543
20	Maine	ME	0.8589	0.9011
21	Maryland	MD	0.9305	0.9519
22	Massachusetts	MA	0.9671	0.9774
23	Michigan	MI	0.8605	0.9022
24	Minnesota	MN	0.9146	0.9407
25	Mississippi	MS	0.7738	0.8389
26	Missouri	MO	0.8127	0.8676
27	Montana	MT	0.8439	0.8903
28	Nebraska	NE	0.8886	0.9223
29	Nevada	NV	0.9555	0.9693
30	New Hampshire	NH	1.0054	1.0037
31	New Jersey[1]	NJ	1.1069	1.0720
32	New Mexico	NM	0.9030	0.9325
33	New York	NY	0.8420	0.8889
34	North Carolina	NC	0.8476	0.8929
35	North Dakota	ND	0.7018	0.7847
36	Ohio	OH	0.8555	0.8986
37	Oklahoma	OK	0.8052	0.8621

CBSA Code	Rural Area	State	Proposed Wage Index	Proposed GAF
38	Oregon	OR	1.0089	1.0061
39	Pennsylvania	PA	0.8521	0.8962
40	Puerto Rico[1]	PR	------	------
41	Rhode Island[1]	RI	------	------
42	South Carolina	SC	0.8438	0.8902
43	South Dakota	SD	0.8435	0.8900
44	Tennessee	TN	0.7919	0.8523
45	Texas	TX	0.8018	0.8596
46	Utah	UT	0.8714	0.9100
47	Vermont	VT	0.9465	0.9630
49	Virginia	VA	0.8060	0.8627
50	Washington	WA	1.0107	1.0073
51	West Virginia	WV	0.7536	0.8239
52	Wisconsin	WI	0.9019	0.9317
53	Wyoming	WY	0.9392	0.9580

[1] All counties in the State or Territory are classified as urban. The New Jersey floor is imputed as specified in §412.64 (h)(4) and discussed in the FY 2005 IPPS final rule (69 FR 49109) and in section III.B.2. of the preamble of the FY 2009 IPPS final rule (73 FR 48567).

TABLE 4C.—PROPOSED WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS THAT ARE RECLASSIFIED BY CBSA AND BY STATE--FY 2011

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
04	Arkansas	AR	0.7517	0.8225
05	California	CA	1.2002	1.1331
07	Connecticut	CT	1.1251	1.0841
10	Florida	FL	0.8458	0.8916
14	Illinois	IL	0.8380	0.8860
14	Illinois	MO	0.8380	0.8860
17	Kansas	KS	0.8027	0.8603
18	Kentucky	KY	0.7992	0.8577
22	Massachusetts	MA	0.9671	0.9774
23	Michigan	MI	0.8605	0.9022
24	Minnesota	IA	0.9142	0.9404
26	Missouri	AR	0.8127	0.8676
26	Missouri	MO	0.8127	0.8676
28	Nebraska	KS	0.8886	0.9223
33	New York	NH	1.0054	1.0037
33	New York	NY	0.8420	0.8889
34	North Carolina	NC	0.8476	0.8929
34	North Carolina	TN	0.8407	0.8880
36	Ohio	OH	0.8555	0.8986
37	Oklahoma	OK	0.8052	0.8621
38	Oregon	OR	1.0089	1.0061
39	Pennsylvania	PA	0.8521	0.8962
44	Tennessee	KY	0.7992	0.8577
45	Texas	LA	0.8022	0.8599
45	Texas	OK	0.8052	0.8621
45	Texas	TX	0.8018	0.8596
47	Vermont	NY	0.9328	0.9535
49	Virginia	KY	0.8060	0.8627
49	Virginia	VA	0.8060	0.8627
49	Virginia	WV	0.8020	0.8598
50	Washington	WA	1.0107	1.0073
10500	Albany, GA	AL	0.8539	0.8975
10500	Albany, GA	GA	0.8547	0.8981
10580	Albany-Schenectady-Troy, NY	NY	0.8708	0.9096
10740	Albuquerque, NM	NM	0.9505	0.9658
10780	Alexandria, LA	LA	0.8164	0.8703
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9418	0.9598
11100	Amarillo, TX	KS	0.8438	0.8902
11100	Amarillo, TX	TX	0.8434	0.8899
11180	Ames, IA	IA	0.9273	0.9496
11260	Anchorage, AK	AK	1.1919	1.1277
11300	Anderson, IN	IN	0.8736	0.9116
11460	Ann Arbor, MI	MI	0.9849	0.9896
12020	Athens-Clarke County, GA	GA	0.9348	0.9549
12060	Atlanta-Sandy Springs-Marietta, GA	AL	0.9563	0.9699
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9572	0.9705
12260	Augusta-Richmond County, GA-SC	SC	0.9571	0.9704
12420	Austin-Round Rock-San Marcos, TX	TX	0.9523	0.9671
12620	Bangor, ME	ME	0.9695	0.9790
12940	Baton Rouge, LA	MS	0.8580	0.9004
12980	Battle Creek, MI	MI	0.9759	0.9834
13020	Bay City, MI	MI	0.8891	0.9227
13644	Bethesda-Rockville-Frederick, MD	DC	1.0573	1.0389
13644	Bethesda-Rockville-Frederick, MD	PA	1.0539	1.0366
13644	Bethesda-Rockville-Frederick, MD	VA	1.0571	1.0388

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
13780	Binghamton, NY	PA	0.8762	0.9135
13820	Birmingham-Hoover, AL	AL	0.8427	0.8894
13900	Bismarck, ND	ND	0.7451	0.8175
13980	Blacksburg-Christiansburg-Radford, VA	WV	0.7746	0.8395
14260	Boise City-Nampa, ID	ID	0.9068	0.9352
14484	Boston-Quincy, MA	MA	1.1613	1.1078
14484	Boston-Quincy, MA	RI	1.1613	1.1078
14540	Bowling Green, KY	KY	0.8347	0.8836
14740	Bremerton-Silverdale, WA	WA	1.0399	1.0272
15260	Brunswick, GA	GA	0.9352	0.9552
15380	Buffalo-Niagara Falls, NY	NY	0.9628	0.9744
15540	Burlington-South Burlington, VT	NY	1.0071	1.0049
15540	Burlington-South Burlington, VT	VT	1.0071	1.0049
15764	Cambridge-Newton-Framingham, MA	NH	1.0990	1.0668
15940	Canton-Massillon, OH	OH	0.8612	0.9027
16020	Cape Girardeau-Jackson, MO-IL	IL	0.8380	0.8860
16020	Cape Girardeau-Jackson, MO-IL	KY	0.8361	0.8846
16020	Cape Girardeau-Jackson, MO-IL	MO	0.8363	0.8848
16180	Carson City, NV	NV	0.9960	0.9973
16580	Champaign-Urbana, IL	IL	0.9154	0.9413
16620	Charleston, WV	WV	0.8093	0.8651
16700	Charleston-North Charleston-Summerville, SC	SC	0.9295	0.9512
16740	Charlotte-Gastonia-Rock Hill, NC-SC	NC	0.9162	0.9418
16820	Charlottesville, VA	VA	0.9243	0.9475
16860	Chattanooga, TN-GA	AL	0.8594	0.9014
16860	Chattanooga, TN-GA	GA	0.8602	0.9020
16860	Chattanooga, TN-GA	TN	0.8531	0.8969
16974	Chicago-Joliet-Naperville, IL	IL	1.0370	1.0252
16974	Chicago-Joliet-Naperville, IL	IN	1.0370	1.0252
16974	Chicago-Joliet-Naperville, IL	WI	1.0370	1.0252
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9637	0.9750
17140	Cincinnati-Middletown, OH-KY-IN	KY	0.9634	0.9748
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9624	0.9741
17300	Clarksville, TN-KY	KY	0.7992	0.8577
17460	Cleveland-Elyria-Mentor, OH	OH	0.9082	0.9362
17780	College Station-Bryan, TX	TX	0.9244	0.9476
17860	Columbia, MO	MO	0.8261	0.8774
17900	Columbia, SC	SC	0.8695	0.9087
17980	Columbus, GA-AL	AL	0.8613	0.9028
17980	Columbus, GA-AL	GA	0.8621	0.9034
18140	Columbus, OH	OH	1.0025	1.0017
18580	Corpus Christi, TX	TX	0.8576	0.9001

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
18700	Corvallis, OR	OR	1.0149	1.0102
18880	Crestview-Fort Walton Beach-Destin, FL	FL	0.8565	0.8994
19124	Dallas-Plano-Irving, TX	TX	0.9584	0.9713
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8658	0.9060
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8654	0.9057
19380	Dayton, OH	OH	0.9172	0.9425
19460	Decatur, AL	AL	0.7583	0.8274
19740	Denver-Aurora-Broomfield, CO	CO	1.0303	1.0207
19780	Des Moines-West Des Moines, IA	IA	0.9525	0.9672
19804	Detroit-Livonia-Dearborn, MI	MI	0.9776	0.9846
20100	Dover, DE	DE	1.0090	1.0062
20500	Durham-Chapel Hill, NC	NC	0.9662	0.9767
20500	Durham-Chapel Hill, NC	VA	0.9661	0.9767
20764	Edison-New Brunswick, NJ	NJ	1.1069	1.0720
21060	Elizabethtown, KY	KY	0.8389	0.8867
21140	Elkhart-Goshen, IN	IN	0.9457	0.9625
21500	Erie, PA	NY	0.8420	0.8889
21500	Erie, PA	PA	0.8521	0.8962
21660	Eugene-Springfield, OR	OR	1.1032	1.0696
22180	Fayetteville, NC	NC	0.9238	0.9472
22220	Fayetteville-Springdale-Rogers, AR-MO	OK	0.8646	0.9052
22420	Flint, MI	MI	1.0134	1.0092
22520	Florence-Muscle Shoals, AL	MS	0.8035	0.8609
22540	Fond du Lac, WI	WI	0.9178	0.9430
22660	Fort Collins-Loveland, CO	CO	0.9581	0.9711
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0364	1.0248
23060	Fort Wayne, IN	IN	0.9245	0.9477
23104	Fort Worth-Arlington, TX	TX	0.9427	0.9604
23540	Gainesville, FL	FL	0.9406	0.9589
23844	Gary, IN	IN	0.9069	0.9353
24300	Grand Junction, CO	CO	1.0051	1.0035
24340	Grand Rapids-Wyoming, MI	MI	0.9315	0.9526
24500	Great Falls, MT	MT	0.8439	0.8903
24540	Greeley, CO	NE	0.9418	0.9598
24540	Greeley, CO	WY	0.9418	0.9598
24580	Green Bay, WI	MI	0.9249	0.9479
24580	Green Bay, WI	WI	0.9249	0.9479
24660	Greensboro-High Point, NC	NC	0.8996	0.9301
24780	Greenville, NC	NC	0.9192	0.9439
24860	Greenville-Mauldin-Easley, SC	NC	0.9127	0.9394
24860	Greenville-Mauldin-Easley, SC	SC	0.9128	0.9394

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
25060	Gulfport-Biloxi, MS	MS	0.8350	0.8838
25420	Harrisburg-Carlisle, PA	PA	0.9172	0.9425
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1251	1.0841
25540	Hartford-West Hartford-East Hartford, CT	MA	1.1117	1.0752
25860	Hickory-Lenoir-Morganton, NC	NC	0.8537	0.8973
26300	Hot Springs, AR	AR	0.9071	0.9354
26420	Houston-Sugar Land-Baytown, TX	TX	0.9946	0.9963
26580	Huntington-Ashland, WV-KY-OH	KY	0.8767	0.9138
26580	Huntington-Ashland, WV-KY-OH	NC	0.8768	0.9139
26580	Huntington-Ashland, WV-KY-OH	OH	0.8757	0.9131
26580	Huntington-Ashland, WV-KY-OH	WV	0.8723	0.9107
26620	Huntsville, AL	AL	0.8646	0.9052
26620	Huntsville, AL	TN	0.8582	0.9006
26820	Idaho Falls, ID	ID	0.9676	0.9777
26900	Indianapolis-Carmel, IN	IN	0.9555	0.9693
26980	Iowa City, IA	IA	0.9422	0.9600
27060	Ithaca, NY	NY	0.9187	0.9436
27140	Jackson, MS	MS	0.8125	0.8675
27180	Jackson, TN	MS	0.8379	0.8859
27620	Jefferson City, MO	MO	0.8605	0.9022
27860	Jonesboro, AR	AR	0.7833	0.8460
27900	Joplin, MO	KS	0.8448	0.8909
27900	Joplin, MO	OK	0.8446	0.8908
28020	Kalamazoo-Portage, MI	MI	0.9979	0.9986
28140	Kansas City, MO-KS	KS	0.9558	0.9695
28140	Kansas City, MO-KS	MO	0.9558	0.9695
28420	Kennewick-Pasco-Richland, WA	ID	0.9659	0.9765
28700	Kingsport-Bristol-Bristol, TN-VA	KY	0.7992	0.8577
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7919	0.8523
28940	Knoxville, TN	KY	0.7992	0.8577
28940	Knoxville, TN	TN	0.7919	0.8523
29180	Lafayette, LA	LA	0.8473	0.8927
29404	Lake County-Kenosha County, IL-WI	IL	1.0515	1.0350
29460	Lakeland-Winter Haven, FL	FL	0.8628	0.9039
29540	Lancaster, PA	PA	0.9760	0.9835
29620	Lansing-East Lansing, MI	MI	1.0144	1.0098
29700	Laredo, TX	TX	0.8312	0.8811
29740	Las Cruces, NM	NM	0.9183	0.9433
29820	Las Vegas-Paradise, NV	AZ	1.1811	1.1207
30020	Lawton, OK	OK	0.8306	0.8806
30460	Lexington-Fayette, KY	KY	0.8798	0.9160
30620	Lima, OH	OH	0.9254	0.9483

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
30700	Lincoln, NE	NE	0.9490	0.9648
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8490	0.8940
30980	Longview, TX	TX	0.8593	0.9014
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.2002	1.1331
31140	Louisville-Jefferson County, KY-IN	KY	0.8848	0.9196
31420	Macon, GA	GA	0.8970	0.9283
31540	Madison, WI	WI	1.1096	1.0738
31900	Mansfield, OH	OH	0.8917	0.9245
32780	Medford, OR	OR	1.0089	1.0061
32820	Memphis, TN-MS-AR	AR	0.8981	0.9290
32820	Memphis, TN-MS-AR	MS	0.8981	0.9290
32820	Memphis, TN-MS-AR	TN	0.8907	0.9238
33124	Miami-Miami Beach-Kendall, FL	FL	1.0222	1.0151
33260	Midland, TX	TX	0.9554	0.9692
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0226	1.0154
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.1027	1.0692
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.1027	1.0692
33540	Missoula, MT	MT	0.8618	0.9032
33660	Mobile, AL	AL	0.7899	0.8509
33700	Modesto, CA	CA	1.2002	1.1331
33740	Monroe, LA	AR	0.8122	0.8672
33740	Monroe, LA	LA	0.8122	0.8672
33780	Monroe, MI	OH	0.9653	0.9761
33860	Montgomery, AL	AL	0.8506	0.8951
34060	Morgantown, WV	WV	0.8266	0.8777
34740	Muskegon-Norton Shores, MI	MI	0.9386	0.9575
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	NC	0.8680	0.9076
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	KY	0.9320	0.9529
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9246	0.9477
35004	Nassau-Suffolk, NY	CT	1.2234	1.1481
35084	Newark-Union, NJ-PA	NJ	1.1099	1.0740
35084	Newark-Union, NJ-PA	NY	1.1332	1.0894
35084	Newark-Union, NJ-PA	PA	1.1296	1.0870
35300	New Haven-Milford, CT	CT	1.1654	1.1105
35380	New Orleans-Metairie-Kenner, LA	LA	0.9005	0.9307
35644	New York-White Plains-Wayne, NY-NJ	CT	1.2817	1.1853
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.2619	1.1727
35644	New York-White Plains-Wayne, NY-NJ	NY	1.2884	1.1895
35840	North Port-Bradenton-Sarasota-Venice, FL	FL	0.9265	0.9491
35980	Norwich-New London, CT	RI	1.1412	1.0947
36084	Oakland-Fremont-Hayward, CA	CA	1.5428	1.3457
36140	Ocean City, NJ	DE	1.0903	1.0610

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
36220	Odessa, TX	NM	0.9315	0.9526
36220	Odessa, TX	TX	0.9311	0.9523
36260	Ogden-Clearfield, UT	UT	0.9354	0.9553
36420	Oklahoma City, OK	OK	0.8900	0.9233
36500	Olympia, WA	WA	1.1015	1.0684
36740	Orlando-Kissimmee-Sanford, FL	FL	0.9178	0.9430
37460	Panama City-Lynn Haven-Panama City Beach, FL	AL	0.8002	0.8584
37764	Peabody, MA	NH	1.1021	1.0688
37860	Pensacola-Ferry Pass-Brent, FL	AL	0.8144	0.8688
37900	Peoria, IL	IL	0.9179	0.9430
37964	Philadelphia, PA	NJ	1.1069	1.0720
37964	Philadelphia, PA	PA	1.0663	1.0449
38060	Phoenix-Mesa-Glendale, AZ	AZ	1.0519	1.0353
38220	Pine Bluff, AR	MS	0.8311	0.8810
38300	Pittsburgh, PA	OH	0.8555	0.8986
38300	Pittsburgh, PA	PA	0.8521	0.8962
38300	Pittsburgh, PA	WV	0.8441	0.8904
38340	Pittsfield, MA	NY	1.0158	1.0108
38340	Pittsfield, MA	VT	1.0158	1.0108
38860	Portland-South Portland-Biddeford, ME	ME	0.9509	0.9661
38900	Portland-Vancouver-Hillsboro, OR-WA	OR	1.1221	1.0821
38900	Portland-Vancouver-Hillsboro, OR-WA	WA	1.1212	1.0815
38940	Port St. Lucie, FL	FL	1.0283	1.0193
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.1246	1.0837
39340	Provo-Orem, UT	UT	0.9272	0.9496
39580	Raleigh-Cary, NC	NC	0.9713	0.9803
39740	Reading, PA	PA	0.8856	0.9202
39820	Redding, CA	CA	1.3277	1.2142
39900	Reno-Sparks, NV	NV	1.0439	1.0299
40060	Richmond, VA	VA	0.9536	0.9680
40140	Riverside-San Bernardino-Ontario, CA	AZ	1.1429	1.0958
40220	Roanoke, VA	VA	0.8864	0.9207
40220	Roanoke, VA	WV	0.8820	0.9176
40380	Rochester, NY	NY	0.8708	0.9096
40420	Rockford, IL	IL	0.9874	0.9914
40484	Rockingham County-Strafford County, NH	ME	1.0218	1.0149
40900	Sacramento--Arden-Arcade--Roseville, CA	CA	1.3217	1.2105
40980	Saginaw-Saginaw Township North, MI	MI	0.9102	0.9376
41100	St. George, UT	UT	0.9311	0.9523
41180	St. Louis, MO-IL	IL	0.8955	0.9272
41180	St. Louis, MO-IL	MO	0.8955	0.9272

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
41620	Salt Lake City, UT	UT	0.9362	0.9559
41700	San Antonio-New Braunfels, TX	TX	0.9071	0.9354
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.5855	1.3711
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.2002	1.1331
42100	Santa Cruz-Watsonville, CA	CA	1.6059	1.3832
42140	Santa Fe, NM	NM	1.0400	1.0272
42220	Santa Rosa-Petaluma, CA	CA	1.5173	1.3304
42340	Savannah, GA	GA	0.8858	0.9203
42340	Savannah, GA	SC	0.8858	0.9203
42644	Seattle-Bellevue-Everett, WA	WA	1.1272	1.0855
43300	Sherman-Denison, TX	OK	0.8445	0.8907
43340	Shreveport-Bossier City, LA	LA	0.8651	0.9055
43580	Sioux City, IA-NE-SD	NE	0.8968	0.9281
43620	Sioux Falls, SD	SD	0.9388	0.9577
43780	South Bend-Mishawaka, IN-MI	IN	0.9488	0.9646
43900	Spartanburg, SC	SC	0.8970	0.9283
44060	Spokane, WA	ID	1.0384	1.0261
44100	Springfield, IL	IL	0.8948	0.9267
44140	Springfield, MA	NH	1.0258	1.0176
44180	Springfield, MO	AR	0.8413	0.8884
44180	Springfield, MO	MO	0.8413	0.8884
44940	Sumter, SC	SC	0.8438	0.8902
45060	Syracuse, NY	NY	0.9710	0.9800
45220	Tallahassee, FL	GA	0.8795	0.9158
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.9094	0.9370
45460	Terre Haute, IN	IN	0.8757	0.9131
45780	Toledo, OH	OH	0.9246	0.9477
45820	Topeka, KS	KS	0.8948	0.9267
46140	Tulsa, OK	OK	0.8798	0.9160
46220	Tuscaloosa, AL	AL	0.8015	0.8594
46220	Tuscaloosa, AL	MS	0.8022	0.8599
46340	Tyler, TX	TX	0.8259	0.8772
46540	Utica-Rome, NY	NY	0.8737	0.9117
46660	Valdosta, GA	GA	0.7840	0.8465
46700	Vallejo-Fairfield, CA	CA	1.4010	1.2597
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8954	0.9271
47580	Warner Robins, GA	GA	0.8470	0.8925
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0559	1.0380
48140	Wausau, WI	WI	0.9113	0.9384
48620	Wichita, KS	KS	0.8756	0.9130
48700	Williamsport, PA	PA	0.8521	0.8962
48864	Wilmington, DE-MD-NJ	DE	1.0690	1.0468

CBSA Code	Area	State	Proposed Wage Index	Proposed GAF
48900	Wilmington, NC	SC	0.9265	0.9491
49180	Winston-Salem, NC	NC	0.8974	0.9285
49180	Winston-Salem, NC	VA	0.8973	0.9285
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8555	0.8986
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8521	0.8962

TABLE 4D-1.—PROPOSED RURAL FLOOR BUDGET NEUTRALITY FACTORS FOR ACUTE CARE HOSPITALS—FY 2011

[The rural floor budget neutrality adjustment factor is a 100 percent State-level factor.]

State	Proposed Rural Floor Budget Neutrality Adjustment Factor
Alabama	0.99910
Alaska	0.94328
Arizona	1.00000
Arkansas	1.00000
California	0.97557
Colorado	0.98680
Connecticut	0.99483
Delaware	1.00000
Washington, D.C.	1.00000
Florida	0.99847
Georgia	1.00000
Hawaii	1.00000
Idaho	1.00000
Illinois	1.00000
Indiana	1.00000
Iowa	0.99954
Kansas	1.00000
Kentucky	0.99973
Louisiana	1.00000
Maine	1.00000
Maryland*	1.00000
Massachusetts	1.00000
Michigan	1.00000
Minnesota	1.00000
Mississippi	1.00000
Missouri	1.00000
Montana	0.99988
Nebraska	1.00000
Nevada	1.00000
New Hampshire	1.00000
New Jersey **	0.97946
New Mexico	1.00000
New York	1.00000
North Carolina	0.99989
North Dakota	1.00000
Ohio	0.99864
Oklahoma	0.99975

State	Proposed Rural Floor Budget Neutrality Adjustment Factor
Oregon	0.99974
Pennsylvania	0.99681
Puerto Rico	1.00000
Rhode Island	1.00000
South Carolina	1.00000
South Dakota	1.00000
Tennessee	0.99171
Texas	0.99956
Utah	1.00000
Vermont	1.00000
Virginia	0.99977
Washington	0.99891
West Virginia	0.99479
Wisconsin	1.00000
Wyoming	1.00000

* Maryland hospitals, under section 1814(b)(3) of the Act, are waived from the IPPS ratesetting. Therefore, the rural floor budget neutrality adjustment does not apply.
** The rural floor budget neutrality factor for New Jersey is based on an imputed floor (see TABLE 4B).

TABLE 4D-2.--URBAN AREAS WITH ACUTE CARE HOSPITALS RECEIVING THE PROPOSED STATEWIDE RURAL FLOOR OR IMPUTED FLOOR WAGE INDEX--FY 2011

[*Only hospitals that are geographically located in the specified State receive the State's rural or imputed floor wage index.]

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Urban Area	State*	Proposed Rural or Imputed Floor Wage Index
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1069
11260	Anchorage, AK	AK	1.1919
12100	Atlantic City-Hammonton, NJ	NJ	1.1069
12540	Bakersfield-Delano, CA	CA	1.2002
15804	Camden, NJ	NJ	1.1069
16940	Cheyenne, WY	WY	0.9392
17020	Chico, CA	CA	1.2002
17300	Clarksville, TN-KY	KY	0.7992
17300	Clarksville, TN-KY	TN	0.7919
17420	Cleveland, TN	TN	0.7919
17820	Colorado Springs, CO	CO	0.9581
19060	Cumberland, MD-WV	MD	0.9305
19500	Decatur, IL	IL	0.8380
20100	Dover, DE	DE	1.0090
20764	Edison-New Brunswick, NJ	NJ	1.1069
20940	El Centro, CA	CA	1.2002
21500	Erie, PA	PA	0.8521
21780	Evansville, IN-KY	IN	0.8399
21820	Fairbanks, AK	AK	1.1919
22020	Fargo, ND-MN	MN	0.9146
22140	Farmington, NM	NM	0.9030
22660	Fort Collins-Loveland, CO	CO	0.9581
22900	Fort Smith, AR-OK	OK	0.8052
23420	Fresno, CA	CA	1.2002
23460	Gadsden, AL	AL	0.7448
24220	Grand Forks, ND-MN	MN	0.9146
24500	Great Falls, MT	MT	0.8439
24540	Greeley, CO	CO	0.9581
25260	Hanford-Corcoran, CA	CA	1.2002
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1251
27340	Jacksonville, NC	NC	0.8476
27740	Johnson City, TN	TN	0.7919

CBSA Code	Urban Area	State*	Proposed Rural or Imputed Floor Wage Index
27780	Johnstown, PA	PA	0.8521
28420	Kennewick-Pasco-Richland, WA	WA	1.0107
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7919
28700	Kingsport-Bristol-Bristol, TN-VA	VA	0.8060
28940	Knoxville, TN	TN	0.7919
30140	Lebanon, PA	PA	0.8521
30300	Lewiston, ID-WA	WA	1.0107
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.2002
31460	Madera-Chowchilla, CA	CA	1.2002
31700	Manchester-Nashua, NH	NH	1.0054
31740	Manhattan, KS	KS	0.8027
32780	Medford, OR	OR	1.0089
32900	Merced, CA	CA	1.2002
33700	Modesto, CA	CA	1.2002
34100	Morristown, TN	TN	0.7919
34580	Mount Vernon-Anacortes, WA	WA	1.0107
34620	Muncie, IN	IN	0.8399
36140	Ocean City, NJ	NJ	1.1069
37380	Palm Coast, FL	FL	0.8458
37460	Panama City-Lynn Haven-Panama City Beach, FL	FL	0.8458
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8555
37620	Parkersburg-Marietta-Vienna, WV-OH	WV	0.7536
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8458
39380	Pueblo, CO	CO	0.9581
40140	Riverside-San Bernardino-Ontario, CA	CA	1.2002
41540	Salisbury, MD	MD	0.9305
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.2002
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.2002
42060	Santa Barbara-Santa Maria-Goleta, CA	CA	1.2002
42540	Scranton--Wilkes-Barre, PA	PA	0.8521
44600	Steubenville-Weirton, OH-WV	OH	0.8555
44600	Steubenville-Weirton, OH-WV	WV	0.7536
44940	Sumter, SC	SC	0.8438
45500	Texarkana, TX-Texarkana, AR	TX	0.8018
45940	Trenton-Ewing, NJ	NJ	1.1069
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1069
47300	Visalia-Porterville, CA	CA	1.2002
47940	Waterloo-Cedar Falls, IA	IA	0.8533
48300	Wenatchee-East Wenatchee, WA	WA	1.0107
48540	Wheeling, WV-OH	OH	0.8555
48540	Wheeling, WV-OH	WV	0.7536
48700	Williamsport, PA	PA	0.8521
48864	Wilmington, DE-MD-NJ	NJ	1.1069
49420	Yakima, WA	WA	1.0107
49700	Yuba City, CA	CA	1.2002

TABLE 4E.—URBAN CBSAs AND CONSTITUENT COUNTIES FOR ACUTE CARE HOSPITALS—FY 2011

CBSA Code	Urban Area (Constituent Counties)
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR
10420	Akron, OH Portage County, OH Summit County, OH
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA
11020	Altoona, PA Blair County, PA
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX
11180	Ames, IA Story County, IA
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK
11300	Anderson, IN Madison County, IN
11340	Anderson, SC Anderson County, SC
11460	Ann Arbor, MI Washtenaw County, MI
11500	Anniston-Oxford, AL Calhoun County, AL
11540	Appleton, WI Calumet County, WI Outagamie County, WI
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA

CBSA Code	Urban Area (Constituent Counties)
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ Hammonton County, NJ
12220	Auburn-Opelika, AL Lee County, AL
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC
12420	Austin-Round Rock-San Marcos, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX
12540	Bakersfield-Delano, CA Kern County, CA
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD
12620	Bangor, ME Penobscot County, ME
12700	Barnstable Town, MA Barnstable County, MA
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA
12980	Battle Creek, MI Calhoun County, MI
13020	Bay City, MI Bay County, MI
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX
13380	Bellingham, WA Whatcom County, WA
13460	Bend, OR Deschutes County, OR

CBSA Code	Urban Area (Constituent Counties)
13644	Bethesda-Rockville-Frederick, MD Frederick County, MD Montgomery County, MD
13740	Billings, MT Carbon County, MT Yellowstone County, MT
13780	Binghamton, NY Broome County, NY Tioga County, NY
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL
13900	Bismarck, ND Burleigh County, ND Morton County, ND
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN
14060	Bloomington-Normal, IL McLean County, IL
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA
14500	Boulder, CO Boulder County, CO

CBSA Code	Urban Area (Constituent Counties)
14540	Bowling Green, KY Edmonson County, KY Warren County, KY
14740	Bremerton-Silverdale, WA Kitsap County, WA
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT
15180	Brownsville-Harlingen, TX Cameron County, TX
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY
15500	Burlington, NC Alamance County, NC
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH
15980	Cape Coral-Fort Myers, FL Lee County, FL
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO
16180	Carson City, NV Carson City, NV
16220	Casper, WY Natrona County, WY

CBSA Code	Urban Area (Constituent Counties)
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC Summerville County, SC
16740	Charlotte-Gastonia-Rock Hill, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN
16940	Cheyenne, WY Laramie County, WY

CBSA Code	Urban Area (Constituent Counties)
16974	Chicago-Joliet-Naperville, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL
17020	Chico, CA Butte County, CA
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN
17420	Cleveland, TN Bradley County, TN Polk County, TN
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH
17660	Coeur d'Alene, ID Kootenai County, ID

CBSA Code	Urban Area (Constituent Counties)
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX
17820	Colorado Springs, CO El Paso County, CO Teller County, CO
17860	Columbia, MO Boone County, MO Howard County, MO
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA
18020	Columbus, IN Bartholomew County, IN
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX
18700	Corvallis, OR Benton County, OR
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa County, FL

CBSA Code	Urban Area (Constituent Counties)
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX
19140	Dalton, GA Murray County, GA Whitfield County, GA
19180	Danville, IL Vermilion County, IL
19260	Danville, VA Pittsylvania County, VA Danville City, VA
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH
19460	Decatur, AL Lawrence County, AL Morgan County, AL
19500	Decatur, IL Macon County, IL
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL

CBSA Code	Urban Area (Constituent Counties)
19740	Denver-Aurora-Broomfield, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL
20100	Dover, DE Kent County, DE
20220	Dubuque, IA Dubuque County, IA
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI

CBSA Code	Urban Area (Constituent Counties)
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ New Brunswick County, NJ Ocean County, NJ Somerset County, NJ
20940	El Centro, CA Imperial County, CA
21060	Elizabethtown, KY Hardin County, KY Larue County, KY
21140	Elkhart-Goshen, IN Elkhart County, IN
21300	Elmira, NY Chemung County, NY
21340	El Paso, TX El Paso County, TX
21500	Erie, PA Erie County, PA
21660	Eugene-Springfield, OR Lane County, OR
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY
21820	Fairbanks, AK Fairbanks North Star Borough, AK
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR
22020	Fargo, ND-MN Clay County, MN Cass County, ND
22140	Farmington, NM San Juan County, NM
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC

CBSA Code	Urban Area (Constituent Counties)
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO
22380	Flagstaff, AZ Coconino County, AZ
22420	Flint, MI Genesee County, MI
22500	Florence, SC Darlington County, SC Florence County, SC
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL
22540	Fond du Lac, WI Fond du Lac County, WI
22660	Fort Collins-Loveland, CO Larimer County, CO
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX
23420	Fresno, CA Fresno County, CA
23460	Gadsden, AL Etowah County, AL
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL

CBSA Code	Urban Area (Constituent Counties)
23580	Gainesville, GA Hall County, GA
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN
24020	Glens Falls, NY Warren County, NY Washington County, NY
24140	Goldsboro, NC Wayne County, NC
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND
24300	Grand Junction, CO Mesa County, CO
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI
24500	Great Falls, MT Cascade County, MT
24540	Greeley, CO Weld County, CO
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC
24780	Greenville, NC Greene County, NC Pitt County, NC
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC

CBSA Code	Urban Area (Constituent Counties)
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV
25260	Hanford-Corcoran, CA Kings County, CA
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA
26100	Holland-Grand Haven, MI Ottawa County, MI
26180	Honolulu, HI Honolulu County, HI
26300	Hot Springs, AR Garland County, AR

CBSA Code	Urban Area (Constituent Counties)
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV
26620	Huntsville, AL Limestone County, AL Madison County, AL
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN
26980	Iowa City, IA Johnson County, IA Washington County, IA
27060	Ithaca, NY Tompkins County, NY
27100	Jackson, MI Jackson County, MI

CBSA Code	Urban Area (Constituent Counties)
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS
27180	Jackson, TN Chester County, TN Madison County, TN
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL
27340	Jacksonville, NC Onslow County, NC
27500	Janesville, WI Rock County, WI
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN
27780	Johnstown, PA Cambria County, PA
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR
27900	Joplin, MO Jasper County, MO Newton County, MO
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI
28100	Kankakee-Bradley, IL Kankakee County, IL

CBSA Code	Urban Area (Constituent Counties)
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA
28740	Kingston, NY Ulster County, NY
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN
29020	Kokomo, IN Howard County, IN Tipton County, IN
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI

CBSA Code	Urban Area (Constituent Counties)
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ
29460	Lakeland-Winter Haven, FL Polk County, FL Winter Haven County, FL
29540	Lancaster, PA Lancaster County, PA
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI
29700	Laredo, TX Webb County, TX
29740	Las Cruces, NM Dona Ana County, NM
29820	Las Vegas-Paradise, NV Clark County, NV
29940	Lawrence, KS Douglas County, KS
30020	Lawton, OK Comanche County, OK
30140	Lebanon, PA Lebanon County, PA
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA
30340	Lewiston-Auburn, ME Androscoggin County, ME
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY
30620	Lima, OH Allen County, OH
30700	Lincoln, NE Lancaster County, NE Seward County, NE
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR
30860	Logan, UT-ID Franklin County, ID Cache County, UT
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX
31020	Longview, WA Cowlitz County, WA
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Jefferson County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY

CBSA Code	Urban Area (Constituent Counties)
31180	Lubbock, TX Crosby County, TX Lubbock County, TX
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA
31460	Madera-Chowchilla, CA Madera County, CA
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI
31700	Manchester-Nashua, NH Hillsborough County, NH
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN
31900	Mansfield, OH Richland County, OH
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX
32780	Medford, OR Jackson County, OR

CBSA Code	Urban Area (Constituent Counties)
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN
32900	Merced, CA Merced County, CA
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL
33140	Michigan City-La Porte, IN LaPorte County, IN
33260	Midland, TX Midland County, TX
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI
33540	Missoula, MT Missoula County, MT
33660	Mobile, AL Mobile County, AL
33700	Modesto, CA Stanislaus County, CA

CBSA Code	Urban Area (Constituent Counties)
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA
33780	Monroe, MI Monroe County, MI
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL
34060	Morgantown, WV Monongalia County, WV Preston County, WV
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN
34580	Mount Vernon-Anacortes, WA Skagit County, WA
34620	Muncie, IN Delaware County, IN
34740	Muskegon-Norton Shores, MI Muskegon County, MI
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC
34900	Napa, CA Napa County, CA
34940	Naples-Marco Island, FL Collier County, FL
34980	Nashville-Davidson-Murfreesboro-Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN

CBSA Code	Urban Area (Constituent Counties)
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA
35300	New Haven-Milford, CT New Haven County, CT
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY
35660	Niles-Benton Harbor, MI Berrien County, MI
35840	North Port-Bradenton-Sarasota, FL Manatee County, FL Sarasota County, FL
35980	Norwich-New London, CT New London County, CT
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA
36100	Ocala, FL Marion County, FL

CBSA Code	Urban Area (Constituent Counties)
36140	Ocean City, NJ Cape May County, NJ
36220	Odessa, TX Ector County, TX
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK
36500	Olympia, WA Thurston County, WA
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE
36740	Orlando-Kissimmee-Sanford, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL
36780	Oshkosh-Neenah, WI Winnebago County, WI
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL
37380	Palm Coast, FL Flager County, FL

CBSA Code	Urban Area (Constituent Counties)
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV
37700	Pascagoula, MS George County, MS Jackson County, MS
37764	Peabody, MA Essex County, MA
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA
38060	Phoenix-Mesa-Glendale, AZ Maricopa County, AZ Pinal County, AZ
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA
38340	Pittsfield, MA Berkshire County, MA

CBSA Code	Urban Area (Constituent Counties)
38540	Pocatello, ID Bannock County, ID Power County, ID
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME
38900	Portland-Vancouver-Hillsboro, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY
39140	Prescott, AZ Yavapai County, AZ
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI
39340	Provo-Orem, UT Juab County, UT Utah County, UT
39380	Pueblo, CO Pueblo County, CO
39460	Punta Gorda, FL Charlotte County, FL
39540	Racine, WI Racine County, WI

CBSA Code	Urban Area (Constituent Counties)
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC
39660	Rapid City, SD Meade County, SD Pennington County, SD
39740	Reading, PA Berks County, PA
39820	Redding, CA Shasta County, CA
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA

CBSA Code	Urban Area (Constituent Counties)
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY
40420	Rockford, IL Boone County, IL Winnebago County, IL
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC
40660	Rome, GA Floyd County, GA
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI
41060	St. Cloud, MN Benton County, MN Stearns County, MN
41100	St. George, UT Washington County, UT

CBSA Code	Urban Area (Constituent Counties)
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO
41420	Salem, OR Marion County, OR Polk County, OR
41500	Salinas, CA Monterey County, CA
41540	Salisbury, MD Somerset County, MD Wicomico County, MD
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT
41660	San Angelo, TX Irion County, TX Tom Green County, TX

CBSA Code	Urban Area (Constituent Counties)
41700	San Antonio-New Braunfels, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA
41780	Sandusky, OH Erie County, OH
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA

CBSA Code	Urban Area (Constituent Counties)
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA
42140	Santa Fe, NM Santa Fe County, NM
42220	Santa Rosa-Petaluma, CA Sonoma County, CA
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA
42680	Sebastian-Vero Beach, FL Indian River County, FL
43100	Sheboygan, WI Sheboygan County, WI
43300	Sherman-Denison, TX Grayson County, TX
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI

CBSA Code	Urban Area (Constituent Counties)
43900	Spartanburg, SC Spartanburg County, SC
44060	Spokane, WA Spokane County, WA
44100	Springfield, IL Menard County, IL Sangamon County, IL
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO
44220	Springfield, OH Clark County, OH
44300	State College, PA Centre County, PA
44600	Steubenville-Weirton, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV
44700	Stockton, CA San Joaquin County, CA
44940	Sumter, SC Sumter County, SC
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY
45104	Tacoma, WA Pierce County, WA
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL

CBSA Code	Urban Area (Constituent Counties)
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS
45940	Trenton-Ewing, NJ Mercer County, NJ
46060	Tucson, AZ Pima County, AZ
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL
46340	Tyler, TX Smith County, TX

CBSA Code	Urban Area (Constituent Counties)
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA
46700	Vallejo-Fairfield, CA Solano County, CA
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA
47300	Visalia-Porterville, CA Tulare County, CA
47380	Waco, TX McLennan County, TX
47580	Warner Robins, GA Houston County, GA

CBSA Code	Urban Area (Constituent Counties)
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA
48140	Wausau, WI Marathon County, WI
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV

CBSA Code	Urban Area (Constituent Counties)
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX
48700	Williamsport, PA Lycoming County, PA
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC
49340	Worcester, MA Worcester County, MA
49420	Yakima, WA Yakima County, WA
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR
49620	York-Hanover, PA York County, PA
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA

CBSA Code	Urban Area (Constituent Counties)
49700	Yuba City, CA Sutter County, CA Yuba County, CA
49740	Yuma, AZ Yuma County, AZ

TABLE 4F.—PROPOSED PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS BY CBSA--FY 2011

(Note: The rural floor budget neutrality adjustment is not applicable to the Puerto Rico specific wage index.)

CBSA Code	Area	Proposed Wage Index	Proposed GAF	Wage Index – Reclassified Hospitals	GAF – Reclassified Hospitals
10380	Aguadilla-Isabela-San Sebastián, PR	0.8107	0.8661	------	------
21940	Fajardo, PR	0.9207	0.9450	------	------
25020	Guayama, PR	0.8570	0.8997	------	------
32420	Mayagüez, PR	0.8593	0.9014	------	------
38660	Ponce, PR	1.0201	1.0137	------	------
41900	San Germán-Cabo Rojo, PR	1.0812	1.0549	------	------
41980	San Juan-Caguas-Guaynabo, PR	1.0224	1.0153	------	------
49500	Yauco, PR	0.8385	0.8864	------	------

TABLE 4J.—PROPOSED OUT-MIGRATION ADJUSTMENT FOR ACUTE CARE HOSPITALS--FY 2011

The following list represents all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act. Hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act are designated with an asterisk. We will automatically assume that hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act wish to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Section 1886(d)(10) hospitals that wish to receive the out-migration adjustment, rather than their reclassification, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this proposed rule. Otherwise, they will be deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8)(B) of the Act will be deemed to have waived the out-migration adjustment, unless they explicitly notified CMS that they elected to receive the out-migration adjustment instead within 45 days from the publication of this proposed rule. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attn: Wage Index Adjustment Waivers, Division of Acute Care, Room C4-08-06, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
010005	*	0.0296	MARSHALL	01470
010008		0.0174	CRENSHAW	01200
010010		0.0296	MARSHALL	01470
010012		0.0186	DE KALB	01240
010015		0.0046	CLARKE	01120
010021		0.0123	DALE	01220
010022	*	0.1128	CHEROKEE	01090
010025	*	0.0389	CHAMBERS	01080
010027		0.0062	COFFEE	01150
010029	*	0.0289	LEE	01400
010032		0.0325	RANDOLPH	01550
010035	*	0.0254	CULLMAN	01210
010038		0.0047	CALHOUN	01070
010040		0.0113	ETOWAH	01270
010045		0.0222	FAYETTE	01280
010046	*	0.0113	ETOWAH	01270
010047		0.0127	BUTLER	01060
010049		0.0062	COFFEE	01150
010052	*	0.0245	TALLAPOOSA	01610
010059	*	0.0097	LAWRENCE	01390
010061	*	0.0542	JACKSON	01350

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
010065	*	0.0245	TALLAPOOSA	01610
010078		0.0047	CALHOUN	01070
010083	*	0.0134	BALDWIN	01010
010091		0.0046	CLARKE	01120
010100	*	0.0134	BALDWIN	01010
010101	*	0.0211	TALLADEGA	01600
010109		0.0309	PICKENS	01530
010110		0.0215	BULLOCK	01050
010125		0.0476	WINSTON	01660
010128		0.0046	CLARKE	01120
010129		0.0134	BALDWIN	01010
010138		0.0066	SUMTER	01590
010143	*	0.0254	CULLMAN	01210
010146		0.0047	CALHOUN	01070
010150		0.0127	BUTLER	01060
010158	*	0.0023	FRANKLIN	01290
010164	*	0.0211	TALLADEGA	01600
030067		0.0298	LAPAZ	03055
040014	*	0.0199	WHITE	04720
040019		0.0258	ST. FRANCIS	04610
040039	*	0.0172	GREENE	04270
040047		0.0117	RANDOLPH	04600
040067		0.0007	COLUMBIA	04130
040071	*	0.0149	JEFFERSON	04340
040076	*	0.1000	HOT SPRING	04290
040081		0.0357	PIKE	04540
050002	*	0.0010	ALAMEDA	05000
050007		0.0146	SAN MATEO	05510
050009	*	0.0180	NAPA	05380
050013	*	0.0180	NAPA	05380
050014	*	0.0139	AMADOR	05020
050042	*	0.0162	TEHAMA	05620
050043	*	0.0010	ALAMEDA	05000
050070		0.0146	SAN MATEO	05510
050073	*	0.0171	SOLANO	05580
050075	*	0.0010	ALAMEDA	05000
050084	*	0.0132	SAN JOAQUIN	05490
050090	*	0.0058	SONOMA	05590
050101	*	0.0171	SOLANO	05580
050113		0.0146	SAN MATEO	05510
050118	*	0.0132	SAN JOAQUIN	05490
050122		0.0132	SAN JOAQUIN	05490
050133		0.0178	YUBA	05680

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
050136	*	0.0058	SONOMA	05590
050150	*	0.0342	NEVADA	05390
050167		0.0132	SAN JOAQUIN	05490
050174	*	0.0058	SONOMA	05590
050195	*	0.0010	ALAMEDA	05000
050197	*	0.0146	SAN MATEO	05510
050211	*	0.0010	ALAMEDA	05000
050264	*	0.0010	ALAMEDA	05000
050283	*	0.0010	ALAMEDA	05000
050289		0.0146	SAN MATEO	05510
050291	*	0.0058	SONOMA	05590
050305	*	0.0010	ALAMEDA	05000
050313		0.0132	SAN JOAQUIN	05490
050320	*	0.0010	ALAMEDA	05000
050325		0.0033	TUOLUMNE	05650
050335	*	0.0033	TUOLUMNE	05650
050336		0.0132	SAN JOAQUIN	05490
050366	*	0.0015	CALAVERAS	05040
050367	*	0.0171	SOLANO	05580
050385	*	0.0058	SONOMA	05590
050444		0.0233	MERCED	05340
050488	*	0.0010	ALAMEDA	05000
050512	*	0.0010	ALAMEDA	05000
050528	*	0.0233	MERCED	05340
050541	*	0.0146	SAN MATEO	05510
050547	*	0.0058	SONOMA	05590
050667	*	0.0180	NAPA	05380
050680	*	0.0171	SOLANO	05580
050690	*	0.0058	SONOMA	05590
050748	*	0.0132	SAN JOAQUIN	05490
050754		0.0146	SAN MATEO	05510
060001	*	0.0042	WELD	06610
060003	*	0.0069	BOULDER	06060
060027	*	0.0069	BOULDER	06060
060103	*	0.0069	BOULDER	06060
060116	*	0.0069	BOULDER	06060
060121	*	0.0042	WELD	06610
070003	*	0.0020	WINDHAM	07070
070004	*	0.0135	LITCHFIELD	07020
070006	*	0.0045	FAIRFIELD	07000
070010	*	0.0045	FAIRFIELD	07000
070011	*	0.0135	LITCHFIELD	07020
070015	*	0.0135	LITCHFIELD	07020
070018	*	0.0045	FAIRFIELD	07000

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
070020		0.0101	MIDDLESEX	07030
070021	*	0.0020	WINDHAM	07070
070028	*	0.0045	FAIRFIELD	07000
070033	*	0.0045	FAIRFIELD	07000
070034	*	0.0045	FAIRFIELD	07000
100014	*	0.0047	VOLUSIA	10630
100017	*	0.0047	VOLUSIA	10630
100023	*	0.0031	CITRUS	10080
100045	*	0.0047	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0047	VOLUSIA	10630
100072	*	0.0047	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070
100081	*	0.0097	WALTON	10650
100118	*	0.0177	FLAGLER	10170
100139	*	0.0006	LEVY	10370
100232	*	0.0054	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100249	*	0.0031	CITRUS	10080
100252	*	0.0151	OKEECHOBEE	10460
100290	*	0.0452	SUMTER	10590
100292	*	0.0097	WALTON	10650
110023	*	0.0416	GORDON	11500
110029	*	0.0052	HALL	11550
110040	*	0.1455	JACKSON	11610
110041	*	0.0623	HABERSHAM	11540
110100		0.0790	JEFFERSON	11620
110101		0.0067	COOK	11311
110142		0.0185	EVANS	11441
110146	*	0.0364	CAMDEN	11170
110150	*	0.0227	BALDWIN	11030
110187	*	0.0643	LUMPKIN	11701
110189	*	0.0066	FANNIN	11450
110190	*	0.0241	MACON	11710
110205		0.0507	GILMER	11471
130003	*	0.0235	NEZ PERCE	13340
130024		0.0675	BONNER	13080
130049	*	0.0319	KOOTENAI	13270
130066		0.0319	KOOTENAI	13270
130067	*	0.0725	BINGHAM	13050
140001		0.0369	FULTON	14370
140026		0.0315	LA SALLE	14580
140043	*	0.0056	WHITESIDE	14988
140058	*	0.0126	MORGAN	14770

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
140110	*	0.0315	LA SALLE	14580
140116	*	0.0041	MC HENRY	14640
140160	*	0.0332	STEPHENSON	14970
140161	*	0.0168	LIVINGSTON	14610
140167	*	0.0632	IROQUOIS	14460
140176	*	0.0041	MC HENRY	14640
140234		0.0315	LA SALLE	14580
150022		0.0158	MONTGOMERY	15530
150030	*	0.0192	HENRY	15320
150072		0.0105	CASS	15080
150076	*	0.0215	MARSHALL	15490
150088	*	0.0111	MADISON	15470
150091	*	0.0050	HUNTINGTON	15340
150102	*	0.0108	STARKE	15740
150113	*	0.0111	MADISON	15470
150133	*	0.0193	KOSCIUSKO	15420
150146	*	0.0087	NOBLE	15560
160013		0.0179	MUSCATINE	16690
160032		0.0235	JASPER	16490
160080	*	0.0066	CLINTON	16220
170137	*	0.0402	DOUGLAS	17220
170150		0.0166	COWLEY	17170
180012	*	0.0080	HARDIN	18460
180017	*	0.0035	BARREN	18040
180049		0.0488	MADISON	18750
180064		0.0314	MONTGOMERY	18860
180066		0.0439	LOGAN	18700
180070		0.0240	GRAYSON	18420
180079		0.0259	HARRISON	18480
190003	*	0.0085	IBERIA	19220
190015	*	0.0243	TANGIPAHOA	19520
190017	*	0.0187	ST. LANDRY	19480
190034		0.0189	VERMILION	19560
190044		0.0261	ACADIA	19000
190050		0.0044	BEAUREGARD	19050
190053		0.0101	JEFFRSON DAVIS	19260
190054		0.0085	IBERIA	19220
190078		0.0187	ST. LANDRY	19480
190086	*	0.0061	LINCOLN	19300
190088		0.0387	WEBSTER	19590
190099		0.0189	AVOYELLES	19040
190106	*	0.0102	ALLEN	19010
190116		0.0085	MOREHOUSE	19330

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
190133		0.0102	ALLEN	19010
190140		0.0035	FRANKLIN	19200
190144	*	0.0387	WEBSTER	19590
190145		0.0090	LA SALLE	19290
190184		0.0047	CALDWELL	19100
190190	*	0.0047	CALDWELL	19100
190191		0.0187	ST. LANDRY	19480
190246		0.0047	CALDWELL	19100
190257	*	0.0061	LINCOLN	19300
200024	*	0.0094	ANDROSCOGGIN	20000
200032		0.0331	OXFORD	20080
200034	*	0.0094	ANDROSCOGGIN	20000
200050	*	0.0227	HANCOCK	20040
210001		0.0187	WASHINGTON	21210
210023		0.0079	ANNE ARUNDEL	21010
210028		0.0254	ST. MARYS	21180
210043		0.0079	ANNE ARUNDEL	21010
220001	*	0.0064	WORCESTER	22170
220002	*	0.0271	MIDDLESEX	22090
220010	*	0.0355	ESSEX	22040
220011	*	0.0271	MIDDLESEX	22090
220019	*	0.0064	WORCESTER	22170
220025	*	0.0064	WORCESTER	22170
220029	*	0.0355	ESSEX	22040
220033	*	0.0355	ESSEX	22040
220035	*	0.0355	ESSEX	22040
220049	*	0.0271	MIDDLESEX	22090
220058	*	0.0064	WORCESTER	22170
220062	*	0.0064	WORCESTER	22170
220063	*	0.0271	MIDDLESEX	22090
220070	*	0.0271	MIDDLESEX	22090
220080	*	0.0355	ESSEX	22040
220082	*	0.0271	MIDDLESEX	22090
220084	*	0.0271	MIDDLESEX	22090
220090	*	0.0064	WORCESTER	22170
220095	*	0.0064	WORCESTER	22170
220098	*	0.0271	MIDDLESEX	22090
220101	*	0.0271	MIDDLESEX	22090
220105	*	0.0271	MIDDLESEX	22090
220163	*	0.0064	WORCESTER	22170
220171	*	0.0271	MIDDLESEX	22090
220174	*	0.0355	ESSEX	22040
220175	*	0.0271	MIDDLESEX	22090
220176	*	0.0064	WORCESTER	22170

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
230002	*	0.0043	WAYNE	23810
230003	*	0.0220	OTTAWA	23690
230005		0.0473	LENAWEE	23450
230013	*	0.0025	OAKLAND	23620
230015		0.0295	ST. JOSEPH	23740
230019	*	0.0025	OAKLAND	23620
230020	*	0.0043	WAYNE	23810
230021	*	0.0101	BERRIEN	23100
230022	*	0.0212	BRANCH	23110
230024	*	0.0043	WAYNE	23810
230029	*	0.0025	OAKLAND	23620
230035	*	0.0095	MONTCALM	23580
230037	*	0.0210	HILLSDALE	23290
230041		0.0052	BAY	23080
230047	*	0.0021	MACOMB	23490
230053	*	0.0043	WAYNE	23810
230069	*	0.0210	LIVINGSTON	23460
230071	*	0.0025	OAKLAND	23620
230072	*	0.0220	OTTAWA	23690
230075		0.0047	CALHOUN	23120
230078	*	0.0101	BERRIEN	23100
230089	*	0.0043	WAYNE	23810
230092		0.0223	JACKSON	23370
230093		0.0058	MECOSTA	23530
230096	*	0.0295	ST. JOSEPH	23740
230099	*	0.0231	MONROE	23570
230104	*	0.0043	WAYNE	23810
230121	*	0.0678	SHIAWASSEE	23770
230130	*	0.0025	OAKLAND	23620
230135	*	0.0043	WAYNE	23810
230142	*	0.0043	WAYNE	23810
230146	*	0.0043	WAYNE	23810
230151	*	0.0025	OAKLAND	23620
230165	*	0.0043	WAYNE	23810
230174	*	0.0220	OTTAWA	23690
230176	*	0.0043	WAYNE	23810
230195	*	0.0021	MACOMB	23490
230204	*	0.0021	MACOMB	23490
230207	*	0.0025	OAKLAND	23620
230208	*	0.0095	MONTCALM	23580
230217		0.0047	CALHOUN	23120
230222	*	0.0035	MIDLAND	23550
230227	*	0.0021	MACOMB	23490
230244	*	0.0043	WAYNE	23810

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
230254	*	0.0025	OAKLAND	23620
230257	*	0.0021	MACOMB	23490
230264	*	0.0021	MACOMB	23490
230269	*	0.0025	OAKLAND	23620
230270	*	0.0043	WAYNE	23810
230273	*	0.0043	WAYNE	23810
230277	*	0.0025	OAKLAND	23620
230279	*	0.0210	LIVINGSTON	23460
230297	*	0.0043	WAYNE	23810
230301	*	0.0025	OAKLAND	23620
230302	*	0.0025	OAKLAND	23620
240018		0.0805	GOODHUE	24240
240044		0.0625	WINONA	24840
240064		0.0134	ITASCA	24300
240069	*	0.0267	STEELE	24730
240071	*	0.0385	RICE	24650
240117		0.0527	MOWER	24490
240211		0.0812	PINE	24570
250023	*	0.0541	PEARL RIVER	25540
250040	*	0.0021	JACKSON	25290
250117	*	0.0541	PEARL RIVER	25540
250128		0.0446	PANOLA	25530
250162		0.0014	HANCOCK	25220
260059		0.0077	LACLEDE	26520
260064		0.0089	AUDRAIN	26030
260097		0.0300	JOHNSON	26500
260116	*	0.0087	ST. FRANCOIS	26930
260160		0.0144	STODDARD	26985
260163		0.0087	ST. FRANCOIS	26930
280077	*	0.0080	DODGE	28260
290002	*	0.0277	LYON	29090
300011	*	0.0238	HILLSBOROUGH	30050
300012	*	0.0238	HILLSBOROUGH	30050
300017	*	0.0396	ROCKINGHAM	30070
300020	*	0.0238	HILLSBOROUGH	30050
300023	*	0.0396	ROCKINGHAM	30070
300029	*	0.0396	ROCKINGHAM	30070
300034	*	0.0238	HILLSBOROUGH	30050
310002	*	0.0268	ESSEX	31200
310009	*	0.0268	ESSEX	31200
310015	*	0.0254	MORRIS	31300
310017	*	0.0254	MORRIS	31300
310038	*	0.0209	MIDDLESEX	31270
310039	*	0.0209	MIDDLESEX	31270

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
310050	*	0.0254	MORRIS	31300
310054	*	0.0268	ESSEX	31200
310070	*	0.0209	MIDDLESEX	31270
310076	*	0.0268	ESSEX	31200
310083	*	0.0268	ESSEX	31200
310096	*	0.0268	ESSEX	31200
310108	*	0.0209	MIDDLESEX	31270
310119	*	0.0268	ESSEX	31200
320003	*	0.0490	SAN MIGUEL	32230
320011		0.0344	RIO ARRIBA	32190
320018		0.0024	DONA ANA	32060
320085		0.0024	DONA ANA	32060
320088		0.0024	DONA ANA	32060
330004		0.0633	ULSTER	33740
330008	*	0.0126	WYOMING	33900
330010		0.0067	MONTGOMERY	33380
330027	*	0.0123	NASSAU	33400
330033		0.0223	CHENANGO	33080
330047		0.0067	MONTGOMERY	33380
330073	*	0.0151	GENESEE	33290
330094	*	0.0503	COLUMBIA	33200
330103		0.0131	CATTARAUGUS	33040
330106	*	0.0123	NASSAU	33400
330126	*	0.0642	ORANGE	33540
330132		0.0131	CATTARAUGUS	33040
330135		0.0642	ORANGE	33540
330144		0.0034	STEUBEN	33690
330151		0.0034	STEUBEN	33690
330167	*	0.0123	NASSAU	33400
330175		0.0260	CORTLAND	33210
330181	*	0.0123	NASSAU	33400
330182	*	0.0123	NASSAU	33400
330191	*	0.0017	WARREN	33750
330198	*	0.0123	NASSAU	33400
330205		0.0642	ORANGE	33540
330222		0.0016	SARATOGA	33640
330224	*	0.0633	ULSTER	33740
330225	*	0.0123	NASSAU	33400
330235	*	0.0306	CAYUGA	33050
330259	*	0.0123	NASSAU	33400
330264		0.0642	ORANGE	33540
330276		0.0036	FULTON	33280
330277	*	0.0034	STEUBEN	33690

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
330331	*	0.0123	NASSAU	33400
330332	*	0.0123	NASSAU	33400
330372	*	0.0123	NASSAU	33400
330386	*	0.0745	SULLIVAN	33710
340020		0.0156	LEE	34520
340021	*	0.0162	CLEVELAND	34220
340024		0.0177	SAMPSON	34810
340027	*	0.0128	LENOIR	34530
340037	*	0.0162	CLEVELAND	34220
340038		0.0253	BEAUFORT	34060
340039	*	0.0101	IREDELL	34480
340068	*	0.0087	COLUMBUS	34230
340069	*	0.0015	WAKE	34910
340070	*	0.0395	ALAMANCE	34000
340071	*	0.0226	HARNETT	34420
340073	*	0.0015	WAKE	34910
340085	*	0.0250	DAVIDSON	34280
340096	*	0.0250	DAVIDSON	34280
340114	*	0.0015	WAKE	34910
340126	*	0.0100	WILSON	34970
340129	*	0.0101	IREDELL	34480
340133		0.0319	MARTIN	34580
340138	*	0.0015	WAKE	34910
340144	*	0.0101	IREDELL	34480
340145	*	0.0336	LINCOLN	34540
340151		0.0052	HALIFAX	34410
340173	*	0.0015	WAKE	34910
360002		0.0141	ASHLAND	36020
360010	*	0.0074	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0077	ERIE	36220
360036	*	0.0126	WAYNE	36860
360040		0.0387	KNOX	36430
360044		0.0127	DARKE	36190
360055	*	0.0011	TRUMBULL	36790
360065	*	0.0075	HURON	36400
360070		0.0038	STARK	36770
360071		0.0035	VAN WERT	36820
360084		0.0038	STARK	36770
360086	*	0.0186	CLARK	36110
360096		0.0071	COLUMBIANA	36140
360107		0.0119	SANDUSKY	36730
360125	*	0.0133	ASHTABULA	36030

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
360131		0.0038	STARK	36770
360151		0.0038	STARK	36770
360156		0.0119	SANDUSKY	36730
360161		0.0011	TRUMBULL	36790
360175	*	0.0183	CLINTON	36130
360185	*	0.0071	COLUMBIANA	36140
360245	*	0.0133	ASHTABULA	36030
360355		0.0186	CLARK	36110
370014	*	0.0361	BRYAN	37060
370015	*	0.0366	MAYES	37480
370023		0.0090	STEPHENS	37680
370065		0.0096	CRAIG	37170
370072		0.0258	LATIMER	37380
370083		0.0051	PUSHMATAHA	37630
370100		0.0100	CHOCTAW	37110
370149		0.0302	POTTAWATOMIE	37620
370156		0.0121	GARVIN	37240
370169		0.0163	MCINTOSH	37450
370172		0.0258	LATIMER	37380
370214		0.0121	GARVIN	37240
380022	*	0.0067	LINN	38210
390008		0.0060	LAWRENCE	39450
390016	*	0.0060	LAWRENCE	39450
390030	*	0.0147	SCHUYLKILL	39650
390031	*	0.0147	SCHUYLKILL	39650
390039		0.0037	SOMERSET	39680
390044		0.0191	BERKS	39110
390052		0.0047	CLEARFIELD	39230
390056		0.0036	HUNTINGDON	39380
390065	*	0.0532	ADAMS	39000
390066	*	0.0372	LEBANON	39460
390079	*	0.0003	BRADFORD	39130
390086	*	0.0047	CLEARFIELD	39230
390096		0.0191	BERKS	39110
390110	*	0.0003	CAMBRIA	39160
390112		0.0037	SOMERSET	39680
390113	*	0.0053	CRAWFORD	39260
390117		0.0002	BEDFORD	39100
390122		0.0053	CRAWFORD	39260
390125		0.0022	WAYNE	39760
390130	*	0.0003	CAMBRIA	39160
390138	*	0.0218	FRANKLIN	39350

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
390146		0.0022	WARREN	39740
390150		0.0031	GREENE	39370
390151	*	0.0218	FRANKLIN	39350
390162	*	0.0215	NORTHAMPTON	39590
390173		0.0037	INDIANA	39390
390183	*	0.0147	SCHUYLKILL	39650
390201		0.1170	MONROE	39550
390236		0.0003	BRADFORD	39130
390313	*	0.0147	SCHUYLKILL	39650
390316		0.0191	BERKS	39110
420005		0.0012	DILLON	42160
420007	*	0.0027	SPARTANBURG	42410
420019		0.0158	CHESTER	42110
420020	*	0.0024	GEORGETOWN	42210
420027	*	0.0108	ANDERSON	42030
420030	*	0.0069	COLLETON	42140
420036	*	0.0064	LANCASTER	42280
420039	*	0.0176	UNION	42430
420043		0.0157	CHEROKEE	42100
420053		0.0035	NEWBERRY	42350
420054		0.0008	MARLBORO	42340
420055		0.0029	MARION	42330
420062		0.0125	CHESTERFIELD	42120
420068	*	0.0027	ORANGEBURG	42370
420069	*	0.0052	CLARENDON	42130
420070	*	0.0051	SUMTER	42420
420083	*	0.0027	SPARTANBURG	42410
420098		0.0024	GEORGETOWN	42210
430008		0.0535	BROOKINGS	43050
430048		0.0129	LAWRENCE	43400
430094		0.0129	LAWRENCE	43400
440007		0.0219	COFFEE	44150
440008		0.0449	HENDERSON	44380
440016		0.0144	CARROLL	44080
440031		0.0019	ROANE	44720
440033		0.0027	CAMPBELL	44060
440035	*	0.0301	MONTGOMERY	44620
440047		0.0338	GIBSON	44260
440051		0.0082	MC NAIRY	44540
440057		0.0021	CLAIBORNE	44120
440060		0.0338	GIBSON	44260
440063		0.0033	WASHINGTON	44890

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
440070		0.0109	DECATUR	44190
440081		0.0052	SEVIER	44770
440084		0.0025	MONROE	44610
440105		0.0033	WASHINGTON	44890
440109		0.0070	HARDIN	44350
440115		0.0338	GIBSON	44260
440137		0.0738	BEDFORD	44010
440144	*	0.0219	COFFEE	44150
440148		0.0296	DE KALB	44200
440174	*	0.0312	HAYWOOD	44370
440180		0.0027	CAMPBELL	44060
440181		0.0365	HARDEMAN	44340
440182		0.0144	CARROLL	44080
440184		0.0033	WASHINGTON	44890
440185	*	0.0230	BRADLEY	44050
450032	*	0.0254	HARRISON	45620
450039	*	0.0024	TARRANT	45910
450052	*	0.0276	BOSQUE	45160
450064	*	0.0024	TARRANT	45910
450087	*	0.0024	TARRANT	45910
450090		0.0650	COOKE	45340
450099	*	0.0145	GRAY	45563
450135	*	0.0024	TARRANT	45910
450137	*	0.0024	TARRANT	45910
450144	*	0.0559	ANDREWS	45010
450163		0.0054	KLEBERG	45743
450192		0.0271	HILL	45651
450194		0.0213	CHEROKEE	45281
450210		0.0151	PANOLA	45842
450224	*	0.0195	WOOD	45974
450236		0.0389	HOPKINS	45654
450270		0.0271	HILL	45651
450283	*	0.0653	VAN ZANDT	45947
450347	*	0.0370	WALKER	45949
450348	*	0.0059	FALLS	45500
450370	*	0.0235	COLORADO	45312
450389	*	0.0618	HENDERSON	45640
450395		0.0441	POLK	45850
450419	*	0.0024	TARRANT	45910
450438	*	0.0235	COLORADO	45312
450451		0.0536	SOMERVELL	45893
450460		0.0053	TYLER	45942
450497		0.0375	MONTAGUE	45800

Provider Number	Reclassified for FY 2011	Proposed Out-Migration Adjustment	Qualifying County Name	County Code
450539		0.0067	HALE	45582
450547	*	0.0195	WOOD	45974
450563	*	0.0024	TARRANT	45910
450565	*	0.0470	PALO PINTO	45841
450573		0.0126	JASPER	45690
450596	*	0.0743	HOOD	45653
450597		0.0003	DE WITT	45420
450639	*	0.0024	TARRANT	45910
450641		0.0375	MONTAGUE	45800
450672	*	0.0024	TARRANT	45910
450675	*	0.0024	TARRANT	45910
450677	*	0.0024	TARRANT	45910
450698		0.0127	LAMB	45751
450747	*	0.0126	ANDERSON	45000
450755		0.0276	HOCKLEY	45652
450770	*	0.0182	MILAM	45795
450779	*	0.0024	TARRANT	45910
450813		0.0126	ANDERSON	45000
450872	*	0.0024	TARRANT	45910
450880	*	0.0024	TARRANT	45910
450884		0.0049	UPSHUR	45943
450886	*	0.0024	TARRANT	45910
450888		0.0024	TARRANT	45910
460001		0.0001	UTAH	46240
460013		0.0001	UTAH	46240
460017		0.0383	BOX ELDER	46010
460023		0.0001	UTAH	46240
460039	*	0.0383	BOX ELDER	46010
460043		0.0001	UTAH	46240
460052		0.0001	UTAH	46240
490002		0.0003	RUSSELL	49830
490019	*	0.1088	CULPEPER	49230
490038		0.0003	SMYTH	49860
490084		0.0187	ESSEX	49280
490105		0.0003	SMYTH	49860
490110		0.0185	MONTGOMERY	49600
500003	*	0.0166	SKAGIT	50280
500007	*	0.0166	SKAGIT	50280
500019		0.0131	LEWIS	50200
500024		0.0065	THURSTON	50330
500039	*	0.0094	KITSAP	50170
500041	*	0.0020	COWLITZ	50070
500139		0.0065	THURSTON	50330
500143		0.0065	THURSTON	50330
510012		0.0124	MASON	51260
510018	*	0.0188	JACKSON	51170
510047	*	0.0269	MARION	51240
520009		0.0027	OUTAGAMIE	52430
520028	*	0.0286	GREEN	52220
520035		0.0076	SHEBOYGAN	52580
520044		0.0076	SHEBOYGAN	52580
520045		0.0022	WINNEBAGO	52690
520048		0.0022	WINNEBAGO	52690
520057		0.0193	SAUK	52550
520059	*	0.0195	RACINE	52500
520071	*	0.0161	JEFFERSON	52270
520076	*	0.0146	DODGE	52130
520088		0.0084	FOND DU LAC	52190
520095	*	0.0193	SAUK	52550
520096	*	0.0195	RACINE	52500
520102	*	0.0242	WALWORTH	52630
520116	*	0.0161	JEFFERSON	52270
520160		0.0027	OUTAGAMIE	52430
520198		0.0022	WINNEBAGO	52690

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
001	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	26.1241	31.7	41.8
002	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.5332	17.7	22.8
003	Yes	No	PRE	SURG	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.0135	30.0	36.6
004	Yes	No	PRE	SURG	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.1832	22.2	27.1
005	No	No	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.2640	15.0	20.0
006	No	No	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.8067	8.3	9.2
007	No	No	PRE	SURG	LUNG TRANSPLANT	9.3918	15.6	18.7
008	No	No	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	4.9951	10.2	11.8
010	No	No	PRE	SURG	PANCREAS TRANSPLANT	3.7220	8.6	9.7
011	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.7558	12.3	15.6
012	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.1179	8.5	10.1
013	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	1.9480	5.7	6.7
014	No	No	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	11.3961	20.7	27.7
015	No	No	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT	5.8721	16.7	19.2
020	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	8.2168	14.0	17.2
021	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	6.2673	12.2	13.9
022	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	4.1377	6.6	8.4
023	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	5.0829	8.3	11.8
024	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.4948	5.7	8.1
025	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.7528	8.8	11.5
026	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	2.9804	5.8	7.3
027	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.1382	3.0	3.9
028	Yes	Yes	01	SURG	SPINAL PROCEDURES W MCC	5.3583	10.1	13.1
029	Yes	Yes	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	2.8798	4.7	6.6
030	Yes	Yes	01	SURG	SPINAL PROCEDURES W/O CC/MCC	1.6452	2.5	3.3
031	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.1020	8.5	12.2
032	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	1.9339	3.7	5.4
033	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.3695	2.1	2.7
034	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.5290	4.7	7.0
035	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.1572	2.2	3.2
036	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.6539	1.3	1.5
037	No	No	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.1652	5.8	8.4
038	No	No	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5610	2.4	3.5
039	No	No	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.0278	1.4	1.7
040	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.9264	9.0	12.2
041	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.1447	5.0	6.7
042	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.6950	2.3	3.2
052	No	No	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.5964	4.5	6.6

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
053	No	No	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.8417	2.9	3.6
054	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.4801	4.6	6.3
055	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0651	3.5	4.6
056	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1.6720	5.5	7.2
057	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	0.9316	3.7	4.9
058	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.5781	5.5	7.3
059	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	0.9818	4.1	4.9
060	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.7525	3.2	3.8
061	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	2.9397	6.4	8.4
062	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	1.9450	4.8	5.6
063	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	1.5296	3.4	3.9
064	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8601	5.1	6.9
065	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	1.1637	4.0	4.8
066	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.8174	2.7	3.3
067	No	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.4176	4.2	5.5
068	No	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8746	2.7	3.3
069	No	No	01	MED	TRANSIENT ISCHEMIA	0.7292	2.3	2.8
070	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.8345	5.6	7.4
071	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.1008	4.1	5.1
072	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7468	2.5	3.1
073	No	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.2959	4.2	5.6
074	No	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.8592	3.2	4.1
075	No	No	01	MED	VIRAL MENINGITIS W CC/MCC	1.6538	5.5	7.0
076	No	No	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.9054	3.3	3.9
077	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.7332	5.1	6.4
078	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	1.0145	3.5	4.4
079	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7500	2.6	3.1
080	No	No	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.1831	3.6	4.9
081	No	No	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.7350	2.7	3.4
082	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.0028	3.5	6.1
083	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.3194	3.4	4.7
084	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.8899	2.2	2.8
085	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.1345	5.2	7.2
086	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.1979	3.7	4.6
087	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.7872	2.3	2.9
088	No	No	01	MED	CONCUSSION W MCC	1.5102	4.2	5.5
089	No	No	01	MED	CONCUSSION W CC	0.9644	2.9	3.7
090	No	No	01	MED	CONCUSSION W/O CC/MCC	0.6943	1.9	2.3
091	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.6299	4.4	6.2
092	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9372	3.3	4.2
093	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.6800	2.3	2.9
094	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.6910	8.9	11.8
095	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.3934	6.6	8.4
096	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	1.9171	4.6	5.7

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
097	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.2271	9.0	11.6
098	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.9053	6.4	7.9
099	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2170	4.1	5.2
100	Yes	No	01	MED	SEIZURES W MCC	1.5091	4.5	6.0
101	Yes	No	01	MED	SEIZURES W/O MCC	0.7588	2.8	3.4
102	No	No	01	MED	HEADACHES W MCC	0.9997	3.1	4.3
103	No	No	01	MED	HEADACHES W/O MCC	0.6691	2.4	3.0
113	No	No	02	SURG	ORBITAL PROCEDURES W CC/MCC	1.8278	3.9	5.6
114	No	No	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	0.9224	2.0	2.6
115	No	No	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.2130	3.4	4.6
116	No	No	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.2920	3.0	4.5
117	No	No	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	0.7393	1.6	2.0
121	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	0.9040	4.1	5.1
122	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.6451	3.3	4.0
123	No	No	02	MED	NEUROLOGICAL EYE DISORDERS	0.7135	2.2	2.7
124	No	No	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.1861	3.8	5.3
125	No	No	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.6819	2.6	3.4
129	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.2555	3.7	5.2
130	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.2316	2.3	2.9
131	No	No	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.0829	4.1	5.6
132	No	No	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.2451	2.1	2.7
133	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	1.6960	3.6	5.4
134	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	0.8518	1.7	2.1
135	No	No	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	1.9029	4.3	6.3
136	No	No	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	0.9772	1.7	2.2
137	No	No	03	SURG	MOUTH PROCEDURES W CC/MCC	1.2952	3.6	5.0
138	No	No	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.7822	1.9	2.5
139	No	No	03	SURG	SALIVARY GLAND PROCEDURES	0.8827	1.4	1.8
146	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	2.1722	6.5	9.0
147	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2284	4.1	5.7
148	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.8118	2.4	3.3
149	No	No	03	MED	DYSEQUILIBRIUM	0.6363	2.2	2.6
150	No	No	03	MED	EPISTAXIS W MCC	1.2811	3.7	5.0
151	No	No	03	MED	EPISTAXIS W/O MCC	0.6366	2.3	2.9
152	No	No	03	MED	OTITIS MEDIA & URI W MCC	0.9623	3.3	4.3
153	No	No	03	MED	OTITIS MEDIA & URI W/O MCC	0.6256	2.5	3.1
154	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.3957	4.3	5.8
155	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.9032	3.3	4.2
156	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6184	2.4	2.9
157	No	No	03	MED	DENTAL & ORAL DISEASES W MCC	1.5699	4.8	6.7
158	No	No	03	MED	DENTAL & ORAL DISEASES W CC	0.8951	3.3	4.3
159	No	No	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.5858	2.1	2.7
163	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W MCC	5.0701	11.5	14.0
164	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W CC	2.6177	6.2	7.4
165	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.7756	3.7	4.4
166	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.7415	9.5	12.0
167	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.0537	5.8	7.4
168	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3012	3.3	4.3
175	Yes	No	04	MED	PULMONARY EMBOLISM W MCC	1.6088	5.7	6.8
176	Yes	No	04	MED	PULMONARY EMBOLISM W/O MCC	1.0666	4.2	4.9

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
177	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	2.0651	6.8	8.6
178	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.4859	5.6	6.8
179	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	0.9836	4.1	5.0
180	No	No	04	MED	RESPIRATORY NEOPLASMS W MCC	1.7310	5.7	7.5
181	No	No	04	MED	RESPIRATORY NEOPLASMS W CC	1.2155	4.2	5.4
182	No	No	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.8086	2.8	3.7
183	No	No	04	MED	MAJOR CHEST TRAUMA W MCC	1.4874	5.2	6.5
184	No	No	04	MED	MAJOR CHEST TRAUMA W CC	0.9670	3.6	4.3
185	No	No	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.6761	2.6	3.0
186	Yes	No	04	MED	PLEURAL EFFUSION W MCC	1.5600	5.3	6.7
187	Yes	No	04	MED	PLEURAL EFFUSION W CC	1.0991	3.9	4.9
188	Yes	No	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7628	2.8	3.5
189	No	No	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2776	4.3	5.5
190	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1894	4.5	5.5
191	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9712	3.8	4.6
192	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7200	3.1	3.7
193	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4753	5.3	6.5
194	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	1.0124	4.2	5.0
195	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7073	3.1	3.7
196	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6053	5.6	7.0
197	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1149	4.2	5.1
198	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.8149	3.1	3.8
199	No	No	04	MED	PNEUMOTHORAX W MCC	1.7760	6.2	8.0
200	No	No	04	MED	PNEUMOTHORAX W CC	1.0198	3.7	4.8
201	No	No	04	MED	PNEUMOTHORAX W/O CC/MCC	0.7167	2.8	3.5
202	No	No	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.8395	3.4	4.1
203	No	No	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6051	2.6	3.2
204	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.6705	2.1	2.7
205	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.3018	4.0	5.3
206	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.7546	2.6	3.3
207	Yes	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	5.1936	12.6	14.8
208	No	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	2.2522	5.1	7.0
215	No	No	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.7451	7.0	12.6
216	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	10.0309	14.7	17.1
217	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.8081	9.8	11.0
218	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.3407	7.2	8.0
219	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	8.0975	10.8	13.1
220	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.3923	7.2	8.0
221	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.4941	5.6	6.0
222	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.5634	9.4	11.9
223	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.4649	4.5	6.2
224	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.6030	7.7	9.7
225	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	6.0613	4.2	5.3
226	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.4967	5.0	7.8
227	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.2285	2.0	3.1

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					W/O MCC			
228	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	7.6151	11.8	14.2
229	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W CC	4.7934	7.3	8.3
230	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	3.5608	4.6	5.5
231	No	No	05	SURG	CORONARY BYPASS W PTCA W MCC	7.8893	10.9	12.9
232	No	No	05	SURG	CORONARY BYPASS W PTCA W/O MCC	5.8492	8.5	9.4
233	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	7.2273	12.1	13.7
234	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	4.8441	8.2	8.9
235	Yes	No	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.8556	9.3	10.8
236	Yes	No	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.7839	6.0	6.5
237	No	No	05	SURG	MAJOR CARDIOVASC PROCEDURES W MCC OR THORACIC AORTIC ANEURYSM REPAIR	5.1927	7.1	10.2
238	No	No	05	SURG	MAJOR CARDIOVASC PROCEDURES W/O MCC	3.1008	2.9	4.2
239	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.5646	11.3	14.3
240	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.6639	7.8	9.6
241	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.4626	5.0	6.0
242	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.7327	6.3	8.1
243	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.6570	3.8	4.9
244	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.0486	2.2	2.8
245	No	No	05	SURG	AICD GENERATOR PROCEDURES	4.2684	2.5	3.8
246	No	No	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	3.1923	3.5	5.0
247	No	No	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	1.9812	1.8	2.3
248	No	No	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	2.9295	4.4	6.0
249	No	No	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.7814	2.2	2.8
250	No	No	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.8844	5.0	7.0
251	No	No	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.8040	2.1	2.9
252	No	No	05	SURG	OTHER VASCULAR PROCEDURES W MCC	2.9853	5.2	7.9
253	No	No	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.4104	4.4	6.0
254	No	No	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.6244	2.0	2.7
255	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.4930	7.0	9.2
256	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.5992	5.6	7.0
257	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	0.9629	3.4	4.3
258	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	2.8707	5.2	7.0
259	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	1.8381	2.4	3.2
260	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.5636	7.7	10.8
261	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.6515	3.2	4.5
262	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.1284	2.0	2.6
263	No	No	05	SURG	VEIN LIGATION & STRIPPING	1.7560	3.5	5.6
264	Yes	No	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.5446	5.5	8.3
265	No	No	05	SURG	AICD LEAD PROCEDURES	2.3205	2.2	3.3
280	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.8435	5.2	6.6
281	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	1.1852	3.6	4.4

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282	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.8042	2.2	2.8
283	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.7107	3.2	5.1
284	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.8884	2.1	3.0
285	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5717	1.4	1.8
286	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	1.9978	4.8	6.5
287	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.0876	2.5	3.2
288	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	2.9607	8.6	10.9
289	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.8355	6.4	7.8
290	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.2880	4.4	5.6
291	Yes	No	05	MED	HEART FAILURE & SHOCK W MCC	1.4882	4.8	6.2
292	Yes	No	05	MED	HEART FAILURE & SHOCK W CC	1.0245	4.0	4.9
293	Yes	No	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6810	2.8	3.3
294	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	1.0394	4.4	5.4
295	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.6356	3.4	4.0
296	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC	1.1698	1.8	2.8
297	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6844	1.4	1.8
298	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4523	1.1	1.2
299	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4050	4.7	6.1
300	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9737	3.9	4.9
301	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.6579	2.8	3.5
302	No	No	05	MED	ATHEROSCLEROSIS W MCC	0.9712	3.0	4.0
303	No	No	05	MED	ATHEROSCLEROSIS W/O MCC	0.5804	2.0	2.4
304	No	No	05	MED	HYPERTENSION W MCC	1.0182	3.5	4.5
305	No	No	05	MED	HYPERTENSION W/O MCC	0.6117	2.2	2.7
306	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.4681	4.4	5.9
307	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.7927	2.7	3.4
308	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2270	4.0	5.2
309	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8331	3.0	3.7
310	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5670	2.1	2.5
311	No	No	05	MED	ANGINA PECTORIS	0.5038	1.8	2.2
312	No	No	05	MED	SYNCOPE & COLLAPSE	0.7136	2.4	2.9
313	No	No	05	MED	CHEST PAIN	0.5481	1.7	2.1
314	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1.8232	5.0	6.9
315	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9645	3.3	4.2
316	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.6124	2.1	2.6
326	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	5.8087	12.6	16.3
327	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.7293	6.9	8.8
328	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.4363	2.9	3.8
329	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	5.2995	12.5	15.4
330	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.5865	7.8	9.1
331	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6299	4.8	5.3
332	Yes	No	06	SURG	RECTAL RESECTION W MCC	4.8539	11.8	14.2
333	Yes	No	06	SURG	RECTAL RESECTION W CC	2.5015	7.1	8.1
334	Yes	No	06	SURG	RECTAL RESECTION W/O CC/MCC	1.5980	4.2	4.9
335	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.2742	11.4	13.7
336	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.3459	7.2	8.8
337	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.4851	4.0	5.1
338	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	3.2121	8.3	10.0
339	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG	1.8691	5.6	6.5

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					W CC			
340	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.2447	3.2	3.7
341	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.2602	4.9	6.6
342	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.3301	3.0	3.8
343	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0.9636	1.7	2.0
344	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	3.1533	8.9	11.2
345	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6999	6.0	7.0
346	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.1887	4.2	4.6
347	No	No	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.4021	6.3	8.8
348	No	No	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3720	4.1	5.4
349	No	No	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.7996	2.3	2.9
350	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.4467	5.6	7.8
351	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.3581	3.5	4.5
352	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	0.8651	1.9	2.4
353	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.7608	6.3	8.4
354	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.5574	4.0	5.0
355	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	1.0383	2.3	2.8
356	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	4.0301	9.2	12.7
357	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1501	5.7	7.4
358	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3042	3.0	4.0
368	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.7585	5.1	6.7
369	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.0755	3.7	4.5
370	No	No	06	MED	MAJOR ESOPHAGEAL	0.7497	2.6	3.1

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					DISORDERS W/O CC/MCC			
371	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	2.0998	6.8	8.9
372	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.2891	5.3	6.5
373	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.8543	3.9	4.6
374	Yes	No	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0619	6.3	8.5
375	Yes	No	06	MED	DIGESTIVE MALIGNANCY W CC	1.2773	4.4	5.8
376	Yes	No	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.8405	2.8	3.6
377	Yes	No	06	MED	G.I. HEMORRHAGE W MCC	1.7496	5.0	6.4
378	Yes	No	06	MED	G.I. HEMORRHAGE W CC	1.0235	3.5	4.2
379	Yes	No	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.7107	2.6	3.0
380	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.9498	5.8	7.5
381	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W CC	1.1172	3.9	4.8
382	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.8117	2.9	3.5
383	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.1936	4.2	5.3
384	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8308	3.0	3.6
385	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.9145	6.3	8.4
386	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W CC	1.0439	4.2	5.3
387	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.7775	3.2	3.9
388	Yes	No	06	MED	G.I. OBSTRUCTION W MCC	1.6490	5.5	7.2
389	Yes	No	06	MED	G.I. OBSTRUCTION W CC	0.9323	3.9	4.8
390	Yes	No	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.6361	2.8	3.3
391	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.1553	3.9	5.2
392	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7152	2.8	3.4
393	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.6569	4.9	6.9
394	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9917	3.7	4.7
395	No	No	06	MED	OTHER DIGESTIVE SYSTEM	0.6717	2.5	3.1

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					DIAGNOSES W/O CC/MCC			
405	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.6074	12.0	15.9
406	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.7826	6.5	8.4
407	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	1.8691	4.2	5.2
408	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	3.9590	11.0	13.5
409	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.4837	7.4	8.9
410	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.6208	4.9	5.8
411	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.6953	9.9	11.8
412	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.5380	7.0	8.3
413	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.7385	4.5	5.4
414	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.6719	9.3	11.4
415	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.1000	6.2	7.3
416	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.3123	3.7	4.4
417	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.5055	6.2	7.8
418	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.7047	4.4	5.4
419	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.1754	2.4	3.0
420	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	3.6914	9.2	13.1
421	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.8890	5.1	7.0
422	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.2777	3.1	4.1
423	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	4.4476	10.9	14.4
424	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.4219	7.1	9.1
425	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.6265	4.5	5.7
432	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.6939	4.9	6.5
433	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	0.9487	3.6	4.6
434	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6116	2.5	3.2
435	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.8035	5.6	7.4
436	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.2175	4.2	5.5
437	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.8973	2.8	3.7
438	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.8265	5.4	7.5
439	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	1.0081	4.0	5.0
440	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6878	2.9	3.5
441	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.8335	5.2	7.1
442	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9843	3.7	4.8
443	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6578	2.7	3.3
444	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.5571	4.8	6.2
445	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0681	3.6	4.5
446	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7404	2.5	3.1
453	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	10.3048	10.7	13.5
454	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	7.3001	5.5	6.8
455	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL	5.4796	3.1	3.8

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					FUSION W/O CC/MCC			
456	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	9.2948	10.8	13.5
457	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC	6.2478	5.9	7.0
458	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC	4.9778	3.5	4.1
459	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.5382	7.4	9.1
460	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	3.9004	3.3	3.9
461	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.9653	6.7	8.3
462	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.3634	3.7	4.1
463	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	4.9853	11.1	15.1
464	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.8664	6.9	8.9
465	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.7885	4.1	5.3
466	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	4.9381	7.3	9.0
467	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.2568	4.3	5.0
468	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.5912	3.3	3.6
469	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	3.4827	6.7	8.0
470	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.1173	3.4	3.7
471	No	No	08	SURG	CERVICAL SPINAL FUSION W MCC	4.7410	6.6	9.3
472	No	No	08	SURG	CERVICAL SPINAL FUSION W CC	2.7945	2.6	3.8
473	No	No	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.0987	1.5	1.9
474	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.5131	9.2	12.0
475	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	1.9640	6.1	7.7
476	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	0.9985	3.2	4.1
477	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.3163	8.9	11.1
478	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.2598	5.3	6.9
479	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.6417	2.4	3.4
480	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0913	7.7	9.0
481	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	1.8944	5.1	5.6
482	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.5431	4.1	4.5
483	Yes	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W CC/MCC	2.4235	3.1	3.7
484	Yes	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W/O CC/MCC	1.9713	2.0	2.2
485	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.1808	9.0	10.9
486	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.0450	6.1	7.2
487	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.4752	4.4	5.1
488	Yes	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	1.7294	3.8	4.7
489	Yes	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2220	2.5	2.9
490	No	No	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	1.7996	3.0	4.3
491	No	No	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	0.9982	1.7	2.1
492	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	3.0748	6.8	8.6
493	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR	1.8573	4.2	5.0

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					W CC			
494	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.3220	2.7	3.1
495	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	2.8691	7.6	10.2
496	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.6275	4.1	5.4
497	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.0813	2.0	2.6
498	No	No	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	1.9968	5.4	7.3
499	No	No	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	0.9936	2.2	3.0
500	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W MCC	3.0486	7.7	10.5
501	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5858	4.6	6.0
502	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	1.0354	2.3	2.8
503	No	No	08	SURG	FOOT PROCEDURES W MCC	2.2681	6.5	8.4
504	No	No	08	SURG	FOOT PROCEDURES W CC	1.5696	5.0	6.2
505	No	No	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.0792	2.5	3.1
506	No	No	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.1834	2.7	3.8
507	No	No	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.8823	3.4	4.5
508	No	No	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.4101	1.7	2.1
509	No	No	08	SURG	ARTHROSCOPY	1.3044	2.3	3.5
510	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.1698	5.0	6.3
511	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.4748	3.2	3.9
512	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.0533	1.8	2.1
513	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.3000	3.5	4.8
514	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.8215	2.1	2.6
515	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.1992	7.7	9.9
516	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9292	4.7	5.9
517	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.4856	2.6	3.4
533	Yes	No	08	MED	FRACTURES OF FEMUR W MCC	1.5545	4.9	6.5
534	Yes	No	08	MED	FRACTURES OF FEMUR W/O MCC	0.7576	3.1	3.9
535	Yes	No	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.3495	4.5	5.8
536	Yes	No	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7175	3.2	3.7
537	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.8242	3.5	4.1
538	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.6060	2.6	3.0
539	Yes	No	08	MED	OSTEOMYELITIS W MCC	2.0525	7.1	9.5
540	Yes	No	08	MED	OSTEOMYELITIS W CC	1.3139	5.4	6.8
541	Yes	No	08	MED	OSTEOMYELITIS W/O CC/MCC	0.8733	3.7	4.8
542	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.9499	6.3	8.3
543	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.1564	4.5	5.6
544	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7753	3.4	4.0
545	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.5453	6.3	9.0
546	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.1596	4.2	5.3
547	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.7297	2.9	3.5
548	No	No	08	MED	SEPTIC ARTHRITIS W MCC	1.9836	6.6	8.7
549	No	No	08	MED	SEPTIC ARTHRITIS W CC	1.2003	4.8	6.1
550	No	No	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.8223	3.3	4.0
551	Yes	No	08	MED	MEDICAL BACK PROBLEMS W MCC	1.6337	5.2	6.8
552	Yes	No	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.8160	3.3	4.0

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
553	No	No	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.1369	4.3	5.6
554	No	No	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.6774	3.0	3.6
555	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	1.0941	3.6	4.8
556	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.6536	2.5	3.2
557	Yes	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.5997	5.4	6.9
558	Yes	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8796	3.6	4.3
559	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.7624	5.2	7.1
560	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	0.9992	3.6	4.6
561	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.6201	2.0	2.6
562	Yes	No	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.3925	4.5	5.9
563	Yes	No	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.7120	3.0	3.6
564	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.4686	5.0	6.6
565	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9051	3.7	4.6
566	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.6592	2.7	3.4
573	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W MCC	3.2654	9.2	12.6
574	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.8708	6.7	8.5
575	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC/MCC	1.0915	4.2	5.2
576	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W MCC	3.9309	9.1	13.0
577	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W CC	1.7025	4.1	6.2
578	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.0505	2.4	3.3
579	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.9643	7.7	10.5
580	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.4993	3.8	5.4
581	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	0.9301	1.8	2.4
582	No	No	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.0633	2.0	2.7
583	No	No	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	0.8543	1.5	1.7
584	No	No	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.5258	3.5	5.0
585	No	No	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.0568	1.7	2.1
592	Yes	No	09	MED	SKIN ULCERS W MCC	1.7757	6.2	8.3
593	Yes	No	09	MED	SKIN ULCERS W CC	1.0631	4.8	5.9
594	Yes	No	09	MED	SKIN ULCERS W/O CC/MCC	0.7550	3.6	4.7
595	No	No	09	MED	MAJOR SKIN DISORDERS W MCC	1.8752	5.9	7.9
596	No	No	09	MED	MAJOR SKIN DISORDERS W/O MCC	0.8700	3.7	4.6
597	No	No	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.5651	5.5	7.5
598	No	No	09	MED	MALIGNANT BREAST DISORDERS W CC	1.0728	4.1	5.5
599	No	No	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6318	2.5	3.3
600	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9639	4.1	4.9
601	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6731	3.0	3.6
602	Yes	No	09	MED	CELLULITIS W MCC	1.4705	5.3	6.7
603	Yes	No	09	MED	CELLULITIS W/O MCC	0.8346	3.8	4.5
604	No	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.2286	3.9	5.2
605	No	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.7145	2.7	3.3
606	No	No	09	MED	MINOR SKIN DISORDERS W MCC	1.3114	4.3	6.0
607	No	No	09	MED	MINOR SKIN DISORDERS W/O	0.6803	2.8	3.6

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					MCC			
614	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURFS W CC/MCC	2.4584	4.7	6.5
615	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.3993	2.5	3.0
616	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.4871	12.5	15.6
617	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0083	6.5	7.9
618	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.2176	4.1	5.1
619	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	3.6116	4.6	7.7
620	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8814	2.6	3.4
621	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.4877	1.6	1.9
622	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.3683	9.4	12.4
623	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.8501	6.1	7.6
624	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.0337	3.9	4.8
625	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.2439	4.6	6.9
626	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.1771	2.1	3.1
627	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	0.7884	1.2	1.4
628	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.3820	7.2	10.6
629	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.2645	6.5	8.0
630	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.4425	3.4	4.5
637	Yes	No	10	MED	DIABETES W MCC	1.4431	4.5	6.0
638	Yes	No	10	MED	DIABETES W CC	0.8267	3.2	4.0
639	Yes	No	10	MED	DIABETES W/O CC/MCC	0.5508	2.3	2.8
640	Yes	No	10	MED	NUTRITIONAL & MISC	1.1361	3.6	5.1

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					METABOLIC DISORDERS W MCC			
641	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS W/O MCC	0.6887	2.9	3.6
642	No	No	10	MED	INBORN ERRORS OF METABOLISM	1.0385	3.4	4.7
643	Yes	No	10	MED	ENDOCRINE DISORDERS W MCC	1.8172	6.0	7.6
644	Yes	No	10	MED	ENDOCRINE DISORDERS W CC	1.0586	4.2	5.2
645	Yes	No	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7169	2.9	3.6
652	No	No	11	SURG	KIDNEY TRANSPLANT	3.0630	6.3	7.5
653	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W MCC	6.0950	13.6	16.6
654	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W CC	3.0117	8.2	9.3
655	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	1.9644	4.8	5.7
656	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.5861	7.7	10.1
657	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	2.0062	4.9	5.9
658	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.4305	3.0	3.4
659	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	3.5110	8.0	10.8
660	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.9077	4.5	6.0
661	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.2709	2.4	2.9
662	No	No	11	SURG	MINOR BLADDER PROCEDURES W MCC	3.0413	7.6	10.8
663	No	No	11	SURG	MINOR BLADDER PROCEDURES W CC	1.4721	3.6	5.2
664	No	No	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.1170	1.5	1.9
665	No	No	11	SURG	PROSTATECTOMY W MCC	2.8519	8.7	11.3
666	No	No	11	SURG	PROSTATECTOMY W CC	1.6440	4.5	6.4
667	No	No	11	SURG	PROSTATECTOMY W/O CC/MCC	0.7945	1.8	2.4
668	No	No	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.5102	6.6	8.9
669	No	No	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.2610	3.2	4.4

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
670	No	No	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.7790	1.8	2.3
671	No	No	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.4360	4.1	5.6
672	No	No	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	0.7921	1.8	2.2
673	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	2.9238	5.9	9.6
674	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.1004	4.6	6.7
675	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.3469	1.6	2.1
682	Yes	No	11	MED	RENAL FAILURE W MCC	1.6383	5.1	6.8
683	Yes	No	11	MED	RENAL FAILURE W CC	1.0208	4.0	4.9
684	Yes	No	11	MED	RENAL FAILURE W/O CC/MCC	0.6561	2.8	3.3
685	No	No	11	MED	ADMIT FOR RENAL DIALYSIS	0.8892	2.5	3.4
686	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.8264	5.8	7.8
687	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0822	3.8	5.0
688	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.6447	2.2	2.8
689	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.2155	4.6	5.8
690	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7838	3.4	4.1
691	No	No	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.6152	3.3	4.3
692	No	No	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1211	1.8	2.2
693	No	No	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.3487	3.9	5.2
694	No	No	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.7098	2.0	2.6
695	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.2029	4.3	5.6
696	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.6555	2.6	3.2
697	No	No	11	MED	URETHRAL STRICTURE	0.7776	2.4	3.1
698	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.6033	5.2	6.8
699	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	0.9988	3.7	4.7
700	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.6703	2.6	3.2
707	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.7846	3.2	4.2
708	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.2691	1.6	1.9
709	No	No	12	SURG	PENIS PROCEDURES W CC/MCC	1.8781	3.3	5.7
710	No	No	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.2779	1.4	1.7
711	No	No	12	SURG	TESTES PROCEDURES W CC/MCC	1.7619	5.1	7.3
712	No	No	12	SURG	TESTES PROCEDURES W/O CC/MCC	0.8121	2.1	2.7
713	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.1836	2.9	4.1
714	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.6583	1.6	1.8
715	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	1.7470	4.1	6.1
716	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	1.0022	1.2	1.4
717	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.6076	4.6	6.4
718	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	0.8033	2.0	2.6
722	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.6785	5.4	7.7
723	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	1.0170	3.9	5.1
724	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6171	2.0	2.7
725	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.2620	4.6	6.1
726	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.6977	2.8	3.5
727	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.3582	4.9	6.3
728	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.7599	3.3	4.1
729	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	0.9802	3.6	4.7
730	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6377	2.3	2.8
734	No	No	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.4243	5.1	6.9

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
735	No	No	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.1801	2.2	2.7
736	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.3876	11.5	14.0
737	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	2.0407	5.7	6.7
738	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.2377	3.2	3.6
739	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.4188	7.5	9.9
740	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.5323	3.8	4.7
741	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.1068	2.2	2.6
742	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.3971	3.2	4.1
743	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	0.9150	1.8	2.1
744	No	No	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.5367	4.0	5.6
745	No	No	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	0.8077	1.9	2.4
746	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.3373	3.0	4.2
747	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.8929	1.5	1.8
748	No	No	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.9231	1.4	1.7
749	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.5219	6.2	8.5
750	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	0.9389	2.2	2.8
754	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	2.0061	6.4	8.8
755	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1371	4.0	5.3
756	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6370	2.3	3.1
757	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.6490	6.0	7.8
758	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0895	4.7	5.7
759	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7344	3.3	4.0
760	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.8298	2.9	3.8
761	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.5246	1.8	2.2
765	No	No	14	SURG	CESAREAN SECTION W CC/MCC	1.1316	3.9	4.9
766	No	No	14	SURG	CESAREAN SECTION W/O CC/MCC	0.8063	2.9	3.1
767	No	No	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.9173	2.4	2.7
768	No	No	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.8108	0.0	0.0
769	No	No	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	2.0588	3.6	5.7
770	No	No	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7140	1.6	2.1
774	No	No	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.6894	2.6	3.2
775	No	No	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.5276	2.1	2.3
776	No	No	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6419	2.6	3.3
777	No	No	14	MED	ECTOPIC PREGNANCY	0.7401	1.7	2.1
778	No	No	14	MED	THREATENED ABORTION	0.4880	2.0	3.2
779	No	No	14	MED	ABORTION W/O D&C	0.5637	1.6	2.1
780	No	No	14	MED	FALSE LABOR	0.2277	1.2	1.6
781	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.6807	2.7	3.8
782	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4731	1.9	2.6
789	No	No	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.4874	0.0	0.0
790	No	No	15	MED	EXTREME IMMATURITY OR	4.9049	0.0	0.0

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					RESPIRATORY DISTRESS SYNDROME, NEONATE			
791	No	No	15	MED	PREMATURITY W MAJOR PROBLEMS	3.3499	0.0	0.0
792	No	No	15	MED	PREMATURITY W/O MAJOR PROBLEMS	2.0213	0.0	0.0
793	No	No	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.4411	0.0	0.0
794	No	No	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.2179	0.0	0.0
795	No	No	15	MED	NORMAL NEWBORN	0.1649	0.0	0.0
799	No	No	16	SURG	SPLENECTOMY W MCC	4.9483	10.4	13.4
800	No	No	16	SURG	SPLENECTOMY W CC	2.6030	5.9	7.5
801	No	No	16	SURG	SPLENECTOMY W/O CC/MCC	1.5588	3.1	3.9
802	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.6327	8.6	12.2
803	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.8899	4.9	6.5
804	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.0419	2.3	3.0
808	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.1429	6.3	8.2
809	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.1935	4.0	5.1
810	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.9204	3.0	3.7
811	No	No	16	MED	RED BLOOD CELL DISORDERS W MCC	1.2574	3.9	5.3
812	No	No	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.7996	2.8	3.7
813	No	No	16	MED	COAGULATION DISORDERS	1.4355	3.6	5.0
814	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.6466	5.0	6.9
815	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9989	3.6	4.6
816	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.6826	2.6	3.2
820	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.7484	13.2	17.5
821	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.3960	5.3	7.4
822	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2251	2.3	3.1
823	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	4.5904	12.2	16.0
824	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.3004	6.6	8.7
825	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	1.2439	2.7	3.9
826	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	4.8575	11.2	14.8
827	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.1547	5.3	6.9
828	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.3894	3.0	3.8
829	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC	2.7281	6.2	9.3
830	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	1.0911	2.3	3.1
834	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	4.9043	10.1	16.2
835	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.4310	5.7	9.3
836	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.1364	3.0	4.4
837	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	6.6543	17.9	23.6
838	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	3.1384	8.1	12.3
839	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.2874	4.6	5.7
840	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	2.9245	7.8	10.6
841	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6376	5.1	6.8
842	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	1.0382	3.2	4.2
843	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W	1.8400	6.0	8.0

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					MCC			
844	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.1895	4.3	5.6
845	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8099	2.9	3.8
846	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.1885	5.4	8.0
847	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	0.9901	2.8	3.4
848	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.8070	2.4	3.0
849	No	No	17	MED	RADIOTHERAPY	1.2501	4.4	6.0
853	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.5154	12.1	15.7
854	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.7976	8.2	10.0
855	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.3920	3.9	5.4
856	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	5.1335	11.2	15.0
857	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.1011	6.2	7.9
858	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3079	4.1	5.1
862	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.9553	5.8	7.8
863	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.9765	4.0	4.9
864	No	No	18	MED	FEVER	0.8255	3.0	3.8
865	No	No	18	MED	VIRAL ILLNESS W MCC	1.5524	4.5	6.4
866	No	No	18	MED	VIRAL ILLNESS W/O MCC	0.7420	2.8	3.5
867	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.4723	6.8	9.2
868	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES	1.1597	4.3	5.4

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					DIAGNOSES W CC			
869	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7183	3.0	3.6
870	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	5.8105	12.8	15.2
871	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.9056	5.4	7.2
872	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.1522	4.5	5.4
876	No	No	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.8176	8.1	12.7
880	No	No	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6148	2.3	3.0
881	No	No	19	MED	DEPRESSIVE NEUROSES	0.6140	3.1	4.2
882	No	No	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.6250	3.1	4.3
883	No	No	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.0741	4.9	7.7
884	Yes	No	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.9345	4.0	5.4
885	No	No	19	MED	PSYCHOSES	0.8920	5.4	7.4
886	No	No	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.8253	3.9	6.2
887	No	No	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.7744	2.9	4.0
894	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4007	2.1	2.9
895	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	1.0145	8.5	10.9
896	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.4528	4.7	6.5
897	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.6413	3.2	4.0
901	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	3.9427	9.1	14.1
902	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.7989	5.4	7.5
903	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.0616	3.3	4.4
904	No	No	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	3.0388	7.3	11.1

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
905	No	No	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.1720	3.4	4.5
906	No	No	21	SURG	HAND PROCEDURES FOR INJURIES	1.0393	2.1	3.1
907	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	3.8155	7.8	11.1
908	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.9277	4.7	6.3
909	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.1622	2.6	3.4
913	No	No	21	MED	TRAUMATIC INJURY W MCC	1.3305	4.0	5.6
914	No	No	21	MED	TRAUMATIC INJURY W/O MCC	0.6943	2.5	3.2
915	No	No	21	MED	ALLERGIC REACTIONS W MCC	1.4162	3.6	5.1
916	No	No	21	MED	ALLERGIC REACTIONS W/O MCC	0.4820	1.7	2.1
917	Yes	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4814	3.7	5.1
918	Yes	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.6234	2.1	2.7
919	No	No	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.5999	4.4	6.2
920	No	No	21	MED	COMPLICATIONS OF TREATMENT W CC	0.9760	3.2	4.3
921	No	No	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.6179	2.2	2.8
922	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.3409	3.8	5.4
923	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.6742	2.3	3.2
927	No	No	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	12.6506	21.8	28.2
928	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	4.7191	10.8	14.9
929	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.0261	5.3	7.7
933	No	No	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	2.2750	2.3	5.2
934	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	1.3530	4.1	5.8
935	No	No	22	MED	NON-EXTENSIVE BURNS	1.2817	3.5	5.2
939	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	2.8683	6.8	10.0
940	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	1.6847	3.6	5.4
941	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.1488	2.0	2.6
945	Yes	No	23	MED	REHABILITATION W CC/MCC	1.2883	8.3	10.2
946	Yes	No	23	MED	REHABILITATION W/O CC/MCC	1.1140	6.6	7.5
947	Yes	No	23	MED	SIGNS & SYMPTOMS W MCC	1.0970	3.7	4.9
948	Yes	No	23	MED	SIGNS & SYMPTOMS W/O MCC	0.6840	2.7	3.4
949	No	No	23	MED	AFTERCARE W CC/MCC	0.9823	2.6	4.3
950	No	No	23	MED	AFTERCARE W/O CC/MCC	0.4983	2.1	2.8
951	No	No	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.6963	2.2	4.5
955	No	No	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.4991	9.0	12.6
956	Yes	No	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.3461	7.0	8.4
957	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	6.3035	10.2	14.3
958	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	3.8041	7.6	9.5
959	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.2479	4.5	5.6
963	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.8145	6.0	8.7
964	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.4818	4.5	5.6
965	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9316	3.1	3.8
969	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.5054	12.1	17.1
970	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.7380	6.3	8.7
974	No	No	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.5819	6.9	9.6
975	No	No	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.3551	5.1	6.6
976	No	No	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.9004	3.5	4.4
977	No	No	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0398	3.6	4.9
981	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	5.0726	11.0	14.1
982	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL	2.9434	6.8	8.7

MS-DRG	FY 2011 Proposed Rule Post-Acute DRG	FY 2011 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					DIAGNOSIS W CC			
983	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.7800	3.1	4.2
984	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3086	10.5	13.3
985	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.1518	6.9	9.0
986	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.1129	2.8	4.1
987	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.4500	9.3	12.2
988	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.8721	5.6	7.4
989	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.0568	2.5	3.5
998	No	No		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
999	No	No		**	UNGROUPABLE	0.0000	0.0	0.0

MS-DRGs 998 and 999 contain cases that could not be assigned to valid DRGs.
Note: If there is no value in either the geometric mean length of stay or the arithmetic mean length of stay columns, the volume of cases is insufficient to determine a meaningful computation of these statistics.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
237.73	Schwannomatosis	N	01	091,092,093
237.78	Other neurofibromatosis	N	01	091,092,093
275.01	Hereditary hemochromatosis	N	10	642
275.02	Hemochromatosis due to repeated red blood cell transfusions	N	10	642
275.03	Other hemochromatosis	N	10	642
275.09	Other disorders of iron metabolism	N	10	642
276.61	Transfusion associated circulatory overload	N	10 15	640,641 791[1],793[1]
276.69	Other fluid overload	N	10 15	640,641 791[1],793[1]
278.03	Obesity hypoventilation syndrome	N	04	205,206
287.41	Posttransfusion purpura	N	15 16 25	791[1],793[1] 813 977
287.49	Other secondary thrombocytopenia	N	15 16 25	791[1],793[1] 813 977
447.70	Aortic ectasia, unspecified site	N	05	299,300,301
447.71	Thoracic aortic ectasia	N	05	299,300,301
447.72	Abdominal aortic ectasia	N	05	299,300,301
447.73	Thoracoabdominal aortic ectasia	N	05	299,300,301
560.32	Fecal impaction	N	06 15	388,389,390 791[1],793[1]
724.03	Spinal stenosis, lumbar region, with neurogenic claudication	N	08	551,552
752.31	Agenesis of uterus	N	13	742,743,760,761
752.32	Hypoplasia of uterus	N	13	742,743,760,761
752.33	Unicornuate uterus	N	13	742,743,760,761
752.34	Bicornuate uterus	N	13	742,743,760,761
752.35	Septate uterus	N	13	742,743,760,761
752.36	Arcuate uterus	N	13	742,743,760,761
752.39	Other anomalies of uterus	N	13	742,743,760,761
752.43	Cervical agenesis	N	13	742,743,760,761
752.44	Cervical duplication	N	13	742,743,760,761
752.45	Vaginal agenesis	N	13	742,743,760,761

Diagnosis Code	Description	CC	MDC	MS-DRG
752.46	Transverse vaginal septum	N	13	742,743,760,761
752.47	Longitudinal vaginal septum	N	13	742,743,760,761
780.33	Post traumatic seizures	N	01	100,101
780.66	Febrile nonhemolytic transfusion reaction	N	18 25	864 977
784.92	Jaw pain	N	PRE 03	011,012,013 157,158,159
786.30	Hemoptysis, unspecified	CC	04	204
786.31	Acute idiopathic pulmonary hemorrhage in infants [AIPHI]	CC	04	204
786.39	Other hemoptysis	CC	04	204
787.60	Full incontinence of feces	N	06	391,392
787.61	Incomplete defecation	N	06	391,392
787.62	Fecal smearing	N	06	391,392
787.63	Fecal urgency	N	06	391,392
799.50	Unspecified signs and symptoms involving cognition	N	19	884
799.51	Attention or concentration deficit	N	19	886
799.52	Cognitive communication deficit	N	19	884
799.53	Visuospatial deficit	N	01	091,092,093
799.54	Psychomotor deficit	N	19	884
799.55	Frontal lobe and executive function deficit	N	19	884
799.59	Other signs and symptoms involving cognition	N	19	884
970.81	Poisoning by cocaine	N	21	917,918
970.89	Poisoning by other central nervous system stimulants	N	21	917,918
999.60	ABO incompatibility reaction, unspecified	CC	15 16	791[1],793[1] 811,812
999.61	ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed	CC	15 16	791[1],793[1] 811,812
999.62	ABO incompatibility with acute hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.63	ABO incompatibility with delayed hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.69	Other ABO incompatibility reaction	CC	15 16	791[1],793[1] 811,812
999.70	Rh incompatibility reaction, unspecified	CC	15 16	791[1],793[1] 811,812
999.71	Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed	CC	15 16	791[1],793[1] 811,812
999.72	Rh incompatibility with acute hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.73	Rh incompatibility with delayed hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.74	Other Rh incompatibility reaction	CC	15 16	791[1],793[1] 811,812
999.75	Non-ABO incompatibility reaction, unspecified	CC	15 16	791[1],793[1] 811,812
999.76	Non-ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed	CC	15 16	791[1],793[1] 811,812
999.77	Non-ABO incompatibility with acute hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.78	Non-ABO incompatibility with delayed hemolytic transfusion reaction	CC	15 16	791[1],793[1] 811,812
999.79	Other non-ABO incompatibility reaction	CC	15 16	791[1],793[1] 811,812
999.80	Transfusion reaction, unspecified	N	15 16	791[1],793[1] 811,812
999.83	Hemolytic transfusion reaction, incompatibility unspecified	CC	15 16	791[1],793[1] 811,812
999.84	Acute hemolytic transfusion reaction, incompatibilty unspecified	CC	15 16	791[1],793[1] 811,812
999.85	Delayed hemolytic transfusion reaction, incompatibility unspecified	CC	15 16	791[1],793[1] 811,812
V11.4	Personal history of combat and operational stress reaction	N	23	951

Diagnosis Code	Description	CC	MDC	MS-DRG
V13.23	Personal history of vaginal dysplasia	N	23	951
V13.24	Personal history of vulvar dysplasia	N	23	951
V13.62	Personal history of other (corrected) congenital malformations of genitourinary system	N	23	951
V13.63	Personal history of (corrected) congenital malformations of nervous system	N	23	951
V13.64	Personal history of (corrected) congenital malformations of eye, ear, face and neck	N	23	951
V13.65	Personal history of (corrected) congenital malformations of heart and circulatory system	N	23	951
V13.66	Personal history of (corrected) congenital malformations of respiratory system	N	23	951
V13.67	Personal history of (corrected) congenital malformations of digestive system	N	23	951
V13.68	Personal history of (corrected) congenital malformations of integument, limbs, and musculoskeletal system	N	23	951
V15.53	Personal history of retained foreign body fully removed	N	23	951
V25.11	Encounter for insertion of intrauterine contraceptive device	N	23	951
V25.12	Encounter for removal of intrauterine contraceptive device	N	23	951
V25.13	Encounter for removal and reinsertion of intrauterine contraceptive device	N	23	951
V49.86	Do not resuscitate status	N	23	951
V62.85	Homicidal ideation	N	23	951
V85.41	Body Mass Index 40.0-44.9, adult	CC	10	640,641
V85.42	Body Mass Index 45.0-49.9, adult	CC	10	640,641
V85.43	Body Mass Index 50.0-59.9, adult	CC	10	640,641
V85.44	Body Mass Index 60.0-69.9, adult	CC	10	640,641
V85.45	Body Mass Index 70 and over, adult	CC	10	640,641
V88.11	Acquired total absence of pancreas	N	23	951
V88.12	Acquired partial absence of pancreas	N	23	951
V90.01	Retained depleted uranium fragments	N	23	951
V90.09	Other retained radioactive fragments	N	23	951
V90.10	Retained metal fragments, unspecified	N	23	951
V90.11	Retained magnetic metal fragments	N	23	951
V90.12	Retained nonmagnetic metal fragments	N	23	951
V90.2	Retained plastic fragments	N	23	951
V90.31	Retained animal quills or spines	N	23	951
V90.32	Retained tooth	N	23	951
V90.33	Retained wood fragments	N	23	951
V90.39	Other retained organic fragments	N	23	951
V90.81	Retained glass fragments	N	23	951
V90.83	Retained stone or crystalline fragments	N	23	951
V90.89	Other specified retained foreign body	N	23	951
V90.9	Retained foreign body, unspecified material	N	23	951
V91.00	Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs	N	23	951
V91.01	Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)	N	23	951
V91.02	Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)	N	23	951
V91.03	Twin gestation, dichorionic/diamniotic (two placentae, two amniotic sacs)	N	23	951
V91.09	Twin gestation, unable to determine number of placenta and number of amniotic sacs	N	23	951
V91.10	Triplet gestation, unspecified number of placenta and unspecified number of amniotic sacs	N	23	951
V91.11	Triplet gestation, with two or more monochorionic fetuses	N	23	951
V91.12	Triplet gestation, with two or more monoamniotic fetuses	N	23	951
V91.19	Triplet gestation, unable to determine number of placenta and number of amniotic sacs	N	23	951
V91.20	Quadruplet gestation, unspecified number of placenta and unspecified number of amniotic sacs	N	23	951
V91.21	Quadruplet gestation, with two or more monochorionic fetuses	N	23	951
V91.22	Quadruplet gestation, with two or more monoamniotic fetuses	N	23	951
V91.29	Quadruplet gestation, unable to determine number of placenta and number of amniotic sacs	N	23	951
V91.90	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs	N	23	951
V91.91	Other specified multiple gestation, with two or more monochorionic fetuses	N	23	951
V91.92	Other specified multiple gestation, with two or more monoamniotic fetuses	N	23	951
V91.99	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs	N	23	951

Notes:
[1] Secondary diagnosis of major problem

TABLE 6B.—NEW PROCEDURE CODES

Procedure Code	Description	O.R.	MDC	MS-DRG
00.60	Insertion of drug-eluting stent(s) of superficial femoral artery	N		
32.27	Bronchoscopic bronchial thermoplasty, ablation of airway smooth muscle	Y	04	163,164,165
39.81	Implantation or replacement of carotid sinus stimulation device, total system	Y	05	252,253,254
39.82	Implantation or replacement of carotid sinus stimulation lead(s) only	Y	05	252,253,254
39.83	Implantation or replacement of carotid sinus stimulation pulse generator only	Y	05	252,253,254
39.84	Revision of carotid sinus stimulation lead(s) only	Y	05	252,253,254
39.85	Revision of carotid sinus stimulation pulse generator	Y	05	252,253,254
39.86	Removal of carotid sinus stimulation device, total system	Y	05	252,253,254
39.87	Removal of carotid sinus stimulation lead(s) only	Y	05	252,253,254
39.88	Removal of carotid sinus stimulation pulse generator only	Y	05	252,253,254
39.89	Other operations on carotid body, carotid sinus and other vascular bodies	Y	05	252,253,254
81.88	Reverse total shoulder replacement	Y	08 21 24	483,484 907,908,909 957,958,959

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
275.0	Disorders of iron metabolism	N	10	642
276.6	Fluid overload	N	10 15	640,641 791[1],793[1]
287.4	Secondary thrombocytopenia	N	15 16 25	791[1],793[1] 813 977
752.3	Other anomalies of uterus	N	13	742,743,760,761
786.3	Hemoptysis	CC	04	204
787.6	Incontinence of feces	N	06	391,392
970.8	Poisoning by other specified central nervous system stimulants	N	21	917,918
999.6	ABO incompatibility reaction	CC	15 16	791[1],793[1] 811,812
999.7	Rh incompatibility reaction	CC	15 16	791[1],793[1] 811,812
V25.1	Encounter for insertion of intrauterine contraceptive device	N	23	951
V85.4	Body Mass Index 40 and over, adult	CC	10	640,641

Notes:
[1] Secondary diagnosis of major problem

TABLE 6D.—INVALID PROCEDURE CODES

Procedure Code	Description	O.R.	MDC	MS-DRG
39.8	Operations on carotid body, carotid sinus and other vascular bodies	Y	01 04 05	037,038,039 166,167,168 252,253,254

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis Code	Description	CC	MDC	MS-DRG
629.81	Recurrent pregnancy loss without current pregnancy	N	13	742,743,760,761
646.30	Recurrent pregnancy loss, unspecified as to episode of care or not applicable	N	14	998
646.31	Recurrent pregnancy loss, delivered, with or without mention of antepartum condition	CC	14	765,766,767,768,774, 775
646.33	Recurrent pregnancy loss, antepartum condition or complication	N	14	781,782
724.02	Spinal stenosis, lumbar region, without neurogenic claudication	N	08	551,552
781.8	Neurologic neglect syndrome	CC	01	091,092,093
V13.61	Personal history of (corrected) hypospadias	N	23	951
V13.69	Personal history of other (corrected) congenital malformations	N	23	951
V26.35	Encounter for testing of male partner of female with recurrent pregnancy loss	N	23	951

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure Code	Description	O.R.	MDC	MS-DRG
00.55	Insertion of drug-eluting stent(s) of other peripheral vessel(s)	N		
81.80	Other total shoulder replacement	Y	08 21 24	483,484 907,908,909 957,958,959
99.14	Injection or infusion of immunoglobulin	N		

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGHTS OF STAY; FY 2009 MedPAR UPDATE – DECEMBER 2009 GROUPER V27.0 MS-DRGs

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	1,001	40.5395	12	19	31	50	80
2	239	20.7113	8	11	15	26	39
3	21,956	36.6115	15	21	30	44	63
4	21,395	27.1269	11	16	22	32	46
5	949	19.6185	6	9	14	24	41
6	348	8.3937	5	6	8	10	12
7	469	18.7058	8	11	15	23	31
8	508	11.7835	6	7	9	13	21
9	1,818	21.3311	8	15	19	25	33
10	137	9.7007	5	7	8	11	13
11	1,534	15.5782	6	8	12	19	29
12	1,895	9.9135	4	6	8	12	17
13	1,008	6.7401	3	4	6	8	11
20	1,102	17.1207	6	10	16	23	29
21	448	13.9866	7	10	14	17	22
22	146	8.3767	2	4	8	12	14
23	4,479	11.7948	2	5	9	16	23
24	1,635	7.8526	1	3	6	10	15
25	12,006	11.4943	3	6	9	15	22
26	11,045	7.2149	2	4	6	9	13
27	12,591	3.8861	1	2	3	5	7
28	1,983	13.0479	4	7	11	16	24
29	3,373	6.3409	1	3	5	8	12
30	3,432	3.2797	1	1	3	4	7
31	1,247	12.0938	2	5	9	16	24
32	2,730	5.2289	1	2	4	7	11
33	3,351	2.6640	1	1	2	3	5
34	976	6.9191	1	2	6	9	14
35	2,179	2.9849	1	1	2	4	7
36	5,732	1.5223	1	1	1	1	3
37	5,691	8.2903	2	3	7	11	17
38	13,702	3.3307	1	1	2	4	8
39	43,823	1.6743	1	1	1	2	3
40	5,628	11.7386	3	6	9	15	22
41	6,741	6.3600	1	3	5	8	12
42	3,808	3.2261	1	1	2	4	7
52	1,250	6.6328	2	3	5	7	11
53	487	3.5832	1	2	3	5	6
54	7,691	6.2942	2	3	5	8	12
55	12,545	4.5368	1	2	3	6	9
56	11,620	6.9885	2	3	5	8	13
57	40,900	4.7691	2	3	4	5	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
58	1,005	7.0537	2	3	5	8	13
59	3,138	4.9143	2	3	4	6	8
60	3,515	3.7713	1	2	3	5	6
61	2,468	8.2265	2	4	7	11	16
62	3,537	5.5785	2	3	5	7	10
63	1,309	3.9152	2	2	3	5	7
64	70,612	6.7735	2	3	5	9	13
65	102,945	4.7452	2	3	4	6	8
66	66,535	3.2734	1	2	3	4	6
67	1,959	5.2409	2	3	4	6	9
68	9,804	3.2279	1	2	3	4	6
69	92,535	2.7913	1	2	2	3	5
70	12,885	7.0182	2	3	5	9	13
71	10,469	4.8679	2	3	4	6	9
72	4,838	3.1174	1	2	2	4	6
73	11,890	5.5112	2	3	4	7	10
74	28,604	3.9747	1	2	3	5	7
75	1,348	6.9733	2	4	5	8	13
76	661	3.9259	1	2	3	5	7
77	1,834	6.4002	2	3	5	8	12
78	1,807	4.0697	1	2	3	5	7
79	774	3.0749	1	2	3	4	5
80	2,027	4.8101	1	2	4	6	9
81	5,465	3.3420	1	2	3	4	6
82	2,546	6.0361	1	1	4	8	13
83	2,422	4.5727	1	2	3	6	9
84	2,542	2.7825	1	1	2	4	5
85	8,441	6.9889	2	3	5	9	14
86	13,175	4.5672	1	2	4	6	8
87	13,012	2.9085	1	1	2	4	5
88	1,078	5.3497	2	3	4	7	10
89	2,947	3.6339	1	2	3	5	7
90	2,481	2.3136	1	1	2	3	4
91	10,887	6.0043	2	3	4	7	12
92	17,603	4.0852	1	2	3	5	7
93	13,215	2.8862	1	1	2	4	5
94	1,527	11.7394	3	6	10	15	21
95	1,085	8.1779	3	5	7	10	15
96	540	5.6667	1	4	5	7	10
97	1,324	11.4373	4	6	9	15	21
98	928	7.6185	3	4	6	10	13
99	423	5.1915	2	3	4	7	10
100	21,435	5.8217	2	3	4	7	11
101	53,878	3.3892	1	2	3	4	6
102	1,501	4.2205	1	2	3	5	9
103	12,310	3.0085	1	1	2	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
113	639	5.5994	1	2	4	7	11
114	431	2.5986	1	1	2	3	5
115	850	4.6082	1	2	4	5	7
116	455	4.4813	1	1	2	5	7
117	549	1.9872	1	1	1	1	2
121	744	5.1022	2	3	4	6	8
122	524	3.9790	1	2	3	5	7
123	2,672	2.7182	1	1	2	3	5
124	975	5.1918	1	2	4	6	10
125	4,038	3.2590	1	2	3	4	6
129	1,508	5.2454	1	2	4	7	11
130	943	2.8908	1	1	2	4	6
131	1,132	5.5998	1	2	4	7	11
132	748	2.7126	1	1	2	3	5
133	2,242	5.3965	1	2	4	7	11
134	2,627	2.0837	1	1	1	2	4
135	466	6.3112	1	2	5	9	13
136	351	2.2422	1	1	1	3	5
137	891	4.9989	1	2	4	6	10
138	747	2.4873	1	1	2	3	5
139	1,363	1.7601	1	1	1	2	3
146	841	8.6992	2	4	7	11	18
147	1,255	5.6805	1	2	4	7	11
148	552	3.3442	1	1	2	4	6
149	33,609	2.6159	1	1	2	3	5
150	1,544	4.7668	1	2	4	6	9
151	5,784	2.7934	1	1	2	4	5
152	2,893	4.1912	1	2	3	5	8
153	10,870	3.0419	1	2	2	4	5
154	3,034	5.6839	1	3	4	7	11
155	5,578	4.1133	1	2	3	5	8
156	3,515	2.8942	1	1	2	4	5
157	1,703	6.3429	2	3	5	8	13
158	3,380	4.2719	1	2	3	5	8
159	1,459	2.7347	1	1	2	3	5
163	14,398	13.8007	5	8	12	18	25
164	17,845	7.2187	3	4	6	9	13
165	10,518	4.3993	2	3	4	6	7
166	25,172	11.8608	4	6	9	15	22
167	17,710	7.0035	2	4	6	9	13
168	4,388	4.2985	1	2	3	6	8
175	16,505	6.7183	3	4	6	8	11
176	34,233	4.8503	2	3	4	6	8
177	79,035	8.4026	3	4	7	11	15
178	60,900	6.6817	3	4	6	8	12
179	16,039	4.9675	2	3	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
180	22,329	7.4210	2	4	6	9	14
181	24,506	5.3350	1	2	4	7	10
182	2,840	3.6532	1	2	3	5	7
183	3,042	6.3534	2	3	5	8	12
184	4,806	4.2239	2	3	4	5	7
185	2,187	3.0393	1	2	3	4	5
186	11,691	6.7234	2	3	5	9	13
187	9,939	4.7687	1	2	4	6	9
188	3,293	3.5299	1	2	3	4	7
189	94,058	5.5455	2	3	4	7	10
190	150,776	5.4847	2	3	5	7	10
191	136,438	4.5856	2	3	4	6	8
192	134,412	3.6580	1	2	3	5	6
193	132,433	6.3110	2	3	5	8	11
194	178,528	4.8665	2	3	4	6	8
195	87,008	3.6926	1	2	3	5	6
196	7,608	6.8980	2	4	6	9	13
197	6,141	4.9870	2	3	4	6	9
198	3,047	3.7670	1	2	3	5	7
199	4,146	7.8968	2	4	6	10	15
200	8,319	4.6915	1	2	4	6	9
201	2,745	3.5457	1	2	3	5	7
202	38,888	4.1342	1	2	3	5	7
203	28,980	3.1588	1	2	3	4	6
204	23,390	2.7325	1	1	2	3	5
205	7,730	5.2508	1	2	4	7	10
206	18,931	3.1590	1	1	3	4	6
207	36,288	14.7898	6	9	13	18	25
208	74,965	7.0337	1	3	6	9	14
215	177	12.6215	1	3	8	14	28
216	10,499	16.8419	8	10	15	21	28
217	5,948	10.3763	6	7	9	13	16
218	1,222	7.9869	5	6	7	9	12
219	14,314	12.8291	5	7	10	15	23
220	15,334	7.7011	4	5	7	9	12
221	4,475	5.9678	4	5	6	7	9
222	3,308	11.6403	4	6	10	15	21
223	3,289	5.4472	1	2	5	8	11
224	3,018	9.6156	3	5	8	12	18
225	4,209	5.0663	2	3	4	7	9
226	8,959	7.9386	1	3	6	11	16
227	28,451	2.7800	1	1	1	4	7
228	2,564	13.9961	6	8	12	17	25
229	2,590	7.9672	4	5	7	10	13
230	806	5.5186	2	4	5	7	9
231	1,473	12.8758	6	8	11	16	22

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
232	1,098	9.0674	5	6	9	11	14
233	17,629	13.4855	7	9	12	16	22
234	25,101	8.6064	5	6	8	10	13
235	11,045	10.6010	5	6	9	13	18
236	23,925	6.3642	4	5	6	7	10
237	24,161	10.0501	2	4	8	13	20
238	37,998	3.9482	1	1	3	6	8
239	12,154	14.2365	5	7	11	18	27
240	9,506	9.1471	3	5	8	11	16
241	1,552	5.9852	2	3	5	8	11
242	23,571	7.7578	2	4	6	10	14
243	35,573	4.6588	1	2	4	6	9
244	44,828	2.8119	1	1	2	4	6
245	3,970	3.8071	1	1	2	5	8
246	35,016	5.0861	1	2	4	7	10
247	139,869	2.1763	1	1	2	3	4
248	16,308	6.0738	1	3	5	8	12
249	44,453	2.6377	1	1	2	3	5
250	9,062	6.9734	2	3	5	9	14
251	35,031	2.7814	1	1	2	4	6
252	45,083	8.0234	1	3	6	10	17
253	40,080	5.6453	1	2	4	7	11
254	38,370	2.6631	1	1	2	3	6
255	2,897	9.2444	3	5	8	12	17
256	2,782	6.6618	2	3	6	8	12
257	394	4.3046	1	2	4	6	8
258	1,023	6.6970	2	3	5	8	13
259	4,793	2.9994	1	1	2	4	6
260	2,078	10.3725	3	5	8	13	21
261	3,592	4.1779	1	2	3	5	8
262	2,423	2.5815	1	1	2	3	5
263	518	5.6602	1	2	3	7	13
264	22,461	8.2590	1	3	6	11	17
265	1,714	3.3495	1	1	2	4	7
280	81,514	6.5098	2	3	5	8	12
281	41,879	4.0679	1	2	3	5	7
282	34,890	2.7555	1	1	2	4	5
283	14,231	4.9678	1	1	3	6	11
284	2,450	2.6686	1	1	1	3	6
285	1,428	1.7983	1	1	1	2	3
286	32,329	6.5479	2	3	5	8	13
287	127,613	3.0171	1	1	2	4	6
288	2,898	10.8037	4	6	9	13	19
289	979	7.2921	3	4	6	9	12
290	240	5.5792	1	3	5	7	10
291	232,185	6.1498	2	3	5	8	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
292	192,392	4.4947	2	3	4	6	8
293	118,010	3.3080	1	2	3	4	6
294	1,546	5.3668	2	3	5	7	9
295	874	4.0378	1	2	4	5	7
296	2,059	2.7071	1	1	1	3	6
297	629	1.7266	1	1	1	2	3
298	372	1.2097	1	1	1	1	1
299	26,735	6.0663	2	3	5	7	11
300	42,906	4.7095	1	3	4	6	8
301	28,789	3.4713	1	2	3	5	6
302	10,132	3.9515	1	2	3	5	7
303	50,124	2.3738	1	1	2	3	4
304	3,969	4.5382	1	2	4	6	8
305	32,236	2.6866	1	1	2	3	5
306	3,773	5.8049	2	3	4	7	11
307	5,337	3.1731	1	2	3	4	6
308	71,058	5.0115	2	2	4	6	9
309	93,276	3.6117	1	2	3	5	7
310	127,913	2.5033	1	1	2	3	4
311	15,715	2.2386	1	1	2	3	4
312	165,015	2.9422	1	1	2	4	5
313	169,337	2.0617	1	1	2	2	4
314	66,894	6.7151	2	3	5	8	13
315	25,869	4.0866	1	2	3	5	8
316	10,674	2.5722	1	1	2	3	5
326	11,940	16.0999	5	8	13	20	30
327	9,818	8.5639	2	5	7	11	16
328	8,538	3.7853	1	2	3	5	8
329	50,242	15.1759	6	8	13	19	27
330	56,158	8.8715	4	5	7	11	15
331	24,253	5.3159	3	4	5	6	8
332	1,825	13.8553	6	8	11	17	25
333	5,068	7.9820	4	5	7	10	13
334	3,027	4.9045	2	3	5	6	8
335	8,404	13.3221	5	8	12	17	23
336	12,225	8.4806	3	5	7	11	15
337	7,648	5.0911	1	3	4	7	9
338	1,571	9.6295	4	5	8	12	17
339	2,700	6.4174	3	4	6	8	11
340	3,036	3.7286	1	2	3	5	6
341	1,065	6.4939	2	3	5	9	13
342	2,745	3.6947	1	2	3	5	7
343	6,461	2.0108	1	1	2	2	4
344	1,132	10.8843	4	6	9	13	21
345	2,834	6.7759	3	4	6	8	11
346	2,591	4.6299	2	3	4	6	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
347	1,798	8.6029	2	4	6	11	17
348	3,935	5.1624	1	2	4	7	10
349	4,039	2.9153	1	1	2	4	6
350	2,080	7.5846	2	3	6	10	15
351	4,131	4.3053	1	2	4	6	8
352	6,456	2.3748	1	1	2	3	4
353	3,824	8.3227	2	4	7	11	16
354	8,960	4.8608	1	3	4	6	9
355	12,947	2.7752	1	1	2	4	5
356	8,909	12.3348	3	6	9	15	24
357	6,591	7.0678	2	4	6	9	13
358	2,045	4.0088	1	2	3	5	8
368	4,134	6.3464	2	3	5	8	12
369	4,797	4.3688	2	2	4	5	8
370	1,777	3.0833	1	2	3	4	5
371	30,894	8.3267	3	4	6	10	16
372	26,332	6.3285	2	4	5	8	11
373	11,202	4.5867	2	3	4	6	8
374	9,912	8.1968	2	4	6	10	16
375	15,328	5.5969	2	3	4	7	10
376	2,537	3.5861	1	2	3	4	6
377	68,239	6.0023	2	3	5	7	11
378	118,605	4.0662	2	2	3	5	7
379	50,778	3.0378	1	2	3	4	5
380	3,797	7.0608	2	3	5	9	13
381	5,326	4.6707	2	3	4	6	8
382	2,708	3.4830	1	2	3	4	6
383	1,656	5.0290	2	3	4	6	9
384	6,876	3.5609	1	2	3	4	6
385	3,198	7.6826	2	4	6	9	15
386	8,050	5.1593	2	3	4	6	9
387	4,132	3.9131	1	2	3	5	7
388	26,490	6.7018	2	3	5	8	13
389	47,015	4.6775	2	3	4	6	8
390	39,806	3.3390	1	2	3	4	6
391	61,486	4.9306	1	2	4	6	9
392	232,434	3.3799	1	2	3	4	6
393	27,251	6.6114	2	3	5	8	13
394	43,392	4.5431	1	2	4	6	8
395	20,065	3.0842	1	2	3	4	6
405	4,575	15.7388	5	8	12	20	31
406	4,893	8.1721	2	5	7	10	15
407	1,927	5.1520	1	3	5	7	8
408	1,640	13.2659	5	7	11	17	24
409	1,299	8.6343	3	5	7	11	15
410	475	5.8400	2	4	5	7	10

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
411	840	11.7000	5	7	10	14	21
412	780	8.0923	3	5	7	10	13
413	524	5.4027	2	3	5	7	9
414	5,253	11.1961	4	6	9	14	20
415	5,229	7.0692	3	4	6	9	12
416	3,992	4.3790	2	3	4	5	7
417	20,292	7.7720	3	4	6	10	14
418	24,952	5.1565	2	3	4	7	9
419	28,245	3.0297	1	1	2	4	6
420	774	13.0530	3	6	10	17	26
421	846	6.5910	1	3	5	9	13
422	234	4.1068	1	2	3	5	8
423	1,617	14.1472	4	7	11	18	28
424	672	8.6577	3	4	7	11	16
425	86	5.6860	2	3	4	7	10
432	13,529	6.4975	2	3	5	8	13
433	6,969	4.3401	1	2	4	5	8
434	398	3.1734	1	2	3	4	6
435	13,761	7.2943	2	3	6	9	14
436	11,039	5.3120	2	3	4	7	10
437	2,182	3.6856	1	2	3	5	7
438	19,674	7.0637	2	3	5	9	14
439	23,206	4.8099	2	3	4	6	9
440	20,560	3.4957	1	2	3	4	6
441	18,105	6.8437	2	3	5	8	14
442	14,938	4.5243	1	2	4	6	8
443	4,688	3.3057	1	2	3	4	6
444	14,810	6.1409	2	3	5	8	11
445	16,827	4.3909	1	2	4	6	8
446	12,789	3.0593	1	2	3	4	6
453	1,255	13.0876	5	6	10	16	25
454	2,962	6.6357	3	4	5	8	12
455	2,482	3.7526	1	2	3	5	6
456	1,241	13.1475	5	7	10	16	24
457	3,086	6.8568	3	4	6	8	12
458	1,565	4.0505	2	3	4	5	7
459	4,695	8.6505	3	5	7	10	16
460	60,945	3.8373	2	2	3	5	6
461	947	7.2893	3	4	6	8	13
462	11,067	4.0499	3	3	3	4	6
463	6,113	14.7572	4	7	11	18	29
464	7,907	8.5108	3	4	7	10	16
465	2,708	5.2688	2	3	4	6	9
466	4,780	8.5090	3	4	7	10	15
467	19,097	4.8438	3	3	4	6	8
468	15,812	3.5808	2	3	3	4	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
469	35,893	7.4293	3	4	6	9	13
470	404,338	3.6454	2	3	3	4	5
471	2,991	9.2207	2	4	7	13	18
472	8,421	3.6774	1	1	2	5	8
473	25,112	1.8500	1	1	1	2	3
474	3,277	11.8758	4	6	9	15	22
475	3,428	7.3629	2	4	6	9	14
476	1,134	4.0908	1	2	3	5	8
477	3,256	10.7457	4	6	9	13	19
478	8,249	6.6555	1	3	6	9	12
479	5,867	3.3936	1	1	2	5	7
480	31,193	8.4968	4	5	7	10	15
481	74,874	5.4504	3	4	5	6	8
482	33,902	4.4797	3	3	4	5	7
483	10,324	3.7260	2	2	3	4	7
484	18,014	2.1959	1	1	2	3	3
485	1,261	10.5147	4	6	8	13	19
486	2,153	7.0060	3	4	6	8	12
487	1,058	5.0888	2	3	4	6	8
488	3,248	4.6918	2	3	3	5	8
489	4,902	2.8499	1	2	3	3	5
490	22,903	4.2505	1	2	3	5	9
491	45,224	2.0655	1	1	1	3	4
492	6,706	8.1353	3	4	7	10	15
493	18,839	4.8463	2	3	4	6	8
494	25,249	3.1465	1	2	3	4	5
495	1,890	9.9476	3	5	8	12	19
496	4,609	5.1833	1	2	4	7	10
497	5,130	2.5558	1	1	2	3	5
498	1,481	7.2552	2	3	6	9	14
499	876	2.9920	1	1	2	3	5
500	2,283	10.1783	3	5	8	13	20
501	4,635	5.7282	2	3	5	7	11
502	5,741	2.8021	1	1	2	3	5
503	1,174	8.4361	3	4	7	11	16
504	2,548	5.9863	2	3	5	8	11
505	2,256	3.1272	1	1	3	4	6
506	717	3.7992	1	1	3	5	8
507	940	4.5160	1	2	3	5	9
508	1,782	2.0561	1	1	2	3	3
509	349	3.4699	1	1	2	4	7
510	1,275	6.1569	2	3	5	8	11
511	4,095	3.8112	1	2	3	5	7
512	8,255	2.1474	1	1	2	3	4
513	1,248	4.8205	1	2	4	6	9
514	921	2.6406	1	1	2	3	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
515	4,912	9.3950	3	5	8	11	17
516	11,267	5.7698	2	3	5	7	10
517	11,169	3.3660	1	1	3	5	7
533	1,004	6.2490	2	3	5	8	12
534	3,277	3.8145	1	2	3	5	7
535	9,037	5.5860	2	3	4	7	10
536	31,028	3.6752	1	3	3	4	6
537	944	4.0911	2	3	3	5	7
538	708	3.0494	1	2	3	4	5
539	3,683	9.2359	3	5	7	11	16
540	3,800	6.6839	2	4	5	8	11
541	1,124	4.8488	1	2	4	6	8
542	7,101	7.9687	3	4	6	10	15
543	15,205	5.5178	2	3	4	7	10
544	6,624	4.0503	2	3	3	5	7
545	4,543	8.6212	2	4	6	11	18
546	5,210	5.0029	2	3	4	6	9
547	3,348	3.5358	1	2	3	4	6
548	728	8.6181	3	4	7	10	16
549	1,066	5.7645	2	3	5	7	10
550	556	4.0108	1	2	3	5	7
551	14,610	6.4630	2	3	5	8	12
552	73,510	3.8977	1	2	3	5	7
553	4,040	5.3376	2	3	4	6	9
554	15,436	3.4756	1	2	3	4	6
555	3,445	4.7660	1	2	4	6	9
556	16,663	3.1124	1	2	3	4	6
557	6,796	6.2217	2	3	5	7	11
558	14,146	4.1105	2	3	4	5	7
559	2,281	6.9833	2	3	5	9	14
560	4,922	4.5211	1	2	4	6	8
561	5,314	2.6314	1	1	2	3	5
562	7,806	5.6471	2	3	4	7	10
563	30,486	3.4819	1	2	3	4	6
564	2,149	6.4044	2	3	5	8	12
565	3,699	4.5250	1	3	4	6	8
566	1,759	3.4179	1	2	3	4	6
573	5,749	12.2113	4	6	9	14	23
574	9,057	8.3095	3	4	7	10	15
575	3,721	5.1774	2	3	4	7	9
576	780	12.9000	3	5	9	17	26
577	2,280	5.7974	1	2	4	7	12
578	2,530	3.2573	1	1	2	4	6
579	4,595	10.2448	3	5	8	13	19
580	10,731	5.0932	1	2	4	7	10
581	10,753	2.3869	1	1	2	3	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
582	4,901	2.6566	1	1	2	3	5
583	7,581	1.7392	1	1	1	2	3
584	862	4.9617	1	2	4	7	10
585	1,462	2.1382	1	1	1	3	4
592	4,964	7.9746	2	4	6	9	14
593	10,203	5.7727	2	3	5	7	10
594	1,483	4.6703	1	2	4	6	8
595	1,674	7.2832	2	4	6	9	14
596	4,415	4.4208	1	2	4	5	8
597	695	7.5007	2	3	6	9	13
598	1,384	5.2854	1	2	4	7	10
599	185	3.2757	1	1	3	4	5
600	1,034	4.9207	2	3	4	6	9
601	778	3.6157	1	2	3	5	6
602	33,771	6.4584	2	3	5	8	12
603	127,084	4.4100	2	3	4	5	8
604	3,668	4.9738	1	2	4	6	9
605	19,162	3.2558	1	2	3	4	6
606	2,247	5.6805	1	3	4	7	11
607	6,374	3.4934	1	2	3	4	6
614	1,706	6.5774	2	3	5	8	13
615	1,449	2.9717	1	2	3	4	5
616	1,678	15.5936	6	8	13	19	28
617	6,516	7.8996	3	4	7	10	14
618	148	5.1419	2	3	4	6	9
619	1,009	7.3310	1	2	4	8	15
620	2,993	3.1617	1	2	2	4	6
621	11,368	1.8438	1	1	2	2	3
622	1,232	12.1640	4	6	9	14	22
623	2,455	7.5825	3	4	6	9	13
624	236	4.8347	2	3	4	6	8
625	1,309	7.0963	1	2	5	9	15
626	2,852	2.8159	1	1	2	3	6
627	12,254	1.4115	1	1	1	1	2
628	3,718	10.5662	2	4	8	13	20
629	4,451	7.9232	3	4	7	10	14
630	446	4.4619	1	2	3	6	8
637	26,230	5.4669	2	3	4	7	10
638	46,738	3.9819	1	2	3	5	7
639	24,880	2.8062	1	1	2	3	5
640	79,621	4.7818	1	2	3	6	9
641	164,528	3.5115	1	2	3	4	6
642	1,603	4.7436	1	2	3	6	9
643	7,683	7.2309	2	4	6	9	13
644	11,845	5.0712	2	3	4	6	9
645	6,422	3.5668	1	2	3	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
652	10,211	7.5052	4	5	6	8	13
653	2,013	15.8987	6	8	13	20	29
654	3,404	9.0858	5	6	8	11	15
655	1,275	5.6549	2	4	6	7	9
656	4,888	9.4728	3	5	7	11	18
657	7,350	5.3278	2	3	5	6	9
658	6,807	3.3676	1	2	3	4	5
659	5,503	10.1098	3	4	8	13	20
660	7,095	5.6238	2	3	4	7	11
661	3,862	2.8933	1	2	2	4	5
662	1,015	10.2749	2	4	8	12	21
663	1,820	4.8462	1	2	3	6	10
664	3,282	1.8525	1	1	1	2	3
665	884	10.5271	3	5	9	13	20
666	1,878	5.9361	1	2	4	8	12
667	2,595	2.3680	1	1	2	3	4
668	5,500	7.7095	2	3	6	10	15
669	12,259	4.0007	1	2	3	5	8
670	8,764	2.2913	1	1	2	3	5
671	799	5.5920	1	2	4	7	11
672	635	2.2000	1	1	2	3	4
673	12,494	9.5253	1	3	7	12	20
674	8,802	6.5558	1	2	5	9	14
675	3,252	2.1125	1	1	1	2	5
682	102,211	6.7567	2	3	5	8	13
683	114,329	4.9315	2	3	4	6	9
684	26,729	3.3482	1	2	3	4	6
685	2,513	3.3979	1	1	2	4	7
686	1,940	7.0340	2	3	5	9	14
687	2,618	4.6902	1	2	4	6	8
688	706	2.8031	1	1	2	3	5
689	89,105	5.4897	2	3	4	7	10
690	185,262	3.9692	2	2	3	5	7
691	999	4.3053	1	2	3	5	9
692	380	2.2421	1	1	2	3	4
693	4,313	4.3438	1	2	3	6	8
694	15,245	2.3793	1	1	2	3	4
695	1,361	5.3475	1	3	4	7	10
696	9,992	3.1414	1	2	3	4	6
697	509	3.1100	1	1	2	4	6
698	32,063	6.3485	2	3	5	8	12
699	23,186	4.4403	1	2	4	6	8
700	8,115	3.2223	1	2	3	4	6
707	5,392	4.2381	1	2	3	5	8
708	16,899	1.8647	1	1	2	2	3
709	817	5.6793	1	1	3	7	13

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
710	1,504	1.6642	1	1	1	2	3
711	740	7.2986	1	3	5	9	15
712	424	2.6604	1	1	2	3	5
713	9,760	4.0614	1	2	3	5	9
714	22,626	1.8214	1	1	2	2	3
715	505	6.0554	1	2	4	8	13
716	685	1.3518	1	1	1	1	2
717	734	6.4074	1	3	5	8	13
718	446	2.6121	1	1	2	3	5
722	907	6.8655	2	3	5	8	13
723	1,505	4.8213	1	2	4	6	9
724	276	2.6957	1	1	2	3	5
725	1,368	4.8450	2	2	4	6	9
726	3,010	3.2664	1	2	3	4	6
727	2,292	6.0105	2	3	5	7	11
728	5,331	3.9081	1	2	3	5	7
729	838	4.6802	1	2	4	6	9
730	276	2.8442	1	1	2	3	5
734	1,520	6.9493	2	3	5	8	14
735	1,138	2.6951	1	1	2	4	5
736	1,046	13.6434	5	7	11	17	25
737	3,134	6.4467	3	4	6	8	11
738	712	3.5941	2	2	3	4	5
739	1,106	9.4313	3	4	7	11	19
740	4,261	4.5226	2	3	4	5	8
741	5,393	2.5524	1	1	2	3	4
742	10,807	4.1279	1	2	3	5	8
743	27,700	2.0692	1	1	2	3	3
744	1,625	5.5680	1	2	4	7	11
745	1,265	2.4403	1	1	2	3	5
746	2,621	4.1801	1	2	3	5	8
747	7,265	1.7794	1	1	1	2	3
748	17,103	1.6853	1	1	1	2	3
749	1,052	8.4753	2	4	7	11	16
750	362	2.7901	1	1	2	3	5
754	1,471	8.2998	2	4	6	11	16
755	2,959	5.0057	1	2	4	6	9
756	440	3.0750	1	1	2	4	6
757	1,772	7.5056	3	4	6	9	14
758	1,770	5.4650	2	3	5	7	10
759	978	4.0112	2	2	3	5	7
760	2,269	3.7532	1	2	3	5	7
761	1,138	2.2417	1	1	2	3	4
765	3,417	4.8674	2	3	4	5	7
766	2,757	3.0812	2	2	3	4	4
767	169	2.6864	2	2	2	3	4

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
768	8	6.7500	1	2	5	6	13
769	122	5.7459	1	2	4	7	13
770	177	2.0904	1	1	1	2	4
774	1,667	3.2190	2	2	2	3	4
775	5,860	2.3258	1	2	2	3	3
776	588	3.3248	1	2	2	4	6
777	198	2.0505	1	1	2	3	4
778	444	3.2050	1	1	2	3	6
779	121	2.1405	1	1	1	2	4
780	42	1.6190	1	1	1	1	2
781	3,387	3.8432	1	1	3	4	7
782	188	2.6117	1	1	2	3	5
793	3	3.6667	1	1	3	7	7
794	1	1.0000	1	1	1	1	1
799	582	13.2405	4	7	11	17	25
800	641	7.2246	2	4	6	9	14
801	357	3.9076	1	2	3	5	7
802	1,095	11.7826	3	5	8	13	21
803	1,004	6.0936	2	3	5	7	11
804	764	2.9686	1	1	2	4	6
808	9,279	8.0600	2	4	6	10	15
809	13,025	4.9646	2	3	4	6	9
810	2,170	3.7392	1	2	3	5	7
811	37,741	5.1436	1	2	4	6	10
812	91,512	3.5555	1	2	3	4	7
813	11,471	4.9750	1	2	4	6	10
814	2,052	6.6774	2	3	5	8	12
815	3,337	4.4489	1	2	4	5	8
816	1,532	3.2428	1	2	3	4	6
820	1,396	17.0659	5	8	13	22	33
821	1,934	7.0817	1	3	5	9	15
822	1,738	3.0984	1	1	2	4	6
823	2,425	14.9126	5	7	12	18	28
824	2,581	8.1395	2	4	7	11	16
825	1,442	3.9286	1	1	3	5	8
826	680	14.2985	5	7	11	18	27
827	1,420	6.6838	2	3	5	8	13
828	696	3.7586	1	2	3	5	7
829	1,398	9.3369	2	3	7	11	20
830	385	3.1247	1	1	2	4	6
834	4,288	15.1749	2	4	9	23	35
835	2,465	9.3513	2	3	5	10	25
836	1,201	4.4388	1	2	3	5	8
837	1,390	22.5914	5	8	22	31	42
838	1,431	12.2697	3	4	6	20	30
839	1,284	5.6830	2	4	5	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
840	9,929	10.0469	3	4	8	13	20
841	8,550	6.3908	2	3	5	8	12
842	3,644	4.1715	1	2	3	5	8
843	1,876	7.7953	2	4	6	10	14
844	2,566	5.4189	2	3	4	7	10
845	667	3.7676	1	2	3	5	7
846	3,055	7.8206	2	3	5	9	17
847	21,591	3.3495	1	2	3	4	6
848	1,107	2.9883	1	1	3	4	5
849	1,163	6.0404	2	3	5	6	11
853	42,325	15.3906	5	8	12	19	28
854	5,584	9.1653	3	5	8	11	16
855	337	5.3976	1	2	4	7	10
856	6,574	14.8006	4	7	11	18	28
857	9,165	7.5920	3	4	6	9	14
858	2,325	5.0533	2	3	4	6	9
862	10,485	7.6788	2	4	6	9	15
863	20,692	4.7970	2	3	4	6	8
864	18,172	3.7732	1	2	3	5	7
865	3,069	6.0336	2	3	4	7	12
866	6,641	3.3212	1	2	3	4	6
867	5,759	8.9976	2	4	7	11	18
868	2,409	5.1582	2	3	4	6	9
869	779	3.6393	1	2	3	4	6
870	25,752	15.1737	6	9	13	18	26
871	280,970	7.0555	2	3	6	9	13
872	75,906	5.1518	2	3	4	6	9
876	656	12.6799	2	4	8	14	29
880	8,144	3.0149	1	1	2	4	6
881	4,536	4.2377	1	2	3	5	8
882	1,797	4.2966	1	2	3	5	8
883	863	7.7034	1	3	5	8	15
884	18,110	5.3720	2	3	4	6	9
885	88,160	7.3601	2	3	6	9	13
886	525	6.1657	1	2	4	6	12
887	466	4.0494	1	2	3	5	7
894	4,520	2.9412	1	1	2	3	4
895	6,273	10.9396	3	4	6	8	9
896	8,621	6.1897	2	3	4	7	11
897	35,167	3.9315	1	2	3	4	6
901	1,074	13.7719	3	5	9	17	29
902	1,753	7.1843	2	3	5	8	14
903	1,027	4.4450	1	2	3	5	8
904	1,895	11.1135	2	4	7	13	23
905	763	4.5242	1	2	4	6	9
906	707	3.0905	1	1	2	3	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
907	9,288	11.0101	3	5	8	14	22
908	8,383	6.1103	2	3	5	8	12
909	4,760	3.3786	1	1	3	4	7
913	1,159	5.3572	1	2	4	6	10
914	5,171	3.1251	1	1	3	4	6
915	1,808	4.6858	1	2	3	6	9
916	5,255	2.0278	1	1	1	2	4
917	22,772	4.9226	1	2	4	6	10
918	33,100	2.6100	1	1	2	3	5
919	12,011	6.1429	2	3	4	7	12
920	14,002	4.1465	1	2	3	5	8
921	7,314	2.8138	1	1	2	3	5
922	1,467	5.0266	1	2	4	6	10
923	2,780	3.1299	1	1	2	4	5
927	188	28.2128	8	13	23	39	55
928	948	14.8597	3	7	12	20	29
929	366	7.6721	1	3	6	10	15
933	138	5.2319	1	1	1	5	12
934	608	5.8257	1	2	4	7	11
935	2,111	5.2321	1	2	3	6	10
939	816	9.8750	2	4	7	13	20
940	1,539	5.1313	1	2	3	7	11
941	1,455	2.5904	1	1	2	3	5
945	5,971	10.1921	4	6	8	11	15
946	2,809	7.4938	3	5	6	7	8
947	15,418	4.8159	1	2	4	6	9
948	52,323	3.3628	1	2	3	4	6
949	640	4.2969	1	1	2	4	7
950	276	2.7572	1	1	2	3	4
951	1,028	4.5360	1	1	2	3	6
955	443	12.6456	3	5	9	17	24
956	4,421	8.4180	4	5	7	10	15
957	1,516	14.0468	3	7	11	18	27
958	1,134	9.5273	3	5	8	12	16
959	200	5.5800	2	3	5	7	10
963	2,001	8.4983	1	3	7	11	18
964	2,672	5.4963	2	3	5	7	10
965	913	3.7558	1	2	3	5	7
969	638	17.0611	4	7	13	22	35
970	95	8.4526	1	3	7	12	17
974	6,029	9.3641	2	4	7	12	18
975	3,693	6.4075	2	3	5	8	12
976	1,529	4.4173	1	2	3	5	7
977	3,547	4.8765	1	2	4	6	9
981	28,575	13.8055	4	7	11	17	26
982	16,651	8.2634	2	4	7	11	15
983	4,894	4.2284	1	2	3	6	9
984	747	12.6051	4	7	11	16	22
985	814	8.4017	2	4	7	12	16
986	447	4.0559	1	1	2	6	9
987	9,573	11.8354	3	6	10	15	22
988	9,352	7.0079	2	3	6	9	14
989	3,950	3.5337	1	1	2	5	7
	10,957,307						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGHTS OF STAY; FY 2009 MedPAR UPDATE – DECEMBER 2009 GROUPER V28.0 MS-DRGs

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	907	41.8412	12	19	33	53	82
2	333	22.7628	9	12	17	29	42
3	21,956	36.6115	15	21	30	44	63
4	21,395	27.1269	11	16	22	32	46
5	889	19.9944	6	9	14	25	43
6	408	9.2255	5	6	8	11	14
7	469	18.7058	8	11	15	23	31
8	509	11.7741	6	7	9	13	21
10	137	9.7007	5	7	8	11	13
11	1,466	15.5989	6	8	12	19	29
12	1,963	10.0942	4	6	8	13	17
13	1,008	6.7401	3	4	6	8	11
14	446	27.7489	7	19	25	34	50
15	1,372	19.2449	10	15	18	22	28
20	1,081	17.2026	6	10	16	23	29
21	469	13.9382	7	10	14	17	22
22	146	8.3767	2	4	8	12	14
23	4,406	11.7690	2	5	9	16	23
24	1,708	8.0878	1	3	7	11	16
25	11,582	11.5431	3	6	9	15	22
26	11,469	7.3239	2	4	6	9	14
27	12,591	3.8861	1	2	3	5	7
28	1,851	13.1059	4	6	11	16	25
29	3,505	6.5629	1	3	5	9	13
30	3,432	3.2797	1	1	3	4	7
31	1,169	12.2104	2	5	9	16	25
32	2,808	5.3711	1	2	4	7	12
33	3,351	2.6640	1	1	2	3	5
34	819	7.0195	1	2	6	10	15
35	2,336	3.2140	1	1	2	4	8
36	5,732	1.5223	1	1	1	1	3
37	4,944	8.3833	1	3	7	11	18
38	14,449	3.5553	1	1	2	5	8
39	43,823	1.6743	1	1	1	2	3
40	4,817	12.1704	3	6	9	15	23
41	7,552	6.6622	1	3	6	8	13
42	3,808	3.2261	1	1	2	4	7
52	1,250	6.6328	2	3	5	7	11
53	487	3.5832	1	2	3	5	6
54	7,208	6.2757	2	3	5	8	12
55	13,028	4.6122	1	2	3	6	9
56	9,289	7.1527	2	3	5	9	14
57	43,231	4.8535	2	3	4	6	8
58	893	7.2878	2	3	5	9	14
59	3,250	4.9237	2	3	4	6	8
60	3,515	3.7713	1	2	3	5	6
61	2,266	8.3530	2	4	7	11	16
62	3,739	5.6448	2	3	5	7	10
63	1,309	3.9152	2	2	3	5	7
64	60,945	6.9291	2	3	5	9	14
65	112,612	4.8351	2	3	4	6	9
66	66,535	3.2734	1	2	3	4	6
67	1,387	5.4737	2	3	4	7	10
68	10,376	3.3077	1	2	3	4	6
69	92,535	2.7913	1	2	2	3	5
70	9,646	7.3534	2	3	6	9	14
71	13,708	5.1401	2	3	4	6	9
72	4,838	3.1174	1	2	2	4	6
73	8,926	5.6255	2	3	4	7	11
74	31,568	4.0866	1	2	3	5	7
75	1,348	6.9733	2	4	5	8	13
76	661	3.9259	1	2	3	5	7
77	1,519	6.4352	2	3	5	8	12
78	2,122	4.3907	1	2	4	5	8
79	774	3.0749	1	2	3	4	5
80	1,625	4.9145	1	2	4	6	10
81	5,867	3.4137	1	2	3	4	6
82	2,372	6.0544	1	1	4	8	13
83	2,596	4.6541	1	2	4	6	9
84	2,542	2.7825	1	1	2	4	5
85	7,305	7.2197	2	3	6	9	14
86	14,311	4.6416	1	2	4	6	8
87	13,012	2.9085	1	1	2	4	5
88	870	5.5345	2	3	4	7	11
89	3,155	3.6960	1	2	3	5	7
90	2,481	2.3136	1	1	2	3	4
91	8,739	6.2049	1	3	4	7	13
92	19,751	4.2052	1	2	3	5	8
93	13,215	2.8862	1	1	2	4	5
94	1,426	11.8296	3	6	10	15	21
95	1,186	8.3727	3	5	7	11	15
96	540	5.6667	1	4	5	7	10
97	1,187	11.6352	4	6	9	15	22
98	1,065	7.8892	3	4	7	10	14
99	423	5.1915	2	3	4	7	10
100	19,259	5.9589	2	3	4	7	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
101	56,054	3.4365	1	2	3	4	6
102	1,285	4.2716	1	2	3	5	9
103	12,526	3.0242	1	1	2	4	6
113	639	5.5994	1	2	4	7	11
114	431	2.5986	1	1	2	3	5
115	850	4.6082	1	2	4	5	7
116	455	4.4813	1	1	2	5	7
117	549	1.9872	1	1	1	1	2
121	744	5.1022	2	3	4	6	8
122	524	3.9790	1	2	3	5	7
123	2,672	2.7182	1	1	2	3	5
124	739	5.2612	1	2	4	6	11
125	4,274	3.3538	1	2	3	4	6
129	1,508	5.2454	1	2	4	7	11
130	943	2.8908	1	1	2	4	6
131	1,132	5.5998	1	2	4	7	11
132	748	2.7126	1	1	2	3	5
133	2,242	5.3965	1	2	4	7	11
134	2,627	2.0837	1	1	1	2	4
135	466	6.3112	1	2	5	9	13
136	351	2.2422	1	1	1	3	5
137	891	4.9989	1	2	4	6	10
138	747	2.4873	1	1	2	3	5
139	1,363	1.7601	1	1	1	2	3
146	734	9.0327	2	4	7	11	19
147	1,362	5.7379	1	2	4	7	11
148	552	3.3442	1	1	2	4	6
149	33,609	2.6159	1	1	2	3	5
150	1,162	4.9699	1	2	4	6	10
151	6,166	2.8774	1	1	2	4	5
152	2,298	4.2963	1	2	3	5	8
153	11,465	3.0804	1	2	3	4	5
154	2,458	5.7754	1	3	4	7	12
155	6,154	4.2238	1	2	3	5	8
156	3,515	2.8942	1	1	2	4	5
157	1,374	6.6798	2	3	5	8	14
158	3,709	4.3308	1	2	3	5	8
159	1,459	2.7347	1	1	2	3	5
163	13,439	14.0385	5	8	12	18	25
164	18,804	7.3844	3	4	6	9	13
165	10,518	4.3993	2	3	4	6	7
166	23,100	11.9825	4	6	10	15	22
167	19,782	7.3702	2	4	6	9	14
168	4,388	4.2985	1	2	3	6	8
175	14,080	6.8241	3	4	6	8	12
176	36,658	4.9333	2	3	5	6	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
177	68,128	8.5605	3	5	7	11	16
178	71,807	6.7933	3	4	6	8	12
179	16,039	4.9675	2	3	4	6	9
180	20,637	7.4786	2	4	6	10	14
181	26,198	5.4244	1	3	4	7	10
182	2,840	3.6532	1	2	3	5	7
183	2,664	6.4842	2	3	5	8	12
184	5,184	4.3119	2	3	4	5	8
185	2,187	3.0393	1	2	3	4	5
186	10,686	6.7318	2	3	5	9	13
187	10,944	4.9400	1	2	4	6	9
188	3,293	3.5299	1	2	3	4	7
189	94,058	5.5455	2	3	4	7	10
190	136,856	5.5075	2	3	5	7	10
191	150,358	4.6481	2	3	4	6	8
192	134,412	3.6580	1	2	3	5	6
193	103,907	6.4847	2	4	5	8	12
194	207,054	4.9783	2	3	4	6	9
195	87,008	3.6926	1	2	3	5	6
196	6,959	6.9585	2	4	6	9	13
197	6,790	5.1077	2	3	4	6	9
198	3,047	3.7670	1	2	3	5	7
199	3,790	8.0317	2	4	6	10	15
200	8,675	4.7641	1	2	4	6	9
201	2,745	3.5457	1	2	3	5	7
202	38,888	4.1342	1	2	3	5	7
203	28,980	3.1588	1	2	3	4	6
204	23,390	2.7325	1	1	2	3	5
205	6,677	5.3037	1	2	4	7	10
206	19,984	3.2516	1	2	3	4	6
207	36,288	14.7898	6	9	13	18	25
208	74,965	7.0337	1	3	6	9	14
215	177	12.6215	1	3	8	14	28
216	9,532	17.0712	8	11	15	21	29
217	6,915	10.9643	6	7	10	13	18
218	1,222	7.9869	5	6	7	9	12
219	12,766	13.1024	5	7	11	16	24
220	16,882	7.9647	4	6	7	9	13
221	4,475	5.9678	4	5	6	7	9
222	2,754	11.8500	4	6	10	15	22
223	3,843	6.1897	1	2	5	8	12
224	2,738	9.7064	3	5	8	12	18
225	4,489	5.2947	2	3	5	7	10
226	7,266	7.7703	1	2	6	11	16
227	30,144	3.1103	1	1	1	4	7
228	2,305	14.2430	6	8	12	18	25

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
229	2,849	8.3155	4	5	7	10	14
230	806	5.5186	2	4	5	7	9
231	1,351	12.9067	6	8	11	16	22
232	1,220	9.4139	5	7	9	11	14
233	15,293	13.7411	7	9	12	16	23
234	27,437	8.8794	5	6	8	11	13
235	9,468	10.8477	5	6	9	13	19
236	25,502	6.5346	4	5	6	8	10
237	22,101	10.1669	2	4	8	13	20
238	40,058	4.1976	1	1	3	6	9
239	10,869	14.3506	5	7	11	18	27
240	10,791	9.6381	3	5	8	12	18
241	1,552	5.9852	2	3	5	8	11
242	17,882	8.0936	2	4	6	10	15
243	41,262	4.9405	1	2	4	6	9
244	44,828	2.8119	1	1	2	4	6
245	3,970	3.8071	1	1	2	5	8
246	30,909	5.0086	1	2	4	6	10
247	143,976	2.2759	1	1	2	3	4
248	14,361	6.0490	1	3	5	8	12
249	46,400	2.7896	1	1	2	3	5
250	7,652	6.9611	2	3	5	9	14
251	36,441	2.9462	1	1	2	4	6
252	40,567	7.8947	1	3	6	10	17
253	44,596	6.0032	1	2	5	8	12
254	38,370	2.6631	1	1	2	3	6
255	2,483	9.2114	2	4	7	12	17
256	3,196	7.0219	2	4	6	9	13
257	394	4.3046	1	2	4	6	8
258	763	6.9685	2	3	5	9	13
259	5,053	3.1486	1	1	2	4	6
260	1,770	10.7571	2	5	8	14	22
261	3,900	4.4926	1	2	3	6	9
262	2,423	2.5815	1	1	2	3	5
263	518	5.6602	1	2	3	7	13
264	22,461	8.2590	1	3	6	11	17
265	1,714	3.3495	1	1	2	4	7
280	70,000	6.6250	2	3	5	8	12
281	53,393	4.4435	1	2	4	6	8
282	34,890	2.7555	1	1	2	4	5
283	12,651	5.1395	1	1	3	7	12
284	4,030	3.0310	1	1	2	4	7
285	1,428	1.7983	1	1	1	2	3
286	25,188	6.4764	2	3	5	8	13
287	134,754	3.2176	1	1	2	4	6
288	2,679	10.8634	4	6	9	13	19

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
289	1,198	7.8005	3	5	7	10	13
290	240	5.5792	1	3	5	7	10
291	176,332	6.1577	2	3	5	8	12
292	248,245	4.8614	2	3	4	6	9
293	118,010	3.3080	1	2	3	4	6
294	1,546	5.3668	2	3	5	7	9
295	874	4.0378	1	2	4	5	7
296	1,921	2.7673	1	1	1	3	6
297	767	1.7523	1	1	1	2	3
298	372	1.2097	1	1	1	1	1
299	21,223	6.0532	2	3	5	7	11
300	48,418	4.8697	2	3	4	6	8
301	28,789	3.4713	1	2	3	5	6
302	7,760	3.9586	1	2	3	5	7
303	52,496	2.4440	1	1	2	3	4
304	2,867	4.5438	1	2	3	6	8
305	33,338	2.7473	1	1	2	3	5
306	3,079	5.9328	2	3	4	7	11
307	6,031	3.4107	1	2	3	4	6
308	56,626	5.1614	2	3	4	6	10
309	107,708	3.7205	1	2	3	5	7
310	127,913	2.5033	1	1	2	3	4
311	15,715	2.2386	1	1	2	3	4
312	165,015	2.9422	1	1	2	4	5
313	169,337	2.0617	1	1	2	2	4
314	61,174	6.8924	2	3	5	9	13
315	31,589	4.2192	1	2	3	5	8
316	10,674	2.5722	1	1	2	3	5
326	11,327	16.2594	5	8	13	20	30
327	10,431	8.8336	2	5	7	11	16
328	8,538	3.7853	1	2	3	5	8
329	46,072	15.4141	6	8	13	19	28
330	60,328	9.1253	4	6	8	11	16
331	24,253	5.3159	3	4	5	6	8
332	1,602	14.2085	6	8	12	18	26
333	5,291	8.1227	4	5	7	10	14
334	3,027	4.9045	2	3	5	6	8
335	7,054	13.7044	5	8	12	17	24
336	13,575	8.7634	3	5	8	11	15
337	7,648	5.0911	1	3	4	7	9
338	1,283	10.0405	4	6	8	13	17
339	2,988	6.5505	3	4	6	8	11
340	3,036	3.7286	1	2	3	5	6
341	907	6.6185	2	3	5	9	13
342	2,903	3.8081	1	2	3	5	7
343	6,461	2.0108	1	1	2	2	4

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
344	914	11.1838	4	6	9	14	21
345	3,052	6.9797	3	4	6	8	12
346	2,591	4.6299	2	3	4	6	7
347	1,478	8.7794	2	4	6	11	17
348	4,255	5.3598	2	3	4	7	10
349	4,039	2.9153	1	1	2	4	6
350	1,676	7.7739	2	3	6	10	15
351	4,535	4.5275	1	2	4	6	9
352	6,456	2.3748	1	1	2	3	4
353	3,228	8.4365	2	4	7	11	16
354	9,556	5.0383	2	3	4	6	9
355	12,947	2.7752	1	1	2	4	5
356	7,895	12.6730	3	6	10	16	24
357	7,605	7.4191	2	4	6	9	14
358	2,045	4.0088	1	2	3	5	8
368	3,305	6.6865	2	3	5	8	12
369	5,626	4.4604	2	3	4	5	8
370	1,777	3.0833	1	2	3	4	5
371	22,536	8.8666	3	4	7	11	17
372	34,690	6.4592	2	4	5	8	12
373	11,202	4.5867	2	3	4	6	8
374	8,074	8.4488	2	4	7	11	16
375	17,166	5.7567	2	3	4	7	11
376	2,537	3.5861	1	2	3	4	6
377	48,282	6.4252	2	3	5	8	12
378	138,562	4.1977	2	2	4	5	7
379	50,778	3.0378	1	2	3	4	5
380	2,927	7.5364	2	4	6	9	14
381	6,196	4.7816	2	3	4	6	9
382	2,708	3.4830	1	2	3	4	6
383	1,131	5.2856	2	3	4	6	9
384	7,401	3.6259	1	2	3	4	6
385	2,207	8.3715	2	4	6	10	16
386	9,041	5.2677	2	3	4	7	10
387	4,132	3.9131	1	2	3	5	7
388	18,652	7.2489	2	3	6	9	14
389	54,853	4.7808	2	3	4	6	9
390	39,806	3.3390	1	2	3	4	6
391	45,147	5.1526	1	2	4	6	10
392	248,773	3.4414	1	2	3	4	6
393	21,581	6.8656	2	3	5	8	14
394	49,062	4.6703	1	2	4	6	9
395	20,065	3.0842	1	2	3	4	6
405	4,357	15.8947	5	8	12	20	31
406	5,111	8.3620	2	5	7	10	15
407	1,927	5.1520	1	3	5	7	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
408	1,493	13.4662	5	7	11	17	24
409	1,446	8.8983	4	5	8	11	16
410	475	5.8400	2	4	5	7	10
411	782	11.7852	5	7	10	14	21
412	838	8.2625	3	5	7	10	14
413	524	5.4027	2	3	5	7	9
414	4,700	11.3732	4	6	9	14	20
415	5,782	7.3200	3	4	6	9	12
416	3,992	4.3790	2	3	4	5	7
417	17,753	7.8448	3	4	6	10	15
418	27,491	5.3511	2	3	5	7	10
419	28,245	3.0297	1	1	2	4	6
420	712	13.1110	3	6	10	17	27
421	908	6.9868	2	3	5	9	14
422	234	4.1068	1	2	3	5	8
423	1,487	14.3658	4	7	11	18	28
424	802	9.1421	3	5	7	11	17
425	86	5.6860	2	3	4	7	10
432	12,413	6.5409	2	3	5	8	13
433	8,085	4.5713	1	2	4	6	8
434	398	3.1734	1	2	3	4	6
435	12,205	7.3902	2	3	6	9	14
436	12,595	5.4640	2	3	4	7	10
437	2,182	3.6856	1	2	3	5	7
438	14,979	7.4713	2	3	5	9	15
439	27,901	4.9703	2	3	4	6	9
440	20,560	3.4957	1	2	3	4	6
441	14,431	7.1160	2	3	5	9	14
442	18,612	4.7711	2	2	4	6	9
443	4,688	3.3057	1	2	3	4	6
444	12,611	6.2323	2	3	5	8	12
445	19,026	4.5326	1	2	4	6	8
446	12,789	3.0593	1	2	3	4	6
453	1,133	13.4704	5	7	10	17	26
454	3,084	6.7503	3	4	5	8	13
455	2,482	3.7526	1	2	3	5	6
456	1,130	13.4611	5	7	10	17	25
457	3,197	6.9643	3	4	6	8	12
458	1,565	4.0505	2	3	4	5	7
459	3,823	9.0876	4	5	7	11	17
460	61,817	3.8782	2	3	3	5	6
461	638	8.3103	3	4	7	9	15
462	11,376	4.0806	3	3	3	4	6
463	5,302	15.1032	4	7	11	18	30
464	8,718	8.8815	3	4	7	11	17
465	2,708	5.2688	2	3	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
466	3,705	8.9744	3	5	7	11	16
467	20,172	4.9536	3	3	4	6	8
468	15,812	3.5808	2	3	3	4	5
469	27,090	7.9945	3	5	7	9	14
470	413,141	3.6890	2	3	3	4	5
471	2,812	9.2649	2	4	7	13	18
472	8,600	3.7783	1	1	2	5	8
473	25,112	1.8500	1	1	1	2	3
474	2,922	11.9521	4	6	9	15	22
475	3,783	7.7275	3	4	6	10	14
476	1,134	4.0908	1	2	3	5	8
477	2,596	11.0882	4	6	9	14	20
478	8,909	6.8587	2	3	6	9	13
479	5,867	3.3936	1	1	2	5	7
480	24,275	9.0228	4	5	7	11	16
481	81,792	5.5520	3	4	5	6	8
482	33,902	4.4797	3	3	4	5	7
483	10,324	3.7260	2	2	3	4	7
484	18,014	2.1959	1	1	2	3	3
485	1,023	10.9101	4	6	9	13	19
486	2,391	7.1861	3	4	6	8	12
487	1,058	5.0888	2	3	4	6	8
488	3,248	4.6918	2	3	3	5	8
489	4,902	2.8499	1	2	3	3	5
490	22,903	4.2505	1	2	3	5	9
491	45,224	2.0655	1	1	1	3	4
492	5,167	8.5982	3	5	7	11	16
493	20,378	4.9773	2	3	4	6	9
494	25,249	3.1465	1	2	3	4	5
495	1,614	10.1691	3	5	8	13	19
496	4,885	5.3793	1	3	4	7	10
497	5,130	2.5558	1	1	2	3	5
498	1,481	7.2552	2	3	6	9	14
499	876	2.9920	1	1	2	3	5
500	1,850	10.4573	3	5	8	13	21
501	5,068	6.0065	2	3	5	8	11
502	5,741	2.8021	1	1	2	3	5
503	914	8.4344	2	4	7	11	16
504	2,808	6.2137	2	3	5	8	11
505	2,256	3.1272	1	1	3	4	6
506	717	3.7992	1	1	3	5	8
507	940	4.5160	1	2	3	5	9
508	1,782	2.0561	1	1	2	3	3
509	349	3.4699	1	1	2	4	7
510	1,058	6.2968	2	3	5	8	12
511	4,312	3.8949	1	2	3	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
512	8,255	2.1474	1	1	2	3	4
513	1,248	4.8205	1	2	4	6	9
514	921	2.6406	1	1	2	3	5
515	3,952	9.8641	3	5	8	12	18
516	12,227	5.9028	2	3	5	8	11
517	11,169	3.3660	1	1	3	5	7
533	818	6.4792	2	3	5	8	12
534	3,463	3.8908	1	2	3	5	7
535	7,263	5.7939	2	3	4	7	11
536	32,802	3.7325	1	3	3	4	6
537	944	4.0911	2	3	3	5	7
538	708	3.0494	1	2	3	4	5
539	3,238	9.4632	3	5	7	11	17
540	4,245	6.7781	2	4	5	8	11
541	1,124	4.8488	1	2	4	6	8
542	5,511	8.3028	3	4	6	10	16
543	16,795	5.6402	2	3	5	7	10
544	6,624	4.0503	2	3	3	5	7
545	3,605	9.0019	2	4	6	11	18
546	6,148	5.3317	2	3	4	7	10
547	3,348	3.5358	1	2	3	4	6
548	579	8.7323	3	4	7	11	17
549	1,215	6.0601	2	3	5	7	11
550	556	4.0108	1	2	3	5	7
551	10,908	6.7836	2	3	5	8	13
552	77,212	3.9754	1	2	3	5	7
553	2,162	5.6300	2	3	4	7	10
554	17,314	3.6410	1	2	3	4	6
555	2,593	4.8481	1	2	4	6	9
556	17,515	3.1807	1	2	3	4	6
557	3,723	6.8571	2	4	5	8	12
558	17,219	4.3499	2	3	4	5	7
559	1,902	7.1420	2	3	5	9	14
560	5,301	4.6403	1	2	4	6	8
561	5,314	2.6314	1	1	2	3	5
562	5,861	5.8555	2	3	5	7	11
563	32,431	3.5741	1	2	3	4	6
564	1,779	6.5509	2	3	5	8	13
565	4,069	4.6319	1	3	4	6	8
566	1,759	3.4179	1	2	3	4	6
573	4,789	12.5780	4	6	9	15	24
574	10,017	8.5081	3	4	7	10	15
575	3,721	5.1774	2	3	4	7	9
576	646	13.0294	3	5	9	17	26
577	2,414	6.1570	1	2	4	8	13
578	2,530	3.2573	1	1	2	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
579	3,778	10.4611	3	5	8	13	20
580	11,548	5.3869	1	2	4	7	11
581	10,753	2.3869	1	1	2	3	5
582	4,901	2.6566	1	1	2	3	5
583	7,581	1.7392	1	1	1	2	3
584	862	4.9617	1	2	4	7	10
585	1,462	2.1382	1	1	1	3	4
592	3,956	8.2786	2	4	6	10	15
593	11,211	5.8634	2	3	5	7	10
594	1,483	4.6703	1	2	4	6	8
595	1,117	7.8809	2	4	6	10	15
596	4,972	4.6072	1	2	4	6	8
597	559	7.5277	2	3	6	9	14
598	1,520	5.4737	1	3	4	7	10
599	185	3.2757	1	1	3	4	5
600	1,034	4.9207	2	3	4	6	9
601	778	3.6157	1	2	3	5	6
602	22,955	6.6712	2	3	5	8	12
603	137,900	4.5353	2	3	4	6	8
604	2,660	5.1549	1	2	4	6	10
605	20,170	3.3178	1	2	3	4	6
606	1,532	6.0091	1	2	4	7	12
607	7,089	3.6430	1	2	3	4	7
614	1,566	6.5447	2	3	5	8	13
615	1,351	2.9704	1	2	3	4	5
616	1,632	15.6746	6	8	13	19	28
617	6,562	7.9334	3	4	7	10	14
618	148	5.1419	2	3	4	6	9
619	840	7.7405	1	2	4	8	17
620	3,287	3.3998	1	2	3	4	6
621	11,451	1.8512	1	1	2	2	3
622	1,161	12.4358	4	6	9	15	23
623	2,541	7.6025	3	4	6	9	13
624	251	4.7649	2	3	4	6	8
625	1,200	6.9017	1	2	5	8	15
626	2,961	3.0523	1	1	2	3	7
627	12,254	1.4115	1	1	1	1	2
628	3,451	10.6140	2	4	8	14	21
629	4,718	8.0377	3	4	7	10	14
630	446	4.4619	1	2	3	6	8
637	18,691	5.9589	2	3	4	7	11
638	54,277	4.0187	1	2	3	5	7
639	24,880	2.8062	1	1	2	3	5
640	56,552	5.0713	1	2	4	6	10
641	187,597	3.5804	1	2	3	4	6
642	1,603	4.7436	1	2	3	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
643	5,944	7.6445	3	4	6	9	14
644	13,584	5.1667	2	3	4	7	9
645	6,422	3.5668	1	2	3	4	6
652	10,210	7.5053	4	5	6	8	13
653	1,695	16.6053	7	9	14	21	30
654	3,722	9.3461	5	6	8	11	15
655	1,275	5.6549	2	4	6	7	9
656	3,223	10.0583	3	5	8	12	20
657	9,015	5.8840	2	3	5	7	10
658	6,807	3.3676	1	2	3	4	5
659	4,058	10.8544	3	5	8	14	21
660	8,540	6.0290	2	3	5	8	12
661	3,862	2.8933	1	2	2	4	5
662	794	10.8363	2	4	8	13	22
663	2,041	5.2156	1	2	4	7	11
664	3,282	1.8525	1	1	1	2	3
665	571	11.3345	3	6	10	14	21
666	2,191	6.3816	1	2	5	9	13
667	2,595	2.3680	1	1	2	3	4
668	3,076	8.9451	2	4	7	12	18
669	14,683	4.3541	1	2	3	6	9
670	8,764	2.2913	1	1	2	3	5
671	799	5.5920	1	2	4	7	11
672	635	2.2000	1	1	2	3	4
673	11,751	9.5646	1	3	7	12	20
674	9,545	6.7385	1	2	5	9	14
675	3,252	2.1125	1	1	1	2	5
682	99,106	6.8064	2	3	5	9	13
683	117,434	4.9378	2	3	4	6	9
684	26,729	3.3482	1	2	3	4	6
685	2,513	3.3979	1	1	2	4	7
686	1,144	7.7736	2	4	6	10	15
687	3,414	4.9889	1	2	4	6	9
688	706	2.8031	1	1	2	3	5
689	60,772	5.7814	2	3	5	7	10
690	213,595	4.0879	2	2	3	5	7
691	999	4.3053	1	2	3	5	9
692	380	2.2421	1	1	2	3	4
693	1,779	5.1793	1	2	4	7	10
694	17,779	2.5757	1	1	2	3	5
695	1,094	5.6307	2	3	4	7	11
696	10,259	3.1686	1	2	3	4	6
697	509	3.1100	1	1	2	4	6
698	23,432	6.7565	2	3	5	8	13
699	31,817	4.6574	1	2	4	6	8
700	8,115	3.2223	1	2	3	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
707	5,392	4.2381	1	2	3	5	8
708	16,899	1.8647	1	1	2	2	3
709	817	5.6793	1	1	3	7	13
710	1,504	1.6642	1	1	1	2	3
711	740	7.2986	1	3	5	9	15
712	424	2.6604	1	1	2	3	5
713	9,760	4.0614	1	2	3	5	9
714	22,626	1.8214	1	1	2	2	3
715	505	6.0554	1	2	4	8	13
716	685	1.3518	1	1	1	1	2
717	734	6.4074	1	3	5	8	13
718	446	2.6121	1	1	2	3	5
722	477	7.7191	2	3	6	10	15
723	1,935	5.0651	1	2	4	6	9
724	276	2.6957	1	1	2	3	5
725	469	6.0874	2	3	4	8	11
726	3,909	3.4804	1	2	3	4	6
727	1,530	6.3399	2	3	5	8	11
728	6,093	4.0883	1	2	3	5	7
729	838	4.6802	1	2	4	6	9
730	276	2.8442	1	1	2	3	5
734	1,520	6.9493	2	3	5	8	14
735	1,138	2.6951	1	1	2	4	5
736	903	13.9989	5	8	11	17	25
737	3,277	6.6628	3	4	6	8	11
738	712	3.5941	2	2	3	4	5
739	905	9.8663	3	5	7	12	20
740	4,462	4.6555	2	3	4	5	8
741	5,393	2.5524	1	1	2	3	4
742	10,807	4.1279	1	2	3	5	8
743	27,700	2.0692	1	1	2	3	3
744	1,625	5.5680	1	2	4	7	11
745	1,265	2.4403	1	1	2	3	5
746	2,621	4.1801	1	2	3	5	8
747	7,265	1.7794	1	1	1	2	3
748	17,103	1.6853	1	1	1	2	3
749	1,052	8.4753	2	4	7	11	16
750	362	2.7901	1	1	2	3	5
754	1,024	8.7656	2	4	7	11	17
755	3,406	5.2980	1	2	4	7	10
756	440	3.0750	1	1	2	4	6
757	1,322	7.7526	3	4	6	9	14
758	2,220	5.7315	2	3	5	7	10
759	978	4.0112	2	2	3	5	7
760	2,269	3.7532	1	2	3	5	7
761	1,138	2.2417	1	1	2	3	4

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
765	3,417	4.8674	2	3	4	5	7
766	2,757	3.0812	2	2	3	4	4
767	169	2.6864	2	2	2	3	4
768	8	6.7500	1	2	5	6	13
769	122	5.7459	1	2	4	7	13
770	177	2.0904	1	1	1	2	4
774	1,667	3.2190	2	2	2	3	4
775	5,860	2.3258	1	2	2	3	3
776	588	3.3248	1	2	2	4	6
777	198	2.0505	1	1	2	3	4
778	444	3.2050	1	1	2	3	6
779	121	2.1405	1	1	1	2	4
780	42	1.6190	1	1	1	1	2
781	3,387	3.8432	1	1	3	4	7
782	188	2.6117	1	1	2	3	5
793	3	3.6667	1	1	3	7	7
794	1	1.0000	1	1	1	1	1
799	537	13.3762	4	7	11	17	25
800	686	7.5131	2	4	6	9	15
801	357	3.9076	1	2	3	5	7
802	936	12.1891	3	5	9	14	22
803	1,163	6.5443	2	3	5	8	13
804	764	2.9686	1	1	2	4	6
808	7,983	8.2525	3	4	6	10	16
809	14,321	5.1374	2	3	4	6	9
810	2,170	3.7392	1	2	3	5	7
811	29,074	5.2696	1	2	4	6	10
812	100,179	3.6564	1	2	3	5	7
813	11,471	4.9750	1	2	4	6	10
814	1,597	6.9080	2	3	5	8	13
815	3,792	4.6192	1	2	4	6	8
816	1,532	3.2428	1	2	3	4	6
820	1,269	17.4704	5	8	14	22	34
821	2,061	7.4478	2	3	6	10	15
822	1,738	3.0984	1	1	2	4	6
823	1,872	15.9583	5	8	12	20	30
824	3,134	8.7100	2	4	7	12	17
825	1,442	3.9286	1	1	3	5	8
826	602	14.7741	5	7	11	18	27
827	1,498	6.8892	2	3	6	8	13
828	696	3.7586	1	2	3	5	7
829	1,398	9.3369	2	3	7	11	20
830	385	3.1247	1	1	2	4	6
834	3,703	16.1674	2	5	11	24	37
835	3,050	9.2633	2	3	5	10	25
836	1,201	4.4388	1	2	3	5	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
837	1,268	23.5733	5	9	23	32	43
838	1,553	12.2788	3	4	6	20	30
839	1,284	5.6830	2	4	5	5	7
840	7,561	10.6359	3	5	8	14	21
841	10,918	6.7759	2	3	5	8	13
842	3,644	4.1715	1	2	3	5	8
843	1,480	8.0122	2	4	6	10	15
844	2,962	5.6283	2	3	4	7	11
845	667	3.7676	1	2	3	5	7
846	2,614	7.9591	2	3	5	9	18
847	22,032	3.4226	1	2	3	4	6
848	1,107	2.9883	1	1	3	4	5
849	1,163	6.0404	2	3	5	6	11
853	39,169	15.7007	5	8	13	19	29
854	8,740	10.0237	4	6	8	12	18
855	337	5.3976	1	2	4	7	10
856	5,929	15.0469	4	7	11	18	29
857	9,810	7.9171	3	4	6	9	15
858	2,325	5.0533	2	3	4	6	9
862	9,500	7.7561	2	4	6	9	15
863	21,677	4.8940	2	3	4	6	8
864	18,172	3.7732	1	2	3	5	7
865	2,269	6.4293	2	3	4	8	13
866	7,441	3.4921	1	2	3	4	6
867	5,314	9.1929	2	4	7	11	18
868	2,854	5.3931	2	3	4	7	10
869	779	3.6393	1	2	3	4	6
870	25,752	15.1737	6	9	13	18	26
871	246,509	7.1936	2	3	6	9	14
872	110,367	5.4377	2	3	5	7	10
876	656	12.6799	2	4	8	14	29
880	8,144	3.0149	1	1	2	4	6
881	4,536	4.2377	1	2	3	5	8
882	1,797	4.2966	1	2	3	5	8
883	863	7.7034	1	3	5	8	15
884	18,110	5.3720	2	3	4	6	9
885	88,160	7.3601	2	3	6	9	13
886	525	6.1657	1	2	4	6	12
887	466	4.0494	1	2	3	5	7
894	4,520	2.9412	1	1	2	3	4
895	6,273	10.9396	3	4	6	8	9
896	6,925	6.5217	2	3	5	8	12
897	36,863	3.9730	1	2	3	4	6
901	937	14.1206	3	5	9	17	30
902	1,890	7.4889	2	3	6	9	14
903	1,027	4.4450	1	2	3	5	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
904	1,895	11.1135	2	4	7	13	23
905	763	4.5242	1	2	4	6	9
906	707	3.0905	1	1	2	3	6
907	8,654	11.1347	2	5	8	14	22
908	9,017	6.3353	2	3	5	8	12
909	4,760	3.3786	1	1	3	4	7
913	872	5.6239	1	3	4	6	11
914	5,458	3.1999	1	2	3	4	6
915	1,429	5.0539	1	2	4	6	10
916	5,634	2.1132	1	1	2	3	4
917	19,117	5.1092	1	2	4	6	10
918	36,755	2.7429	1	1	2	3	5
919	10,767	6.2020	2	3	4	8	12
920	15,246	4.2676	1	2	3	5	8
921	7,314	2.8138	1	1	2	3	5
922	1,046	5.4312	1	2	4	7	10
923	3,201	3.2471	1	1	2	4	6
927	188	28.2128	8	13	23	39	55
928	948	14.8597	3	7	12	20	29
929	366	7.6721	1	3	6	10	15
933	138	5.2319	1	1	1	5	12
934	608	5.8257	1	2	4	7	11
935	2,111	5.2321	1	2	3	6	10
939	718	9.9624	2	4	7	13	21
940	1,637	5.3769	1	2	4	7	12
941	1,455	2.5904	1	1	2	3	5
945	5,971	10.1921	4	6	8	11	15
946	2,809	7.4938	3	5	6	7	8
947	12,298	4.9270	1	2	4	6	9
948	55,443	3.4200	1	2	3	4	6
949	640	4.2969	1	1	2	4	7
950	276	2.7572	1	1	2	3	4
951	1,028	4.5360	1	1	2	3	6
955	443	12.6456	3	5	9	17	24
956	4,421	8.4180	4	5	7	10	15
957	1,436	14.2806	3	7	12	19	27
958	1,214	9.5486	3	5	8	12	16
959	200	5.5800	2	3	5	7	10
963	1,769	8.6733	1	3	7	12	18
964	2,904	5.6295	2	3	5	7	10
965	913	3.7558	1	2	3	5	7
969	631	17.1236	4	7	13	22	35
970	102	8.6569	1	4	7	12	17
974	5,213	9.6277	2	4	7	12	19
975	4,509	6.6378	2	3	5	8	12
976	1,529	4.4173	1	2	3	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
977	3,547	4.8765	1	2	4	6	9
981	25,561	14.1288	4	7	11	18	26
982	19,665	8.6927	3	4	7	11	16
983	4,894	4.2284	1	2	3	6	9
984	505	13.2911	4	7	12	17	24
985	1,056	9.0369	2	4	8	12	17
986	447	4.0559	1	1	2	6	9
987	7,986	12.1990	3	6	10	15	23
988	10,939	7.4428	2	3	6	10	14
989	3,950	3.5337	1	1	2	5	7
	10,957,307						

TABLE 8A.—PROPOSED STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS (CCRs) FOR ACUTE CARE HOSPITALS—MARCH 2010

State	Urban	Rural
Alabama	0.247	0.318
Alaska	0.342	0.654
Arizona	0.27	0.357
Arkansas	0.313	0.328
California	0.218	0.277
Colorado	0.279	0.413
Connecticut	0.39	0.517
Delaware	0.483	0.447
District of Columbia*	0.325	----
Florida	0.222	0.251
Georgia	0.311	0.374
Hawaii	0.375	0.48
Idaho	0.454	0.546
Illinois	0.293	0.363
Indiana	0.37	0.429
Iowa	0.338	0.418
Kansas	0.28	0.408
Kentucky	0.368	0.353
Louisiana	0.295	0.334
Maine	0.487	0.478
Maryland	0.719	0.767
Massachusetts	0.468	0.963
Michigan	0.371	0.441
Minnesota	0.383	0.509
Mississippi	0.285	0.336
Missouri	0.317	0.34
Montana	0.401	0.461
Nebraska	0.334	0.44
Nevada	0.202	0.432
New Hampshire	0.422	0.42
New Jersey*	0.175	----
New Mexico	0.341	0.357
New York	0.344	0.51
North Carolina	0.374	0.38
North Dakota	0.445	0.343
Ohio	0.317	0.486
Oklahoma	0.294	0.366

State	Urban	Rural
Oregon	0.432	0.397
Pennsylvania	0.254	0.409
Puerto Rico*	0.489	----
Rhode Island*	0.373	----
South Carolina	0.274	0.303
South Dakota	0.322	0.398
Tennessee	0.282	0.346
Texas	0.245	0.328
Utah	0.396	0.586
Vermont	0.558	0.632
Virginia	0.341	0.346
Washington	0.343	0.445
West Virginia	0.438	0.465
Wisconsin	0.391	0.441
Wyoming	0.393	0.523

*All counties in the State or Territory are classified as urban.

TABLE 8B.—PROPOSED STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CCRs) FOR ACUTE CARE HOSPITALS—MARCH 2010

State	Ratio
Alabama	0.024
Alaska	0.039
Arizona	0.027
Arkansas	0.024
California	0.015
Colorado	0.029
Connecticut	0.026
Delaware	0.035
District of Columbia	0.018
Florida	0.022
Georgia	0.027
Hawaii	0.029
Idaho	0.038
Illinois	0.025
Indiana	0.037
Iowa	0.028
Kansas	0.03
Kentucky	0.03
Louisiana	0.025
Maine	0.03
Maryland	0.059
Massachusetts	0.033
Michigan	0.031
Minnesota	0.031
Mississippi	0.026
Missouri	0.028
Montana	0.034
Nebraska	0.034
Nevada	0.023
New Hampshire	0.034
New Jersey	0.013
New Mexico	0.034
New York	0.026
North Carolina	0.032
North Dakota	0.029
Ohio	0.028
Oklahoma	0.025
Oregon	0.037

State	Ratio
Pennsylvania	0.021
Puerto Rico	0.041
Rhode Island	0.02
South Carolina	0.026
South Dakota	0.027
Tennessee	0.025
Texas	0.025
Utah	0.037
Vermont	0.045
Virginia	0.033
Washington	0.028
West Virginia	0.031
Wisconsin	0.038
Wyoming	0.04

TABLE 8C.—PROPOSED STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS (CCRs) FOR LTCHs—DECEMBER 2009

State	Urban	Rural
Alabama	0.268	0.347
Alaska	0.373	0.745
Arizona	0.296	0.389
Arkansas	0.334	0.357
California	0.232	0.298
Colorado	0.306	0.46
Connecticut	0.41	0.566
Delaware	0.517	0.483
District of Columbia*	0.343	----
Florida	0.243	0.308
Georgia	0.335	0.409
Hawaii	0.399	0.511
Idaho	0.491	0.585
Illinois	0.317	0.392
Indiana	0.404	0.48
Iowa	0.364	0.462
Kansas	0.307	0.446
Kentucky	0.397	0.386
Louisiana	0.32	0.362
Maine	0.519	0.505
Maryland**	0.327	0.42
Massachusetts	0.498	1.06
Michigan	0.402	0.478
Minnesota	0.412	0.554
Mississippi	0.312	0.364
Missouri	0.341	0.373
Montana	0.431	0.503
Nebraska	0.367	0.479
Nevada	0.224	0.503
New Hampshire	0.456	0.449
New Jersey*	0.189	----
New Mexico	0.375	0.393
New York	0.368	0.544
North Carolina	0.405	0.408
North Dakota	0.459	0.371
Ohio	0.344	0.528
Oklahoma	0.303	0.396
Oregon	0.458	0.433
Pennsylvania	0.273	0.443

State	Urban	Rural
Puerto Rico*	0.531	----
Rhode Island*	0.393	----
South Carolina	0.3	0.325
South Dakota	0.346	0.431
Tennessee	0.305	0.382
Texas	0.267	0.372
Utah	0.435	0.637
Vermont	0.608	0.67
Virginia	0.373	0.378
Washington	0.374	0.476
West Virginia	0.462	0.5
Wisconsin	0.42	0.481
Wyoming	0.429	0.568

*All counties in the State or Territory are classified as urban. However, no short-term acute care IPPS hospitals or LTCHs are located in those areas as of July 2010.

**National average IPPS total CCRs, as discussed in section V.C.2. of this Addendum.

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS--FY 2011

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
010001	20020	10500	
010005	01	13820	
010009	19460	26620	
010022	01	12060	
010025	01	17980	
010029	12220	17980	
010035	01	13820	
010046	23460	13820	
010052	01	33860	
010054	19460	26620	
010055	20020	37460	
010059	19460	26620	
010061	01	16860	
010065	01	13820	
010083	01	33660	
010085	19460	26620	
010100	01	37860	
010101	01	13820	
010102	01	33860	
010118	01	46220	
010126	01	33860	
010143	01	26620	
010158	01	19460	
010164	01	13820	
020008	02	11260	
030033	03	38060	
030069	29420	40140	
030101	29420	29820	
040014	04	30780	
040017	04	26	
040027	04	44180	
040039	04	26	
040041	04	30780	
040069	04	26	
040071	38220	30780	
040076	04	26300	LUGAR
040080	04	27860	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
040085	04	32820	
040088	04	33740	
040119	04	30780	
050002	36084	41940	
050006	05	39820	
050009	34900	42220	
050013	34900	42220	
050014	05	40900	
050022	40140	42044	
050038	41940	42100	
050042	05	39820	
050043	36084	41940	
050046	37100	31084	
050054	40140	42044	
050069	42044	31084	
050071	41940	42100	
050073	46700	36084	
050075	36084	41940	
050082	37100	31084	
050084	44700	40900	
050089	40140	31084	
050090	42220	36084	
050095	36084	41940	
050099	40140	31084	
050101	46700	36084	
050102	40140	42044	
050118	44700	33700	
050125	41940	42100	
050129	40140	31084	
050131	41884	36084	
050136	42220	36084	
050140	40140	31084	
050150	05	40900	
050152	41884	36084	
050153	41940	42100	
050159	37100	31084	
050168	42044	31084	
050173	42044	31084	
050174	42220	36084	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050188	41940	42100	
050193	42044	31084	
050195	36084	41940	
050197	41884	41940	
050211	36084	41940	
050224	42044	31084	
050226	42044	31084	
050230	42044	31084	
050236	37100	31084	
050243	40140	42044	
050245	40140	31084	
050264	36084	41940	
050272	40140	31084	
050279	40140	31084	
050283	36084	41940	
050291	42220	36084	
050292	40140	42044	
050300	40140	31084	
050305	36084	41940	
050308	41940	42100	
050320	36084	41940	
050327	40140	31084	
050329	40140	42044	
050334	41500	41940	
050335	05	33700	
050348	42044	31084	
050360	41884	36084	
050366	05	40900	
050367	46700	36084	
050380	41940	42100	
050385	42220	36084	
050390	40140	42044	
050394	37100	31084	
050423	40140	42044	
050426	42044	31084	
050441	41940	42100	
050488	36084	41940	
050510	41884	36084	
050512	36084	41940	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050517	40140	31084	
050526	42044	31084	
050534	40140	42044	
050541	41884	41940	
050543	42044	31084	
050547	42220	36084	
050548	42044	31084	
050549	37100	31084	
050551	42044	31084	
050567	42044	31084	
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050586	40140	31084	
050589	42044	31084	
050603	42044	31084	
050604	41940	42100	
050609	42044	31084	
050616	37100	31084	
050662	41940	42100	
050667	34900	46700	
050668	41884	36084	
050678	42044	31084	
050680	46700	36084	
050684	40140	42044	
050686	40140	42044	
050688	41940	42100	
050690	42220	36084	
050693	42044	31084	
050694	40140	42044	
050701	40140	42044	
050709	40140	31084	
050720	42044	31084	
050744	42044	31084	
050745	42044	31084	
050746	42044	31084	
050747	42044	31084	
050748	44700	33700	
050749	37100	31084	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050758	40140	31084	
060001	24540	19740	
060003	14500	19740	
060023	24300	19740	
060027	14500	19740	
060031	17820	19740	
060049	06	22660	
060075	06	24300	
060096	06	19740	
060103	14500	19740	
060116	14500	19740	
060118	06	19740	
060121	24540	19740	
070001	35300	35004	
070003	07	25540	LUGAR
070005	35300	35004	
070006	14860	35644	
070010	14860	35644	
070011	07	25540	LUGAR
070015	07	35644	
070016	35300	35004	
070017	35300	35004	
070018	14860	35644	
070019	35300	35004	
070021	07	25540	LUGAR
070022	35300	35004	
070028	14860	35644	
070031	35300	35004	
070033	14860	35644	
070034	14860	35644	
070036	25540	35300	
070038	35300	35004	
070039	35300	35004	
080004	20100	48864	
080006	08	20100	
080007	08	36140	
090004	47894	13644	
100002	48424	22744	
100014	19660	36740	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
100017	19660	36740	
100022	33124	22744	
100023	10	45300	
100024	10	33124	
100045	19660	36740	
100047	39460	35840	
100049	10	29460	
100068	19660	36740	
100072	19660	36740	
100077	39460	35840	
100080	48424	22744	
100081	10	18880	LUGAR
100105	42680	38940	
100109	10	36740	
100130	48424	22744	
100139	10	23540	LUGAR
100150	10	33124	
100157	29460	45300	
100160	10	33124	
100168	48424	22744	
100176	48424	22744	
100217	42680	38940	
100232	10	23540	
100234	48424	22744	
100236	39460	35840	
100249	10	45300	
100252	10	38940	
100253	48424	22744	
100258	48424	22744	
100268	48424	22744	
100269	48424	22744	
100275	48424	22744	
100287	48424	22744	
100288	48424	22744	
100290	10	36740	
100292	10	18880	LUGAR
110001	19140	16860	
110002	11	31420	
110016	11	17980	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
110023	11	12060	
110029	23580	12060	
110038	11	46660	
110040	11	12060	LUGAR
110041	11	12060	
110054	40660	12060	
110069	47580	31420	
110075	11	42340	
110095	11	10500	
110105	11	10500	
110112	11	10500	
110122	46660	45220	
110125	11	31420	
110146	11	15260	
110150	11	31420	
110153	47580	31420	
110168	40660	12060	
110187	11	12060	LUGAR
110189	11	12060	
110190	11	47580	
130002	13	14260	
130003	30300	28420	
130049	17660	44060	
130067	13	26820	LUGAR
140008	16974	29404	
140010	16974	29404	
140012	14	16974	
140015	14	41180	
140018	16974	29404	
140032	14	41180	
140034	14	41180	
140040	14	37900	
140043	14	19340	
140046	14	41180	
140048	16974	29404	
140049	16974	29404	
140051	16974	29404	
140054	16974	29404	
140058	14	44100	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
140062	16974	29404	
140063	16974	29404	
140064	14	37900	
140065	16974	29404	
140068	16974	29404	
140075	16974	29404	
140080	16974	29404	
140082	16974	29404	
140083	16974	29404	
140088	16974	29404	
140094	16974	29404	
140095	16974	29404	
140103	16974	29404	
140110	14	16974	
140114	16974	29404	
140115	16974	29404	
140116	16974	29404	
140117	16974	29404	
140118	16974	29404	
140119	16974	29404	
140124	16974	29404	
140133	16974	29404	
140135	19500	16580	
140150	16974	29404	
140151	16974	29404	
140155	28100	16974	
140158	16974	29404	
140160	14	40420	
140161	14	16974	
140164	14	16020	
140166	19500	16580	
140172	16974	29404	
140176	16974	29404	
140177	16974	29404	
140179	16974	29404	
140180	16974	29404	
140181	16974	29404	
140182	16974	29404	
140186	28100	16974	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
140191	16974	29404	
140197	16974	29404	
140206	16974	29404	
140207	16974	29404	
140208	16974	29404	
140223	16974	29404	
140224	16974	29404	
140240	16974	29404	
140250	16974	29404	
140251	16974	29404	
140252	16974	29404	
140258	16974	29404	
140276	16974	29404	
140281	16974	29404	
140290	16974	29404	
140300	16974	29404	
140301	16974	29404	
140303	16974	29404	
150002	23844	16974	
150004	23844	16974	
150006	33140	43780	
150008	23844	16974	
150011	15	26900	
150015	33140	23844	
150018	21140	43780	
150023	45460	26900	
150030	15	26900	LUGAR
150034	23844	16974	
150042	15	45460	
150048	15	17140	
150051	14020	26900	
150064	15	26900	
150065	15	26900	
150069	15	17140	
150076	15	43780	
150088	11300	26900	
150089	34620	11300	
150090	23844	16974	
150091	15	23060	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
150102	15	23844	LUGAR
150112	18020	26900	
150113	11300	26900	
150125	23844	16974	
150126	23844	16974	
150133	15	43780	
150146	15	21140	
150165	23844	16974	
150166	23844	16974	
150170	23844	16974	
160001	16	19780	
160016	16	11180	
160057	16	26980	
160064	16	24	
160080	16	19340	
160147	16	11180	
170006	17	27900	
170013	17	28	
170020	17	48620	
170033	17	48620	
170058	17	28140	
170068	17	11100	
170142	31740	45820	
170175	17	48620	
180002	18	49	
180011	18	30460	
180012	21060	31140	
180013	14540	34980	
180017	18	14540	
180020	18	49	
180024	18	21060	
180027	18	17300	
180029	18	30460	
180043	18	44	
180044	18	26580	
180048	18	31140	
180050	18	28700	
180069	18	26580	
180078	18	26580	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
180080	18	28940	
180102	18	16020	
180104	18	16020	
180116	18	16020	
180124	14540	34980	
180127	18	17140	
180132	18	30460	
190003	19	29180	
190015	19	35380	
190017	19	29180	
190086	19	33740	
190106	19	10780	
190144	19	43340	
190164	19	45	
190167	19	29180	
190190	19	33740	
190218	19	43340	
190257	19	33740	
200002	20	38860	
200020	38860	40484	
200024	30340	38860	
200034	30340	38860	
200039	20	38860	
200050	20	12620	
220001	49340	14484	
220002	15764	14484	
220008	39300	14484	
220010	37764	14484	
220011	15764	14484	
220019	49340	14484	
220020	39300	14484	
220025	49340	14484	
220029	37764	14484	
220033	37764	14484	
220035	37764	14484	
220049	15764	14484	
220058	49340	14484	
220062	49340	14484	
220063	15764	14484	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
220070	15764	14484	
220073	39300	14484	
220074	39300	14484	
220077	44140	25540	
220080	37764	14484	
220082	15764	14484	
220084	15764	14484	
220090	49340	14484	
220095	49340	14484	
220098	15764	14484	
220101	15764	14484	
220105	15764	14484	
220163	49340	14484	
220171	15764	14484	
220174	37764	14484	
220175	15764	14484	
220176	49340	14484	
230002	19804	11460	
230003	26100	34740	
230013	47644	22420	
230019	47644	22420	
230020	19804	11460	
230021	35660	28020	
230022	23	12980	
230024	19804	11460	
230029	47644	22420	
230030	23	40980	
230035	23	24340	LUGAR
230036	23	13020	
230037	23	11460	
230038	24340	34740	
230047	47644	19804	
230053	19804	11460	
230054	23	24580	
230059	24340	34740	
230069	47644	11460	
230071	47644	22420	
230072	26100	34740	
230077	40980	22420	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
230089	19804	11460	
230095	23	13020	
230096	23	28020	
230097	23	24340	
230099	33780	11460	
230104	19804	11460	
230105	23	24340	
230106	24340	34740	
230121	23	29620	LUGAR
230130	47644	22420	
230135	19804	11460	
230142	19804	11460	
230146	19804	11460	
230151	47644	22420	
230165	19804	11460	
230174	26100	34740	
230176	19804	11460	
230195	47644	19804	
230204	47644	19804	
230207	47644	22420	
230208	23	24340	LUGAR
230222	23	13020	
230227	47644	19804	
230236	24340	34740	
230244	19804	11460	
230254	47644	22420	
230257	47644	19804	
230264	47644	19804	
230269	47644	22420	
230270	19804	11460	
230273	19804	11460	
230277	47644	22420	
230279	47644	11460	
230297	19804	11460	
230301	47644	22420	
230302	47644	22420	
230B04	47644	22420	
230B95	19804	11460	
240036	41060	33460	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
240069	24	33460	
240071	24	33460	
240187	24	33460	
250002	25	22520	
250004	25	32820	
250006	25	32820	
250009	25	27180	
250023	25	25060	LUGAR
250031	25	27140	
250034	25	32820	
250040	37700	25060	
250042	25	32820	
250069	25	46220	
250078	25620	25060	
250079	25	27140	
250081	25	46220	
250082	25	38220	
250094	25620	25060	
250095	25	27140	
250097	25	12940	
250099	25	27140	
250100	25	46220	
250104	25	46220	
250117	25	25060	LUGAR
260009	26	27620	
260017	26	27620	
260022	26	17860	
260025	26	41180	
260074	26	17860	
260094	26	44180	
260113	26	14	
260116	26	14	
260119	26	16020	
260175	26	28140	
260186	26	27620	
270003	27	24500	
270012	24500	33540	
270017	27	33540	
270051	27	33540	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
280009	28	30700	
280023	28	30700	
280065	28	24540	
280077	28	30700	
280125	28	43580	
290002	29	16180	LUGAR
290006	29	39900	
290019	16180	39900	
300011	31700	15764	
300012	31700	15764	
300017	40484	37764	
300019	30	44140	
300020	31700	15764	
300029	40484	37764	
300034	31700	15764	
310002	35084	35644	
310009	35084	35644	
310014	15804	37964	
310015	35084	35644	
310017	35084	35644	
310018	35084	35644	
310022	15804	37964	
310029	15804	37964	
310031	15804	20764	
310038	20764	35644	
310039	20764	35644	
310048	20764	35084	
310050	35084	35644	
310054	35084	35644	
310070	20764	35644	
310076	35084	35644	
310081	15804	37964	
310083	35084	35644	
310086	15804	37964	
310093	35084	35644	
310096	35084	35644	
310108	20764	35644	
310119	35084	35644	
320003	32	42140	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
320005	22140	10740	
320006	32	10740	
320013	32	42140	
320014	32	29740	
320033	32	42140	LUGAR
320063	32	36220	
330008	33	15380	LUGAR
330023	39100	35644	
330027	35004	35644	
330073	33	40380	LUGAR
330079	33	47	
330090	21300	27060	
330094	33	38340	
330106	35004	35644	
330126	39100	35644	
330136	33	10580	
330157	33	45060	
330167	35004	35644	
330181	35004	35644	
330182	35004	35644	
330191	24020	10580	
330198	35004	35644	
330213	33	46540	
330224	28740	39100	
330225	35004	35644	
330229	33	21500	
330239	33	21500	
330250	33	15540	
330259	35004	35644	
330277	33	27060	
330331	35004	35644	
330332	35004	35644	
330372	35004	35644	
330386	33	35084	
340004	24660	49180	
340008	34	26580	
340013	34	16740	
340015	34	16740	
340021	34	16740	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
340023	11700	24860	
340027	34	24780	
340037	34	16740	
340039	34	49180	
340050	34	22180	
340051	34	25860	
340068	34	34820	
340069	39580	20500	
340070	15500	24660	
340071	34	39580	LUGAR
340073	39580	20500	
340085	34	24660	LUGAR
340091	24660	49180	
340096	34	24660	LUGAR
340109	34	47260	
340114	39580	20500	
340115	34	20500	
340126	34	39580	
340127	34	20500	LUGAR
340129	34	16740	
340131	34	24780	
340138	39580	20500	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
340173	39580	20500	
350006	35	13900	
360010	36	15940	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	45780	
360027	10420	17460	
360036	36	31900	
360054	36	26580	
360055	49660	17460	
360065	36	17460	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
360078	10420	17460	
360086	44220	19380	
360095	36	45780	
360109	36	18140	
360112	45780	33780	
360121	36	45780	
360133	19380	17140	
360150	10420	17460	
360159	36	18140	
360175	36	18140	
360185	36	49660	LUGAR
360187	44220	19380	
360211	44600	38300	
360241	10420	17460	
360245	36	17460	LUGAR
370004	37	27900	
370006	37	46140	
370014	37	43300	
370015	37	46140	
370016	37	36420	
370018	37	46140	
370019	37	45	
370020	37	36420	
370022	37	30020	
370025	37	46140	
370026	37	36420	
370030	37	46140	
370047	37	36420	
370099	37	36420	
370113	37	22220	
380001	38	38900	
380022	38	18700	LUGAR
380027	38	21660	
380047	13460	21660	
380050	38	32780	
380051	41420	38900	
380090	38	21660	
390006	39	25420	
390013	39	25420	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
390016	39	38300	
390030	39	39740	LUGAR
390031	39	39740	LUGAR
390046	49620	29540	
390048	39	25420	
390065	39	13644	
390066	30140	25420	
390067	25420	29540	
390071	39	48700	LUGAR
390079	39	13780	
390086	39	38300	
390091	39	49660	
390093	39	49660	
390110	27780	38300	
390113	39	21500	
390133	10900	37964	
390138	39	25420	
390151	39	13644	
390162	10900	35084	
390185	42540	10900	
390313	39	39740	LUGAR
410001	39300	14484	
410004	39300	14484	
410005	39300	14484	
410007	39300	14484	
410010	39300	14484	
410011	39300	14484	
410012	39300	14484	
410013	39300	35980	
420007	43900	24860	
420009	42	24860	LUGAR
420020	42	16700	
420027	11340	24860	
420030	42	16700	
420036	42	17900	
420039	42	43900	LUGAR
420067	42	42340	
420068	42	12260	
420069	42	44940	LUGAR

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
420070	44940	17900	
420071	42	24860	
420080	42	42340	
420083	43900	24860	
420085	34820	48900	
420101	42	42340	
430012	43	43620	
440002	27180	32820	
440018	27740	28700	
440025	44	34	
440035	17300	34980	
440056	34100	28940	
440058	44	26620	
440059	44	34980	
440067	34100	28700	
440068	44	16860	
440073	44	34980	
440144	44	34980	
440151	44	34980	
440174	44	32820	
440185	17420	16860	
440192	44	34980	
450007	45	41700	
450032	45	30980	LUGAR
450039	23104	19124	
450064	23104	19124	
450080	45	19124	
450087	23104	19124	
450092	45	29700	
450099	45	11100	
450135	23104	19124	
450137	23104	19124	
450144	45	33260	
450147	47020	18580	
450148	23104	19124	
450178	45	36220	
450187	45	26420	
450211	45	30980	
450214	45	26420	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
450224	45	46340	
450283	45	19124	LUGAR
450324	43300	19124	
450347	45	26420	
450351	45	23104	
450370	45	26420	
450389	45	19124	LUGAR
450400	45	17780	
450419	23104	19124	
450438	45	26420	
450447	45	19124	
450465	45	26420	
450469	43300	19124	
450484	45	30980	
450508	45	30980	
450547	45	19124	
450563	23104	19124	
450565	45	23104	
450596	45	23104	
450604	45	41700	
450639	23104	19124	
450656	45	30980	
450672	23104	19124	
450675	23104	19124	
450677	23104	19124	
450747	45	46340	
450770	45	12420	LUGAR
450779	23104	19124	
450872	23104	19124	
450880	23104	19124	
450886	23104	19124	
460004	36260	41620	
460005	36260	41620	
460007	46	41100	
460026	46	39340	
460039	46	36260	
460041	36260	41620	
460042	36260	41620	
470001	47	15540	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
470012	47	38340	
490004	25500	16820	
490005	49020	47894	
490013	49	20500	
490018	49	16820	
490019	49	16820	
490042	13980	40220	
490043	47894	13644	
490063	47894	13644	
490066	47260	40060	
490079	49	49180	
490101	47894	13644	
490107	47894	13644	
490122	47894	13644	
500003	34580	42644	
500007	34580	42644	
500016	48300	42644	
500021	45104	42644	
500031	50	36500	
500039	14740	42644	
500041	31020	38900	
500072	50	14740	
500079	45104	42644	
500108	45104	42644	
500129	45104	42644	
510002	51	40220	
510006	51	34060	
510018	51	16620	LUGAR
510046	51	49	
510047	51	34060	
510050	48540	38300	
510062	51	16620	
510070	51	16620	
510071	51	13980	
510077	51	26580	
520002	52	48140	
520013	20740	33460	
520021	29404	16974	
520028	52	31540	LUGAR

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
520037	52	48140	
520059	39540	33340	
520071	52	33340	LUGAR
520076	52	33340	
520095	52	31540	
520096	39540	33340	
520102	52	33340	LUGAR
520107	52	22540	
520113	52	24580	
520116	52	33340	LUGAR
520189	29404	16974	
530014	16940	24540	

TABLE 9C.–HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT–FY 2011

Provider No.	Geographic CBSA	Redesignated Rural Area
040118	27860	04
050192	23420	05
050528	32900	05
050618	40140	05
070004	07	07
100048	37860	10
100118	37380	10
100134	27260	10
140167	14	14
170074	31740	17
170137	29940	17
180016	31140	18
180038	36980	18
220051	38340	22
230078	35660	23
250017	25	25
260006	41140	26
260034	28140	26
260047	27620	26
260195	44180	26
300023	40484	33
330215	46540	33
330235	33	33
330268	10580	33
340010	24140	34
340121	48900	34
360125	36	36
370054	36420	37
380040	13460	38
390130	27780	39
390183	39	39
390233	49620	39
450052	45	45
450078	10180	45
450243	10180	45
450348	45	45
490116	13980	49
500148	48300	50

TABLE 10.— GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG)—MARCH 2010[1]

MS-DRG	Number of Cases	Threshold
1	907	$434,245
2	333	$240,232
3	21,932	$280,834
4	21,377	$171,837
5	889	$181,631
6	408	$106,603
7	469	$180,685
8	508	$111,800
10	137	$87,191
11	1,465	$84,611
12	1,963	$62,285
13	1,008	$44,014
14	446	$173,221
15	1,371	$110,828
20	1,081	$161,767
21	468	$124,259
22	146	$85,874
23	4,406	$96,764
24	1,708	$70,333
25	11,578	$86,631
26	11,464	$61,699
27	12,575	$49,489
28	1,850	$90,885
29	3,505	$55,101
30	3,432	$35,818
31	1,169	$69,659
32	2,808	$42,884
33	3,346	$35,451
34	818	$71,961
35	2,329	$51,071
36	5,711	$43,574
37	4,943	$62,277
38	14,446	$39,441
39	43,741	$29,380
40	4,815	$69,423
41	7,549	$46,033

MS-DRG	Number of Cases	Threshold
42	3,807	$39,316
52	1,250	$35,010
53	487	$24,212
54	7,203	$33,761
55	13,021	$29,356
56	9,282	$33,807
57	43,183	$23,053
58	893	$33,327
59	3,245	$26,683
60	3,512	$20,846
61	2,265	$63,317
62	3,736	$49,373
63	1,306	$43,140
64	60,920	$39,190
65	112,506	$31,542
66	66,435	$23,769
67	1,387	$35,073
68	10,359	$26,739
69	92,456	$21,784
70	9,641	$38,473
71	13,705	$29,897
72	4,836	$21,740
73	8,924	$30,863
74	31,535	$24,268
75	1,345	$38,691
76	660	$26,901
77	1,517	$38,495
78	2,120	$29,153
79	773	$21,987
80	1,625	$29,586
81	5,863	$20,738
82	2,372	$40,097
83	2,594	$32,688
84	2,540	$25,202
85	7,305	$40,772
86	14,305	$30,370
87	13,004	$21,699
88	870	$35,610
89	3,155	$27,526
90	2,481	$20,786
91	8,734	$34,747
92	19,740	$25,249

MS-DRG	Number of Cases	Threshold
93	13,201	$19,449
94	1,426	$65,792
95	1,185	$49,565
96	540	$42,502
97	1,186	$61,456
98	1,063	$42,348
99	422	$33,115
100	19,251	$33,637
101	56,024	$21,484
102	1,284	$27,641
103	12,514	$20,151
113	639	$40,406
114	431	$26,196
115	849	$31,885
116	455	$31,888
117	549	$21,050
121	744	$23,633
122	523	$15,971
123	2,670	$21,955
124	738	$28,841
125	4,273	$18,988
129	1,508	$48,976
130	939	$34,737
131	1,132	$46,345
132	745	$33,424
133	2,242	$36,924
134	2,622	$24,387
135	466	$42,963
136	351	$28,285
137	890	$31,653
138	746	$22,447
139	1,361	$25,472
146	734	$41,764
147	1,362	$29,480
148	552	$23,055
149	33,589	$18,807
150	1,162	$29,226
151	6,159	$16,053
152	2,298	$25,939
153	11,461	$17,571
154	2,458	$32,534
155	6,150	$25,001

MS-DRG	Number of Cases	Threshold
156	3,513	$17,470
157	1,374	$33,896
158	3,705	$24,494
159	1,458	$16,289
163	13,429	$92,474
164	18,789	$56,614
165	10,516	$43,737
166	23,092	$68,109
167	19,774	$46,238
168	4,387	$34,990
175	14,073	$38,408
176	36,633	$29,043
177	68,096	$42,241
178	71,786	$34,277
179	16,033	$25,958
180	20,621	$38,793
181	26,178	$31,187
182	2,834	$23,827
183	2,662	$35,329
184	5,183	$26,627
185	2,185	$18,859
186	10,686	$35,963
187	10,940	$29,659
188	3,291	$21,555
189	94,000	$32,121
190	136,797	$30,807
191	150,301	$26,417
192	134,340	$19,737
193	103,862	$34,826
194	206,953	$27,354
195	86,964	$19,374
196	6,956	$36,218
197	6,785	$29,750
198	3,045	$22,571
199	3,790	$38,729
200	8,673	$27,771
201	2,745	$19,061
202	38,878	$23,055
203	28,973	$16,710
204	23,374	$19,911
205	6,673	$30,904
206	19,971	$21,524

MS-DRG	Number of Cases	Threshold
207	36,206	$96,662
208	74,943	$48,685
215	177	$197,565
216	9,531	$182,613
217	6,914	$133,364
218	1,220	$112,405
219	12,757	$149,444
220	16,859	$110,276
221	4,462	$96,359
222	2,753	$167,255
223	3,841	$131,602
224	2,736	$152,310
225	4,479	$125,719
226	7,259	$124,233
227	30,034	$103,955
228	2,305	$142,545
229	2,844	$101,007
230	806	$79,269
231	1,350	$165,608
232	1,219	$131,481
233	15,280	$140,586
234	27,390	$106,146
235	9,464	$111,951
236	25,454	$83,813
237	22,095	$98,558
238	40,046	$66,101
239	10,860	$70,090
240	10,778	$47,663
241	1,549	$34,093
242	17,876	$73,344
243	41,219	$58,653
244	44,714	$48,782
245	3,963	$84,900
246	30,895	$74,642
247	143,690	$54,799
248	14,355	$69,420
249	46,331	$51,231
250	7,651	$64,700
251	36,366	$49,826
252	40,559	$57,835
253	44,579	$53,429
254	38,311	$41,802

MS-DRG	Number of Cases	Threshold
255	2,482	$45,768
256	3,195	$35,494
257	394	$25,161
258	762	$59,622
259	5,040	$43,543
260	1,769	$63,839
261	3,898	$37,685
262	2,417	$30,338
263	517	$35,655
264	22,458	$46,679
265	1,714	$47,659
280	69,980	$39,490
281	53,379	$31,733
282	34,872	$24,367
283	12,645	$36,266
284	4,028	$25,976
285	1,426	$17,208
286	25,184	$47,068
287	134,625	$34,930
288	2,679	$54,285
289	1,196	$39,615
290	240	$31,203
291	176,278	$33,680
292	248,137	$26,745
293	117,949	$18,319
294	1,546	$26,111
295	874	$15,647
296	1,917	$31,226
297	762	$21,036
298	370	$13,581
299	21,212	$32,155
300	48,392	$24,880
301	28,761	$17,012
302	7,755	$26,119
303	52,448	$17,051
304	2,864	$28,173
305	33,320	$17,776
306	3,078	$32,067
307	6,028	$21,707
308	56,608	$30,569
309	107,651	$22,974
310	127,822	$16,117

MS-DRG	Number of Cases	Threshold
311	15,707	$15,028
312	164,947	$20,561
313	169,249	$17,054
314	61,143	$36,453
315	31,566	$26,084
316	10,661	$17,666
326	11,323	$100,038
327	10,427	$56,127
328	8,536	$37,088
329	46,053	$93,370
330	60,286	$55,007
331	24,223	$40,753
332	1,602	$86,827
333	5,288	$53,532
334	3,027	$39,164
335	7,048	$80,849
336	13,571	$51,477
337	7,645	$38,166
338	1,283	$66,771
339	2,986	$46,480
340	3,035	$35,170
341	906	$51,011
342	2,901	$37,261
343	6,446	$28,320
344	914	$61,169
345	3,050	$40,209
346	2,589	$30,770
347	1,477	$46,158
348	4,253	$33,994
349	4,036	$22,321
350	1,676	$49,482
351	4,531	$35,490
352	6,446	$24,273
353	3,228	$54,617
354	9,551	$38,734
355	12,936	$28,045
356	7,893	$69,691
357	7,603	$47,181
358	2,044	$35,035
368	3,304	$38,781
369	5,624	$29,781
370	1,776	$21,455

MS-DRG	Number of Cases	Threshold
371	22,527	$40,135
372	34,664	$31,161
373	11,188	$22,331
374	8,067	$41,336
375	17,153	$31,518
376	2,535	$24,404
377	48,249	$37,454
378	138,450	$27,315
379	50,738	$19,552
380	2,926	$41,150
381	6,193	$30,795
382	2,706	$23,160
383	1,129	$32,602
384	7,393	$25,019
385	2,206	$39,912
386	9,038	$29,099
387	4,129	$22,146
388	18,643	$35,848
389	54,825	$25,881
390	39,776	$18,232
391	45,134	$29,680
392	248,631	$20,958
393	21,573	$35,248
394	49,036	$27,559
395	20,047	$19,463
405	4,356	$94,902
406	5,109	$57,667
407	1,925	$43,571
408	1,492	$76,268
409	1,446	$53,357
410	474	$40,046
411	782	$75,017
412	838	$57,460
413	524	$44,552
414	4,697	$69,885
415	5,774	$48,153
416	3,984	$35,009
417	17,747	$55,518
418	27,480	$43,966
419	28,223	$34,296
420	711	$69,211
421	908	$43,258

MS-DRG	Number of Cases	Threshold
422	234	$34,441
423	1,486	$78,374
424	802	$51,529
425	86	$39,079
432	12,406	$36,533
433	8,081	$26,786
434	398	$17,634
435	12,193	$39,619
436	12,588	$31,248
437	2,181	$27,130
438	14,974	$38,269
439	27,894	$28,968
440	20,546	$20,564
441	14,420	$36,621
442	18,594	$26,589
443	4,681	$18,613
444	12,604	$36,356
445	19,019	$30,426
446	12,775	$22,512
453	1,132	$182,692
454	3,077	$132,948
455	2,469	$102,744
456	1,130	$164,516
457	3,192	$114,426
458	1,561	$93,166
459	3,821	$114,004
460	61,691	$76,529
461	636	$95,750
462	11,335	$71,162
463	5,297	$72,652
464	8,717	$52,913
465	2,706	$39,867
466	3,703	$87,195
467	20,146	$65,733
468	15,777	$55,334
469	27,068	$67,299
470	412,246	$49,549
471	2,809	$88,964
472	8,590	$59,484
473	25,031	$49,259
474	2,921	$58,249
475	3,780	$40,794

MS-DRG	Number of Cases	Threshold
476	1,133	$26,002
477	2,596	$65,108
478	8,906	$51,186
479	5,865	$41,443
480	24,261	$61,969
481	81,675	$45,348
482	33,813	$39,284
483	10,312	$54,770
484	17,960	$47,483
485	1,022	$63,293
486	2,389	$47,100
487	1,056	$38,013
488	3,242	$39,904
489	4,891	$31,977
490	22,896	$41,626
491	45,102	$27,812
492	5,163	$60,846
493	20,358	$43,967
494	25,195	$34,948
495	1,614	$54,469
496	4,879	$38,810
497	5,123	$29,492
498	1,480	$43,377
499	875	$26,447
500	1,848	$55,259
501	5,063	$37,568
502	5,734	$27,688
503	914	$46,218
504	2,807	$37,301
505	2,256	$29,136
506	716	$31,618
507	940	$43,481
508	1,782	$35,680
509	349	$34,621
510	1,057	$48,362
511	4,310	$38,156
512	8,239	$28,922
513	1,248	$33,152
514	920	$22,905
515	3,952	$61,716
516	12,225	$45,041
517	11,158	$37,652

MS-DRG	Number of Cases	Threshold
533	818	$32,358
534	3,460	$18,488
535	7,260	$30,780
536	32,783	$17,853
537	944	$21,930
538	707	$16,133
539	3,237	$38,638
540	4,242	$31,087
541	1,124	$22,751
542	5,508	$39,262
543	16,786	$29,624
544	6,621	$20,148
545	3,601	$42,580
546	6,143	$28,738
547	3,344	$20,085
548	578	$39,621
549	1,215	$29,575
550	555	$20,310
551	10,903	$35,750
552	77,153	$22,274
553	2,150	$28,226
554	17,287	$17,720
555	2,590	$27,936
556	17,502	$18,051
557	3,722	$35,286
558	17,209	$23,595
559	1,899	$34,415
560	5,300	$24,964
561	5,307	$16,072
562	5,857	$31,319
563	32,421	$18,265
564	1,779	$32,772
565	4,064	$24,269
566	1,758	$17,800
573	4,788	$50,542
574	10,014	$37,184
575	3,719	$27,509
576	644	$63,202
577	2,414	$37,754
578	2,529	$28,880
579	3,776	$52,443
580	11,546	$35,468

MS-DRG	Number of Cases	Threshold
581	10,745	$26,778
582	4,896	$29,747
583	7,560	$24,267
584	862	$36,952
585	1,459	$30,205
592	3,953	$34,195
593	11,208	$25,280
594	1,482	$17,532
595	1,114	$35,853
596	4,967	$22,362
597	559	$34,968
598	1,519	$28,537
599	185	$18,944
600	1,034	$25,106
601	778	$17,823
602	22,941	$32,031
603	137,791	$21,037
604	2,660	$30,594
605	20,161	$19,580
606	1,531	$28,668
607	7,082	$17,523
614	1,566	$52,876
615	1,350	$38,331
616	1,630	$73,334
617	6,557	$41,763
618	148	$31,392
619	840	$66,833
620	3,281	$45,226
621	11,420	$39,418
622	1,161	$51,332
623	2,540	$37,658
624	251	$27,170
625	1,200	$47,825
626	2,958	$33,033
627	12,193	$22,852
628	3,450	$60,959
629	4,714	$46,582
630	446	$36,422
637	18,690	$32,234
638	54,251	$21,744
639	24,864	$14,934
640	56,538	$27,789

MS-DRG	Number of Cases	Threshold
641	187,502	$18,502
642	1,603	$26,187
643	5,943	$37,831
644	13,581	$28,528
645	6,414	$20,136
652	10,206	$69,446
653	1,695	$103,526
654	3,717	$62,937
655	1,275	$45,981
656	3,219	$69,622
657	9,011	$47,214
658	6,794	$38,290
659	4,057	$62,116
660	8,536	$42,838
661	3,858	$35,296
662	794	$54,224
663	2,041	$35,553
664	3,279	$30,167
665	571	$54,953
666	2,190	$37,500
667	2,593	$21,648
668	3,075	$50,865
669	14,675	$33,924
670	8,752	$21,741
671	799	$34,868
672	633	$21,959
673	11,749	$52,536
674	9,543	$45,904
675	3,249	$37,269
682	99,060	$34,669
683	117,393	$26,883
684	26,713	$17,930
685	2,509	$22,911
686	1,144	$38,658
687	3,412	$28,835
688	705	$18,931
689	60,753	$29,890
690	213,524	$20,821
691	997	$39,723
692	380	$29,377
693	1,778	$34,011

MS-DRG	Number of Cases	Threshold
694	17,760	$21,450
695	1,093	$29,370
696	10,252	$17,381
697	509	$21,088
698	23,414	$34,055
699	31,796	$26,373
700	8,108	$18,232
707	5,391	$43,551
708	16,866	$36,159
709	817	$38,918
710	1,503	$32,486
711	739	$38,867
712	424	$23,105
713	9,757	$30,924
714	22,569	$17,966
715	505	$39,925
716	685	$32,503
717	734	$35,429
718	446	$22,030
722	477	$34,256
723	1,933	$27,779
724	276	$17,297
725	468	$30,772
726	3,907	$18,897
727	1,529	$31,681
728	6,091	$20,560
729	836	$25,783
730	276	$17,460
734	1,520	$49,324
735	1,137	$33,179
736	903	$83,470
737	3,274	$47,200
738	711	$34,082
739	905	$63,570
740	4,458	$39,308
741	5,381	$30,656
742	10,803	$35,874
743	27,629	$25,402
744	1,623	$35,398
745	1,263	$24,085
746	2,619	$34,032

MS-DRG	Number of Cases	Threshold
747	7,244	$24,914
748	17,063	$25,408
749	1,052	$49,175
750	362	$25,774
754	1,022	$40,025
755	3,404	$28,901
756	440	$18,265
757	1,322	$36,079
758	2,220	$29,154
759	978	$20,075
760	2,268	$22,173
761	1,135	$15,266
765	3,416	$23,396
766	2,753	$15,950
767	168	$18,876
769	122	$36,289
770	177	$19,526
774	1,665	$13,966
775	5,850	$10,155
776	588	$17,142
777	197	$22,190
778	444	$10,944
779	121	$14,296
780	42	$5,027
781	3,387	$16,074
782	188	$10,992
799	537	$93,801
800	686	$56,226
801	356	$39,392
802	935	$61,181
803	1,162	$41,905
804	764	$30,381
808	7,976	$42,063
809	14,309	$29,974
810	2,165	$25,051
811	29,067	$29,896
812	100,121	$21,370
813	11,434	$30,788
814	1,595	$35,777
815	3,792	$27,743
816	1,528	$19,965

MS-DRG	Number of Cases	Threshold
820	1,268	$101,585
821	2,060	$50,233
822	1,736	$33,712
823	1,872	$83,644
824	3,132	$50,598
825	1,442	$33,753
826	602	$86,073
827	1,497	$47,782
828	694	$36,506
829	1,398	$51,566
830	384	$31,420
834	3,700	$70,199
835	3,043	$39,872
836	1,199	$26,518
837	1,266	$106,271
838	1,553	$53,954
839	1,282	$31,359
840	7,556	$51,514
841	10,908	$36,242
842	3,637	$28,006
843	1,480	$38,892
844	2,961	$30,255
845	666	$23,011
846	2,613	$42,088
847	22,015	$29,252
848	1,106	$24,344
849	1,161	$32,275
853	39,157	$91,531
854	8,734	$55,845
855	337	$34,562
856	5,924	$76,601
857	9,805	$41,686
858	2,324	$32,633
862	9,495	$38,011
863	21,662	$24,948
864	18,165	$22,959
865	2,268	$32,370
866	7,434	$20,691
867	5,312	$44,169
868	2,854	$28,484
869	778	$18,946

MS-DRG	Number of Cases	Threshold
870	25,704	$106,185
871	246,469	$39,940
872	110,301	$29,921
876	656	$47,281
880	8,141	$17,733
881	4,536	$13,825
882	1,797	$13,928
883	863	$21,336
884	18,103	$22,036
885	88,143	$17,427
886	525	$16,974
887	466	$20,752
894	4,519	$9,250
895	6,272	$18,826
896	6,916	$31,320
897	36,847	$15,672
901	937	$59,770
902	1,889	$36,330
903	1,026	$27,622
904	1,894	$50,605
905	763	$30,023
906	706	$27,779
907	8,651	$64,343
908	9,015	$41,044
909	4,756	$30,985
913	871	$31,045
914	5,457	$19,215
915	1,429	$32,069
916	5,627	$12,701
917	19,110	$33,847
918	36,704	$17,074
919	10,760	$34,206
920	15,239	$25,970
921	7,309	$16,831
922	1,046	$31,696
923	3,197	$18,119
927	188	$191,332
928	947	$70,439
929	366	$39,682
933	138	$35,364
934	608	$27,112

MS-DRG	Number of Cases	Threshold
935	2,111	$25,585
939	718	$53,737
940	1,636	$38,331
941	1,454	$31,143
945	5,962	$22,482
946	2,808	$19,520
947	12,288	$28,163
948	55,407	$18,688
949	639	$24,011
950	276	$12,574
951	1,027	$17,059
955	443	$101,419
956	4,421	$63,509
957	1,436	$116,430
958	1,214	$76,277
959	200	$50,235
963	1,769	$55,015
964	2,904	$35,973
965	911	$25,761
969	631	$88,018
970	102	$55,798
974	5,213	$46,839
975	4,509	$31,862
976	1,528	$24,990
977	3,545	$27,392
981	25,552	$87,682
982	19,654	$58,273
983	4,889	$41,091
984	505	$63,106
985	1,056	$46,172
986	447	$30,153
987	7,984	$61,556
988	10,936	$41,576
989	3,945	$29,355
999	17	$24,638

[1]Cases taken from the FY 2009 MedPAR file; MS-DRGs are from GROUPER Version 28.0.

TABLE 11.—PROPOSED MS-LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND SHORT-STAY OUTLIER (SSO) THRESHOLD FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2010 THROUGH SEPTEMBER 30, 2011 UNDER THE LTCH PPS

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
1	1	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	0	0.0000	0.0	0.0
2	1	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	0	0.0000	0.0	0.0
3	3	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	270	4.6420	65.4	54.5
4	4	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	1,536	2.9398	43.7	36.4
5	5	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	0	0.0000	0.0	0.0
6	5	LIVER TRANSPLANT W/O MCC	0	0.0000	0.0	0.0
7	7	LUNG TRANSPLANT	0	0.0000	0.0	0.0
8	8	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0	0.0000	0.0	0.0
10	10	PANCREAS TRANSPLANT	0	0.0000	0.0	0.0
11	11	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	1	1.0834	28.9	24.1
12	11	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	0	0.8745	23.3	19.4
13	11	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	0	0.4878	18.1	15.1
14	14	ALLOGENEIC BONE MARROW TRANSPLANT	0	0.5578	19.4	16.2
15	15	AUTOLOGOUS BONE MARROW TRANSPLANT	0	0.5578	19.4	16.2
20	20	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	1	1.6495	36.4	30.3
21	20	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	0	0.6040	22.1	18.4
22	20	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	0	0.4878	18.1	15.1
23	23	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	0	1.0834	28.9	24.1
24	23	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	0	0.4878	18.1	15.1
25	25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	2	1.0834	28.9	24.1
26	25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	1	0.4878	18.1	15.1
27	25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	0	0.4878	18.1	15.1
28	28	SPINAL PROCEDURES W MCC	11	1.0834	28.9	24.1
29	28	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	16	0.8667	24.6	20.5

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
30	28	SPINAL PROCEDURES W/O CC/MCC	0	0.8667	24.6	20.5
31	31	VENTRICULAR SHUNT PROCEDURES W MCC	1	1.0834	28.9	24.1
32	31	VENTRICULAR SHUNT PROCEDURES W CC	0	1.0834	28.9	24.1
33	31	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
34	34	CAROTID ARTERY STENT PROCEDURE W MCC	0	1.6495	36.4	30.3
35	34	CAROTID ARTERY STENT PROCEDURE W CC	0	1.6495	36.4	30.3
36	34	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	0	1.6495	36.4	30.3
37	37	EXTRACRANIAL PROCEDURES W MCC*	13	1.6495	36.4	30.3
38	37	EXTRACRANIAL PROCEDURES W CC	4	1.6495	36.4	30.3
39	37	EXTRACRANIAL PROCEDURES W/O CC/MCC	0	1.6495	36.4	30.3
40	40	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	116	1.2680	34.0	28.3
41	40	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	82	0.8898	29.0	24.2
42	40	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	3	0.4878	18.1	15.1
52	52	SPINAL DISORDERS & INJURIES W CC/MCC*	64	1.1123	41.2	34.3
53	52	SPINAL DISORDERS & INJURIES W/O CC/MCC	6	1.1123	41.2	34.3
54	54	NERVOUS SYSTEM NEOPLASMS W MCC	32	0.7988	27.3	22.8
55	54	NERVOUS SYSTEM NEOPLASMS W/O MCC	35	0.5857	19.2	16.0
56	56	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1,122	0.8046	25.6	21.3
57	56	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	1,142	0.5744	23.7	19.8
58	58	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	11	1.6495	36.4	30.3
59	58	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	14	0.6280	20.9	17.4
60	58	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	4	0.4878	18.1	15.1
61	61	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	0	0.9204	23.3	19.4
62	61	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	0	0.6172	22.1	18.4
63	61	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	0	0.6172	22.1	18.4
64	64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	145	0.8377	24.2	20.2
65	64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	52	0.6040	22.1	18.4
66	64	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	9	0.4878	18.1	15.1
67	67	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	0	0.4878	18.1	15.1
68	67	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	3	0.4878	18.1	15.1
69	69	TRANSIENT ISCHEMIA	2	1.0834	28.9	24.1
70	70	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	182	0.9204	23.3	19.4
71	70	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC*	92	0.6172	22.1	18.4
72	70	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	9	0.6172	22.1	18.4
73	73	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	112	0.8684	24.9	20.8
74	73	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	111	0.6375	21.9	18.3
75	75	VIRAL MENINGITIS W CC/MCC	9	0.8667	24.6	20.5
76	75	VIRAL MENINGITIS W/O CC/MCC	0	0.8667	24.6	20.5
77	77	HYPERTENSIVE ENCEPHALOPATHY W MCC	2	0.8667	24.6	20.5
78	77	HYPERTENSIVE ENCEPHALOPATHY W CC	2	0.8667	24.6	20.5
79	77	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0	0.6280	20.9	17.4
80	80	NONTRAUMATIC STUPOR & COMA W MCC	8	1.0834	28.9	24.1
81	80	NONTRAUMATIC STUPOR & COMA W/O MCC	6	0.4878	18.1	15.1
82	82	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	15	0.8667	24.6	20.5
83	82	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	9	0.6280	20.9	17.4
84	82	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	1	0.4878	18.1	15.1
85	85	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	92	0.9280	25.1	20.9
86	85	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	56	0.6865	23.9	19.9
87	85	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	8	0.4878	18.1	15.1
88	88	CONCUSSION W MCC	0	1.0834	28.9	24.1
89	88	CONCUSSION W CC	1	1.0834	28.9	24.1
90	88	CONCUSSION W/O CC/MCC	1	0.8667	24.6	20.5
91	91	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	264	0.8775	24.3	20.3
92	91	OTHER DISORDERS OF NERVOUS SYSTEM W CC	98	0.7482	24.2	20.2
93	91	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	7	0.4878	18.1	15.1
94	94	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	247	1.1110	29.4	24.5
95	94	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC*	99	0.8203	25.3	21.1
96	94	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	22	0.8203	25.3	21.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
97	97	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	70	0.9186	24.6	20.5
98	97	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	23	0.6280	20.9	17.4
99	97	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	4	0.4878	18.1	15.1
100	100	SEIZURES W MCC	32	0.7248	21.5	17.9
101	100	SEIZURES W/O MCC	36	0.6180	21.8	18.2
102	102	HEADACHES W MCC	2	0.8667	24.6	20.5
103	102	HEADACHES W/O MCC	0	0.4878	18.1	15.1
113	113	ORBITAL PROCEDURES W CC/MCC	1	1.0834	28.9	24.1
114	113	ORBITAL PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
115	115	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	0	1.0834	28.9	24.1
116	116	INTRAOCULAR PROCEDURES W CC/MCC	0	1.0834	28.9	24.1
117	116	INTRAOCULAR PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
121	121	ACUTE MAJOR EYE INFECTIONS W CC/MCC	9	0.6280	20.9	17.4
122	121	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	3	0.4878	18.1	15.1
123	123	NEUROLOGICAL EYE DISORDERS	0	1.0834	28.9	24.1
124	124	OTHER DISORDERS OF THE EYE W MCC*	6	1.0834	28.9	24.1
125	124	OTHER DISORDERS OF THE EYE W/O MCC	3	1.0834	28.9	24.1
129	129	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	0	1.2634	27.1	22.6
130	129	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	0	0.4878	18.1	15.1
131	131	CRANIAL/FACIAL PROCEDURES W CC/MCC	1	1.6495	36.4	30.3
132	131	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	0	0.8203	25.3	21.1
133	133	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	9	1.6495	36.4	30.3
134	133	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	0	0.4878	18.1	15.1
135	135	SINUS & MASTOID PROCEDURES W CC/MCC	0	1.6495	36.4	30.3
136	135	SINUS & MASTOID PROCEDURES W/O CC/MCC	0	0.4878	18.1	15.1
137	137	MOUTH PROCEDURES W CC/MCC	0	0.6280	20.9	17.4
138	137	MOUTH PROCEDURES W/O CC/MCC	0	0.6280	20.9	17.4
139	139	SALIVARY GLAND PROCEDURES	0	0.6280	20.9	17.4
146	146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	39	1.2634	27.1	22.6
147	146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	31	0.8745	23.3	19.4
148	146	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	3	0.4878	18.1	15.1
149	149	DYSEQUILIBRIUM	2	0.4878	18.1	15.1
150	150	EPISTAXIS W MCC	0	0.8587	25.4	21.2
151	150	EPISTAXIS W/O MCC	1	0.4878	18.1	15.1
152	152	OTITIS MEDIA & URI W MCC	31	0.8587	25.4	21.2
153	152	OTITIS MEDIA & URI W/O MCC	28	0.5982	19.9	16.6
154	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	49	1.0726	26.3	21.9
155	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC*	42	0.8203	25.3	21.1
156	154	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	8	0.8203	25.3	21.1
157	157	DENTAL & ORAL DISEASES W MCC	9	1.0834	28.9	24.1
158	157	DENTAL & ORAL DISEASES W CC	24	0.6280	20.9	17.4
159	157	DENTAL & ORAL DISEASES W/O CC/MCC	4	0.6280	20.9	17.4
163	163	MAJOR CHEST PROCEDURES W MCC	28	2.4302	42.0	35.0
164	163	MAJOR CHEST PROCEDURES W CC	5	1.6495	36.4	30.3
165	163	MAJOR CHEST PROCEDURES W/O CC/MCC	0	1.5463	31.4	26.2
166	166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	1,742	2.5489	42.0	35.0
167	166	OTHER RESP SYSTEM O.R. PROCEDURES W CC*	174	1.5463	31.4	26.2
168	166	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	8	1.5463	31.4	26.2
175	175	PULMONARY EMBOLISM W MCC	105	0.7521	22.7	18.9
176	175	PULMONARY EMBOLISM W/O MCC	72	0.5489	18.8	15.7
177	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	4,071	0.8895	22.9	19.1
178	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1,912	0.7193	20.8	17.3
179	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	143	0.6009	17.1	14.3
180	180	RESPIRATORY NEOPLASMS W MCC	117	0.7510	20.1	16.8
181	180	RESPIRATORY NEOPLASMS W CC	64	0.6640	19.9	16.6
182	180	RESPIRATORY NEOPLASMS W/O CC/MCC	2	0.6280	20.9	17.4
183	183	MAJOR CHEST TRAUMA W MCC	0	2.4302	42.0	35.0
184	183	MAJOR CHEST TRAUMA W CC	0	1.6495	36.4	30.3
185	183	MAJOR CHEST TRAUMA W/O CC/MCC	0	1.5463	31.4	26.2
186	186	PLEURAL EFFUSION W MCC	147	0.7405	20.7	17.3
187	186	PLEURAL EFFUSION W CC	41	0.5699	18.8	15.7
188	186	PLEURAL EFFUSION W/O CC/MCC	3	0.4878	18.1	15.1
189	189	PULMONARY EDEMA & RESPIRATORY FAILURE	8,376	0.9737	23.5	19.6
190	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	2,365	0.7421	20.2	16.8
191	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	1,129	0.6316	18.4	15.3
192	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	286	0.5081	16.4	13.7
193	193	SIMPLE PNEUMONIA & PLEURISY W MCC	2,120	0.7644	20.9	17.4
194	193	SIMPLE PNEUMONIA & PLEURISY W CC	1,554	0.6152	18.9	15.8
195	193	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	162	0.4881	16.7	13.9

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
196	196	INTERSTITIAL LUNG DISEASE W MCC	96	0.7048	20.4	17.0
197	196	INTERSTITIAL LUNG DISEASE W CC	71	0.6056	18.6	15.5
198	196	INTERSTITIAL LUNG DISEASE W/O CC/MCC	20	0.4878	18.1	15.1
199	199	PNEUMOTHORAX W MCC	80	0.7749	21.5	17.9
200	199	PNEUMOTHORAX W CC	15	0.6280	20.9	17.4
201	199	PNEUMOTHORAX W/O CC/MCC	4	0.4878	18.1	15.1
202	202	BRONCHITIS & ASTHMA W CC/MCC	114	0.7236	20.9	17.4
203	202	BRONCHITIS & ASTHMA W/O CC/MCC	10	0.6280	20.9	17.4
204	204	RESPIRATORY SIGNS & SYMPTOMS	144	0.7769	21.1	17.6
205	205	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	376	0.8291	22.1	18.4
206	205	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	145	0.7030	20.7	17.3
207	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	14,744	2.0241	33.3	27.8
208	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	1,828	1.0948	22.2	18.5
215	215	OTHER HEART ASSIST SYSTEM IMPLANT	0	0.6280	20.9	17.4
216	216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	0	1.6495	36.4	30.3
217	216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	0	1.2501	30.4	25.3
218	216	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	0	0.6280	20.9	17.4
219	219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	0	1.6495	36.4	30.3
220	219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	1	1.6495	36.4	30.3
221	219	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	0	0.6280	20.9	17.4
222	222	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	0	1.6495	36.4	30.3
223	222	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	0	0.8667	24.6	20.5
224	224	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	0	1.6495	36.4	30.3
225	224	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	1	0.6280	20.9	17.4
226	226	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6	1.6495	36.4	30.3
227	226	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	2	1.6495	36.4	30.3
228	228	OTHER CARDIOTHORACIC PROCEDURES W MCC	0	1.3830	30.1	25.1
229	228	OTHER CARDIOTHORACIC PROCEDURES W CC	0	1.2501	30.4	25.3
230	228	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	0	0.6280	20.9	17.4
231	231	CORONARY BYPASS W PTCA W MCC	0	1.6495	36.4	30.3
232	231	CORONARY BYPASS W PTCA W/O MCC	0	0.6280	20.9	17.4
233	233	CORONARY BYPASS W CARDIAC CATH W MCC	0	1.6495	36.4	30.3
234	233	CORONARY BYPASS W CARDIAC CATH W/O MCC	0	0.6280	20.9	17.4
235	235	CORONARY BYPASS W/O CARDIAC CATH W MCC	0	1.6495	36.4	30.3
236	235	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	1	0.6280	20.9	17.4
237	237	MAJOR CARDIOVASC PROCEDURES W MCC OR THORACIC AORTIC ANEURYSM REPAIR	6	1.6495	36.4	30.3
238	237	MAJOR CARDIOVASC PROCEDURES W/O MCC	0	0.6280	20.9	17.4
239	239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	142	1.5508	36.9	30.8
240	239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	55	1.3458	35.0	29.2
241	239	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	0	0.6280	20.9	17.4
242	242	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3	1.6495	36.4	30.3
243	242	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	6	0.8667	24.6	20.5
244	242	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	1	0.4878	18.1	15.1
245	245	AICD GENERATOR PROCEDURES	0	0.4878	18.1	15.1
246	246	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	0	1.3830	30.1	25.1
247	246	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2	0.8667	24.6	20.5
248	248	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	1	1.6495	36.4	30.3
249	248	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1	0.6280	20.9	17.4
250	250	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	3	1.0834	28.9	24.1
251	250	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	0	1.0834	28.9	24.1
252	252	OTHER VASCULAR PROCEDURES W MCC	110	1.3830	30.1	25.1
253	252	OTHER VASCULAR PROCEDURES W CC	46	1.2501	30.4	25.3
254	252	OTHER VASCULAR PROCEDURES W/O CC/MCC	2	0.6280	20.9	17.4

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
255	255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	37	1.2192	33.9	28.3
256	255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	22	1.0834	28.9	24.1
257	255	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	0	0.6280	20.9	17.4
258	258	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	1	0.8667	24.6	20.5
259	258	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	0	0.6280	20.9	17.4
260	260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	2	1.6495	36.4	30.3
261	260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	3	1.0834	28.9	24.1
262	260	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1	0.6280	20.9	17.4
263	263	VEIN LIGATION & STRIPPING	2	1.6495	36.4	30.3
264	264	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	594	1.0441	30.6	25.5
265	265	AICD LEAD PROCEDURES	0	1.0441	30.6	25.5
280	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	271	0.7702	22.2	18.5
281	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	105	0.6663	20.9	17.4
282	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	12	0.4878	18.1	15.1
283	283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	46	0.9091	17.2	14.3
284	283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	6	0.6280	20.9	17.4
285	283	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0	0.6280	20.9	17.4
286	286	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	11	1.6495	36.4	30.3
287	286	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	5	0.8667	24.6	20.5
288	288	ACUTE & SUBACUTE ENDOCARDITIS W MCC	646	1.0263	26.3	21.9
289	288	ACUTE & SUBACUTE ENDOCARDITIS W CC	240	0.8452	26.2	21.8
290	288	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	25	0.7600	27.8	23.2
291	291	HEART FAILURE & SHOCK W MCC	1,436	0.7773	21.5	17.9
292	291	HEART FAILURE & SHOCK W CC	872	0.6120	19.5	16.3
293	291	HEART FAILURE & SHOCK W/O CC/MCC	83	0.4418	16.9	14.1
294	294	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	8	1.6495	36.4	30.3
295	294	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0	0.5156	20.0	16.7
296	296	CARDIAC ARREST, UNEXPLAINED W MCC	0	0.7773	21.5	17.9
297	296	CARDIAC ARREST, UNEXPLAINED W CC	0	0.6120	19.5	16.3
298	296	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0	0.4418	16.9	14.1
299	299	PERIPHERAL VASCULAR DISORDERS W MCC	735	0.7976	23.7	19.8
300	299	PERIPHERAL VASCULAR DISORDERS W CC	696	0.5845	21.6	18.0
301	299	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	39	0.5156	20.0	16.7
302	302	ATHEROSCLEROSIS W MCC	49	0.8801	22.6	18.8
303	302	ATHEROSCLEROSIS W/O MCC	38	0.5651	21.5	17.9
304	304	HYPERTENSION W MCC	3	1.6495	36.4	30.3
305	304	HYPERTENSION W/O MCC	14	0.6280	20.9	17.4
306	306	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	58	0.8633	24.3	20.3
307	306	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	37	0.8144	24.4	20.3
308	308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	131	0.7120	20.7	17.3
309	308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	55	0.5307	19.3	16.1
310	308	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	11	0.4878	18.1	15.1
311	311	ANGINA PECTORIS	1	0.8667	24.6	20.5
312	312	SYNCOPE & COLLAPSE	29	0.4995	17.3	14.4
313	313	CHEST PAIN	3	0.8667	24.6	20.5
314	314	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1,566	0.9068	23.1	19.3
315	314	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	314	0.6812	21.5	17.9
316	314	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	26	0.5394	19.2	16.0
326	326	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	24	1.6495	36.4	30.3
327	326	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	3	0.8667	24.6	20.5
328	326	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1	0.8667	24.6	20.5
329	329	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	28	1.7888	41.2	34.3
330	329	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	8	1.6495	36.4	30.3
331	329	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
332	332	RECTAL RESECTION W MCC	0	1.0834	28.9	24.1
333	332	RECTAL RESECTION W CC	0	0.8667	24.6	20.5
334	332	RECTAL RESECTION W/O CC/MCC	0	0.8667	24.6	20.5
335	335	PERITONEAL ADHESIOLYSIS W MCC	10	1.6495	36.4	30.3
336	335	PERITONEAL ADHESIOLYSIS W CC	1	1.0834	28.9	24.1
337	335	PERITONEAL ADHESIOLYSIS W/O CC/MCC	0	1.0834	28.9	24.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
338	338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	0	0.7254	22.0	18.3
339	338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	0	0.7254	22.0	18.3
340	338	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0	0.5065	17.1	14.3
341	341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	0	0.9536	24.3	20.3
342	341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	0	0.7254	22.0	18.3
343	341	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0	0.5065	17.1	14.3
344	344	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC*	1	1.0834	28.9	24.1
345	344	MINOR SMALL & LARGE BOWEL PROCEDURES W CC*	1	1.0834	28.9	24.1
346	344	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
347	347	ANAL & STOMAL PROCEDURES W MCC	3	1.0834	28.9	24.1
348	347	ANAL & STOMAL PROCEDURES W CC	2	0.8667	24.6	20.5
349	347	ANAL & STOMAL PROCEDURES W/O CC/MCC	0	0.8667	24.6	20.5
350	350	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	1	1.6495	36.4	30.3
351	350	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	0	0.4878	18.1	15.1
352	350	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	0	0.4878	18.1	15.1
353	353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	3	1.0834	28.9	24.1
354	353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1	0.4878	18.1	15.1
355	353	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	0	0.4878	18.1	15.1
356	356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	141	1.7106	35.6	29.7
357	356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	26	1.1300	29.0	24.2
358	356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	3	1.0834	28.9	24.1
368	368	MAJOR ESOPHAGEAL DISORDERS W MCC	34	1.0400	22.4	18.7
369	368	MAJOR ESOPHAGEAL DISORDERS W CC	12	0.6280	20.9	17.4
370	368	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC*	1	0.6280	20.9	17.4
371	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	949	0.9536	24.3	20.3
372	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	342	0.7254	22.0	18.3
373	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	31	0.5065	17.1	14.3
374	374	DIGESTIVE MALIGNANCY W MCC	101	0.8268	21.0	17.5
375	374	DIGESTIVE MALIGNANCY W CC	56	0.6770	21.3	17.8
376	374	DIGESTIVE MALIGNANCY W/O CC/MCC	3	0.4878	18.1	15.1
377	377	G.I. HEMORRHAGE W MCC	88	0.7978	22.5	18.8
378	377	G.I. HEMORRHAGE W CC	43	0.6163	21.3	17.8
379	377	G.I. HEMORRHAGE W/O CC/MCC	8	0.4878	18.1	15.1
380	380	COMPLICATED PEPTIC ULCER W MCC	22	1.0834	28.9	24.1
381	380	COMPLICATED PEPTIC ULCER W CC	17	0.8667	24.6	20.5
382	380	COMPLICATED PEPTIC ULCER W/O CC/MCC	1	0.8667	24.6	20.5
383	383	UNCOMPLICATED PEPTIC ULCER W MCC	9	0.4878	18.1	15.1
384	383	UNCOMPLICATED PEPTIC ULCER W/O MCC*	5	0.4878	18.1	15.1
385	385	INFLAMMATORY BOWEL DISEASE W MCC	32	0.9126	23.3	19.4
386	385	INFLAMMATORY BOWEL DISEASE W CC	26	0.7394	25.5	21.3
387	385	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	2	0.4878	18.1	15.1
388	388	G.I. OBSTRUCTION W MCC	218	0.9443	23.4	19.5
389	388	G.I. OBSTRUCTION W CC	83	0.6325	19.8	16.5
390	388	G.I. OBSTRUCTION W/O CC/MCC	10	0.4878	18.1	15.1
391	391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	342	0.9298	23.1	19.3
392	391	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	194	0.6310	19.9	16.6
393	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	970	1.0710	25.8	21.5
394	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	389	0.7560	21.8	18.2
395	393	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	17	0.6280	20.9	17.4
405	405	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	17	1.6495	36.4	30.3
406	405	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2	1.0834	28.9	24.1
407	405	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	0	0.6280	20.9	17.4
408	408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	1	1.6495	36.4	30.3
409	408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	1	1.0834	28.9	24.1
410	408	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	0	0.6280	20.9	17.4
411	411	CHOLECYSTECTOMY W C.D.E. W MCC	1	1.6495	36.4	30.3
412	411	CHOLECYSTECTOMY W C.D.E. W CC	0	1.6495	36.4	30.3
413	411	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	0	0.6280	20.9	17.4
414	414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	0	1.6495	36.4	30.3
415	414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	0	1.6495	36.4	30.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
416	414	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1	1.6495	36.4	30.3
417	417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	10	1.6495	36.4	30.3
418	417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	2	1.6495	36.4	30.3
419	417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1	0.6280	20.9	17.4
420	420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	0	1.6495	36.4	30.3
421	420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	0	1.6495	36.4	30.3
422	420	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	0	1.6495	36.4	30.3
423	423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	17	1.6495	36.4	30.3
424	423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	3	1.6495	36.4	30.3
425	423	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	0	1.6495	36.4	30.3
432	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	80	0.6674	20.3	16.9
433	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	11	0.6280	20.9	17.4
434	432	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0	0.6280	20.9	17.4
435	435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	41	0.8842	20.1	16.8
436	435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	11	0.6280	20.9	17.4
437	435	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	1	0.4878	18.1	15.1
438	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	310	1.0513	23.8	19.8
439	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	122	0.7550	21.1	17.6
440	438	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	13	0.4878	18.1	15.1
441	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	228	0.8011	22.2	18.5
442	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC*	72	0.7091	23.1	19.3
443	441	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	8	0.7091	23.1	19.3
444	444	DISORDERS OF THE BILIARY TRACT W MCC	127	0.7728	21.5	17.9
445	444	DISORDERS OF THE BILIARY TRACT W CC*	47	0.5847	20.7	17.3
446	444	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	12	0.5847	20.7	17.3
453	453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	0	1.6495	36.4	30.3
454	453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	0	1.6495	36.4	30.3
455	453	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	0	1.0834	28.9	24.1
456	456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	2	1.6495	36.4	30.3
457	456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC	0	1.6495	36.4	30.3
458	456	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC	0	1.0834	28.9	24.1
459	459	SPINAL FUSION EXCEPT CERVICAL W MCC	2	1.6495	36.4	30.3
460	459	SPINAL FUSION EXCEPT CERVICAL W/O MCC	1	1.0834	28.9	24.1
461	461	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	0	1.6495	36.4	30.3
462	461	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	0	1.6495	36.4	30.3
463	463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	845	1.4194	39.1	32.6
464	463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	306	1.0953	34.3	28.6
465	463	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	23	0.8667	24.6	20.5
466	466	REVISION OF HIP OR KNEE REPLACEMENT W MCC	4	1.6495	36.4	30.3
467	466	REVISION OF HIP OR KNEE REPLACEMENT W CC	1	0.8667	24.6	20.5
468	466	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC*	0	0.8667	24.6	20.5
469	469	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	2	1.6495	36.4	30.3
470	469	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2	1.6495	36.4	30.3
471	471	CERVICAL SPINAL FUSION W MCC	0	1.0834	28.9	24.1
472	471	CERVICAL SPINAL FUSION W CC	1	1.0834	28.9	24.1
473	471	CERVICAL SPINAL FUSION W/O CC/MCC	0	1.0834	28.9	24.1
474	474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	140	1.3860	36.9	30.8
475	474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	51	1.0993	34.1	28.4
476	474	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	4	0.6280	20.9	17.4
477	477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	32	1.3916	38.2	31.8
478	477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	13	1.0834	28.9	24.1
479	477	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC*	1	1.0834	28.9	24.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
480	480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC*	13	1.6495	36.4	30.3
481	480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	6	1.6495	36.4	30.3
482	480	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1	1.6495	36.4	30.3
483	483	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W CC/MCC	0	1.6495	36.4	30.3
484	483	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W/O CC/MCC	0	1.6495	36.4	30.3
485	485	KNEE PROCEDURES W PDX OF INFECTION W MCC	11	1.0834	28.9	24.1
486	485	KNEE PROCEDURES W PDX OF INFECTION W CC	9	1.0834	28.9	24.1
487	485	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	2	0.6280	20.9	17.4
488	488	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	0	1.0834	28.9	24.1
489	488	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	0	0.6280	20.9	17.4
490	490	BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	9	1.0834	28.9	24.1
491	490	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	2	0.4878	18.1	15.1
492	492	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	11	1.6495	36.4	30.3
493	492	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	17	1.6495	36.4	30.3
494	492	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1	0.8667	24.6	20.5
495	495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	81	1.4624	37.6	31.3
496	495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	22	1.0834	28.9	24.1
497	495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1	1.0834	28.9	24.1
498	498	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	18	1.6495	36.4	30.3
499	498	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	1	0.8667	24.6	20.5
500	500	SOFT TISSUE PROCEDURES W MCC	129	1.3544	36.4	30.3
501	500	SOFT TISSUE PROCEDURES W CC	38	0.9664	30.7	25.6
502	500	SOFT TISSUE PROCEDURES W/O CC/MCC	5	0.6280	20.9	17.4
503	503	FOOT PROCEDURES W MCC*	33	1.0106	31.5	26.3
504	503	FOOT PROCEDURES W CC	22	1.0106	31.5	26.3
505	503	FOOT PROCEDURES W/O CC/MCC	2	1.0106	31.5	26.3
506	506	MAJOR THUMB OR JOINT PROCEDURES	1	0.8667	24.6	20.5
507	507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	2	1.6495	36.4	30.3
508	507	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	0	0.8667	24.6	20.5
509	509	ARTHROSCOPY	2	1.6495	36.4	30.3
510	510	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	0	1.3468	31.7	26.4
511	510	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	0	0.8667	24.6	20.5
512	510	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	0	0.8667	24.6	20.5
513	513	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	8	1.0834	28.9	24.1
514	513	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0	0.8667	24.6	20.5
515	515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	83	1.3468	31.7	26.4
516	515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	23	0.8667	24.6	20.5
517	515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC*	5	0.8667	24.6	20.5
533	533	FRACTURES OF FEMUR W MCC	3	1.0834	28.9	24.1
534	533	FRACTURES OF FEMUR W/O MCC	1	1.0834	28.9	24.1
535	535	FRACTURES OF HIP & PELVIS W MCC	26	0.7420	25.4	21.2
536	535	FRACTURES OF HIP & PELVIS W/O MCC	13	0.6280	20.9	17.4
537	537	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	1	0.4878	18.1	15.1
538	537	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0	0.4878	18.1	15.1
539	539	OSTEOMYELITIS W MCC	1,932	1.0093	30.7	25.6
540	539	OSTEOMYELITIS W CC	962	0.7936	27.5	22.9
541	539	OSTEOMYELITIS W/O CC/MCC	148	0.6821	24.4	20.3
542	542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	37	0.9292	21.9	18.3
543	542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	25	0.6938	22.1	18.4
544	542	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	4	0.6280	20.9	17.4
545	545	CONNECTIVE TISSUE DISORDERS W MCC	61	0.8812	21.8	18.2
546	545	CONNECTIVE TISSUE DISORDERS W CC	47	0.7162	24.1	20.1
547	545	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	2	0.4878	18.1	15.1
548	548	SEPTIC ARTHRITIS W MCC	260	0.9215	27.2	22.7
549	548	SEPTIC ARTHRITIS W CC	214	0.7472	26.6	22.2
550	548	SEPTIC ARTHRITIS W/O CC/MCC	39	0.5739	25.1	20.9
551	551	MEDICAL BACK PROBLEMS W MCC	130	0.9177	26.4	22.0
552	551	MEDICAL BACK PROBLEMS W/O MCC	116	0.5946	21.7	18.1
553	553	BONE DISEASES & ARTHROPATHIES W MCC	6	0.4878	18.1	15.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
554	553	BONE DISEASES & ARTHROPATHIES W/O MCC*	17	0.4878	18.1	15.1
555	555	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC*	15	0.6280	20.9	17.4
556	555	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	12	0.6280	20.9	17.4
557	557	TENDONITIS, MYOSITIS & BURSITIS W MCC	114	0.8794	26.1	21.8
558	557	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	109	0.6295	21.9	18.3
559	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1,722	0.8472	25.6	21.3
560	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1,411	0.6950	24.9	20.8
561	559	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	243	0.5788	23.0	19.2
562	562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	13	0.8667	24.6	20.5
563	562	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	14	0.8667	24.6	20.5
564	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	384	0.8675	23.5	19.6
565	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	207	0.6727	22.6	18.8
566	564	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	25	0.5464	19.5	16.3
573	573	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W MCC	1,862	1.3702	38.2	31.8
574	573	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1,163	1.0312	34.5	28.8
575	573	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC/MCC	77	0.7628	28.0	23.3
576	576	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W MCC	44	1.4531	38.4	32.0
577	576	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W CC	26	0.9545	30.8	25.7
578	576	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	3	0.4878	18.1	15.1
579	579	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	626	1.3095	35.4	29.5
580	579	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	315	0.9380	31.5	26.3
581	579	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	12	0.8667	24.6	20.5
582	582	MASTECTOMY FOR MALIGNANCY W CC/MCC	0	1.6495	36.4	30.3
583	582	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	0	0.5998	20.1	16.8
584	584	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	4	0.6280	20.9	17.4
585	584	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	0	0.6016	22.3	18.6
592	592	SKIN ULCERS W MCC	3,450	0.9187	26.5	22.1
593	592	SKIN ULCERS W CC	2,181	0.6858	25.1	20.9
594	592	SKIN ULCERS W/O CC/MCC	151	0.5644	23.1	19.3
595	595	MAJOR SKIN DISORDERS W MCC	48	0.9095	24.7	20.6
596	595	MAJOR SKIN DISORDERS W/O MCC	33	0.5998	20.1	16.8
597	597	MALIGNANT BREAST DISORDERS W MCC	15	1.6495	36.4	30.3
598	597	MALIGNANT BREAST DISORDERS W CC	11	0.6280	20.9	17.4
599	597	MALIGNANT BREAST DISORDERS W/O CC/MCC	0	0.4878	18.1	15.1
600	600	NON-MALIGNANT BREAST DISORDERS W CC/MCC	29	0.6625	24.0	20.0
601	600	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	5	0.4878	18.1	15.1
602	602	CELLULITIS W MCC	1,133	0.7276	22.1	18.4
603	602	CELLULITIS W/O MCC	1,519	0.5291	19.1	15.9
604	604	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	37	0.6494	23.4	19.5
605	604	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	50	0.6016	22.3	18.6
606	606	MINOR SKIN DISORDERS W MCC	94	0.8380	22.8	19.0
607	606	MINOR SKIN DISORDERS W/O MCC	98	0.5684	20.2	16.8
614	614	ADRENAL & PITUITARY PROCEDURES W CC/MCC	0	0.9743	28.6	23.8
615	614	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	0	0.8667	24.6	20.5
616	616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	104	1.5785	39.7	33.1
617	616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	115	1.0153	31.1	25.9
618	616	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	0	1.0153	31.1	25.9
619	619	O.R. PROCEDURES FOR OBESITY W MCC	3	1.0834	28.9	24.1
620	619	O.R. PROCEDURES FOR OBESITY W CC	0	1.0834	28.9	24.1
621	619	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	0	1.0834	28.9	24.1
622	622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	261	1.2544	35.9	29.9
623	622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	352	0.9977	30.8	25.7
624	622	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	9	0.6280	20.9	17.4
625	625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	1	0.6280	20.9	17.4

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
626	625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC*	0	0.6280	20.9	17.4
627	625	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC*	0	0.6280	20.9	17.4
628	628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	68	1.2313	32.7	27.3
629	628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	108	0.9743	28.6	23.8
630	628	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	3	0.8667	24.6	20.5
637	637	DIABETES W MCC	687	0.8949	26.2	21.8
638	637	DIABETES W CC	1,035	0.7071	23.4	19.5
639	637	DIABETES W/O CC/MCC	32	0.4679	20.0	16.7
640	640	NUTRITIONAL & MISC METABOLIC DISORDERS W MCC	678	0.8741	23.1	19.3
641	640	NUTRITIONAL & MISC METABOLIC DISORDERS W/O MCC	465	0.6222	20.6	17.2
642	642	INBORN ERRORS OF METABOLISM	5	1.0834	28.9	24.1
643	643	ENDOCRINE DISORDERS W MCC	17	0.6280	20.9	17.4
644	643	ENDOCRINE DISORDERS W CC	18	0.6280	20.9	17.4
645	643	ENDOCRINE DISORDERS W/O CC/MCC	4	0.4878	18.1	15.1
652	652	KIDNEY TRANSPLANT	0	0.0000	0.0	0.0
653	653	MAJOR BLADDER PROCEDURES W MCC	1	1.6495	36.4	30.3
654	653	MAJOR BLADDER PROCEDURES W CC	0	1.0834	28.9	24.1
655	653	MAJOR BLADDER PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
656	656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	1	0.4878	18.1	15.1
657	656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	0	0.4878	18.1	15.1
658	656	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	0	0.4878	18.1	15.1
659	659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC*	4	1.0834	28.9	24.1
660	659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	4	1.0834	28.9	24.1
661	659	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	0	1.0834	28.9	24.1
662	662	MINOR BLADDER PROCEDURES W MCC	0	1.0834	28.9	24.1
663	662	MINOR BLADDER PROCEDURES W CC	1	1.0834	28.9	24.1
664	662	MINOR BLADDER PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
665	665	PROSTATECTOMY W MCC	2	1.0834	28.9	24.1
666	665	PROSTATECTOMY W CC	0	1.0834	28.9	24.1
667	665	PROSTATECTOMY W/O CC/MCC	0	1.0834	28.9	24.1
668	668	TRANSURETHRAL PROCEDURES W MCC	9	1.0834	28.9	24.1
669	668	TRANSURETHRAL PROCEDURES W CC	1	0.6280	20.9	17.4
670	668	TRANSURETHRAL PROCEDURES W/O CC/MCC	0	0.6280	20.9	17.4
671	671	URETHRAL PROCEDURES W CC/MCC	3	0.8667	24.6	20.5
672	671	URETHRAL PROCEDURES W/O CC/MCC	0	0.8667	24.6	20.5
673	673	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	212	1.3836	32.9	27.4
674	673	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	44	0.9783	27.9	23.3
675	673	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	3	0.8667	24.6	20.5
682	682	RENAL FAILURE W MCC	1,584	0.9085	23.1	19.3
683	682	RENAL FAILURE W CC	538	0.6892	21.0	17.5
684	682	RENAL FAILURE W/O CC/MCC	28	0.6199	17.1	14.3
685	685	ADMIT FOR RENAL DIALYSIS	1	1.0834	28.9	24.1
686	686	KIDNEY & URINARY TRACT NEOPLASMS W MCC	15	0.8667	24.6	20.5
687	686	KIDNEY & URINARY TRACT NEOPLASMS W CC	14	0.6280	20.9	17.4
688	686	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0	0.6280	20.9	17.4
689	689	KIDNEY & URINARY TRACT INFECTIONS W MCC	942	0.6715	21.7	18.1
690	689	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	682	0.5198	19.3	16.1
691	691	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	0	0.8667	24.6	20.5
692	691	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	0	0.4878	18.1	15.1
693	693	URINARY STONES W/O ESW LITHOTRIPSY W MCC	11	0.8667	24.6	20.5
694	693	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	1	0.4878	18.1	15.1
695	695	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	5	0.8667	24.6	20.5
696	695	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	4	0.4878	18.1	15.1
697	697	URETHRAL STRICTURE	1	0.8667	24.6	20.5
698	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	345	0.8846	22.9	19.1
699	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	134	0.6313	20.2	16.8
700	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	11	0.6280	20.9	17.4
707	707	MAJOR MALE PELVIC PROCEDURES W CC/MCC	0	1.0834	28.9	24.1
708	707	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
709	709	PENIS PROCEDURES W CC/MCC	5	1.0834	28.9	24.1
710	709	PENIS PROCEDURES W/O CC/MCC	1	0.6280	20.9	17.4
711	711	TESTES PROCEDURES W CC/MCC	5	1.0834	28.9	24.1
712	711	TESTES PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1

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713	713	TRANSURETHRAL PROSTATECTOMY W CC/MCC	4	0.8667	24.6	20.5
714	713	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0	0.6280	20.9	17.4
715	715	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	0	1.6495	36.4	30.3
716	715	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	0	1.0834	28.9	24.1
717	717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	11	1.6495	36.4	30.3
718	717	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	1	1.0834	28.9	24.1
722	722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	8	1.0834	28.9	24.1
723	722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	9	0.6280	20.9	17.4
724	722	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0	0.6280	20.9	17.4
725	725	BENIGN PROSTATIC HYPERTROPHY W MCC	2	1.6495	36.4	30.3
726	725	BENIGN PROSTATIC HYPERTROPHY W/O MCC	1	0.8667	24.6	20.5
727	727	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	75	0.8106	22.6	18.8
728	727	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	57	0.5026	17.3	14.4
729	729	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	68	0.8981	26.5	22.1
730	729	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	3	0.4878	18.1	15.1
734	734	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	0	1.0834	28.9	24.1
735	734	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	0	1.0834	28.9	24.1
736	736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	0	1.0834	28.9	24.1
737	736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	0	0.6280	20.9	17.4
738	736	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	0	0.6280	20.9	17.4
739	739	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	0	1.2313	32.7	27.3
740	739	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC*	0	0.9743	28.6	23.8
741	739	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	0	0.8667	24.6	20.5
742	742	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC*	0	0.9743	28.6	23.8
743	742	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	0	0.8667	24.6	20.5
744	744	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	0	1.0834	28.9	24.1
745	744	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	0	1.0834	28.9	24.1
746	746	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	4	1.0834	28.9	24.1
747	746	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
748	748	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0	1.0834	28.9	24.1
749	749	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	7	1.0834	28.9	24.1
750	749	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	0	1.0834	28.9	24.1
754	754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	17	1.0834	28.9	24.1
755	754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	11	0.6280	20.9	17.4
756	754	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC*	0	0.6279	20.9	17.4
757	757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	72	0.7744	24.6	20.5
758	757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	40	0.6839	23.9	19.9
759	757	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	7	0.4878	18.1	15.1
760	760	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC*	4	0.8667	24.6	20.5
761	760	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC*	2	0.8667	24.6	20.5
765	765	CESAREAN SECTION W CC/MCC	0	1.0834	28.9	24.1
766	765	CESAREAN SECTION W/O CC/MCC	0	1.0834	28.9	24.1
767	767	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0	1.0834	28.9	24.1
768	768	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0	1.0834	28.9	24.1
769	769	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	2	1.6495	36.4	30.3
770	770	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0	1.0834	28.9	24.1
774	774	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0	1.0834	28.9	24.1
775	775	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0	1.0834	28.9	24.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
776	776	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	1	0.6280	20.9	17.4
777	777	ECTOPIC PREGNANCY	0	0.6280	20.9	17.4
778	778	THREATENED ABORTION	0	0.6280	20.9	17.4
779	779	ABORTION W/O D&C	0	0.6280	20.9	17.4
780	780	FALSE LABOR	0	0.6280	20.9	17.4
781	781	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	3	0.4878	18.1	15.1
782	782	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0	0.4878	18.1	15.1
789	789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0	0.4878	18.1	15.1
790	790	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	0	0.4878	18.1	15.1
791	791	PREMATURITY W MAJOR PROBLEMS	0	0.4878	18.1	15.1
792	792	PREMATURITY W/O MAJOR PROBLEMS	0	0.4878	18.1	15.1
793	793	FULL TERM NEONATE W MAJOR PROBLEMS	0	0.4878	18.1	15.1
794	794	NEONATE W OTHER SIGNIFICANT PROBLEMS	0	0.4878	18.1	15.1
795	795	NORMAL NEWBORN	0	0.4878	18.1	15.1
799	799	SPLENECTOMY W MCC	0	1.0834	28.9	24.1
800	799	SPLENECTOMY W CC	0	1.0834	28.9	24.1
801	799	SPLENECTOMY W/O CC/MCC	0	1.0834	28.9	24.1
802	802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	1	1.0834	28.9	24.1
803	802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	0	1.0834	28.9	24.1
804	802	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	0	1.0834	28.9	24.1
808	808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	12	0.8667	24.6	20.5
809	808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	14	0.6280	20.9	17.4
810	808	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0	0.5578	19.4	16.2
811	811	RED BLOOD CELL DISORDERS W MCC	65	0.8441	21.1	17.6
812	811	RED BLOOD CELL DISORDERS W/O MCC	38	0.5578	19.4	16.2
813	813	COAGULATION DISORDERS	35	0.7443	20.8	17.3
814	814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	29	0.8803	24.8	20.7
815	814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	14	0.6280	20.9	17.4
816	814	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0	0.6280	20.9	17.4
820	820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	0	0.4878	18.1	15.1
821	820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	1	0.4878	18.1	15.1
822	820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	0	0.4878	18.1	15.1
823	823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	3	1.6495	36.4	30.3
824	823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1	0.4878	18.1	15.1
825	823	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	0	0.4878	18.1	15.1
826	826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	0	0.8667	24.6	20.5
827	826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	1	0.8667	24.6	20.5
828	826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	0	0.8667	24.6	20.5
829	829	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC	7	1.6495	36.4	30.3
830	829	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	0	1.6495	36.4	30.3
834	834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	22	0.8667	24.6	20.5
835	834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	12	0.8667	24.6	20.5
836	834	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1	0.6280	20.9	17.4
837	837	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	0	1.3820	29.1	24.3
838	837	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	0	1.3026	28.6	23.8
839	837	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	0	1.3026	28.6	23.8
840	840	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	91	0.8901	22.1	18.4
841	840	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	38	0.6737	18.8	15.7
842	840	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	4	0.4878	18.1	15.1
843	843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	7	0.8667	24.6	20.5
844	843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	7	0.8667	24.6	20.5
845	843	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	1	0.4878	18.1	15.1
846	846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	57	1.3820	29.1	24.3
847	846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	54	1.3026	28.6	23.8
848	846	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0	1.3026	28.6	23.8
849	849	RADIOTHERAPY	119	0.7730	22.7	18.9

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
853	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	1,059	1.7413	37.6	31.3
854	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	96	1.1085	30.2	25.2
855	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	2	0.8667	24.6	20.5
856	856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	361	1.4571	34.1	28.4
857	856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	194	1.0415	30.5	25.4
858	856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	10	0.8667	24.6	20.5
862	862	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1,722	0.9661	25.3	21.1
863	862	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	1,019	0.6984	23.0	19.2
864	864	FEVER	3	0.4878	18.1	15.1
865	865	VIRAL ILLNESS W MCC	26	0.8013	21.3	17.8
866	865	VIRAL ILLNESS W/O MCC*	13	0.8013	21.3	17.8
867	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	450	1.0443	23.7	19.8
868	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	64	0.6882	19.5	16.3
869	867	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	2	0.4878	18.1	15.1
870	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	1,282	2.1404	31.7	26.4
871	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	5,885	0.8725	23.1	19.3
872	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1,275	0.6255	20.3	16.9
876	876	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	3	1.6495	36.4	30.3
880	880	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	9	0.6280	20.9	17.4
881	881	DEPRESSIVE NEUROSES	34	0.3912	21.9	18.3
882	882	NEUROSES EXCEPT DEPRESSIVE	10	0.4878	18.1	15.1
883	883	DISORDERS OF PERSONALITY & IMPULSE CONTROL	7	0.6280	20.9	17.4
884	884	ORGANIC DISTURBANCES & MENTAL RETARDATION	76	0.5153	25.7	21.4
885	885	PSYCHOSES	877	0.3977	24.2	20.2
886	886	BEHAVIORAL & DEVELOPMENTAL DISORDERS	38	0.4205	24.7	20.6
887	887	OTHER MENTAL DISORDER DIAGNOSES	2	0.4878	18.1	15.1
894	894	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0	0.4878	18.1	15.1
895	895	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	0	0.4878	18.1	15.1
896	896	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	12	0.8667	24.6	20.5
897	896	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	8	0.4878	18.1	15.1
901	901	WOUND DEBRIDEMENTS FOR INJURIES W MCC	292	1.3896	34.4	28.7
902	901	WOUND DEBRIDEMENTS FOR INJURIES W CC	138	1.0410	29.9	24.9
903	901	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	6	0.6280	20.9	17.4
904	904	SKIN GRAFTS FOR INJURIES W CC/MCC	100	1.3723	38.3	31.9
905	904	SKIN GRAFTS FOR INJURIES W/O CC/MCC	2	0.8667	24.6	20.5
906	906	HAND PROCEDURES FOR INJURIES	3	0.6280	20.9	17.4
907	907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	135	1.4580	34.3	28.6
908	907	OTHER O.R. PROCEDURES FOR INJURIES W CC	57	0.9544	28.7	23.9
909	907	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	4	0.6280	20.9	17.4
913	913	TRAUMATIC INJURY W MCC	49	0.7653	24.3	20.3
914	913	TRAUMATIC INJURY W/O MCC	79	0.5687	20.1	16.8
915	915	ALLERGIC REACTIONS W MCC	1	0.4878	18.1	15.1
916	915	ALLERGIC REACTIONS W/O MCC	0	0.4878	18.1	15.1
917	917	POISONING & TOXIC EFFECTS OF DRUGS W MCC	8	1.0834	28.9	24.1
918	917	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	3	0.4878	18.1	15.1
919	919	COMPLICATIONS OF TREATMENT W MCC	1,547	1.0957	26.7	22.3
920	919	COMPLICATIONS OF TREATMENT W CC	888	0.8190	24.9	20.8
921	919	COMPLICATIONS OF TREATMENT W/O CC/MCC	53	0.5150	18.4	15.3
922	922	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	7	0.8667	24.6	20.5
923	922	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	11	0.4878	18.1	15.1
927	927	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	0	1.0834	28.9	24.1
928	928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	11	1.0834	28.9	24.1
929	928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	1	1.0834	28.9	24.1
933	933	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	11	0.6280	20.9	17.4
934	934	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	31	0.6455	23.9	19.9
935	935	NON-EXTENSIVE BURNS	64	0.6800	22.2	18.5
939	939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	225	1.4032	33.6	28.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2009 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
940	939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	98	1.0076	31.1	25.9
941	939	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	9	0.6280	20.9	17.4
945	945	REHABILITATION W CC/MCC	1,338	0.6482	21.1	17.6
946	945	REHABILITATION W/O CC/MCC	89	0.4068	17.2	14.3
947	947	SIGNS & SYMPTOMS W MCC	41	0.8225	23.5	19.6
948	947	SIGNS & SYMPTOMS W/O MCC	51	0.4846	19.9	16.6
949	949	AFTERCARE W CC/MCC	3,264	0.7151	22.1	18.4
950	949	AFTERCARE W/O CC/MCC	194	0.4499	17.1	14.3
951	951	OTHER FACTORS INFLUENCING HEALTH STATUS	66	1.5229	27.2	22.7
955	955	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	0	1.0834	28.9	24.1
956	956	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	0	1.6495	36.4	30.3
957	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	1	0.6280	20.9	17.4
958	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC*	0	0.6280	20.9	17.4
959	957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC*	0	0.6280	20.9	17.4
963	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC*	8	1.0834	28.9	24.1
964	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	8	1.0834	28.9	24.1
965	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	1	0.4878	18.1	15.1
969	969	HIV W EXTENSIVE O.R. PROCEDURE W MCC	12	1.6495	36.4	30.3
970	969	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2	0.8667	24.6	20.5
974	974	HIV W MAJOR RELATED CONDITION W MCC	210	1.0512	23.2	19.3
975	974	HIV W MAJOR RELATED CONDITION W CC	58	0.6394	18.6	15.5
976	974	HIV W MAJOR RELATED CONDITION W/O CC/MCC	7	0.4878	18.1	15.1
977	977	HIV W OR W/O OTHER RELATED CONDITION	30	0.6746	19.9	16.6
981	981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	1,045	2.1787	41.6	34.7
982	981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	219	1.1314	30.7	25.6
983	981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	6	0.6280	20.9	17.4
984	984	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	19	1.6495	36.4	30.3
985	984	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	8	1.0834	28.9	24.1
986	984	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	0	1.0834	28.9	24.1
987	987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	467	1.8330	38.5	32.1
988	987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	172	1.0342	30.2	25.2
989	987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	4	0.6280	20.9	17.4
998	998	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0	0.0000	0.0	0.0
999	999	UNGROUPABLE	0	0.0000	0.0	0.0

[1] The SSO Threshold is calculated as 5/6th of the geometric average length of stay of the MS-LTC-DRG (as specified in §412.529(a) in conjunction with §412.503).

* In determining the proposed MS-LTC-DRG relative weights for FY 2011, these MS-LTC-DRGs were adjusted for nonmonotonicity as discussed in section VIII.B.3.g. (step 6) of the preamble of this proposed rule.

TABLE 12A.—PROPOSED LTCH PPS WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2010 THROUGH SEPTEMBER 30, 2011

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
10180	Abilene, TX	
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	0.8016
10380	Aguadilla-Isabela-San Sebastián, PR	
	Aguada Municipio, PR	
	Aguadilla Municipio, PR	
	Añasco Municipio, PR	
	Isabela Municipio, PR	
	Lares Municipio, PR	
	Moca Municipio, PR	
	Rincón Municipio, PR	
	San Sebastián Municipio, PR	0.3476
10420	Akron, OH	
	Portage County, OH	
	Summit County, OH	0.8857
10500	Albany, GA	
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	0.9050
10580	Albany-Schenectady-Troy, NY	
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	0.8667
10740	Albuquerque, NM	
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	0.9454
10780	Alexandria, LA	
	Grant Parish, LA	
	Rapides Parish, LA	0.8008
10900	Allentown-Bethlehem-Easton, PA-NJ	
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	0.9178
11020	Altoona, PA	
	Blair County, PA	0.8634
11100	Amarillo, TX	
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	0.8658
11180	Ames, IA	
	Story County, IA	0.9986
11260	Anchorage, AK	
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	1.1984
11300	Anderson, IN	
	Madison County, IN	0.9207
11340	Anderson, SC	
	Anderson County, SC	0.8969
11460	Ann Arbor, MI	
	Washtenaw County, MI	1.0140
11500	Anniston-Oxford, AL	
	Calhoun County, AL	0.7931
11540	Appleton, WI	
	Calumet County, WI	
	Outagamie County, WI	0.9376
11700	Asheville, NC	
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	0.9016
12020	Athens-Clarke County, GA	
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	0.9546

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
12060	Atlanta-Sandy Springs-Marietta, GA	
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	0.9566
12100	Atlantic City, NJ- Hammonton, New Jersey	
	Atlantic County, NJ	1.1147
12220	Auburn-Opelika, AL	
	Lee County, AL	0.7255
12260	Augusta-Richmond County, GA-SC	
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	0.9522

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
12420	Austin-Round Rock-San Marcos, TX	
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	0.9529
12540	Bakersfield-Delano, CA	
	Kern County, CA	1.1655
12580	Baltimore-Towson, MD	
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
	Baltimore City, MD	1.0267
12620	Bangor, ME	
	Penobscot County, ME	0.9793
12700	Barnstable Town, MA	
	Barnstable County, MA	1.2844
12940	Baton Rouge, LA	
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	0.8597
12980	Battle Creek, MI	
	Calhoun County, MI	0.9671
13020	Bay City, MI	
	Bay County, MI	0.9235
13140	Beaumont-Port Arthur, TX	
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	0.8502
13380	Bellingham, WA	
	Whatcom County, WA	1.1408
13460	Bend, OR	
	Deschutes County, OR	1.1388

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
13644	Bethesda- - Rockville-Frederick, MD Frederick County, MD Montgomery County, MD	1.0542
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8688
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8733
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.8616
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7360
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8328
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9004
14060	Bloomington-Normal, IL McLean County, IL	0.9455
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9288
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2215
14500	Boulder, CO Boulder County, CO	1.0081
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8680
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0684
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2567
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9188
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9224
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9545
15500	Burlington, NC Alamance County, NC	0.8878
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9963
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1268
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0403
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8761
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9191
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.8905
16180	Carson City, NV Carson City, NV	1.0482
16220	Casper, WY Natrona County, WY	0.9670

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
16300	Cedar Rapids, IA	
	Benton County, IA	
	Jones County, IA	
	Linn County, IA	0.8858
16580	Champaign-Urbana, IL	
	Champaign County, IL	
	Ford County, IL	
	Piatt County, IL	1.0251
16620	Charleston, WV	
	Boone County, WV	
	Clay County, WV	
	Kanawha County, WV	
	Lincoln County, WV	
	Putnam County, WV	0.7908
16700	Charleston-North CharlestonSummerville, SC	
	Berkeley County, SC	
	Charleston County, SC	
	Dorchester County, SC	0.9345
16740	Charlotte-Gastonia-Rock Hill, NC-SC	
	Anson County, NC	
	Cabarrus County, NC	
	Gaston County, NC	
	Mecklenburg County, NC	
	Union County, NC	
	York County, SC	0.9435
16820	Charlottesville, VA	
	Albemarle County, VA	
	Fluvanna County, VA	
	Greene County, VA	
	Nelson County, VA	
	Charlottesville City, VA	0.9358
16860	Chattanooga, TN-GA	
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	0.8755
16940	Cheyenne, WY	
	Laramie County, WY	0.9408

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
16974	Chicago- Joliet-Naperville, IL	
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	McHenry County, IL	
	Will County, IL	1.0573
17020	Chico, CA	
	Butte County, CA	1.1572
17140	Cincinnati-Middletown, OH-KY-IN	
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN	
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
	Warren County, OH	0.9714
17300	Clarksville, TN-KY	
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	0.7898
17420	Cleveland, TN	
	Bradley County, TN	
	Polk County, TN	0.7744
17460	Cleveland-Elyria-Mentor, OH	
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	0.9052
17660	Coeur d'Alene, ID	
	Kootenai County, ID	0.9379

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
17780	College Station-Bryan, TX	
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	0.9604
17820	Colorado Springs, CO	
	El Paso County, CO	
	Teller County, CO	0.9497
17860	Columbia, MO	
	Boone County, MO	
	Howard County, MO	0.8295
17900	Columbia, SC	
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	0.8721
17980	Columbus, GA-AL	
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	0.9042
18020	Columbus, IN	
	Bartholomew County, IN	0.9449
18140	Columbus, OH	
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
	Union County, OH	1.0157
18580	Corpus Christi, TX	
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	0.8599
18700	Corvallis, OR	
	Benton County, OR	1.0472
18880	Crestview-Fort Walton Beach- Destin, FL	
	Okaloosa County, FL	0.8856
19060	Cumberland, MD-WV	
	Allegany County, MD	
	Mineral County, WV	0.8199
19124	Dallas-Plano-Irving, TX	
	Collin County, TX	
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	
	Ellis County, TX	
	Hunt County, TX	
	Kaufman County, TX	
	Rockwall County, TX	0.9848
19140	Dalton, GA	
	Murray County, GA	
	Whitfield County, GA	0.8610
19180	Danville, IL	
	Vermilion County, IL	0.9708
19260	Danville, VA	
	Pittsylvania County, VA	
	Danville City, VA	0.8182
19340	Davenport-Moline-Rock Island, IA-IL	
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	0.8414
19380	Dayton, OH	
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	0.9155
19460	Decatur, AL	
	Lawrence County, AL	
	Morgan County, AL	0.7618
19500	Decatur, IL	
	Macon County, IL	0.7929
19660	Deltona-Daytona Beach-Ormond Beach, FL	
	Volusia County, FL	0.8750

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
19740	Denver-Aurora-Broomfield, CO	
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	1.0735
19780	Des Moines,-West Des Moines, IA	
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	0.9637
19804	Detroit-Livonia-Dearborn, MI	
	Wayne County, MI	0.9702
20020	Dothan, AL	
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	0.7635
20100	Dover, DE	
	Kent County, DE	0.9937
20220	Dubuque, IA	
	Dubuque County, IA	0.8788
20260	Duluth, MN-WI	
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	1.0469
20500	Durham-Chapel Hill, NC	
	Chatham County, NC	
	Durham County, NC	
	Orange County, NC	
	Person County, NC	0.9680
20740	Eau Claire, WI	
	Chippewa County, WI	
	Eau Claire County, WI	0.9655

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
20764	Edison-New Brunswick, NJ	
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	
	Somerset County, NJ	1.1022
20940	El Centro, CA	
	Imperial County, CA	0.9273
21060	Elizabethtown, KY	
	Hardin County, KY	
	Larue County, KY	0.8463
21140	Elkhart-Goshen, IN	
	Elkhart County, IN	0.9480
21300	Elmira, NY	
	Chemung County, NY	0.8459
21340	El Paso, TX	
	El Paso County, TX	0.8489
21500	Erie, PA	
	Erie County, PA	0.8371
21660	Eugene-Springfield, OR	
	Lane County, OR	1.1402
21780	Evansville, IN-KY	
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	Henderson County, KY	
	Webster County, KY	0.8446
21820	Fairbanks, AK	
	Fairbanks North Star Borough, AK	1.1098
21940	Fajardo, PR	
	Ceiba Municipio, PR	
	Fajardo Municipio, PR	
	Luquillo Municipio, PR	0.3889
	Fargo, ND-MN	
22020	Cass County, ND	
	Clay County, MN	0.8049
22140	Farmington, NM	
	San Juan County, NM	0.8000
22180	Fayetteville, NC	
	Cumberland County, NC	
	Hoke County, NC	0.9339

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8630
22380	Flagstaff, AZ Coconino County, AZ	1.2463
22420	Flint, MI Genesee County, MI	1.1515
22500	Florence, SC Darlington County, SC Florence County, SC	0.8264
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8058
22540	Fond du Lac, WI Fond du Lac County, WI	0.9238
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9908
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0170
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7601
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9322
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9490
23420	Fresno, CA Fresno County, CA	1.1439
23460	Gadsden, AL Etowah County, AL	0.7028
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9175
23580	Gainesville, GA Hall County, GA	0.9386
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9099
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8521
24140	Goldsboro, NC Wayne County, NC	0.9081
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7729
24300	Grand Junction, CO Mesa County, CO	0.9866
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9183
24500	Great Falls, MT Cascade County, MT	0.8303
24540	Greeley, CO Weld County, CO	0.9511
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9601
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.8897
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9385

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
24860	Greenville-Mauldin-Easley, SC	
	Greenville County, SC	
	Laurens County, SC	
	Pickens County, SC	0.9563
25020	Guayama, PR	
	Arroyo Municipio, PR	
	Guayama Municipio, PR	
	Patillas Municipio, PR	0.3692
25060	Gulfport-Biloxi, MS	
	Hancock County, MS	
	Harrison County, MS	
	Stone County, MS	0.8990
25180	Hagerstown-Martinsburg, MD-WV	
	Washington County, MD	
	Berkeley County, WV	
	Morgan County, WV	0.9269
25260	Hanford-Corcoran, CA	
	Kings County, CA	1.1223
25420	Harrisburg-Carlisle, PA	
	Cumberland County, PA	
	Dauphin County, PA	
	Perry County, PA	0.9311
25500	Harrisonburg, VA	
	Rockingham County, VA	
	Harrisonburg City, VA	0.9173
25540	Hartford-West Hartford-East Hartford, CT	
	Hartford County, CT	
	Middlesex County, CT	
	Tolland County, CT	1.0936
25620	Hattiesburg, MS	
	Forrest County, MS	
	Lamar County, MS	
	Perry County, MS	0.7727
25860	Hickory-Lenoir-Morganton, NC	
	Alexander County, NC	
	Burke County, NC	
	Caldwell County, NC	
	Catawba County, NC	0.8707
25980	Hinesville-Fort Stewart, GA	
	Liberty County, GA	
	Long County, GA	0.8955
26100	Holland-Grand Haven, MI	
	Ottawa County, MI	0.8646

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
26180	Honolulu, HI	
	Honolulu County, HI	1.1801
26300	Hot Springs, AR	
	Garland County, AR	0.9166
26380	Houma-Bayou Cane-Thibodaux, LA	
	Lafourche Parish, LA	
	Terrebonne Parish, LA	0.7865
26420	Houston-Sugar Land-Baytown, TX	
	Austin County, TX	
	Brazoria County, TX	
	Chambers County, TX	
	Fort Bend County, TX	
	Galveston County, TX	
	Harris County, TX	
	Liberty County, TX	
	Montgomery County, TX	
	San Jacinto County, TX	
	Waller County, TX	0.9838
26580	Huntington-Ashland, WV-KY-OH	
	Boyd County, KY	
	Greenup County, KY	
	Lawrence County, OH	
	Cabell County, WV	
	Wayne County, WV	0.8967
26620	Huntsville, AL	
	Limestone County, AL	
	Madison County, AL	0.9130
26820	Idaho Falls, ID	
	Bonneville County, ID	
	Jefferson County, ID	0.9678
26900	Indianapolis-Carmel, IN	
	Boone County, IN	
	Brown County, IN	
	Hamilton County, IN	
	Hancock County, IN	
	Hendricks County, IN	
	Johnson County, IN	
	Marion County, IN	
	Morgan County, IN	
	Putnam County, IN	
	Shelby County, IN	0.9687

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
26980	Iowa City, IA	
	Johnson County, IA	
	Washington County, IA	0.9672
27060	Ithaca, NY	
	Tompkins County, NY	0.9858
27100	Jackson, MI	
	Jackson County, MI	0.9170
27140	Jackson, MS	
	Copiah County, MS	
	Hinds County, MS	
	Madison County, MS	
	Rankin County, MS	
	Simpson County, MS	0.8105
27180	Jackson, TN	
	Chester County, TN	
	Madison County, TN	0.8418
27260	Jacksonville, FL	
	Baker County, FL	
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL	
	St. Johns County, FL	0.8899
27340	Jacksonville, NC	
	Onslow County, NC	0.7819
27500	Janesville, WI	
	Rock County, WI	0.9430
27620	Jefferson City, MO	
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	0.8448
27740	Johnson City, TN	
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	0.7269
27780	Johnstown, PA	
	Cambria County, PA	0.8103
27860	Jonesboro, AR	
	Craighead County, AR	
	Poinsett County, AR	0.7770
27900	Joplin, MO	
	Jasper County, MO	
	Newton County, MO	0.8227

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
28020	Kalamazoo-Portage, MI	
	Kalamazoo County, MI	
	Van Buren County, MI	1.0309
28100	Kankakee-Bradley, IL	
	Kankakee County, IL	1.0636
28140	Kansas City, MO-KS	
	Franklin County, KS	
	Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Wyandotte County, KS	
	Bates County, MO	
	Caldwell County, MO	
	Cass County, MO	
	Clay County, MO	
	Clinton County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
	Ray County, MO	0.9667
28420	Kennewick- Pasco-Richland, WA	
	Benton County, WA	
	Franklin County, WA	0.9992
28660	Killeen-Temple-Fort Hood, TX	
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	0.8711
28700	Kingsport-Bristol-Bristol, TN-VA	
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	0.7596
28740	Kingston, NY	
	Ulster County, NY	0.9089
28940	Knoxville, TN	
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	0.7856

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9134
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9819
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9304
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8499
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8209
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0799
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0252
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8461
29540	Lancaster, PA Lancaster County, PA	0.9359
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0315
29700	Laredo, TX Webb County, TX	0.7927
29740	Las Cruces, NM Dona Ana County, NM	0.9311
29820	Las Vegas-Paradise, NV Clark County, NV	1.2119
29940	Lawrence, KS Douglas County, KS	0.8547
30020	Lawton, OK Comanche County, OK	0.8298
30140	Lebanon, PA Lebanon County, PA	0.7820

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9373
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.8917
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.8832
30620	Lima, OH Allen County, OH	0.9285
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9633
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8542
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8808
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8582
31020	Longview, WA Cowlitz County, WA	1.0313
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2054

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
31140	Louisville-Jefferson County, KY-IN	
	Clark County, IN	
	Floyd County, IN	
	Harrison County, IN	
	Washington County, IN	
	Bullitt County, KY	
	Henry County, KY	
	Jefferson County, KY	
	Meade County, KY	
	Nelson County, KY	
	Oldham County, KY	
	Shelby County, KY	
	Spencer County, KY	
	Trimble County, KY	0.8898
31180	Lubbock, TX	
	Crosby County, TX	
	Lubbock County, TX	0.8862
31340	Lynchburg, VA	
	Amherst County, VA	
	Appomattox County, VA	
	Bedford County, VA	
	Campbell County, VA	
	Bedford City, VA	
	Lynchburg City, VA	0.8679
31420	Macon, GA	
	Bibb County, GA	
	Crawford County, GA	
	Jones County, GA	
	Monroe County, GA	
	Twiggs County, GA	0.9044
31460	Madera-Chowchilla, CA	
	Madera County, CA	0.7999
31540	Madison, WI	
	Columbia County, WI	
	Dane County, WI	
	Iowa County, WI	1.1307
31700	Manchester-Nashua, NH	
	Hillsborough County, NH	0.9885
31740	Mahattan, KS	
	Geary County, KS	
	Pottawatomie County, KS	
	Riley County; KS	0.7860

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
31860	Mankato-North Mankato, MN	
	Blue Earth County, MN	
	Nicollet County, MN	0.9098
31900	Mansfield, OH	
	Richland County, OH	0.8932
32420	Mayagüez, PR	
	Hormigueros Municipio, PR	
	Mayagüez Municipio, PR	0.3646
32580	McAllen-Edinburg-Mission, TX	
	Hidalgo County, TX	0.8852
32780	Medford, OR	
	Jackson County, OR	1.0077
32820	Memphis, TN-MS-AR	
	Crittenden County, AR	
	DeSoto County, MS	
	Marshall County, MS	
	Tate County, MS	
	Tunica County, MS	
	Fayette County, TN	
	Shelby County, TN	
	Tipton County, TN	0.9205
32900	Merced, CA	
	Merced County, CA	1.2241
33124	Miami-Miami Beach-Kendall, FL	
	Miami-Dade County, FL	1.0144
33140	Michigan City-La Porte, IN	
	LaPorte County, IN	0.9485
33260	Midland, TX	
	Midland County, TX	0.9727
33340	Milwaukee-Waukesha-West Allis, WI	
	Milwaukee County, WI	
	Ozaukee County, WI	
	Washington County, WI	
	Waukesha County, WI	1.0200

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
33460	Minneapolis-St. Paul-Bloomington, MN-WI	
	Anoka County, MN	
	Carver County, MN	
	Chisago County, MN	
	Dakota County, MN	
	Hennepin County, MN	
	Isanti County, MN	
	Ramsey County, MN	
	Scott County, MN	
	Sherburne County, MN	
	Washington County, MN	
	Wright County, MN	
	Pierce County, WI	
	St. Croix County, WI	1.1161
33540	Missoula, MT	
	Missoula County, MT	0.8935
33660	Mobile, AL	
	Mobile County, AL	0.7949
33700	Modesto, CA	
	Stanislaus County, CA	1.2123
33740	Monroe, LA	
	Ouachita Parish, LA	
	Union Parish, LA	0.8008
33780	Monroe, MI	
	Monroe County, MI	0.8698
33860	Montgomery, AL	
	Autauga County, AL	
	Elmore County, AL	
	Lowndes County, AL	
	Montgomery County, AL	0.8346
34060	Morgantown, WV	
	Monongalia County, WV	
	Preston County, WV	0.8150
34100	Morristown, TN	
	Grainger County, TN	
	Hamblen County, TN	
	Jefferson County, TN	0.7046
34580	Mount Vernon-Anacortes, WA	
	Skagit County, WA	1.0379
34620	Muncie, IN	
	Delaware County, IN	0.8219
34740	Muskegon-Norton Shores, MI	
	Muskegon County, MI	0.9805

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
34820	Myrtle Beach- North Myrtle Beach-Conway, SC	
	Horry County, SC	0.8726
34900	Napa, CA	
	Napa County, CA	1.4628
34940	Naples-Marco Island, FL	
	Collier County, FL	0.9714
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	
	Cannon County, TN	
	Cheatham County, TN	
	Davidson County, TN	
	Dickson County, TN	
	Hickman County, TN	
	Macon County, TN	
	Robertson County, TN	
	Rutherford County, TN	
	Smith County, TN	
	Sumner County, TN	
	Trousdale County, TN	
	Williamson County, TN	
	Wilson County, TN	0.9390
35004	Nassau-Suffolk, NY	
	Nassau County, NY	
	Suffolk County, NY	1.2333
35084	Newark-Union, NJ-PA	
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	
	Pike County, PA	1.1461
35300	New Haven-Milford, CT	
	New Haven County, CT	1.1534
35380	New Orleans-Metairie-Kenner, LA	
	Jefferson Parish, LA	
	Orleans Parish, LA	
	Plaquemines Parish, LA	
	St. Bernard Parish, LA	
	St. Charles Parish, LA	
	St. John the Baptist Parish, LA	
	St. Tammany Parish, LA	0.9085

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
35644	New York-White Plains-Wayne, NY-NJ	
	Bergen County, NJ	
	Hudson County, NJ	
	Passaic County, NJ	
	Bronx County, NY	
	Kings County, NY	
	New York County, NY	
	Putnam County, NY	
	Queens County, NY	
	Richmond County, NY	
	Rockland County, NY	
	Westchester County, NY	1.2949
35660	Niles-Benton Harbor, MI	
	Berrien County, MI	0.8887
35840	North Port-Bradenton-Sarasota, FL	
	Manatee County, FL	
	Sarasota County, FL	0.9495
35980	Norwich-New London, CT	
	New London County, CT	1.1234
36084	Oakland-Fremont-Hayward, CA	
	Alameda County, CA	
	Contra Costa County, CA	1.6374
36100	Ocala, FL	
	Marion County, FL	0.8482
36140	Ocean City, NJ	
	Cape May County, NJ	1.0896
36220	Odessa, TX	
	Ector County, TX	0.9451
36260	Ogden-Clearfield, UT	
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	0.9282
36420	Oklahoma City, OK	
	Canadian County, OK	
	Cleveland County, OK	
	Grady County, OK	
	Lincoln County, OK	
	Logan County, OK	
	McClain County, OK	
	Oklahoma County, OK	0.8892
36500	Olympia, WA	
	Thurston County, WA	1.1287

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
36540	Omaha-Council Bluffs, NE-IA	
	Harrison County, IA	
	Mills County, IA	
	Pottawattamie County, IA	
	Cass County, NE	
	Douglas County, NE	
	Sarpy County, NE	
	Saunders County, NE	
	Washington County, NE	0.9599
36740	Orlando-Kissimmee-Sanford, FL	
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	0.9159
36780	Oshkosh-Neenah, WI	
	Winnebago County, WI	0.9582
36980	Owensboro, KY	
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	0.8384
37100	Oxnard-Thousand Oaks-Ventura, CA	
	Ventura County, CA	1.2397
37340	Palm Bay-Melbourne-Titusville, FL	
	Brevard County, FL	0.9226
	Palm Coast, FL	
37380	Flager County, FL	0.8419
37460	Panama City-Lynn Haven-Panama City Beach, FL	
	Bay County, FL	0.7967
37620	Parkersburg-Marietta-Vienna, WV-OH	
	Washington County, OH	
	Pleasants County, WV	
	Wirt County, WV	
	Wood County, WV	0.7467
37700	Pascagoula, MS	
	George County, MS	
	Jackson County, MS	0.8312
	Peabody, MA	
37764	Essex County, MA	1.0996
37860	Pensacola-Ferry Pass-Brent, FL	
	Escambia County, FL	
	Santa Rosa County, FL	0.8267

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
37900	Peoria, IL	
	Marshall County, IL	
	Peoria County, IL	
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	0.9163
37964	Philadelphia, PA	
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	1.0818
38060	Phoenix-Mesa-Glendale, AZ	
	Maricopa County, AZ	
	Pinal County, AZ	1.0662
38220	Pine Bluff, AR	
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	0.8025
38300	Pittsburgh, PA	
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	0.8619
38340	Pittsfield, MA	
	Berkshire County, MA	1.0388
38540	Pocatello, ID	
	Bannock County, ID	
	Power County, ID	0.9523
38660	Ponce, PR	
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	0.4320
38860	Portland-South Portland-Biddeford, ME	
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	0.9905

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
38900	Portland-Vancouver-Hillsboro, OR-WA	
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	1.1495
38940	Port St. Lucie, FL	
	Martin County, FL	
	St. Lucie County, FL	1.0740
39100	Poughkeepsie-Newburgh-Middletown, NY	
	Dutchess County, NY	
	Orange County, NY	1.1350
39140	Prescott, AZ	
	Yavapai County, AZ	1.2253
39300	Providence-New Bedford-Fall River, RI-MA	
	Bristol County, MA	
	Bristol County, RI	
	Kent County, RI	
	Newport County, RI	
	Providence County, RI	
	Washington County, RI	1.0731
39340	Provo-Orem, UT	
	Juab County, UT	
	Utah County, UT	0.9336
39380	Pueblo, CO	
	Pueblo County, CO	0.8735
39460	Punta Gorda, FL	
	Charlotte County, FL	0.8773
39540	Racine, WI	
	Racine County, WI	1.0597
39580	Raleigh-Cary, NC	
	Franklin County, NC	
	Johnston County, NC	
	Wake County, NC	0.9827
39660	Rapid City, SD	
	Meade County, SD	
	Pennington County, SD	1.0459
39740	Reading, PA	
	Berks County, PA	0.8918
39820	Redding, CA	
	Shasta County, CA	1.4146

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
39900	Reno-Sparks, NV	
	Storey County, NV	
	Washoe County, NV	1.0436
40060	Richmond, VA	
	Amelia County, VA	
	Caroline County, VA	
	Charles City County, VA	
	Chesterfield County, VA	
	Cumberland County, VA	
	Dinwiddie County, VA	
	Goochland County, VA	
	Hanover County, VA	
	Henrico County, VA	
	King and Queen County, VA	
	King William County, VA	
	Louisa County, VA	
	New Kent County, VA	
	Powhatan County, VA	
	Prince George County, VA	
	Sussex County, VA	
	Colonial Heights City, VA	
	Hopewell City, VA	
	Petersburg City, VA	
	Richmond City, VA	0.9677
40140	Riverside-San Bernardino-Ontario, CA	
	Riverside County, CA	
	San Bernardino County, CA	1.1553
40220	Roanoke, VA	
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	0.8841
40340	Rochester, MN	
	Dodge County, MN	
	Olmsted County, MN	
	Wabasha County, MN	1.0960
40380	Rochester, NY	
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	
	Orleans County, NY	
	Wayne County, NY	0.8609
40420	Rockford, IL	
	Boone County, IL	
	Winnebago County, IL	1.0049
40484	Rockingham County-Strafford County, NH	
	Rockingham County, NH	
	Strafford County, NH	1.0042
40580	Rocky Mount, NC	
	Edgecombe County, NC	
	Nash County, NC	0.9049
40660	Rome, GA	
	Floyd County, GA	0.8817
40900	Sacramento--Arden-Arcade--Roseville, CA	
	El Dorado County, CA	
	Placer County, CA	
	Sacramento County, CA	
	Yolo County, CA	1.3949
40980	Saginaw-Saginaw Township North, MI	
	Saginaw County, MI	0.8742
41060	St. Cloud, MN	
	Benton County, MN	
	Stearns County, MN	1.1060
41100	St. George, UT	
	Washington County, UT	0.9148
41140	St. Joseph, MO-KS	
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
	DeKalb County, MO	1.0318

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
41180	St. Louis, MO-IL	
	Bond County, IL	
	Calhoun County, IL	
	Clinton County, IL	
	Jersey County, IL	
	Macoupin County, IL	
	Madison County, IL	
	Monroe County, IL	
	St. Clair County, IL	
	Crawford County, MO	
	Franklin County, MO	
	Jefferson County, MO	
	Lincoln County, MO	
	St. Charles County, MO	
	St. Louis County, MO	
	Warren County, MO	
	Washington County, MO	
	St. Louis City, MO	0.9105
41420	Salem, OR	
	Marion County, OR	
	Polk County, OR	1.1151
41500	Salinas, CA	
	Monterey County, CA	1.5711
41540	Salisbury, MD	
	Somerset County, MD	
	Wicomico County, MD	0.9020
41620	Salt Lake City, UT	
	Salt Lake County, UT	
	Summit County, UT	
	Tooele County, UT	0.9281
41660	San Angelo, TX	
	Irion County, TX	
	Tom Green County, TX	0.8317
41700	San Antonio-New Braunfels, TX	
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
	Wilson County, TX	0.9013

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
41740	San Diego-Carlsbad-San Marcos, CA	
	San Diego County, CA	1.1858
41780	Sandusky, OH	
	Erie County, OH	0.8700
41884	San Francisco-San Mateo-Redwood City, CA	
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	1.5740
41900	San Germán-Cabo Rojo, PR	
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	0.4567
41940	San Jose-Sunnyvale-Santa Clara, CA	
	San Benito County, CA	
	Santa Clara County, CA	1.6730

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
41980	San Juan-Caguas-Guaynabo, PR	
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	0.4303

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
42020	San Luis Obispo-Paso Robles, CA	
	San Luis Obispo County, CA	1.2927
42044	Santa Ana-Anaheim-Irvine, CA	
	Orange County, CA	1.2181
42060	Santa Barbara-Santa Maria-Goleta, CA	
	Santa Barbara County, CA	1.1986
42100	Santa Cruz-Watsonville, CA	
	Santa Cruz County, CA	1.6768
42140	Santa Fe, NM	
	Santa Fe County, NM	1.0864
42220	Santa Rosa-Petaluma, CA	
	Sonoma County, CA	1.6167
42340	Savannah, GA	
	Bryan County, GA	
	Chatham County, GA	
	Effingham County, GA	0.8918
42540	Scranton--Wilkes-Barre, PA	
	Lackawanna County, PA	
	Luzerne County, PA	
	Wyoming County, PA	0.8252
42644	Seattle-Tacoma-Bellevue, WA	
	King County, WA	
	Snohomish County, WA	1.1574
42680	Sebastian-Vero Beach, FL	
	Indian River County, FL	0.9111
43100	Sheboygan, WI	
	Sheboygan County, WI	0.9248
43300	Sherman-Denison, TX	
	Grayson County, TX	0.8292
43340	Shreveport-Bossier City, LA	
	Bossier Parish, LA	
	Caddo Parish, LA	
	De Soto Parish, LA	0.8550
43580	Sioux City, IA-NE-SD	
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	0.9106
43620	Sioux Falls, SD	
	Lincoln County, SD	
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	0.9314

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
43780	South Bend-Mishawaka, IN-MI	
	St. Joseph County, IN	
	Cass County, MI	0.9964
43900	Spartanburg, SC	
	Spartanburg County, SC	0.9268
44060	Spokane, WA	
	Spokane County, WA	1.0588
44100	Springfield, IL	
	Menard County, IL	
	Sangamon County, IL	0.9145
44140	Springfield, MA	
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	1.0236
44180	Springfield, MO	
	Christian County, MO	
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	0.8271
44220	Springfield, OH	
	Clark County, OH	0.9249
44300	State College, PA	
	Centre County, PA	0.8793
44600	SteubenvilleWeirton-, WV-OH	
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	0.7326
44700	Stockton, CA	
	San Joaquin County, CA	1.2576
44940	Sumter, SC	
	Sumter County, SC	0.7873
45060	Syracuse, NY	
	Madison County, NY	
	Onondaga County, NY	
	Oswego County, NY	0.9631
45104	Tacoma, WA	
	Pierce County, WA	1.1362
45220	Tallahassee, FL	
	Gadsden County, FL	
	Jefferson County, FL	
	Leon County, FL	
	Wakulla County, FL	0.8820

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
45300	Tampa-St. Petersburg-Clearwater, FL	
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL	
	Pinellas County, FL	0.9068
45460	Terre Haute, IN	
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	0.9220
45500	Texarkana, TX-Texarkana, AR	
	Miller County, AR	
	Bowie County, TX	0.7654
45780	Toledo, OH	
	Fulton County, OH	
	Lucas County, OH	
	Ottawa County, OH	
	Wood County, OH	0.9447
45820	Topeka, KS	
	Jackson County, KS	
	Jefferson County, KS	
	Osage County, KS	
	Shawnee County, KS	
	Wabaunsee County, KS	0.8967
45940	Trenton-Ewing, NJ	
	Mercer County, NJ	1.0167
46060	Tucson, AZ	
	Pima County, AZ	0.9495
46140	Tulsa, OK	
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	Pawnee County, OK	
	Rogers County, OK	
	Tulsa County, OK	
	Wagoner County, OK	0.8802
46220	Tuscaloosa, AL	
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	0.8003
46340	Tyler, TX	
	Smith County, TX	0.8078

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
46540	Utica-Rome, NY	
	Herkimer County, NY	
	Oneida County, NY	0.8485
46660	Valdosta, GA	
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	0.7937
46700	Vallejo-Fairfield, CA	
	Solano County, CA	1.4939
47020	Victoria, TX	
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	0.8232
47220	Vineland-Millville-Bridgeton, NJ	
	Cumberland County, NJ	1.0432
47260	Virginia Beach-Norfolk-Newport News, VA-NC	
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	0.8975
47300	Visalia-Porterville, CA	
	Tulare County, CA	1.0756
47380	Waco, TX	
	McLennan County, TX	0.8417
47580	Warner Robins, GA	
	Houston County, GA	0.7951
47644	Warren-Troy-Farmington Hills, MI	
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	0.9662
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	
	District of Columbia, DC	
	Calvert County, MD	
	Charles County, MD	
	Prince George's County, MD	
	Arlington County, VA	
	Clarke County, VA	
	Fairfax County, VA	
	Fauquier County, VA	
	Loudoun County, VA	
	Prince William County, VA	
	Spotsylvania County, VA	
	Stafford County, VA	
	Warren County, VA	
	Alexandria City, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fredericksburg City, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Jefferson County, WV	1.0722
47940	Waterloo-Cedar Falls, IA	
	Black Hawk County, IA	
	Bremer County, IA	
	Grundy County, IA	0.8476
48140	Wausau, WI	
	Marathon County, WI	0.9358
48300	Wenatchee- East Wenatchee, WA	
	Chelan County, WA	
	Douglas County, WA	0.9631
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	
	Palm Beach County, FL	0.9949
48540	Wheeling, WV-OH	
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	0.6686

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8913
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9581
48700	Williamsport, PA Lycoming County, PA	0.7267
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0597
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9150
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0018
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8953
49340	Worcester, MA Worcester County, MA	1.1030
49420	Yakima, WA Yakima County, WA	1.0083
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3542
49620	York-Hanover, PA York County, PA	0.9542
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8639
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1061
49740	Yuma, AZ Yuma County, AZ	0.9298

TABLE 12B.—PROPOSED LTCH PPS WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2010 THROUGH SEPTEMBER 30, 2011

CBSA Code	Nonurban Area	Proposed LTCH PPS Wage Index
01	Alabama	0.7376
02	Alaska	1.2646
03	Arizona	0.9094
04	Arkansas	0.7234
05	California	1.2456
06	Colorado	0.9949
07	Connecticut	1.1139
08	Delaware	0.9771
10	Florida	0.8422
11	Georgia	0.7567
12	Hawaii	1.1100
13	Idaho	0.7568
14	Illinois	0.8357
15	Indiana	0.8404
16	Iowa	0.8584
17	Kansas	0.7994
18	Kentucky	0.7827
19	Louisiana	0.7724
20	Maine	0.8602
21	Maryland	0.9189
22	Massachusetts	1.1788
23	Michigan	0.8569
24	Minnesota	0.9053
25	Mississippi	0.7647
26	Missouri	0.7648
27	Montana	0.8531
28	Nebraska	0.8920
29	Nevada	0.9365
30	New Hampshire	0.9894
31	New Jersey*	-------
32	New Mexico	0.8948
33	New York	0.8198
34	North Carolina	0.8379
35	North Dakota	0.6842
36	Ohio	0.8542
37	Oklahoma	0.7867
38	Oregon	1.0045
39	Pennsylvania	0.8482
41	Rhode Island*	-------
42	South Carolina	0.8431
43	South Dakota	0.8549
44	Tennessee	0.7879
45	Texas	0.7818
46	Utah	0.8663
47	Vermont	0.9606
49	Virginia	0.7853
50	Washington	1.0200
51	West Virginia	0.7484
52	Wisconsin	0.8976
53	Wyoming	0.9544

*All counties within the State are classified as urban.

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Appendix A: Regulatory Impact Analysis

Note: The impacts of the proposed FY 2011 policy changes and payment rates addressed in this Appendix do not reflect the provisions of the Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152). A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

I. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

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

We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the proposed changes for FY 2011 acute care hospital operating and capital payments will redistribute in excess of $100 million among different types of inpatient cases. The proposed market basket update to the IPPS rates required by the statute, in conjunction with other proposed payment changes in this proposed rule, would result in an estimated $142 million decrease in FY 2011 operating payments (or −0.1 percent increase), and an estimated $20 million decrease in FY 2011 capital payments (or −0.2 percent change). The impact analysis of the capital payments can be found in section VIII. of this Appendix. In addition, as described in section IX. of this Appendix, LTCHs are expected to experience an increase in payments by $41 million (or 0.8 percent).

Our operating impact estimate includes the proposed −2.9 percent documentation and coding adjustment applied to the hospital-specific rates, the proposed −2.4 percent documentation and coding adjustment applied to the Puerto Rico-specific rates and the proposed −2.9 percent adjustment for documentation and coding changes to the IPPS standardized amounts. In addition, our operating impact estimate includes the proposed 2.4 percent market basket update to the standardized amount. The estimates of IPPS operating payments to acute care hospitals do not reflect any changes in hospital admissions or real case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most hospitals and most other providers and suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration definition of a small business (having revenues of $34.5 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers to the Table of Small Business Size Standards for NAIC 622 found on the Small Business Administration Office of Size Standards Web site at: *http://www.sba.gov/contractingopportunities/officials/size/GC-SMALL-BUS-SIZE-STANDARDS.html.)* 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. We believe that the provisions of this proposed rule relating to acute care hospitals would have a significant impact on small entities as explained in this Appendix. Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary LTCHs. Therefore, we are assuming that all LTCHs are considered small entities for the purpose of the analysis in section IX. of this Appendix. Medicare fiscal intermediaries and MACs are not considered to be small entities. Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our proposed regulatory flexibility analysis. Therefore, we are soliciting public comments on our estimates and analysis of the impact of this proposed rule on those small entities.

The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Public Law 104–121, as amended by section 8302 of Public Law 110–28, requires an agency to provide compliance guides for each rule or group of related rules for which an agency is required to prepare a final regulatory flexibility analysis. The compliance guides associated with this proposed rule are available on the CMS IPPS Web page at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp.* We also note that the Hospital Center Web page at *http://www.cms.hhs.gov/center/hospital.asp* was developed to assist hospitals in understanding and adapting to changes in Medicare regulations and in billing and payment procedures. This Web page provides hospitals with substantial downloadable explanatory materials.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed or 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 now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS and the LTCH PPS, we continue to classify these hospitals as urban hospitals. (We refer readers to Table 1 and section VI. of this Appendix for the quantitative effects of the proposed policy changes under the IPPS for operating costs.)

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $133 million. This proposed rule would not mandate any requirements for State,

local, or tribal governments, nor would it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this proposed rule would not have a substantial effect on State and local governments.

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

II. Objectives of the IPPS

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

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

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2011, 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, generally, we do not attempt to make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. However, in the FY 2008 IPPS final rule with comment period, we indicated that we believe that implementation of the MS–DRGs would lead to increases in case-mix that do not reflect actual increases in patients' severity of illness as a result of more comprehensive documentation and coding. As explained in section II.D. of the preamble of this proposed rule, the FY 2008 IPPS final rule with comment period established a documentation and coding adjustment of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 to maintain budget neutrality for the transition to the MS–DRGs. Subsequently, Congress enacted Public Law 110–90. Section 7 of Public Law 110–90 reduced the IPPS documentation and coding adjustment from −1.2 percent to −0.6 percent for FY 2008 and from −1.8 percent to −0.9 percent for FY 2009. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43773), we postponed the documentation and coding adjustment to the average standardized amount until FY 2011 and did not apply the adjustment to the average standardized amount for FY 2010. An analysis of the FY 2008 IPPS claims data and the FY 2009 IPPS claims data found that an estimated recoupment adjustment of −5.8 percent applied to the national standardized amount is required to remove the full effects of documentation and coding due to the transition to MS–DRGs. Therefore, we are proposing to reduce the national standardized amount for IPPS hospitals by 2.9 percent in FY 2011 with additional reductions in subsequent years.

Furthermore, we believe that hospitals that are paid under the hospital-specific payment rate, specifically SCHs and MDHs, experience similar increases in case-mix due to documentation and coding changes that do not reflect real changes in case-mix. Our actuarial office estimates that hospitals paid under the hospital-specific rate experienced a 4.8 percent increase in payments due to documentation and coding changes in FY 2008 and FY 2009. We did not apply a documentation and coding adjustment to the hospital-specific rates when we first implemented the MS–DRG system. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43776), we postponed the documentation and coding adjustment to the hospital-specific payment rate until FY 2011 and did not apply the adjustment to hospital-specific payment rate for FY 2010. We believe that SCHs and MDHs paid under the hospital-specific rate also should receive an adjustment to the hospital-specific rate due to changes in documentation and coding that do not reflect real changes in case-mix. Our best estimate, based on the most recently available data, is that a cumulative adjustment of −5.4 percent to the hospital-specific payment rate would address the effect of the documentation and coding changes on future payments. Therefore, for FY 2011, we are proposing to apply a −2.9 percent documentation and coding adjustment to the hospital-specific payment rate.

Our analysis, as described in section II.D. of the preamble of this proposed rule, shows that Puerto Rico hospitals experienced an increase in case-mix by 1.1 percent in FY 2008 due to changes in documentation and coding. We did not apply a documentation and coding adjustment to the Puerto Rico-specific rate when we first implemented the MS–DRG system. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43777), consistent with our decision to postpone documentation and coding adjustments for the hospital-specific rate and the Federal standardized amount, we also postponed the documentation and coding adjustment to the Puerto Rico-specific payment rate. Analysis of claims data from Puerto Rico hospitals found that a cumulative adjustment of −2.4 percent is required to eliminate the full effect of the documentation and coding changes on future payments from the Puerto Rico-specific rate. Therefore, for FY 2011, we are proposing to apply a −2.4 percent adjustment to the Puerto Rico-specific rate to account for changes due to documentation and coding.

The impacts shown below illustrate the impact of the proposed FY 2011 IPPS changes on acute care hospital operating payments, including the proposed −2.9 percent FY 2011 documentation and coding adjustment to the IPPS national standardized amount, the proposed −2.9 percent FY 2011 documentation and coding adjustment to the hospital-specific payment rates, and the proposed −2.4 percent FY 2011 documentation and coding adjustment to the Puerto Rico-specific standardized amount. The proposed documentation and coding adjustment that would be applicable to the Federal rate under the LTCH PPS for FY 2011 is discussed in section IX. of this Appendix. As we have done in the previous rules, we are soliciting public comments and information about the anticipated effects of the proposed changes on acute care hospitals and our methodology for estimating them.

IV. Hospitals Included in and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs of acute care hospitals encompass most general short-term,

acute care hospitals that participate in the Medicare program. There were 33 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 46 such hospitals in Maryland remain excluded from the IPPS pursuant to the waiver under section 1814(b)(3) of the Act.

As of March 2010, there are 3,472 IPPS acute care hospitals to be included in our analysis. This represents about 64 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 1,338 CAHs. These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. (We refer readers to section VII. of this Appendix for a further description of the impact of CAH-related proposed policy changes.) There are also 1,270 IPPS-excluded hospitals and 2,169 IPPS-excluded hospital units. These IPPS-excluded hospitals and units include IPFs, IRFs, LTCHs, RNHCIs, children's hospitals, and cancer hospitals, which are paid under separate payment systems. Changes in the prospective payment systems for IPFs and IRFs are made through separate rulemaking. Payment impacts for these IPPS-excluded hospitals and units are not included in this proposed rule. The impact of the proposed update and policy changes to the LTCH PPS for FY 2011 are discussed in section IX. of this Appendix.

V. Effects on Hospitals and Hospital Units Excluded From the IPPS

As of March 2010, there were 3,439 hospitals and hospital units excluded from the IPPS. Of these, 78 children's hospitals, 11 cancer hospitals, and 17 RNHCIs are being paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. The remaining providers, 228 rehabilitation hospitals and 961 rehabilitation units, and 429 LTCHs, are paid the Federal prospective per discharge rate under the IRF PPS and the LTCH PPS, respectively, and 507 psychiatric hospitals and 1,208 psychiatric units are paid the Federal per diem amount under the IPF PPS. As stated above, IRFs and IPFs are not affected by rate updates in this proposed rule. The impacts of the changes to LTCHs are discussed in section IX. of this Appendix.

In the past, certain hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Cancer and children's hospitals continue to be paid on a reasonable cost basis subject to TEFRA limits for FY 2011. For these hospitals (cancer and children's hospitals), consistent with the authority provided in section 1886(b)(3)(B)(ii) of the Act, the update is the percentage increase in the FY 2011 IPPS operating market basket. In compliance with section 404 of the MMA, in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43930), we replaced the FY 2002-based IPPS operating and capital market baskets with the revised and rebased FY 2006-based IPPS operating and capital market baskets. Therefore, consistent with current law, based on IHS Global Insight, Inc.'s 2010 first quarter forecast, with historical data through the 2009 fourth quarter, we are estimating that the proposed FY 2011 update to the IPPS operating market basket would be 2.4 percent (that is, the current estimate of the market basket rate-of-increase). In addition, in accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40. Therefore, for RNHCIs, the proposed update is the same as for children's and cancer hospitals, which is the percentage increase in the FY 2011 IPPS operating market basket increase, estimated to be 2.4 percent.

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

We note that, under § 413.40(d)(3), an excluded hospital that continues to be paid under the TEFRA system, 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, cancer and children's hospitals can obtain payment adjustments for justifiable increases in operating costs that exceed the limit.

VI. Quantitative Effects of the Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing proposed policy changes and payment rate updates for the IPPS for operating costs of acute care hospitals. Updates to the capital payments to acute care hospitals are discussed in section VIII. of this Appendix. Based on the overall percentage change in payments per case estimated using our payment simulation model, we estimate that total FY 2011 operating payments would decrease by 0.1 percent compared to FY 2010, largely due to the documentation and coding adjustments and market basket update to the IPPS rates. This amount reflects the proposed FY 2011 documentation and coding adjustments described above and in section II.D. of the preamble of this proposed rule: −2.9 percent for the IPPS national standardized amounts, −2.9 percent for the IPPS hospital-specific rates, and −2.4 percent for the IPPS Puerto Rico-specific standardized amount. The impacts do not illustrate changes in hospital admissions or real case-mix intensity, which will also affect overall payment changes.

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

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2009 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the proposed changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, in this analysis, we do not make adjustments for future changes in such variables as admissions, lengths of stay, or underlying growth in real case-mix. Second, due to the interdependent nature of the IPPS payment

components, it is very difficult to precisely quantify the impact associated with each change. Third, we use various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the FY 2009 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPS (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of the capital IPPS for FY 2011 are discussed in section VIII. of this Appendix.

The changes discussed separately below are the following:

- The effects of the proposed annual reclassification of diagnoses and procedures, full implementation of the MS–DRG system and 100 percent cost-based MS–DRG relative weights.
- The effects of the proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2007, compared to the FY 2006 wage data.
- The effects of the recalibration of the MS–DRG relative weights as required by section 1886(d)(4)(C) of the Act, including the proposed wage and recalibration budget neutrality factors.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2011.
- The effects of the third year of the 3-year transition to apply rural floor budget neutrality adjustment at the State level. For purposes of this impact analysis, we assume that in FY 2011, hospitals will receive a wage index with the State level rural and imputed floor budget neutrality adjustment. However, we recognize that this policy was recently changed by the provisions of section 3141 of Public Law 111–148 and will address the new impact in a separate document in the **Federal Register**.
- The effects of section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.
- The total estimated change in payments based on the proposed FY 2011 policies relative to payments based on FY 2010 policies that include the proposed market basket update of 2.4 percent.

To illustrate the impacts of the proposed FY 2011 changes, our analysis begins with a FY 2010 baseline simulation model using: The proposed FY 2011 market basket update of 2.4 percent; the FY 2010 MS–DRG GROUPER (Version 27.0); the most current CBSA designations for hospitals based on OMB's MSA definitions; the FY 2010 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating MS–DRG and outlier payments.

Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a) of Public Law 109–171, provides that, for FY 2007 and subsequent years, the update factor will be reduced by 2.0 percentage points for any hospital that does not submit quality data in a form and manner and at a time specified by the Secretary. At the time that this impact was prepared, 104 hospitals did not receive the full market basket rate-of-increase for FY 2010 because they failed the quality data submission process or did not choose to participate. For purposes of the simulations shown below, we modeled the proposed payment changes for FY 2011 using a reduced update for these 104 hospitals. However, we do not have enough information at this time to determine which hospitals will not receive the full market basket rate-of-increase for FY 2011.

Each policy change, statutory or otherwise, is then added incrementally to this baseline, finally arriving at an FY 2011 model incorporating all of the changes. This simulation allows us to isolate the effects of each proposed change.

Our final comparison illustrates the proposed percent change in payments per case from FY 2010 to FY 2011. Three factors not discussed separately have significant impacts here. The first factor is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we are proposing to update the standardized amounts for FY 2011 using the most recently forecasted hospital market basket increase for FY 2011 of 2.4 percent. (Hospitals that fail to comply with the quality data submission requirements to receive the full update will receive an update reduced by 2.0 percentage points from 2.4 percent to 0.4 percent.) Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for SCHs and for MDHs are also equal to the market basket percentage increase, or 2.4 percent.

A second significant factor that affects the changes in hospitals' payments per case from FY 2010 to FY 2011 is the change in a hospital's geographic reclassification status from one year to the next. That is, payments may be reduced for hospitals reclassified in FY 2010 that are no longer reclassified in FY 2011. Conversely, payments may increase for hospitals not reclassified in FY 2010 that are reclassified in FY 2011.

A third significant factor is that we currently estimate that actual outlier payments during FY 2011 will be 5.1 percent of total MS–DRG payments. When the FY 2010 final rule was published, we projected FY 2010 outlier payments would be 5.1 percent of total MS–DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2010 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2010 payments per case to estimated FY 2011 payments per case (with outlier payments projected to equal 5.1 percent of total MS–DRG payments).

B. Analysis of Table I

Table I displays the results of our analysis of the proposed changes for FY 2011. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,472 acute care hospitals included in the 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 2,502 hospitals located in urban areas included in our analysis. Among these, there are 1,365 hospitals located in large urban areas (populations over 1 million), and 1,137 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 970 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 2011 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 numbers of hospitals paid based on these categorizations after consideration of geographic reclassifications (including reclassifications under section 1886(d)(8)(B) and section 1886(d)(8)(E) of the Act that have implications for capital payments) are 2,555, 1,403, 1,152 and 917, respectively.

The next three groupings examine the impacts of the changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,434 nonteaching hospitals in our analysis, 798 teaching hospitals with fewer than 100 residents, and 240 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural for DSH purposes. The next category groups together hospitals considered urban or rural, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the changes on rural hospitals by special payment groups (SCHs, RRCs, and MDHs). There were 183 RRCs, 340 SCHs, 187 MDHs, and 108 hospitals that are both SCHs and RRCs, and 13 hospitals that are both an MDH and an RRC.

The next series of groupings are based on the type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data were taken from the FY 2008 or FY 2007 Medicare cost reports.

The next two groupings concern the geographic reclassification status of hospitals. The first grouping displays all urban hospitals that were reclassified by the MGCRB for FY 2011. The second grouping shows the MGCRB rural reclassifications.

The final category shows the impact of the proposed policy changes on the 19 cardiac hospitals in our analysis.

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TABLE I.--IMPACT ANALYSIS OF PROPOSED CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2011

	No. of Hospitals	Proposed FY 2011 Weights & MS-DRG Changes (1)	Application of Recalibration Budget Neutrality (2)	Proposed FY 2011 Wage Data (3)	Application of Wage Budget Neutrality (4)	Proposed FY 2011 DRG, Rel. Wts., Wage Index Changes, with Wage and Recalibration Budget Neutrality (5)	FY 2011 MGCRB Reclassifications (6)	Proposed Rural Floor Budget Neutrality and Within State Rural Floor Budget Neutrality (7)	Proposed FY 2011 Out-Migration Adjustment (8)	All Proposed FY 2011 Changes Prior to the CMI Adjustment (9)	All Proposed FY 2011 Changes w/CMI Adjustment (10)
All Hospitals	3,472	0.3	0	0	0	0	0	0	0	2.8	-0.1
By Geographic Location:											
Urban hospitals	2,502	0.3	0	0	0	0	-0.2	0	0	2.8	-0.1
Large urban areas	1,365	0.2	-0.1	0	0.1	0	-0.3	-0.1	0	2.8	-0.1
Other urban areas	1,137	0.4	0.1	-0.1	-0.1	0	0	0.1	0	2.9	-0.1
Rural hospitals	970	0.3	0	0	0	0	1.6	-0.1	0.1	2.4	-0.5
Bed Size (Urban):											
0-99 beds	635	0.6	0.2	0	0	0.3	-0.5	0	0	2.9	0
100-199 beds	791	0.2	-0.1	0	0	0	0	0.1	0	2.7	-0.2
200-299 beds	461	0.3	0	0	0	0	-0.1	0	0	2.7	-0.2
300-499 beds	425	0.3	0	0	0	0	-0.2	0	0	2.8	-0.1
500 or more beds	190	0.3	0	-0.1	-0.1	0	-0.2	-0.1	0	3	0.1
Bed Size (Rural):											
0-49 beds	337	0.6	0.3	0.1	0.1	0.3	0.6	0	0.2	2.9	0
50-99 beds	366	0.3	0	0	0	0	0.6	0	0.1	2.1	-0.8
100-149 beds	164	0.3	0	0	0	0	2.1	-0.1	0.1	2.5	-0.4
150-199 beds	61	0.3	0	0	0	0.1	2.4	-0.1	0	2.6	-0.3
200 or more beds	42	0.2	-0.1	0	0.1	-0.1	2.3	0	0	2.1	-0.8
Urban by Region:											
New England	121	0.1	-0.2	-0.4	-0.4	-0.6	0.9	0	0	2	-0.9

	No. of Hos-pitals	Pro-posed FY 2011 Weights & MS-DRG Change s (1)	Appli ca-tion of Recal i-bratio n Budg et Neu-trality (2)	Pro-posed FY 2011 Wage Data (3)	Applica-tion of Wage Budget Neu-trality (4)	Pro-posed FY 2011 DRG, Rel. Wts., Wage Index Changes, with Wage and Recal-ibration Budget Neutrality (5)	FY 2011 MGCRB Reclass-ifica-tions (6)	Pro-posed Rural Floor Budget Neu-trality and Within State Rural Floor Budget Neu-trality (7)	Pro-posed FY 2011 Out-Migra-tion Adjust-ment (8)	All Pro-posed FY 2011 Changes Prior to the CMI Adjust-ment (9)	All Pro-posed FY 2011 Changes w/CMI Adjust-ment (10)
Middle Atlantic	330	0.3	0	-0.3	-0.3	-0.3	0.2	0	0	2.3	-0.6
South Atlantic	383	0.1	-0.2	0	0	-0.2	-0.3	0	0	2.8	-0.1
East North Central	403	0.1	-0.1	0.2	0.2	0.1	-0.2	0	0	3	0.1
East South Central	155	0.4	0.2	-0.5	-0.6	-0.4	-0.2	0	0	2.5	-0.4
West North Central	166	0.5	0.2	-0.1	-0.1	0.1	-0.7	0	0	3	0.1
West South Central	342	0.5	0.2	0.2	0.2	0.4	-0.6	0	0	3.2	0.3
Mountain	162	0.3	0	0	0	0	-0.3	0	0	3	0
Pacific	390	0.6	0.2	0.4	0.4	0.5	-0.3	0	0	3.4	0.5
Puerto Rico	50	0.9	0.7	-0.3	-0.3	0.4	-0.8	0	0	3.1	0.3
Rural by Region:											
New England	24	0.2	-0.2	0	0	-0.2	0.5	0	0	1.2	-1.6
Middle Atlantic	70	-0.1	-0.4	0.4	0.4	0	1.4	-0.1	0	2.1	-0.8
South Atlantic	165	-0.2	-0.5	-0.3	-0.4	-0.9	2	0	0.1	1.8	-1
East North Central	120	0.3	0	-0.1	-0.1	-0.2	1.3	0	0	2.2	-0.7
East South Central	175	0.6	0.3	0.2	0.2	0.5	2.4	-0.1	0.2	2.7	-0.2
West North Central	100	0.7	0.4	0	0	0.4	0.5	0	0	2.8	-0.1
West South Central	214	0.7	0.5	0.3	0.4	0.8	1.9	0	0.1	3.4	0.4
Mountain	71	0.7	0.4	0	0	0.4	0.1	0	0	2.8	-0.1
Pacific	31	0	-0.4	0.3	0.3	-0.1	0.9	-0.3	0	1.4	-1.5
By Payment Classification:											
Urban hospitals	2,555	0.3	0	0	0	0	-0.2	0	0	2.8	-0.1
Large urban areas	1,403	0.2	0	0	0.1	0	-0.3	-0.1	0	2.8	-0.1

	No. of Hos-pitals	Pro-posed FY 2011 Weights & MS-DRG Change s (1)	Appli ca-tion of Recal i-bratio n Budg et Neu-trality (2)	Pro-posed FY 2011 Wage Data (3)	Applica-tion of Wage Budget Neu-trality (4)	Pro-posed FY 2011 DRG, Rel. Wts., Wage Index Changes, with Wage and Recal-ibration Budget Neutrality (5)	FY 2011 MGCRB Reclass-ifica-tions (6)	Pro-posed Rural Floor Budget Neu-trality and Within State Rural Floor Budget Neu-trality (7)	Pro-posed FY 2011 Out-Migra-tion Adjust-ment (8)	All Pro-posed FY 2011 Changes Prior to the CMI Adjust-ment (9)	All Pro-posed FY 2011 Changes w/CMI Adjust-ment (10)
Other urban areas	1,152	0.4	0.1	-0.1	-0.1	0	0	0.1	0	2.9	-0.1
Rural areas	917	0.3	0	0	0	0	1.4	0	0.1	2.3	-0.5
Teaching Status:											
Nonteaching	2,434	0.4	0	0.1	0.1	0.1	0.2	0	0	2.8	-0.1
Fewer than 100 residents	798	0.3	0	-0.1	-0.1	-0.1	-0.2	0	0	2.7	-0.2
100 or more residents	240	0.3	0	-0.1	-0.1	-0.1	-0.2	-0.1	0	2.9	0
Urban DSH:											
Non-DSH	834	0.5	0.1	0	0	0	0.1	0	0	2.9	0
100 or more beds	1,510	0.3	0	0	0	0	-0.2	0	0	2.8	-0.1
Less than 100 beds	340	0.2	-0.1	0	0	0	-0.3	-0.1	0	2.4	-0.5
Rural DSH:											
SCH	407	0.3	0	0	0	0	0.2	0	0.1	2.3	-0.6
RRC	209	0.2	-0.1	0.1	0.1	0	2.3	-0.1	0	2.3	-0.6
100 or more beds	30	0.1	-0.2	-0.3	-0.3	-0.5	1.2	0	0.3	2.3	-0.6
Less than 100 beds	142	0.4	0.2	0	0.1	0.2	0.9	-0.1	0.5	2.2	-0.7
Urban teaching and DSH:											
Both teaching and DSH	806	0.3	0	-0.1	-0.1	-0.1	-0.3	0	0	2.8	-0.1
Teaching and no DSH	169	0.3	-0.1	-0.2	-0.2	-0.2	0.4	0	0	2.7	-0.2
No teaching and DSH	1,044	0.3	0	0.2	0.2	0.2	0	0.1	0	2.8	-0.1

	No. of Hos-pitals	Pro-posed FY 2011 Weights & MS-DRG Change s (1)	Appli ca-tion of Recal i-bratio n Budg et Neu-trality (2)	Pro-posed FY 2011 Wage Data (3)	Applica-tion of Wage Budget Neu-trality (4)	Pro-posed FY 2011 DRG, Rel. Wts., Wage Index Changes, with Wage and Recal-ibration Budget Neutrality (5)	FY 2011 MGCRB Reclass-ifica-tions (6)	Pro-posed Rural Floor Budget Neu-trality and Within State Rural Floor Budget Neu-trality (7)	Pro-posed FY 2011 Out-Migra-tion Adjust-ment (8)	All Pro-posed FY 2011 Changes Prior to the CMI Adjust-ment (9)	All Pro-posed FY 2011 Changes w/CMI Adjust-ment (10)
No teaching and no DSH	536	0.6	0.2	0	0	0.2	-0.2	0	0	3.1	0.2
Special Hospital Types:											
RRC	183	0.4	0.1	0	0	0.2	2.9	-0.1	0	2.5	-0.4
SCH	340	0.3	0	0	0	0	0	0	0	2.3	-0.5
MDH	187	0.2	-0.1	0	0	-0.1	0.4	-0.1	0.2	2.3	-0.6
SCH and RRC	108	0.2	-0.2	-0.1	-0.1	-0.2	0.7	0	0	2.1	-0.8
MDH and RRC	13	0.4	0	0.2	0.2	0.2	0.2	0	0.1	2.2	-0.6
Type of Ownership:											
Voluntary	1978	0.3	0	0	0	0	0	0	0	2.7	-0.2
Proprietary	837	0.4	0.1	0.2	0.2	0.3	-0.1	0	0	3	0.1
Government	577	0.3	0	-0.1	-0.1	0	0.1	0.1	0	2.9	-0.1
Medicare Utilization as a Percent of Inpatient Days:											
0-25	353	0.2	-0.1	0	0	0	-0.4	-0.1	0	2.8	-0.1
25-50	1,593	0.3	0	0	0	0	-0.3	0	0	2.9	-0.1
50-65	1,202	0.3	0	0	-0.1	-0.1	0.6	0	0	2.6	-0.3
Over 65	237	0.4	0.2	-0.1	-0.2	0	0.6	0.1	0	2.7	-0.2
FY 2011 Reclassifications by the Medicare Geographic Classification Review Board:											

	No. of Hos-pitals	Pro-posed FY 2011 Weights & MS-DRG Change s (1)	Appli ca-tion of Recal i-bratio n Budg et Neu-trality (2)	Pro-posed FY 2011 Wage Data (3)	Applica-tion of Wage Budget Neu-trality (4)	Pro-posed FY 2011 DRG, Rel. Wts., Wage Index Changes, with Wage and Recal-ibration Budget Neutrality (5)	FY 2011 MGCRB Reclass-ifica-tions (6)	Pro-posed Rural Floor Budget Neu-trality and Within State Rural Floor Budget Neu-trality (7)	Pro-posed FY 2011 Out-Migra-tion Adjust-ment (8)	All Pro-posed FY 2011 Changes Prior to the CMI Adjust-ment (9)	All Pro-posed FY 2011 Changes w/CMI Adjust-ment (10)
All Reclassified Hospitals	810	0.3	0	0.1	0.1	0	1.8	-0.1	0	2.8	-0.1
Non-Reclassified Hospitals	2,662	0.3	0	0	0	0	-0.6	0	0	2.8	-0.1
Urban Hospitals Reclassified	488	0.3	0	0.1	0.1	0	1.6	-0.2	0	2.9	-0.1
Urban Nonreclassified Hospitals, FY 2011:	1,985	0.3	0	0	0	0	-0.7	0.1	0	2.8	-0.1
All Rural Hospitals Reclassified FY 2011:	322	0.3	0	0.1	0.1	0.1	2.7	-0.1	0	2.6	-0.3
Rural Nonreclassified Hospitals FY 2011:	585	0.4	0	0	0	0.1	-0.3	0	0.2	2.2	-0.7
All Section 401 Reclassified Hospitals:	37	-0.1	-0.4	-0.1	-0.1	-0.5	-0.3	0	0	1.8	-1.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	63	-0.2	-0.5	-0.2	-0.2	-0.6	2.9	-0.1	0	1.7	-1.2
Specialty Hospitals											
Cardiac specialty Hospitals	19	1.1	0.8	0.3	0.3	1.1	-0.8	0	0	3.7	0.8

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2009, and hospital cost report data are from reporting periods beginning in FY 2008 and FY 2007.

[2] This column displays the payment impact of the proposed changes to the Version 28 GROUPER and the recalibration of the MS-DRG weights based on FY 2009 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act.

[3] This column displays the application of the recalibration budget neutrality factor of 0.996856, in accordance with section 1886(d)(4)(C)(iii) of the Act.

[4].This column displays the proposed payment impact of the update to wage index data using FY 2007 cost report data.

[5]This column displays the payment impact of the application of the wage budget neutrality factor in accordance with section 1886(d)(3)(E)(i) of the Act. This factor is calculated separately from the recalibration budget neutrality factor. The wage budget neutrality factor is1.000107.

[6] This column displays the combined payment impact of the proposed changes in Columns 2 through 5 and the proposed cumulative budget neutrality factor for MS-DRG and wage changes in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act. The cumulative wage and recalibration budget neutrality factor of 0.996963is the product of the wage budget neutrality factor and the recalibration budget neutrality factor.

[7] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2011 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2011. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.991756.

[8] This column displays the effects of the rural floor and the imputed floor, including the transition to the rural floor budget neutrality adjustment at the State level. Under the transition, hospitals will receive a blended wage index that is 100 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment.

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

[10] This column shows the proposed changes in payments from FY 2010 to FY 2011. It reflects the impact of the proposed FY 2011 market basket update, and the proposed reductions to the FY 2011 standardized amount due to the documentation and coding effect. The proposed FY 2011 documentation and coding adjustment is -2.9 percent to the IPPS standardized amounts, -2.9 percent to the hospital-specific rates, and -2.4 percent to the Puerto Rico-specific amount. It also reflects changes in hospitals' reclassification status in FY 2011 compared to FY 2010. It incorporates all of the proposed changes displayed in Columns 5, 6, 7, and 8 (the changes displayed in Columns 2, 4 are included in Column 5). The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effects.

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C. Effects of the Proposed Changes to the MS–DRG Reclassifications and Relative Cost-Based Weights (Column 1)

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

As discussed in the preamble of this proposed rule, the proposed FY 2011 MS–DRG relative weights will be 100 percent cost-based and 100 percent MS–DRGs. For FY 2011, the MS–DRGs are calculated using the FY 2009 MedPAR data grouped to the Version 28.0 (FY 2011) MS–DRGs. The methods of calculating the proposed relative weights and the reclassification changes to the GROUPER are described in more detail in section II.H. of the preamble to this proposed rule. The proposed changes to the relative weights and MS–DRGs shown in Column 2 are prior to any offset for budget neutrality. Overall, hospitals will experience a 0.3 percent increase in payments due to the changes in the MS–DRGs and relative weights prior to budget neutrality. Urban hospitals and rural hospitals will experience a 0.3 percent increase in payments under the updates to the relative weights and MS–DRGs.

D. Effects of the Application of Recalibration Budget Neutrality (Column 2)

Column 2 shows the effects of the changes to the MS–DRGs and relative weights with the application of the recalibration budget neutrality factor to the standardized amounts. Consistent with section 1886(d)(4)(C)(iii) of the Act, we are calculating a recalibration budget neutrality factor to account for the changes in MS–DRGs and relative weights to ensure that the overall payment impact is budget neutral. In FY 2010, we began calculating a budget neutrality factor to account for changes in MS–DRGs and relative weights separately from the budget neutrality factor to account for changes in wage data. In addition, as described in section II.A.4. of the Addendum to this proposed rule, we are including IME payments made on Medicare Advantage claims to IPPS hospitals in order to calculate budget neutrality.

The "All Hospitals" line in Column 1 indicates that proposed changes due to MS–DRGs and relative weights will increase payments by 0.3 percent before application of the budget neutrality factor. The proposed recalibration budget neutrality factor is 0.996856, which is applied to the standardized amount. Thus, the impact after accounting only for budget neutrality for changes to the MS–DRG relative weights and classification is somewhat lower than the figures shown in Column 1 (approximately 0.3 percent). Consequentially, urban and rural hospitals will not experience a change in payments when recalibration budget neutrality is applied.

E. Effects of Proposed Wage Index Changes (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for acute care hospitals for FY 2011 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2006 and before October 1, 2007. The estimated impact of the updated wage data and labor share on hospital payments is isolated in Column 3 by holding the other payment parameters constant in this simulation. That is, Column 3 shows the percentage change in payments when going from a model using the FY 2010 wage index, based on FY 2006 wage data, the current labor-related share and having a 100-percent occupational mix adjustment applied, to a model using the FY 2011 pre-reclassification wage index with the labor-related share, also having a 100-percent occupational mix adjustment applied, based on FY 2007 wage data (while holding other payment parameters such as use of the Version 28.0 MS–DRG GROUPER constant). The occupational mix adjustment is based on the FY 2008/2009 occupational mix survey.

Column 3 shows the impacts of updating the wage data using FY 2007 cost reports. Overall, the new wage data will lead to a 0.0 percent change for all hospitals before being combined with the wage budget neutrality adjustment shown in Column 5. Among the regions, the largest increase is in the rural Middle Atlantic region, which experiences a 0.4 percent increase before applying an adjustment for budget neutrality. The largest decline from updating the wage data is seen in Urban East South Central (0.5 percent decrease).

In looking at the wage data itself, the national average hourly wage increased 1.2 percent compared to FY 2010. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match or exceed the national 1.2 percent increase in average hourly wage. Of the 3,442 hospitals with wage data for both FYs 2010 and 2011, 2,696, or 78.3 percent, experienced an average hourly wage increase of 1.2 percent or more.

The following chart compares the shifts in proposed wage index values for hospitals for FY 2011 relative to FY 2010. Among urban hospitals, 39 will experience an increase of more than 5 percent and less than 10 percent and 7 will experience an increase of more than 10 percent. Among rural hospitals, 2 will experience an increase of more than 5 percent and less than 10 percent, and none will experience an increase of more than 10 percent. However, 938 rural hospitals will experience increases or decreases of less than 5 percent, while 2,415 urban hospitals will experience increases or decreases of less than 5 percent. Twenty-four urban hospitals will experience decreases in their wage index values of more than 5 percent and less than 10 percent. Sixteen urban hospitals will experience decreases in their wage index values of greater than 10 percent. One rural hospital will experience a decrease of more than 10 percent. These figures reflect changes in the wage index which is an adjustment to either 68.8 percent or 62 percent of a hospital's standardized amount, depending upon whether its wage index is greater than 1.0 or less than or equal to 1.0. Therefore, these figures are illustrating a somewhat larger change in the wage index than will occur to the hospital's total payment.

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	7	0
Increase more than 5 percent and less than 10 percent	39	2
Increase or decrease less than 5 percent	2,415	938

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Decrease more than 5 percent and less than 10 percent	24	0
Decrease more than 10 percent	16	1

F. Application of the Wage Budget Neutrality Factor (Column 4)

Column 4 shows the impact of the new wage data with the application of the wage budget neutrality factor. In FY 2010, we began calculating separate wage budget neutrality and recalibration budget neutrality factors, in accordance with section 1886(d)(3)(E) of the Act, which specifies that budget neutrality to account for wage changes or updates made under that subparagraph must be made without regard to the 62 percent labor-related share guaranteed under section 1886(d)(3)(E)(ii) of the Act. Therefore, for FY 2011, we are calculating the wage budget neutrality factor to ensure that payments under updated wage data and the proposed labor-related share are budget neutral without regard to the lower labor-related share of 62 percent applied to hospitals with a wage index less than or equal to 1. In other words, the wage budget neutrality is calculated under the assumption that all hospitals receive the higher labor-related share of the standardized amount. Because the wage data changes did not change overall payments (displayed in Column 3), the wage budget neutrality factor is minimal at 1.000107, and the overall payment change is 0.0 percent.

G. Combined Effects of Proposed MS–DRG and Wage Index Changes (Column 5)

Section 1886(d)(4)(C)(iii) of the Act requires that changes to MS–DRG reclassifications and the relative weights cannot increase or decrease aggregate payments. 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. We computed a proposed wage budget neutrality factor of 1.000107, and a proposed recalibration budget neutrality factor of 0.996856 (which is applied to the Puerto Rico specific standardized amount and the hospital-specific rates). The product of the two budget neutrality factors is the cumulative wage and recalibration budget neutrality factor. The proposed cumulative wage and recalibration budget neutrality adjustment is 0.996963, or approximately −0.3 percent, which is applied to the national standardized amounts. Because the wage budget neutrality and the recalibration budget neutrality are calculated under different methodologies according to the statute, when the two budget neutralities are combined and applied to the standardized amount, the overall payment impact is not necessarily budget neutral. However, in this proposed rule, we are estimating that the proposed changes in the MS–DRG, relative weights and updated wage data with wage and budget neutrality applied will result in a 0.0 change in payments. The estimated changes shown in this column reflect the combined effects of the changes in Columns 2, 3, and 4 and the budget neutrality factors discussed previously.

We estimate that the combined impact of the proposed changes to the relative weights and MS–DRGs and the proposed updated wage data with budget neutrality applied will result in no change in payments for urban or rural hospitals. Urban New England would experience a 0.6 decrease in payments due to reductions in their case-mix and wages compared to the national average, while the urban Pacific area would experience a 0.5 percent increase in payments because of above average increases in wages and case-mix. Among the rural hospital categories, rural South Atlantic hospitals would experience the greatest decline in payment (−0.9 percent) primarily due to the changes to MS–DRGs and the relative cost weights.

H. Effects of MGCRB Reclassifications (Column 6)

Our impact analysis to this point has assumed acute care 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 other bases than where they are geographically located). 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 2011 which affect hospitals' wage index area assignments.

By spring of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's wage index value. Hospitals may appeal denials of MGCRB decisions to the CMS Administrator. Further, hospitals have 45 days from publication of the IPPS rule in the **Federal Register** to decide whether to withdraw or terminate an approved geographic reclassification for the following year. This column reflects all MGCRB decisions, Administrator appeals and decisions of hospitals for FY 2011 geographic reclassifications.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, for the purposes of this impact analysis, we are applying an adjustment of 0.991756 to ensure that the effects of the section 1886(d)(10) reclassifications are budget neutral (section II.A. of the Addendum to this proposed rule). Geographic reclassification generally benefits hospitals in rural areas. We estimate that geographic reclassification will increase payments to rural hospitals by an average of 1.6 percent. By region, all the rural hospital categories will experience increases in payments due to MGCRB reclassification where rural hospitals in the Mountain region will experience a 0.1 percent increase in payments and rural hospitals in the East South Central region will experience a 2.4 percent increase in payments.

Table 9A of the Addendum to this proposed rule reflects the approved reclassifications for FY 2011.

I. Effects of the Rural Floor and Imputed Floor, Including Application of Budget Neutrality at the State Level (Column 7)

As discussed in section III.B. of the preamble of the FY 2009 IPPS final rule, the FY 2010 IPPS/RY 2010 LTCH final rule and this proposed rule, section 4410 of Public Law 105–33 established the rural floor by requiring that the wage index for a hospital in any urban area cannot be less than the wage index received by rural hospitals in the same State. In FY 2008, we changed how we applied budget neutrality to the rural floor. Rather than applying a budget neutrality adjustment to the standardized amount, a uniform budget neutrality adjustment is applied to the wage index. In the FY 2009 final rule, we finalized the policy to apply the rural floor budget neutrality at the State level with a 3-year transition. In FY 2009, hospitals received a blended wage

index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. In FY 2010, hospitals received a blended wage index that is 50 percent of a wage index with the State level rural and imputed floor budget neutrality and 50 percent of a wage index with the national budget neutrality adjustment. For FY 2011, for purposes of this impact analysis, we assume application of the third year of the transitional period so that wage indices adjusted for the rural floor will have 100 percent of the wage index adjusted with a within-State rural budget neutrality factor. However, we recognize that this policy was recently changed by the provisions of section 3141 of Public Law 111–148.

Furthermore, the FY 2005 IPPS final rule (69 FR 49109) established a temporary imputed floor for all urban States from FY 2005 to FY 2007. The rural floor requires that an urban wage index cannot be lower than the wage index for any rural hospital in that State. Therefore, an imputed floor was established for States that do not have rural areas or rural IPPS hospitals. In the FY 2008 IPPS final rule with comment period (72 FR 47321), we finalized our proposal to extend the imputed floor for 1 additional year. In the FY 2009 IPPS final rule (73 FR 48573), we extended the imputed floor for an additional 3 years through FY 2011. Furthermore, as noted above, in that final rule we provided for a 3-year transition to the rural floor budget neutrality adjustment at the State level. Therefore, we also apply the imputed floor budget neutrality adjustment at the State level through a 3-year transition, so that, for FY 2011, wage indices adjusted for the imputed floor will have 100 percent of the wage index computed using the within-State rural and imputed budget neutrality adjustment.

Column 7 shows the projected impact of the rural floor and the imputed floor and the within-State rural and imputed floor budget neutrality. The column compares the proposed post-reclassification FY 2011 wage index of providers before the rural floor adjustment and the post-reclassification FY 2011 wage index of providers with the rural floor and imputed floor adjustment. Only urban hospitals can benefit from the rural floor provision. Because the provision is budget neutral, in prior years, all other hospitals (that is, all rural hospitals and those urban hospitals to which the adjustment is not made) had experienced a decrease in payments due to the budget neutrality adjustment applied nationally. However, because, for FY 2011, this calculation assumes that the rural floor adjusted wage index is made budget neutral through a within-State budget neutrality factor, rural hospitals and urban hospitals located in States that do not benefit from the rural floor will not experience a change in payments attributable to the rural floor. Conversely, all hospitals in States with hospitals receiving a rural floor will have their wage indices downwardly adjusted to achieve budget neutrality within the State.

We project that, in aggregate, rural hospitals will experience a 0.1 percent decrease in payments as a result of the application of rural floor budget neutrality because the rural hospitals located in States with a rural floor do not benefit from the rural floor, but have their wage indexes downwardly adjusted to ensure that the application of the rural floor is budget neutral overall within the State. We project hospitals located in other urban areas (populations of 1 million or fewer) will experience a 0.1 percent increase in payments because those providers benefit from the rural floor. Urban hospitals in the regions can expect 0 percent change in payments because within each state, the rural floor is budget neutral and increases in payments for providers receiving the rural floor re offset by the within-State budget neutrality factors applied to the wage index of the providers in States with a rural floor. Rural hospitals located in the Pacific area will experience a 0.3 percent decrease in payments because of the rural floor budget neutrality factor in California downwardly adjusts the wage index by 2.4 percent. Rural hospitals located in the Middle Atlantic area will experience a 0.1 percent decrease in payments because of the imputed rural floor budget neutrality factor (0.97946) in New Jersey downwardly adjusts the wage index for rural hospitals by approximately 2 percent.

J. Effects of the Proposed Wage Index Adjustment for Out-Migration (Column 8)

Section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county, post-reclassification and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index. With the out-migration adjustment, small rural DSH providers with less than 100 beds will experience a 0.5 percent increase in payments in FY 2011 relative to no adjustment at all. We included these additional payments to providers in the impact table shown above, and we estimate the impact of these providers receiving the out-migration increase to be approximately $20 million.

K. Effects of All Proposed Changes Prior to Documentation and Coding (or CMI) Adjustment (Column 9)

Column 9 shows our estimate of the changes in payments per discharge from FY 2010 and FY 2011, resulting from all proposed changes reflected in this proposed rule for FY 2011 (including statutory changes), other than the proposed documentation and coding adjustment. Column 9 reflects the impact of all other FY 2011 changes relative to FY 2010, including those shown in Columns 1 through 8. The average increase in payments under the IPPS for all hospitals is approximately 2.8 percent. In addition, it reflects the estimated 0.5 percentage point difference between the projected outlier payments in FY 2010 (5.1 percent of total MS–DRG payments), the current estimate of the percentage of actual outlier payments in FY 2010 (4.7 percent) as described in the introduction to this Appendix and the Addendum to this proposed rule.

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 9 may not equal the sum of the percentage changes described above.

L. Effects of All Proposed Changes With CMI Adjustment (Column 10)

Column 10 shows our estimate of the changes in payments per discharge from FY 2010 and FY 2011, resulting from all proposed changes reflected in this proposed rule for FY 2011 (including statutory changes). This column includes the proposed FY 2011 documentation and coding adjustment of −2.9 percent on the national standardized amount, −2.9 percent on the hospital-specific rates, and −2.4 percent on the Puerto Rico-specific standardized amount, which overall accounts for a 2.9 percent decrease in payments.

Column 10 reflects the impact of all proposed FY 2011 changes relative to

FY 2010, including those shown in Columns 1 through 9. The average decrease in payments under the IPPS for all hospitals is approximately −0.1 percent. As described in Column 9, this average decrease includes the effects of the 2.4 percent market basket update, the 0.5 percentage point difference between the projected outlier payments in FY 2010 (5.1 percent of total MS–DRG payments), and the current estimate of the percentage of actual outlier payments in FY 2010 (4.7 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 10 may not equal the sum of the percentage changes described above.

The overall proposed change in payments per discharge for hospitals paid under the IPPS in FY 2011 is estimated to decrease by 0.1 percent. The payment decreases among the hospital categories are largely attributed to the proposed documentation and coding adjustments. Hospitals in urban areas would experience an estimated 0.1 percent decrease in payments per discharge in FY 2011 compared to FY 2010. Hospital payments per discharge in rural areas are estimated to decrease by 0.5 percent in FY 2011 as compared to FY 2010. The decreases larger than the national average for rural areas are largely attributed to the differential impact of the MS–DRGs and wage data and due to the −2.9 percent documentation and coding adjustment applied to the national standardized amount and the −2.9 percent documentation and coding adjustment to the hospital-specific rate applied to SCHs and MDHs, which generally are classified as rural hospitals.

Among urban census divisions, the largest estimated payment decreases will be 0.9 percent in the New England region and 0.6 percent in the Middle Atlantic region, while urban hospitals in the Pacific will see the largest payment increases (0.5 percent). Among the rural regions, the providers in the New England region will experience the largest decrease in payments (1.6 percent) because of reductions due to case-mix and the documentation and coding adjustments while rural hospitals in the West South Central region will experience an increase in payments by 0.4 percent due to increases in case-mix, wage data and MGCRB reclassification.

Among special categories of rural hospitals, MDHs will receive an estimated payment decrease of 0.6 percent. MDHs are paid the higher of the IPPS rate based on the national standardized amount, that is, the Federal rate, or, if the hospital-specific rate exceeds the Federal rate, the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate. MDHs will experience a decrease in payments because of the proposed documentation and coding adjustments applied to both the hospital-specific rate and the Federal rate. SCHs are also paid the higher of their hospital-specific rate or the federal rate. Overall, SCHs will experience an estimated decrease in payments by 0.5 percent due to the proposed documentation and coding adjustments to the national standardized amount and the hospital-specific rates.

Rural hospitals reclassified for FY 2011 are anticipated to receive a 0.3 percent payment decrease, and rural hospitals that are not reclassifying are estimated to receive a payment decrease of 0.7 percent.

Cardiac hospitals are expected to experience a payment increase of 0.8 percent in FY 2011 relative to FY 2010 due to increases in payments attributable to changes in the MS–DRGs and relative weights.

M. Effects of Proposed Policy on Payment Adjustments for Low-Volume Hospitals

For FY 2011, we are proposing to continue to apply the volume adjustment criteria we specified in the FY 2005 IPPS final rule (69 FR 49099). We expect that three providers will receive the low-volume adjustment for FY 2011. We estimate that low-volume hospitals will experience an increase of $114,000 in payments due to the low volume payment adjustment.

N. Impact Analysis of Table II

Table II presents the projected impact of the proposed changes for FY 2011 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated average payments per discharge for FY 2010 with the proposed payments per discharge for FY 2011, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the proposed changes presented in Table I. The estimated percentage changes shown in the last column of Table II equal the estimated percentage changes in average payments per discharge from Column 10 of Table I.

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TABLE II.--IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2011 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER DISCHARGE)

	Number of Hospitals	Average FY 2010 Payment Per Discharge (2)	Average Proposed FY 2011 Payment Per Discharge (3)	All Proposed FY 2011 Changes (4)
All hospitals	3,472	$10,179	$10,166	-0.1
By Geographic Location:				
Urban hospitals	2,502	$10,607	$10,598	-0.1
Large urban areas (populations over 1 million)	1,365	$11,193	$11,181	-0.1
Other urban areas (populations of 1 million or fewer)	1,137	$9,888	$9,882	-0.1
Rural hospitals	970	$7,577	$7,536	-0.5
Bed Size (Urban):				
0-99 beds	635	$8,056	$8,057	0
100-199 beds	791	$8,926	$8,908	-0.2
200-299 beds	461	$9,861	$9,842	-0.2
300-499 beds	425	$10,995	$10,984	-0.1
500 or more beds	190	$13,104	$13,113	0.1
Bed Size (Rural):				
0-49 beds	337	$6,136	$6,137	0
50-99 beds	366	$7,088	$7,030	-0.8
100-149 beds	164	$7,485	$7,458	-0.4
150-199 beds	61	$8,274	$8,249	-0.3
200 or more beds	42	$9,405	$9,331	-0.8
Urban by Region:				
New England	121	$11,035	$10,937	-0.9
Middle Atlantic	330	$11,677	$11,611	-0.6
South Atlantic	383	$9,841	$9,827	-0.1
East North Central	403	$9,967	$9,975	0.1
East South Central	155	$9,510	$9,475	-0.4
West North Central	166	$10,131	$10,138	0.1
West South Central	342	$9,931	$9,961	0.3
Mountain	162	$10,836	$10,841	0
Pacific	390	$13,032	$13,092	0.5
Puerto Rico	50	$5,133	$5,149	0.3
Rural by Region:				
New England	24	$9,980	$9,817	-1.6
Middle Atlantic	70	$7,939	$7,874	-0.8
South Atlantic	165	$7,348	$7,271	-1
East North Central	120	$7,854	$7,800	-0.7
East South Central	175	$6,872	$6,856	-0.2

	Number of Hospitals	Average FY 2010 Payment Per Discharge (2)	Average Proposed FY 2011 Payment Per Discharge (3)	All Proposed FY 2011 Changes (4)
West North Central	100	$8,013	$8,003	-0.1
West South Central	214	$6,805	$6,835	0.4
Mountain	71	$8,195	$8,184	-0.1
Pacific	31	$10,340	$10,186	-1.5
By Payment Classification:				
Urban hospitals	2,555	$10,584	$10,575	-0.1
Large urban areas (populations over 1 million)	1,403	$11,171	$11,159	-0.1
Other urban areas (populations of 1 million or fewer)	1,152	$9,859	$9,853	-0.1
Rural areas	917	$7,638	$7,596	-0.5
Teaching Status:				
Non-teaching	2,434	$8,547	$8,537	-0.1
Fewer than 100 Residents	798	$10,088	$10,066	-0.2
100 or more Residents	240	$15,040	$15,033	0
Urban DSH:				
Non-DSH	834	$8,866	$8,866	0
100 or more beds	1,510	$11,163	$11,153	-0.1
Less than 100 beds	340	$7,594	$7,558	-0.5
Rural DSH:				
SCH	407	$7,022	$6,983	-0.6
RRC	209	$8,414	$8,362	-0.6
100 or more beds	30	$6,589	$6,547	-0.6
Less than 100 beds	142	$5,898	$5,854	-0.7
Urban teaching and DSH:				
Both teaching and DSH	806	$12,188	$12,173	-0.1
Teaching and no DSH	169	$9,705	$9,686	-0.2
No teaching and DSH	1,044	$9,130	$9,123	-0.1
No teaching and no DSH	536	$8,468	$8,482	0.2
Rural Hospital Types:				
RRC	183	$8,527	$8,493	-0.4
SCH	340	$7,998	$7,956	-0.5
MDH	187	$6,325	$6,288	-0.6
SCH and RRC	108	$9,479	$9,407	-0.8
MDH and RRC	13	$8,007	$7,955	-0.6
Type of Ownership:				
Voluntary	1,978	$10,331	$10,310	-0.2
Proprietary	837	$9,122	$9,132	0.1
Government	577	$10,688	$10,681	-0.1

	Number of Hospitals	Average FY 2010 Payment Per Discharge (2)	Average Proposed FY 2011 Payment Per Discharge (3)	All Proposed FY 2011 Changes (4)
Medicare Utilization as a Percent of Inpatient Days:				
0-25	353	$13,589	$13,576	-0.1
25-50	1593	$11,094	$11,088	-0.1
50-65	1202	$8,511	$8,483	-0.3
Over 65	237	$7,455	$7,438	-0.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2011 Reclassifications:				
All Reclassified Hospitals FY 2011	810	$9,903	$9,889	-0.1
All Non-Reclassified Hospitals FY 2011	2,662	$10,282	$10,268	-0.1
Urban Reclassified Hospitals FY 2011:	488	$10,557	$10,549	-0.1
Urban Non-reclassified Hospitals FY 2011:.....	1,985	$10,632	$10,623	-0.1
Rural Reclassified Hospitals FY 2011:.....:	322	$8,173	$8,145	-0.3
Rural Nonreclassified Hospitals FY 2011:	585	$6,872	$6,822	-0.7
All Section 401 Reclassified Hospitals:	37	$8,923	$8,825	-1.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	63	$7,276	$7,190	-1.2
Specialty Hospitals				
Cardiac Hospitals	19	$11,496	$11,584	0.8

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VII. Effects of Other Proposed Policy Changes

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

A. Effects of Proposed Policy on HACs, Including Infections

In section II.F. of the preamble of this proposed rule, we discuss our implementation of section 1886(d)(4)(D) of the Act, which requires the Secretary to identify conditions that are: (1) High cost, high volume, or both; (2) result in the assignment of a case to an MS–DRG that has a higher payment when present as a secondary diagnosis; and (3) could reasonably have been prevented through application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission, unless based on data and clinical judgment, it cannot be determined at the time of admission whether a condition is present. That is, the case will be paid as though the secondary diagnosis were not present. However, the statute also requires the Secretary to continue counting the condition as a secondary diagnosis that results in a higher IPPS payment when doing the budget neutrality calculations for MS–DRG reclassifications and recalibration. Therefore, we will perform our budget neutrality calculations as though the payment provision did not apply, but Medicare will make a lower payment to the hospital for the specific case that includes the secondary diagnosis. Thus, the provision results in cost savings to the Medicare program.

We note that the provision will only apply when one or more of the selected conditions are the only secondary diagnosis or diagnoses present on the claim that will lead to higher payment. Medicare beneficiaries will generally have multiple secondary diagnoses during a hospital stay, such that beneficiaries having one MCC or CC will frequently have additional conditions that also will generate higher payment. Only a small percentage of the cases will have only one secondary diagnosis that would lead to a higher payment. Therefore, if at least one nonselected secondary diagnosis that leads to higher payment is on the claim, the case will continue to be assigned to the higher paying MS–DRG and there will be no Medicare savings from that case. In addition, as discussed in section II.F.3.e. of the preamble of this proposed rule, it is possible to have two severity levels where the HAC does not affect the MS–DRG assignment or for an MS–DRG not to have severity levels. In either of these circumstances, the case will continue to be assigned to the higher paying MS–DRG and there will be no Medicare savings from that case.

The HAC payment provision went into effect on October 1, 2008. Our savings estimates for the next 5 fiscal years are shown below:

Year	Savings (in millions)
FY 2011	23
FY 2012	24
FY 2013	25
FY 2014	26
FY 2015	26

B. Effects of Proposed Policy Relating to New Medical Service and Technology Add-On Payments

In section II.I. of the preamble to this proposed rule, we discuss the three applications for add-on payments for new medical services and technologies for FY 2011, as well as the status of the new technologies that were approved to receive new technology add-on payments in FY 2010. As explained in that section, add-on payments for new technology under section 1886(d)(5)(K) of the Act are not required to be budget neutral. As discussed in section II.I.4. of the preamble of this proposed rule, we have yet to determine whether any of the three applications we received for consideration for new technology add-on payments for FY 2011 will meet the specified criteria. Consequently, it is premature to estimate the potential payment impact of any potential new technology add-on payments for FY 2011. We note that if any of the three applications are found to be eligible for new technology add-on payments for FY 2011, in the FY 2011 IPPS/LTCH PPS final rule, we would discuss the estimated payment impact for FY 2011 in that final rule.

However, we are proposing to continue to make new technology add-on payments in FY 2011 for the Cardiowest™ Temporary Total Artificial Heart System (TAH-t) and the Spiration® IBV® Valve System. Therefore, we are providing an estimate of total payments for these technologies in FY 2011. We note that new technology add-on payments per case are limited to the lesser of: (1) 50 percent of the costs of the new technology; or (2) 50 percent of the amount by which the costs of the case exceed the standard MS–DRG payment for the case. Because it is difficult to predict the actual new technology add-on payment for each case, our estimate below is based on the increase in add-on payments for FY 2011 as if every claim that would qualify for a new technology add-on payments would receive the maximum add-on payment. Therefore, we currently estimate that payments for the TAH-t will increase overall FY 2011 payments by $9.54 million. For FY 2010, the applicant estimated that approximately 2,286 Medicare beneficiaries would be eligible for the Spiration® IBV® Valve System. Therefore, based on the applicant's estimate from FY 2010, we currently estimate that payments for the Spiration® IBV® Valve System will increase overall FY 2011 payments by $7.80 million.

C. Effects of Proposed Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In Appendix A, section VII.C. of the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44224), we discussed the impact of the FY 2011 RHQDAPU program requirements. In this proposed rule, we are proposing to retire one of the FY 2011 quality measures. We believe that this proposal would not have a significant effect on our previous analysis. We note that, in that final rule, we estimated that 96 hospitals would not receive the full payment update in FY 2010 and that 96 hospitals would not receive the full payment update in FY 2011. As noted above, at the time this analysis was prepared, 104 hospitals did not receive the full payment update in FY 2010.

In section IV.A. of the preamble of this proposed rule, we discuss our proposed requirements for hospitals to report quality data under the RHQDAPU program in order to receive the full payment update for FY 2012, FY 2013, and FY 2014. We estimate that approximately 104 hospitals may not receive the full payment update in any fiscal year. We believe that most of these hospitals would be either small rural or small urban hospitals. However, at this time, information is not available to determine the hospitals that will not meet the requirements for the full hospital market basket increase for FY 2012, FY 2013, and FY 2014.

For the FY 2012 payment determination, hospitals would be required to submit all-patient volume data for selected MS–DRGs that relate to RHQDAPU program measures. The submission of all-patient volume data will occur free of charge to hospitals. Therefore, the additional resource burden to hospitals for this requirement is expected to be minimal. For the FY 2013 payment determination, we have proposed that hospitals will choose one of four proposed registry-based topics for which there are currently a number of nationwide registries each individually collecting data from a significant proportion of IPPS hospitals. We have proposed that hospitals will submit data on proposed measures included within the proposed registry-based topic to a registry that we qualify for this purpose.

For the proposed ICD Complications registry-based topic, currently, 100 percent of hospitals performing ICD implantation participate in the American College of Cardiology-National Cardiovascular Data Registry's (ACC–NCDR) ICD registry and 78 percent of those hospitals are already submitting the additional data elements and secondary population needed to calculate the ICD complication measure. For the proposed Cardiac Surgery registry-based topic, we have estimated that 80 to 90 percent of hospitals performing cardiac surgery currently participate in a cardiac surgery registry. Therefore, the number of additional hospitals not currently participating in a cardiac surgery registry that would choose this topic is expected to be minimal. For the proposed Stroke and Nursing Sensitive Care registry-based topics, there are a number of registries to which at least 25 percent of IPPS hospitals currently submit data. We currently do not know if hospitals would choose one of these two proposed topics if they are not already submitting data to one of these registries. The AMI-statin at discharge measure, proposed for FY 2013 payment determination, would create minimal additional burden as hospitals can collect the data elements from the same charts already being pulled for existing RHQDAPU program AMI measures.

For the FY 2014 payment determination, the proposed addition of four chart-abstracted measures that require hospitals to submit data on all inpatients is expected to create an additional burden for hospitals. The information needed for the proposed ED–Throughput measures is captured as routine documentation, and therefore is not expected to impose much additional burden. The proposed Global Immunization measures would require hospitals to collect information on all inpatients regarding flu and pneumonia vaccinations that they are currently only collecting for patients admitted for pneumonia. Therefore, the number of patients for which these data would need to be collected will increase.

We also note that, beginning with the FY 2012 payment update, hospitals must pass our validation requirement of a minimum of 75 percent reliability, based upon our chart-audit validation process, for three quarters of data from the first quarter of CY 2010 through the third quarter of CY 2010. These data are due to the QIO Clinical Warehouse by August 15, 2010 (first quarter CY 2010 discharges), November 15, 2010 (second quarter CY 2010 discharges), and February 15, 2011 (third quarter CY 2010 discharges). We have continued our efforts to ensure that QIOs provide assistance to all hospitals that wish to participate in the RHQDAPU program. The requirement of 12 charts per hospital submitted for validation would result in approximately 9,600 charts per quarter being submitted to CMS. We reimburse hospitals for the cost of

sending charts to the Clinical Data Abstraction Center (CDAC) contractor at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received by the CDAC contractor is approximately 150 pages. Thus, as a result of the validation requirements we are proposing for the FY 2012 annual payment update, we estimate that CMS would have expenditures of approximately $212,000 per quarter, which is a reduction from the $597,600 per quarter to collect the charts for the FY 2010 and FY 2011 annual payment updates. Given that we reimburse for the data collection effort, we believe that a requirement for 12 charts per hospital per quarter represents a minimal burden to participating hospitals.

We have finalized a new validation methodology for FY 2012. We believe that these modifications will not change the number of hospitals that fail the validation requirement for FY 2012 from previous years. We are changing the way we calculate the validation matches (that is, all relevant data elements submitted by the hospital must match the independently re-abstracted data elements to count as a match), which will make it more difficult for hospitals to satisfy the validation requirement. However, we also will validate data for a smaller number of hospitals each year and we changed the validation threshold from 80 percent to 75 percent. In addition, we conducted analysis in FY 2010 of past validation data and found that at least 95 percent of sampled hospitals are expected to pass the 75 percent validation threshold starting in FY 2012. In combination, we believe that these proposed revisions will counterbalance each other and result in no additional impact to the number of hospitals failing our validation requirement for FY 2012.

If we determine that a hospital is not entitled to receive the full FY 2012 payment update because it failed to satisfy the validation requirement, and the hospital asks for a reconsideration of that decision, we are proposing that the hospital submit complete copies of the medical records that it submitted to the CDAC contractor for purposes of the validation for which the hospital incurs the cost. We estimate that no greater than 40 hospitals would fail this requirement for FY 2012. We estimate that this proposal would cost hospitals approximately 12 cents per page for copying and approximately $4.00 per chart for postage. We have found, based on experience, that an average sized medical chart is approximately 150 pages. Hospitals would be required to return all 36 sampled medical records for the three quarters of data from FY 2010. We estimate that the total cost to the 40 impacted hospitals would be approximately $17,600, or $440 per hospital. We believe that this cost is minimal, compared with the 2.0 percent RHQDAPU program component of the annual payment update at risk. This proposed requirement is necessary so that CMS has all the information it needs to fairly and timely make a decision on the hospital's reconsideration request. We also anticipate that this proposed requirement would benefit hospitals seeking a reconsideration because it will enable us to resolve potential issues earlier in the appeals process, obviating the need for a hearing before the Provider Reimbursement Review Board (PRRB). We believe that this benefit would greatly outweigh the burden of copying and mailing the requested records.

We note that, beginning with FY 2014 and future years, we are considering adding two stratum to the current RHQDAPU validation sample of SCIP, AMI, HF, and PN cases. We will consider selecting two additional samples of three cases per selected hospital per quarter to validate proposed surgical site infection, blood stream infection, ED-Throughput and Global Immunization measures. If we later propose this requirement and adopt it as final through rulemaking, we would randomly select a total of 18 records per quarter per validated hospital in 6 strata (SCIP, AMI, HF, PN, CLABSI/SSI, and ED-Throughput/Immunization measures). The requirement of an additional 6 charts per hospital submitted for validation would result in approximately 4,800 additional charts per quarter being submitted to CMS. We reimburse hospitals for the cost of sending charts to the CDAC contractor at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received by the CDAC contractor is approximately 150 pages. Thus, we would expend approximately $105,600 per quarter to collect the charts for the annual payment update for FY 2014 and future years. Given that we reimburse for the data collection effort, we believe that a proposed requirement of the additional records in FY 2014 per hospital per quarter represents a minimal burden to the participating hospital.

D. Effects of Proposed Policy on Payment for Transfer Cases From Medicare Participating Hospitals to Nonparticipating Hospitals and CAHs

In section IV.B. of the preamble of this proposed rule, we are proposing to expand the acute care transfer policy to transfers to nonparticipating acute care hospitals and to CAHs. This proposed expansion of the acute care transfer policy aims to further align the policy with its original intent, that is, to pay a hospital commensurate with the resources it expends in treating a Medicare beneficiary who is transferred. However, the impacts of this change are not possible to measure, although we believe the any change in Medicare payments to hospitals associated with this proposed change would be negligible. Specifically, because there are relatively few nonparticipating acute care hospitals, we expect that there would be few, if any, transfers to nonparticipating hospitals in a given period. In addition, based on the capped inpatient bed size of CAHs (that is, not more than 25 inpatient beds) and the CAH distance requirements (that is, a CAH must generally be located at least 35 miles from another hospital), we believe that transfers from an IPPS acute care hospital to a CAH occur very infrequently. Therefore, we estimate that this proposed expansion of the acute care transfer policy would not have a material impact on Medicare payments to acute care hospitals.

E. Effects of Proposed Change in Criteria for MDHs

In section IV.D. of the preamble of this proposed rule, we discuss our proposal to revise the existing Medicare-dependency criterion for MDHs at § 412.108(a)(1)(iii) of the regulations (that is, "At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits during the hospital's cost reporting period. * * *") by replacing the word "receiving" with the phrase "entitled to". As a result, we would include in the count of Medicare inpatient days or discharges, all days or discharges attributable to individuals entitled to the Medicare Part A insurance benefit, including individuals who have exhausted their Medicare Part A hospital inpatient coverage benefit.

Based on our analysis of data for cost reporting periods beginning in FYs 2007 and 2008, we estimate that the proposed change to the MDH definition of Medicare-dependency may allow 48 more IPPS hospitals to qualify as an MDH. We estimate that this proposed

change would result in increased expenditure of $3.6 million in FY 2011. (We note that the PPACA (Pub. L. 111–148) extended the sunset date for MDHs from the end of FY 2011 to the end of FY 2012. We plan to issue a separate rulemaking document in the **Federal Register** to address this statutory provision.

F. Effects of Proposed Change Relating to Payment Adjustment for Disproportionate Share Hospitals

In section IV.E. of the preamble of this proposed rule, we are proposing to change, effective for FY 2011 and subsequent years, the data matching process used to calculate the SSI fraction for the Medicare DSH payment adjustment. The SSI fraction is part of the formula used to determine whether a subsection (d) hospital qualifies for a DSH payment adjustment and the amount of any DSH payment.

The numerator of a hospital's DSH SSI fraction is the number of inpatient days for the provider's patients who were entitled to both Medicare Part A and SSI benefits. The denominator of the hospital's SSI fraction is the total number of inpatient days for the provider's patients who were entitled to Part A benefits. In order to calculate the numerator of a hospital's DSH SSI fraction, CMS matches certain Medicare data files with SSI eligibility data files that are furnished by SSA. In Baystate Medical Center v. *Leavitt* (545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008)), the district court concluded that, in certain respects, CMS' current matching process did not use the "best available data" to match Medicare patient day information with SSI eligibility data. In implementing the *Baystate* decision, CMS recalculated the plaintiff's SSI fractions and DSH payments for its FYs 1993 through 1996 by using a revised data matching process that comports with the district court's decision.

We are now proposing to adopt the same revised data matching process for calculating hospitals' DSH SSI fractions for FY 2011 and subsequent fiscal years. In addition, we are proposing to use, in the revised matching process, a later update of the MedPAR claims data file and the SSI eligibility data file. Specifically, we are proposing to use MedPAR claims files and SSI eligibility data that are updated 15 months after the end of the Federal fiscal year, rather than continue with our current practice of using data updated 6 months after the end of the Federal fiscal year. We believe that our proposed revision to the timing of the data match would achieve an appropriate balance between accounting for additional retroactive SSI eligibility determinations and the lifting of SSI payment suspensions and facilitating administrative finality through the timely final settlement of Medicare cost reports.

We are not able to provide a detailed analysis of the potential impact of the proposed revised data matching process. That is, it is not possible to determine whether Medicare DSH adjustment payments to hospitals will generally increase or decrease, because hospitals' SSI fractions will vary depending on various factors, including the use of a more updated MedPAR claims data file, use of a more updated SSI eligibility data file, and the other features of our proposed revised data matching process.

With respect to the use of a more updated MedPAR claims data file, we expect that using a later version of the MedPAR claims file would increase the number of inpatient claims for a given Federal fiscal year and, therefore, would increase the number of Medicare inpatient days included in the denominator of the SSI fraction. Depending on whether or not the additional claims in the MedPAR file were for Medicare patients who were also eligible for SSI during the inpatient stay, the numerator of the SSI fraction might increase or decrease.

As for the use of an updated SSI eligibility file, we note that retroactive SSI eligibility determinations include both the granting and the denial of SSI benefits. Therefore, assuming that some of the retroactive SSI eligibility determinations were for Medicare patients, the use of an updated SSI eligibility file also could increase or decrease the numerator of the SSI fraction. We expect that, as a result of using an updated SSI eligibility file, the SSI fraction for some hospitals would increase while it would decrease for other hospitals.

We also note that, in the *Baystate* decision, the district court found that certain records (for example, "stale records" and "forced pay records") were not included in the SSI eligibility data that SSA gave to CMS for use in the data matching process. However, the SSI eligibility data files began to include certain of these records in the mid-1990's, and stale records and forced pay records were included in the SSI eligibility data files that CMS used in recalculating the specific SSI fractions and DSH adjustment payments at issue in the Baystate case. As certain of these records are already included in the data matching process and we are making no proposals that would change this policy, we are unable to determine if this issue has any cost or savings for FY 2011 and subsequent years.

Finally, our proposed revised data matching process includes the use of SSNs and a greater number of Title II numbers and HICANs. As a result, we might be able to identify some individuals who were entitled to both Part A and SSI benefits that our current data matching process might not have identified. Therefore, we would expect an increase in the SSI fraction for certain providers, but we are unable to determine the extent to which DSH adjustment payments would increase.

G. Effects of Proposed Changes Relating to Payments for IME and Direct GME

1. Identifying "Approved Medical Residency Programs"

In section IV.H.2. of the preamble of this proposed rule, we discuss our proposal to clarify our policy regarding whether an individual is considered to be training in an approved medical residency program such that the individual's time should be included in the FTE count for IME and direct GME purposes, or whether that individual should be treated and bill as a physician. Specifically, our proposed clarification states that individuals should be treated as and bill as physicians if they have already successfully completed at least one residency program (regardless of whether they have passed the board examination for that specialty program), and are engaged in subsequent training that will not provide them with knowledge or skills that could be applied for additional board certification in another subspecialty, nor do they need that training to satisfy requirements for board certification in the specialty program they already successfully completed. We also are proposing to revise the definition of "resident" at § 413.75(b) to mean "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board."

With respect to the policy regarding the treatment of trainees that have already successfully completed at least one residency program, there is no financial impact on the Medicare program because this is a proposed clarification of existing policy and is not a policy revision or addition of a new policy. The proposed policy change to the regulations might have some limited financial impact to the extent that a hospital previously included trainees

who were not formally enrolled in an approved program in its FTE counts, and as a result of the proposed change to the regulations, would no longer be able to include such trainees in its FTE count for IME and direct GME purposes. However, we believe it would be rare for a hospital to have included in its FTE count trainees who are not formally enrolled in a residency program in the typical fashion. Further, we believe that it would be rare for such a hospital to have sufficient room under its IME and direct GME FTE resident caps to include any such "informally enrolled" residents in addition to the typically enrolled residents. Thus, the financial impact of the proposed change in the regulatory definition of "resident" would be insignificant.

2. Submission of Electronic Affiliation Agreements

In section IV.H.3. of the preamble of this proposed rule, we discuss our proposal to allow hospitals to submit Medicare GME affiliation agreements to the CMS Central Office by electronic submission. Over the last several years, we have received numerous inquiries regarding the possibility of submitting the Medicare GME affiliation agreement electronically. To date, CMS has only accepted signed hard copies of Medicare GME affiliation agreements that are received through the mail. Facsimile (FAX) and other electronic submissions of affiliation agreements have not been an acceptable means of transmission of affiliation agreements to CMS Central Office in order for a hospital to meet the requirements of §§ 413.79(f) and 412.105(f)(1)(vi).

The increasing frequency of these inquiries and our concerns regarding environmental and paperwork reduction have prompted us to reconsider our procedure for hospitals to submit Medicare GME affiliation agreements to the CMS Central Office. Accordingly, we are proposing to change our policy to provide for electronic submission of the affiliation agreement that is required to be sent to the CMS Central Office. This proposal would not affect the authority of the fiscal intermediary or MAC to continue to specify its requirements for submission for hospitals in its servicing area.

We are proposing an electronic submission process that would consist of either an e-mail mailbox or a Web site where hospitals would submit their Medicare GME affiliation agreements to the CMS Central Office. As part of this process, a copy of the Medicare GME affiliation agreement would need to be received through the electronic system no later than 11:59 p.m. on July 1 of each academic year. We are proposing that the electronic affiliation agreement would need to be submitted either as a scanned copy or a PDF version of that hard copy agreement. We are proposing not to accept an agreement in any electronic format that could be subject to manipulation. The scanned and/or PDF format will enable CMS to ensure that the agreements are signed and dated as required in the regulations at § 413.75.

We believe that allowing an electronic submission of the affiliation agreement to the CMS Central Office would assist us in more effectively tracking the groups of hospitals that become an affiliation as well as the numbers of FTE cap slots that are being transferred within those groups. In addition, we believe an electronic submission process would minimize the paperwork burden for hospitals.

H. Effects of Proposed Changes Relating to CRNA Services Furnished in Rural Hospitals and CAHs

In section IV.I. of the preamble of this proposed rule, we discuss our proposal to amend the regulations at § 412.113(c)(2)(i)(A) to state that, effective for cost reporting periods beginning on or after October 1, 2010, hospitals and CAHs that have reclassified under section 1886(d)(8)(E) of the Act and § 412.103 are eligible to be paid based on reasonable cost for anesthesia and related care furnished by qualified nonphysician anesthetists. Under existing regulations, a hospital or CAH is not eligible to be paid based on reasonable cost for anesthesia and related care furnished by qualified nonphysician anesthetists if the hospital or CAH has been granted rural status under § 412.103. However, because the Act, as revised by section 608 of Public Law 100–485, allows for reasonable cost payments for CRNA services if the facility is a hospital located in a rural area as defined for purposes of section 1886(d) of the Act, we are proposing to revise the regulations to permit urban hospitals that have been reclassified as rural, in accordance with section 1886(d)(8)(E) of the Act, to qualify for these payments. We are proposing to revise the regulations to state that, effective for cost reporting periods beginning on or after October 1, 2010, hospitals and CAHs that have reclassified pursuant to section 1886(d)(8)(E) of the Act and § 412.103 of the regulations would be eligible to be paid based on reasonable cost for anesthesia services and related care provided by qualified nonphysician anesthetists.

We believe it is difficult to quantify the payment impact of this proposed change because, in order to qualify for reasonable cost-based payment for anesthesia and related services provided by qualified nonphysician anesthetists, a rural hospital or CAH cannot exceed an annual limit of 800 surgical procedures requiring anesthesia. We cannot establish the number of facilities that would meet this threshold. In addition, although a hospital or CAH may contract with more than one qualified nonphysician anesthetist and be paid based on reasonable cost for anesthesia and related services performed by these nonphysician anesthetists, the total number of hours of service furnished by the nonphysician anesthetists may not exceed 2,080 hours annually. We also cannot determine the number of facilities that would exceed this threshold. Therefore, while we believe the impact would be relatively minor, we are unable to quantify the impact of the proposed change.

I. Effects of Implementation of Rural Community Hospital Demonstration Program

In section IV.J. of the preamble of this proposed rule, we discuss our implementation of section 410A of Public Law 108–173, which requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that "[i]n conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented." As discussed in section IV.J. of the preamble of this proposed rule, in the IPPS final rule for each of the previous 6 fiscal years, we have estimated the additional payments as a result of the demonstration for each of the participating hospitals. In order to achieve budget neutrality, we are proposing to adjust the national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are proposing to apply budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. The statutory language requires that "aggregate payments made by the

Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented" but does not identify the range across which aggregate payments must be held equal.

An extension of this demonstration has been mandated by the Patient Protection and Affordable Care Act (Pub. L. 111–148). The provisions of Public Law 111–148 will be addressed in a separate notice in the **Federal Register**. For this proposed rule, because the mandated period for the demonstration was scheduled to end by the end of FY 2010, we are proposing no additional payment offset for upcoming years of the demonstration. However, we are proposing to make an adjustment in the FY 2011 IPPS final rule to the national IPPS rates to account for any differences between the cost of the demonstration program for hospitals participating in the demonstration during FY 2007, represented by their cost reports beginning in FY 2007, and the amount that was offset by the budget neutrality adjustment for FY 2007. The specific numeric value associated with the proposed adjustment to the national IPPS rates cannot be known until cost reports beginning in FY 2007 of the hospitals participating during FY 2007 in the demonstration are settled. We expect those cost reports to be settled prior to the publication of the FY 2011 IPPS final rule, and that we will be able to provide an estimated amount in the FY 2011 IPPS final rule.

J. Effects of Proposed Changes Relating to CAHs

1. CAH Optional Method of Payment for Outpatient Services

In section VI.B.2. of the preamble of this proposed rule, we discuss our proposal to amend the regulations to permit a CAH to elect to be paid for outpatient services under the optional method on a continuous basis. Under existing regulations, if a CAH wishes to be paid under the optional method for outpatient services on a continuous basis, it must submit an annual election to the fiscal intermediary or MAC servicing the CAH at least 30 days prior to the cost reporting period for which the election is made. Due to the significant consequences that result if a CAH fails to make a timely election, we are proposing to amend the regulations at § 413.70(b)(3)(i) to state that, effective for CAH cost reporting periods beginning on or after October 1, 2010, if a CAH has elected the optional method for its most recent cost reporting period beginning prior to October 1, 2010, or chooses to elect the optional method for its upcoming cost reporting period, that election will remain in place until it is terminated. If a CAH chooses to terminate its election, it must submit a termination request to the fiscal intermediary or MAC servicing the CAH at least 30 days prior to the start of the next cost reporting period. In order to provide CAHs that have cost reporting periods beginning in October or November 2010 time to choose to terminate an existing election of the optional method, we are proposing that these CAHs would have until December 1, 2010, to terminate their election. We anticipate that there would be no additional Medicare expenditure associated with this proposed change because we are not proposing any changes that govern payment rules for CAHs. Rather, we believe the regulatory changes we are proposing would reduce any perceived burden associated with the election process and make it easier for CAHs to maintain their election of the optional method on a continuous basis.

2. Consideration of Costs of Provider Taxes as Allowable Costs for CAHs

In section VI.B.3. of the preamble of this proposed rule, we discuss our proposal to clarify our policy on the determination of whether the costs of property taxes are allowable costs under Medicare, as described in sections 2212.1 and 2212.2 of the PRM. This is a clarification of our longstanding policy. Therefore, we have determined that there is no financial impact of the proposed change.

K. Effects of Proposed Policy Relating to Effective Date of Provider Agreements and Supplier Approvals

In section VIII. of the preamble of this proposed rule, we discuss our proposal to clarify the requirements supporting the existing process for assignment of an effective date for a provider agreement or supplier approval. Approximately 54,500 Medicare providers and suppliers are subject to survey and certification requirements under this proposal. However, the proposed clarification would not change the process for providers and suppliers. Therefore, the impact of our proposed clarification is negligible.

L. Effects of Proposed Changes Relating to Hospital Rehabilitation Services and Respiratory Care Services Conditions of Participation

In section IX. of the preamble of this proposed rule, we discuss our proposed changes to the conditions of participation for hospital rehabilitation services and respiratory care services to clarify the categories of practitioners allowed to order rehabilitation services and respiratory care services. We believe that this proposal would impose minimal additional costs on hospitals. In fact, hospitals may realize some minimal cost savings due to the regulatory flexibility of these proposed changes, which may allow for greater consistency with existing State laws and with hospital policies and procedures. The cost of implementing these proposed changes would largely be limited to the one-time cost related to the revision of a hospital's medical staff bylaws and its policies and procedures as they relate to the proposed requirements for the categories of practitioners allowed to order rehabilitation and respiratory care services. There also may be some minimal cost associated with communicating these changes to affected hospital staff.

However, we believe that these costs would be offset by the benefits derived from the overall intent of this proposed clarification to allow qualified, licensed practitioners, who are authorized by the medical staff, to order these services as long as they are responsible for the care of the patient for whom they are ordering the services and as long as such privileges are in accordance with hospital policies and applicable State laws and regulations. Furthermore, the proposed changes would clarify existing hospital conditions of participation to make them more consistent not only with each other, but also with many State laws and with current practice. Therefore, while this proposal would impose a minimal burden on hospitals, we believe that, in sum, the changes proposed would greatly benefit hospitals overall.

VIII. Effects of Proposed Changes in the Capital IPPS

A. General Considerations

Fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (§ 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a

proportion of the capital Federal rate (§ 412.344). As we state in section V. of the preamble of this proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

The basic methodology for determining a capital IPPS payment is set forth at § 412.312. The basic methodology for calculating capital IPPS payments in FY 2011 is as follows:

(Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME adjustment factor, if applicable).

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

The data used in developing the impact analysis presented below are taken from the December 2009 update of the FY 2009 MedPAR file and the December 2009 update of the Provider-Specific File (PSF) that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2009 update of the most recently available hospital cost report data (FYs 2006 and 2007) to categorize hospitals. Our analysis has several qualifications. We use the best data available and make assumptions about case-mix and beneficiary enrollment as described below. In addition, as discussed in section V.E. of the preamble of this proposed rule, we are proposing a −2.9 percent documentation and coding adjustment to the capital Federal rate for FY 2011, in addition to the −0.6 percent adjustment established for FY 2008 and the −0.9 percent adjustment for FY 2009. This proposal results in a cumulative adjustment factor of 0.957 that we are proposing to apply to the capital Federal rate to account for improvements in documentation and coding under the MS–DRGs in FY 2011. We also are proposing to adjust the Puerto Rico-specific capital rate in FY 2011 by −2.4 percent to account for changes in documentation and coding resulting from the adoption of the MS–DRGs.

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

Using cases from the December 2009 update of the FY 2009 MedPAR file, we simulated payments under the capital PPS for FY 2010 and FY 2011 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations.

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

- We estimate that the Medicare case-mix index will increase by 1.0 percent in both FYs 2010 and 2011.
- We estimate that the Medicare discharges will be approximately 11.8 million in FY 2010 and 12.1 million FY 2011.
- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. As discussed in section III.1.a. of the Addendum to this proposed rule, the proposed FY 2011 update is 1.5 percent.
- In addition to the FY 2011 update factor, the proposed FY 2011 capital Federal rate was calculated based on a proposed GAF/DRG budget neutrality factor of 1.0000, a proposed outlier adjustment factor of 0.9424, and a proposed (special) exceptions adjustment factor of 0.9997.
- For FY 2011, as discussed above and in section V.E. of the preamble to this proposed rule, we also are proposing to apply a 0.957 adjustment to the proposed FY 2011 capital Federal rate for changes in documentation and coding that are expected to increase case-mix under the MS–DRGs.

B. Results

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2011 on total capital payments per case, using a universe of 3,472 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2009 update of the FY 2009 MedPAR file, the December 2009 update to the PSF, and the most recent cost report data from the December 2009 update of HCRIS. In Table III, we present a comparison of estimated total payments per case for FY 2010 compared to FY 2011 based on the proposed FY 2011 payment policies. Column 2 shows estimates of payments per case under our model for FY 2010. Column 3 shows estimates of payments per case under our model for FY 2011. Column 4 shows the total percentage change in payments from FY 2010 to FY 2011. The change represented in Column 4 includes the proposed 1.5 percent update to the capital Federal rate and other proposed changes in the adjustments to the capital Federal rate. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case in FY 2011 are expected to decrease as compared to capital payments per case in FY 2010. The proposed capital Federal rate for FY 2011 would increase 1.5 percent as compared to the FY 2010 capital rate. The proposed changes to the GAFs are expected to result, on average, in a slight decrease in capital payments, although, for rural areas, it is more of a contributing factor to the overall estimated decrease in capital payments than to urban areas mostly due to the application of the rural floor to the wage index. Our impact analysis includes actuarial assumptions of growth from FY 2010 to FY 2011 resulting in a slight increase in capital payments. The net result of these proposed changes is an estimated −0.2 percent change in capital payments per discharge from FY 2010 to FY 2011 for all hospitals (as shown below in Table III).

The geographic comparison shows that, on average, all urban hospitals are expected to experience a 0.2 percent decrease in capital IPPS payments per case in FY 2011 as compared to FY

2010, while hospitals in large urban areas are expected to experience a 0.1 percent decrease in capital IPPS payments per case in FY 2011 as compared to FY 2010. Capital IPPS payments per case for rural hospitals are expected to decrease 0.7 percent.

The change comparisons by regions show some regions experiencing slight increases in total capital payments, while other regions are estimated to experience decreases in capital payments from FY 2010 to FY 2011. For the urban regions, changes in capital payments range from a −1.3 percent for the New England urban region to a 0.5 percent for the Pacific urban region. Estimates for two urban regions, East North Central and West North Central, show no change in total capital payments from FY 2010 to FY 2011. Estimates of changes for the rural regions from FY 2010 to FY 2011 range from a 2.3 percent decrease in capital payments in the New England rural region to a 0.6 percent increase for the West South Central rural region. These regional differences are primarily due to the proposed changes to the GAFs and differences in the estimated increase in outlier payments from FY 2010 to FY 2011.

By type of ownership, proprietary hospitals are estimated to experience an increase of 0.1 percent in capital payments per case, and voluntary hospitals are estimated to experience a 0.3 percent decrease in capital payments per case from FY 2010 to FY 2011. We estimate no change in capital payments per case for government hospitals from FY 2010 to FY 2011.

Section 1886(d)(10) of the Act established the MGCRB. Before FY 2005, hospitals could apply to the MGCRB for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of Public Law 108–173 equalized the standardized amounts under the operating IPPS. Therefore, beginning in FY 2005, there is no longer reclassification for the purposes of the standardized amounts; however, hospitals still may apply for reclassification for purposes of the wage index for FY 2011. Reclassification for wage index purposes also affects the GAFs because that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2011, we show the average capital payments per case for reclassified hospitals for FY 2010. All classifications of reclassified hospitals are expected to experience a decrease in capital payments per case in FY 2011 as compared to FY 2010. Urban reclassified and rural reclassified hospitals are expected to have a decrease in capital payments of 0.2 percent and 0.3 percent, respectively. Capital payments for urban nonreclassified are estimated to decrease 0.1 percent while rural nonreclassified hospitals are estimated to decrease 1.1 percent. Other reclassified hospitals (that is, hospitals reclassified under section 1886(d)(8)(B) of the Act) are expected to experience a decrease of 1.6 percent in capital payment from FY 2010 to FY 2011.

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TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2010 Payments Compared To Proposed FY 2011 Payments]

	Number of hospitals	Average FY 2010 payments/ case	Average Proposed FY 2011 payments/ case	Change
By Geographic Location:				
All hospitals	3,472	791	789	-0.2
Large urban areas (populations over 1 million)	1,365	872	871	-0.1
Other urban areas (populations of 1 million of fewer)	1,137	780	778	-0.2
Rural areas	970	549	545	-0.7
Urban hospitals	2,502	831	829	-0.2
0-99 beds	635	656	655	-0.1
100-199 beds	791	714	711	-0.4
200-299 beds	461	782	779	-0.4
300-499 beds	425	854	852	-0.2
500 or more beds	190	1,005	1,007	0.2
Rural hospitals	970	549	545	-0.7
0-49 beds	337	442	442	0.1
50-99 beds	366	509	504	-1.1
100-149 beds	164	554	551	-0.5
150-199 beds	61	600	598	-0.3
200 or more beds	42	670	663	-0.9
By Region:				
Urban by Region	2,502	831	829	-0.2
New England	121	863	852	-1.3
Middle Atlantic	330	885	879	-0.7
South Atlantic	383	783	781	-0.2
East North Central	403	806	806	0.0
East South Central	155	742	739	-0.5
West North Central	166	817	817	0.0
West South Central	342	776	778	0.3
Mountain	162	856	855	-0.1
Pacific	390	987	992	0.5
Puerto Rico	50	373	375	0.4
Rural by Region	970	549	545	-0.7
New England	24	724	708	-2.3
Middle Atlantic	70	565	558	-1.2
South Atlantic	165	540	534	-1.1
East North Central	120	574	569	-0.9
East South Central	175	497	495	-0.4
West North Central	100	562	558	-0.8
West South Central	214	514	517	0.6
Mountain	71	551	553	0.3
Pacific	31	693	685	-1.1
By Payment Classification:				
All hospitals	3,472	791	789	-0.2
Large urban areas (populations over 1 million)	1,403	871	870	-0.1
Other urban areas (populations of 1 million of fewer)	1,152	779	777	-0.2
Rural areas	917	546	542	-0.7
Teaching Status:				
Non-teaching	2,434	674	672	-0.3
Fewer than 100 Residents	798	793	790	-0.4
100 or more Residents	240	1,121	1,122	0.1
Urban DSH:				
100 or more beds	1,510	859	858	-0.1
Less than 100 beds	340	593	589	-0.7
Rural DSH:				
Sole Community (SCH/EACH)	407	480	477	-0.6
Referral Center (RRC/EACH)	209	603	598	-0.8
Other Rural:				
100 or more beds	30	500	495	-1.0
Less than 100 beds	142	453	448	-1.1

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE
[FY 2010 Payments Compared To Proposed FY 2011 Payments]

	Number of hospitals	Average FY 2010 payments/ case	Average Proposed FY 2011 payments/ case	Change
Urban teaching and DSH:				
Both teaching and DSH	806	929	928	-0.1
Teaching and no DSH	169	807	804	-0.4
No teaching and DSH	1,044	717	715	-0.3
No teaching and no DSH	536	731	731	0.0
Rural Hospital Types:				
Non special status hospitals	2,435	834	833	-0.1
RRC/EACH	59	747	743	-0.5
SCH/EACH	38	686	688	0.3
Medicare-dependent hospitals (MDH)	10	472	468	-1.0
SCH, RRC and EACH	13	830	824	-0.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2011 Reclassifications:				
All Urban Reclassified	488	835	834	-0.2
All Urban Non-Reclassified	1,985	831	830	-0.1
All Rural Reclassified	322	590	588	-0.3
All Rural Non-Reclassified	585	496	491	-1.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	55	557	548	-1.6
Type of Ownership:				
Voluntary	1,978	807	804	-0.3
Proprietary	837	718	719	0.1
Government	577	795	794	0.0
Medicare Utilization as a Percent of Inpatient Days:				
0-25	353	966	967	0.1
25-50	1,593	859	859	-0.1
50-65	1,202	678	674	-0.5
Over 65	237	583	580	-0.5

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IX. Effects of Proposed Payment Rate Changes and Policy Changes Under the LTCH PPS

A. Introduction and General Considerations

In section VII. of the preamble and section V. of the Addendum of this proposed rule, we are setting forth the proposed annual update to the payment rates for the LTCH PPS for FY 2011. In the preamble, we specify the statutory authority for the proposed provisions that are presented, identify those proposed policies where discretion has been exercised, and present rationale for our decisions as well as alternatives that were considered. In this section of Appendix A to this proposed rule, we discuss the impact of the proposed changes to the payment rates, factors, and other payment rate policies related to the LTCH PPS that are presented in the preamble of this proposed rule in terms of their estimated fiscal impact on the Medicare budget and on LTCHs.

On March 23, 2010, the Patient Protection and Affordable Care Act, Public Law 111–148, was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and the LTCH PPS. In addition, we plan to issue further instructions implementing the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and for RY 2010 under the LTCH PPS.

Currently, our database of 421 LTCHs includes the data for 77 nonprofit (voluntary ownership control) LTCHs and 301 proprietary LTCHs. Of the remaining 43 LTCHs, 12 LTCHs are government-owned and operated and the ownership type of the other 31 LTCHs is unknown. In the impact analysis, we are using the proposed rates, factors, and policies presented in this proposed rule, including proposed updated wage index values and the labor-related share, and the best available claims and CCR data to estimate the change in payments for FY 2011. The standard Federal rate for RY 2010 is $39,896.65. As discussed in section V.A.2. of the Addendum to this proposed rule, consistent with our historical practice, we are proposing to update the standard Federal rate for FY 2011 by −0.1 percent in order to establish the proposed FY 2011 standard Federal rate at $39,856.75. This includes a proposed market basket update of 2.4 percent and a proposed documentation and coding adjustment of −2.5 percent to account for increases in case-mix that do not reflect real changes in patients' severity of illness associated with the adoption of the MS–LTC–DRGs. Based on the best available data for the 421 LTCHs in our database, we estimate that the proposed update to the standard Federal rate for FY 2011 (discussed in section VII.C. of the

preamble of this proposed rule) and the proposed changes to the area wage adjustment (discussed in section V.B. of the Addendum to this proposed rule) for FY 2011, in addition to an estimated increase in HCO payments and an estimated increase in SSO payments, will result in an increase in estimated payments from RY 2010 of approximately $41 million (or about 0.8 percent). Based on the 421 LTCHs in our database, we estimate FY 2011 LTCH PPS payments to be approximately $4.946 billion, an increase from RY 2010 LTCH PPS payments of approximately $4.905 billion. Because the combined distributional effects and estimated changes to the Medicare program payments would be greater than $100 million, this proposed rule is considered a major economic rule, as defined in this section. We note the approximately $41 million for the projected increase in estimated aggregate LTCH PPS payments from RY 2010 to FY 2011 does not reflect changes in LTCH admissions or case-mix intensity in estimated LTCH PPS payments, which also would affect overall payment changes.

The projected 0.8 percent increase in estimated payments per discharge from RY 2010 to FY 2011 is attributable to several factors, including the proposed −0.1 percent decrease to the standard Federal rate, proposed changes in the wage index values (including the proposed change to the labor-related share) and projected increases in estimated HCO and SSO payments. As Table IV shows, the proposed change attributable solely to the standard Federal rate is projected to result in a decrease of 0.1 percent in estimated payments per discharge from RY 2010 to FY 2011, on average, for all LTCHs, while the proposed changes to the area wage adjustment are projected to result in an increase in estimated payments of 0.1 percent, on average, for all LTCHs.

As discussed in section V.B. of the Addendum to this proposed rule, we are proposing to update the wage index values for FY 2011 based on the most recent available data. In addition, we are proposing to decrease the labor-related share slightly from 75.779 percent to 75.407 percent under the LTCH PPS for FY 2011 based on the most recent available data on the relative importance of the labor-related share of operating and capital costs of the RPL market basket (discussed in section VII.C.2. of the preamble of this proposed rule). This proposed update to the wage data and the labor-related share is expected to increase LTCH PPS payments by 0.1 percent.

Table IV below shows the impact of the proposed payment rate and proposed policy changes on LTCH PPS payments for FY 2011 by comparing RY 2010 estimated payments to FY 2011 estimated payments. The projected increase in payments per discharge from RY 2010 to FY 2011 is 0.8 percent (shown in Column 8). This projected increase in payments is attributable to the impacts of the proposed change to the standard Federal rate (−0.1 percent in Column 6) and the proposed change due to the area wage adjustment (0.1 percent in Column 7), as well as the effect of the estimated increase in payments for HCO cases and SSO cases in FY 2011 as compared to RY 2010 (0.5 percent and 0.3 percent, respectively). That is, estimated total HCO payments are projected to increase from RY 2010 to FY 2011 in order to ensure that estimated HCO payments will be 8 percent of total estimated LTCH PPS payments in FY 2011. An analysis of the most recent available LTCH PPS claims data (FY 2009 claims from the December 2009 update of the MedPAR files) indicates that the RY 2010 HCO threshold of $18,425 may result in HCO payments in RY 2010 that fall below the estimated 8 percent. Specifically, we currently estimate that HCO payments will be approximately 7.5 percent of estimated total LTCH PPS payments in RY 2010. We estimate that the impact of the increase in HCO payments would result in approximately a 0.5 percent increase in estimated payments from RY 2010 to FY 2011 on average for all LTCHs. Furthermore, in calculating the estimated increase in payments from RY 2010 to FY 2011 for HCO and SSO cases, we increased estimated costs by the applicable market basket percentage increase as projected by our actuaries, which increases payments by 0.3 percent relative to last year. We note that estimated payments for all SSO cases comprise approximately 14 percent of estimated total LTCH PPS payments, and estimated payments for HCO cases comprise approximately 8 percent of estimated total LTCH PPS payments. Payments for HCO cases are based on 80 percent of the estimated cost above the HCO threshold, while the majority of the payments for SSO cases (over 65 percent) are based on the estimated cost of the SSO case.

As we discuss in detail throughout this proposed rule, based on the most recent available data, we believe that the provisions of this proposed rule relating to the LTCH PPS will result in an increase in estimated aggregate LTCH PPS payments and that the resulting LTCH PPS payment amounts result in appropriate Medicare payments.

B. Impact on Rural Hospitals

For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table IV, we are projecting a 1.4 percent increase in estimated payments per discharge for FY 2011 as compared to RY 2010 for rural LTCHs that would result from the proposed changes presented in this proposed rule (that is, the proposed update to the standard Federal rate discussed in section V.A. of the Addendum to this proposed rule and the proposed changes to the area wage adjustment as discussed in section V.B. of the Addendum to this proposed rule) as well as the effect of estimated changes to HCO and SSO payments. This estimated impact is based on the data for the 26 rural LTCHs in our database of 421 LTCHs, for which complete data were available.

The estimated increase in LTCH PPS payments from RY 2010 to FY 2011 for rural LTCHs is primarily due to the higher than average impacts from the proposed changes to the area wage adjustment and the proposed reduction in the labor-related share from 75.779 to 75.407 percent, which results in an estimated 0.6 percent increase in payments. We believe that the proposed changes to the area wage adjustment presented in this proposed rule (that is, the proposed use of updated wage data and the proposed change in the labor-related share) would result in accurate and appropriate LTCH PPS payments in FY 2011 because they are based on the most recent available data. Such updated data appropriately reflect national differences in area wage levels and appropriately identifies the portion of the standard Federal rate that should be adjusted to account for such differences in area wages, thereby resulting in accurate and appropriate LTCH PPS payments.

C. Anticipated Effects of Proposed LTCH PPS Payment Rate Change and Policy Changes

We discuss the impact of the proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for FY 2011 (in terms of their estimated fiscal impact on the Medicare budget and on LTCHs) in section VII. of the preamble of this proposed rule.

1. Budgetary Impact

Section 123(a)(1) of the BBRA requires that the PPS developed for

LTCHs "maintain budget neutrality." We believe that the statute's mandate for budget neutrality applies only to the first year of the implementation of the LTCH PPS (that is, FY 2003). Therefore, in calculating the FY 2003 standard Federal rate under § 412.523(d)(2), we set total estimated payments for FY 2003 under the LTCH PPS so that estimated aggregate payments under the LTCH PPS were estimated to equal the amount that would have been paid if the LTCH PPS had not been implemented.

As discussed in section IX.A. of this Appendix A, we project an increase in aggregate LTCH PPS payments in FY 2011 of approximately $41 million (or 0.8 percent) based on the 421 LTCHs in our database.

2. Impact on Providers

The basic methodology for determining a per discharge LTCH PPS payment is set forth in § 412.515 through § 412.536. In addition to the basic MS–LTC–DRG payment (standard Federal rate multiplied by the MS–LTC–DRG relative weight), we make adjustments for differences in area wage levels, COLA for Alaska and Hawaii, and SSOs. Furthermore, LTCHs may also receive HCO payments for those cases that qualify based on the threshold established each year.

To understand the impact of the proposed changes to the LTCH PPS payments presented in this proposed rule on different categories of LTCHs for FY 2011, it is necessary to estimate payments per discharge for RY 2010 using the rates and factors, including the FY 2010 GROUPER (Version 27.0) and relative weights, and policies established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43945 through 43994 and 44021 through 44030). It is also necessary to estimate the payments per discharge that would be made under the proposed LTCH PPS rates, factors, policies, and GROUPER (Version 28.0) for FY 2011 (as discussed in VII. of the preamble and section V. of the Addendum to this proposed rule). These estimates of RY 2010 and FY 2011 LTCH PPS payments are based on the best available LTCH claims data and other factors, such as the application of inflation factors to estimate costs for SSO and HCO cases in each year. We also evaluated the change in estimated RY 2010 payments to estimated FY 2011 payments (on a per discharge basis) for each category of LTCHs.

Hospital groups were based on characteristics provided in the OSCAR data, FY 2006 through FY 2007 cost report data in HCRIS, and PSF data. Hospitals with incomplete characteristics were grouped into the "unknown" category. Hospital groups include the following:

- Location: large urban/other urban/rural.
- Participation date.
- Ownership control.
- Census region.
- Bed size.

To estimate the impacts of the payment rates and policy changes among the various categories of existing providers, we used LTCH cases from the FY 2009 MedPAR file to estimate payments for RY 2010 and to estimate payments for FY 2011 for 421 LTCHs. We believe that the discharges based on the FY 2009 MedPAR data for the 421 LTCHs in our database, which includes 301 proprietary LTCHs, provide sufficient representation in the MS–LTC–DRGs containing discharges for patients who received LTCH care for the most commonly treated LTCH patients' diagnoses.

3. Calculation of Prospective Payments

For purposes of this impact analysis, to estimate per discharge payments under the LTCH PPS, we simulated payments on a case-by-case basis using LTCH claims from the FY 2009 MedPAR files. For modeling estimated LTCH PPS payments for RY 2010, we applied the RY 2010 standard Federal rate (that is, $39,896.65, which is effective for LTCH discharges occurring on or after October 1, 2009, and through September 30, 2010). For modeling estimated LTCH PPS payments for FY 2011, we applied the proposed FY 2011 standard Federal rate of $39,856.75, which would be effective for LTCH discharges occurring on or after October 1, 2010, and through September 30, 2011.

Furthermore, in modeling estimated LTCH PPS payments for both RY 2010 and FY 2011 in this impact analysis, we applied the RY 2010 and proposed FY 2011 adjustments for area wage differences and the COLA for Alaska and Hawaii. Specifically, we adjusted for area wage differences for estimated RY 2010 payments using the RY 2010 LTCH PPS labor-related share of 75.779 percent (74 FR 43968), the wage index values established in the Tables 12A and 12B of the Addendum to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44192 through 44213) and the RY 2010 COLA factors shown in the table in section V. of the Addendum to that final rule (74 FR 44026). Similarly, we adjusted for area wage differences for estimated FY 2011 payments using the proposed LTCH PPS FY 2011 labor-related share of 75.407 percent (section VII.C.2.d. of the preamble of this proposed rule), the FY 2011 proposed wage index values presented in Tables 12A and 12B of the Addendum to this proposed rule, and the FY 2011 COLA factors shown in the table in section V.B.5. of the Addendum to this proposed rule.

As discussed above, our impact analysis reflects an estimated change in payments for SSO cases as well as an estimated increase in payments for HCO cases (as described in section V.C. of the Addendum to this proposed rule). In modeling proposed payments for SSO and HCO cases in RY 2010, we applied an inflation factor of 1.024 percent (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2009 MedPAR files and the best available CCRs from the December 2009 update of the PSF. In modeling proposed payments for SSO and HCO cases in FY 2011, we applied an inflation factor of 1.049 (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2009 MedPAR files and the best available CCRs from the December 2009 update of the PSF. Furthermore, in modeling estimated LTCH PPS payments for both RY 2010 and FY 2011 in this impact analysis, we applied the RY 2010 HCO fixed-loss amount of $18,425 (74 FR 44029) and the proposed FY 2011 fixed loss amount of $18,692 (as discussed in section V.C.3. of the Addendum of this proposed rule).

These impacts reflect the estimated "losses" or "gains" among the various classifications of LTCHs from the RY 2010 to FY 2011 based on the proposed payment rates and policy changes presented in this proposed rule. Table IV illustrates the estimated aggregate impact of the LTCH PPS among various classifications of LTCHs.

- The first column, LTCH Classification, identifies the type of LTCH.
- The second column lists the number of LTCHs of each classification type.
- The third column identifies the number of LTCH cases.
- The fourth column shows the estimated payment per discharge for RY 2010 (as described above).
- The fifth column shows the estimated payment per discharge for FY 2011 (as described above).
- The sixth column shows the percentage change in estimated payments per discharge from RY 2010 to FY 2011 for proposed changes to the standard Federal rate (as discussed in section V.A. of the Addendum to this proposed rule).
- The seventh column shows the percentage change in estimated

payments per discharge from RY 2010 to FY 2011 for proposed changes to the area wage adjustment at § 412.525(c) (as discussed in section V.B. of the Addendum to this proposed rule).

• The eighth column shows the percentage change in estimated payments per discharge from RY 2010 (Column 4) to FY 2011 (Column 5) for all proposed changes (and includes the effect of estimated changes to HCO and SSO payments).

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TABLE IV: Impact of Proposed Payment Rate and Policy Changes to LTCH PPS Payments for FY 2011 (Estimated FY 2010 Payments Compared to Estimated FY 2011 Payments*)

LTCH Classification (1)	Number of LTCHs (2)	Number of LTCH PPS Cases (3)	Average RY 2010 LTCH PPS Rate Year Payment Per Case[1] (4)	Average FY 2011 LTCH PPS Rate Year Proposed Payment Per Case[2] (5)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Proposed Changes to the Federal Rate[3] (6)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Proposed Changes to the Area Wage Adjustment[4] (7)	Percent Change in Payments Per Discharge from RY 2010 to FY 2011 for All Proposed Changes[5] (8)
ALL PROVIDERS	421	131,490	37,304	37,616	-0.1	0.1	0.8
BY LOCATION:							
RURAL	26	5,610	31,693	32,125	-0.1	0.6	1.4
URBAN	395	125,880	37,554	37,860	-0.1	0.1	0.8
LARGE	204	75,855	39,025	39,364	-0.1	0.1	0.9
OTHER	191	50,025	35,324	35,580	-0.1	0.1	0.7
BY PARTICIPATION DATE:							
BEFORE OCT. 1983	17	6,244	32,058	32,423	-0.1	0.2	1.1
OCT. 1983 - SEPT. 1993	44	16,824	38,212	38,574	-0.1	0.1	0.9
OCT. 1993 - SEPT. 2002	189	63,987	36,781	37,053	-0.1	0.1	0.7
AFTER OCTOBER 2002	161	41,657	38,501	38,831	-0.1	0.1	0.9
UNKNOWN PARTICIPATION DATE	10	2,778	37,710	38,233	-0.1	0.3	1.4
BY OWNERSHIP TYPE:							
VOLUNTAFY	77	19,922	37,393	37,822	-0.1	0.2	1.1
PROPRIETARY	301	105,986	37,212	37,492	-0.1	0.1	0.8
GOVERNMENT	12	1,588	38,960	39,458	-0.1	-0.2	1.3
UNKNOWN OWNERSHIP TYPE	31	3,994	38,639	39,134	-0.1	0.1	1.3
BY REGION:							
NEW ENGLAND	15	7,584	32,848	33,213	-0.1	0.1	1.1
MIDDLE ATLANTIC	29	7,742	38,086	38,320	-0.1	-0.2	0.6
SOUTH ATLANTIC	55	14,665	40,522	40,765	-0.1	-0.2	0.6
EAST NORTH CENTRAL	68	19,194	40,304	40,652	-0.1	0.2	0.9
EAST SOUTH CENTRAL	31	7,909	37,380	37,569	-0.1	-0.2	0.5
WEST NORTH CENTRAL	24	5,178	38,607	38,834	-0.1	0.0	0.6
WEST SOUTH CENTRAL	142	50,537	32,924	33,239	-0.1	0.3	1
MOUNTAIN	32	6,268	40,358	40,725	-0.1	0.0	0.9
PACIFIC	25	12,413	46,801	47,221	-0.1	0.3	0.9
BY BED SIZE:							

LTCH Classification (1)	Number of LTCHs (2)	Number of LTCH PPS Cases (3)	Average RY 2010 LTCH PPS Rate Year Payment Per Case[1] (4)	Average FY 2011 LTCH PPS Rate Year Proposed Payment Per Case[2] (5)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Proposed Changes to the Federal Rate [3] (6)	Percent Change in Estimated Payments Per Discharge from RY 2010 to FY 2011 for Proposed Changes to the Area Wage Adjustment[4] (7)	Percent Change in Payments Per Discharge from RY 2010 to FY 2011 for All Proposed Changes[5] (8)
BEDS: 0-24	42	5,288	32,969	33,438	-0.1	0.6	1.4
BEDS: 25-49	192	41,372	37,081	37,298	-0.1	0.0	0.6
BEDS: 50-74	101	32,024	38,230	38,567	-0.1	0.1	0.9
BEDS: 75-124	50	22,652	39,512	39,955	-0.1	0.3	1.1
BEDS: 125-199	21	15,145	35,296	35,660	-0.1	0.2	1
BEDS: 200 +	15	15,009	36,168	36,378	-0.1	0.0	0.6

[1] Estimated RY 2010 payments based on the rates, factors, including the FY 2010 GROUPER (Version 27.0) and relative weights, and policies established in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43945 through 43994 and 44021 through 44030).
[2] Estimated FY 2011 LTCH PPS payments based on the proposed payment rates and policy changes presented in the preamble and the Addendum of this proposed rule.
[3] Percent change in estimated payments per discharge from RY 2010 to FY 2011 for the proposed changes to the standard Federal rate, as discussed in section V.A. of the Addendum to this proposed rule.
[4] Percent change in estimated payments per discharge from RY 2010 to FY 2011 for proposed changes to the area wage adjustment at §412.525(c) (as discussed in section V.B. of the Addendum to this proposed rule).
[5] Percent change in estimated payments per discharge from RY 2010 LTCH PPS (shown in Column 4) to FY 2011 LTCH PPS (shown in Column 5), including all of the proposed changes presented in the preamble of this proposed rule. Note, this column, which shows the percent change in estimated payments per discharge for all proposed changes, does not equal the sum of the percent changes in estimated payments per discharge for proposed changes to the standard Federal rate (column 6) and the proposed changes to the area wage adjustment (Column 7) due to the effect of estimated changes in both estimated payments to SSO cases that are paid based on estimated costs and aggregate HCO payments (as discussed in this impact analysis), as well as other interactive effects that cannot be isolated.

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4. Results

Based on the most recent available data (as described previously for 421 LTCHs, we have prepared the following summary of the impact (as shown in Table IV) of the proposed LTCH PPS payment rate and policy changes presented in this proposed rule. The impact analysis in Table IV shows that estimated payments per discharge are expected to increase approximately 0.8 percent, on average, for all LTCHs from RY 2010 to FY 2011 as a result of the proposed payment rate and policy changes presented in this proposed rule, as well as estimated increases in HCO and SSO payments. We note that we are proposing a −0.1 percent decrease to the standard Federal rate for FY 2011, based on the latest market basket estimate (2.4 percent) and the adjustment for the cumulative effect of changes in documentation and coding in FYs 2008 and 2009 (−2.5 percent). We noted earlier in this section that for most categories of LTCHs, as shown in Table IV (Column 6), the impact of the proposed decrease of −0.1 percent to the standard Federal rate is projected to result in approximately a −0.1 percent decrease in estimated payments per discharge for all LTCHs from RY 2010 to FY 2011. Furthermore, as discussed previously in this regulatory impact analysis, the average increase in estimated payments per discharge from the RY 2010 to FY 2011 for all LTCHs of approximately 0.8 percent (as shown in Table IV) was determined by comparing estimated FY 2011 LTCH PPS payments (using the proposed rates and policies discussed in this proposed rule) to estimated RY 2010 LTCH PPS payments (as described above in section IX.C. of this Appendix A).

a. Location

Based on the most recent available data, the vast majority of LTCHs are located in urban areas. Only approximately 6 percent of the LTCHs are identified as being located in a rural area, and approximately 4 percent of all LTCH cases are treated in these rural hospitals. The impact analysis presented in Table IV shows that the average percent increase in estimated payments per discharge from RY 2010 to FY 2011 for all hospitals is 0.8 percent for all proposed changes. For rural LTCHs, the percent change for all proposed changes is estimated to be 1.4 percent, while for urban LTCHs, we estimate the increase to be 0.8 percent. Large urban LTCHs are projected to experience an increase of 0.9 percent in estimated payments per discharge from RY 2010 to FY 2011, while other urban LTCHs are projected to experience an increase of 0.7 percent in estimated payments per discharge from RY 2010 to FY 2011, as shown in Table IV.

b. Participation Date

LTCHs are grouped by participation date into four categories: (1) Before October 1983; (2) between October 1983 and September 1993; (3) between October 1993 and September 2002; and (4) after October 2002. Based on the most recent available data, the majority (approximately 49 percent) of the LTCH cases are in hospitals that began participating between October 1993 and September 2002, and are projected to experience nearly the average increase (0.7 percent) in estimated payments per discharge from RY 2010 to FY 2011, as shown in Table IV.

In the participation category where LTCHs began participating in Medicare before October 1983, LTCHs are projected to experience a higher than average percent increase (1.1 percent) in

estimated payments per discharge from RY 2010 to FY 2011, as shown in Table IV. Approximately 4 percent of LTCHs began participating in Medicare before October 1983. The LTCHs in this category are projected to experience a higher than average increase in estimated payments because of estimated increases in payments due to the proposed change to the area wage adjustment, the proposed changes in the MS–LTC–DRG classifications and relative weights, and also because of estimated increases in their SSO payments relative to last year. Approximately 10 percent of LTCHs began participating in Medicare between October 1983 and September 1993. These LTCHs are projected to experience a slightly above average increase (0.9 percent) in estimated payments from RY 2010 to FY 2011. LTCHs that began participating in Medicare after October 2002 currently represent approximately 38 percent of all LTCHs, and are projected to experience a slightly above average increase (0.9 percent) in estimated payments from RY 2010 to FY 2011.

c. Ownership Control

Other than LTCHs whose ownership control type is unknown, LTCHs are grouped into three categories based on ownership control type: voluntary, proprietary, and government. Based on the most recent available data, approximately 18 percent of LTCHs are identified as voluntary (Table IV). We expect that, for these LTCHs in the voluntary category, estimated FY 2011 LTCH payments per discharge will increase higher than the average (1.1 percent) in comparison to estimated payments in RY 2010 primarily because we project an increase in estimated HCO payments and SSO payments to be higher than the average for these LTCHs. The majority (71 percent) of LTCHs are identified as proprietary and these LTCHs are projected to experience an average increase (0.8 percent) in estimated payments per discharge from RY 2010 to FY 2011. Finally, government-owned and operated LTCHs (3 percent) are expected to experience a higher than the average increase (1.3 percent) in estimated payments primarily due to a larger than the average increase in estimated HCO payments and increases under the proposed MS–LTC–DRG GROUPER (Version 28) and relative weights.

d. Census Region

Estimated payments per discharge for FY 2011 are projected to increase for LTCHs located in all regions in comparison to RY 2010. Of the 9 census regions, we project that the increase in estimated payments per discharge will have the largest positive impact on LTCHs in the New England and West South Central regions (1.1 percent, 1.0, respectively, as shown in Table IV). The estimated percent increase in payments per discharge from RY 2010 to FY 2011 for New England is largely attributable to the projected increase in estimated HCO and SSO payments (explained in greater detail above in section XV.B.4. of this Appendix A). The projected increase in estimated payments per discharge from RY 2010 to FY 2011 for LTCHs in the West South Central region is mostly due to the 43 percent of providers in this region that would receive a higher wage index in FY 2011 compared to RY 2010 and because all the providers have a proposed FY 2011 wage index less than 1, which results in an estimated payment increase because the proposed labor-related share (the portion of the rate adjusted by the wage index) is being reduced so their lower wage index adjusts a smaller portion of the rate.

In contrast, LTCHs located in the East South Central region are projected to experience a lower than average increase in estimated payments per discharge from RY 2010 to FY 2011. The less than average estimated increase in payments of 0.5 percent for LTCHs in the East South Central region is primarily due to estimated decreases in payments associated with the proposed wage index because 50 percent of LTCHs located in this region will have a proposed FY 2011 wage index value that is less than their RY 2010 wage index value. Similarly, LTCHs in the Middle Atlantic and South Atlantic are expected to experience a below average increase in payments of 0.6 percent primarily due to an estimated decrease in payment because of the proposed FY 2011 wage index changes.

e. Bed Size

LTCHs were grouped into six categories based on bed size: 0–24 beds; 25–49 beds; 50–74 beds; 75–124 beds; 125–199 beds; and greater than 200 beds.

We project that payments for small LTCHs (0–24 beds) will experience a 1.4 percent increase in payments due to increases in their wage index while large LTCHs (200+ beds) will experience smaller than average increase in payments of 0.6 percent. LTCHs with between 75 and 124 beds and between 125 and 199 beds are expected to experience an above average increase in payments per discharge from RY 2010 to FY 2011 (1.1 percent and 1.0 percent, respectively) primarily due to a larger than average estimated increase in payments from the proposed FY 2011 changes to the area wage adjustment.

D. Effect on the Medicare Program

As noted previously, we project that the provisions of this proposed rule will result in an increase in estimated aggregate LTCH PPS payments in FY 2011 of approximately $41 million (or about 0.8 percent) for the 421 LTCHs in our database.

E. Effect on Medicare Beneficiaries

Under the LTCH PPS, hospitals receive payment based on the average resources consumed by patients for each diagnosis. We do not expect any changes in the quality of care or access to services for Medicare beneficiaries under the LTCH PPS, but we expect that paying prospectively for LTCH services would enhance the efficiency of the Medicare program.

X. Effects of Proposed Policy Changes Regarding Accreditation Requirements for Medicaid Providers of Inpatient Psychiatric Services for Individuals Under Age 21

In section X. of the preamble of this proposed rule, we discuss our proposal to remove the Medicaid requirement for Joint Commission accreditation of psychiatric hospitals, hospitals with inpatient psychiatric programs, and PRTFs. Psychiatric hospitals would have the choice of meeting the requirements to participate in Medicare as a psychiatric hospital under 42 CFR 482.60, or obtaining accreditation from a national accrediting organization whose psychiatric hospital accrediting program has been approved by CMS. Hospitals with inpatient psychiatric programs would have the choice of meeting the requirements for participation in Medicare as a hospital as specified in 42 CFR part 482 or obtaining accreditation from a national accrediting organization whose hospital accreditation program has been approved by CMS. In addition, PRTFs would be afforded the flexibility in obtaining accreditation by a national accrediting organization whose program has been approved by CMS, or by any other accrediting organization with comparable standards that is recognized by the State. This proposal would remove specific references to national accrediting bodies to provide appropriate administrative flexibility to account for any changes in qualifying accrediting organizations.

Ensuring access to services is a priority for CMS, and we believe that this proposal would result in psychiatric hospitals, hospitals with

inpatient psychiatric programs, and PRTFs meeting comparable standards required in order to provide services. In addition, the proposed revision to the accreditation requirement aligns Medicaid standards with existing standards in the Medicare program. We believe that this flexibility in obtaining accreditation will facilitate the provision of medically necessary, Medicaid-reimbursable psychiatric services to vulnerable children, while maintaining the high quality of care demanded by the Medicaid program.

We are not preparing an analysis for this proposal under the RFA because we have determined that the proposal would not have a significant economic impact on a substantial number of small entities.

We are not preparing an analysis for section 1102(b) of the Act because this proposal would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $135 million. This proposal would not result in an impact of $135 million or more on State, local or tribal governments, in the aggregate, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because this proposal does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

XI. Alternatives Considered

This proposed rule contains a range of policies. The preamble of this proposed rule provides descriptions of the statutory provisions that are addressed, identifies implementing policies where discretion has been exercised, and presents rationales for our decisions and, where relevant, alternatives that were considered.

XII. Overall Conclusion

A. Acute Care Hospitals

Table I of section VI. of this Appendix demonstrates the estimated distributional impact of the IPPS budget neutrality requirements for the proposed MS–DRG and wage index changes, and for the wage index reclassifications under the MGCRB. Table I also shows an overall decrease of 0.1 percent in operating payments. We estimate that operating payments will decrease by approximately $142 million in FY 2011. In addition, this estimate includes the reporting of hospital quality data program costs of $2.4 million, and a savings of $21 million associated with the proposed HACs policies and all other proposed operating payment policies described in section VII. of this Appendix. We estimate that capital payments will experience −0.2 percent change in payments per case, as shown in Table III of section VIII. of this Appendix. We estimate that capital payments will decrease by approximately $20 million in FY 2011 compared to FY 2010. The proposed cumulative operating and capital payments should result in a net decrease of $181 million to IPPS providers. The discussions presented in the previous pages, in combination with the rest of this proposed rule, constitute a regulatory impact analysis.

B. LTCHs

Overall, LTCHs are projected to experience an increase in estimated payments per discharge in FY 2011. In the impact analysis, we are using the proposed rates, factors, and policies presented in this proposed rule, including proposed updated wage index values and relative weights, and the best available claims and CCR data to estimate the change in payments under the LTCH PPS for FY 2011. Accordingly, based on the best available data for the 421 LTCHs in our database, we estimate that FY 2011 LTCH PPS payments will increase approximately $41 million (or about 0.8 percent).

XIII. Accounting Statements

A. Acute Care Hospitals

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table V below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule as they relate to acute care hospitals. This table provides our best estimate of the change in Medicare payments to providers as a result of the proposed changes to the IPPS presented in this proposed rule. All expenditures are classified as transfers to Medicare providers.

TABLE V—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM FY 2010 TO FY 2011

Category	Transfers
Annualized Monetized Transfers.	−$181 million.
From Whom to Whom	Federal Government to IPPS Medicare Providers.
Total	−$181 million.

B. LTCHs

As discussed in section IX. of this Appendix, the impact analysis for the proposed changes under the LTCH PPS for this proposed rule projects an increase in estimated aggregate payments of approximately $41 million (or about 0.8 percent) for the 421 LTCHs in our database that are subject to payment under the LTCH PPS. Therefore, as required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table VI below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule as they relate to changes to the LTCH PPS. Table VI provides our best estimate of the proposed increase in Medicare payments under the LTCH PPS as a result of the proposed provisions presented in this proposed rule based on the data for the 421 LTCHs in our database. All expenditures are classified as transfers to Medicare providers (that is, LTCHs).

TABLE VI—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM THE 2010 LTCH PPS RATE YEAR TO THE FY 2011 LTCH PPS

Category	Transfers
Annualized Monetized Transfers.	Positive transfer—Estimated increase in expenditures: $41 million.
From Whom to Whom	Federal Government to LTCH PPS Medicare Providers.
Total	$41 million.

XIV. Executive Order 12866

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

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

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the MedPAC, recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish update factors recommended by the Secretary in the proposed and final IPPS rules, respectively. Accordingly, this Appendix provides the recommendations for the update factors for the IPPS national standardized amount, the Puerto Rico-specific standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for certain hospitals excluded from the IPPS, as well as LTCHs, IPFs, and IRFs. We also discuss our response to MedPAC's recommended update factors for inpatient hospital services.

II. Inpatient Hospital Update for FY 2011

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public L. 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. A number of the provisions of Public Law 111–148, as amended by Public Law 111–152, affect the IPPS and the LTCH PPS and the providers and suppliers addressed in this proposed rule. However, due to the timing of the passage of the legislation, we are unable to address those provisions in this proposed rule. Therefore, the proposed policies and payment rates in this proposed rule do not reflect the new legislation. We plan to issue separate documents in the **Federal Register** addressing the provisions of Public Law 111–148, as amended, that affect our proposed policies and payment rates for FY 2011 under the IPPS and LTCH PPS, as well as the provisions of Public Law 111–148, as amended, that affect the policies and payment rates for FY 2010 under the IPPS and LTCH PPS.

Section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Public Law 109–171, sets the FY 2011 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to the hospital submitting quality information under rules established by the Secretary in accordance with section 1886(b)(3)(B)(viii) of the Act. For hospitals that do not provide these data, the update is equal to the market basket percentage increase less 2.0 percentage points.

Consistent with current law, based on IHS Global Insight, Inc.'s first quarter 2010 forecast, with historical data through the 2009 fourth quarter, of the FY 2011 IPPS market basket increase, we are estimating that the FY 2011 update to the standardized amount will be 2.4 percent (that is, the current estimate of the market basket rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, we are estimating that the update to the standardized amount will be 0.4 percent (that is, the current estimate of the market basket rate-of-increase minus 2.0 percentage points).

Section 1886(d)(9)(C)(1) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. For FY 2011, we are proposing to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is estimated to be 2.4 percent.

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2011 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS, or the rate-of-increase in the market basket). Therefore, the update to the hospital-specific rates applicable to SCHs and MDHs is estimated to be 2.4 or 0.4 percent, depending upon whether the hospital submits quality data.

Section 1886(b)(3)(B)(ii) of the Act is used for purposes of determining the percentage increase in the rate-of-increase limits for children's and cancer hospitals. Section 1886(b)(3)(B)(ii) of the Act sets the percentage increase in the rate-of-increase limits equal to the market basket percentage increase. In accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. Section 1886(j)(3)(C) of the Act addresses the increase factor for the Federal prospective payment rate of IRFs. Section 123 of Public Law 106–113, as amended by section 307(b) of Public Law 106–554, provides the statutory authority for updating payment rates under the LTCH PPS. In addition, section 124 of Public Law 106–113 provides the statutory authority for updating all aspects of the payment rates for IPFs.

Currently, children's hospitals, cancer hospitals, and RNHCIs are the remaining three types of hospitals still reimbursed under the reasonable cost methodology. We are proposing to provide our current estimate of the FY 2011 IPPS operating market basket percentage increase (2.4 percent) to update the target limits for children's hospitals, cancer hospitals, and RNHCIs.

For FY 2011, as discussed in section VII. of the preamble to this proposed rule, we are proposing an update of −0.1 percent to the LTCH PPS standard Federal rate, which is based on a proposed market basket increase of 2.4 percent (based on IHS Global Insight, Inc.'s first quarter 2010 forecast of the FY 2002-based RPL market basket increase for FY 2011) and an adjustment of −2.5 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity.

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS. IPF PPS payments are based on a Federal per diem rate that is derived from the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality.

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), and thereafter, the Federal prospective payments to IRFs are based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (69 FR 45721).

III. Secretary's Recommendations

MedPAC is recommending an inpatient hospital update equal to the market basket rate of increase for FY 2011. MedPAC's rationale for this update recommendation is described in more detail below. As mentioned above, section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the MedPAC, recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically

appropriate and necessary care of high quality. Consistent with the update factor in the President's budget, we are recommending an update to the standardized amount of 2.9 percent. We are recommending that this same update factor apply to SCHs and MDHs.

Section 1886(d)(9)(C)(i) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. For FY 2011, we are proposing to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is estimated to be 2.4 percent.

In addition to making a recommendation for IPPS hospitals, in accordance with section 1886(e)(4)(A) of the Act, we also are recommending update factors for all other types of hospitals. Consistent with the update factor in the President's budget, we are recommending an update for children's hospitals, cancer hospitals, and RNHCIs of 2.9 percent.

For FY 2011, consistent with the proposal set forth in section VII. of the preamble of this proposed rule, we are recommending an update of −0.1 percent to the LTCH PPS standard Federal rate. In addition, based on IHS Global Insight, Inc.'s first quarter 2010 forecast of the RPL market basket increase, we are recommending an update of 2.4 percent to the IRF PPS Federal rate for FY 2011 and an update of 2.4 percent to the IPF PPS Federal rate for RY 2011 for the Federal per diem payment amount.

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

In its March 2010 Report to Congress, MedPAC assessed the adequacy of current payments and costs, and the relationship between payments and an appropriate cost base. MedPAC recommended an update to the hospital inpatient rates equal to the increase in the hospital market basket in FY 2011, concurrent with implementation of a quality incentive program. MedPAC's reasoning is that under a quality program, an individual hospital's quality performance should determine whether its net increase in payments is above or below the market basket increase. MedPAC noted the importance of hospitals to control their costs rather than accommodate the current rate of cost growth.

MedPAC also noted that indicators of payment adequacy are positive. MedPAC expects Medicare margins to remain low in 2011. At the same time though, MedPAC's analysis finds that high-performing hospitals have been able to maintain relatively low costs while maintaining a relatively high quality of care. In addition, roughly half of these providers are generating a profit on their Medicare business.

Response: Similar to our response last year, we agree with MedPAC that hospitals should control costs rather than have Medicare accommodate the current rate of growth. As MedPAC noted, the lack of financial pressure at certain hospitals can lead to higher costs and in turn bring down the overall Medicare margin for the industry.

In addition to the quality data that hospitals are required to submit to CMS, as discussed in section II. of the preamble of this proposed rule, CMS implemented the MS–DRGs in FY 2008 to better account for severity of illness under the IPPS and is basing the DRG weights on costs rather than charges. We continue to believe that these refinements will better match Medicare payment of the cost of care and provide incentives for hospitals to be more efficient in controlling costs.

We note that, because the operating and capital prospective payment systems remain separate, we are continuing to use separate updates for operating and capital payments. The proposed update to the capital rate is discussed in section III. of the Addendum to this proposed rule.

[FR Doc. 2010–9163 Filed 4–19–10; 4:15 pm]

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May 4, 2010

Part III

Nuclear Regulatory Commission

10 CFR Part 50

American Society of Mechanical Engineers (ASME) Codes and New and Revised ASME Code Cases; Proposed Rule

NUCLEAR REGULATORY COMMISSION

10 CFR Part 50

RIN 3150–AI35

[NRC 2008–0554]

American Society of Mechanical Engineers (ASME) Codes and New and Revised ASME Code Cases

AGENCY: Nuclear Regulatory Commission (NRC).

ACTION: Proposed rule.

SUMMARY: The NRC proposes to amend its regulations to incorporate by reference the 2005 Addenda through 2008 Addenda of Section III, Division 1, and the 2005 Addenda through 2008 Addenda of Section XI, Division 1, of the ASME *Boiler and Pressure Vessel Code* (ASME B&PV Code); and the 2005 Addenda and 2006 Addenda of the ASME Code for Operation and *Maintenance of Nuclear Power Plants* (ASME OM Code). The NRC also proposes to incorporate by reference ASME Code Case N–722–1, "Additional Examinations for PWR Pressure Retaining Welds in Class 1 Components Fabricated With Alloy 600/82/182 Materials Section XI, Division 1," and Code Case N–770, "Alternative Examination Requirements and Acceptance Standards for Class 1 PWR [Pressurized-Water Reactor] Piping and Vessel Nozzle Butt Welds Fabricated with UNS N06082 or UNS W86182 Weld Filler Material with or without Application of Listed Mitigation Activities."

DATES: Submit comments by July 19, 2010. Comments received after this date will be considered if it is practical to do so, but the NRC is able to ensure consideration only of comments received on or before this date.

ADDRESSES: Please include Docket ID NRC–2008–0554 in the subject line of your comments For instructions on submitting comments and accessing documents related to this action, *see* Section I, "Submitting Comments and Accessing Information" in the **SUPPLEMENTARY INFORMATION** section of this document. You may submit comments by any one of the following methods.

Federal Rulemaking Web Site: Go to *http://www.regulations.gov* and search for documents filed under Docket ID NRC–2008–0554. Address questions about NRC dockets to Carol Gallagher, telephone 301–492–3668, e-mail *Carol.Gallager@nrc.gov.*

Mail comments to: Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, ATTN: Rulemakings and Adjudications Staff.

E-mail comments to: Rulemaking.Comments@nrc.gov. If you do not receive a reply e-mail confirming that we have received your comments, contact us directly at 301–415–1677.

Hand-deliver comments to: 11555 Rockville Pike, Rockville, Maryland 20852, between 7:30 a.m. and 4:15 p.m. Federal workdays. (Telephone 301–415–1677)

Fax comments to: Secretary, U.S. Nuclear Regulatory Commission at 301–415–1101.

You may submit comments on the information collections by the methods indicated in the Paperwork Reduction Act Statement.

FOR FURTHER INFORMATION CONTACT: L. Mark Padovan, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, telephone 301–415–1423, e-mail *Mark.Padovan@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Submitting Comments and Accessing Information
II. Background
III. Discussion of NRC Approval of New Edition and Addenda to the Code, ASME Code Cases N–722–1 and N–770, and Other Proposed Changes to 10 CFR 50.55a
a. Quality Standards, ASME Codes and Institute of Electrical and Electronics Engineers (IEEE) Standards, and Alternatives
b. Applicant/Licensee-Proposed Alternatives to the Requirements of 10 CFR 50.55a
c. Standards Approved for Incorporation by Reference
d. ASME B&PV Code, Section III
e. ASME B&PV Code, Section XI
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g. Reactor Coolant Pressure Boundary, Quality Group B Components, and Quality Group C Components
h. Inservice Testing Requirements
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j. Substitution of the Term "Condition" in 10 CFR 50.55a
IV. Paragraph-by-Paragraph Discussion
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VII. Voluntary Consensus Standards
VIII. Finding of No Significant Environmental Impact: Environmental Assessment
IX. Paperwork Reduction Act Statement
X. Regulatory and Backfit Analysis
XI. Regulatory Flexibility Certification

I. Submitting Comments and Accessing Information

Comments submitted in writing or in electronic form will be posted on the NRC Web site and on the Federal rulemaking Web site Regulations.gov. Because your comments will not be edited to remove any identifying or contact information, the NRC cautions you against including any information in your submission that you do not want to be publicly disclosed. The NRC requests that any party soliciting or aggregating comments received from other persons for submission to the NRC inform those persons that the NRC will not edit their comments to remove any identifying or contact information, and therefore, they should not include any information in their comments that they do not want publicly disclosed.

You can access publicly available documents related to this document, including the following documents, using the following methods:

NRC's Public Document Room (PDR): The public may examine, and have copied for a fee, publicly-available documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland.

NRC's Agencywide Documents Access and Management System (ADAMS): Publicly available documents created or received at the NRC are available electronically at the NRC's Electronic Reading Room at *http://www.nrc.gov/reading-rm/adams.html.* From this page, the public can gain entry into ADAMS, which provides text and image files of NRC's public documents. If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the NRC's PDR reference staff at 1–800–397–4209, 301–415–4737, or by e-mail to *pdr.resource@nrc.gov.*

Federal Rulemaking Web Site: Public comments and supporting materials related to this proposed rule can be found at *http://www.regulations.gov* by searching on Docket ID NRC–2008–0554.

Document	PDR	Rulemaking Web site	Reading room
ASME B&PV Code*	X		
ASME Code Case N–770*	X		
ASME Code Case N–772–1*	X		

Document	PDR	Rulemaking Web site	Reading room
ASME OM Code*	X		
EPRI Report NP–5151**, "Evaluation of Reactor Vessel Beltline Integrity Following Unanticipated Operating Events," April 1987			
Final Safety Evaluation by the Office of Nuclear Reactor Regulation on Topical Report NEI 94–01, Revision 2, "Industry Guideline for Implementing Performance-Based Option of 10 CFR Part 50, Appendix J," June 25, 2008	X		ML081140105
GALL Report, NUREG–1801, Rev.1, September 2005:			
Volume 1,	X		ML052770419
Volume 2	X		ML052780376
NQA–1*, "Quality Assurance Requirements for Nuclear Facilities," 1994 Edition			
NUREG–1800, Rev. 1, "Standard Review Plan for Review of License Renewal Applications for Nuclear Power Plants, September 2005	X		ML052770566
Regulatory and Backfit Analysis for proposed rule	X	X	ML092510270
Regulatory Guide 1.178, "An Approach for Plant-Specific Risk-Informed Decisionmaking for Inservice Inspection of Piping"	X		
Regulatory Guide 1.193, Revision 2, "ASME Code Cases not Approved for Use."	X		ML072470294
Regulatory Guide 1.200, "An Approach for Determining the Technical Adequacy of Probabilistic Risk Assessment Results for Risk-Informed Activities"	X		
Standard Review Plan 3.9.8, "Risk-Informed Inservice Inspection of Piping"	X		

* Available on the ASME Web site.
** Available on the EPRI Web site.

II. Background

The ASME develops and publishes the ASME B&PV Code, which contains requirements for the design, construction, and inservice inspection (ISI) of nuclear power plant components; and the ASME OM Code, which contains requirements for inservice testing (IST) of nuclear power plant components. The ASME issues new editions of the ASME B&PV Code every 3 years and issues addenda to the editions yearly except in years when a new edition is issued. Periodically, the ASME publishes new editions and addenda of the ASME OM Code. The new editions and addenda typically revise provisions of the Codes to broaden their applicability, add specific elements to current provisions, delete specific provisions, and/or clarify them to narrow the applicability of the provision. The revisions to the editions and addenda of the Codes do not significantly change Code philosophy or approach.

The ASME B&PV and OM Codes are national voluntary consensus standards, and are required by the National Technology Transfer and Advancement Act of 1995, Public Law 104–113, to be used by government agencies instead of government-unique standards, unless the use of such a standard is inconsistent with applicable law or is otherwise impractical. It has been the NRC's practice to review new editions and addenda of the ASME B&PV and OM Codes and periodically update 10 CFR 50.55a to incorporate newer editions and addenda by reference. The NRC approves and/or mandates the use of editions and addenda of the Codes in 10 CFR 50.55a through the rulemaking process of "incorporation by reference." As such, each provision of the Codes incorporated by reference into, and mandated by, 10 CFR 50.55a constitutes a legally-binding NRC requirement imposed by rule. As the Codes are consensus documents, there may be disagreement among the technical experts regarding what constitutes an acceptable level of safety. The NRC proposed conditions enhance the provisions in the Code in instances where the NRC has determined that the provisions do not provide an acceptable level of safety. In other instances, research data or experience has shown that certain Code provisions are unnecessarily conservative, and the NRC has determined that the Code revisions are acceptable. This rulemaking is the latest in a series of rulemakings which incorporate by reference new editions and/or addenda of the Codes which are approved for use, either unconditionally or with conditions. The editions and addenda of the ASME B&PV and OM Codes were last incorporated by reference into the regulations in a final rule dated September 10, 2008 (73 FR 52730), as corrected on October 2, 2008 (73 FR 57235), incorporating Section III of the 2004 Edition of the ASME B&PV Code, Section XI of the 2004 Edition of the ASME B&PV Code, and the 2004 Edition of the ASME OM Code, subject to NRC conditions.

III. Discussion of NRC Approval of New Edition and Addenda to the Codes, ASME Code Cases N–722–1 and N–770, and Other Proposed Changes to 10 CFR 50.55a

The NRC proposes to amend its regulations to incorporate by reference the 2005 Addenda through 2008 Addenda of Section III, Division 1, and Section XI, Division 1 of the ASME B&PV Code; and the 2005 Addenda and 2006 Addenda of the ASME OM Code into 10 CFR 50.55a. The NRC also proposes to incorporate by reference Code Case N–770, and revision 1 to Code Case N–722, which was incorporated by reference into the NRC's regulations on September 10, 2008 (73 FR 52729).

The NRC follows a three-step process to determine acceptability of new provisions in new editions and addenda to the Codes, and the need for conditions on the uses of these Codes. This process was employed in the review of the Codes that are the subjects of this proposed rule. First, NRC staff actively participates with other ASME committee members with full involvement in discussions and technical debates in the development of new and revised Codes. This includes a technical justification in support of each new or revised Code. Second, the NRC committee representatives discuss the Codes and technical justifications with other cognizant NRC staff to ensure an adequate technical review. Finally, the proposed NRC position on each Code is reviewed and approved by NRC management as part of the rulemaking amending 10 CFR 50.55a to incorporate by reference new editions and addenda of the ASME Codes, and conditions on

their use. This regulatory process, when considered together with the ASME's own process for developing and approving ASME Codes provides reasonable assurances that the NRC approves for use only those new and revised Code edition and addenda (with conditions as necessary) that provide reasonable assurance of adequate protection to public health and safety and that do not have significant adverse impacts on the environment.

The NRC reviewed changes to the Codes in the editions and addenda of the Codes identified in this rulemaking. The NRC concluded, in accordance with the process for review of changes to the Codes, that each of the editions and addenda of the Codes, and the 1994 Edition of NQA–1, are technically adequate, consistent with current NRC regulations, and approved for use with the specified conditions. Table 1 identifies where the NRC proposes to change (clarify the regulation; or impose new, revise existing, or remove conditions in) 10 CFR 50.55a. Due to the extent of the proposed revisions to 10 CFR 50.55a(b)(2), the NRC is proposing to revise this portion of the regulations in its entirety, including the redesignation of paragraphs within the section. These proposed redesignations are also outlined in Table 1 of this document.

TABLE 1—REDESIGNATION OF PARAGRAPHS AND DESCRIPTION OF PROPOSED CHANGES TO 10 CFR 50.55a

Proposed regulation	Current regulation	Description of proposed changes
Applicant/Licensee-Proposed Alternatives to the Requirements of 10 CFR 50.55a		
Paragraph (a)	Paragraph (a)	Revise to title the paragraph *Quality standards, ASME Codes and IEEE standards, and alternatives.*
Paragraph (a)(3)	Paragraph (a)(3)	Revise to clarify that an alternative is to be submitted to, and approved by, the NRC prior to implementing the alternative.
Standards Approved for Incorporation by Reference		
Introductory text to paragraph (b)	Introductory text to paragraph (b)	Revise to title the paragraph *Standards approved for incorporation by reference.* Revise to incorporate by reference the ASME B&PV Code, Section III, Division 1 (excluding Non-mandatory Appendices), and Section XI, Division 1, and ASME OM Code, which are referenced in paragraphs (b)(1), (b)(2), and (b)(3) of this section. In addition, ASME Code Cases N–722–1 and N-770 would be incorporated by reference.
ASME B&PV Code, Section III		
Introductory text to paragraph (b)(1)	Introductory text to paragraph (b)(1).	Revise to clarify the wording and include the 1974 Edition (Division 1) through the 2008 Addenda (Division 1), subject to conditions. Change "limitations and modifications" to "conditions."
Paragraph (b)(1)(ii)	Paragraph (b)(1)(ii), "Weld leg dimensions".	Revise the current conditions on the use of stress indices used for welds in piping design under Subarticles NB–3600, NC–3600, and ND–3600. Make editorial corrections and additions.
Introductory text to paragraph (b)(1)(iii).	Introductory text to paragraph (b)(1)(iii), "Seismic design of piping".	Revise to include the latest addenda to Section III of the ASME B&PV Code (2006 Addenda through the 2008 Addenda) and Subarticle NB–3200 of the 2004 Edition through the 2008 Addenda of the ASME B&PV Code subject to the condition outlined in paragraph (b)(1)(iii)(B). Change "limitation" to "condition."
Paragraphs (b)(1)(iii)(A), (b)(1)(iii)(B), and (b)(1)(iii)(C).		Add new conditions on the use of Subarticles NB–3200, NB–3600, NC–3600 and ND–3600 identified in the introductory text to paragraph (b)(1)(iii).
Paragraph (b)(1)(iv)	Paragraph (b)(1)(iv) "Quality assurance".	Revise to incorporate by reference the 1994 Edition of NQA–1, "Quality Assurance Requirements for Nuclear Facilities."
Paragraph (b)(1)(vii)		Add a new condition to prohibit the use of paragraph NB–7742 of the 2006 Addenda up to and including the 2007 Edition and 2008 Addenda of the ASME B&PV Code, Section III.
ASME B&PV Code, Section XI		
Introductory text to paragraph (b)(2)	Introductory text to paragraph (b)(2).	Revise to clarify the wording and incorporate by reference the 2005 Addenda through 2008 Addenda of the ASME B&PV Code into § 50.55a; only Subsections IWA, IWB, IWC, IWD, IWE, IWF, IWL; Mandatory and Non-Mandatory Appendices of Division 1 are incorporated by reference into 10 CFR 50.55a, with conditions. Change "limitations and modifications" to "conditions."
NA	Paragraph (b)(2)(i), "Limitations on specific editions and addenda".	Remove because licensees are no longer using the 1974 and 1977 Editions and addenda of the ASME B&PV Code.
Paragraph (b)(2)(i)	Paragraph (b)(2)(ii), "Pressure-retaining welds in ASME Code Class 1 piping (applies to Table IWB–2500 and IWB–2500–1 and Category B–J".	Redesignate paragraph (b)(2)(ii) as paragraph (b)(2)(i).
NA	Paragraph (b)(2)(iii), "Steam generator tubing (modifies Article IWB–2000)".	Remove because the condition in the paragraph is redundant to the 1989 Edition through the 2008 Addenda of Section XI.

TABLE 1—REDESIGNATION OF PARAGRAPHS AND DESCRIPTION OF PROPOSED CHANGES TO 10 CFR 50.55a—Continued

Proposed regulation	Current regulation	Description of proposed changes
NA	Paragraph (b)(2)(iv), "Pressure retaining welds in ASME Code Class 2 piping".	Remove because licensees are no longer using these older editions and addenda of the code.
NA	Paragraph (b)(2)(v), re: Evaluation procedures and acceptance criteria for austenitic piping.	Remove because licensees are no longer using the Winter 1983 Addenda and the Winter 1984 Addenda of Section XI.
Paragraph (b)(2)(ii)	Paragraph (b)(2)(vi), "Effective edition and addenda of Subsection IWE and Subsection IWL, Section XI".	Redesignate paragraph (b)(2)(vi) as paragraph (b)(2)(ii). Change "modified and supplemented" to "conditioned."
Paragraph (b)(2)(iii)	Paragraph (b)(2)(vii), "Section XI references to OM Part 4, OM Part 6 and OM Part 10 (Table IWA–1600–1)".	Redesignate paragraph (b)(2)(vii) as paragraph (b)(2)(iii).
Paragraph (b)(2)(iv)	Paragraph (b)(2)(viii), "Examination of concrete containments".	Redesignate paragraph (b)(2)(viii) as paragraph (b)(2)(iv), and revise the introductory text to remove the conditions in redesignated paragraphs (b)(2)(iv)(F) and (b)(2)(iv)(G) when using the 2007 Edition with 2008 Addenda of the ASME Code, Section XI.
Paragraph (b)(2)(v)	Paragraph (b)(2)(ix), "Examination of metal containments and the liners of concrete containments".	Redesignate paragraph (b)(2)(ix) as paragraph (b)(2)(v), and revise the introductory text to remove the conditions in redesignated paragraphs (b)(2)(v)(F), (b)(2)(v)(G), (b)(2)(v)(H) and (b)(2)(v)(I) when applying the 2004 Edition with 2006 Addenda through the 2007 Edition with 2008 Addenda of the ASME Code, Section XI and remove the condition in redesignated paragraph (b)(2)(v)(I) when applying the 2004 Edition, up to and including, the 2005 Addenda. Add a new condition as paragraph (b)(2)(v)(J) on the use of Article IWE–5000 of Subsection IWE when applying the 2007 Edition up to and including the 2008 Addenda of the ASME Code, Section XI.
Paragraph (b)(2)(vi)	Paragraph (b)(2)(x), "Quality assurance".	Redesignate paragraph (b)(2)(x) as paragraph (b)(2)(vi).
Paragraph (b)(2)(vii)	Paragraph (b)(2)(xi) [Reserved]	Redesignate paragraph (b)(2)(xi) as paragraph (b)(2)(vii).
Paragraph (b)(2)(viii)	Paragraph (b)(2)(xii), "Underwater welding".	Redesignate paragraph (b)(2)(xii) as paragraph (b)(2)(viii).
Paragraph (b)(2)(ix)	Paragraph (b)(2)(xiii) [Reserved]	Redesignate paragraph (b)(2)(xiii) as paragraph (b)(2)(ix).
Paragraph (b)(2)(x)	Paragraph (b)(2)(xiv), "Appendix VIII personnel qualification".	Redesignate paragraph (b)(2)(xiv) as paragraph (b)(2)(x).
Paragraph (b)(2)(xi)	Paragraph (b)(2)(xv), "Appendix VIII specimen set and qualification requirements".	Redesignate paragraph (b)(2)(xv) as paragraph (b)(2)(xi) and revise it so that existing conditions would not apply to the 2007 Edition through the 2008 Addenda of Section XI. Change "provisions" to "conditions" in the introductory text to redesignated paragraphs (b)(2)(xi), (b)(2)(xi)(B), (b)(2)(xi)(C), (b)(2)(xi)(D), (b)(2)(xi)(E), (b)(2)(xi)(F), (b)(2)(xi)(G), (b)(2)(xi)(K), and (b)(2)(xi)(K)(*1*). Change "provisions of" to "conditions in" in paragraph (b)(2)(xi)(G)(3). Change "modified" and "modification" to "conditioned" and "condition" in (b)(2)(xi)(K)(*2*)(*i*), (b)(2)(xi)(K)(*2*)(*iii*), (b)(2)(xi)(K)(*3*)(*i*), (b)(2)(xi)(K)(*3*)(*ii*), (b)(2)(xi)(K)(*4*), and (b)(2)(xi)(L), where applicable.
Paragraph (b)(2)(xii)	Paragraph (b)(2)(xvi), "Appendix VIII single side ferritic vessel and piping and stainless steel piping examination".	Redesignate paragraph (b)(2)(xvi) as paragraph (b)(2)(xii). Change "modified" to "conditioned" in redesignated paragraphs (b)(2)(xii)(A) and (b)(2)(xii)(B).
Paragraph (b)(2)(xiii)	Paragraph (b)(2)(xvii), "Reconciliation of Quality Requirements".	Redesignate paragraph (b)(2)(xvii) as paragraph (b)(2)(xiii).
Paragraph (b)(2)(xiv)(A)	Paragraph (b)(2)(xviii)(A), "Certification of NDE personnel".	Redesignate paragraph (b)(2)(xviii)(A) as paragraph (b)(2)(xiv)(A).
Paragraph (b)(2)(xiv)(B)	Paragraph (b)(2)(xviii)(B), "Certification of NDE personnel".	Redesignate paragraph (b)(2)(xviii)(B) as paragraph (b)(2)(xiv)(B), and revise it so that existing condition would not apply to the 2007 Edition through the 2008 Addenda of Section XI.
Paragraph (b)(2)(xiv)(C)	Paragraph (b)(2)(xviii)(C), "Certification of NDE personnel".	Redesignate paragraph (b)(2)(xviii)(C) as paragraph (b)(2)(xiv)(C), and revise it such that the existing conditions on the qualification of VT–3 examination personnel would not apply to the 2005 Addenda through the 2008 Addenda of Section XI.
Paragraph (b)(2)(xv)	Paragraph (b)(2)(xix), "Substitution of alternative methods".	Redesignate paragraph (b)(2)(xix) as paragraph (b)(2)(xv), and revise it so that existing conditions for the substitution of alternative examination methods would not apply when using the 2005 Addenda through the 2008 Addenda.
Paragraph (b)(2)(xvi)	Paragraph (b)(2)(xx), "System leakage tests".	Redesignate paragraph (b)(2)(xx) as paragraph (b)(2)(xvi).
Paragraph (b)(2)(xvii)	Paragraph (b)(2)(xxi), "Table IWB–2500–1 examination requirements".	Redesignate paragraph (b)(2)(xxi) as paragraph (b)(2)(xvii).

TABLE 1—REDESIGNATION OF PARAGRAPHS AND DESCRIPTION OF PROPOSED CHANGES TO 10 CFR 50.55a—Continued

Proposed regulation	Current regulation	Description of proposed changes
Paragraph (b)(2)(xviii)	Paragraph (b)(2)(xxii), "Surface examination".	Redesignate paragraph (b)(2)(xxii) as paragraph (b)(2)(xviii).
Paragraph (b)(2)(xix)	Paragraph (b)(2)(xxiii), "Evaluation of thermally cut surfaces".	Redesignate paragraph (b)(2)(xxiii) as paragraph (b)(2)(xix).
Paragraph (b)(2)(xx)	Paragraph (b)(2)(xxiv), "Incorporation of the performance demonstration initiative and addition of ultrasonic examination criteria".	Redesignate paragraph (b)(2)(xxiv) as paragraph (b)(2)(xx), and revise it so that existing condition would not apply when using the 2007 Edition through the 2008 Addenda.
Paragraph (b)(2)(xxi)	Paragraph (b)(2)(xxv), "Mitigation of defects by modification".	Redesignate paragraph (b)(2)(xxv) as paragraph (b)(2)(xxi).
Paragraph (b)(2)(xxii)	Paragraph (b)(2)(xxvi), "Pressure testing class 1, 2, and 3 mechanical joints".	Redesignate paragraph (b)(2)(xxvi) as paragraph (b)(2)(xxii).
Paragraph (b)(2)(xxiii)	Paragraph (b)(2)(xxvii), "Removal of insulation".	Redesignate paragraph (b)(2)(xxvii) as paragraph (b)(2)(xxiii), and revise it to refer to IWA–5242 of the 2003 Addenda through the 2006 Addenda or IWA–5241 of the 2007 Edition through the 2008 Addenda of Section XI of the ASME B&PV Code for performing VT–2 visual examination of insulated components in systems borated for the purpose of controlling reactivity.
New paragraph (b)(2)(xxiv), "Analysis of flaws".	NA	Add to place conditions on the use of Section XI, Nonmandatory Appendix A, "Analysis of Flaws."
New paragraph (b)(2)(xxv), "Evaluation of unanticipated operating events".	NA	Add to place condition specifying that Section E–1200 of the ASME B&PV Code, Section XI, Nonmandatory Appendix E, "Evaluation of Unanticipated Operating Events," is not acceptable for use.
New paragraph (b)(2)(xxvi), "Nonmandatory Appendix R".	NA	Add condition that would require licensees to submit an alternative in accordance with § 50.55a(a)(3), and obtain NRC authorization of the proposed alternative prior to implementing Section XI, Non-Mandatory Appendix R, RI–ISI programs.
ASME OM Code		
Introductory text to paragraph (b)(3)	Introductory text to paragraph (b)(3).	Revise to incorporate by reference the 2005 and 2006 Addenda of the ASME OM Code; Subsections ISTA, ISTB, ISTC, ISTD; Mandatory Appendices I and II; and Nonmandatory Appendices A through H and J of the ASME OM Code into § 50.55a. Change "limitations and modifications" to "conditions."
Paragraph (b)(3)(v)	Paragraph (b)(3)(v), "Subsection ISTD".	Revise to recognize that snubbers are tested in accordance with Section ISTD of the ASME OM Code when using the 2006 Addenda and later editions and addenda of Section XI of the ASME B&PV Code.
Paragraph (b)(3)(vi)	Paragraph (b)(3)(vi), "Exercise interval for manual valves".	Revise to state that this paragraph applies only when using the 1999 through 2005 Addenda of the ASME OM Code, as the 2006 Addenda of the ASME OM Code was revised to be consistent with the conditions in paragraph (b)(3)(vi).
Reactor Coolant Pressure Boundary, Quality Group B Components, and Quality Group C Components		
Paragraphs (c)(3), (d)(2) and (e)(2)	Paragraphs (c)(3), (d)(2) and (e)(2).	Revise to replace "but—" with "subject to the following conditions" at the end of the introductory text to the paragraphs for clarity.
Inservice Testing		
Paragraphs (f)(2), (f)(3)(v), and (f)(4).	Paragraphs (f)(2), (f)(3)(v), and (f)(4).	Change "limitations and modifications" to "conditions."
Paragraph (f)(5)(iv)	Paragraph (f)(5)(iv)	Revise to clarify that licensees are required to submit requests for relief based on impracticality within 12 months after the expiration of the IST interval for which relief is being sought.
Inservice Inspection		
Paragraph (g)(2)	Paragraph (g)(2)	Revise to include provisions for examination and testing snubbers in Subsection ISTD of the ASME OM Code, and the optional ASME code cases listed in Regulatory Guide 1.192. Change "limitations and modifications" to "conditions."
Paragraph (g)(3)(i)	Paragraph (g)(3)(i)	Revise to include provisions for examination and testing snubbers in Subsection ISTD of the ASME OM Code, and the optional ASME code cases listed in Regulatory Guide 1.192.
Paragraph (g)(3)(ii)	Paragraph (g)(3)(ii)	Revise to include the provisions for examination and testing snubbers in Subsection ISTD of the ASME OM Code, and the optional ASME code cases listed in Regulatory Guide 1.192.
Paragraph (g)(3)(v)	Paragraph (g)(3)(v)	Change "limitations and modifications" to "conditions."

TABLE 1—REDESIGNATION OF PARAGRAPHS AND DESCRIPTION OF PROPOSED CHANGES TO 10 CFR 50.55a—Continued

Proposed regulation	Current regulation	Description of proposed changes
Introductory text to paragraph (g)(4)	Introductory text to paragraph (g)(4).	Revise to include the provisions for examination and testing snubbers in Subsection ISTD of the ASME OM Code. Change "limitation" to "condition" and "modifications" to "conditions."
Paragraph (g)(4)(i)	Paragraph (g)(4)(i)	Revise to include the provisions for examination and testing snubbers in Subsection ISTD of the ASME OM Code, and the optional ASME code cases listed in Regulatory Guide 1.192. Change "limitations and modifications" to "conditions."
Paragraph (g)(4)(ii)	Paragraph (g)(4)(ii)	Revise to include the provisions for examination and testing snubbers in Subsection ISTD of the ASME OM Code, and the optional ASME code cases listed in Regulatory Guide 1.192. Change "limitations and modifications" to "conditions."
Paragraph (g)(4)(iii)	Paragraph (g)(4)(iii)	Revise to provide the proper references to Section XI, Table IWB–2500–1, "Examination Category B–J," Item Numbers B9.20, B9.21 and B9.22.
Paragraph (g)(4)(iv)	Paragraph (g)(4)(iv)	Change "limitations and modifications" to "conditions."
Paragraph (g)(5)(iii)	Paragraph (g)(5)(iii)	Revise to clarify that a request for relief must be submitted to the NRC no later than 12 months after the examination has been attempted during a given ISI interval and the ASME B&PV Code requirement determined to be impractical.
Paragraph (g)(5)(iv)	Paragraph (g)(5)(iv)	Revise to clarify that licensees are required to submit requests for relief based on impracticality within 12 months after the expiration of the ISI interval for which relief is being sought.
Paragraph (g)(6)(ii)(B)	Paragraph (g)(6)(ii)(B)	Change "modifications and limitations" to "conditions."
Paragraphs (g)(6)(ii)(E)(*1*), (g)(6)(ii)(E)(*2*), and (g)(6)(ii)(E)(*3*).	Paragraphs (g)(6)(ii)(E)(*1*), (g)(6)(ii)(E)(*2*), and (g)(6)(ii)(E)(*3*), "Reactor coolant pressure boundary visual inspections".	Revise to update the requirements to Code Case N–722–1.
New paragraph (g)(6)(ii)(F), "Inspection requirements for class 1 pressurized water reactor piping and vessel nozzle butt welds".	NA	Add to incorporate ASME Code Case N–770, "Alternative Examination Requirements and Acceptance Standards for Class 1 PWR Piping and Vessel Nozzle Butt Welds Fabricated with UNS N06082 or UNS W86182 Weld Filler Material With or Without Application of Listed Mitigation Activities, Section XI, Division 1," with conditions, into 10 CFR 50.55a.
Footnote 1	Footnote 1	Revise footnote 1 to clarify what portion of welds has to be inspected during the plant interval that remains after January 1, 2009.

For redesignated paragraphs in 10 CFR 50.55a, Table 2 cross-references the proposed regulations with the current regulations, and Table 3 cross-references the current regulations with the proposed regulations.

TABLE 2—CROSS REFERENCE OF PROPOSED REGULATIONS WITH CURRENT REGULATIONS

Proposed regulation	Current regulation	Description of proposed redesignations
ASME B&PV Code, Section XI		
Paragraph (b)(2)(i)	Paragraph (b)(2)(ii)	Redesignate paragraph (b)(2)(ii) as paragraph (b)(2)(i).
Paragraph (b)(2)(ii)	Paragraph (b)(2)(vi)	Redesignate paragraph (b)(2)(vi) as paragraph (b)(2)(ii).
Paragraph (b)(2)(iii)	Paragraph (b)(2)(vii)	Redesignate paragraph (b)(2)(vii) as paragraph (b)(2)(iii).
Paragraph (b)(2)(iv)	Paragraph (b)(2)(viii)	Redesignate paragraph (b)(2)(viii) as paragraph (b)(2)(iv).
Paragraph (b)(2)(v)	Paragraph (b)(2)(ix)	Redesignate paragraph (b)(2)(ix) as paragraph (b)(2)(v).
Paragraph (b)(2)(vi)	Paragraph (b)(2)(x)	Redesignate paragraph (b)(2)(x) as paragraph (b)(2)(vi).
Paragraph (b)(2)(vii)	Paragraph (b)(2)(xi)	Redesignate paragraph (b)(2)(xi) as paragraph (b)(2)(vii).
Paragraph (b)(2)(viii)	Paragraph (b)(2)(xii)	Redesignate paragraph (b)(2)(xii) as paragraph (b)(2)(viii).
Paragraph (b)(2)(ix)	Paragraph (b)(2)(xiii)	Redesignate paragraph (b)(2)(xiii) as paragraph (b)(2)(ix).
Paragraph (b)(2)(x)	Paragraph (b)(2)(xiv)	Redesignate paragraph (b)(2)(xiv) as paragraph (b)(2)(x).
Paragraph (b)(2)(xi)	Paragraph (b)(2)(xv)	Redesignate paragraph (b)(2)(xv) as paragraph (b)(2)(xi).
Paragraph (b)(2)(xii)	Paragraph (b)(2)(xvi)	Redesignate paragraph (b)(2)(xvi) as paragraph (b)(2)(xii).
Paragraph (b)(2)(xiii)	Paragraph (b)(2)(xvii)	Redesignate paragraph (b)(2)(xvii) as paragraph (b)(2)(xiii).
Paragraph (b)(2)(xiv)(A)	Paragraph (b)(2)(xviii)(A)	Redesignate paragraph (b)(2)(xviii)(A) as paragraph (b)(2)(xiv)(A).
Paragraph (b)(2)(xiv)(B)	Paragraph (b)(2)(xviii)(B)	Redesignate paragraph (b)(2)(xviii)(B) as paragraph (b)(2)(xiv)(B).
Paragraph (b)(2)(xiv)(C)	Paragraph (b)(2)(xviii)(C)	Redesignate paragraph (b)(2)(xviii)(C) as paragraph (b)(2)(xiv)(C).
Paragraph (b)(2)(xv)	Paragraph (b)(2)(xix)	Redesignate paragraph (b)(2)(xix) as paragraph (b)(2)(xv).
Paragraph (b)(2)(xvi)	Paragraph (b)(2)(xx)	Redesignate paragraph (b)(2)(xx) as paragraph (b)(2)(xvi).
Paragraph (b)(2)(xvii)	Paragraph (b)(2)(xxi)	Redesignate paragraph (b)(2)(xxi) as paragraph (b)(2)(xvii).
Paragraph (b)(2)(xviii)	Paragraph (b)(2)(xxii)	Redesignate paragraph (b)(2)(xxii) as paragraph (b)(2)(xviii).
Paragraph (b)(2)(xix)	Paragraph (b)(2)(xxiii)	Redesignate paragraph (b)(2)(xxiii) as paragraph (b)(2)(xix).
Paragraph (b)(2)(xx)	Paragraph (b)(2)(xxiv)	Redesignate paragraph (b)(2)(xxiv) as paragraph (b)(2)(xx).
Paragraph (b)(2)(xxi)	Paragraph (b)(2)(xxv)	Redesignate paragraph (b)(2)(xxv) as paragraph (b)(2)(xxi).
Paragraph (b)(2)(xxii)	Paragraph (b)(2)(xxvi)	Redesignate paragraph (b)(2)(xxvi) as paragraph (b)(2)(xxii).

TABLE 2—CROSS REFERENCE OF PROPOSED REGULATIONS WITH CURRENT REGULATIONS—Continued

Proposed regulation	Current regulation	Description of proposed redesignations
Paragraph (b)(2)(xxiii)	Paragraph (b)(2)(xxvii)	Redesignate paragraph (b)(2)(xxvii) as paragraph (b)(2)(xxiii).

TABLE 3—CROSS REFERENCE OF CURRENT REGULATIONS WITH PROPOSED REGULATIONS

Current regulation	Proposed regulation	Description of proposed redesignations
ASME B&PV Code, Section XI		
Paragraph (b)(2)(ii)	Paragraph (b)(2)(i)	Redesignate paragraph (b)(2)(ii) as paragraph (b)(2)(i).
Paragraph (b)(2)(vi)	Paragraph (b)(2)(ii)	Redesignate paragraph (b)(2)(vi) as paragraph (b)(2)(ii).
Paragraph (b)(2)(vii)	Paragraph (b)(2)(iii)	Redesignate paragraph (b)(2)(vii) as paragraph (b)(2)(iii).
Paragraph (b)(2)(viii)	Paragraph (b)(2)(iv)	Redesignate paragraph (b)(2)(viii) as paragraph (b)(2)(iv).
Paragraph (b)(2)(ix)	Paragraph (b)(2)(v)	Redesignate paragraph (b)(2)(ix) as paragraph (b)(2)(v).
Paragraph (b)(2)(x)	Paragraph (b)(2)(vi)	Redesignate paragraph (b)(2)(x) as paragraph (b)(2)(vi).
Paragraph (b)(2)(xi)	Paragraph (b)(2)(vii)	Redesignate paragraph (b)(2)(xi) as paragraph (b)(2)(vii).
Paragraph (b)(2)(xii)	Paragraph (b)(2)(viii)	Redesignate paragraph (b)(2)(xii) as paragraph (b)(2)(viii).
Paragraph (b)(2)(xiii)	Paragraph (b)(2)(ix)	Redesignate paragraph (b)(2)(xiii) as paragraph (b)(2)(ix).
Paragraph (b)(2)(xiv)	Paragraph (b)(2)(x)	Redesignate paragraph (b)(2)(xiv) as paragraph (b)(2)(x).
Paragraph (b)(2)(xv)	Paragraph (b)(2)(xi)	Redesignate paragraph (b)(2)(xv) as paragraph (b)(2)(xi).
Paragraph (b)(2)(xvi)	Paragraph (b)(2)(xii)	Redesignate paragraph (b)(2)(xvi) as paragraph (b)(2)(xii).
Paragraph (b)(2)(xvii)	Paragraph (b)(2)(xiii)	Redesignate paragraph (b)(2)(xvii) as paragraph (b)(2)(xiii).
Paragraph (b)(2)(xviii)(A)	Paragraph (b)(2)(xiv)(A)	Redesignate paragraph (b)(2)(xviii)(A) as paragraph (b)(2)(xiv)(A).
Paragraph (b)(2)(xviii)(B)	Paragraph (b)(2)(xiv)(B)	Redesignate paragraph (b)(2)(xviii)(B) as paragraph (b)(2)(xiv)(B).
Paragraph (b)(2)(xviii)(C)	Paragraph (b)(2)(xiv)(C)	Redesignate paragraph (b)(2)(xviii)(C) as paragraph (b)(2)(xiv)(C).
Paragraph (b)(2)(xix)	Paragraph (b)(2)(xv)	Redesignate paragraph (b)(2)(xix) as paragraph (b)(2)(xv).
Paragraph (b)(2)(xx)	Paragraph (b)(2)(xvi)	Redesignate paragraph (b)(2)(xx) as paragraph (b)(2)(xvi).
Paragraph (b)(2)(xxi)	Paragraph (b)(2)(xvii)	Redesignate paragraph (b)(2)(xxi) as paragraph (b)(2)(xvii).
Paragraph (b)(2)(xxii)	Paragraph (b)(2)(xviii)	Redesignate paragraph (b)(2)(xxii) as paragraph (b)(2)(xviii).
Paragraph (b)(2)(xxiii)	Paragraph (b)(2)(xix)	Redesignate paragraph (b)(2)(xxiii) as paragraph (b)(2)(xix).
Paragraph (b)(2)(xxiv)	Paragraph (b)(2)(xx)	Redesignate paragraph (b)(2)(xxiv) as paragraph (b)(2)(xx).
Paragraph (b)(2)(xxv)	Paragraph (b)(2)(xxi)	Redesignate paragraph (b)(2)(xxv) as paragraph (b)(2)(xxi).
Paragraph (b)(2)(xxvi)	Paragraph (b)(2)(xxii)	Redesignate paragraph (b)(2)(xxvi) as paragraph (b)(2)(xxii).
Paragraph (b)(2)(xxvii)	Paragraph (b)(2)(xxiii)	Redesignate paragraph (b)(2)(xxvii) as paragraph (b)(2)(xxiii).

The following paragraphs contain the NRC's evaluation of the changes to the Code editions and addenda (including new Code provisions) and Code Cases N–722–1 and N–770, where the NRC proposes to add new, revise existing, or remove conditions in 10 CFR 50.55a.

Quality Standards, ASME Codes and Institute of Electrical and Electronics Engineers (IEEE) Standards, and Alternatives

10 CFR 50.55a(a)

The NRC proposes to add the paragraph heading "Quality standards, ASME Codes and IEEE standards, and alternatives" to § 50.55a(a). This will be consistent with paragraph headings throughout 10 CFR 50.55a.

Applicant/Licensee-Proposed Alternatives to the Requirements of 10 CFR 50.55a

10 CFR 50.55a(a)(3)

The current regulations at § 50.55a(a)(3) do not clearly convey that alternatives to the requirements of §§ 50.55a(c), (d), (e), (f), (g), and (h) must be submitted to, and authorized by, the NRC prior to implementing the alternatives. Licensees have misinterpreted § 50.55a(a)(3) and erroneously concluded that it is permissible to obtain NRC authorization of an alternative after its implementation. The NRC proposes to add a sentence to § 50.55a(a)(3) to clarify that an alternative must be submitted to, and authorized by, the NRC prior to implementing the alternative.

Standards Approved for Incorporation by Reference

10 CFR 50.55a(b)

The NRC proposes to add the paragraph heading "Standards approved for incorporation by reference" to § 50.55a(b). This will be consistent with paragraph headings throughout 10 CFR 50.55a.

The question has arisen many times in the past of whether Subsection NE, "Class MC Components;" Subsection NF, "Supports;" Subsection NG, "Core Support Structures;" and Appendices of the ASME B&PV Code, Section III, are NRC requirements. The NRC is clarifying in this section how the regulations in 10 CFR 50.55a apply to these Section III subsections and appendices. This discussion sets forth the NRC's views regarding the applicable NRC requirements, clarifies which portions of Section III are approved for use by applicants and licensees, identifies which portions of Section III are NRC requirements, and which portions of Section III are not covered by the regulations in 10 CFR 50.55a. The requirements of Subsection NH, "Class 1 Components in Elevated Temperature Service," of Section III are already addressed in § 50.55a(b)(1)(vi), and the bases for these requirements have been discussed in the final rule (69 FR 58804) issued on October 1, 2004, that amended 10 CFR 50.55a to incorporate by reference the 2001 Edition up to and including the 2003 Addenda of the ASME Code, Section III.

First, it should be noted that in 10 CFR 50.55a, the NRC mandates the use of Section III, Division 1, rules for ASME Code Class 1, 2, and 3 components in 10 CFR 50.55a(c), (d) and (e), respectively. Specifically, 10 CFR 50.55a(c), (d) and (e) state that for applicants constructing a nuclear power plant, those components which are part of the reactor coolant pressure boundary must meet the requirements for Class 1 components in Section III (*e.g.,*

Subsection NB, "Class 1 Components"); components classified as Quality Group B must meet the requirements for Class 2 components (*e.g.,* Subsection NC, "Class 2 Components"); and components classified as Quality Group C must meet the requirements for Class 3 components (*e.g.,* Subsection ND, "Class 3 Components"). The NRC considers the rules of Subsection NCA and Section III mandatory appendices to be mandated as well, but only as they apply to Class 1, 2, and 3 components because the language in 10 CFR 50.55a(c), (d) and (e) also covers general requirements in Subsection NCA and mandatory appendices in Section III that are applicable to Class 1, 2, and 3 components.

In addition, the introductory text of 10 CFR 50.55a(b) states, in part, that the ASME Code, Section III, is approved for incorporation by reference by the Director of the Federal Register pursuant to 5 U.S.C. 552(a) and 1 CFR part 51. However, the regulatory language does not identify specific subsections in Section III that are incorporated by reference, and one can only assume that all of Section III (including all subsections, appendices and Division 2 and 3 rules) are incorporated by reference. Although it is clear that Subsections NB, NC and ND are regulatory requirements because they are mandated by 10 CFR 50.55a(c), (d) and (e) as discussed in this document, the lack of specific rule language in 10 CFR 50.55a mandating the use of Subsections NE, NF, and NG have created confusion about the regulatory requirements applicable to Subsections NE, NF, and NG. Subsection NE provides rules for constructing metal containment components (Class MC). Subsection NF provides rules for constructing supports for Class 1, 2, 3, and MC components. Subsection NG provides rules for constructing reactor core support structures. In this sense, "constructing" is an all-inclusive term that comprises the design, fabrication, installation, examination, testing, inspection and selection of materials for nuclear power plant components.

The NRC is, therefore, clarifying that when Subsections NE, NF and NG are incorporated by reference, but not mandated, these subsections are not NRC requirements. Rather, the NRC considers Subsections NE, NF and NG to be approved by the NRC for use by applicants and licensees of nuclear power plants by virtue of the NRC's overall approval of Section III, Division 1 rules without condition. In this manner, approval of the rules in Subsections NE, NF and NG is similar to regulatory guidance provided in NRC regulatory guides in that it provides an acceptable method for meeting NRC requirements and, in this particular case, in 10 CFR Part 50, Appendix A, General Design Criterion (GDC) 1, "Quality standards and records." Applicants and licensees may propose means other than those specified by the provisions in Subsections NE, NF and NG for meeting the applicable regulation. It should be noted that the NRC reviews an applicant's proposed means of meeting the requirements of GDC 1 as part of its review of an application for each manufacturing license, standard design approval, standard design certification and combined license under 10 CFR part 52 and for each construction permit and operating license under 10 CFR part 50 using the guidelines of NRC NUREG–0800, "Standard Review Plan [SRP] for the Review of Safety Analysis Reports for Nuclear Power Plants—LWR Edition." During its review of new reactor designs under 10 CFR part 52, the NRC is reviewing the criteria and extent of compliance of standard plant designs and combined licenses with the rules of the specific edition and addenda to Subsections NE, NF and NG for applicability to these new reactor designs. The process being used by the NRC in the review of Subsections NE, NF, and NG for new reactors as described in this document is essentially the same process used by the NRC for the licensing of all nuclear power plants since the SRP was first issued in 1975. Therefore, this clarification does not establish new positions or requirements in the regulatory application of Subsections NE, NF and NG to the construction of nuclear power plants.

Because the NRC staff participates on the ASME Code committees in the development of and revisions to Subsections NE, NF and NG, the NRC is cognizant of the acceptability of the Code rules applicable to Subsections NE, NF and NG. NRC use of consensus technical standards meets the requirements of Public Law 104–113, "National Technology Transfer and Advancement Act of 1995," which requires Federal agencies to use technical standards that are developed by voluntary consensus standards bodies, instead of government-unique standards, as a means to carry out policy objectives or activities determined by Federal agencies, unless contrary to law or the use of the standard is impractical.

Consistent with this discussion, the NRC does not propose to substantially change the language in the introductory text to 10 CFR 50.55a(b). The NRC proposes to modify the regulatory language in the introductory text of 10 CFR 50.55a(b) to clarify that non-mandatory appendices are excluded from Section III rules that are incorporated by reference because the NRC does not review the acceptability of non-mandatory Section III appendices. Similarly, the NRC proposes to clarify in the introductory text of 10 CFR 50.55a(b) that only Division 1 rules of Section III and Section XI are incorporated by reference (*i.e.,* Divisions 2 and 3 rules are not incorporated by reference and are not approved by the NRC regulations in 10 CFR 50.55a). The NRC is also proposing to incorporate by reference ASME Code Case N–722–1, "Additional Examinations for PWR Pressure Retaining Welds in Class 1 Components Fabricated With Alloy 600/82/182 Materials Section XI, Division 1," and Code Case N–770, "Alternative Examination Requirements and Acceptance Standards for Class 1 PWR [Pressurized-Water Reactor] Piping and Vessel Nozzle Butt Welds Fabricated with UNS N06082 or UNS W86182 Weld Filler Material with or without Application of Listed Mitigation Activities."

ASME B&PV Code, Section III

The NRC proposes to:

- Revise the current regulations in § 50.55a(b)(1), (b)(1)(ii), and (b)(1)(iii) to detail the specific ASME B&PV Code, Section III Subsections which are referenced in the ensuing paragraphs.
- Revise the current requirements in these paragraphs to include the latest editions and addenda incorporated into Section III of the ASME B&PV Code with respect to the regulations regarding seismic design.
- Clarify the current wording of the introductory text of § 50.55a(b)(1).
- Modify the current conditions in § 50.55a(b)(1)(ii) on the use of stress indices used for welds in piping design under Subarticles NB–3600, NC–3600, and ND–3600.
- Add three new requirements at § 50.55a(b)(1)(iii)(A), (b)(1)(iii)(B), and (b)(1)(iii)(C) to impose conditions on the use of Subarticles NB–3200, NB–3600, NC–3600 and ND–3600 identified in § 50.55a(b)(1)(iii).

Introductory Text to 10 CFR 50.55a(b)(1)

The proposed amendment to the introductory text of § 50.55a(b)(1) would revise the language to clarify that references to Section III refer to Section III of the ASME Boiler and Pressure Vessel Code.

10 CFR 50.55a(b)(1)(ii) and (b)(1)(iii) Weld-Leg Dimensions and Seismic Design of Piping

The current requirements regarding piping seismic rules in Section III the ASME B&PV Code were first introduced in the 1994 Addenda to the ASME B&PV Code. These rules were subsequently modified in the 2001 Edition and 2002 Addenda to the ASME B&PV Code. The current regulations in § 50.55a(b)(1)(ii) outline the conditions on the use of stress indices used for welds in piping design under Subarticles NB–3600, NC–3600, and ND–3600. The current regulations in § 50.55a(b)(1)(iii) only allow the use of ASME B&PV Code, Section III, 1993 Addenda and earlier editions with respect to Subarticles NB–3200, NB–3600, NC–3600, and ND–3600.

The current version of the ASME B&PV Code does not adequately address the seismic design requirements specified in Subparagraphs NB–3683.2(c), NB–3683.4(c)(1) and (c)(2), and Paragraph NB–3656, Figures NB–3222–1, NC–3673.2(b)–1, and ND–3673.2(b)–1 and Table 3681(a)–1 of the ASME B&PV Code. The proposed amendment would modify § 50.55a(b)(1)(ii) to address the NRC's concern about the undersized weld-leg dimension of less than 1.09t that makes the weld weaker than the pipe. Additional requirements regarding the stress indices identified in the proposed addition to the regulations (*i.e.* § 50.55a(b)(1)(iii)(A)) are warranted based on industry testing which supports the NRC's position. Additionally, the proposed requirement in § 50.55a(b)(1)(iii)(B) would resolve an issue identified by the NRC staff regarding the inclusion of reversing dynamic loads when calculating the primary bending stresses for Level B service limits. The proposed condition in § 50.55a(b)(1)(iii)(C) is part of the ASME B&PV Code requirements for applying the seismic design rules in Subarticles NB–3600, NC–3600, and ND–3600 in the 2006 Addenda through the 2008 Addenda.

The current regulations in § 50.55a(b)(1) and (b)(1)(iii) reference the current seismic design requirements of Section III of the ASME B&PV Code. The proposed modification would allow the use of the latest edition and addenda of Section III of the ASME B&PV Code with the three proposed additional requirements at § 50.55a(b)(1)(iii)(A), (b)(1)(iii)(B), and (b)(1)(iii)(C) which would provide three conditions on the use of the latest ASME B&PV Code edition and addenda. The current requirements in § 50.55a(b)(1)(ii) limit the use of certain stress indices used for welds in the piping design portions of Section III of the ASME B&PV Code. The proposed modification would also revise the current conditions on the use of the stress indices outlined in § 50.55a(b)(1)(ii).

The proposed condition identified in § 50.55a(b)(1)(ii) would address the NRC concerns with the undersized welds ($C_x = 0.75\ t_n$), which are not acceptable because the current ASME Code design rules would result in a circumferential, fillet-welded or socket-welded joint where the weld size is smaller than the adjoining pipe wall thickness. An editorial addition would also be included in the proposed condition and would reflect the addition of a condition on the use of paragraph NB–3683.4(c)(2). The use of paragraph NB–3683.4(c)(1) is currently not allowed and would continue to be prohibited in the proposed rulemaking. The addition of the condition on the use of paragraph NB–3683.4(c)(2) is purely editorial in nature since, by imposing a condition on the use of NB–3683.4(c)(1), the regulations would inherently impose a condition on the use of NB–3683.4(c)(2) given their use within Section III of the ASME B&PV Code. Therefore, this condition would not be new from a technical standpoint. Also, an editorial correction would be made regarding Footnote 11, which should be the Footnote 13 for the 2004 Edition through the 2008 Addenda in Figure NC–3673.2(b)–1 and Figure ND–3673.2(b)–1.

The proposed addition identified as § 50.55a(b)(1)(iii)(A) would address the NRC's position regarding the B_2' indices in paragraph NB–3656 of Section III of the ASME B&PV Code. The NRC proposes this condition to capture the dynamic strain aging effects that were reflected in the testing performed by Battelle Columbus Laboratories which concluded that ferritic steels tend to have lower margins and a decrease in toughness at higher temperatures due to dynamic strain aging. (*See* NUREG/CR–6226, "Effect of Dynamic Strain Aging on the Strength and Toughness of Nuclear Ferritic Piping at LWR Temperatures" for the Battelle testing results). Therefore, this additional requirement would provide the means necessary to prevent significant reductions in the margins of ferritic steel components (elbows and tees) at high temperatures, thus providing better assurance of the materials' structural integrity.

The proposed addition identified as § 50.55a(b)(1)(iii)(B) would address the NRC's position regarding Note (1) of Figure NB–3222–1 of Section III of the ASME B&PV Code. The NRC proposes this condition based on the premise that while the inclusion of reversing dynamic loads in the calculation of primary bending stresses for Level B service limits may not be warranted when the Operating Basis Earthquake is not included in the design basis for the facility, at other times these loads must be considered. Such is the case when a licensee's Operating Basis Earthquake level is more than one-third the value of the Safe Shutdown Earthquake. However, the current wording of Note (1) in Figure NB–3222–1 of Section III of the ASME B&PV Code does not account for this situation. Therefore, the NRC proposes to include this condition on the use of the latest addenda of Section III of the ASME B&PV Code.

The proposed addition identified as § 50.55a(b)(1)(iii)(C) would address the NRC's position regarding the limitation of D_o/t ratio of ASME Class 1, 2 and 3 piping when applying Subarticles NB–3600, NC–3600 and ND–3600 in the 2006 Addenda through the 2008 Addenda of Section III of the ASME B&PV Code. In the 1994 Addenda, the D_o/t ratio was identified by ASME Code Committee to be 50 or less for applying the seismic rules in Subarticles NB–3600, NC–3600 and ND–3600. This upper limit for D_o/t was revised to be 40 in the 2002 Addenda through the 2008 Addenda based on EPRI testing associated with reversing dynamic seismic loading. However, the 2007 Edition allows D_o/t to be greater than 50 in Note 1 to Table NB 3681(a)–1 and Note 3 to Figures NC/ND–3673.2(b)–1. NUREG–1367 limits D_o/t to no more than 50 for functional capability considerations. To ensure consistency with ASME B&PV Code requirements found in paragraphs NB–3656, NC–3655, and ND–3655, D_o/t should be limited to no more than 40. Furthermore, the use of D_o/t larger than 40 would be beyond the piping configuration included in the EPRI testing, and thus is not justified for design considerations. Therefore, the NRC concludes that the applicable D_o/t for the seismic design of piping as limited by the ASME B&PV Code in Subarticles NB–3600, NC–3600, and ND–3600 in the 2006 Addenda through the 2008 Addenda must not be greater than 40 as addressed in § 50.55a(b)(1)(iii)(C).

10 CFR 50.55a(b)(1)(iv) Quality Assurance

The proposed amendment would revise § 50.55a(b)(1)(iv) to be consistent with a revised quality assurance provision in the 2006 Addenda of the ASME B&PV Code, Section III,

Subsection NCA. The proposed amendment would allow the use of 1994 Edition of NQA–1, "Quality Assurance Requirements for Nuclear Facility Applications," when using the 2006 Addenda of Section III of the ASME B&PV Code and later editions and addenda. The reference to ASME NQA–1 in Article 4000 of the ASME B&PV Code, Section III was updated to a later edition of NQA–1 in the 2006 Addenda. NCA–4110(b) was revised to require that the N–Type Certificate Holders comply with the Basic Requirements and Supplements of the ASME NQA–1–1994 Edition. Previous editions/addenda of the ASME B&PV Code, Section III referenced earlier editions and addenda of ASME NQA–1. There are no significant differences between of NQA–1–1994 Edition and the editions and addenda of NQA–1 currently referenced in the regulation. The NRC has reviewed and found the changes to Subsection NCA that reference the 1994 Edition of NQA–1 to be acceptable.

10 CFR 50.55a(b)(1)(vii) Capacity Certification and Demonstration of Function of Incompressible-Fluid Pressure-Relief Valves (New)

The proposed addition identified as § 50.55a(b)(1)(vii) would modify requirements in Subsection NB of the ASME B&PV Code, Section III, for certifying the capacity of incompressible-fluid, pressure-relief valves when the testing facility has less than the full range of pressure capability necessary for achieving valve set-pressure conditions during the testing. In the 2006 Addenda, new requirements were added to the ASME B&PV Code, Section III, that have a parallel structure in paragraphs NB–7742, NC–7742, and ND–7742 for Class 1, 2, and 3 incompressible-fluid, pressure-relief valves, respectively. These new paragraphs address new valve designs having a range of possible sizes and set-pressure conditions. The method described in these paragraphs for performing the tests and evaluating data involves performing tests at less than the highest value of the set-pressure range, and establishing an incompressible fluid flow coefficient of discharge that then allows extrapolation of capacities to higher pressures.

These paragraphs are new, and did not exist in prior editions or addenda of the ASME B&PV Code, Section III. These new paragraphs address circumstances in which a certified test facility lacks the fluid-pressure capability at the necessary flow rate for testing a new, incompressible-fluid, pressure-relief valve design. The NRC has identified no issues with performing the tests at less than the highest value of the set-pressure range for incompressible-fluid, pressure-relief valves, and finds these new requirements for Class 2 and 3 components acceptable as described in paragraphs NC–7742 and ND–7742. However, the NRC has identified missing words from paragraph NB–7742 for Class 1 components. The parallel structure of the counterpart paragraphs (NC–7742 and ND–7742) reveals that the words "for the design and the maximum set pressure" are missing from subparagraph NB–7742(a)(2). Without these words, the paragraph is confusing, illogical, and could lead to a non-conservative interpretation of the required test pressures for new Class 1 incompressible-fluid, pressure-relief valve designs. Because the new paragraph NB–7742 does not contain the above-described words, the NRC finds that the paragraph is not acceptable for use. New Class 1 incompressible-fluid, pressure-relief valve designs must be tested at the highest values of set-pressure ranges as required by prior editions and addenda of the ASME B&PV Code, Section III.

ASME B&PV Code, Section XI

The current regulations in § 50.55a(b)(2) incorporate by reference ASME B&PV Code, Section XI, 1970 Edition through the 1976 Winter Addenda; and the 1977 Edition (Division 1) through the 2004 Addenda (Division 1), subject to the conditions identified in current § 50.55a(b)(2)(i) through (b)(2)(xxvii). The proposed amendment would revise the introductory text to § 50.55a(b)(2) to incorporate by reference the 2005 Addenda (Division 1) through the 2008 Addenda (Division 1) of the ASME B&PV Code, Section XI, clarify the wording, and remove or revise some of the conditions as explained in this document.

Introductory Text of 10 CFR 50.55a(b)(2)

The proposed amendment to the introductory text of § 50.55a(b)(2) would revise the language to clarify that references to Section XI refer to Section XI of the ASME Boiler and Pressure Vessel Code.

10 CFR 50.55a(b)(2)(i) Limitations on Specific Editions and Addenda (Current)

The NRC proposes to remove § 50.55a(b)(2)(i) from the current regulations. This paragraph currently specifies which addenda may be used when applying the 1974 and 1977 Editions of Section XI of the ASME B&PV Code. Section 50.55a(g)(4)(ii) requires that licensees' successive 120-month inspection intervals comply with the requirements of the latest edition and addenda of the code incorporated by reference in § 50.55a(b)(2). Subsequently, licensees are no longer using these older editions (1974 and 1977 Editions) and addenda of the ASME B&PV Code, and therefore the NRC proposes to remove this paragraph.

This paragraph will be replaced by the current § 50.55a(b)(2)(ii) which describes a method for determining the extent of examination of Code Class 1 piping welds for facilities where the application for a construction permit was docketed prior to July 1, 1978.

10 CFR 50.55a(b)(2)(iii) Steam Generator Tubing (Current)

The NRC proposes to remove § 50.55a(b)(2)(iii) from the current regulations. The current regulations in § 50.55a(b)(2)(iii) state that if the technical specifications of a nuclear power plant include surveillance requirements for steam generators different than those in Section XI, Article IWB–2000, the ISI program of steam generator tubing is governed by the requirements in the technical specifications. The 1989 Edition through the 2008 Addenda of Section XI IWB–2413, "Inspection Program for Steam Generator Tubing," state that "The examinations shall be governed by the plant Technical Specification." Since the condition in § 50.55a(b)(2)(iii) is redundant to the 1989 Edition through the 2008 Addenda of Section XI, the NRC proposes to remove this condition.

This paragraph will be replaced by the current § 50.55a(b)(2)(vii) which describes Section XI references to OM Part 4, OM Part 6 and OM Part 10 of the ASME OM Code.

10 CFR 50.55a(b)(2)(iv) Pressure-Retaining Welds in ASME Code Class 2 Piping (Current)

The NRC proposes to remove § 50.55a(b)(2)(iv) from the current regulations. This paragraph states how to select appropriate Code Class 2 pipe welds in residual heat removal systems, emergency core cooling systems, and containment heat removal systems when applying editions and addenda up to the 1983 Edition through the Summer 1983 Addenda of Section XI of the ASME B&PV Code. Section 50.55a(g)(4)(ii) requires that licensee's successive 120-month inspection intervals comply with the requirements of the latest edition and addenda of the code incorporated by reference in § 50.55a(b)(2). Subsequently, licensees

are no longer using these older editions and addenda of the code (editions and addenda up to the 1983 Edition through the Summer 1983 Addenda of Section XI), and therefore, the NRC proposes to remove the requirements of current § 50.55a(b)(2)(iv).

This paragraph will be replaced by the current § 50.55a(b)(2)(viii) which describes examinations of concrete containments.

10 CFR 50.55a(b)(2)(v) Evaluation Procedure and Acceptance Criteria for Austenitic Piping (Current)

The NRC proposes to remove § 50.55a(b)(2)(v) from the current regulations. This paragraph deals with evaluation procedures and acceptance criteria for austenitic piping when applying the Winter 1983 Addenda and the Winter 1984 Addenda of Section XI. Section 50.55a(g)(4)(ii) requires that licensees' successive 120-month inspection intervals comply with the requirements of the latest edition and addenda of the code incorporated by reference in § 50.55a(b)(2). Subsequently, licensees are no longer using these older editions and addenda of the code (editions and addenda up to the 1983 Edition through the Summer 1983 Addenda of Section XI), and therefore, the NRC proposes to remove the requirements of current § 50.55a(b)(2)(iv). This paragraph will be replaced by the current § 50.55a(b)(2)(ix) which describes examination of metal containments and the liners of concrete containments.

10 CFR 50.55a(b)(2)(vi) Effective Edition and Addenda of Subsection IWE and Subsection IWL, Section XI (Current); 10 CFR 50.55a(b)(2)(ii) (Redesignated)

The NRC proposes to redesignate § 50.55a(b)(2)(vi) in the current rule to § 50.55a(b)(2)(ii) in the proposed rule. This paragraph stipulates the editions and addenda of Subsection IWE and Subsection IWL of Section XI of the ASME B&PV Code which are approved for use when licensees are implementing the initial 120-month inspection interval for containment inservice inspection requirements found in Section XI of the Code. The current paragraph also indicates that the use of these applicable editions and addenda is subject to the conditions found in § 50.55a(b)(2)(viii) and (b)(2)(ix) for Subsection IWL and Subsection IWE, respectively. The proposed rule would redesignate § 50.55a(b)(2)(viii) and (b)(2)(ix) as § 50.55a(b)(2)(iv) and (b)(2)(v), respectively, and conforming changes would be made to the references contained in redesignated § 50.55a(b)(2)(ii). Additionally, the proposed rule would change the words "modified and supplemented" to "conditioned" for clarification purposes.

10 CFR 50.55a(b)(2)(viii) Examination of Concrete Containments (Current); 10 CFR 50.55a(b)(2)(iv) (Redesignated)

The NRC proposes to redesignate § 50.55a(b)(2)(viii) in the current rule to § 50.55a(b)(2)(iv) in the proposed rule. This paragraph stipulates the conditions that apply to the inservice examination of concrete containments using Subsection IWL of various editions and addenda of the ASME B&PV Code, Section XI, incorporated by reference in § 50.55a(b)(2). The current regulations, in part, require that licensees applying Subsection IWL, 2001 Edition through the 2004 Edition shall apply the conditions in § 50.55a(b)(2)(viii)(E) through (b)(2)(viii)(G). The NRC proposes to remove the conditions in redesignated § 50.55a(b)(2)(iv)(F) and (b)(2)(iv)(G) of the proposed rule when applying Subsection IWL of the 2007 Edition with 2008 addenda of the ASME B&PV Code, Section XI because the intent of these conditions has been incorporated into the 2007 Edition with the 2008 addenda of the ASME B&PV Code, as explained in this document. Accordingly, the proposed rule would require that licensees applying Subsection IWL, 2007 Edition with the 2008 Addenda shall apply only the condition in redesignated § 50.55a(b)(2)(iv)(E). Further, in the proposed rule, the conditions in redesignated § 50.55a(b)(2)(iv)(E) through (b)(2)(iv)(G) remain applicable to licensees applying Subsection IWL, 2004 Edition through the 2006 Addenda.

The condition in the redesignated § 50.55a(b)(2)(iv)(F) relates to qualification of personnel that examine containment concrete surfaces and tendon hardware, wires, or strands. This condition in the current regulations states that personnel that examine containment concrete surfaces and tendon hardware, wires, or strands must meet the qualification provisions in IWA–2300, and that the "owner-defined" personnel qualification provisions in IWL–2310(d) are not approved for use. IWA–2300 stipulates qualification provisions for personnel performing nondestructive examination, including VT–1, VT–2, and VT–3 visual examinations. Paragraph IWA–2312(c) requires training, qualification, and certification of visual examination personnel to comply with the requirements of Appendix VI of the Code, which makes reference to ANSI/ASNT CP–189, and allows for limited certification (for personnel who are restricted to performing examinations of limited or specific scope, *i.e.,* limited operations or limited techniques) per IWA–2350.

In Subsection IWL of the 2007 Edition, the ASME revised paragraph IWL–2100 to state, in part, that except as noted in IWL–2320, the requirements of IWA–2300 do not apply. Also, the 2007 Edition deleted subparagraphs IWL–2310(d) and IWL–2310(e), which allowed certain requirements (*i.e.,* requirements for personnel qualification and requirements for visual examination of concrete and tendon anchorage hardware, wires, or strands) to be owner-defined. Further, the 2007 Edition with 2008 Addenda added a new paragraph IWL–2320 "Personnel Qualifications" and re-designated the former IWL–2320 "Responsible Engineer" as IWL–2330 "Responsible Engineer."

The new paragraph IWL–2320 stipulates specific plant experience, training, written and practical examination and frequency of administration to demonstrate training proficiency, and vision test requirements for qualification of personnel approved by the Responsible Engineer for performing general or detailed visual examinations of structural concrete, reinforcing steel and post-tensioning system components (*i.e.,* wires, strands, anchorage hardware, corrosion protection medium and free water) of Class CC containments. The provision requires documentation of qualification requirements in the Employer's written practice. The Responsible Engineer is responsible for approval, instruction and training of personnel performing general and detailed visual examinations. The new provision also provided the requisite detailed requirements for the instruction material to be used to qualify personnel performing IWL inspections. Specifically, the addition included requirements for preservice and inservice inspections for concrete (references American Concrete Institute 201.1R), reinforcing steel, and post-tensioning items such as wires, strands, anchorage hardware, corrosion protection medium, and free water. Thus, the qualification requirements adequately include the areas and extent of required plant experience, instructional topics for classroom training in IWL requirements and plant-specific IWL visual examination procedures, and require the vision test requirements of IWA–2321. The new paragraph IWL–2320, "Personnel Qualifications," details specific

guidance for personnel qualification for containment concrete and reinforcing steel and post-tensioning system visual inspections that provide an acceptable level of quality and safety similar to the requirements in IWA–2300 and therefore, addressed the intent of the conditions in § 50.55a(b)(2)(viii)(F) of the current regulations. Therefore, the condition in redesignated § 50.55a(b)(2)(iv)(F) is not required to be applied for licensees using Subsection IWL, 2007 Edition with the 2008 Addenda. It is noted that the NRC's acceptance of the new code provision IWL–2320, "Personnel Qualifications," is based on paragraph IWL–2320 of the 2007 Edition as supplemented by the addition by errata in the 2008 addenda.

The condition in redesignated § 50.55a(b)(2)(iv)(G) of the proposed rule requires that corrosion protection material be restored following concrete containment post-tensioning system repair and replacement activities in accordance with the quality assurance program requirements specified in IWA–1400." In the 2007 Edition of Subsection IWL, the following revisions were made related to corrosion protection medium for post-tensioning systems:

1. The revised paragraph IWL 4110 added footnote 1 which states that the corrosion protection medium is exempt from the requirements of IWL–4000. However, corrosion protection medium must be restored in accordance with IWL–2526 following concrete containment post-tensioning system repair/replacement activities.

2. The revised Line Item L2.40 "Corrosion Protection Medium" of Table IWL–2500–1 added reference to paragraph IWL–2526 in the columns for Test or Examination Requirement, Test or Examination Method, and Extent of Examination.

3. In the revised paragraph IWL–2526, subparagraph (b) requires that following the completion of tests and examinations required by Examination Category L–B, Items L2.10, L.2.20, and L2.30, the corrosion protection medium must be replaced to ensure sufficient coverage of anchorage hardware, wires, and strands. The total amount replaced in each tendon sheath must be recorded and differences between amount removed and amount replaced must be documented.

4. In the revised paragraph IWL–2526, subparagraph (d) requires that the Responsible Engineer specify the method for corrosion protection medium.

With the understanding that the Responsible Engineer (who per IWL–2320 is a Registered Professional Engineer) will ensure that the corrosion protection medium is restored in accordance with the applicable Quality Assurance Program, the revised paragraphs IWL–4110(b)(3) [with footnote 1] and IWL–2526, and revised line item L2.40 in Table IWL–2500–1 of Subsection IWL, 2007 Edition through the 2008 Addenda adequately incorporated the intent of the condition in § 50.55a(b)(2)(viii)(G) of the current regulations and is acceptable to the NRC. Therefore, the condition in redesignated § 50.55a(b)(2)(iv)(G) is not required to be applied for licensees using Subsection IWL, 2007 Edition through the 2008 Addenda.

10 CFR 50.55a(b)(2)(ix) Examination of Metal Containments and the Liners of Concrete Containments (Current); 10 CFR 50.55a(b)(2)(v) (Redesignated)

The NRC proposes to redesignate § 50.55a(b)(2)(ix) as § 50.55a(b)(2)(v). This paragraph stipulates the conditions that apply to the inservice examination of metal containments and liners of concrete containments using Subsection IWE of various editions and addenda of the ASME B&PV Code, Section XI, incorporated by reference in § 50.55a(b)(2). The NRC proposes to remove the conditions in newly redesignated § 50.55a(b)(2)(v)(F), (b)(2)(v)(G), (b)(2)(v)(H) and (b)(2)(v)(I) when applying the 2004 Edition with 2006 Addenda through the 2007 Edition with 2008 Addenda of the ASME Code, Section XI because these conditions have now been incorporated into the Code. The NRC further proposes to remove the condition in redesignated § 50.55a(b)(2)(v)(I) when applying the 2004 Edition, up to and including, the 2005 Addenda. The NRC also proposes to add a new condition as § 50.55a(b)(2)(v)(J) on the use of Article IWE–5000 of Subsection IWE when applying the 2007 Edition, up to and including the 2008 Addenda of the ASME Code, Section XI. These proposed changes are further explained in this document.

The current regulations, in part, require that licensees applying Subsection IWE, 1998 Edition through the 2004 Edition apply the conditions in § 50.55a(b)(2)(ix)(A), (b)(2)(ix)(B), and (b)(2)(ix)(F) through (b)(2)(ix)(I). In the proposed rule, the conditions in newly redesignated § 50.55a(b)(2)(v)(F) through (b)(2)(v)(I) would remain applicable to licensees applying Subsection IWL, 1998 Edition through the 2001 Edition with the 2003 Addenda. As a minor correction to the current regulations, the proposed rule would require that licensees applying Subsection IWE of the 2004 Edition through the 2005 Addenda of the ASME B&PV Code, satisfy the requirements of newly redesignated § 50.55a(b)(2)(v)(A), (b)(2)(v)(B), and (b)(2)(v)(F) through (b)(2)(v)(H). This correction is being made since paragraph IWE–3511.3 of the 2004 Edition of the ASME B&PV Code incorporated the condition in newly redesignated § 50.55a(b)(2)(v)(I), which requires that the ultrasonic examination acceptance standard specified in IWE–3511.3 for Class MC pressure-retaining components must also be applied to metallic liners of Class CC pressure-retaining components. Further, the proposed rule would require that licensees applying Subsection IWE, 2004 Edition with the 2006 Addenda through the latest edition and addenda incorporated by reference in § 50.55a(b)(2) satisfy the requirements of newly redesignated § 50.55a(b)(2)(v)(A) and (b)(2)(v)(B). This is because the intent of the conditions in newly redesignated § 50.55a(b)(2)(v)(F) through (b)(2)(v)(H) were incorporated into Subsection IWE, 2004 Edition with the 2006 addenda, and the condition in newly redesignated § 50.55a(b)(2)(v)(I) was incorporated into Subsection IWE, 2004 Edition, as explained in this document.

The condition in redesignated § 50.55a(b)(2)(ix)(F) of the proposed rule requires that VT–1 and VT–3 examinations be conducted in accordance with IWA–2200. Personnel conducting examinations in accordance with the VT–1 or VT–3 examination method must be qualified in accordance with IWA–2300, and the "owner-defined" personnel qualification provisions in IWE–2330(a) for personnel that conduct VT–1 and VT–3 examinations are not approved for use. This condition defines the code provision (IWA–2200) and personnel qualification (IWA–2300) requirements for personnel performing visual examinations by the VT–1 or VT–3 method, as specified in the conditions in redesignated § 50.55a(b)(2)(v)(G) and (b)(2)(v)(H) of the proposed rule. The condition does not allow use of the "owner-defined" personnel qualification provisions in IWA–2330(a) for personnel that conduct VT–1 and VT–3 examinations. The revised code provision in IWE–2330(a) of the 2006 Addenda requires that personnel performing VT–1 and VT–3 visual examinations shall meet the qualification requirements of IWA–2300. The revised code provision in IWL–2100 of the 2006 Addenda states that IWA–2000 applies with the exception that IWA–2210 and IWA–

2300 do not apply to general visual examination only (except as required by 2330(b) for vision test requirements). Therefore, the code provisions in IWA–2200 and IWA–2300 will apply to VT–1 and VT–3 examinations. Thus, the revised code provisions in IWE–2330(a) and IWE–2100 of the 2006 through 2008 Addenda fully incorporates the condition in newly redesignated § 50.55a(b)(2)(v)(F). Therefore, the condition in newly redesignated § 50.55a(b)(2)(v)(F) is not required to be applied for licensees using Subsection IWE, 2004 Edition with the 2006 Addenda and the 2007 Edition through the 2008 Addenda.

The condition in redesignated § 50.55a(b)(2)(v)(G) of the proposed rule requires that the VT–3 examination method be used to conduct the examinations in Items E1.12 and E1.20 of Table IWE 2500–1, and the VT–1 examination method be used to conduct the examination in Item E4.11 of Table IWE–2500–1. An examination of the pressure-retaining bolted connections in Item E1.11 of Table IWE–2500–1 using the VT–3 examination method must be conducted once each interval. The "owner-defined" visual examination provisions in IWE–2310(a) are not approved for use for VT–1 and VT–3 examinations. This condition, applicable in the current regulations to the 1998 Edition through the 2004 Edition, requires that the VT–3 and VT–1 examination methods be used in lieu of the "General Visual" and "Detailed Visual" methods, respectively, as specified in Table IWE–2500–1 for the Item Numbers listed in the condition, and that the owner-defined visual examination provisions in IWE–2310(a) cannot be used for VT–1 and VT–3 examinations. In the 2006 Addenda through the 2008 Addenda, Table IWE–2500–1 was revised to change the examination method for Item Numbers E1.12 and E1.20 to the VT–3 method and for Item E4.11 to the VT–1 method. Also, a new Examination Category E–G was added for pressure-retaining bolting with Item No. E8.10 which requires 100 percent of each bolted connection to be examined, using the VT–1 method and the acceptance standard in the newly added paragraph IWE–3530, once during each Inspection Interval with the connection assembled and bolting in-place, provided the connection is not disassembled during the interval, or in the disassembled configuration if the connection is disassembled for any reason during the interval. This VT–1 examination, which is more stringent than the VT–3 method specified in the condition, is in addition to the general visual examination of 100 percent of the pressure-retaining bolted connections during each inspection period required to be performed under Item No. E1.11 of Table IWE–2500–1. Further, the revised IWL–2310 does not have any owner-defined provisions for performing visual examinations including VT–1 and VT–3 examinations. Thus, the provisions in the revised Table IWE–2500–1 and the revised paragraph IWE–2310 addressed the intent of the condition in newly redesignated § 50.55a(b)(2)(v)(G). Therefore, the condition in newly redesignated § 50.55a(b)(2)(v)(G) is not required to be applied for licensees using Subsection IWE, 2004 Edition with the 2006 Addenda and the 2007 Edition through the 2008 Addenda.

The condition in redesignated § 50.55a(b)(2)(v)(H) of the proposed rule requires that containment bolted connections that are disassembled during the scheduled performance of the examinations in Item E1.11 of Table IWE–2500–1 be examined using the VT–3 examination method. Flaws or degradation identified during the performance of a VT–3 examination must be examined in accordance with the VT–1 examination method, and the criteria in the material specification or IWB 3517.1 must be used to evaluate containment bolting flaws or degradation. As an alternative to performing VT–3 examinations of containment bolted connections that are disassembled during the scheduled performance of Item E1.11, VT–3 examinations of containment bolted connections may be conducted whenever containment bolted connections are disassembled for any reason. The condition in newly redesignated § 50.55a(b)(2)(v)(H) is similar to the condition for bolted connections in newly redesignated § 50.55a(b)(2)(v)(G), but applies only to examination of pressure-retaining bolted connections that are disassembled. The condition requires flaws or degradation identified during the VT–3 examination to be examined using the VT–1 method. The NRC notes that the VT–1 (and not VT–3) examination method is the method specified in the new Item E8.10 for pressure-retaining bolted connections in the revised Table IWE–2500–1 in the 2006 Addenda through 2008 Addenda of the ASME B&PV Code. Further, the acceptance standard for the VT–1 examination of pressure-retaining bolting in the new paragraph IWE–3530 requires that the relevant conditions, as defined in IWA–9000, and listed in IWB–3517.1, shall be corrected or evaluated to meet the requirements of IWE–3122, prior to continued service. Therefore, the new provision for pressure-retaining bolting in Table IWE 2500–1, as discussed in this document, and the new acceptance standard specified in IWE–3530, as discussed in this document, fully addressed the intent of the condition in newly redesignated § 50.55a(b)(2)(v)(H). Therefore, the condition in newly redesignated § 50.55a(b)(2)(v)(H) is not required to be applied for licensees using Subsection IWE, 2004 Edition with the 2006 Addenda and the 2007 Edition through the 2008 Addenda.

The condition in redesignated § 50.55a(b)(2)(ix)(I) of the proposed rule requires that the ultrasonic examination acceptance standard specified in IWE–3511.3 for Class MC pressure-retaining components also be applied to metallic liners of Class CC pressure-retaining components. This condition requires that the acceptance standard in IWE–3511.3 also apply to the metallic shell and penetration liners of Class CC pressure-retaining components in the re-designated paragraph IWE–3522, "Ultrasonic Examination," in the 2004 Edition through the 2007 Edition and 2008 Addenda. Therefore, the condition in newly redesignated § 50.55a(b)(2)(v)(I) is not required to be applied for licensees using Subsection IWE, 2004 Edition through the 2007 Edition and the 2008 Addenda.

Although the revised paragraph IWE–2310 (IWE–2313 to be specific) and new subparagraphs IWE–2420(c) and IWE–2500(d), in the 2006 Addenda through the 2008 Addenda, address the condition in newly redesignated § 50.55a(b)(2)(v)(A) of the proposed rule with regard to requiring evaluation of acceptability of inaccessible areas when conditions exists in accessible areas that could indicate the presence or result in degradation to such inaccessible areas, the NRC has retained the condition in the proposed rule, since the information specified in the condition to be provided in the ISI Summary Report are not explicitly addressed in the ASME B&PV Code.

10 CFR 50.55a(b)(2)(v)(J) (New)

The NRC proposes to add a new § 50.55a(b)(2)(v)(J) to place a condition on the use of Article IWE–5000, "System Pressure Tests," of Subsection IWE when applying the 2007 Edition up to and including the 2008 Addenda of the ASME Code, Section XI. The revised Article IWE–5000 does not make a distinction between "major" and "minor" modification (or repair/replacement) with regard to the type of pneumatic leakage tests specified following repair/replacement activities. It requires a pneumatic leakage test to be performed

following welding or brazing associated with repair or replacement activities, prior to returning the component to service. However, it allows a licensee the option of only performing a local bubble test even for a "major" containment modification or repair/replacement. Following "major" containment repair/replacement activities, it makes the performance of the appropriate pneumatic leakage test (which is a Type A test) in accordance with 10 CFR part 50, appendix J, optional, and hence the NRC proposes to add a new condition in this rule. It is the NRC's position that a 10 CFR part 50, appendix J, Type A test or alternatively, a short duration structural test, must be performed following a "major" containment modification or repair/replacement, prior to returning the containment to operation. This is because a "major" containment modification such as the replacement of a large penetration or the creation of large construction opening(s) for equipment replacement results in the breach of the containment pressure boundary that invalidates the periodic verification of structural and leak tight integrity provided by the previous Type A test as required by the Containment Leakage Rate Testing Program in 10 CFR part 50, appendix J. Further, the breach of pressure boundary of the magnitude resulting from a "major" containment modification has a global effect on containment structural integrity and not a localized effect. Therefore, performing a Type A test or an alternate short duration structural test, prior to returning to operation, is necessary to provide a reasonable assurance and verification of containment structural and leakage integrity following restoration of a breach in the containment pressure boundary due to a "major" repair/replacement activity. Thus, the new condition in § 50.55a(b)(2)(v)(J) of the proposed rule will require the performance of Type A test, or short duration structural test, following a "major" containment modification.

The proposed new condition would provide a general, qualitative definition of what constitutes a "major" modification or repair/replacement activity for containments. The proposed condition would also define the combination of actions that would constitute an acceptable, alternate short-duration structural test that may be performed in lieu of a Type A test following a major containment modification. These proposed requirements to perform a Type A test, or alternate short-duration structural test, following a "major" containment modification are consistent with the NRC's position and condition in Section 4.1.4 and Section 3.1.4 of the Final Safety Evaluation by the Office Of Nuclear Reactor Regulation dated June 25, 2008 (ADAMS No. ML081140105), on Topical Report NEI 94–01, Revision 2, "Industry Guideline for Implementing Performance-Based Option of 10 CFR Part 50, Appendix J." The new condition would also require that, when applying IWE–5000, if a Type A, B or C test is performed in accordance with 10 CFR part 50, appendix J, the acceptance standard for the test shall also be in accordance with 10 CFR part 50, appendix J. This is because the acceptance standard for leakage in IWE–5223.5 is based only on Section V, Article 10, for any pneumatic leakage test performed when applying IWE–5000 of the 2007 Edition up to and including the 2008 Addenda of Section XI of the ASME Code. The requirement in the new condition for performing a Type A test or an alternate short duration structural test, prior to returning to operation following a major containment modification, is necessary to provide a reasonable assurance and verification of containment structural and leakage integrity following restoration of a breach in the containment pressure boundary due to the "major" repair/replacement activity.

10 CFR 50.55a(b)(2)(xv) Appendix VIII Specimen Set and Qualification Requirements (Current); 10 CFR 50.55a(b)(2)(xi) (Redesignated)

The NRC proposes to redesignate § 50.55a(b)(2)(xv) as § 50.55a(b)(2)(xi) and revise the current regulations so the current conditions in that paragraph would not apply to the 2007 Edition through the 2008 Addenda of Section XI of the ASME B&PV Code. The current regulation has conditions that may be used to modify Appendix VIII of Section XI, 1995 Edition through the 2001 Edition. The ASME Boiler and Pressure Vessel Code Committees took action to address these conditions in the 2007 Edition of the Code and revised Appendix VIII to address the NRC's concerns with specimen sets and qualification requirements. Therefore, the conditions are not required when using the 2007 Edition through the 2008 Addenda of the ASME B&PV Code, and the NRC is proposing that the current § 50.55a(b)(2)(xv) should be revised not to apply these conditions when using the 2007 Edition through the 2008 Addenda of the ASME B&PV Code.

10 CFR 50.55a(b)(2)(xviii) Certification of NDE Personnel (Current); 10 CFR 50.55a(b)(2)(xiv) (Redesignated)

The NRC proposes to redesignate § 50.55a(b)(2)(xviii)(B) as § 50.55a(b)(2)(xiv)(B) and revise the current regulations so the current condition in that paragraph would not apply to the 2007 Edition through the 2008 Addenda of Section XI of the ASME B&PV Code. Section 50.55a(b)(2)(xviii)(B) in the current regulations limits the activities that can be performed by NDE personnel certified in accordance with IWA–2316 of the 1998 Edition through the 2004 Addenda of the ASME B&PV Code. These personnel are limited to observing for leakage during system leakage and hydrostatic tests conducted in accordance with IWA–5211(a) and (b). The ASME Boiler and Pressure Vessel Code Committees took action to address this, and modified IWA 2316 in the 2005 Addenda and the 2007 Edition to limit the activities performed by personnel qualified in accordance with IWA–2316. Therefore, the condition is not required when using the 2007 Edition through the 2008 Addenda. Accordingly, the NRC is proposing that the current § 50.55a(b)(2)(xviii)(B) be revised for this condition not to apply when using the 2007 Edition through the 2008 Addenda of the ASME B&PV Code.

The NRC proposes to redesignate § 50.55a(b)(2)(xviii)(C) as § 50.55a(b)(2)(xiv)(C) and revise the current requirement so the current condition in that paragraph would not apply to the 2005 Addenda through the 2008 Addenda of Section XI of the ASME B&PV Code. This paragraph in the current regulations places conditions on the qualification of VT–3 examination personnel certified under paragraph IWA–2317 of the 1998 Edition through the 2004 Addenda. The regulation requires the administering of an initial qualification examination to demonstrate proficiency of this training, and administering subsequent examinations on a 3-year interval. The ASME Boiler and Pressure Vessel Code Committees took action to address this condition and modified IWA–2317 in the 2005 Addenda of the ASME B&PV Code to require a written examination for initial qualification and at least every 3 years thereafter for VT–3 qualification. Therefore, the condition is not required when using the 2005 Addenda through the 2008 Addenda.

10 CFR 50.55a(b)(2)(xix) Substitution of Alternative Methods (Current); 10 CFR 50.55a(b)(2)(xv) (Redesignated)

The NRC proposes to redesignate § 50.55a(b)(2)(xix) as § 50.55a(b)(2)(xv) and revise the current regulations so the current conditions for the substitution of alternative examination methods in that paragraph would not apply when using the 2005 Addenda through the 2008 Addenda. The conditions in current § 50.55a(b)(2)(xix) do not allow the use of Section XI, IWA 2240 of the 1998 Edition through the 2004 Edition of the ASME B&PV Code. These conditions also do not allow the use of IWA–4520(c) of the 1997 Addenda through the 2004 Edition of Section XI of the ASME B&PV Code. In 2005, the ASME Boiler and Pressure Vessel Code Committees took action to address these conditions and modified IWA–2240 and deleted IWA–4520(c) in the 2005 Addenda, such that, alternative examination methods or newly developed techniques are not allowed to be substituted for the methods specified in the construction code. Therefore, these conditions are not required when using the 2005 Addenda through the 2008 Addenda.

In newly redesignated § 50.55a(b)(2)(xv), the NRC is also proposing to impose the condition that paragraphs IWA–4520(b)(2) and IWA–4521 of the 2007 Edition of Section XI, Division 1, of the ASME B&PV Code, with the 2008 Addenda are not approved for use. In the 2008 Addenda of Section XI of the ASME B&PV Code, the ASME added new provisions in IWA 4520(b)(2) and IWA–4521 that allow the substitution of ultrasonic examination (UT) for radiographic examination (RT) specified in the Construction Code. Substitution of UT for RT as addressed in paragraph IWA–4520(b)(2) of the ASME B&PV Code, Section XI, for the repair/replacement welds in 2008 Addenda is of a concern to the NRC because, depending on flaw type (*i.e.,* volumetric or planar) and orientation, UT and RT are not equally effective for flaw detection and characterization. The NRC had originally identified concerns relative to the calibration blocks to be used, and developed two conditions that appear in Regulatory Guide 1.84, "Design, Fabrication, and Materials Code Case Acceptability, ASME Section III, Proposed Revision 34."

RT is effective in detecting volumetric-type flaws (*e.g.,* slag, porosity, root concavity, and misalignment), planar type flaws with large openings (*e.g.,* lack of fusion and large cracks in high stressed areas), and those flaws that are oriented in a plane parallel to the X-ray beam. RT is effective in all materials common to the nuclear industry for detecting the type of flaws generated during construction, due to workmanship issues and, therefore, ensures an acceptable level of weld quality and safety at the time of construction. In contrast, UT is most effective in detecting and sizing planar-type flaws associated with inservice degradation due to, for example, fatigue or stress corrosion cracking. Significant advances have recently been made regarding the use of UT to detect flaws in cast stainless steel. However, the ASME Code provisions addressing the inspection of cast stainless steels are still under development and are, therefore, not yet published for use. Finally, UT requires more surface scanning area than RT to perform examinations.

To ensure that a UT technique would be capable of detecting typical construction flaws, the NRC would require a licensee to demonstrate, through performance-based ASME B&PV Code, Section XI, Appendix VIII-like requirements, its capability of identifying the construction flaws which are easily detected by RT. Performance-based qualifications require demonstrations on mockups having flaws with realistic UT responses and with a statistically sufficient number of representative flaws and non-flawed volumes to establish procedure effectiveness and personnel skill. The statistical approach to qualification has been shown to improve the reliability of inspections, to improve the probability of flaw detection, and to reduce the number of false calls. The addition of only two or three construction flaws to a demonstration is not sufficient to capture the variety of flaws common to construction or to statistically evaluate procedure effectiveness and personnel skills.

The NRC is concerned that using the second leg of the ultrasound metal path (V-path) to achieve two direction scanning from only one side of the weld may not be adequate in detecting construction flaws. Single side examinations have not been demonstrated for construction flaws for any material. Single side examinations of welds have been successfully qualified for planar flaws in ferritic carbon and low alloy steels but have not been reliably demonstrated for austenitic stainless steel and nickel alloys.

Based on this information, the NRC concludes that the substitution of UT for RT may not be adequate for detecting some construction flaws, specifically in single-V full penetration groove welds. Therefore, substitution of UT for RT is not generically acceptable. This position is consistent with the NRC's previous position with respect to the review of ASME Code Case N–659–1, which is published in Regulatory Guide 1.193, Revision 2, "ASME Code Cases not Approved for Use." Accordingly, the NRC proposes to impose the condition that paragraphs IWA–4520(b)(2), and IWA–4521 of the 2007 Edition of Section XI, Division 1, with 2008 Addenda are not approved for use.

10 CFR 50.55a(b)(2)(xxiv) Incorporation of the Performance Demonstration Initiative and Addition of Ultrasonic Examination Criteria (Current); 10 CFR 50.55a(b)(2)(xx) (Redesignated)

The NRC proposes to redesignate § 50.55a(b)(2)(xxiv) as § 50.55a(b)(2)(xx) and revise the current regulations not to apply the current condition when using the 2007 Edition through the 2008 Addenda. Current § 50.55a(b)(2)(xxiv) prohibits the use of Appendix VIII, the supplements of Appendix VIII and Article I–3000 of ASME B&PV Code, 2002 Addenda through the 2004 Edition. In 2007, the ASME Boiler and Pressure Vessel Code Committees took action to address this condition and modified Appendix VIII and its Supplements in the 2007 Edition. Therefore, the condition is not required when using the 2007 Edition through the 2008 Addenda, and the NRC proposes to eliminate this condition when using the 2007 Edition through the 2008 Addenda.

10 CFR 50.55a(b)(2)(xxvii) Removal of Insulation (Current); 10 CFR 50.55a(b)(2)(xxii) (Redesignated)

The NRC proposes to redesignate § 50.55a(b)(2)(xxvii) as § 50.55a(b)(2)(xxiii) and revise the paragraph to refer to IWA–5242 of the 2003 Addenda through the 2006 Addenda or IWA–5241 of the 2007 Edition through the 2008 Addenda of Section XI of the ASME B&PV Code for performing VT–2 visual examination of insulated components in systems borated for the purpose of controlling reactivity. The current regulations at § 50.55a(b)(2)(xxvii) place specific requirements on when insulation must be removed to visually examine insulated components in accordance with IWA–5242. In the 2007 Edition of the ASME B&PV Code, Section XI, paragraph IWA–5242 was deleted and these requirements were included in paragraph IWA–5241.

10 CFR 50.55a(b)(2)(xxiv) Analysis of Flaws (New)

The NRC proposes to add a new § 50.55a(b)(2)(xxiv) to place conditions on the use of Section XI, Nonmandatory Appendix A, "Analysis of Flaws." The proposed regulation would place a condition on the use of Appendix A related to the fatigue crack growth rate calculation for subsurface flaws defined in paragraph A–4300(b)(1) when the ratio of the minimum cyclic stress to the maximum cyclic stress (R) is less than zero. The fatigue crack growth rate, da/dN, is defined as follows when using Equation (1) in paragraph A–4300(a) and Equation (2) in paragraph A–4300(b)(1):

$da/dN = 1.99 \times 10^{-10}\ S\ (\Delta K_I)^{3.07}$, where S is a scaling parameter and ΔK_I is the range of applied stress intensity factor

S and ΔK_I are defined in A–4300(b)(1) of the ASME B&PV Code, Section XI, Appendix A as follows:

For $-2 \leq R \leq 0$ and $K_{max} - K_{min} \leq 1.12\ \sigma_f \sqrt{(\pi a)}$, $S = 1$ and $\Delta K_I = K_{max}$

For $R < -2$ and $K_{max} - K_{min} \leq 1.12\ \sigma_f \sqrt{(\pi a)}$, $S = 1$ and $\Delta K_I = (1–R)\ K_{max}/3$

For $R < 0$ and $K_{max} - K_{min} > 1.12\ \sigma_f \sqrt{(\pi a)}$, $S = 1$ and $\Delta K_I = K_{max}—K_{min}$

The above guidelines permit reduction of ΔK_I from the value of $(K_{max} - K_{min})$ when $K_{max} - K_{min} \leq 1.12\ \sigma_f \sqrt{(\pi a)}$. This is adequate if the material property σ_f is from test-based data of the component material and if the geometry of the cracked component can be modeled as an edge crack in a half plane, so that the formula $K = 1.12\ \sigma \sqrt{(\pi a)}$ applies. In most ASME B&PV Code, Section XI, Appendix A applications, test-based σ_f is not available, and the generic value from the ASME B&PV Code tabulations is used. Further, the geometry of a subsurface flaw in a plate differs significantly from the model of an edge crack in a half plane. Consequently, for the case where full ΔK_I should be used, the calculation in accordance with ASME B&PV Code, Section XI, Appendix A may show that $K_{max} - K_{min} \leq 1.12\ \sigma_f \sqrt{(\pi a)}$ and prompt a wrongful reduction of ΔK_I.

To address the use of the generic σ_f value instead of the test-based value for the cracked component and the significant difference between the cracked component geometry and the cracked test-specimen geometry on which the criterion of $1.12\ \sigma_f \sqrt{(\pi a)}$ is derived, the NRC proposes to revise the criterion of $1.12\ \sigma_f \sqrt{(\pi a)}$ to 0.8 times $1.12\ \sigma_f \sqrt{(\pi a)}$. By doing so, reduction of ΔK_I will not take place during the range of $K_{max} - K_{min}$ from $0.8 \times 1.12\ \sigma_f \sqrt{(\pi a)}$ to $1.12\ \sigma_f \sqrt{(\pi a)}$, erasing the non-conservatism from the two sources mentioned above. Selection of a multiplying factor of 0.8 is based on the following:

- The 10 percent error that could be introduced for the subsurface flaw configurations having membrane stress correction factors less than 1.12 as indicated in Appendix A, Figure A–3310–1, and
- Another 10-percent error that accounts for the uncertainty in the σ_f value.

Applying the revised criterion of $0.8 \times 1.12\ \sigma_f \sqrt{(\pi a)}$, results in the proposed following condition on the use of the fatigue crack growth rate calculation for subsurface flaws defined in paragraph A–4300(b)(1) of Section XI, Nonmandatory Appendix A when R is less than zero:

$da/dN = 1.99 \times 10^{-10}\ S\ (\Delta K_I)^{3.07}$

For $R < 0$, ΔK_I depends on the crack depth, a, and the flow stress, σ_f. The flow stress is defined by $\sigma_f = ½(\sigma_{ys} + \sigma_{ult})$, where σ_{ys} is the yield strength and σ_{ult} is the ultimate tensile strength in units ksi (MPa) and a is in units in. (mm).

For $-2 \leq R \leq 0$ and $K_{max} - K_{min} \leq 0.8 \times 1.12\ \sigma_f \sqrt{(\pi a)}$, $S = 1$ and $\Delta K_I = K_{max.}$

For $R < -2$ and $K_{max} - K_{min} \leq 0.8 \times 1.12\ \sigma_f \sqrt{(\pi a)}$, $S = 1$ and $\Delta K_I = (1–R)\ K_{max}/3$.

For $R < 0$ and $K_{max} - K_{min} > 0.8 \times 1.12\ \sigma_f \sqrt{(\pi a)}$, $S = 1$ and $\Delta K_I = K_{max} - K_{min.}$

10 CFR 50.55a(b)(2)(xxv) Evaluation of Unanticipated Operating Events (New)

The NRC proposes to add a new § 50.55a(b)(2)(xxv) to condition the use of ASME B&PV Code, Section XI, Nonmandatory Appendix E, "Evaluation of Unanticipated Operating Events." Appendix E provides acceptance criteria and guidance evaluating the effects of out-of-limit conditions on structural integrity of the reactor vessel beltline region. The NRC proposes to specify that Section E–1200 is not acceptable, and to set forth two conditions on the use of Section E–1300. One proposed condition would require that a 1/4T flaw be used in the linear elastic fracture mechanics (LEFM) evaluation with a margin of 1.4 applying to K_{Im} in the two LEFM criteria. The other proposed condition would also use K_{Ic} instead of K_{IR} in the Appendix E analysis.

Appendix E of the ASME B&PV Code, Section XI, addresses the evaluation of the structural integrity of the reactor pressure vessel (RPV) after an out-of-limit condition occurs using LEFM based on a postulated surface flaw. The underlying Appendix E methodology is based on the following two LEFM criteria:

$1.6(K_{Im}) + K_{Ir} = K_{Ic}$ for the low temperature overpressure (LTOP) condition

$1.6(K_{Im} + K_{It}) + K_{Ir} = K_{Ic}$, for the pressurized thermal transient (PTT) condition

Where K_{Im}, K_{Ir}, and K_{It} are the applied primary, residual, and thermal stresses, respectively, and K_{Ic} is plane-strain fracture toughness. Both are based on a postulated flaw of 1-inch in depth. The details regarding these criteria are documented in the Electric Power Research Institute's (EPRI) report NP–5151, "Evaluation of Reactor Vessel Beltline Integrity Following Unanticipated Operating Events," dated April 1987. The justification for selecting the 1-inch deep flaw is given in the EPRI report as follows:

The crack size range has an upper limit of one inch. Experience shows that the fabrication practice and inspection requirements for nuclear pressure vessels generally preclude the undetected presence of larger flaws.

The above qualitative justification for selecting the 1-inch depth for the postulated flaw is not sufficient. The ASME B&PV Code, Section XI, Appendix G, "Fracture Toughness Criteria for Protection Against Failure," analysis, which can be considered as the first "screening" criterion for safe operation of an RPV, is based on a postulated flaw of one-quarter of the RPV wall thickness (1/4T). The Section XI, Appendix E analysis is employed when the ASME B&PV Code, Appendix G requirements are exceeded due to an out-of-limit condition. Hence, it is considered as the second "screening" criterion, *i.e.,* once satisfied, a refined analysis or a special RPV inspection is not needed. As the second screening tool, the Section XI, Appendix E analysis has to be conservative. In addition, the following three concerns prompt the NRC to propose the use of a 1/4T flaw in the Appendix E, Section E–1300 analysis:

- In the probabilistic fracture mechanics (PFM) analyses supporting the proposed PTS rule, the truncated flaw depth for a repair weld flaw is 2 inches. For a deterministic analysis, the possibility of having a repair weld flaw line up with a clad flaw to become a surface flaw cannot be ruled out.
- The Pressure Vessel Research User's Facility (PVRUF) and Shoreham RPV flaw data, used to develop generic flaw distributions for the proposed PTS rule, identified flaws that were consistently smaller than the proposed bounding flaw. However, the PVRUF and Shoreham data represent only a limited sampling of all RPV welds and may not directly provide an adequate bounding flaw size for a deterministic analysis like that of ASME B&PV Code, Section XI, Appendix E.
- The use of a 1/4T flaw assumption also provides additional assurance that

any service-induced growth of current fabrication flaws will be bounded for any RPVs having experienced severe transients over the course of their operating lifetimes.

Requiring that a 1/4T flaw be used in the LEFM evaluation with a margin of 1.4 applying to K_{Im} in the two LEFM criteria establishes a consistent approach regarding the postulated flaw size in the two deterministic LEFM analyses in ASME B&PV Code, Section XI, Appendices E and G. Applying the margin of 1.4 only to K_{Im} is consistent with the ASME B&PV Code, Section XI, Appendix G approach, making the decreased margin between the two appendices traceable. The proposed use of a smaller margin of 1.4 in the ASME B&PV Code, Section XI, Appendix E analysis is justified because all significant stress intensity factors resulting from an actual transient are considered. Further, using a 1/4T flaw is also consistent with prior NRC approaches for evaluation of RPV structural integrity after out-of-limit events. The EPRI NP–5151 report mentioned that reference toughness K_{IR} has been used in the LEFM evaluation in the prior NRC evaluation of RPV structural integrity after out-of-limit events. Consistent with the evolution of the ASME B&PV Code, Section XI, Appendix G analysis, the NRC now proposes to use K_{Ic} instead of K_{IR} in the ASME B&PV Code, Section XI, Appendix E analysis.

10 CFR 50.55a(b)(2)(xxvi) Risk-Informed Inservice Inspection (New)

The NRC proposes to add a new condition in § 50.55a(b)(2)(xxvi) to condition the use of ASME B&PV Code, Section XI, Non-Mandatory Appendix R, "Risk-Informed Inspection Requirements of Piping." The proposed condition would require licensees to submit an alternative in accordance with § 50.55a(a)(3) and obtain NRC authorization of the proposed alternative prior to implementing Appendix R, RI–ISI programs. The 2004 Edition of the ASME B&PV Code, Section XI currently incorporated by reference in the regulations did not contain provisions for Risk-Informed Inservice Inspection (RI–ISI). The 2005 Addenda introduced Non-Mandatory Appendix R into Section XI to provide risk-informed requirements for the ISI of ASME B&PV Code Class 1, 2 and 3 piping. The addition of Appendix R to Section XI was essentially the incorporation of ASME Code Cases N–577 and N–578 into the ASME B&PV Code. The NRC determined that ASME Code Cases N–577 and N–578 were unacceptable for use and are currently listed in Regulatory Guide 1.193,"ASME Code Cases Not Approved for Use," Revision 2. Licensees have been implementing RI–ISI requirements for piping as an alternative to the ASME B&PV Code, Section XI requirements of Tables IWB–2500–1, IWC–2500–1 and IWD–2500–1 submitted in accordance with § 50.55a(a)(3). Adding a condition as § 50.55a(b)(2)(xxvi) that would require licensees to submit an alternative in accordance with § 50.55a(a)(3) and obtain NRC authorization of the proposed alternative prior to implementing Appendix R, RI–ISI programs would ensure that future RI–ISI programs continue to comply with RG 1.178, "An Approach for Plant-Specific Risk-Informed Decisionmaking for Inservice Inspection of Piping," RG1.200, "An Approach for Determining the Technical Adequacy of Probabilistic Risk Assessment Results for Risk-Informed Activities," and NRC Standard Review Plan 3.9.8, "Risk-Informed Inservice Inspection of Piping."

ASME OM Code

The proposed amendment would revise the introductory text in § 50.55a(b)(3) to incorporate by reference the 2005 and 2006 Addenda of the ASME OM Code into 10 CFR 50.55a. The proposed amendment to § 50.55a(b)(3) would also clarify that Subsections ISTA, ISTB, ISTC, and ISTD, Mandatory Appendices I and II, and Nonmandatory Appendices A through H and J of the ASME OM Code would be incorporated by reference.

The conditions in § 50.55a(b)(3)(i), (b)(3)(ii), and (b)(3)(iv) would continue to apply to the 2005 and 2006 Addenda because the earlier ASME B&PV Code provisions that these regulations are based on were not revised in the 2005 and 2006 Addenda of the ASME B&PV Code to address the underlying issues which led the NRC to impose the conditions on the ASME B&PV Code.

The NRC proposes to revise the current requirements in § 50.55a(b)(3)(v) to be consistent with the revised snubber ISI provisions in the 2006 Addenda of the ASME B&PV Code, Section XI. To accomplish this § 50.55a(b)(3)(v) will be divided into § 50.55a(b)(3)(v)(A) and § 50.55a(b)(3)(v)(B). Where § 50.55a(b)(3)(v)(A) allows licensees using editions and addenda up to the 2005 Addenda of ASME Section XI to optionally use Subsection ISTD, ASME OM Code in place of the requirements for snubbers in Section XI. Section 50.55a(b)(3)(v)(B) would require licensees using the 2006 Addenda and later editions and addenda of Section XI to follow the requirements of Subsection ISTD of the ASME OM Code for snubbers. Provisions for the ISI of snubbers have been in Subsection ISTD since the ASME OM Code was first issued in 1990.

10 CFR 50.55a(b)(3)(v) Subsection ISTD

The current requirement in § 50.55a(b)(3)(v) allows licensees using editions and addenda up to the 2004 Edition of the ASME B&PV Code, Section XI to optionally use Subsection ISTD, ASME OM Code in place of the requirements for snubbers in Section XI, and states that snubber preservice and inservice examinations must be performed using the VT–3 visual examination method when using Subsection ISTD of the ASME OM Code. The NRC previously imposed this requirement to ensure that an appropriate visual examination method was used for the inspection of integral and non-integral snubber attachments, such as lugs, bolting, and clamps when using Subsection ISTD of the ASME OM Code. The proposed § 50.55a(b)(3)(v)(A) allows licensees using editions and addenda up to the 2005 Addenda of ASME B&PV Code, Section XI to optionally use Subsection ISTD, ASME OM Code in place of the requirements for snubbers in Section XI and continues to invoke the VT–3 requirement. This option does not apply when using the 2006 Addenda and later editions and addenda of Section XI of the ASME B&PV Code. Figure IWF–1300–1 was revised in the 2006 Addenda of Section XI to clarify that integral and non-integral snubber attachments are in the scope of Section XI. Therefore, the visual examination method specified in the 2006 Addenda and later editions and addenda of Section XI applies to the examination of integral and non-integral snubber attachments. The proposed § 50.55a(b)(3)(v)(B) would require licensees using the 2006 Addenda and later editions and addenda of Section XI to follow the requirements of Subsection ISTD of the ASME OM Code for snubbers.

10 CFR 50.55a(b)(3)(vi) Exercise Interval for Manual Valves

The NRC proposes to revise the current requirement for exercising manual valves in § 50.55a(b)(3)(vi) to limit its application to the 1999 through 2005 Addenda of the ASME OM Code. The current requirement would not apply to the 2006 Addenda of the ASME OM Code because the earlier ASME OM Code provision that this regulation was based on was revised in the 2006

Addenda of the ASME OM Code to address the underlying issue which led to the NRC to impose the condition. The exercise interval in Subarticle ISTC–3540 for manually operated valves was revised in the 2006 Addenda of the ASME OM Code to be the same as the current requirement in § 50.55a(b)(3)(vi).

Reactor Coolant Pressure Boundary, Quality Group B Components, and Quality Group C Components

The NRC proposes to revise § 50.55a(c)(3), (d)(2), and (e)(2) to replace "but—" with "subject to the following conditions" at the end of the introductory text to each paragraph for clarity.

Inservice Testing Requirements

10 CFR 50.55a(f)(5)(iv) Requests for Relief

The NRC proposes to modify the wording of § 50.55a(f)(5)(iv) to clarify that licensees are required to submit requests for relief based on impracticality within 12 months after the expiration of the IST interval for which relief is being sought. Section 50.55a(f)(5)(iv) in the current regulations describes the licensee's responsibility to demonstrate to the satisfaction of the NRC those items determined to be impractical and discusses the timeframe for this determination. The NRC proposes to clarify § 50.55a(f)(5)(iv) to more clearly articulate the requirements for licensee action when compliance with certain code requirements is determined to be impractical. Licensees have interpreted the current language in § 50.55a(f)(5)(iv) in a number of ways, especially regarding NRC approval of their submittal within the specified timeframe. Since the licensee has little or no control over the timeliness of NRC action on their submittal, this interpretation is problematic.

Inservice Inspection Requirements

Snubber Examination and Testing

The current requirements at § 50.55a(g)(2), (g)(3)(i), (g)(3)(ii), the introductory text of (g)(4), and (g)(4)(i) and (g)(4)(ii) reference Section XI of the ASME B&PV Code for component support ISI (including snubber examination and testing) provisions. The current requirement at § 50.55a(b)(3)(v) allows licensees the option of using Subsection ISTD of the ASME OM Code in lieu of the ISI provisions for snubbers in Article IWF–5000 of Section XI. When using the 2005 Addenda to Section XI, Article IWF–5000 is required to be used with the option to use OM Code Subsection ISTD noted. In the 2006 Addenda and later editions and addenda of Section XI, the snubber requirements in Article IWF–5000 no longer exist because Article IWF–5000 was deleted in the 2006 Addenda of Section XI. Therefore, the proposed amendment would revise § 50.55a(b)(3)(v) to require that licensees use the provisions for examination and testing snubbers in Subsection ISTD of the ASME OM Code when using the 2006 Addenda and later editions and addenda of Section XI.

The NRC proposes to revise the current regulations in § 50.55a(g)(2), (g)(3)(i), (g)(3)(ii), (g)(4)(i) and (g)(4)(ii) to require that licensees use the provisions for preservice and inservice examination and testing of snubbers in Subsection ISTD of the ASME OM Code when using the 2006 Addenda and later edition of Section XI. Licensees may also use optional code cases in RG 1.192 as approved by the NRC. The NRC proposes to clarify that preservice examination may meet preservice examination requirements in Section III as an alternative to preservice examination of Section XI. The NRC also proposes to revise the current regulation in the introductory text of § 50.55a(g)(4) to require that licensees using the ASME OM Code follow the provision in Subsection ISTD for examination and testing of snubbers. Provisions for examinations and tests of snubbers have been in Article IWF–5000 since Subsection IWF was first issued in the Winter 1978 Addenda of Section XI. Article IWF–5000 was deleted in the 2006 Addenda of Section XI. Subarticle IWF–1220 in the 2006 Addenda of Section XI states that the examination and testing requirements for snubbers are now outside the scope of Section XI, and that the examination and test requirements for snubbers can be found in Subsection ISTD of the ASME OM Code. Provisions for the examination and testing of snubbers have been in Subsection ISTD since the ASME OM Code was first issued in 1990.

10 CFR 50.55a(g)(4)(iii) Surface Examinations of High-Pressure Safety Injection Systems

The current regulations at § 50.55a(g)(4)(iii) give licensees the option of not performing surface examinations of high-pressure safety injection systems as specified in Section XI, Table IWB–2500–1, "Examination Category B–J," Item Numbers B9.20, B9.21 and B9.22. Later editions and addenda of Section XI have been modified and the surface examination requirement no longer exists in Table IWB–2500–1, and some of the Item Numbers have either changed or been deleted. The surface examination requirement was remove from Table IWB–2500–1 in the 2003 Addenda. Therefore, the paragraph needs to be revised for this condition to apply to those licensees using Code editions and addenda prior to the 2003 Addenda.

10 CFR 50.55a(g)(5)(iii) and (g)(5)(iv) Inservice Inspection Requests for Relief

Section 50.55a(g)(5)(iii) currently requires the licensee to notify the NRC if compliance with certain code requirements are found to be impractical. The NRC proposes to add a sentence to § 50.55a(g)(5)(iii) to clarify that a request for relief must be submitted to the NRC no later than 12 months after the examination has been attempted during a given ISI interval and the ASME B&PV Code requirement determined to be impractical. In the past, licensees have submitted requests under § 50.55a(g)(5)(iii) prior to performing the ASME B&PV Code examination in a given interval based on limited examination coverage from previous ISI 10-year intervals. The NRC has concluded that this is an inappropriate basis for a determination of impracticality as new examination techniques are often developed from one interval to the next, which could result in a reasonable expectation of improved results. As a result, the NRC has concluded that a licensee usually cannot make the determination that an examination is indeed impractical without first attempting the examination in the current ISI interval.

In addition, if the NRC were to grant relief prior to the component having been examined and the results of the examination are less than stated in the request for relief, the licensee would be required to resubmit the request for relief to address the actual examination. This places an unnecessary burden on the licensee and the NRC to review the same issue twice. The proposed amendment to the regulations attempts to clarify that the determination of impracticality should be based on actual attempts to perform a requirement and only submitted after the attempt to perform a requirement has been unsuccessful.

The NRC proposes to modify the wording of § 50.55a(g)(5)(iv) to clarify that licensees are required to submit requests for relief based on impracticality within 12 months after the expiration of the ISI interval for which relief is being sought. Section 50.55a(g)(5)(iv) in the current regulations describe the licensee's responsibility to demonstrate to the satisfaction of the NRC those items

determined to be impractical and discusses the timeframe for this determination. The NRC proposes to clarify § 50.55a(g)(5)(iv) to more clearly articulate the requirements for licensee action when compliance with certain code requirements is determined to be impractical. It is the NRC's experience that licensees have interpreted the current language in § 50.55a(g)(5)(iv) in a number of ways, especially regarding NRC approval of their submittal within the specified timeframe. Since the licensee has little or no control over the timeliness of NRC action on their submittal, this interpretation is problematic.

10 CFR 50.55a(g)(6)(ii)(E) Reactor Coolant Pressure Boundary Visual Inspections

The NRC proposes to update § 50.55a(g)(6)(ii)(E)(*1*) through (g)(6)(ii)(E)(*3*) to the requirements of Code Case N–722–1, and to revise footnote 1 to clarify requirements in that paragraph that pertain to reactor coolant pressure boundary visual inspections. In the most recent update to 10 CFR 50.55a, the NRC added new requirements in § 50.55a(g)(6)(ii)(E). The new requirements were for all licensees of PWRs to augment their ISI program by implementing ASME Code Case N–722, subject to the conditions specified in § 50.55a(g)(6)(ii)(E)(*2*) through (g)(6)(ii)(E)(*4*). ASME Code Case N–722–1, "Additional Examinations for PWR Pressure Retaining Welds in Class 1 Components Fabricated With Alloy 600/82/182 Materials Section XI, Division 1," was published in Supplement 8 of the 2007 Edition of the ASME Boiler and Pressure Vessel Code Nuclear Code Case book. This revision of the code case contains one additional note which indicates that visual examination of Alloy 600/82/182 materials in flange seal leak-off lines is not required. This change will eliminate the need for licensees to submit relief requests for flange seal leak-off lines which are not normally exposed to a corrosive environment and are inaccessible for visual examination.

The wording in the second sentence of footnote 1 to § 50.55a(g)(6)(ii)(E) has generated some confusion, and has the unintended consequence of some licensees believing that they need to submit additional relief requests related to the percentage of inspections to be completed during the current interval. The second sentence in the footnote is intended to specify what portion of welds has to be inspected during a plant interval that remains after January 1, 2009. The intent was to require licensees to distribute the population such that the portion of welds to be inspected in the remaining portion of the interval be based on the portion of the interval remaining as of January 1, 2009. Instead, the wording is being incorrectly interpreted by some licensees as requiring all the welds to be distributed over, and inspected during, the remaining periods and outages in the interval. The NRC proposes to revise footnote 1 to § 50.55a(g)(6)(ii)(E) to clarify this issue.

10 CFR 50.55a(g)(6)(ii)(F) Examination Requirements for Class 1 Piping and Nozzle Dissimilar-Metal Butt Welds (New)

The NRC proposes to add a new § 50.55a(g)(6)(ii)(F) to require licensees to implement ASME Code Case N–770, "Alternative Examination Requirements and Acceptance Standards for Class 1 PWR Piping and Vessel Nozzle Butt Welds Fabricated with UNS N06082 or UNS W86182 Weld Filler Material With or Without the Application of Listed Mitigation Activities, Section XI, Division 1," with 15 conditions. Code Case N–770 contains baseline and ISI requirements for unmitigated butt welds fabricated with Alloy 82/182 material and preservice and ISI requirements for mitigated butt welds.

The application of ASME Code Case N–770 is necessary because the inspections currently required by the ASME Code, Section XI, were not written to address degradation of Alloy 82/182 butt welds by primary water stress corrosion cracking (PWSCC), and the safety consequences of inadequate inspections can be significant. NRC's determination that current inspections of certain Class 1 butt welds are inadequate is based upon operating experience and analysis. The absence of an effective inspection regime could, over time, result in unacceptable circumferential cracking or the degradation of reactor coolant system components by corrosion from leaks in these welds. These degradation mechanisms increase the probability of a loss of coolant accident. The current ASME Code requirements for inspection of Alloy 82/182 butt welds are not frequent enough to ensure that ASME Code-allowable limits will continue to be met in the event that PWSCC initiates. The growth rate of PWSCC in these welds is rapid enough that PWSCC could lead to leakage or rupture before the degradation would be detected by the inspections in the ASME Code, Section XI, currently required by 10 CFR 50.55a or by the 2005 Addenda through the 2008 Addenda of Section XI.

In late 2005, the NRC sent a letter to ASME requesting it to address the inspection requirements for Class 1 PWR piping butt welds fabricated with Alloy 82/182 weld materials. ASME approved the development of an ASME code case on appropriate inspection frequency requirements for Class 1 butt welds containing Alloy 82/182 to address primary water stress-corrosion cracking (PWSCC). The code case format was chosen by ASME to address this safety-significant issue because a code case is a stand-alone set of provisions that can be approved more quickly than revisions to the ASME B&PV Code. Code cases are voluntary, however, so these provisions were developed with the expectation that the NRC would incorporate the code case by reference into the regulations. ASME Code Case N–770, was approved by ASME on January 30, 2009, and was published in Supplement 8 of the 2007 Edition of the ASME Boiler and Pressure Vessel Code Nuclear Code Cases book. ASME Code Case N–770 provides inspection frequencies and methods for Alloy 82/182 butt welds that are unmitigated as well as butt welds that have been mitigated for PWSCC by any of several mitigation methods. ASME Code Case N–770, with proposed conditions, resolves the deficiencies in the ASME B&PV Code, Section XI, inspection requirements for Alloy 82/182 butt welds by providing inspection requirements that ensure that ASME Code-allowable limits will not be exceeded and PWSCC will not lead to leaks or ruptures of piping welds. Therefore, the NRC proposes to require the implementation of Code Case N–770, with conditions.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*2*)) to require that welds mitigated by inlays, cladding, or stress improvement by welding, be categorized as unmitigated welds pending plant-specific NRC review of the mitigation techniques and NRC authorization of an alternative ASME Code Case N–770 Inspection Item for the mitigated weld. ASME Code Case N–770 provides inspection methods and frequencies for welds mitigated by certain specified techniques. Inspections of mitigated welds are performed much less frequently than unmitigated welds. Requirements for most of the mitigation methods are contained in other ASME code cases under development. The NRC has typically approved the application of pressure boundary weld mitigation techniques on a case-by-case basis. This condition is necessary to ensure that appropriate mitigation techniques are

applied to welds before they are categorized as mitigated under Code Case N–770.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*3*)) to require that the baseline examination of welds in Inspection Items A–1, A–2, and B (unmitigated welds) be completed at the next refueling outage after the effective date of the final rule. Paragraph –2200 of Code Case N–770 permits welds in Inspection Items A–1, A–2, and B (unmitigated welds) that have not received a baseline examination to be examined within the next two refueling outages from adoption of the Code Case. Welds in Inspection Items A–1, A–2, and B are the welds most likely to experience PWSCC and some of these welds may not have received a baseline examination, even under the industry initiative, MRP–139. This condition is necessary to ensure the integrity of these welds by requiring that all welds in Inspection Items A–1, A–2 and B be inspected at the first opportunity to perform the inspections.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*4*)) to require essentially 100 percent coverage for axial flaws. Paragraph –2500(c) of Code Case N–770 permits examination of axial flaws with inspection coverage limitations provided essentially 100 percent coverage for circumferential flaws is achieved and the maximum coverage practical is achieved for axial flaws. This requirement on inspection limitations is inconsistent with comparable inspection requirements of the ASME B&PV Code, Section XI. Axial flaws can lead to through wall cracks and leakage of reactor coolant, which is a safety concern. This condition is necessary for the NRC to ensure that, through NRC review of an authorization of alternative inspection coverage, appropriate actions are being taken to address potential inspection limitations for axial flaws.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*5*)) to reword Paragraph –3132.3(b) on determining flaw growth using wording consistent with that used in the ASME B&PV Code, Section XI. Paragraph –3132.3(b) contains the statement that a "flaw is not considered to have grown if the size difference (from a previous examination) is within the measurement accuracy of the nondestructive examination (NDE) technique employed." The "measurement accuracy of the NDE technique employed" is not defined in the code case or in the ASME B&PV Code. Use of this terminology may result in a departure from the past practice when applying ASME B&PV Code, Section XI. Under the requirements of Section XI, one concludes that flaw growth has not occurred when a "previously evaluated flaw has remained essentially unchanged." The proposed condition uses this wording. This condition is necessary to clarify the requirements for determining whether flaw growth has occurred and make the requirements consistent with ASME B&PV Code requirements endorsed by the NRC in 10 CFR 50.55a.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*6*)) on welds that are determined through a volumetric examination to have cracking that penetrates beyond the thickness of the inlay or cladding. The condition would require such welds to be reclassified as Inspection Item A–1, A–2, or B, as appropriate, until corrected by repair/replacement activity in accordance with IWA–4000 or by corrective measures beyond the scope of Code Case N–770. Code Case N–770 would permit welds mitigated by inlay or cladding (i.e., onlay) in Inspection Items G, H, J, and K, to remain in those Inspection Items if cracking that penetrates through the thickness of the inlay or cladding occurs. The purpose of an inlay or cladding is to provide a corrosion resistant barrier between reactor coolant and the underlying Alloy 82/182 weld material that is susceptible to PWSCC. If cracking penetrates through the thickness of an inlay or cladding, the inspection frequencies of Inspection Items G, H, J, and K would no longer be appropriate even after satisfying the successive examination requirements of paragraph –2420. This condition is necessary because welds with cracking that penetrates beyond the thickness of the protective barrier of the inlay or cladding would no longer be mitigated and would need to be inspected under one of the Inspection Items for unmitigated welds.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*7*)) on welds in Inspection Items G, H, J, and K, (welds mitigated by inlay or cladding) that the ISI surface examination requirements of Table 1 should apply whether the inservice volumetric examinations are performed from the weld outside diameter or the weld inside diameter. Code Case N–770 only requires a surface examination for welds in Inspection Items G, H, J, and K if a volumetric examination is performed from the weld inside diameter surface. A volumetric examination performed from the weld outside diameter surface would not be capable of detecting flaws in an inlay or cladding. This condition is necessary to ensure that weld inlays or cladding are still performing their intended function of providing a protective barrier between the reactor coolant and the underlying Alloy 82/182 weld that is susceptible to PWSCC.

The NRC also proposes, as part of a new condition as § 50.55a(g)(6)(ii)(F)(*7*), to require that all hot-leg operating temperature welds in Inspection Items G, H, J, and K (welds mitigated by inlay or cladding) be inspected each interval and that a 25 percent sample of cold leg operating temperature welds in Inspection Items G, H, J, and K be inspected whenever the core barrel is removed (unless it has already been inspected within the past 10 years) or 20 years, whichever is less. Code Case N–770 permits welds in Inspection Items G, H, J, and K to be placed in a 25 percent sample inspection program under certain conditions after the required initial inspection. The NRC has performed analyses of crack growth in welds mitigated by Alloy 52/152 inlay or cladding using experimentally derived crack growth data for this weld material. The results of those analyses show that welds in Inspection Items G, H, J, and K at hot leg temperature have to be examined once per interval and welds at cold leg temperature have to be inspected under a sample inspection program to detect potentially significant crack growth. This condition is being proposed to ensure that ASME Code-allowable limits would not be exceeded and PWSCC would not lead to leaks or ruptures.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*8*)) to prohibit the first examination following weld inlay, cladding, or stress improvement for Inspection Items D, G, and H from being deferred to the end of the interval. Code Case N–770 provides requirements on the timing of the first examination following weld inlay, cladding, or stress improvement. Inspection Items D, G, and H pertain to mitigation of cracked welds and the timing of the initial examinations in the code case has been specified in the code case so that the welds are not in service for an extended time period prior to the initial examination. However, the code case does not explicitly preclude deferral of these examinations to the end of the interval. Therefore, this NRC condition is needed to ensure that the initial examinations of welds in Inspection Items D, G, and H take place on an appropriate schedule to verify the effectiveness of the mitigation process.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*9*)) on Measurement or Quantification Criterion I–1.1 of Appendix I to require the assumption in the weld residual stress (WRS) analysis of a construction weld repair from the

inside diameter to a depth of 50 percent of the weld thickness extending 360° around the weld. Measurement or Quantification Criterion I–1.1 does not specify the circumferential extent of the repair that must be assumed. This condition is necessary to clarify the size of the repair to be assumed in the weld residual stress analysis which would ensure that appropriate criteria for the WRS analysis are used for mitigation by stress improvement.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*10*)) on Measurement or Quantification Criterion I–2.1 of Appendix I to require that the last sentence be replaced. This criterion was inappropriately worded since this criterion pertains to the permanence of a mitigation process by stress improvement and plastic "shakedown" rather than "ratcheting" is the phenomenon that could lead to stress relaxation. This condition is necessary to clarify the type of analysis necessary to ensure that the mitigation process is permanent and that the inspection frequencies associated with the process continue to be correct.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*11*)) to require that in applying Measurement or Quantification Criterion I–7.1 of Appendix I, an analysis be performed using IWB–3600 evaluation methods and acceptance criteria to verify that the mitigation process will not cause any existing flaws to grow. Measurement or Quantification Criterion I–7.1 permits the growth of existing flaws in welds mitigated by stress improvement. This is an inappropriate provision since the process of mitigating by stress improvement is intended to prevent growth of existing flaws which could lead to leakage or rupture of the weld. This condition is necessary to ensure that stress improvement of welds with existing flaws is an effective mitigation technique consistent with the inspection frequency in the code case.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*12*)) to require that the NRC be provided with a report if the volumetric examination of any mitigated weld detects new flaws or growth of existing flaws that exceed the acceptance standards of IWB–3514 and are found to be acceptable for continued service through an analytical evaluation or a repair or the alternative requirements of an ASME code case. The report would summarize the evaluation, along with inputs, methodologies, assumptions, and cause of the new flaw or flaw growth and would be provided to the NRC prior to the weld being placed in service. Welds that are mitigated have been modified by a technique, such as weld inlays, cladding, or stress improvement. Mitigation techniques are designed to prevent new flaws from occurring and prevent the growth of any existing flaws. If volumetric examination detects new flaws or growth of existing flaws in the required examination volume, the mitigation will not be performing as designed and the NRC will need to evaluate the licensee's actions to address the problem. Therefore, this condition is needed to verify the acceptability of the weld prior to being placed back in service.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*13*)) to require that the last sentence of the Extent and Frequency of Examination for Inspection Items C and F be revised. Inspection Items C and F apply to butt welds mitigated by full structural weld overlays of Alloy 52/152 material. Note 10 of the Code Case requires that welds in Inspection Items C and F that are not included in the 25 percent sample be examined prior to the end of the mitigation evaluation period if the plant is to be operated beyond that time. This condition would ensure that welds in the 25 percent sample are also examined prior to the end of the mitigation evaluation period; that is, prior to the end of life of the overlay predicted by the mitigation evaluation. Inspection prior to the end of the mitigation evaluation period is necessary to ensure that appropriate information has been obtained to verify the condition of the weld overlay and update the analysis for the predicted life of the weld overlay.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*14*)) on the ½-inch (13 mm) dimension shown in Figures 2(b) and 5(b) of Code Case N–770. The condition would require that a dimension "b" be used instead of ½ inch, where "b" is equivalent to the nominal thickness of the nozzle or pipe being overlaid, as appropriate. The code case contains information on component thicknesses to be used in application of the acceptance standards of ASME B&PV Code, Section XI, IWB–3514, to evaluate flaws detected during preservice inspection of weld overlays. The ½-inch (13 mm) dimension shown in Figures 2(b) and 5(b) is non-conservative. The appropriate dimension is a function of the nominal thickness of the nozzle or pipe being overlaid and not a single specified value for all pipes and nozzles. This condition is necessary to ensure that acceptance standards used for evaluation of any flaws detected during preservice inspection of weld overlays assure an appropriate level of safety.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*15*)) on the use of the acceptance standards of ASME B&PV Code, Section XI, IWB–3514, for evaluating indications in inlays or onlays. The proposed condition specifies that the thickness "t" in IWB–3514 is the thickness of the inlay or onlay. The code case requires that the preservice examination for inlays or onlays consist of a surface examination, which does not allow planar flaws, and a volumetric examination. The volumetric examination allows the use of the acceptance standards of IWB–3514 provided the surface examination acceptance standards are satisfied. That is, it would allow the acceptance of some subsurface indications, but IWB–3514 acceptance standards would only allow very small flaws. However, the code case does not specify the value "t" to be used in the application of IWB–3514. The appropriate value "t" when applying IWB–3514 to inlays or onlays is the thickness of the inlay or onlay, since the acceptance standards in this case only apply to accepting flaws within the inlay or onlay. This condition is necessary to preclude the misapplication of the acceptance standards of IWB–3514 and potential acceptance of flaws that could compromise the integrity and function of the inlay or onlay as a protective barrier.

The NRC proposes to add a condition (§ 50.55a(g)(6)(ii)(F)(*16*)) on welds mitigated by stress improvement by welding in Inspection Items D and E to not permit them to be placed into a population to be examined on a sample basis after the initial examination. Stress improvement by welding is also called an optimized weld overlay. Code Case N–770 permits welds mitigated by this technique to be placed in a 25 percent inspection sample after the initial examination. Sample inspections could result in three-quarters of the welds never being examined after the initial examination. Although full structural weld overlays have been used extensively in the nuclear industry for many years, the industry does not have experience with optimized weld overlays. Optimized weld overlays are designed to rely on the outer 25 percent of the original Alloy 82/182 material to satisfy the design margins and would not satisfy design margins if significant cracking were to occur. If significant cracking were to occur in the Alloy 82/182 material, the optimized weld overlay material would prevent the weld from leaking and could potentially rupture without prior evidence of leakage under design basis conditions.

The proposed condition is necessary to ensure that all optimized weld overlays are periodically inspected for potential degradation.

After ASME Code Case N–770 was approved by ASME in early 2009, the NRC brought concerns on the code case to the attention of members of the ASME B&PV Code, Section XI, task group that developed it. These concerns are the subject of these proposed conditions. The ASME B&PV Code, Section XI, has been working on a revision to Code Case N–770 to address many of these concerns. The NRC will consider endorsing an ASME-approved revision to Code Case N–770 in the final rule to update 10 CFR 50.55a, depending upon when such a revision is issued and the contents of the revision, and may remove some or all conditions depending upon whether the revised Code Case addresses the concerns previously discussed.

Substitution of the Term "Condition" in 10 CFR 50.55a

The NRC proposes to substitute the word "condition(s)" for the words "limitation(s)" "modification(s)" and "provision(s)," throughout 10 CFR 50.55a as shown in Table 1 of this document for consistency. The NRC does not believe it necessary to distinguish among different types of "caveats" that it imposes on the use of the ASME Codes, and therefore proposes to use a single term for clarity and consistency.

IV. Paragraph-by-Paragraph Discussion

Quality Standards, ASME Codes and IEEE Standards, and Alternatives

10 CFR 50.55a(a)

The NRC proposes to add the title "Quality standards, ASME Codes and IEEE standards, and alternatives" to paragraph (a).

Applicant/Licensee Proposed Alternatives to the Requirements of 10 CFR 50.55a

10 CFR 50.55a(a)(3)

The NRC proposes to add a sentence to paragraph (a)(3) to clarify that an alternative is to be submitted to, and approved by, the NRC prior to an applicant or licensee implementing the alternative. For applicants, approval of an alternative must be obtained before construction begins (rather than during the design process).

Standards Approved for Incorporation by Reference

10 CFR 50.55a(b)

The NRC proposes to add the title "Standards approved for incorporation by reference" to paragraph (b).

The NRC proposes to modify the language in paragraph (b) to clarify that non-mandatory appendices are excluded from the ASME B&PV Code, Section III requirements that are incorporated by reference into 10 CFR 50.55a, and to clarify that only Division 1 requirements of Section III and Section XI are incorporated by reference (not Division 2 and Division 3 requirements).

ASME B&PV Code, Section III

10 CFR 50.55a(b)(1)

The NRC proposes to amend paragraph (b)(1) to incorporate by reference the 2005 Addenda (Division 1) through 2008 Addenda (Division 1) of Section III of the ASME B&PV Code into 10 CFR 50.55a, subject to the conditions outlined in modified paragraphs (b)(1)(i) through 50.55a(b)(1)(vi) and proposed paragraph (b)(vii). The paragraph modification would also include an editorial change to the references to Section III ASME B&PV Code for clarification purposes. As a result, applicants and licensees may use the 1974 Edition (Division 1) through the 2008 Addenda (Division 1) of Section III of the ASME B&PV Code subject to the conditions contained within modified paragraphs (b)(1)(i) through (b)(1)(vi) and new paragraph (b)(1)(vii).

10 CFR 50.55a(b)(1)(ii)

The NRC proposes to apply the existing condition in paragraph (b)(1)(ii) regarding stress indices used for weld stresses in piping design to the comparable provisions in the ASME Code editions and addenda incorporated by reference in this proposed rule. The paragraph modification also includes the addition of a condition on the use of paragraph NB–3683.4(c)(2) for applicants and licensees applying the 1989 Addenda through the latest edition and addenda of Section III of the ASME B&PV Code. As a result, this modification prohibits the use of Footnote 13 from the 2004 Edition through the 2008 Addenda of Section III of the ASME B&PV Code to Figures NC–3673.2(b)–1 and ND–3673.2(b)–1 for welds with leg size less than 1.09 times the nominal pipe wall thickness (t_n) for applicants and licensees applying the 1989 Addenda through the latest edition and addenda of Section III of the ASME B&PV Code. Also as a result, the use of paragraph NB–3683.4(c)(2), is not allowed for applicants and licensees applying the 1989 Addenda through the latest edition and addenda of Section III of the ASME B&PV Code.

10 CFR 50.55a(b)(1)(iii)

The NRC proposes to modify paragraph (b)(1)(iii) to impose conditions on the seismic design of piping when licensees use the latest editions and addenda of the ASME B&PV Code, Section III, incorporated by reference in modified paragraph (b). The paragraph would also be modified with an editorial change to replace "limitations and modifications" with "conditions" and "limitation" with "condition." The modified paragraph would allow the use of Subarticles NB–3200, NB–3600, NC–3600, and ND–3600 for the seismic design of piping when applying editions and addenda, up to and including the 1993 Addenda of the ASME B&PV Code, Section III, subject to the condition in modified paragraph (b)(1)(ii). The modified paragraph would not allow the use of Subarticles NB–3200, NB–3600, NC–3600, and ND–3600 for the seismic design of piping when applying the 1994 Addenda through the 2006 Addenda of Section III of the ASME B&PV Code except that Subarticle NB–3200 in the 2004 Edition through the 2008 Addenda of Section III of the ASME B&PV Code may be used by applicants and licensees subject to the condition in new paragraph (b)(1)(iii)(B). The modified paragraph would allow the use of Subarticles NB–3200, NB–3600, NC–3600, and ND–3600 for the seismic design of piping when applying the 2006 Addenda through the 2008 Addenda of Section III of the ASME B&PV Code, subject to the three new conditions in new paragraphs (b)(1)(iii)(A), (b)(1)(iii)(B), and (b)(1)(iii)(C).

10 CFR 50.55a(b)(1)(iii)(A)

NRC proposes to add a new paragraph (b)(1)(iii)(A) to impose a condition on the minimum value of the B_2 indices when applicants and licensees use Subarticle NB–3600 of the 2006 Addenda up to and including the 2008 Addenda of the ASME Code, Section III, for the seismic design of piping. As a result, licensees and applicants using Subarticle NB–3600 of the 2006 Addenda up to and including the 2008 Addenda of the ASME B&PV Code, Section III, for the seismic design of piping must use a value for the B_2 index, defined in Subparagraph NB–3656(b)(3), equal to or greater than $0.75B_2$, from Table NB–3681(A)–1, for Class 1 elbows and tees of ferritic steel

materials operating at temperatures above 300°F.

10 CFR 50.55a(b)(1)(iii)(B)

The NRC proposes to add a new paragraph (b)(1)(iii)(B) requiring licensees and applicants using Note (1) of Figure NB–3222–1 in Section III of the 2004 Edition up to and including the 2008 Addenda of the ASME B&PV Code to include reversing dynamic loads in calculating primary bending stresses, if consideration of these loads is warranted.

10 CFR 50.55a(b)(1)(iii)(C)

The NRC proposes to add a new paragraph(b)(1)(iii)(C) to impose a condition on the use of Subarticles NB–3600, NC–3600, and ND–3600 of the ASME B&PV Code, Section III when applying the 2006 Addenda through the 2008 Addenda of Section III of the ASME B&PV Code by requiring the outer diameter-over-thickness ratio (D_o/t) to be less than or equal to 40. As a result, licensees and applicants may not apply Subparagraph NB–3683.2(C), Note (1) to Table NB–3681(a)–1, and Note (3) to Figures NC–3673.2(b)–1 and ND–3673.2(b)–1.

10 CFR 50.55a(b)(1)(iv)

The NRC proposes to modify paragraph (b)(1)(iv) to allow the use the 1994 Edition of NQA–1 when applying the 2006 Addenda and later Editions and Addenda of the ASME B&PV Code, Section III.

10 CFR 50.55a(b)(1)(vii)

The NRC proposes to add a new paragraph (b)(1)(vii) to prohibit the use of paragraph NB–7742 when applying the 2006 Addenda up to and including the 2007 Edition and 2008 Addenda of the ASME B&PV Code, Section III. As a result, new Class 1 incompressible-fluid, pressure-relief valve designs must be tested at the highest values of set-pressure ranges as required by prior editions and addenda of the ASME B&PV Code, Section III.

ASME B&PV Code, Section XI

10 CFR 50.55a(b)(2)

The NRC proposes to revise the introductory text to paragraph (b)(2) to incorporate by reference only Subsections IWA, IWB, IWC, IWD, IWE, IWF, IWL, Mandatory and Non-Mandatory Appendices, of the 2005 Addenda through 2008 Addenda of Section XI of the ASME B&PV Code, with conditions, into 10 CFR 50.55a. It would also be revised to make an editorial change to the reference to Section XI of the ASME B&PV Code.

10 CFR 50.55a(b)(2)(i)

The NRC proposes to delete the requirements of current paragraph (b)(2)(i) which address limitations on specific editions and addenda. Licensees are no longer using these older editions (1974 and 1977 Editions) and addenda of the ASME B&PV Code. The requirements of current paragraph (b)(2)(ii) which address pressure-retaining welds in ASME Code Class 1 piping would be redesignated as paragraph (b)(2)(i), with no change to redesignated language.

10 CFR 50.55a(b)(2)(ii)

The NRC proposes to redesignate the requirements of current paragraph (b)(2)(vi), which address containment inservice inspection requirements, as paragraph (b)(2)(ii). This paragraph is also modified to clarify the conditions applicable to this paragraph.

10 CFR 50.55a(b)(2)(iii)

The NRC proposes to delete the requirements of current paragraph (b)(2)(iii) which address steam generator tubing. The NRC proposes removal of this condition because the condition is redundant to the 1989 Edition through the 2008 Addenda of Section XI. The requirements of current paragraph (b)(2)(vii) which address Section XI references to OM Part 4, OM Part 6, and OM Part 10 would be redesignated as paragraph (b)(2)(iii), with no change to redesignated language.

10 CFR 50.55a(b)(2)(iv)

The NRC proposes to redesignate the requirements of current paragraph (b)(2)(viii), which address the inservice examination of concrete containments in accordance with Subsection IWL of the ASME B&PV Code, Section XI, as paragraph (b)(2)(iv). This paragraph is also modified so that the conditions in redesignated paragraphs (b)(2)(iv)(F) and (b)(2)(iv)(G) do not apply when using the 2007 Edition with 2008 Addenda of the ASME B&PV Code, Section XI.

10 CFR 50.55a(b)(2)(v)

The NRC proposes to redesignate the requirements of current paragraph (b)(2)(ix), which address the examination of metal containments and the liners of concrete containments in accordance with Subsection IWE of the ASME B&PV Code, Section XI, as paragraph (b)(2)(v). This paragraph is also modified so that the conditions in redesignated paragraphs (b)(2)(v)(F), (b)(2)(v)(G), (b)(2)(v)(H) and (b)(2)(v)(I) do not apply when using the 2004 Edition with 2006 Addenda through the 2007 Edition with 2008 Addenda of Subsection IWE of the ASME B&PV Code, Section XI. Also, this paragraph is modified so that the condition in redesignated paragraph (b)(2)(v)(I) would not apply when using the 2004 Edition, up to and including, the 2005 Addenda of Subsection IWE of the ASME B&PV Code, Section XI.

10 CFR 50.55a(b)(2)(v)(J)

The NRC proposes to add a new paragraph (b)(2)(v)(J) to address major containment modifications as they apply to Class MC and Class CC containment structures and the use of Article IWE–5000, of Subsection IWE when applying the 2007 Edition up to and including the 2008 Addenda of the ASME B&PV Code, Section XI.

10 CFR 50.55a(b)(2)(vi)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(x), which address Quality Assurance, as paragraph (b)(2)(vi), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(vii)

The NRC proposes to redesignate the current paragraph (b)(2)(xi), which is "Reserved," as paragraph (b)(2)(vii), and that it remain reserved for possible future use.

10 CFR 50.55a(b)(2)(viii)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xii), which address underwater welding, as paragraph (b)(2)(viii), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(ix)

The NRC proposes to redesignate the current paragraph (b)(2)(xiii), which is "Reserved," as paragraph (b)(2)(ix), and that it remain reserved for possible future use.

10 CFR 50.55a(b)(2)(x)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xiv), which address Appendix VIII personnel qualifications, as paragraph (b)(2)(x), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(xi)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xv), which address Appendix VIII specimen set and qualification requirements, as paragraph (b)(2)(xi). The paragraph would be modified by limiting the use of the provisions described in redesignated paragraphs (b)(2)(xi)(A) through (b)(2)(xi)(M) to licensees using editions and addenda of the B&PV Code after the 2001 Edition through the 2006 Addenda.

10 CFR 50.55a(b)(2)(xii)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xvi), which address Appendix VIII single-sided ferritic-vessel and piping and stainless steel piping examination, as paragraph (b)(2)(xii), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(xiii)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xvii), which address reconciliation of quality requirements, as paragraph (b)(2)(xiii), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(xiv)(A)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xviii)(A), which address certification of NDE personnel, as paragraph (b)(2)(xiv)(A), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(xiv)(B)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xviii)(B), which address Certification of NDE personnel, as paragraph (b)(2)(xiv)(B). In addition, the requirements would be revised such that the condition would not apply to the 2007 Edition through the 2008 Addenda of Section XI.

10 CFR 50.55a(b)(2)(xiv)(C)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xviii)(C), which address certification of NDE personnel, as paragraph (b)(2)(xiv)(C). In addition, the requirements would be revised such that the current conditions on the qualification of VT–3 examination personnel would not apply to the 2005 Addenda through the 2008 Addenda of Section XI.

10 CFR 50.55a(b)(2)(xv)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xix), which address substitution of alternative methods, as paragraph (b)(2)(xv). In addition, the requirements would be revised so the current conditions for the substitution of alternative examination methods in that paragraph would not apply when using the 2005 Addenda through the 2008 Addenda. The paragraph would also be revised to impose the condition that paragraphs IWA–4520(b)(2) and IWA–4521 of the 2007 Edition of Section XI, Division 1, with 2008 Addenda, are not approved for use.

10 CFR 50.55a(b)(2)(xvi)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xx), which address system leakage tests, as paragraph (b)(2)(xvi), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(xvii)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xxi), which address Table IWB–2500–1 examination requirements, as paragraph (b)(2)(xvii), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(xviii)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xxii), which address surface examination, as paragraph (b)(2)(xviii), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(xix)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xxiii), which address evaluation of thermally cut surfaces, as paragraph (b)(2)(xix), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(xx)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xxiv), which address incorporation of the performance demonstration initiative and addition of ultrasonic examination criteria, as paragraph (b)(2)(xx). In addition, the requirements would be revised so that the current condition would not apply when using the 2007 Edition through the 2008 Addenda of Section XI of the ASME B&PV Code.

10 CFR 50.55a(b)(2)(xxi)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xxv), which address mitigation of defects by modification, as paragraph (b)(2)(xxi), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(xxii)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xxvi), which address pressure testing of Class 1, 2, and 3 mechanical joints, as paragraph (b)(2)(xxii), with no change to the redesignated language.

10 CFR 50.55a(b)(2)(xxiii)

The NRC proposes to redesignate the requirements in current paragraph (b)(2)(xxvii), which address removal of insulation, as paragraph (b)(2)(xxiii). In addition, the requirements would be revised to add a condition to refer to paragraph IWA–5241 instead of IWA–5242 for the 2007 Edition and later addenda of Section XI of the ASME B&PV Code.

10 CFR 50.55a(b)(2)(xxiv)

The NRC proposes to add a new paragraph (b)(2)(xxiv) which would condition the use of the fatigue crack growth rate calculation for subsurface flaws defined in paragraph A–4300(b)(1) of Section XI, Nonmandatory Appendix A when the ratio of the minimum cyclic stress to the maximum cyclic stress (R) is less than zero.

10 CFR 50.55a(b)(2)(xxv)

The NRC proposes to add a new paragraph (b)(2)(xxv) which would condition the use of ASME B&PV Code, Section XI, Non-Mandatory Appendix E, by establishing that Section E–1200 is not acceptable for use.

10 CFR 50.55a(b)(2)(xxvi)

The NRC proposes to add a new paragraph (b)(2)(xxvi) which would condition the use of ASME B&PV Code, Section XI, Non-Mandatory Appendix R to require licensees to submit an alternative in accordance with paragraph (a)(3) and obtain NRC authorization of the proposed alternative prior to implementing Appendix R, RI–ISI programs.

ASME OM Code

10 CFR 50.55a(b)(3)

The NRC proposes to revise the introductory text of paragraph (b)(3) to require that the 2004 Edition with the 2005 and 2006 Addenda of the ASME OM Code be used during the initial 120-month IST interval under paragraph (f)(4)(i) and during mandatory 120-month IST program updates under paragraph (f)(4)(ii). The proposed revision would also allow users to voluntarily update their IST programs to the 2004 Edition with the 2005 and 2006 Addenda of the ASME OM Code under paragraph (f)(4)(iv).

10 CFR 50.55a(b)(3)(v)

The NRC proposes to revise paragraph (b)(3)(v) to require that the provisions in Subsection ISTD of the ASME OM Code be used for the inservice examination and testing of snubbers when using the 2006 Addenda and later editions and addenda of Section XI.

10 CFR 50.55a(b)(3)(vi)

The NRC proposes to revise paragraph (b)(3)(vi) to require that the current condition for exercising manual valves continue to apply when using the 1999 through 2005 Addenda of the ASME OM Code. This condition would not apply to the 2006 Addenda and later

editions and addenda of the ASME OM Code.

Reactor Coolant Pressure Boundary, Quality Group B Components and Quality Group C Components

The NRC proposes to revise paragraphs (c)(3), (d)(2), and (e)(2) to replace "but—" with "subject to the following conditions" at the end of the introductory text to the paragraphs for clarity.

Inservice Testing Requirements

10 CFR 50.55a(f)(5)(iv)

The NRC proposes to revise paragraph (f)(5)(iv) to clarify that licensees are required to submit requests for relief based on impracticality within 12 months after the expiration of the IST interval for which relief is being sought.

Inservice Inspection Requirements

10 CFR 50.55a(g)(2), (g)(3)(i), (g)(3)(ii), the Introductory Text of (g)(4), (g)(4)(i), and (g)(4)(ii)

The NRC proposes to revise paragraphs (g)(2), (g)(3)(i), (g)(3)(ii), (g)(4)(i) and (g)(4)(ii) to require that the provisions in Subsection ISTD of the ASME OM Code, and the optional ASME code cases listed in Regulatory Guide 1.192, be used for the ISI of snubbers. The introductory text of paragraph (g)(4) would be revised to require that licensees use the provisions for examination and testing snubbers in Subsection ISTD of the ASME OM Code.

10 CFR 50.55a(g)(4)(iii)

The NRC proposes to revise paragraph (g)(4)(iii) to provide the proper references to Section XI, Table IWB–2500–1, "Examination Category B–J," Item Numbers B9.20, B9.21 and B9.22.

10 CFR 50.55a(g)(5)(iii)

The NRC proposes to revise paragraph (g)(5)(iii) by adding a sentence to clarify that a request for relief must be submitted to the NRC no later than 12 months after the examination has been attempted during a given ISI interval and the ASME Code requirement determined to be impractical.

10 CFR 55a(g)(5)(iv)

The NRC proposes to revise paragraph (g)(5)(iv) to clarify that licensees are required to submit requests for relief based on impracticality within 12 months after the end of the ISI interval for which relief is being sought.

10 CFR 50.55a(g)(6)(ii)(E)(1) through (g)(6)(ii)(E)(3)

The NRC proposes to revise paragraphs (g)(6)(ii)(E)(1) through (g)(6)(ii)(E)(3) to update the requirement to implement Code Case N–722–1.

10 CFR 50.55a(g)(6)(ii)(F)

The NRC proposes to add a new paragraph (g)(6)(ii)(F), "Inspection Requirements for Class 1 Pressurized Water Reactor Piping and Vessel Nozzle Butt Welds," to require licensees to implement ASME Code Case N–770, with conditions.

Footnote 1 to 10 CFR 50.55a(g)(6)(ii)(E)

The NRC proposes to revise footnote 1 to paragraph (g)(6)(ii)(E) to clarify that for inspections conducted once per interval, the portion of welds to be inspected in the remaining portion of the interval be based on rules already established by the ASME B&PV Code.

Substitution of the Term "Condition" in 10 CFR 50.55a

The NRC proposes to substitute the words "limitation(s)," "modification(s)," and "provision(s)" with the word "condition(s)" throughout 10 CFR 50.55a, as shown in Table 1 of this document, for consistency.

V. Generic Aging Lessons Learned Report

In September 2005, the NRC issued "Generic Aging Lessons Learned (GALL) Report," NUREG–1801, Volumes 1 and 2, Revision 1, for applicants to use in preparing their license renewal applications. The GALL Report evaluates existing programs and documents the bases for determining when existing programs, without change or augmentation, are adequate for aging management compliance in the license renewal rule, as given in 10 CFR 54.21(a)(3). In Revision 1 of the GALL Report, editions of the ASME B&PV Code, Section XI, Subsections IWB, IWC, IWD, IWE, IWF, and IWL from the 1995 Edition through the 2001 Edition, inclusive of the 2003 Addenda, were evaluated and were found to be acceptable editions and addenda for complying with the requirements of 10 CFR 54.21(a)(3), unless specifically noted in specific sections of the GALL Report.

In the GALL Report, Section XI.M1, "ASME Section XI Inservice Inspection, Subsections IWB, IWC, and IWD;" Section XI.S1, "ASME Section XI, Subsection IWE;" Section XI.S2,"ASME Section XI, Subsection IWL;" and Section XI.S3, "ASME Section XI, Subsection IWF" describe the evaluation and technical bases for determining the adequacy of these ASME Code subsections. In addition, many other aging management programs (AMPs) in the GALL report rely in part, but to a lesser degree, on the requirements in the ASME B&PV Code, Section XI.

The NRC has evaluated Subsections IWB, IWC, IWD, IWE, IWF, and IWL of Section XI of the ASME B&PV Code, 2004 Edition with the 2005 Addenda through the 2007 Edition with the 2008 Addenda as part of the § 50.55a amendment process to determine if the conclusions of the GALL Report also apply to AMPs that rely upon the ASME B&PV Code editions and addenda that are proposed to be incorporated by reference into § 50.55a by this rule. The NRC finds that the 2004 Edition, inclusive of the 2005 and 2006 Addenda, and the 2007 Edition, inclusive of the 2008 Addenda of Sections XI of the ASME B&PV Code, Subsections IWB, IWC, IWD, IWE, IWF, and IWL, as subject to the conditions of this rule, are acceptable to be adopted as AMPs for license renewal and the conclusions of the GALL Report remain valid, except where specifically noted and augmented in the GALL Report. Accordingly, an applicant for license renewal may use Subsections IWB, IWC, IWD, IWE, IWF, and IWL of Section XI of the 2004 Edition with the 2005 and 2006 Addenda through the 2007 Edition with the 2008 Addenda of the ASME B&PV Code, subject to conditions proposed in this rule, as acceptable alternatives to the requirements of the 1995 Edition through the 2001 Edition up to and including the 2003 Addenda of the ASME B&PV Code, Section XI, referenced in Revision 1 of the GALL Report in its plant-specific license renewal application. Similarly, a licensee approved for license renewal that relied on the GALL AMPs may use Subsections IWB, IWC, IWD, IWE, IWF, and IWL of Section XI of the 2004 Edition with the 2005 Addenda and the 2006 Addenda through the 2007 Edition with the 2008 Addenda of the ASME B&PV Code as acceptable alternatives to the AMPs described in the Revision 1 of the GALL report. However, a licensee must assess and follow applicable NRC requirements with regard to changes to its licensing basis.

The NRC, however, notes that the GALL Report includes Subsection IWE and IWL AMPs that are evaluated based on the requirements in the 1992 Edition and 2001 Edition through the 2003 Addenda of Section XI of the ASME B&PV Code. Also, some of the terminology used and some details in these AMPs are based on the 1992 Edition. Since these AMPs in Revision 1 of the GALL report have a specific ASME B&PV Code year in the description of the AMP or in one or more of the ten elements, the details in the AMP based on a specific ASME

B&PV Code edition may not be accurate for other editions.

Revision 1 of the GALL report includes AMPs that are based on the requirements in the 1995 Edition through the 2003 Addenda of Section XI of the ASME B&PV Code but in which the AMPs may recommend additional augmentation of the Code requirements in order to achieve aging management for license renewal. The technical or regulatory aspects of the AMPs, for which augmentation is recommended, also apply if using the 2004 Edition inclusive of the 2005 Addenda, or the 2007 Edition, inclusive of the 2008 Addenda, of Section XI of the ASME B&PV Code to meet the requirements of 10 CFR 54.21(a)(3). A license renewal applicant may either augment its AMPs in these areas, as described in the GALL report, or propose alternatives (exceptions) for the NRC to review as part of a plant-specific program element justification for its AMP.

For PWRs, the NRC currently provides license renewal guidance for augmented inspections of PWR upper reactor vessel heads and their penetration nozzles in GALL AMP XI.M11, "Nickel-Alloy Nozzles and Penetrations" and Alloy 600 Line items. As part of this AMP, PWR upper reactor vessel heads and their penetrations are discussed in GALL AMP XI.M11A, "Nickel-Alloy Penetration Nozzles Welded to the Upper Reactor Vessel Closure Heads of Pressurized Water Reactors (PWR Only)." The current program elements and aging management recommendations in GALL AMP XI.M11A are based on the augmented inspection requirements in the First Revised Order EA–03–009, "Issuance of First Revised Order (EA–03–009) Establishing Interim Inspection Requirements for Reactor Pressure Vessel Heads at Pressurized Water Reactors." For licensees that have been granted a renewed operating license and have committed to an AMP that is based on both conformance with GALL AMP XI.M11A and compliance with First Revised Order EA–03–009, the licensees may update the program elements of their AMP to reflect compliance with the proposed requirements in 10 CFR 50.55a(g)(6)(ii)(D) and (g)(6)(ii)(E) without having to identify an exception to GALL AMP XI.M11A. For new or current license renewal applicants, they may reference conformance with GALL AMP XI.M11 and compliance with the proposed augmented inspection requirements in paragraphs 10 CFR 50.55a(g)(6)(ii)(D), (g)(6)(ii)(E) and (g)(6)(ii)(F) without the need for taking an exception to the program elements in GALL AMP XI.M11 or GALL AMP XI.M11A.

VI. Specific Request for Comments

The NRC requests public comment on the changes to Code editions and addenda, and Code Cases N–722–1 and N–770, as part of this proposed rulemaking. The NRC also requests comments on specific NRC questions associated with its implementing 10 CFR 50.55a rulemaking process improvements to make incorporating by reference ASME B&PV Code editions and addenda into 10 CFR 50.55a more predictable and consistent. The primary process improvement is to have a 2-year rulemaking cycle consisting of 1-year to develop an adequate Regulatory Basis and send a proposed rule to NRC management for approval, and an additional 1-year from publishing the proposed rulemaking in the **Federal Register** to publishing the final rule (this includes the public comment period). This 2-year rulemaking cycle is to remain consistent, regardless of the number of code editions or addenda incorporated into 10 CFR 50.55a in the rulemaking. This should make publishing these rulemakings more consistent. However, this does not help users of the ASME B&PV Code predict when the NRC will incorporate new editions and addenda of the ASME Code into 10 CFR 50.55a as that would depend on when the NRC begins each 2-year rulemaking cycle.

As previously mentioned, the ASME issues new editions of the ASME B&PV Code every 3 years, issues addenda to the editions yearly except in years when a new edition is issued, and periodically publishes new editions and addenda of the ASME OM Code. However, the NRC understands that ASME is re-evaluating this process. The NRC could begin its rulemaking cycle any time (subject to availability of resources and other constraints) after the ASME publishes its code editions and addenda. However, the NRC is trying to determine how often it should publish its ASME B&PV Code rulemakings to suit the largest number of users. Some users have told the NRC that they prefer to have code rulemakings published every 2 years, while others have indicated that they prefer a 3-year interval. Accordingly, the NRC is requesting comments on the following questions:

1. What should the scope of the ASME B&PV Code edition and addenda rulemaking be (*i.e.,* how many editions and addenda should be compiled into a single rulemaking)?

2. What should the frequency of ASME B&PV Code edition and addenda rulemaking be (*i.e.,* how often should the NRC incorporate by reference Code editions and addenda into 10 CFR 50.55a)?

3. In what ways should the NRC communicate the scope, schedule for publishing the rulemakings in the **Federal Register**, and status of 10 CFR 50.55a rulemakings to external users?

The NRC will review the responses to these questions to help determine agency positions on the scope, frequency, and methods to communicate 10 CFR 50.55a rulemakings.

VII. Voluntary Consensus Standards

The National Technology Transfer and Advancement Act of 1995, Public Law 104–113, requires agencies to use technical standards that are developed or adopted by voluntary consensus standards bodies instead of government-unique standards, unless the use of such a standard is inconsistent with applicable law or is otherwise impractical. Public Law.104–113 requires Federal agencies to use industry consensus standards to the extent practical; it does not require Federal agencies to endorse a standard in its entirety. The law does not prohibit an agency from generally adopting a voluntary consensus standard while taking exception to specific portions of the standard if those provisions are deemed to be "inconsistent with applicable law or otherwise impractical." Furthermore, taking specific exceptions furthers the Congressional intent of Federal reliance on voluntary consensus standards because it allows the adoption of substantial portions of consensus standards without the need to reject the standards in their entirety because of limited provisions which are not acceptable to the agency.

The NRC is proposing to amend its regulations to incorporate by reference more recent editions and addenda of Sections III and XI of the ASME B&PV Code and ASME OM Code, for construction, in-service inspection, and in-service testing of nuclear power plant components. ASME B&PV and OM Codes are national consensus standards developed by participants with broad and varied interests, in which all interested parties (including the NRC and licensees of nuclear power plants) participate. In an SRM dated September 10, 1999, the Commission indicated its intent that a rulemaking identify all parts of an adopted voluntary consensus standard that are not adopted and to justify not adopting such parts. The parts of the ASME B&PV Code and OM Code that the NRC proposes not to adopt, or to partially adopt, are

previously identified in Section II and in the draft regulatory and backfit analysis. The parts of the ASME B&PV Code, OM Code, and Code Cases N–722–1 and N–770 that the NRC proposes to be conditionally acceptable, along with the conditions under which they may be applied, are also identified in Section II and in the draft regulatory and backfit analysis. If the NRC did not conditionally accept ASME editions, addenda, and code cases, it would disapprove these entirely. The effect would be that licensees would need to submit a larger number of relief requests, which would be an unnecessary additional burden for both the licensee and the NRC. For these reasons, the treatment of ASME Code editions and addenda, and code cases and any conditions proposed to be placed on them in this proposed rule does not conflict with any policy on agency use of consensus standards specified in OMB Circular A–119.

The justification for not adopting parts of, or conditioning, the ASME B&PV Code, OM Code, and Code Cases N–722–1 and N–770 as set forth in these statements of consideration and the draft regulatory and backfit analysis for this proposed rule, satisfy the requirements of Section 12(d)(3) of Public Law 104–113, Office of Management and Budget (OMB) Circular A–119, and the Commission's direction in the SRM dated September 10, 1999. In accordance with the National Technology Transfer and Advancement Act of 1995 and OMB Circular A–119, the NRC is requesting public comment regarding whether other national or international consensus standards could be endorsed as an alternative to the ASME B&PV Code and the ASME OM Code.

VIII. Finding of No Significant Environmental Impact: Environmental Assessment

This proposed action is in accordance with the NRC's policy to incorporate by reference in 10 CFR 50.55a new editions and addenda of the ASME B&PV and OM Codes to provide updated rules for constructing and inspecting components and testing pumps, valves, and dynamic restraints (snubbers) in light-water nuclear power plants. ASME Codes are national voluntary consensus standards and are required by the National Technology Transfer and Advancement Act of 1995, Public Law 104–113, to be used by government agencies unless the use of such a standard is inconsistent with applicable law or otherwise impractical. The National Environmental Policy Act (NEPA) requires Federal government agencies to study the impacts of their "major Federal actions significantly affecting the quality of the human environment," and prepare detailed statements on the environmental impacts of the proposed action and alternatives to the proposed action (42 U.S.C. 4332(C)); NEPA Sec. 102(C)).

The NRC has determined under NEPA, as amended, and the NRC's regulations in Subpart A of 10 CFR Part 51, that this proposed rule, if adopted, would not be a major Federal action significantly affecting the quality of the human environment and, therefore, an environmental impact statement is not required. The proposed rulemaking will not significantly increase the probability or consequences of accidents; no changes are being made in the types of effluents that may be released off-site; and there is no significant increase in public radiation exposure. The NRC estimates the radiological dose to plant personnel performing the inspections required by Code Case N–770 would be about 3 rems per plant over a 10-year interval, and a one-time exposure for mitigating welds of about 30 rems per plant. As required by 10 CFR part 20, and in accordance with current plant procedures and radiation protection programs, plant radiation protection staff will continue monitoring dose rates and would make adjustments in shielding, access requirements, decontamination methods, and procedures as necessary to minimize the dose to workers. The increased occupational dose to individual workers stemming from the Code Case N–770 inspections must be maintained within the limits of 10 CFR part 20 and as low as reasonably achievable. Therefore, the NRC concludes that the increase in occupational exposure would not be significant. The proposed rulemaking does not involve non-radiological plant effluents and has no other environmental impact. Therefore, no significant non-radiological impacts are associated with the proposed action. The determination of this draft environmental assessment is that there will be no significant off-site impact to the public from this action. However, the NRC is seeking public comment of the draft environmental assessment. Comments on any aspect of the environmental assessment may be submitted to the NRC as indicated under the **ADDRESSES** heading of this document.

IX. Paperwork Reduction Act Statement

The public burden for this information collection is estimated to be a reduction of 120 hours, which is insignificant. Because the burden for this information collection is insignificant, Office of Management and Budget (OMB) clearance is not required. Existing requirements were approved by the Office of Management and Budget, control number 3150–0011.

This proposed rule would impose ASME Code Cases N–722–1 and N–770 which results in licensees having to revise their ISI programs and procedures. The NRC estimates that the burden of preparing new ISI program content and procedures is 40 person-hours per plant over the next 3 years. This one-time burden affects 69 PWR plants, so the total burden on an annual basis would be 920 hours. However, there are a number of changes in the ASME Code edition and addenda associated with this proposed rulemaking related to qualification of inspections in Section XI, Appendix VIII. These changes would result in a one-time reduction of about 5 relief requests per plant (104 PWR and BWR plants) per 10-year ISI interval that would have otherwise been necessary. Assuming 20 hours of licensee time to prepare each relief request results in a one-time paperwork reduction of about 1,040 hours on an annual basis. Overall, the burden on licensees for information collection for this proposed rulemaking is reduced by 120 hours.

The NRC is seeking public comment on the potential impact of the information collections contained in this proposed rule and on the following issues:

1. Is the proposed information collection necessary for the proper performance of the functions of the NRC, including whether the information will have practical utility?
2. Is the estimate of burden accurate?
3. Is there a way to enhance the quality, utility, and clarity of the information to be collected?
4. How can the burden of the information collection be minimized, including the use of automated collection techniques?

A copy of the NRC Form 670, "Information Required for Making an Insignificant Burden Determination To Support a Decision That OMB Clearance Is Not Required," may be viewed free of charge at the NRC Public Document Room, One White Flint North, 11555 Rockville Pike, Room O–1 F21, Rockville, MD 20852. The NRC Form 670 and rule are available at the NRC worldwide Web site: *http://www.nrc.gov/public-involve/doccomment/omb/index.html* for 60 days after the signature date of this notice.

Send comments on any aspect of these proposed information collections, including suggestions for reducing the burden and on the above issues, by June 3, 2010 to the Records and FOIA/Privacy Services Branch (T–5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, or by Internet electronic mail to *INFOCOLLECTS.RESOURCE@NRC.GOV* and to Christine J. Kymn, the Desk Officer, Office of Information and Regulatory Affairs, NEOB–10202 (3150–0011), Office of Management and Budget, Washington, DC 20503. Comments received after this date will be considered if it is practical to do so, but assurance of consideration cannot be given to comments received after this date. You may also e-mail comments to *ckym@omb.eop.gov* or comment by telephone at 202–395–4638.

Public Protection Notification

The NRC may not conduct or sponsor, and a person is not required to respond to, a request for information or an information collection unless the requesting document displays a currently valid OMB control number.

X. Regulatory and Backfit Analysis

The NRC has prepared a Regulatory and Backfit Analysis on this proposed rule. The analysis is available for review as indicated in Section I, "Submitting Comments and Accessing Information," of this document.

XI. Regulatory Flexibility Certification

Under the Regulatory Flexibility Act of 1980 (5 U.S.C. 605(b)), the NRC certifies that this proposed rule would not impose a significant economical impact on a substantial number of small entities. This proposed rule would affect only the licensing and operation of commercial nuclear power plants. A licensee who is a subsidiary of a large entity does not qualify as a small entity. The companies that own these plants are not "small entities" as defined in the Regulatory Flexibility Act or the size standards established by the NRC (10 CFR 2.810), as the companies:

- Provide services that are not engaged in manufacturing, and have average gross receipts of more than $6.5 million over their last 3 completed fiscal years, and have more than 500 employees;
- Are not governments of a city, county, town, township or village;
- Are not school districts or special districts with populations of less than 50; and
- Are not small educational institutions.

List of Subjects in 10 CFR Part 50

Antitrust, Classified information, Criminal penalties, Fire protection, Intergovernmental relations, Nuclear power plants and reactors, Radiation protection, Reactor siting criteria, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, and under the authority of the Atomic Energy Act of 1954, as amended; the Energy Reorganization Act of 1974, as amended; and 5 U.S.C. 553, the NRC proposes to adopt the following amendments to 10 CFR part 50.

PART 50—DOMESTIC LICENSING OF PRODUCTION AND UTILIZATION FACILITIES

1. The authority citation for part 50 continues to read as follows:

Authority: Secs. 102, 103, 104, 105, 161, 182, 183, 186, 189, 68 Stat. 936, 937, 938, 948, 953, 954, 955, 956, as amended, sec. 234, 83 Stat. 444, as amended (42 U.S.C. 2132, 2133, 2134, 2135, 2201, 2232, 2233, 2236, 2239, 2282); secs. 201, as amended, 202, 206, 88 Stat. 1242, as amended, 1244, 1246 (42 U.S.C. 5841, 5842, 5846); sec. 1704, 112 Stat. 2750 (44 U.S.C. 3504 note); Energy Policy Act of 2005, Pub. L. 109–58, 119 Stat. 194 (2005).

Section 50.7 also issued under Pub. L. 95–601, sec. 10, 92 Stat. 2951 as amended by Pub. L. 102–486, sec. 2902, 106 Stat. 3123 (42 U.S.C. 5841), Section 50.10 also issued under secs. 101, 185, 68 Stat. 955, as amended (42 U.S.C. 2131, 2235); sec. 102, Pub. L. 91–190, 83 Stat. 853 (42 U.S.C. 4332). Sections 50.13, 50.54(dd), and 50.103 also issued under sec. 108, 68 Stat. 939, as amended (42 U.S.C. 2138).

Sections 50.23, 50.35, 50.55, and 50.56 also issued under sec. 185, 68 Stat. 955 (42 U.S.C. 2235). Sections 50.33a, 50.55a and Appendix Q also issued under sec. 102, Pub. L. 91–190, 83 Stat. 853 (42 U.S.C. 4332). Sections 50.34 and 50.54 also issued under sec. 204, 88 Stat. 1245 (42 U.S.C. 5844). Sections 50.58, 50.91, and 50.92 also issued under Pub. L. 97–415, 96 Stat. 2073 (42 U.S.C. 2239). Section 50.78 also issued under sec. 122, 68 Stat. 939 (42 U.S.C. 2152). Sections 50.80–50.81 also issued under sec. 184, 68 Stat. 954, as amended (42 U.S.C. 2234). Appendix F also issued under sec. 187, 68 Stat. 955 (42 U.S.C. 2237).

2. In § 50.55a:

a. Revise paragraph (a), the introductory text of paragraphs (b) and (b)(1), paragraphs (b)(1)(ii), (b)(1)(iii), and (b)(1)(iv); and add paragraph (b)(1)(vii);

b. Revise paragraph (b)(2);

c. Revise the introductory text of paragraph (b)(3), paragraphs (b)(3)(v), (b)(3)(vi), (c)(3), (d)(2), (e)(2), (f)(2), (f)(3)(v), (f)(4), (f)(5)(iv), (g)(2), (g)(3), (g)(4), (g)(5)(iii), (g)(5)(iv), (g)(6)(ii)(B), (g)(6)(ii)(E)(*1*), (g)(6)(ii)(E)(*2*), and (g)(6)(ii)(E)(*3*);

d. Add paragraph (g)(6)(ii)(F); and

e. Revise footnote 1 to this section that appears after paragraph (h)(3) to read as follows:

§ 50.55a Codes and standards.

* * * * *

(a) *Quality standards, ASME Codes and IEEE standards, and alternatives.*

(1) Structures, systems, and components must be designed, fabricated, erected, constructed, tested, and inspected to quality standards commensurate with the importance of the safety function to be performed.

(2) Systems and components of boiling and pressurized water-cooled nuclear power reactors must meet the requirements of the ASME Boiler and Pressure Vessel Code specified in paragraphs (b), (c), (d), (e), (f), and (g) of this section. Protection systems of nuclear power reactors of all types must meet the requirements specified in paragraph (h) of this section.

(3) Proposed alternatives to the requirements of paragraphs (c), (d), (e), (f), (g), and (h) of this section, or portions thereof, may be used when authorized by the Director, Office of Nuclear Reactor Regulation, or Director, Office of New Reactors, as appropriate. Any proposed alternatives must be submitted and authorized prior to implementation. The applicant or licensee shall demonstrate that:

(i) The proposed alternatives would provide an acceptable level of quality and safety; or

(ii) Compliance with the specified requirements of this section would result in hardship or unusual difficulty without a compensating increase in the level of quality and safety.

(b) *Standards approved for incorporation by reference.* The following standards have been approved for incorporation by reference by the Director of the Federal Register pursuant to 5 U.S.C. 552(a) and 1 CFR Part 51: Section III, Division 1 (excluding Non-mandatory Appendices) and Section XI, Division 1, of the ASME Boiler and Pressure Vessel Code, and the ASME Code for Operation and Maintenance of Nuclear Power Plants, which are referenced in paragraphs (b)(1), (b)(2), and (b)(3) of this section; NRC Regulatory Guide 1.84, Revision 34, "Design, Fabrication, and Materials Code Case Acceptability, ASME Section III" (October 2007), NRC Regulatory Guide 1.147, Revision 15, "Inservice Inspection Code Case Acceptability, ASME Section XI, Division 1" (October 2007), and Regulatory Guide 1.192, "Operation and Maintenance Code Case Acceptability, ASME OM Code" (June 2003), which list ASME Code cases that

the NRC has approved in accordance with the requirements in paragraphs (b)(4), (b)(5), and (b)(6) of this section; ASME Code Case N–722–1, "Additional Examinations for PWR Pressure Retaining Welds in Class 1 Components Fabricated with Alloy 600/82/182 Materials, Section XI, Division 1" (ASME Approval Date: January 26, 2009), which has been approved by the NRC with conditions in accordance with the requirements in paragraph (g)(6)(ii)(E) of this section; ASME Code Case N–729–1, "Alternative Examination Requirements for PWR Reactor Vessel Upper Heads With Nozzles Having Pressure-Retaining Partial-Penetration Welds, Section XI, Division 1" (ASME Approval Date: March 28, 2006), which has been approved by the NRC with conditions in accordance with the requirements in paragraph (g)(6)(ii)(D) of this section; and ASME Code Case N–770, "Alternative Examination Requirements and Acceptance Standards for Class 1 PWR Piping and Vessel Nozzle Butt Welds Fabricated with UNS N06082 or UNS W86182 Weld Filler Material With or Without Application of Listed Mitigation Activities, Section XI, Division 1," (ASME Approval Date: January 26, 2009), which has been approved by the NRC with conditions in accordance with the requirements in paragraph (g)(6)(ii)(F) of this section. Copies of the ASME Boiler and Pressure Vessel Code, the ASME Code for Operation and Maintenance of Nuclear Power Plants, ASME Code Case N–722–1, ASME Code Case N–729–1, and ASME Code Case N–770 may be purchased from the American Society of Mechanical Engineers, Three Park Avenue, New York, NY 10016 or through the Web *http://www.asme.org/Codes/.* Single copies of NRC Regulatory Guides 1.84, Revision 34; 1.147, Revision 15; and 1.192 may be obtained free of charge by writing the Reproduction and Distribution Services Section, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; or by fax to 301–415–2289; or by e-mail to *DISTRIBUTION.RESOURCE@nrc.gov.* Copies of the ASME Codes and NRC Regulatory Guides incorporated by reference in this section may be inspected at the NRC Technical Library, Two White Flint North, 11545 Rockville Pike, Rockville, MD 20852–2738 or call 301–415–5610, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

(1) As used in this section, references to Section III refer to Section III of the ASME Boiler and Pressure Vessel Code, and include the 1963 Edition through 1973 Winter Addenda, and the 1974 Edition (Division 1) through the 2008 Addenda (Division 1), subject to the following conditions:

* * * * *

(ii) *Weld leg dimensions.* When applying the 1989 Addenda through the latest edition and addenda incorporated by reference in paragraph (b)(1) of this section, applicants or licensees may not apply subparagraphs NB–3683.4(c)(1) and NB–3683.4(c)(2) or Footnote 11 from the 1989 Addenda through the 2003 Addenda, or Footnote 13 from the 2004 Edition through the 2008 Addenda to Figures NC–3673.2(b)–1 and ND–3673.2(b)–1 for welds with leg size less than 1.09 t_n.

(iii) *Seismic design of piping.* Applicants or licensees may use Subarticles NB–3200, NB–3600, NC–3600, and ND–3600 for seismic design of piping, up to and including the 1993 Addenda, subject to the condition specified in paragraph (b)(1)(ii) of this section. Applicants or licensees may not use these subarticles for seismic design of piping in the 1994 Addenda through the 2006 Addenda incorporated by reference in paragraph (b)(1) of this section except that Subarticle NB–3200 in the 2004 Edition through the 2008 Addenda may be used by applicants and licensees subject to the condition in paragraph (b)(1)(iii)(B) of this section. Applicants or licensees may use Subarticles NB–3600, NC–3600 and ND–3600 for the seismic design of piping in the 2006 Addenda through the 2008 Addenda subject to the conditions of this paragraph corresponding to these subarticles.

(A) For Class 1 elbows and tees of ferritic steel materials operating at temperatures above 300 °F, the allowable B_2' index defined in Subparagraph NB–3656(b)(3) shall be no less than $0.75B_2$ from Table NB–3681(A)–1.

(B) When applying Note (1) of Figure NB–3222–1 for Level B service limits, the calculation of P_b stresses must include reversing dynamic loads (including inertia earthquake effects) if evaluation of these loads is required.

(C) D_o/t must not be greater than 40, where D_o is the outer diameter of pipe, and t is the nominal pipe thickness. Subparagraph NB–3683.2(C), Note (1) to Table NB–3681(a)–1, Note (3) to Figures NC–3673.2(b)–1 and ND–3673.2(b)–1 may not be applied.

(iv) *Quality assurance.* When applying editions and addenda later than the 1989 Edition of Section III, the requirements of NQA–1, "Quality Assurance Requirements for Nuclear Facilities," 1986 Edition through the 1994 Edition, are acceptable for use, provided that the edition and addenda of NQA–1 specified in NCA–4000 is used in conjunction with the administrative, quality, and technical provisions contained in the edition and addenda of Section III being used.

* * * * *

(vii) *Capacity certification and demonstration of function of incompressible-fluid pressure-relief valves.* When applying the 2006 Addenda through the 2008 Addenda, applicants or licensees may not apply paragraph NB–7742 of the ASME B&PV Code, Section III. New Class 1 incompressible-fluid, pressure-relief valve designs must be tested at the highest values of set-pressure ranges as required by prior editions and addenda of the ASME B&PV Code, Section III.

(2) As used in this section, references to Section XI refer to Section XI, Division 1, of the ASME Boiler and Pressure Vessel Code, and include the 1970 Edition though the 1976 Winter Addenda, and the 1977 Edition through the 2007 Edition with the 2008 Addenda, subject to the following conditions:

(i) *Pressure-retaining welds in ASME Code Class 1 piping (applies to Table IWB–2500 and IWB–2500–1 and Category B–J).* If the facility's application for a construction permit was docketed prior to July 1, 1978, the extent of examination for Code Class 1 pipe welds may be determined by the requirements of Table IWB–2500 and Table IWB–2600 Category B–J of Section XI of the ASME B&PV Code in the 1974 Edition and addenda through the Summer 1975 Addenda or other requirements the NRC may adopt.

(ii) *Effective edition and addenda of Subsection IWE and Subsection IWL, Section XI.* Applicants or licensees may use either the 1992 Edition with the 1992 Addenda or the 1995 Edition with the 1996 Addenda of Subsection IWE and Subsection IWL as conditioned by the requirements in paragraphs (b)(2)(iv) and (b)(2)(v) of this section when implementing the initial 120-month inspection interval for the containment inservice inspection requirements of this section. Successive 120-month interval updates must be implemented in accordance with paragraph (g)(4)(ii) of this section.

(iii) *Section XI References to OM Part 4, OM Part 6 and OM Part 10 (Table*

IWA–1600–1). When using Table IWA–1600–1, "Referenced Standards and Specifications," in the Section XI, Division 1, 1987 Addenda, 1988 Addenda, or 1989 Edition, the specified "Revision Date or Indicator" for ASME/ANSI OM Part 4, ASME/ANSI Part 6, and ASME/ANSI Part 10 must be the OMa–1988 Addenda to the OM–1987 Edition. These requirements have been incorporated into the OM Code which is incorporated by reference in paragraph (b)(3) of this section.

(iv) *Examination of concrete containments.* Applicants or licensees applying Subsection IWL, 1992 Edition with the 1992 Addenda, shall apply paragraphs (b)(2)(iv)(A) of this section. Applicants or licensees applying Subsection IWL, 1995 Edition with the 1996 Addenda, shall apply paragraphs (b)(2)(iv)(A), (b)(2)(iv)(D)(*3*), and (b)(2)(iv)(E) of this section. Applicants or licensees applying Subsection IWL, 1998 Edition through the 2000 Addenda shall apply paragraphs (b)(2)(iv)(E) and (b)(2)(iv)(F) of this section. Applicants or licensees applying Subsection IWL, 2001 Edition through the 2004 Edition, up to and including the 2006 Addenda, shall apply paragraphs (b)(2)(iv)(E) through (b)(2)(iv)(G) of this section. Applicants or licensees applying Subsection IWL, 2007 Edition through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section, shall apply paragraph (b)(2)(iv)(E) of this section.

(A) Grease caps that are accessible must be visually examined to detect grease leakage or grease cap deformations. Grease caps must be removed for this examination when there is evidence of grease cap deformation that indicates deterioration of anchorage hardware.

(B) When evaluation of consecutive surveillances of prestressing forces for the same tendon or tendons in a group indicates a trend of prestress loss such that the tendon force(s) would be less than the minimum design prestress requirements before the next inspection interval, an evaluation must be performed and reported in the Engineering Evaluation Report as prescribed in IWL–3300.

(C) When the elongation corresponding to a specific load (adjusted for effective wires or strands) during retensioning of tendons differs by more than 10 percent from that recorded during the last measurement, an evaluation must be performed to determine whether the difference is related to wire failures or slip of wires in anchorage. A difference of more than 10 percent must be identified in the ISI Summary Report required by IWA–6000.

(D) The applicant or licensee shall report the following conditions, if they occur, in the ISI Summary Report required by IWA–6000:

(*1*) The sampled sheathing filler grease contains chemically combined water exceeding 10 percent by weight or the presence of free water;

(*2*) The absolute difference between the amount removed and the amount replaced exceeds 10 percent of the tendon net duct volume;

(*3*) Grease leakage is detected during general visual examination of the containment surface.

(E) For Class CC applications, the applicant or licensee shall evaluate the acceptability of inaccessible areas when conditions exist in accessible areas that could indicate the presence of or result in degradation to such inaccessible areas. For each inaccessible area identified, the applicant or licensee shall provide the following in the ISI Summary Report required by IWA–6000:

(*1*) A description of the type and estimated extent of degradation, and the conditions that led to the degradation;

(*2*) An evaluation of each area, and the result of the evaluation, and;

(*3*) A description of necessary corrective actions.

(F) Personnel that examine containment concrete surfaces and tendon hardware, wires, or strands must meet the qualification provisions in IWA–2300. The "owner-defined" personnel qualification provisions in IWL–2310(d) are not approved for use.

(G) Corrosion protection material must be restored following concrete containment post-tensioning system repair and replacement activities in accordance with the quality assurance program requirements specified in IWA–1400.

(v) *Examination of metal containments and the liners of concrete containments.* Applicants or licensees applying Subsection IWE, 1992 Edition with the 1992 Addenda, or the 1995 Edition with the 1996 Addenda, shall satisfy the requirements of paragraphs (b)(2)(v)(A) through (b)(2)(v)(E) of this section. Applicants or licensees applying Subsection IWE, 1998 Edition through the 2001 Edition with the 2003 Addenda, shall satisfy the requirements of paragraphs (b)(2)(v)(A), (b)(2)(v)(B), and (b)(2)(v)(F) through (b)(2)(v)(I) of this section. Applicants or licensees applying Subsection IWE, 2004 Edition, up to and including, the 2005 Addenda, shall satisfy the requirements of paragraphs (b)(2)(v)(A), (b)(2)(v)(B), and (b)(2)(v)(F) through (b)(2)(v)(H) of this section. Applicants or licensees Licensees applying Subsection IWE, 2004 Edition with the 2006 Addenda, shall satisfy the requirements of paragraphs (b)(2)(v)(A) and (b)(2)(v)(B) of this section. Applicants or licensees applying Subsection IWE, 2007 Edition through the latest addenda incorporated by reference in paragraph (b)(2) of this section, shall satisfy the requirements of paragraphs (b)(2)(v)(A), (b)(2)(v)(B) and (b)(2)(v)(J) of this section.

(A) For Class MC applications, the applicant or licensee shall evaluate the acceptability of inaccessible areas when conditions exist in accessible areas that could indicate the presence of or result in degradation to such inaccessible areas. For each inaccessible area identified, the applicant or licensee shall provide the following in the ISI Summary Report as required by IWA–6000:

(*1*) A description of the type and estimated extent of degradation, and the conditions that led to the degradation;

(*2*) An evaluation of each area, and the result of the evaluation, and;

(*3*) A description of necessary corrective actions.

(B) When performing remotely the visual examinations required by Subsection IWE, the maximum direct examination distance specified in Table IWA–2210–1 may be extended and the minimum illumination requirements specified in Table IWA–2210–1 may be decreased provided that the conditions or indications for which the visual examination is performed can be detected at the chosen distance and illumination.

(C) The examinations specified in Examination Category E–B, Pressure Retaining Welds, and Examination Category E–F, Pressure Retaining Dissimilar Metal Welds, are optional.

(D) Paragraph (b)(2)(v)(D) of this section may be used as an alternative to the requirements of IWE–2430.

(*1*) If the examinations reveal flaws or areas of degradation exceeding the acceptance standards of Table IWE–3410–1, an evaluation must be performed to determine whether additional component examinations are required. For each flaw or area of degradation identified which exceeds acceptance standards, the applicant or licensee shall provide the following in the ISI Summary Report required by IWA–6000:

(*i*) A description of each flaw or area, including the extent of degradation, and the conditions that led to the degradation;

(*ii*) The acceptability of each flaw or area, and the need for additional examinations to verify that similar

degradation does not exist in similar components, and;

(*iii*) A description of necessary corrective actions.

(*2*) The number and type of additional examinations to ensure detection of similar degradation in similar components.

(E) A general visual examination as required by Subsection IWE must be performed once each period.

(F) VT–1 and VT–3 examinations must be conducted in accordance with IWA–2200. Personnel conducting examinations in accordance with the VT–1 or VT–3 examination method shall be qualified in accordance with IWA–2300. The "owner-defined" personnel qualification provisions in IWE–2330(a) for personnel that conduct VT–1 and VT–3 examinations are not approved for use.

(G) The VT–3 examination method must be used to conduct the examinations in Items E1.12 and E1.20 of Table IWE–2500–1, and the VT–1 examination method must be used to conduct the examination in Item E4.11 of Table IWE–2500–1. An examination of the pressure-retaining bolted connections in Item E1.11 of Table IWE–2500–1 using the VT–3 examination method must be conducted once each interval. The "owner-defined" visual examination provisions in IWE–2310(a) are not approved for use for VT–1 and VT–3 examinations.

(H) Containment bolted connections that are disassembled during the scheduled performance of the examinations in Item E1.11 of Table IWE–2500–1 must be examined using the VT–3 examination method. Flaws or degradation identified during the performance of a VT–3 examination must be examined in accordance with the VT–1 examination method. The criteria in the material specification or IWB–3517.1 must be used to evaluate containment bolting flaws or degradation. As an alternative to performing VT–3 examinations of containment bolted connections that are disassembled during the scheduled performance of Item E1.11, VT–3 examinations of containment bolted connections may be conducted whenever containment bolted connections are disassembled for any reason.

(I) The ultrasonic examination acceptance standard specified in IWE–3511.3 for Class MC pressure-retaining components must also be applied to metallic liners of Class CC pressure-retaining components.

(J) In general, the cutting of a large hole in the containment pressure boundary for replacement of steam generators, reactor vessel heads, pressurizers, or other similar modification is considered a "major" modification or repair/replacement for Class MC and Class CC containment structures. When applying IWE–5000, any repair/replacement that is a "major" containment modification, as defined in this section, must be followed by a Type A test to provide assurance of containment structural and leaktight integrity prior to returning to service, in accordance with 10 CFR part 50, appendix J, Option A or Option B on which the applicant's or licensee's Containment Leak-Rate Testing Program is based. When applying IWE–5000, if a Type A, B, or C Test is performed, the acceptance standard for the test must be in accordance with 10 CFR part 50, appendix J. In lieu of performing the Type A test, the applicant or licensee may conduct a short-duration structural test of the containment, which is a combination of actions to ensure that:

(*1*) The modified containment meets the pre-service non-destructive examination (NDE) test requirements as required by the construction code;

(*2*) The locally welded areas are examined for essentially zero leakage using a soap bubble test, or an equivalent test;

(*3*) The entire containment is subjected to the peak calculated containment design basis accident pressure, P_a, for a minimum of 10 minutes (Class MC steel containment) and 1 hour (Class CC concrete containment); and

(*4*) The outside surfaces of concrete containments are visually examined as required by Subsection IWL, during the peak pressure, and that the outside and inside surfaces of the steel containment surfaces are examined as required by Subsection IWE, during or immediately after the test.

(vi) *Quality assurance.* When applying Section XI editions and addenda later than the 1989 Edition, the requirements of NQA–1, "Quality Assurance Requirements for Nuclear Facilities," 1979 Addenda through the 1989 Edition, are acceptable as permitted by IWA–1400 of Section XI, if the licensee uses its 10 CFR part 50, appendix B, quality assurance program, in conjunction with Section XI requirements. Commitments contained in the licensee's quality assurance program description that are more stringent than those contained in NQA–1 must govern Section XI activities. Further, where NQA–1 and Section XI do not address the commitments contained in the licensee's Appendix B quality assurance program description, the commitments must be applied to Section XI activities.

(vii) [Reserved]

(viii) *Underwater welding.* The provisions in IWA–4660, "Underwater Welding," of Section XI, 1997 Addenda through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section, are not approved for use on irradiated material.

(ix) [Reserved]

(x) *Appendix VIII personnel qualification.* All personnel qualified for performing ultrasonic examinations in accordance with Appendix VIII shall receive 8 hours of annual hands-on training on specimens that contain cracks. Licensees applying the 1999 Addenda through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section may use the annual practice requirements in VII–4240 of Appendix VII of Section XI in place of the 8 hours of annual hands-on training provided that the supplemental practice is performed on material or welds that contain cracks, or by analyzing prerecorded data from material or welds that contain cracks. In either case, training must be completed no earlier than 6 months prior to performing ultrasonic examinations at a licensee's facility.

(xi) *Appendix VIII specimen set and qualification requirements.* Licensees using Appendix VIII in the 1995 Edition through the 2001 Edition of the ASME Boiler and Pressure Vessel Code may elect to comply with all of the provisions in paragraphs (b)(2)(xi)(A) through (b)(2)(xi)(M) of this section, except for paragraph (b)(2)(xi)(F) of this section, which may be used at the licensee's option. Licensees using editions and addenda after 2001 Edition through the 2006 Addenda shall use the 2001 Edition of Appendix VIII, and may elect to comply with all of the provisions in paragraphs (b)(2)(xi)(A) through (b)(2)(xi)(M) of this section, except for paragraph (b)(2)(xi)(F) of this section, which may be used at the licensee's option.

(A) When applying Supplements 2, 3, and 10 to Appendix VIII, the following examination coverage criteria requirements must be used:

(*1*) Piping must be examined in two axial directions, and when examination in the circumferential direction is required, the circumferential examination must be performed in two directions, provided access is available. Dissimilar metal welds must be examined axially and circumferentially.

(*2*) Where examination from both sides is not possible, full coverage credit may be claimed from a single side for ferritic welds. Where examination from

both sides is not possible on austenitic welds or dissimilar metal welds, full coverage credit from a single side may be claimed only after completing a successful single-sided Appendix VIII demonstration using flaws on the opposite side of the weld. Dissimilar metal weld qualifications must be demonstrated from the austenitic side of the weld and may be used to perform examinations from either side of the weld.

(B) The following conditions must be used in addition to the requirements of Supplement 4 to Appendix VIII:

(*1*) Paragraph 3.1, Detection acceptance criteria—Personnel are qualified for detection if the results of the performance demonstration satisfy the detection requirements of ASME Section XI, Appendix VIII, Table VIII–S4–1 and no flaw greater than 0.25 inch through wall dimension is missed.

(*2*) Paragraph 1.1(c), Detection test matrix—Flaws smaller than the 50 percent of allowable flaw size, as defined in IWB–3500, need not be included as detection flaws. For procedures applied from the inside surface, use the minimum thickness specified in the scope of the procedure to calculate a/t. For procedures applied from the outside surface, the actual thickness of the test specimen is to be used to calculate a/t.

(C) When applying Supplement 4 to Appendix VIII, the following conditions must be used:

(*1*) A depth sizing requirement of 0.15 inch RMS must be used in lieu of the requirements in Subparagraphs 3.2(a) and 3.2(c), and a length sizing requirement of 0.75 inch RMS must be used in lieu of the requirement in Subparagraph 3.2(b).

(*2*) In lieu of the location acceptance criteria requirements of Subparagraph 2.1(b), a flaw will be considered detected when reported within 1.0 inch or 10 percent of the metal path to the flaw, whichever is greater, of its true location in the X and Y directions.

(*3*) In lieu of the flaw type requirements of Subparagraph 1.1(e)(1), a minimum of 70 percent of the flaws in the detection and sizing tests shall be cracks. Notches, if used, must be limited by the following:

(*i*) Notches must be limited to the case where examinations are performed from the clad surface.

(*ii*) Notches must be semielliptical with a tip width of less than or equal to 0.010 inches.

(*iii*) Notches must be perpendicular to the surface within ±2 degrees.

(*4*) In lieu of the detection test matrix requirements in paragraphs 1.1(e)(2) and 1.1(e)(3), personnel demonstration test sets must contain a representative distribution of flaw orientations, sizes, and locations.

(D) The following conditions must be used in addition to the requirements of Supplement 6 to Appendix VIII:

(*1*) Paragraph 3.1, Detection Acceptance Criteria—Personnel are qualified for detection if:

(*i*) No surface connected flaw greater than 0.25 inch through wall has been missed.

(*ii*) No embedded flaw greater than 0.50 inch through wall has been missed.

(*2*) Paragraph 3.1, Detection Acceptance Criteria—For procedure qualification, all flaws within the scope of the procedure are detected.

(*3*) Paragraph 1.1(b) for detection and sizing test flaws and locations—Flaws smaller than the 50 percent of allowable flaw size, as defined in IWB–3500, need not be included as detection flaws. Flaws which are less than the allowable flaw size, as defined in IWB–3500, may be used as detection and sizing flaws.

(*4*) Notches are not permitted.

(E) When applying Supplement 6 to Appendix VIII, the following conditions must be used:

(*1*) A depth sizing requirement of 0.25 inch RMS must be used in lieu of the requirements of subparagraphs 3.2(a), 3.2(c)(2), and 3.2(c)(3).

(*2*) In lieu of the location acceptance criteria requirements in Subparagraph 2.1(b), a flaw will be considered detected when reported within 1.0 inch or 10 percent of the metal path to the flaw, whichever is greater, of its true location in the X and Y directions.

(*3*) In lieu of the length sizing criteria requirements of Subparagraph 3.2(b), a length sizing acceptance criteria of 0.75 inch RMS must be used.

(*4*) In lieu of the detection specimen requirements in Subparagraph 1.1(e)(1), a minimum of 55 percent of the flaws must be cracks. The remaining flaws may be cracks or fabrication type flaws, such as slag and lack of fusion. The use of notches is not allowed.

(*5*) In lieu of paragraphs 1.1(e)(2) and 1.1(e)(3) detection test matrix, personnel demonstration test sets must contain a representative distribution of flaw orientations, sizes, and locations.

(F) The following conditions may be used for personnel qualification for combined Supplement 4 to Appendix VIII and Supplement 6 to Appendix VIII qualification. Licensees choosing to apply this combined qualification shall apply all of the provisions of Supplements 4 and 6 including the following conditions:

(*1*) For detection and sizing, the total number of flaws must be at least 10. A minimum of 5 flaws shall be from Supplement 4, and a minimum of 50 percent of the flaws must be from Supplement 6. At least 50 percent of the flaws in any sizing must be cracks. Notches are not acceptable for Supplement 6.

(*2*) Examination personnel are qualified for detection and length sizing when the results of any combined performance demonstration satisfy the acceptance criteria of Supplement 4 to Appendix VIII.

(*3*) Examination personnel are qualified for depth sizing when Supplement 4 to Appendix VIII and Supplement 6 to Appendix VIII flaws are sized within the respective acceptance criteria of those supplements.

(G) When applying Supplement 4 to Appendix VIII, Supplement 6 to Appendix VIII, or combined Supplement 4 and Supplement 6 qualification, the following additional conditions must be used, and examination coverage must include:

(*1*) The clad to base metal interface, including a minimum of 15 percent T (measured from the clad to base metal interface), must be examined from four orthogonal directions using procedures and personnel qualified in accordance with Supplement 4 to Appendix VIII.

(*2*) If the clad-to-base-metal-interface procedure demonstrates delectability of flaws with a tilt angle relative to the weld centerline of at least 45 degrees, the remainder of the examination volume is considered fully examined if coverage is obtained in one parallel and one perpendicular direction. This must be accomplished using a procedure and personnel qualified for single-side examination in accordance with Supplement 6. Subsequent examinations of this volume may be performed using examination techniques qualified for a tilt angle of at least 10 degrees.

(*3*) The examination volume not addressed by paragraph (b)(2)(xi)(G)(*1*) of this section is considered fully examined if coverage is obtained in one parallel and one perpendicular direction, using a procedure and personnel qualified for single sided examination when the conditions in paragraph (b)(2)(xi)(G)(*2*) are met.

(H) When applying Supplement 5 to Appendix VIII, at least 50 percent of the flaws in the demonstration test set must be cracks and the maximum mis-orientation must be demonstrated with cracks. Flaws in nozzles with bore diameters equal to or less than 4 inches may be notches.

(I) When applying Supplement 5, Paragraph (a), to Appendix VIII, the number of false calls allowed must be

D/10, with a maximum of 3, where D is the diameter of the nozzle.

(J) [Reserved]

(K) When performing nozzle-to-vessel weld examinations, the following conditions must be used when the requirements contained in Supplement 7 to Appendix VIII are applied for nozzle-to-vessel welds in conjunction with Supplement 4 to Appendix VIII, Supplement 6 to Appendix VIII, or combined Supplement 4 and Supplement 6 qualification.

(*1*) For examination of nozzle-to-vessel welds conducted from the bore, the following conditions are required to qualify the procedures, equipment, and personnel:

(*i*) For detection, a minimum of four flaws in one or more full-scale nozzle mock-ups must be added to the test set. The specimens must comply with Supplement 6, paragraph 1.1, to Appendix VIII, except for flaw locations specified in Table VIII S6–1. Flaws may be notches, fabrication flaws or cracks. Seventy-five (75) percent of the flaws must be cracks or fabrication flaws. Flaw locations and orientations must be selected from the choices shown in paragraph (b)(2)(xi)(K)(*4*) of this section, Table VIII–S7–1—Modified, with the exception that flaws in the outer eighty-five (85) percent of the weld need not be perpendicular to the weld. There may be no more than two flaws from each category, and at least one subsurface flaw must be included.

(*ii*) For length sizing, a minimum of four flaws as in paragraph (b)(2)(xi)(K)(*1*)(*i*) of this section must be included in the test set. The length sizing results must be added to the results of combined Supplement 4 to Appendix VIII and Supplement 6 to Appendix VIII. The combined results must meet the acceptance standards contained in paragraph (b)(2)(xi)(E)(*3*) of this section.

(*iii*) For depth sizing, a minimum of four flaws as in paragraph (b)(2)(xi)(K)(*1*)(*i*) of this section must be included in the test set. Their depths must be distributed over the ranges of Supplement 4, Paragraph 1.1, to Appendix VIII, for the inner 15 percent of the wall thickness and Supplement 6, Paragraph 1.1, to Appendix VIII, for the remainder of the wall thickness. The depth sizing results must be combined with the sizing results from Supplement 4 to Appendix VIII for the inner 15 percent and to Supplement 6 to Appendix VIII for the remainder of the wall thickness. The combined results must meet the depth sizing acceptance criteria contained in paragraphs (b)(2)(xi)(C)(*1*), (b)(2)(xi)(E)(*1*), and (b)(2)(xi)(F)(*3*) of this section.

(*2*) For examination of reactor pressure vessel nozzle-to-vessel welds conducted from the inside of the vessel,

(*i*) The clad to base metal interface and the adjacent examination volume to a minimum depth of 15 percent T (measured from the clad to base metal interface) must be examined from four orthogonal directions using a procedure and personnel qualified in accordance with Supplement 4 to Appendix VIII as conditioned by paragraphs (b)(2)(xi)(B) and (b)(2)(xi)(C) of this section.

(*ii*) When the examination volume defined in paragraph (b)(2)(xi)(K)(*2*)(*i*) of this section cannot be effectively examined in all four directions, the examination must be augmented by examination from the nozzle bore using a procedure and personnel qualified in accordance with paragraph (b)(2)(xi)(K)(*1*) of this section.

(*iii*) The remainder of the examination volume not covered by paragraph (b)(2)(xi)(K)(2)(*ii*) of this section or a combination of paragraphs (b)(2)(xi)(K)(*2*)(i) and (b)(2)(xi)(K)(*2*)(*ii*) of this section, must be examined from the nozzle bore using a procedure and personnel qualified in accordance with paragraph (b)(2)(xi)(K)(*1*) of this section, or from the vessel shell using a procedure and personnel qualified for single sided examination in accordance with Supplement 6 to Appendix VIII, as conditioned by paragraphs (b)(2)(xi)(D) through (b)(2)(xi)(G) of this section.

(*3*) For examination of reactor pressure vessel nozzle-to-shell welds conducted from the outside of the vessel,

(*i*) The clad to base metal interface and the adjacent metal to a depth of 15 percent T, (measured from the clad to base metal interface) must be examined from one radial and two opposing circumferential directions using a procedure and personnel qualified in accordance with Supplement 4 to Appendix VIII, as conditioned by paragraphs (b)(2)(xi)(B) and (b)(2)(xi)(C) of this section, for examinations performed in the radial direction, and Supplement 5 to Appendix VIII, as conditioned by paragraph (b)(2)(xi)(J) of this section, for examinations performed in the circumferential direction.

(*ii*) The examination volume not addressed by paragraph (b)(2)(xi)(K)(*3*)(*i*) of this section must be examined in a minimum of one radial direction using a procedure and personnel qualified for single sided examination in accordance with Supplement 6 to Appendix VIII, as conditioned by paragraphs (b)(2)(xi)(D) through (b)(2)(xi)(G) of this section.

(*4*) Table VIII–S7–1, "Flaw Locations and Orientations," Supplement 7 to Appendix VIII, is conditioned as follows:

TABLE VIII–S7–1—MODIFIED

Flaw Locations and Orientations		
	Parallel to weld	Perpendicular to weld
Inner 15 percent	X	X
OD Surface	X	
Subsurface	X	

(L) As a condition to the requirements of Supplement 8, Subparagraph 1.1(c), to Appendix VIII, notches may be located within one diameter of each end of the bolt or stud.

(M) When implementing Supplement 12 to Appendix VIII, only the provisions related to the coordinated implementation of Supplement 3 to Supplement 2 performance demonstrations are to be applied.

(xii) *Appendix VIII single side ferritic vessel and piping and stainless steel piping examination.*

(A) Examinations performed from one side of a ferritic vessel weld must be conducted with equipment, procedures, and personnel that have demonstrated proficiency with single side examinations. To demonstrate equivalency to two sided examinations, the demonstration must be performed to the requirements of Appendix VIII as conditioned by this paragraph and paragraphs (b)(2)(xi)(B) through (b)(2)(xi)(G) of this section, on specimens containing flaws with non-optimum sound energy reflecting

characteristics or flaws similar to those in the vessel being examined.

(B) Examinations performed from one side of a ferritic or stainless steel pipe weld must be conducted with equipment, procedures, and personnel that have demonstrated proficiency with single side examinations. To demonstrate equivalency to two sided examinations, the demonstration must be performed to the requirements of Appendix VIII as conditioned by this paragraph and paragraph (b)(2)(xi)(A) of this section.

(xiii) *Reconciliation of quality requirements.* When purchasing replacement items, in addition to the reconciliation provisions of IWA–4200, 1995 Addenda through 1998 Edition, the replacement items must be purchased, to the extent necessary, in accordance with the licensee's quality assurance program description required by 10 CFR 50.34(b)(6)(ii).

(xiv) *Certification of NDE personnel.* (A) Level I and II nondestructive examination personnel shall be recertified on a 3-year interval in lieu of the 5-year interval specified in the 1997 Addenda and 1998 Edition of IWA–2314, and IWA–2314(a) and IWA–2314(b) of the 1999 Addenda through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section.

(B) When applying editions and addenda prior to the 2007 Edition of Section XI, paragraph IWA–2316 may only be used to qualify personnel that observe leakage during system leakage and hydrostatic tests conducted in accordance with IWA 5211(a) and (b).

(C) When applying editions and addenda prior to the 2004 Edition through the 2005 Addenda of Section XI, licensee's qualifying visual examination personnel for VT–3 visual examination under paragraph IWA–2317 of Section XI, must demonstrate the proficiency of the training by administering an initial qualification examination and administering subsequent examinations on a 3-year interval.

(xv) *Substitution of alternative methods.* The provisions for substituting alternative examination methods, a combination of methods, or newly developed techniques in the 1997 Addenda of IWA–2240 must be applied when using the 1998 Edition through the 2004 Edition of Section XI of the ASME B&PV Code. The provisions in IWA–4520(c), 1997 Addenda through the 2004 Edition, allowing the substitution of alternative methods, a combination of methods, or newly developed techniques for the methods specified in the Construction Code are not approved for use. The provisions in IWA–4520(b)(2) and IWA–4521 of the 2008 Addenda through the latest edition and addenda approved in paragraph (b)(2) of this section, allowing the substitution of ultrasonic examination for radiographic examination specified in the Construction Code are not approved for use.

(xvi) *System leakage tests.*

(A) When performing system leakage tests in accordance with IWA–5213(a), 1997 through 2002 Addenda, the licensee shall maintain a 10-minute hold time after test pressure has been reached for Class 2 and Class 3 components that are not in use during normal operating conditions. No hold time is required for the remaining Class 2 and Class 3 components provided that the system has been in operation for at least 4 hours for insulated components or 10 minutes for uninsulated components.

(B) The NDE provision in IWA–4540(a)(2) of the 2002 Addenda of Section XI must be applied when performing system leakage tests after repair and replacement activities performed by welding or brazing on a pressure retaining boundary using the 2003 Addenda through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section.

(xvii) *Table IWB–2500–1 examination requirements.*

(A) The provisions of Table IWB–2500–1, Examination Category B–D, Full Penetration Welded Nozzles in Vessels, Items B3.40 and B3.60 (Inspection Program A) and Items B3.120-and B3.140 (Inspection Program B) of the 1998 Edition must be applied when using the 1999 Addenda through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section. A visual examination with magnification that has a resolution sensitivity to detect a 1-mil width wire or crack, utilizing the allowable flaw length criteria in Table IWB–3512–1, 1997 Addenda through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section, with a limiting assumption on the flaw aspect ratio (*i.e.,* a/l=0.5), may be performed instead of an ultrasonic examination.

(B) The provisions of Table IWB–2500–1, Examination Category B–G–2, Item B7.80, that are in the 1995 Edition are applicable only to reused bolting when using the 1997 Addenda through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section.

(xviii) *Surface examination.* The use of the provision in IWA–2220, "Surface Examination," of Section XI, 2001 Edition through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section, that allow use of an ultrasonic examination method is prohibited.

(xix) *Evaluation of thermally cut surfaces.* The use of the provisions for eliminating mechanical processing of thermally cut surfaces in IWA–4461.4.2 of Section XI, 2001 Edition through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section are prohibited.

(xx) *Incorporation of the performance demonstration initiative and addition of ultrasonic examination criteria.* The use of Appendix VIII and the supplements to Appendix VIII and Article I–3000 of Section XI of the ASME B&PV Code, 2002 Addenda through the 2006 Addenda is prohibited.

(xxi) *Mitigation of defects by modification.* The use of the provisions in IWA–4340, "Mitigation of Defects by Modification," Section XI, 2001 Edition through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section are prohibited.

(xxii) *Pressure testing Class 1, 2, and 3 mechanical joints.* The repair and replacement activity provisions in IWA–4540(c) of the 1998 Edition of Section XI for pressure testing Class 1, 2, and 3 mechanical joints must be applied when using the 2001 Edition through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section.

(xxiii) *Removal of insulation.* When performing visual examination in accordance with IWA–5242 of Section XI of the ASME B&PV Code, 2003 Addenda through the 2006 Addenda, or IWA–5241 of the 2007 Edition through the latest edition and addenda incorporated in paragraph (b)(2) of the section, insulation must be removed from 17–4 PH or 410 stainless steel studs or bolts aged at a temperature below 1100°F or having a Rockwell Method C hardness value above 30, and from A–286 stainless steel studs or bolts preloaded to 100,000 pounds per square inch or higher.

(xxiv) *Analysis of flaws.* Licensees using ASME B&PV Code, Section XI, Appendix A shall use the following conditions when implementing Equation (2) in A–4300(b)(1):

For $R < 0$, ΔK_I depends on the crack depth (a), and the flow stress (σ_f). The flow stress is defined by $\sigma_f = \frac{1}{2}(\sigma_{ys} + \sigma_{ult})$, where σ_{ys} is the yield strength and σ_{ult} is the ultimate tensile strength in units ksi (MPa) and a is in units in. (mm). For $-2 \leq R \leq 0$ and $K_{max} - K_{min} \leq 0.8 \times 1.12\ \sigma_f \sqrt{(\pi a)}$, $S = 1$ and $\Delta K_I = K_{max}$. For $R < -2$ and $K_{max} - K_{min} \leq 0.8 \times 1.12\ \sigma_f \sqrt{(\pi a)}$, $S = 1$ and $\Delta K_I = (1-R)\ K_{max}/3$. For $R < 0$ and $K_{max} - K_{min} > 0.8 \times 1.12\ \sigma_f \sqrt{(\pi a)}$, $S = 1$ and $\Delta K_I = K_{max} - K_{min}$.

(xxv) *Evaluation of unanticipated operating events.* The provisions of ASME B&PV Code, Section XI, Appendix E, Section E–1200 are not approved for use. In addition, when using the provisions of Section E–1300, the analytical procedure must be based on a postulated semi-elliptical surface flaw of a one-quarter vessel thickness (*i.e.,* the "minimum initiation crack size" in Table E–2 shall be a 1/4T flaw) and the linear elastic fracture mechanics criteria be as follows:

$1.4K_{Im} + K_{Ir} = K_{Ic}$ for the LTOP condition, and $1.4K_{Im} + K_{It} + K_{Ir} = K_{Ic}$, for the PTT condition

(xxvi) *Nonmandatory Appendix R.* Nonmandatory Appendix R, "Risk-Informed Inspection Requirements for Piping," of Section XI, 2005 Addenda through the latest edition and addenda incorporated by reference in paragraph (b)(2) of this section, may not be implemented without prior NRC authorization of the proposed alternative in accordance with paragraph (a)(3)(i) of this section.

(3) As used in this section, references to the OM Code refer to the ASME *Code for Operation and Maintenance of Nuclear Power Plants,* Subsections ISTA, ISTB, ISTC, and ISTD, Mandatory Appendices I and II, and Nonmandatory Appendices A through H and J, and include the 1995 Edition through the 2006 Addenda subject to the following conditions:

* * * * *

(v) *Subsection ISTD.* Article IWF–5000, "Inservice Inspection Requirements for Snubbers," of the ASME B&PV Code, Section XI, must be used when performing inservice inspection examinations and tests of snubbers at nuclear power plants.

(A) Licensees may use Subsection ISTD, "Preservice and Inservice Examination and Testing of Dynamic Restraints (Snubbers) in Light-Water Reactor Power Plants," ASME OM Code, 1995 Edition through the latest edition and addenda incorporated by reference in paragraph (b)(3) of this section, in place of the requirements for snubbers in the editions and addenda up to the 2005 Addenda of the ASME B&PV Code, Section XI, IWF–5200(a) and (b) and IWF–5300(a) and (b), by making appropriate changes to their technical specifications or licensee-controlled documents. Preservice and inservice examinations must be performed using the VT–3 visual examination method described in IWA–2213.

(B) Licensees shall comply with the provisions for examining and testing snubbers in Subsection ISTD of the ASME OM Code and make appropriate changes to their technical specifications or licensee-controlled documents when using the 2006 Addenda and later editions and addenda of Section XI of the ASME B&PV Code.

(vi) *Exercise interval for manual valves.* Manual valves must be exercised on a 2-year interval rather that the 5-year interval specified in paragraph ISTC–3540 of the 1999 through the 2005 Addenda of the ASME OM Code, provided that adverse conditions do not require more frequent testing.

* * * * *

(c) * * *

(3) The Code edition, addenda, and optional ASME Code cases to be applied to components of the reactor coolant pressure boundary must be determined by the provisions of paragraph NCA–1140, Subsection NCA of Section III of the ASME Boiler and Pressure Vessel Code, subject to the following conditions:

(i) The edition and addenda applied to a component must be those which are incorporated by reference in paragraph (b)(1) of this section;

(ii) The ASME Code provisions applied to the pressure vessel may be dated no earlier than the Summer 1972 Addenda of the 1971 edition;

(iii) The ASME Code provisions applied to piping, pumps, and valves may be dated no earlier than the Winter 1972 Addenda of the 1971 edition; and

(iv) The optional Code cases applied to a component must be those listed in NRC Regulatory Guide 1.84 that is incorporated by reference in paragraph (b) of this section.

* * * * *

(d) * * *

(2) The Code edition, addenda, and optional ASME Code cases to be applied to the systems and components identified in paragraph (d)(1) of this section must be determined by the rules of paragraph NCA–1140, Subsection NCA of Section III of the ASME Boiler and Pressure Vessel Code, subject to the following conditions:

(i) The edition and addenda must be those which are incorporated by reference in paragraph (b)(1) of this section;

(ii) The ASME Code provisions applied to the systems and components may be dated no earlier than the 1980 Edition; and

(iii) The optional Code cases must be those listed in the NRC Regulatory Guide 1.84 that is incorporated by reference in paragraph (b) of this section.

(e) * * *

(2) The Code edition, addenda, and optional ASME Code cases to be applied to the systems and components identified in paragraph (e)(1) of this section must be determined by the rules of paragraph NCA–1140, subsection NCA of Section III of the ASME Boiler and Pressure Vessel Code, subject to the following conditions:

(i) The edition and addenda must be those which are incorporated by reference in paragraph (b)(1) of this section;

(ii) The ASME Code provisions applied to the systems and components may be dated no earlier than the 1980 Edition; and

(iii) The optional Code cases must be those listed in NRC Regulatory Guide 1.84 that is incorporated by reference in paragraph (b) of this section.

(f) * * *

(2) For a boiling or pressurized water-cooled nuclear power facility whose construction permit was issued on or after January 1, 1971, but before July 1, 1974, pumps and valves which are classified as ASME Code Class 1 and Class 2 must be designed and provided with access to enable the performance of inservice tests for operational readiness set forth in editions and addenda of Section XI of the ASME Boiler and Pressure Vessel Code incorporated by reference in paragraph (b) of this section (or the optional ASME Code cases listed in NRC Regulatory Guide 1.147, Revision 15, or 1.192 that are incorporated by reference in paragraph (b) of this section) in effect 6 months before the date of issuance of the construction permit. The pumps and valves may meet the inservice test requirements set forth in subsequent editions of this Code and addenda which are incorporated by reference in paragraph (b) of this section (or the optional ASME Code Cases listed in NRC Regulatory Guide 1.147, Revision 15, or 1.192 that are incorporated by reference in paragraph (b) of this section), subject to the applicable conditions listed therein.

(3) * * *

(v) All pumps and valves may meet the test requirements set forth in subsequent editions of codes and addenda or portions thereof which are incorporated by reference in paragraph (b) of this section, subject to the conditions listed in paragraph (b) of this section.

(4) Throughout the service life of a boiling or pressurized water-cooled nuclear power facility, pumps and valves which are classified as ASME Code Class 1, Class 2, and Class 3 must meet the inservice test requirements, except design and access provisions, set forth in the ASME OM Code and addenda that become effective

subsequent to editions and addenda specified in paragraphs (f)(2) and (f)(3) of this section and that are incorporated by reference in paragraph (b) of this section, to the extent practical within the limitations of design, geometry and materials of construction of the components.

(i) Inservice tests to verify operational readiness of pumps and valves, whose function is required for safety, conducted during the initial 120-month interval must comply with the requirements in the latest edition and addenda of the Code incorporated by reference in paragraph (b) of this section on the date 12 months before the date of issuance of the operating license under this part, or 12 months before the date scheduled for initial loading fuel under a combined license under part 52 of this chapter (or the optional ASME Code cases listed in NRC Regulatory Guide 1.192, that is incorporated by reference in paragraph (b) of this section), subject to the conditions listed in paragraph (b) of this section.

(ii) Inservice tests to verify operational readiness of pumps and valves, whose function is required for safety, conducted during successive 120-month intervals must comply with the requirements of the latest edition and addenda of the Code incorporated by reference in paragraph (b) of this section 12 months before the start of the 120-month interval (or the optional ASME Code cases listed in NRC Regulatory Guide 1.147, Revision 15, or Regulatory Guide 1.192 that are incorporated by reference in paragraph (b) of this section), subject to the conditions listed in paragraph (b) of this section.

(iii) [Reserved]

(iv) Inservice tests of pumps and valves may meet the requirements set forth in subsequent editions and addenda that are incorporated by reference in paragraph (b) of this section, subject to the conditions listed in paragraph (b) of this section, and subject to NRC approval. Portions of editions or addenda may be used provided that all related requirements of the respective editions or addenda are met.

(5) * * *

(iv) Where a pump or valve test requirement by the code or addenda is determined to be impractical by the licensee and is not included in the revised inservice test program as permitted by paragraph (f)(4) of this section, the basis for this determination must be submitted for NRC review and approval not later than 12 months after the expiration of the initial 120-month interval of operation from start of facility commercial operation and each subsequent 120-month interval of operation during which the test is determined to be impractical.

* * * * *

(g) * * *

(2) For a boiling or pressurized water-cooled nuclear power facility whose construction permit was issued on or after January 1, 1971, but before July 1, 1974, components (including supports) which are classified as ASME Code Class 1 and Class 2 must be designed and be provided with access to enable the performance of inservice examination of such components (including supports) and must meet the preservice examination requirements set forth in editions and addenda of Section III or Section XI of the ASME B&PV Code (or ASME OM Code for snubber examination and testing) incorporated by reference in paragraph (b) of this section (or the optional ASME code cases listed in NRC Regulatory Guide 1.147, Revision 15, that are incorporated by reference in paragraph (b) of this section) in effect six months before the date of issuance of the construction permit. The components (including supports) may meet the requirements set forth in subsequent editions and addenda of this Code which are incorporated by reference in paragraph (b) of this section (or the optional ASME code cases listed in NRC Regulatory Guide 1.147, Revision 15, when using Section XI, or Regulatory Guide 1.192 when using the OM Code, that are incorporated by reference in paragraph (b) of this section), subject to the applicable conditions.

(3) For a boiling or pressurized water-cooled nuclear power facility whose construction permit under this part, or design certification, design approval, combined license, or manufacturing license under part 52 of this chapter, was issued on or after July 1, 1974:

(i) Components (including supports) which are classified as ASME Code Class 1 must be designed and provided with access to enable the performance of inservice examination of these components and must meet the preservice examination requirements set forth in the editions and addenda of Section III or Section XI of the ASME B&PV Code (or ASME OM Code for snubber examination and testing) incorporated by reference in paragraph (b) of this section (or the optional ASME code cases listed in NRC Regulatory Guide 1.147, Revision 15, when using Section XI; or Regulatory Guide 1.192 when using the OM Code, that are incorporated by reference in paragraph (b) of this section) applied to the construction of the particular component.

(ii) Components which are classified as ASME Code Class 2 and Class 3 and supports for components which are classified as ASME Code Class 1, Class 2, and Class 3 must be designed and be provided with access to enable the performance of inservice examination of these components and must meet the preservice examination requirements set forth in the editions and addenda of Section III or Section XI of the ASME B&PV Code (or ASME OM Code for snubber examination and testing) incorporated by reference in paragraph (b) of this section (or the optional ASME code cases listed in NRC Regulatory Guide 1.147, Revision 15, when using Section XI; or Regulatory Guide 1.192 when using the OM Code, that are incorporated by reference in paragraph (b) of this section) applied to the construction of the particular component.

(iii)–(iv) [Reserved]

(v) All components (including supports) may meet the requirements set forth in subsequent editions of codes and addenda or portions thereof which are incorporated by reference in paragraph (b) of this section, subject to the conditions listed therein.

(4) Throughout the service life of a boiling or pressurized water-cooled nuclear power facility, components (including supports) which are classified as ASME Code Class 1, Class 2, and Class 3 must meet the requirements, except design and access provisions and preservice examination requirements, set forth in Section XI of editions and addenda of the ASME B&PV Code (or ASME OM Code for snubber examination and testing) that become effective subsequent to editions specified in paragraphs (g)(2) and (g)(3) of this section and that are incorporated by reference in paragraph (b) of this section, to the extent practical within the limitations of design, geometry and materials of construction of the components. Components which are classified as Class MC pressure retaining components and their integral attachments, and components which are classified as Class CC pressure retaining components and their integral attachments must meet the requirements, except design and access provisions and preservice examination requirements, set forth in Section XI of the ASME B&PV Code and addenda that are incorporated by reference in paragraph (b) of this section, subject to the condition listed in paragraph (b)(2)(ii) of this section and the conditions listed in paragraphs (b)(2)(iv) and (b)(2)(v) of this section, to the extent

practical within the limitation of design, geometry and materials of construction of the components.

(i) Inservice examination of components and system pressure tests conducted during the initial 120-month inspection interval must comply with the requirements in the latest edition and addenda of the Code incorporated by reference in paragraph (b) of this section on the date 12 months before the date of issuance of the operating license (or the optional ASME code cases listed in NRC Regulatory Guide 1.147, Revision 15, when using Section XI; or Regulatory Guide 1.192 when using the OM Code, that are incorporated by reference in paragraph (b) of this section), subject to the conditions listed in paragraph (b) of this section.

(ii) Inservice examination of components and system pressure tests conducted during successive 120-month inspection intervals must comply with the requirements of the latest edition and addenda of the Code incorporated by reference in paragraph (b) of this section 12 months before the start of the 120-month inspection interval (or the optional ASME code cases listed in NRC Regulatory Guide 1.147, Revision 15, when using Section XI; or Regulatory Guide 1.192 when using the OM Code, that are incorporated by reference in paragraph (b) of this section), subject to the conditions listed in paragraph (b) of this section.

(iii) When applying editions and addenda prior to the 2003 Addenda of Section XI of the ASME B&PV Code licensees may, but are not required to, perform the surface examinations of high-pressure safety injection systems specified in Table IWB–2500–1, Examination Category B–J, Item Numbers B9.20, B9.21 and B9.22.

(iv) Inservice examination of components and system pressure tests may meet the requirements set forth in subsequent editions and addenda that are incorporated by reference in paragraph (b) of this section, subject to the conditions listed in paragraph (b) of this section, and subject to Commission approval. Portions of editions or addenda may be used provided that all related requirements of the respective editions or addenda are met.

(v) For a boiling or pressurized water-cooled nuclear power facility whose construction permit under this part or combined license under part 52 of this chapter was issued after January 1, 1956:

(A) Metal containment pressure retaining components and their integral attachments must meet the inservice inspection, repair, and replacement requirements applicable to components which are classified as ASME Code Class MC;

(B) Metallic shell and penetration liners which are pressure retaining components and their integral attachments in concrete containments must meet the inservice inspection, repair, and replacement requirements applicable to components which are classified as ASME Code Class MC;

(C) Concrete containment pressure retaining components and their integral attachments, and the post-tensioning systems of concrete containments must meet the inservice inspections, repair, and replacement requirements applicable to components which are classified as ASME Code Class CC.

(5) * * *

(iii) If the licensee has determined that conformance with a code requirement is impractical for its facility, the licensee shall notify the Commission and submit, as specified in § 50.4, information to support the determinations. Determinations of impracticality in accordance with this section must be based on the demonstrated limitations experienced when attempting to comply with the code requirements during the inservice inspection interval for which the request is being submitted. Requests for relief made in accordance with this section must be submitted to the NRC no later than 12 months after the examination has been attempted.

(iv) Where the licensee determines that an examination required by Code edition or addenda is impractical, and is not included in the revised inservice inspection program as permitted by paragraph (g)(4) of this section, the basis for this determination must be submitted for NRC review and approval not later than 12 months after the expiration of the initial or subsequent 120-month inspection interval for which relief is sought.

(6) * * *

(ii) * * *

(B) Licensees do not have to submit to the NRC for approval of their containment inservice inspection programs which were developed to satisfy the requirements of Subsection

IWE and Subsection IWL with specified conditions. The program elements and the required documentation must be maintained on site for audit.

* * * * *

(E) * * *

(*1*) All licensees of pressurized water reactors shall augment their inservice inspection program by implementing ASME Code Case N–722–1 subject to the conditions specified in paragraphs (g)(6)(ii)(E)(*2*) through (g)(6)(ii)(E)(*4*) of this section. The inspection requirements of ASME Code Case N–722–1 do not apply to components with pressure retaining welds fabricated with Alloy 600/82/182 materials that have been mitigated by weld overlay or stress improvement.

(*2*) If a visual examination determines that leakage is occurring from a specific item listed in Table 1 of ASME Code Case N–722–1 that is not exempted by the ASME Code, Section XI, IWB–1220(b)(1), additional actions must be performed to characterize the location, orientation, and length of crack(s) in Alloy 600 nozzle wrought material and location, orientation, and length of crack(s) in Alloy 82/182 butt welds. Alternatively, licensees may replace the Alloy 600/82/182 materials in all the components under the item number of the leaking component.

(*3*) If the actions in paragraph (g)(6)(ii)(E)(*2*) of this section determine that a flaw is circumferentially oriented and potentially a result of primary water stress corrosion cracking, licensees shall perform non-visual NDE inspections of components that fall under that ASME Code Case N–722–1 item number. The number of components inspected must equal or exceed the number of components found to be leaking under that item number. If circumferential cracking is identified in the sample, non-visual NDE must be performed in the remaining components under that item number.

* * * * *

(F) *Inspection requirements for class 1 pressurized-water reactor piping and vessel nozzle butt welds.*

(*1*) Licensees of existing operating pressurized-water reactors as of [publication date of the final rule] shall implement the requirements of ASME Code Case N–770, subject to the conditions specified in paragraphs (g)(6)(ii)(F)(*2*) through (g)(6)(ii)(F)(*16*) of this section, by the first refueling outage after [date that is 60 days after the date of publication of the final rule].

(*2*) Full structural weld overlays authorized by the NRC staff may be categorized as Inspection Items C or F, as appropriate; welds that have been mitigated by stress improvement without welding may be categorized as Inspection Items D or E, as appropriate, provided the criteria in Appendix I of the code case have been met; for ISI frequencies, all other butt welds that rely on Alloy 82/182 for structural integrity shall be categorized as Inspection Items A–1, A–2 or B until the NRC staff has reviewed the mitigation and authorized an alternative code case

Inspection Item for the mitigated weld, or until an alternative code case Inspection Item is used based on conformance with an ASME mitigation code case endorsed in Regulatory Guide 1.147 with conditions, if applicable, and incorporated in this section.

(*3*) Welds in Table 1, Inspection Items A–1, A–2, and B, that have not received a baseline examination using Section XI, Appendix VIII requirements, shall be examined at the next refueling outage after [the effective date of the final rule].

(*4*) The axial examination coverage requirements of –2500(c) may not be considered to be satisfied unless essentially 100 percent coverage is achieved.

(*5*) Replace paragraph—3132.3(b) with "Previously-evaluated flaws that were mitigated by the techniques identified in Table 1 need not be reevaluated nor have additional successive or additional examinations performed if new planar flaws have not been identified or previously evaluated flaws have remained essentially unchanged."

(*6*) If a weld mitigated by inlay or cladding is determined through a volumetric examination to have cracking that penetrates beyond the thickness of the inlay or cladding, the weld must be reclassified as and inspected using the frequencies of Inspection Item A–1, A–2, or B, as appropriate, until corrected by repair/replacement activity in accordance with IWA–4000 or by corrective measures beyond the scope of Code Case N–770.

(*7*) For Inspection Items G, H, J, and K, the surface examination requirements of Table 1 must apply whether the inservice volumetric examinations are performed from the weld outside diameter or the weld inside diameter. All hot leg operating temperature welds in inspection items G, H, J, and K must be inspected each interval. A 25 percent sample of cold leg operating temperature welds must be inspected whenever the core barrel is removed (unless it has already been inspected within the past 10 years) or 20 years, whichever is less.

(*8*) The first examination following weld inlay, cladding, weld overlay or stress improvement for Inspection Items D, G, and H may not be deferred to the end of the interval.

(*9*) In applying Measurement or Quantification Criterion I–1.1 of Appendix I, a construction weld repair from the inside diameter to a depth of 50 percent of the weld thickness extending 360° around the weld shall be assumed.

(*10*) The last sentence of Measurement or Quantification Criterion I–2.1 of Appendix I shall be replaced by, "The analysis or demonstration test shall account for (a) load combinations that could relieve plastic stress due to shakedown and (b) any material properties related to stress relaxation over time."

(*11*) Replace Measurement or Quantification Criterion I–7.1 of Appendix I, with "An analysis shall be performed using IWB–3600 evaluation methods and acceptance criteria to verify that the mitigation process will not cause any existing flaws to grow.

(*12*) For any mitigated weld whose volumetric examination detects new flaws or growth of existing flaws in the required examination volume that exceed the acceptance standards of IWB–3514 and are found to be acceptable for continued service through an analytical evaluation meeting the requirements of IWB–3600 or a repair meeting the requirements of IWA–4000 or the alternative requirements of an ASME code case, a report summarizing the evaluation, along with inputs, methodologies, assumptions, and cause of the new flaw or flaw growth is to be provided to the NRC prior to the weld being placed in service other than modes 5 or 6.

(*13*) Replace the last sentence of the Extent and Frequency of Examination for Inspection Items C and F with, "Twenty-five percent of this population shall be added to the ISI Program in accordance with –2410 and shall be examined the shorter of once each inspection interval or the life of the overlay."

(*14*) In Figures 2(b) and 5(b), the dimension "b" must be used in place of ½ inch (13 mm), where "b" is equivalent to the nominal thickness of the nozzle or pipe being overlaid, as appropriate.

(*15*) For Inspection Items G, H, J, and K, when applying the acceptance standards of ASME B&PV Code, Section XI, IWB–3514, the thickness "t" in IWB–3514 is the thickness of the inlay or onlay.

(*16*) Welds mitigated by optimized weld overlays in Inspection Items D and E are not permitted to be placed into a population to be examined on a sample basis and must be examined once each inspection interval.

* * * * *

[1] For inspections to be conducted once per interval, the inspections shall be performed in accordance with the schedule in Section XI, paragraph IWB–2400, except for plants with inservice inspection programs based on a Section XI edition or addenda prior to the 1994 Addenda. For plants with inservice inspection programs based on a Section XI edition or addenda prior to the 1994 Addenda, the inspection shall be performed in accordance with the schedule in Section XI, paragraph IWB–2400, of the 1994 Addenda.

* * * * *

Dated at Rockville, Maryland, this 19th day of April 2010.

For the Nuclear Regulatory Commission.

Eric J. Leeds,

Director, Office of Nuclear Reactor Regulation.

[FR Doc. 2010–9700 Filed 5–3–10; 8:45 am]

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