DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2008 (RY 2009)

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

ACTION: Notice.

SUMMARY: This notice updates the prospective payment rates for Medicare inpatient psychiatric hospital services provided by inpatient psychiatric facilities (IPFs). These changes are applicable to IPF discharges occurring during the rate year beginning July 1, 2008 through June 30, 2009.

DATES: *Effective Date:* The updated IPF prospective payment rates are effective for discharges occurring on or after July 1, 2008 through June 30, 2009.

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Acronyms

Because of the many terms to which we refer by acronym in this notice, we are listing the acronyms used and their corresponding terms in alphabetical order below:

BBRA Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, (Pub. L. 106–113).
CBSA Core-Based Statistical Area.
CCR Cost-to-charge ratio.
CMSA Consolidated Metropolitan Statistical Area.
DSM–IV–TR Diagnostic and Statistical Manual of Mental Disorders Fourth Edition—Text Revision.
DRGs Diagnosis-related groups.
FY Federal fiscal year.
ICD–9–CM International Classification of Diseases, 9th Revision, Clinical Modification.
IPFs Inpatient psychiatric facilities.
IRFs Inpatient rehabilitation facilities.
LTCHs Long-term care hospitals.
MedPAR Medicare provider analysis and review file.
MSA Metropolitan Statistical Area.
RY Rate Year.
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, (Pub. L. 97–248).

I. Background

A. Annual Requirements for Updating the IPF PPS

In November 2004, we implemented the IPF PPS in a final rule that appeared in the November 15, 2004 **Federal Register** (69 FR 66922). In developing the IPF PPS, in order to ensure that the IPF PPS is able to account adequately for each IPF's case-mix, we performed an extensive regression analysis of the relationship between the per diem costs and certain patient and facility characteristics to determine those characteristics associated with statistically significant cost differences on a per diem basis. For characteristics with statistically significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments.

In that final rule, we explained that we believe it is important to delay updating the adjustment factors derived from the regression analysis until we have IPF PPS data that includes as much information as possible regarding the patient-level characteristics of the population that each IPF serves. Therefore, we indicated that we did not intend to update the regression analysis and recalculate the Federal per diem base rate and the patient- and facility-level adjustments until we complete that analysis. Until that analysis is complete, we stated our intention to publish a notice in the **Federal Register** each spring to update the IPF PPS (71 FR 27041).

Updates to the IPF PPS as specified in 42 CFR 412.428 include the following:

- A description of the methodology and data used to calculate the updated Federal per diem base payment amount.
- The rate of increase factor as described in § 412.424(a)(2)(iii), which is based on the excluded hospital with capital market basket under the update methodology of section 1886(b)(3)(B)(ii) of the Act for each year.
- For discharges occurring on or after July 1, 2006, the rate of increase factor for the Federal portion of the IPF's payment, which is based on the rehabilitation, psychiatric, and long-term care (RPL) market basket.
- For discharges occurring on or after October 1, 2005, the rate of increase factor for the reasonable cost portion of the IPF's payment, which is based on the 2002-based excluded hospital market basket.
- The best available hospital wage index and information regarding

whether an adjustment to the Federal per diem base rate, is needed to maintain budget neutrality.

- Updates to the fixed dollar loss threshold amount in order to maintain the appropriate outlier percentage.
- Description of the ICD–9–CM coding and DRG classification changes discussed in the annual update to the hospital inpatient prospective payment system (IPPS) regulations.
- Update to the electroconvulsive therapy (ECT) payment by a factor specified by CMS.
- Update to the national urban and rural cost-to-charge ratio medians and ceilings.
- Update to the cost of living adjustment factors for IPFs located in Alaska and Hawaii, if appropriate.

Our most recent annual update occurred in the May 2007 IPF PPS notice (72 FR 25602) that set forth updates to the IPF PPS payment rates for RY 2008.

This notice does not initiate any policy changes with regard to the IPF PPS; rather, it simply provides an update to the rates for RY 2009 (that is, the prospective payment rates applicable for discharges beginning July 1, 2008 through June 30, 2009). In establishing these payment rates, we update the IPF per diem payment rates that were published in the May 2007 IPF PPS notice in accordance with our established policies.

B. Overview of the Legislative Requirements for the IPF PPS

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, (Pub. L. 106–113) (BBRA) required implementation of the IPF PPS. Specifically, section 124 of the BBRA mandated that the Secretary develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units that includes an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units.

Section 405(g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) extended the IPF PPS to distinct part psychiatric units of critical access hospitals (CAHs).

To implement these provisions, we published various proposed and final rules in the **Federal Register**. For more information regarding these rules, see the CMS Web sites *http://www.cms.hhs.gov/InpatientPsychFacilPPS/* and *http://www.cms.hhs.gov/InpatientpsychfacilPPS/02_regulations.asp*.

C. IPF PPS—General Overview

The November 2004 IPF PPS final rule (69 FR 66922) established the IPF PPS, as authorized under section 124 of the BBRA and codified at subpart N of part 412 of the Medicare regulations. The November 2004 IPF PPS final rule set forth the per diem Federal rates for the implementation year (that is, the 18-month period from January 1, 2005 through June 30, 2006) that provided payment for the inpatient operating and capital costs to IPFs for covered psychiatric services they furnish (that is, routine, ancillary, and capital costs), but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IPF PPS. Covered psychiatric services include services for which benefits are provided under the fee-for-service Part A (Hospital Insurance Program) Medicare program.

The IPF PPS established the Federal per diem base rate for each patient day in an IPF derived from the national average daily routine operating, ancillary, and capital costs in IPFs in FY 2002. The average per diem cost was updated to the midpoint of the first year under the IPF PPS, standardized to account for the overall positive effects of the IPF PPS payment adjustments, and adjusted for budget neutrality.

The Federal per diem payment under the IPF PPS is comprised of the Federal per diem base rate described above and certain patient- and facility-level payment adjustments that were found in the regression analysis to be associated with statistically significant per diem cost differences.

The patient-level adjustments include age, DRG assignment, comorbidities, and variable per diem adjustments to reflect higher per diem costs in the early days of an IPF stay. Facility-level adjustments include adjustments for the IPF's wage index, rural location, teaching status, a cost of living adjustment for IPFs located in Alaska and Hawaii, and presence of a qualifying emergency department (ED).

The IPF PPS provides additional payments for: Outlier cases; stop-loss protection (which is applicable only during the IPF PPS transition period); interrupted stays; and a per treatment adjustment for patients who undergo ECT.

A complete discussion of the regression analysis appears in the November 2004 IPF PPS final rule (69 FR 66933 through 66936).

Section 124 of BBRA does not specify an annual update rate strategy for the IPF PPS and is broadly written to give the Secretary discretion in establishing an update methodology. Therefore, in the November 2004 IPF PPS final rule (69 FR 66966), we implemented the IPF PPS using the following update strategy—(1) calculate the final Federal per diem base rate to be budget neutral for the 18-month period of January 1, 2005 through June 30, 2006; (2) use a July 1 through June 30 annual update cycle; and (3) allow the IPF PPS first update to be effective for discharges on or after July 1, 2006 through June 30, 2007.

II. Transition Period for Implementation of the IPF PPS

In the November 2004 IPF PPS final rule, we established § 412.426 to provide for a 3-year transition period from reasonable cost-based reimbursement to full prospective payment for IPFs. The purpose of the transition period is to allow existing IPFs time to adjust their cost structures and to integrate the effects of changing to the IPF PPS.

New IPFs, as defined in § 412.426(c), are paid 100 percent of the Federal per diem payment amount. For those IPFs that are transitioning to the new system, payment is based on an increasing percentage of the PPS payment and a decreasing percentage of each IPF's facility-specific Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) reimbursement rate.

TABLE 1.—IPF PPS TRANSITION BLEND FACTORS

Transition Year	Cost reporting periods beginning on or after	TEFRA rate percentage	IPF PPS federal rate percentage
1	January 1, 2005	75	25
2	January 1, 2006	50	50
3	January 1, 2007	25	75

TABLE 1.—IPF PPS TRANSITION BLEND FACTORS—Continued

Transition Year	Cost reporting periods beginning on or after	TEFRA rate percentage	IPF PPS federal rate percentage
	January 1, 2008	0	100

Changes to the blend percentages occur at the beginning of an IPF's cost reporting period. However, regardless of when an IPF's cost reporting year begins, the payment update will be effective for discharges occurring on or after July 1, 2008 through June 30, 2009. IPFs with cost reporting periods beginning January 1, 2008 will have completed the transition period and will receive 100 percent IPF PPS payments. Other IPFs with cost reporting periods beginning after January 1, 2008, during 2008, will also begin to receive 100 percent IPF PPS payments. This means that beginning January 1, 2009, all IPFs will receive 100 percent IPF PPS payments and the IPF PPS transition period will have ended.

For RY 2009, the transition period established in the November 2004 IPF PPS final rule will no longer be applied.

III. Updates to the IPF PPS for RY Beginning July 1, 2008

The Federal per diem base rate is used as the standard payment per day under the IPF PPS and is adjusted by the applicable wage index factor and the patient- and facility-level adjustments that are applicable to the IPF stay. A detailed explanation of how we calculated the average per diem cost appears in the November 2004 IPF PPS final rule (69 FR 66926).

A. Determining the Standardized Budget-Neutral Federal Per Diem Base Rate

Section 124(a)(1) of the BBRA requires that we implement the IPF PPS in a budget neutral manner. In other words, the amount of total payments under the IPF PPS, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the IPF PPS were not implemented. Therefore, we calculated the budget-neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the TEFRA methodology had the IPF PPS not been implemented.

Under the IPF PPS methodology, we calculated the final Federal per diem base rate to be budget neutral during the IPF PPS implementation period (that is, the 18-month period from January 1, 2005 through June 30, 2006) using a July 1 update cycle. We updated the average cost per day to the midpoint of the IPF PPS implementation period (that is, October 1, 2005), and this amount was used in the payment model to establish the budget-neutrality adjustment.

A step-by-step description of the methodology used to estimate payments under the TEFRA payment system appears in the November 2004 IPF PPS final rule (69 FR 66926).

1. Standardization of the Federal Per Diem Base Rate and Electroconvulsive Therapy Rate

In the November 2004 IPF PPS final rule, we describe how we standardized the IPF PPS Federal per diem base rate in order to account for the overall positive effects of the IPF PPS payment adjustment factors. To standardize the IPF PPS payments, we compared the IPF PPS payment amounts calculated from the FY 2002 Medicare Provider Analysis and Review (MedPAR) file to the projected TEFRA payments from the FY 2002 cost report file updated to the midpoint of the IPF PPS implementation period (that is, October 2005). The standardization factor was calculated by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. The standardization factor was calculated to be 0.8367.

As described in detail in the May 2006 IPF PPS final rule (71 FR 27045), in reviewing the methodology used to simulate the IPF PPS payments used for the November 2004 IPF PPS final rule, we discovered that due to a computer code error, total IPF PPS payments were underestimated by about 1.36 percent. Since the IPF PPS payment total should have been larger than the estimated figure, the standardization factor should have been smaller (0.8254 vs. 0.8367). In turn, the Federal per diem base rate and the ECT rate should have been reduced by 0.8254 instead of 0.8367.

To resolve this issue, in RY 2007, we amended the Federal per diem base rate and the ECT payment rate prospectively. Using the standardization factor of 0.8254, the average cost per day was effectively reduced by 17.46 percent (100 percent minus 82.54 percent = 17.46 percent).

2. Calculation of the Budget Neutrality Adjustment

To compute the budget neutrality adjustment for the IPF PPS, we separately identified each component of the adjustment, that is, the outlier adjustment, stop-loss adjustment, and behavioral offset.

A complete discussion of how we calculate each component of the budget neutrality adjustment appears in the November 2004 IPF PPS final rule (69 FR 66932 through 66933) and in the May 2006 IPF PPS final rule (71 FR 27044 through 27046).

a. Outlier Adjustment

Since the IPF PPS payment amount for each IPF includes applicable outlier amounts, we reduced the standardized Federal per diem base rate to account for aggregate IPF PPS payments estimated to be made as outlier payments. The outlier adjustment was calculated to be 2 percent. As a result, the standardized Federal per diem base rate was reduced by 2 percent to account for projected outlier payments.

b. Stop-Loss Provision Adjustment

As explained in the November 2004 IPF PPS final rule, we provided a stop-loss payment during the transition from cost-based reimbursement to the per diem payment system to ensure that an IPF's total PPS payments were no less than a minimum percentage of their TEFRA payment, had the IPF PPS not been implemented. We reduced the standardized Federal per diem base rate by the percentage of aggregate IPF PPS payments estimated to be made for stop-loss payments. As a result, the standardized Federal per diem base rate was reduced by 0.39 percent to account for stop-loss payments. Since the transition will be completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent PPS and, therefore, the stop loss provision will no longer be applicable. We indicated in the November 2004 IPF PPS final rule that we would remove this 0.39 percent adjustment to the Federal per diem base rate after the transition (69 FR 66932). Therefore, for RY 2009, the Federal per diem base rate and ECT rates will be increased by 0.39 percent.

c. Behavioral Offset

As explained in the November 2004 IPF PPS final rule, implementation of the IPF PPS may result in certain changes in IPF practices especially with respect to coding for comorbid medical conditions. As a result, Medicare may make higher payments than assumed in our calculations. Accounting for these effects through an adjustment is commonly known as a behavioral offset.

Based on accepted actuarial practices and consistent with the assumptions made in other PPSs, we assumed in determining the behavioral offset that IPFs would regain 15 percent of potential ''losses'' and augment payment increases by 5 percent. We applied this actuarial assumption, which is based on our historical experience with new payment systems, to the estimated ''losses'' and ''gains'' among the IPFs. The behavioral offset for the IPF PPS was calculated to be 2.66 percent. As a result, we reduced the standardized Federal per diem base rate by 2.66 percent to account for behavioral changes. As indicated in the November 2004 IPF PPS final rule, we do not plan to change adjustment factors or projections, including the behavioral offset, until we analyze IPF PPS data. At that time, we will re-assess the accuracy of the behavioral offset along with the other factors impacting budget neutrality.

If we find that an adjustment is warranted, the percent difference may be applied prospectively to the established PPS rates to ensure the rates accurately reflect the payment level intended by the statute. In conducting this analysis, we will be interested in the extent to which improved documentation and coding of patients' principal and other diagnoses, which may not reflect real increases in underlying resource demands, has occurred under the PPS.

B. Update of the Federal Per Diem Base Rate and Electroconvulsive Therapy Rate

1. Market Basket for IPFs Reimbursed Under the IPF PPS

As described in the November 2004 IPF PPS final rule, the average per diem cost was updated to the midpoint of the implementation year (69 FR 66931). This updated average per diem cost of $724.43 was reduced by 17.46 percent to account for standardization to projected TEFRA payments for the implementation period, by 2 percent to account for outlier payments, by 0.39 percent to account for stop-loss payments, and by 2.66 percent to account for the behavioral offset. The Federal per diem base rate in the implementation year was $575.95, the per diem base rate for RY 2007 was $595.09, and the per diem base rate for RY 2008 was $614.99.

Applying the market basket increase of 3.2 percent, the stop-loss adjustment of 0.39 percent, and the wage index budget neutrality factor of 1.0010 yields a Federal per diem base rate of $637.78 for RY 2009. Similarly, applying the market basket increase, stop-loss adjustment, and wage index budget neutrality factor to the RY 2008 ECT rate yields an ECT rate of $274.58 for RY 2009.

a. Market Basket Index for the IPF PPS

The market basket index that was used to develop the IPF PPS was the excluded hospital with capital market basket. The market basket was based on 1997 Medicare cost report data and included data for Medicare participating IPFs, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), cancer, and children's hospitals.

We are presently unable to create a separate market basket specifically for psychiatric hospitals due to the following two reasons: (1) There is a very small sample size for free-standing psychiatric facilities; and (2) there are limited expense data for some categories on the free-standing psychiatric cost reports (for example, approximately 4 percent of free-standing psychiatric facilities reported contract labor cost data for FY 2002). However, since all IRFs, LTCHs, and IPFs are now paid under a PPS, we are updating PPS payments made under the IRF PPS, the IPF PPS, and the LTCH PPS, using a market basket reflecting the operating and capital cost structures for IRFs, IPFs, and LTCHs (hereafter referred to as the rehabilitation, psychiatric, long-term care (RPL) market basket).

We have excluded cancer and children's hospitals from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which are implemented in regulations at § 413.40. They are not reimbursed under a PPS. Also, the FY 2002 cost structures for cancer and children's hospitals are noticeably different than the cost structures of the IRFs, IPFs, and LTCHs.

The services offered in IRFs, IPFs, and LTCHs are typically more labor-intensive than those offered in cancer and children's hospitals. Therefore, the compensation cost weights for IRFs, IPFs, and LTCHs are larger than those in cancer and children's hospitals. In addition, the depreciation cost weights for IRFs, IPFs, and LTCHs are noticeably smaller than those for cancer and children's hospitals.

A complete discussion of the RPL market basket appears in the May 2006 IPF PPS final rule (71 FR 27046 through 27054).

b. Overview of the RPL Market Basket

The RPL market basket is a fixed weight, Laspeyres-type price index. A market basket is described as a fixed-weight index because it answers the question of how much it would cost, at another time, to purchase the same mix of goods and services purchased to provide hospital services in a base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services (intensity) purchased subsequent to the base period are not measured. In this manner, the market basket measures only pure price change. Only when the index is rebased would the quantity and intensity effects be captured in the cost weights. Therefore, we rebase the market basket periodically so that cost weights reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) to furnish patient care between base periods.

The terms rebasing and revising, while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index (for example, shifting the base year cost structure from FY 1997 to FY 2002). Revising means changing data sources, methodology, or price proxies used in the input price index. In 2006, we rebased and revised the market basket used to update the IPF PPS. Table 2 below sets forth the completed FY 2002-based RPL market basket including the cost categories, weights, and price proxies.

TABLE 2.—FY 2002-BASED RPL MARKET BASKET COST CATEGORIES, WEIGHTS, AND PROXIES

Expense categories	FY 2002-based RPL market basket cost weight	FY 2002-based RPL market basket price proxies
TOTAL	100.000	
Compensation	65.877	
Wages and Salaries *	52.895	ECI-Wages and Salaries, Civilian Hospital Workers.
Employee Benefits *	12.982	ECI-Benefits, Civilian Hospital Workers.
Professional Fees, Non-Medical 1A*	2.892	ECI-Compensation for Professional & Related occupations.
Utilities	0.656	
Electricity	0.351	PPI-Commercial Electric Power.
Fuel Oil, Coal, etc.	0.108	PPI-Commercial Natural Gas.
Water and Sewage	0.197	CPI–U—Water & Sewage Maintenance.
Professional Liability Insurance	1.161	CMS Professional Liability Premium Index.
All Other Products and Services	19.265	
All Other Products	13.323	
Pharmaceuticals	5.103	PPI Prescription Drugs.
Food: Direct Purchases	0.873	PPI Processed Foods & Feeds.
Food: Contract Service	0.620	CPI–U Food Away From Home.
Chemicals	1.100	PPI Industrial Chemicals.
Medical Instruments	1.014	PPI Medical Instruments & Equipment.
Photographic Supplies	0.096	PPI Photographic Supplies.
Rubber and Plastics	1.052	PPI Rubber & Plastic Products.
Paper Products	1.000	PPI Converted Paper & Paperboard Products.
Apparel	0.207	PPI Apparel.
Machinery and Equipment	0.297	PPI Machinery & Equipment.
Miscellaneous Products **	1.963	PPI Finished Goods less Food & Energy.
All Other Services	5.942	
Telephone	0.240	CPI–U Telephone Services.
Postage	0.682	CPI–U Postage.
All Other: Labor Intensive *	2.219	ECI-Compensation for Private Service Occupations.
All Other: Non-labor Intensive	2.800	CPI–U All Items.
Capital-Related Costs ***	10.149	
Depreciation	6.186	
Fixed Assets	4.250	Boeckh Institutional Construction 23-year useful life.
Movable Equipment	1.937	WPI Machinery & Equipment 11-year useful life.
Interest Costs	2.775	
Nonprofit	2.081	Average yield on domestic municipal bonds (Bond Buyer 20 bonds) vintage-weighted (23 years).
For Profit	0.694	Average yield on Moody's Aaa bond vintage-weighted (23 years).
Other Capital-Related Costs	1.187	CPI–U Residential Rent.

* Labor-related.
** Blood and blood-related products is included in miscellaneous products.
*** A portion of capital costs (0.46) are labor-related.
Note: Due to rounding, weights may not sum to total.

For RY 2009, we evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance. *Reliability* indicates that the index is based on valid statistical methods and has low sampling variability. *Timeliness* implies that the proxy is published regularly, preferably at least once a quarter. *Availability* means that the proxy is publicly available. Finally, *relevance* means that the proxy is applicable and representative of the cost category weight to which it is applied. The Consumer Price Indexes (CPIs), Producer Price Indexes (PPIs), and Employment Cost Indexes (ECIs) used as proxies in this market basket meet these criteria.

We note that the proxies are the same as those used for the FY 1997-based excluded hospital with capital market basket. Because these proxies meet our criteria of reliability, timeliness, availability, and relevance, we believe they continue to be the best measure of price changes for the cost categories. For further discussion on the FY 1997-based excluded hospital with capital market basket, see the August 1, 2002 IPPS final rule (67 FR at 50042).

The RY 2009 (that is, beginning July 1, 2008) update for the IPF PPS using the FY 2002-based RPL market basket and Global Insight's 1st quarter 2008 forecast for the market basket components is 3.2 percent. This includes increases in both the operating section and the capital section for the 12-month RY period (that is, July 1, 2008 through June 30, 2009). Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets.

2. Labor-Related Share

Due to the variations in costs and geographic wage levels, we believe that payment rates under the IPF PPS should continue to be adjusted by a geographic wage index. This wage index applies to the labor-related portion of the Federal per diem base rate, hereafter referred to as the labor-related share.

The labor-related share is determined by identifying the national average proportion of operating costs that are related to, influenced by, or vary with the local labor market. Using our current definition of labor-related, the labor-related share is the sum of the relative importance of wages and salaries, fringe benefits, professional fees, labor-intensive services, and a portion of the capital share from an appropriate market basket. We used the FY 2002-based RPL market basket cost weights

relative importance to determine the labor-related share for the IPF PPS.

The labor-related share for RY 2009 is the sum of the RY 2009 relative importance of each labor-related cost category, and reflects the different rates of price change for these cost categories between the base year (FY 2002) and RY 2009. The sum of the relative importance for the RY 2009 operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) is 71.681, as shown in Table 3 below. The portion of capital that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage used in the FY 1997-based IRF and IPF payment systems.

Since the relative importance for capital is 8.586 percent of the FY 2002-based RPL market basket in RY 2009, we are taking 46 percent of 8.586 percent to determine the labor-related share of capital for RY 2009. The result is 3.950 percent, which we added to 71.681 percent for the operating cost amount to determine the total labor-related share for RY 2009. Thus, the labor-related share that we are using for IPF PPS in RY 2009 is 75.631 percent. Table 3 below shows the RY 2009 labor-related share using the FY 2002-based RPL market basket. We note that this labor-related share is determined by using the same methodology as employed in calculating all previous IPF labor-related shares.

A complete discussion of the IPF labor-related share methodology appears in the November 2004 IPF PPS final rule (69 FR 66952 through 66954).

TABLE 3.—TOTAL LABOR-RELATED SHARE—RELATIVE IMPORTANCE FOR RY 2009

Cost category	FY 2002-based RPL Market Basket Relative Importance (Percent) RY 2008*	FY 2002-based RPL Market Basket Relative Importance (Percent) RY 2009**
Wages and salaries	52.588	52.645
Employee benefits	14.127	14.004
Professional fees	2.907	2.895
All other labor-intensive services	2.145	2.137
SUBTOTAL	71.767	71.681
Labor-related share of capital costs (0.46)	4.021	3.950
TOTAL	75.788	75.631

* Based on 2007 1st Quarter forecast.
** Based on 2008 1st Quarter forecast.

3. IPFs Paid Based on a Blend of the Reasonable Cost-Based Payments

As stated in the FY 2006 IPPS final rule (70 FR 47399), for IPFs that are transitioning to the fully Federal prospective payment rate, we will continue using the rebased and revised FY 2002-based excluded hospital market basket to update the reasonable cost-based portion of their payments.

For RY 2009, all IPFs will have fully transitioned to PPS payment and therefore, be paid based on 100 percent IPF PPS. The reasonable cost-based payment which is subject to TEFRA limits will no longer be applied.

IV. Update of the IPF PPS Adjustment Factors

A. Overview of the IPF PPS Adjustment Factors

The IPF PPS payment adjustments were derived from a regression analysis of 100 percent of the FY 2002 MedPAR data file, which contained 483,038 cases. We used the same results of this regression analysis to implement the November 2004 and May 2006 IPF PPS final rules. While we have since used more recent claims data to set the fixed dollar loss threshold amount, we use the same results of this regression analysis to update the IPF PPS for RY 2008 as well as RY 2009.

As previously stated, we do not plan to update the regression analysis until we analyze IPF PPS data. We plan to monitor claims and payment data independently from cost report data to assess issues, or whether changes in case-mix or payment shifts have occurred between free standing governmental, non-profit and private psychiatric hospitals, and psychiatric units of general hospitals, and other issues of importance to psychiatric facilities.

A complete discussion of the data file used for the regression analysis appears in the November 2004 IPF PPS final rule (69 FR 66935 through 66936).

B. Patient-Level Adjustments

In the May 2006 IPF PPS final rule (71 FR 27040) for RY 2007 and in the May 2007 IPF PPS notice (72 FR 25602) for RY 2008, we provided payment adjustments for the following patient-level characteristics: DRG assignment of the patient's principal diagnosis; selected comorbidities; patient age; and the variable per diem adjustments. As previously stated in the November 2004 IPF PPS final rule, we do not intend to update the adjustment factors derived from the regression analysis until we analyze IPF PPS data that include as much information as possible regarding the patient-level characteristics of the population that each IPF serves.

1. Adjustment for MS–DRG Assignment

The IPF PPS includes payment adjustments for the psychiatric DRG assigned to the claim based on each patient's principal diagnosis. In the May 4, 2007 IPF PPS update notice (72 FR 25602), we explained that the IPF PPS includes 15 diagnosis-related group (DRG) adjustment factors. The adjustment factors were expressed relative to the most frequently reported psychiatric DRG in FY 2002, that is, DRG 430 (psychoses). The coefficient values and adjustment factors were derived from the regression analysis.

In accordance with § 412.27(a), payment under the IPF PPS is conditioned on IPFs admitting ''only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, (DSM–IV–TR) or in Chapter Five (''Mental Disorders'') of the

International Classification of Diseases, Ninth Revision, Clinical Modification [(ICD–9–CM)].'' IPF claims with a principal diagnosis included in Chapter Five of the ICD–9–CM or the DSM–IV–TR will be paid the Federal per diem base rate under the IPF PPS, and all other applicable adjustments, including any applicable DRG adjustment. Psychiatric principal diagnoses that do not group to one of the 15 designated DRGs still receive the Federal per diem base rate and all other applicable adjustments, but the payment would not include a DRG adjustment.

The Standards for Electronic Transaction final rule published in the **Federal Register** on August 17, 2000 (65 FR 50312) adopted the ICD–9–CM as the designated code set for reporting diseases, injuries, impairments, other health related problems, their manifestations, and causes of injury, disease, impairment, or other health related problems. Therefore, we use the ICD–9–CM as the designated code set for the IPF PPS.

We believe that it is important to maintain the same diagnostic coding and DRG classification for IPFs that are used under the IPPS for providing the same psychiatric care. Therefore, when the IPF PPS was implemented for cost reporting periods beginning on or after January 1, 2005, we adopted the same diagnostic code set and DRG patient classification system (that is, the CMS DRGs) that was utilized at the time under the hospital inpatient prospective payment system (IPPS). Since the inception of the IPF PPS, the DRGs used as the patient classification system under the IPF PPS have corresponded exactly with the CMS DRGs applicable under the IPPS for acute care hospitals.

Every year, changes to the ICD–9–CM coding system are addressed in the IPPS proposed and final rules. The changes to the codes are effective October 1 of each year and must be used by acute care hospitals under the IPPS to report diagnostic and procedure information. The IPF PPS has always incorporated those ICD–9–CM coding changes made in the annual IPPS update. The IPF PPS announces the changes in a change request, at the same time the coding changes to IPPS and LTCH PPS are announced. Those ICD–9–CM coding changes are also published in the next IPF PPS RY update, in either the proposed and final rules, or in an update notice.

As part of CMS' effort to better recognize resource use and the severity of illness among patients, CMS adopted the new Medicare Severity diagnosis related groups (MS–DRGs) for the IPPS in the FY 2008 IPPS final rule with comment period (72 FR 47130). By better accounting for patients' severity of illness in Medicare payment rates, the MS–DRGs encourage hospitals to improve their coding and documentation of patient diagnoses. The MS–DRGs, which are based on the CMS DRGs, represent a significant increase in the number of DRGs (from 538 to 745, an increase of 207). For a full description of the development and implementation of the MS–DRGs, see the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175). Also see Transmittal 1374 (change request 5748), dated November 7, 2007, for the ICD–9–CM coding changes.

All of the ICD–9–CM coding changes are reflected in the FY 2008 GROUPER, Version 25.0, effective for IPPS discharges occurring on or after October 1, 2007 through September 30, 2008. The GROUPER Version 25.0 software package assigns each case to a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The Medicare Code Editor (MCE) 24.0 uses the new ICD–9–CM codes to validate coding for IPPS discharges on or after October 1, 2007. For additional information on the GROUPER Version 25.0 and MCE 24.0, see Transmittal 1374, dated November 7, 2007. The IPF PPS has always used the same GROUPER and Code Editor as the IPPS. Therefore, the ICD–9–CM changes, which were reflected in the GROUPER Version 25.0 and MCE 24.0 on October 1, 2007, also became effective for the IPF PPS for discharges occurring on or after October 1, 2007.

The impact of the new MS–DRGs on the IPF PPS is negligible. Mapping the current DRGs to the MS–DRGs, there are now 17 MS–DRGs, instead of the original 15, for which the IPF PPS provides an adjustment. In addition, although the code set is updated, the same associated adjustment factors apply now that have been in place since implementation of the IPF PPS, with one exception that is unrelated to the update to the codes. When DRGs 521 and 522 were consolidated into MS–DRG 895, we carried over the adjustment factor of 1.02 from DRG 521 to the newly consolidated MS–DRG. This was done to reflect the higher claims volume under DRG 521, with more than eight times the number of claims than billed under DRG 522. The updated codes, which were effective October 1, 2007, must be used to report diagnostic or procedure information on IPF PPS claims. These updates are reflected in Table 4.

The official version of the ICD–9–CM is available on CD–ROM from the U.S. Government Printing Office. The FY 2008 version can be ordered by contacting the Superintendent of Documents, U.S. Government Printing Office, Department 50, Washington, DC 20402–9329, telephone number (202) 512–1800. Questions concerning the ICD–9–CM should be directed 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, Mailstop C4–08–06, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Further information concerning the official version of the ICD–9–CM can be found in the IPPS final rule with comment period, ''Changes to Hospital Inpatient Prospective Payment System and Fiscal Year 2008 Rates'' in the August 22, 2007 **Federal Register** (72 FR 47130) and at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1533fc.pdf.*

Table 4 below lists the FY 2008 new ICD–9–CM diagnosis codes that group to one of the 17 MS–DRGs for which the IPF PPS provides an adjustment. This table is only a listing of FY 2008 changes and does not reflect all of the currently valid and applicable ICD–9–CM codes classified in the MS–DRGs. When coded as a principal code or diagnosis, these codes receive the correlating MS–DRG adjustment.

TABLE 4.—FY 2008 NEW DIAGNOSIS CODES

Diagnosis code	Description	MS–DRG
315.34	Speech and language developmental delay due to hearing loss.	886
331.5	Idiopathic normal pressure hydrocephalus (INPH).	056, 057

Since we do not plan to update the regression analysis until we analyze IPF PPS data, the MS–DRG adjustment factors, shown in Table 5 below, will continue to be paid for RY 2009. Table 5 reflects the changes that were made to the DRGs under the IPF PPS in a crosswalk of DRGs prior to October 1, 2007 to the new MS–DRGs, which were effective October 1, 2007.

TABLE 5.—FY 2008 CROSSWALK OF CURRENT DRGS TO NEW MS–DRGS APPLICABLE FOR THE PRINCIPAL DIAGNOSIS ADJUSTMENT

(v24) DRG prior to 10/01/07	(v25) MS–DRG after 10/01/07	MS–DRG descriptions	Adjustment factor
	056	Degenerative nervous system disorders w MCC	
12	057	Degenerative nervous system disorders w/o MCC	1.05
	080	Nontraumatic stupor & coma w MCC	
023	081	Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	
523	897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

2. Payment for Comorbid Conditions

The intent of the comorbidity adjustment is to recognize the increased costs associated with comorbid conditions by providing additional payments for certain concurrent medical or psychiatric conditions that are expensive to treat. In the May 2007 IPF PPS update notice (72 FR 25602), we explained that the IPF PPS includes 17 comorbidity categories and identified the new, revised and deleted ICD–9–CM diagnosis codes that generate a comborbid condition payment adjustment under the IPF PPS for RY 2008 (72 FR 25609–13).

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis, and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, affect the length of stay (LOS) or affect both treatment and LOS.

For each claim, an IPF may receive only one comorbidity adjustment per comorbidity category, but it may receive an adjustment for more than one comorbidity category. Billing instructions require that IPFs must enter the full ICD–9–CM codes for up to 8 additional diagnoses if they co-exist at the time of admission or develop subsequently.

The comorbidity adjustments were determined based on the regression analysis using the diagnoses reported by hospitals in FY 2002. The principal diagnoses were used to establish the DRG adjustment and were not accounted for in establishing the comorbidity category adjustments, except where ICD–9–CM ''code first'' instructions apply. As we explained in the May 2007 IPF PPS notice (72 FR 25602), the code first rule applies when a condition has both an underlying etiology and a manifestation due to the underlying etiology. For these conditions, the ICD–9–CM has a coding convention that requires the underlying conditions to be sequenced first followed by the manifestation. Whenever a combination exists, there is a ''use additional code'' note at the etiology code and a ''code first'' note at the manifestation code.

As discussed in the DRG section, it is our policy to maintain the same diagnostic coding set for IPFs that is used under the IPPS for providing the same psychiatric care. Although the ICD–9–CM code set has been updated, the same adjustment factors have been in place since the implementation of the IPF PPS. Table 6 below lists the FY 2008 new ICD diagnosis codes that impact the comorbidity adjustments under the IPF PPS. Table 6 is not a list of all currently valid ICD codes applicable for the IPF PPS comorbidity adjustments.

TABLE 6.—FY 2008 NEW ICD CODES APPLICABLE FOR THE COMORBIDITY ADJUSTMENTS DIAGNOSIS

Diagnosis code	Description	Comorbidity category
040.41	Infant botulism	Infectious Diseases.
040.42	Wound botulism	Infectious Diseases.
058.10	Roseola infantum, unspecified	Infectious Diseases.
058.11	Roseola infantum due to human herpesvirus 6	Infectious Diseases.
058.12	Roseola infantum due to human herpesvirus 7	Infectious Diseases.
058.21	Human herpesvirus 6 encephalitis	Infectious Diseases.
058.29	Other human herpesvirus encephalitis	Infectious Diseases.
058.81	Human herpesvirus 6 infection	Infectious Diseases.
058.82	Human herpesvirus 7 infection	Infectious Diseases.
058.89	Other human herpesvirus infection	Infectious Diseases.
200.30	Marginal zone lymphoma, unspecified site, extranodal and solid organ sites.	Oncology Treatment.
200.31	Marginal zone lymphoma, lymph nodes of head, face, and neck.	Oncology Treatment.
200.32	Marginal zone lymphoma, intrathoracic lymph nodes	Oncology Treatment.

TABLE 6.—FY 2008 NEW ICD CODES APPLICABLE FOR THE COMORBIDITY ADJUSTMENTS DIAGNOSIS—Continued

Diagnosis code	Description	Comorbidity category
200.33	Marginal zone lymphoma, intraabdominal lymph nodes	Oncology Treatment.
200.34	Marginal zone lymphoma, lymph nodes of axilla and upper limb.	Oncology Treatment.
200.35	Marginal zone lymphoma, lymph nodes of inguinal region and lower limb.	Oncology Treatment.
200.36	Marginal zone lymphoma, intrapelvic lymph nodes	Oncology Treatment.
200.37	Marginal zone lymphoma, spleen	Oncology Treatment.
200.38	Marginal zone lymphoma, lymph nodes of multiple sites	Oncology Treatment.
200.40	Mantle cell lymphoma, unspecified site, extranodal and solid organ sites.	Oncology Treatment.
200.41	Mantle cell lymphoma, lymph nodes of head, face, and neck	Oncology Treatment.
200.42	Mantle cell lymphoma, intrathoracic lymph nodes	Oncology Treatment.
200.43	Mantle cell lymphoma, intra-abdominal lymph nodes	Oncology Treatment.
200.44	Mantle cell lymphoma, lymph nodes of axilla and upper limb	Oncology Treatment.
200.45	Mantle cell lymphoma, lymph nodes of inguinal region and lower limb.	Oncology Treatment.
200.46	Mantle cell lymphoma, intrapelvic lymph nodes	Oncology Treatment.
200.47	Mantle cell lymphoma, spleen	Oncology Treatment.
200.48	Mantle cell lymphoma, lymph nodes of multiple sites	Oncology Treatment.
200.50	Primary central nervous system lymphoma, unspecified site, extranodal and solid organ sites.	Oncology Treatment.
200.51	Primary central nervous system lymphoma, lymph nodes of head, face, and neck.	Oncology Treatment.
200.52	Primary central nervous system lymphoma, intrathoracic lymph nodes.	Oncology Treatment.
200.53	Primary central nervous system lymphoma, intra-abdominal lymph nodes.	Oncology Treatment.
200.54	Primary central nervous system lymphoma, lymph nodes of axilla and upper limb.	Oncology Treatment.
200.55	Primary central nervous system lymphoma, lymph nodes of inguinal region and lower limb.	Oncology Treatment.
200.56	Primary central nervous system lymphoma, intrapelvic lymph nodes.	Oncology Treatment.
200.57	Primary central nervous system lymphoma, spleen	Oncology Treatment.
200.58	Primary central nervous system lymphoma, lymph nodes of multiple sites.	Oncology Treatment.
200.60	Anaplastic large cell lymphoma, unspecified site, extranodal and solid organ sites.	Oncology Treatment.
200.61	Anaplastic large cell lymphoma, lymph nodes of head, face, and neck.	Oncology Treatment.
200.62	Anaplastic large cell lymphoma, intrathoracic lymph nodes	Oncology Treatment.
200.63	Anaplastic large cell lymphoma, intra-abdominal lymph nodes	Oncology Treatment.
200.64	Anaplastic large cell lymphoma, lymph nodes of axilla and upper limb.	Oncology Treatment.
200.65	Anaplastic large cell lymphoma, lymph nodes of inguinal region and lower limb.	Oncology Treatment.
200.66	Anaplastic large cell lymphoma, intrapelvic lymph nodes	Oncology Treatment.
200.67	Anaplastic large cell lymphoma, spleen	Oncology Treatment.
200.68	Anaplastic large cell lymphoma, lymph nodes of multiple sites	Oncology Treatment.
200.70	Large cell lymphoma, unspecified site, extranodal and solid organ sites.	Oncology Treatment.
200.71	Large cell lymphoma, lymph nodes of head, face, and neck	Oncology Treatment.
200.72	Large cell lymphoma, intrathoracic lymph nodes	Oncology Treatment.
200.73	Large cell lymphoma, intra-abdominal lymph nodes	Oncology Treatment.
200.74	Large cell lymphoma, lymph nodes of axilla and upper limb	Oncology Treatment.
200.75	Large cell lymphoma, lymph nodes of inguinal region and lower limb.	Oncology Treatment.
200.76	Large cell lymphoma, intrapelvic lymph nodes	Oncology Treatment.
200.77	Large cell lymphoma, spleen	Oncology Treatment.
200.78	Large cell lymphoma, lymph nodes of multiple sites	Oncology Treatment.
202.70	Peripheral T cell lymphoma, unspecified site, extranodal and solid organ sites.	Oncology Treatment.
202.71	Peripheral T cell lymphoma, lymph nodes of head, face, and neck.	Oncology Treatment.
202.72	Peripheral T cell lymphoma, intrathoracic lymph nodes	Oncology Treatment.
202.73	Peripheral T cell lymphoma, intra-abdominal lymph nodes	Oncology Treatment.
202.74	Peripheral T cell lymphoma, lymph nodes of axilla and upper limb.	Oncology Treatment.
202.75	Peripheral T cell lymphoma, lymph nodes of inguinal region and lower limb.	Oncology Treatment.
202.76	Peripheral T cell lymphoma, intrapelvic lymph nodes	Oncology Treatment.
202.77	Peripheral T cell lymphoma, spleen	Oncology Treatment.

TABLE 6.—FY 2008 NEW ICD CODES APPLICABLE FOR THE COMORBIDITY ADJUSTMENTS DIAGNOSIS—Continued

Diagnosis code	Description	Comorbidity category
202.78	Peripheral T cell lymphoma, lymph nodes of multiple sites	Oncology Treatment.
233.30	Carcinoma in situ, unspecified female genital organ	Oncology Treatment.
233.31	Carcinoma in situ, vagina	Oncology Treatment.
233.32	Carcinoma in situ, vulva	Oncology Treatment.
233.39	Carcinoma in situ, other female genital organ	Oncology Treatment.

Table 7 lists the invalid ICD–9–CM codes no longer applicable for the comorbidity adjustment. .

TABLE 7.—FY 2008 INVALID ICD CODES NO LONGER APPLICABLE FOR THE COMORBIDITY ADJUSTMENT

Diagnosis code	Description	Comorbidity category.
233.3	Carcinoma in situ, other and unspecified female genital organs.	Oncology Treatment.

The seventeen comorbidity categories for which we are providing an adjustment, their respective codes, including the new FY 2008 ICD codes, and their respective adjustment factors, are listed below in Table 8. .

TABLE 8.—RY 2009 DIAGNOSIS CODES AND ADJUSTMENT FACTORS FOR COMORBIDITY CATEGORIES

Description of comorbidity	ICD–9CM code	Adjustment factor
Developmental Disabilities	317, 3180, 3181, 3182, and 319	1.04
Coagulation Factor Deficits	2860 through 2864	1.13
Tracheostomy	51900—through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585.	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V451, V560, V561, and V562.	1.11
Oncology Treatment	1400 through 2399 with a radiation therapy code 92.21–92.29 or chemotherapy code 99.25.	1.07
Uncontrolled Diabetes-Mellitus with or without complications.	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093.	1.05
Severe Protein Calorie Malnutrition	260 through 262	1.13
Eating and Conduct Disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious Disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959.	1.07
Drug and/or Alcohol Induced Mental Disorders.	2910, 2920, 29212, 2922, 30300, and 30400	1.03
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614	1.12
Artificial Openings-Digestive and Urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe Musculoskeletal and Connective Tissue Diseases.	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029.	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897.	1.11

3. Patient Age Adjustments

As explained in the November 2004 IPF PPS final rule, we analyzed the impact of age on per diem cost by examining the age variable (that is, the range of ages) for payment adjustments.

In general, we found that the cost per day increases with increasing age. The older age groups are more costly than the under 45 age group, the differences in per diem cost increase for each successive age group, and the differences are statistically significant.

For RY 2009, we are continuing to use the patient age adjustments currently in effect and shown in Table 9 below.

TABLE 9.—AGE GROUPINGS AND ADJUSTMENT FACTORS

Age	Adjustment factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04

TABLE 9.—AGE GROUPINGS AND ADJUSTMENT FACTORS—Continued

Age	Adjustment factor
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

4. Variable Per Diem Adjustments

We explained in the November 2004 IPF PPS final rule that a regression analysis indicated that per diem cost declines as the LOS increases (69 FR 66946). The variable per diem adjustments to the Federal per diem base rate account for ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF.

We used a regression analysis to estimate the average differences in per diem cost among stays of different lengths. As a result of this analysis, we established variable per diem adjustments that begin on day 1 and decline gradually until day 21 of a patient's stay. For day 22 and thereafter, the variable per diem adjustment remains the same each day for the remainder of the stay. However, the adjustment applied to day 1 depends upon whether the IPF has a qualifying ED. If an IPF has a qualifying ED, it receives a 1.31 adjustment factor for day 1 of each patient stay. If an IPF does not have a qualifying ED, it receives a 1.19 adjustment factor for day 1 of the stay. The ED adjustment is explained in more detail in section IV.C.5 of this notice.

For RY 2009, we are continuing to use the variable per diem adjustment factors currently in effect as shown in Table 10 below.

A complete discussion of the variable per diem adjustments appears in the November 2004 IPF PPS final rule (69 FR 66946).

TABLE 10.—VARIABLE PER DIEM ADJUSTMENTS

Day-of-stay	Adjustment factor
Day 1—IPF Without a Qualified ED	1.19
Day 1—IPF With a Qualified ED	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00
Day 10	1.00
Day 11	0.99
Day 12	0.99
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
After Day 21	0.92

C. Facility-Level Adjustments

The IPF PPS includes facility-level adjustments for the wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED.

1. Wage Index Adjustment

As discussed in the May 2006 IPF PPS final rule, and in the May 2007 notice, in providing an adjustment for area wage levels, the labor-related portion of an IPF's Federal prospective payment is adjusted using an appropriate wage index. An IPF's area wage index value is determined based on the actual location of the IPF in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through (C).

Since the inception of the IPF PPS, we have used hospital wage data in developing a wage index to be applied to IPFs. We are continuing that practice for RY 2009. We apply the wage index adjustment to the labor-related portion of the Federal rate, which is 75.631 percent. This percentage reflects the labor-related relative importance of the RPL market basket for RY 2009. The IPF PPS uses the pre-floor, pre-reclassified hospital wage index. Changes to the wage index are made in a budget neutral manner, so that updates do not increase expenditures.

For RY 2009, we are applying the most recent hospital wage index using the most recent hospital wage data, and applying an adjustment in accordance with our budget neutrality policy. This policy requires us to estimate the total amount of IPF PPS payments in RY 2008 and divide that amount by the total estimated IPF PPS payments in RY 2009. The estimated payments are based on FY 2006 IPF claims, inflated to the appropriate RY. This quotient is the wage index budget neutrality factor, and it is applied in the update of the Federal per diem base rate for RY 2009. The wage index budget neutrality factor for RY 2009 is 1.0010.

The wage index applicable for RY 2009 appears in Table 1 and Table 2 in Addendum B of this notice. As explained in the May 2006 IPF PPS final rule for RY 2007 (71 FR 27061), and in the IPF PPS May 2007 notice for RY 2008 (72 FR 25602), the IPF PPS applies the hospital wage index without a hold-harmless policy, and without an out-commuting adjustment or out-migration adjustment because we feel these policies apply only to the IPPS.

In the May 2006 IPF PPS final rule for RY 2007 (71 FR 27061), we adopted the changes discussed in the Office of Management and Budget (OMB) Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for Metropolitan Statistical Areas (MSAs), and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. In adopting the OMB Core-Based Statistical Area (CBSA) geographic designations, since the IPF PPS was already in a transition period from TEFRA payments to PPS payments, we did not provide a separate transition for the wage index.

As was the case in RY 2008, for RY 2009, we will be using the full CBSA-based wage index values as presented in Tables 1 and 2 in Addendum B of this notice.

Finally, we continue to use the same methodology discussed in the IPF PPS proposed rule for RY 2007 (71 FR 3633), and finalized in the May 2006 IPF PPS final rule for RY 2007 (71 FR 27061) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the RY 2009 IPF PPS wage index. For RY 2009, those areas consist of rural Massachusetts, rural Puerto Rico and urban CBSA (25980) Hinesville-Fort Stewart, GA.

A complete discussion of the CBSA labor market definitions appears in the May 2006 IPF PPS final rule (71 FR 27061 through 27067).

a. Clarification of New England Deemed Counties

We are also taking this opportunity to address the change in the treatment of ''New England deemed counties'' (that is, those counties in New England listed in § 412.64(b)(1)(ii)(B) that were deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983) that was made in the FY 2008 IPPS final rule with comment period. These counties include the following: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Of these five ''New England deemed counties,'' three (York County, Sagadahoc County, and Newport County) are also included in metropolitan statistical areas defined by OMB and are considered urban under both the current IPPS and IPF PPS labor market area definitions in § 412.64(b)(1)(ii)(A). The remaining two, Litchfield County and Merrimack County, are geographically located in areas that are considered rural under the current IPPS (and IPF PPS) labor market area definitions (however, they have been previously deemed urban under the IPPS in certain circumstances as discussed below).

In the FY 2008 IPPS final rule with comment period (72 FR 47337 through 47338), § 412.64(b)(1)(ii)(B) was revised such that the two ''New England deemed counties'' that are still considered rural under the OMB definitions (Litchfield County, CT and Merrimack County, NH), are no longer considered urban effective for discharges occurring on or after October 1, 2007, and therefore, are considered rural in accordance with § 412.64(b)(1)(ii)(C). However, for purposes of payment under the IPPS, acute-care hospitals located within those areas are treated as being reclassified to their deemed urban area effective for discharges occurring on or after October 1, 2007 (see 72 FR 47337 through 47338). We note that the IPF PPS does not provide for such geographic reclassification (71 FR 27061 through 27067). Also in the FY 2008 IPPS final rule with comment period (72 FR 47338), we explained that we limited this policy change for the ''New England deemed counties'' only to IPPS hospitals, and any change to non-IPPS provider wage indices would be addressed in the respective payment system rules.

Accordingly, as stated above, we are taking the opportunity to clarify the treatment of ''New England deemed counties'' under the IPF PPS in this notice. As discussed above, under existing § 412.402 and § 412.424(d)(1)(i), an IPF's wage index is determined based on the location of the IPF in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through (C). Under existing § 412.402, an urban area under the IPF PPS is currently defined at § 412.64(b)(1)(ii)(A) and (B), and a rural area is defined at § 412.64(b)(1)(ii)(C) as any area outside of an urban area.

Historical changes to the labor market area/geographic classifications and annual updates to the wage index values under the IPF PPS are made effective July 1 each year. When we established the most recent IPF PPS payment rate update, effective for IPF discharges occurring on or after July 1, 2007 through June 30, 2008, we considered the ''New England deemed counties'' (including Litchfield County, CT and Merrimack County, NH) as urban for RY 2008 (in accordance with the definitions of urban and rural stated in the RY 2008 IPF PPS notice (72 FR 25602) and as evidenced by the inclusion of Litchfield County as one of the constituent counties of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT), and the inclusion of Merrimack County as one of the constituent counties of urban CBSA 31700 (Manchester-Nashua, NH)). (See 72 FR 25643 and 25651, respectively).

As noted above, existing § 412.402 indicates that the terms ''rural'' and ''urban'' are defined according to the definitions of those terms in § 412.64(b)(1)(ii)(A) through (C). Effective for discharges on or after July 1, 2008, § 412.64(b)(1)(ii)(B) is no longer applicable under the IPF PPS. Therefore, as Litchfield County, CT and Merrimack County, NH would be considered rural areas in accordance with our regulations at § 412.402, these two counties will be ''rural'' under the IPF PPS effective with the next update of the IPF PPS payment rates, which will be July 1, 2008 (under the IPF PPS effective for discharges on or after July 1, 2008, Litchfield County, CT and Merrimack County, NH are not urban under § 412.64(b)(1)(ii)(A) through (B), as revised under the RY 2008 IPPS final rule with comment period, and therefore are rural under § 412.64(b)(1)(ii)(C)). Litchfield County, CT and Merrimack County, NH will be considered ''rural'' effective for IPF PPS discharges occurring on or after July 1, 2008, and will no longer be considered as being part of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT) and urban CBSA 31700 (Manchester-Nashua, NH), respectively. We do not need to make any changes to our regulations to effectuate this change. We note that this policy is consistent with our policy of not taking into account IPPS geographic reclassifications in determining payments under the IPF PPS.

Four IPFs (two in Litchfield County, CT, and two in Merrimack County, NH) greatly benefit from treating the counties in which they are located as rural. These IPFs will begin to receive the rural facility adjustment and see an approximate 17 percent increase in payments. Five IPFs in NH that are currently treated as rural will experience an approximate 3 percent decrease in payments because the rural NH wage index value decreases when this change is made. One IPF in CT that is currently treated as rural will experience an approximate 4 percent decrease in payments because the rural CT wage index value is lower when this change is made.

The area wage index values for CBSAs 31700 and 25540 increase with the change. No other IPFs in CT or NH are affected by treating Litchfield and Merrimack Counties as rural.

b. Multi-Campus—Wage Index Data Collection

Historically, under the IPF PPS, we have established IPF PPS wage index values calculated from acute care IPPS hospital wage data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. As we discussed in the May 2006 IPF PPS final rule (71 FR 27040), hospitals that are excluded from the IPPS are not required to provide wage-related information on the Medicare cost report (which is needed in order to make geographic reclassifications). Thus, the wage adjustment established under the IPF PPS is based on an IPF's actual location without regard to the urban or rural designation of any related or affiliated provider.

In the RY 2008 IPF PPS notice (72 FR 25602), we established IPF PPS wage index values for the RY 2008 calculated from the same data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2003) used to compute the FY 2007 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act because that was the best available data at that time. The IPF PPS wage index values applicable for discharges occurring on or after July 1, 2007 through June 30, 2008 are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to the RY 2008 IPF PPS final rule (72 FR 25627 through 25673).

For RY 2009, the same data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2004) used to compute the FY 2008 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act was used to determine the applicable wage index values under the IPF PPS because these data (FY 2004) are the most recent complete data. (For information on the data used to compute the FY 2008 IPPS wage index, refer to the FY 2008 IPPS final rule with comment period (72 FR 47308 through 47309, 47315)). We are continuing to use IPPS wage data as a proxy to determine the IPF wage index values for RY 2009 because both IPFs and acute-care hospitals are required to meet the same certification criteria set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program and they both compete in the same labor markets, and therefore, experience similar wage-related costs. We note that the IPPS wage data used to determine the RY 2009 IPF wage index values reflects our policy that was adopted under the IPPS beginning in FY 2008 that apportions the wage data for multi-campus hospitals located in different

labor market areas (CBSAs) to each CBSA where the campuses are located (see the FY 2008 IPPS final rule with comment period (72 FR 47317 through 47320)). The RY 2009 IPF PPS wage index values presented in this notice were computed consistent with our pre-reclassified IPPS wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments under the IPF PPS).

For the RY 2009 IPF PPS, the wage index was computed from IPPS wage data (submitted by hospitals for cost reporting periods beginning in FY 2004 (just like the FY 2008 IPPS wage index)), which allocated salaries and hours to the campuses of two multi-campus hospitals with campuses that are located in different labor areas, one in Massachusetts and another in Illinois. Thus, the RY 2009 IPF PPS wage index values for the following CBSAs are affected by this policy: Boston-Quincy, MA (CBSA 14484), Providence-New Bedford-Falls River, RI–MA (CBSA 39300), Chicago-Naperville-Joliet, IL (CBSA 16974) and Lake County-Kenosha County, IL–WI (CBSA 29404) (refer to Table 1 in the Addendum of this notice).

The table below describes the change in wage index value and the number of IPFs affected by the multi-campus hospital policy change:

TABLE 11.—IPFS AFFECTED BY THE MULTI-CAMPUS HOSPITAL POLICY CHANGE

CBSA	No. of IPFs	Wage index value change
14484 (Boston-Quincy, MA)	17	0.0153
16974 (Chicago-Naperville-Joliet, IL)	47	−0.002
29404 (Lake County-Kenosha County, IL–WI)	2	0.0288
39300 (Providence-New Bedford-Falls River, RI–MA)	12	−0.0111

c. OMB Bulletins

The Office of Management and Budget (OMB) publishes bulletins regarding CBSA changes, including changes to CBSA numbers and titles. In the May 2006 IPF PPS final rule for FY 2006 (71 FR 27040), we adopted the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003), available online at *http://www.whitehouse.gov/omb/bulletins/b03-04.html*. Those changes were strictly nomenclature changes and did not represent substantive changes to the CBSA-based designations. In this notice, we incorporate the CBSA nomenclature changes published in the most recent OMB bulletin that applies to the hospital wage data used to determine the current IPF PPS wage index, and we expect to do the same for all such OMB CBSA nomenclature changes in future IPF PPS rules and notices, as necessary. The OMB bulletins may be accessed online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

2. Adjustment for Rural Location

In the November 2004 IPF PPS final rule, we provided a 17 percent payment adjustment for IPFs located in a rural area. This adjustment was based on the regression analysis, which indicated that the per diem cost of rural facilities was 17 percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression. For RY 2009, we are applying a 17 percent payment adjustment for IPFs located in a rural area as defined at § 412.64(b)(1)(ii)(C). A complete discussion of the adjustment for rural locations appears in the November 2004 IPF PPS final rule (69 FR 66954).

3. Teaching Adjustment

In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(1)(iii) to establish a facility-level adjustment for IPFs that are, or are part of, teaching institutions. The teaching adjustment accounts for the higher indirect operating costs experienced by facilities that participate in graduate medical education (GME) programs. Payments are made based on the number of full-time equivalent interns and residents training in the IPF.

Medicare makes direct GME payments (for direct costs such as resident and teaching physician salaries, and other direct teaching costs) to all teaching hospitals including those paid under the IPPS, and those that were once paid under the TEFRA rate-of-increase limits but are now paid under other PPSs. These direct GME payments are made separately from payments for hospital operating costs and are not part of the PPSs. The direct GME payments do not address the estimated higher indirect operating costs teaching hospitals may face.

For teaching hospitals paid under the TEFRA rate of increase limits, Medicare did not make separate medical education payments because payments to these hospitals were based on the hospitals' reasonable costs. Since payments under TEFRA were based on hospitals' reasonable costs, the higher indirect costs that might be associated with teaching programs would automatically have been factored into the TEFRA payments.

The results of the regression analysis of FY 2002 IPF data established the basis for the payment adjustments included in the November 2004 IPF PPS final rule. The results showed that the indirect teaching cost variable is significant in explaining the higher costs of IPFs that have teaching programs. We calculated the teaching adjustment based on the IPF's ''teaching variable,'' which is one plus the ratio of the number of full-time equivalent (FTE) residents training in the IPF (subject to limitations described below) to the IPF's average daily census (ADC).

In the regression analysis, the logarithm of the teaching variable had a coefficient value of 0.5150. We converted this cost effect to a teaching payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value. We note that the coefficient value of 0.5150 was based on the regression analysis holding all other components of the payment system constant.

As with other adjustment factors derived through the regression analysis, we do not plan to rerun the regression analysis until we analyze IPF PPS data. Therefore, for RY 2009, we are retaining the coefficient value of 0.5150 for the teaching adjustment to the Federal per diem base rate.

A complete discussion of how the teaching adjustment was calculated appears in the November 2004 IPF PPS final rule (69 FR 66954 through 66957) and the May 2006 IPF PPS final rule (71 FR 27067 through 27070).

4. Cost of Living Adjustment for IPFs Located in Alaska and Hawaii

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the county in which the IPF is located. As we explained in the November 2004 IPF PPS final rule, the FY 2002 data

demonstrated that IPFs in Alaska and Hawaii had per diem costs that were disproportionately higher than other IPFs. Other Medicare PPSs (for example, the IPPS and LTCH PPS) have adopted a cost of living adjustment (COLA) to account for the cost differential of care furnished in Alaska and Hawaii.

We analyzed the effect of applying a COLA to payments for IPFs located in Alaska and Hawaii. The results of our analysis demonstrated that a COLA for IPFs located in Alaska and Hawaii would improve payment equity for these facilities. As a result of this analysis, we provided a COLA in the November 2004 IPF PPS final rule.

In general, the COLA accounts for the higher costs in the IPF and eliminates the projected loss that IPFs in Alaska and Hawaii would experience absent the COLA. A COLA factor for IPFs located in Alaska and Hawaii is made by multiplying the non-labor share of the Federal per diem base rate by the applicable COLA factor based on the COLA area in which the IPF is located.

As previously stated, we will update the COLA factors according to updates established by the U.S. Office of Personnel Management (OPM), which issued a final rule to change COLA rates effective September 1, 2006.

The COLA factors are published on the OPM Web site at *http://www.opm.gov/oca/cola/rates.asp*.

We note that the COLA areas for Alaska are not defined by county as are the COLA areas for Hawaii. In 5 CFR 591.207, the OPM established the following COLA areas:

(a) City of Anchorage, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(b) City of Fairbanks, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(c) City of Juneau, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(d) Rest of the State of Alaska.

In the November 2004 and May 2006 IPF PPS final rules, we showed only one COLA for Alaska because all four areas were the same amount (1.25). Effective September 1, 2006, the OPM updated the COLA amounts and there are now two different amounts for the Alaska COLA areas (1.24 and 1.25).

For RY 2009, IPFs located in Alaska and Hawaii will receive the updated COLA factors based on the COLA area in which the IPF is located and as shown in Table 12 below.

TABLE 12.— COLA FACTORS FOR ALASKA AND HAWAII IPFS

	Location	COLA
Alaska	Anchorage	1.24
	Fairbanks	1.24
	Juneau	1.24
	Rest of Alaska	1.25
Hawaii	Honolulu County	1.25
	Hawaii County	1.17
	Kauai County	1.25
	Maui County	1.25
	Kalawao County	1.25

5. Adjustment for IPFs With a Qualifying Emergency Department (ED)

Currently, the IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs. We provide an adjustment to the standardized Federal per diem base rate to account for the costs associated with maintaining a full-service ED. The adjustment is intended to account for ED costs allocated to the hospital's distinct part psychiatric unit for preadmission services otherwise payable under the Medicare Outpatient Prospective Payment System (OPPS) furnished to a beneficiary during the day immediately preceding the date of admission to the IPF (see § 413.40(c)) and the overhead cost of maintaining the ED. This payment is a facility-level adjustment that applies to all IPF admissions (with the one exception as described below), regardless of whether a particular patient receives preadmission services in the hospital's ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. That is, IPFs with a qualifying ED receive an adjustment factor of 1.31 as the variable per diem adjustment for day 1 of each stay. If an IPF does not have a qualifying ED, it receives an adjustment factor of 1.19 as the variable per diem adjustment for day 1 of each patient stay.

The ED adjustment is made on every qualifying claim except as described below. As specified in § 412.424(d)(1)(v)(B), the ED adjustment is not made where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit. An ED adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH. If we provided the ED adjustment in these cases, the hospital would be paid twice for the overhead costs of the ED (69 FR 66960).

Therefore, when patients are discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit, the IPF receives the 1.19 adjustment factor as the variable per diem adjustment for the first day of the patient's stay in the IPF.

For RY 2009, we are retaining the 1.31 adjustment factor for IPFs with qualifying EDs. A complete discussion of the steps involved in the calculation of the ED adjustment factor appears in the November 2004 IPF PPS final rule (69 FR 66959 through 66960) and the May 2006 IPF PPS final rule (71 FR 27070 through 27072).

D. Other Payment Adjustments and Policies

For RY 2009, the IPF PPS includes the following payment adjustments: An outlier adjustment to promote access to IPF care for those patients who require expensive care and to limit the financial risk of IPFs treating unusually costly patients. In this section, we also explain the reason for ending the stop-loss provision that was applicable during the transition period.

1. Outlier Payments

In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(3)(i) to provide a per-case payment for IPF stays that are extraordinarily costly. Providing additional payments to IPFs for extremely costly cases strongly improves the accuracy of the IPF PPS in determining resource costs at the patient and facility level. These additional

payments reduce the financial losses that would otherwise be incurred in treating patients who require more costly care and, therefore, reduce the incentives for IPFs to under-serve these patients.

We make outlier payments for discharges in which an IPF's estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the Federal per diem payment amount for the case.

In instances when the case qualifies for an outlier payment, we pay 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay (consistent with the median LOS for IPFs in FY 2002), and 60 percent of the difference for day 10 and thereafter. We established the 80 percent and 60 percent loss sharing ratios because we were concerned that a single ratio established at 80 percent (like other Medicare PPSs) might provide an incentive under the IPF per diem payment system to increase LOS in order to receive additional payments. After establishing the loss sharing ratios, we determined the current fixed dollar loss threshold amount of $6,488 through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target.

a. Update to the Outlier Fixed Dollar Loss Threshold Amount

In accordance with the update methodology described in § 412.428(d), we are updating the fixed dollar loss threshold amount used under the IPF PPS outlier policy. Based on the regression analysis and payment simulations used to develop the IPF PPS, we established a 2 percent outlier policy which strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the Federal per diem base rate for all other cases that are not outlier cases.

We believe it is necessary to update the fixed dollar loss threshold amount because analysis of the latest available data (that is, FY 2006 IPF claims) and rate increases indicates adjusting the fixed dollar loss amount is necessary in order to maintain an outlier percentage that equals 2 percent of total estimated IPF PPS payments.

In the May 2006 IPF PPS Final Rule (71 FR 27072), we describe the process by which we calculate the outlier fixed dollar loss threshold amount. We continue to use this process for RY 2009. We begin by simulating aggregate payments with and without an outlier policy, and applying an iterative process to a fixed dollar loss amount that will result in outlier payments being equal to 2 percent of total estimated payments under the simulation. Based on this process, for RY 2009, the IPF PPS will use $6,113 as the fixed dollar loss threshold amount in the outlier calculation in order to maintain the 2 percent outlier policy.

b. Statistical Accuracy of Cost-to-Charge Ratios

As previously stated, under the IPF PPS, an outlier payment is made if an IPF's cost for a stay exceeds a fixed dollar loss threshold amount. In order to establish an IPF's cost for a particular case, we multiply the IPF's reported charges on the discharge bill by its overall cost to charge ratio (CCR). This approach to determining an IPF's cost is consistent with the approach used under the IPPS and other PPSs. In FY 2004, we implemented changes to the IPPS outlier policy used to determine CCRs for acute care hospitals because we became aware that payment vulnerabilities resulted in inappropriate outlier payments. Under the IPPS, we established a statistical measure of accuracy for CCRs in order to ensure that aberrant CCR data did not result in inappropriate outlier payments.

As we indicated in the November 2004 IPF PPS final rule, because we believe that the IPF outlier policy is susceptible to the same payment vulnerabilities as the IPPS, we adopted an approach to ensure the statistical accuracy of CCRs under the IPF PPS (69 FR 66961). Therefore, we adopted the following procedure in the November 2004 IPF PPS final rule:

- We calculated two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas. We computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and rural IPFs.

To determine the rural and urban ceilings, we multiplied each of the standard deviations by 3 and added the result to the appropriate national CCR average (either rural or urban). The upper threshold CCR for IPFs in RY 2009 is 1.8041 for rural IPFs, and 1.6724 for urban IPFs, based on CBSA-based geographic designations. If an IPF's CCR is above the applicable ceiling, the ratio is considered statistically inaccurate and we assign the appropriate national (either rural or urban) median CCR to the IPF.

We are applying the national CCRs to the following situations:

++ New IPFs that have not yet submitted their first Medicare cost report.

++ IPFs whose CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).

++ Other IPFs for whom the Medicare contractor obtains inaccurate or incomplete data with which to calculate a CCR.

For new IPFs, we are using these national CCRs until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.

We are not making any changes to the procedures for ensuring the statistical accuracy of CCRs in RY 2009. However, we are updating the national urban and rural CCRs (ceilings and medians) for IPFs for RY 2009 based on the CCRs entered in the latest available IPF PPS Provider Specific File.

The national CCRs for RY 2009 are 0.686 for rural IPFs and 0.5370 for urban IPFs and will be used in each of the three situations listed above. These calculations are based on the IPF's location (either urban or rural) using the CBSA-based geographic designations.

A complete discussion regarding the national median CCRs appears in the November 2004 IPF PPS final rule (69 FR 66961 through 66964).

2. Stop-Loss Provision

In the November 2004 IPF PPS final rule, we implemented a stop-loss policy that reduces financial risk to IPFs expected to experience substantial reductions in Medicare payments during the period of transition to the IPF PPS. This stop-loss policy guarantees that each facility receives total IPF PPS payments that are no less than 70 percent of its TEFRA payments had the IPF PPS not been implemented.

This policy is applied to the IPF PPS portion of Medicare payments during the 3-year transition. During the first year, for transitioning IPFs, three-quarters of the payment was based on TEFRA and one-quarter on the IPF PPS payment amount. In the second year, one-half of the payment was based on TEFRA and one-half on the IPF PPS payment amount. In the third year, one-quarter of the payment was based on TEFRA and three-quarters on the IPF PPS. For cost report periods beginning on or after January 1, 2008, payments are based 100 percent on the IPF PPS.

The combined effects of the transition and the stop-loss policies ensure that the total estimated IPF PPS payments were no less than 92.5 percent in the first year, 85 percent in the second year,

and 77.5 percent in the third year. Under the 70 percent policy, in the third year, 25 percent of an IPF's payment is TEFRA payments, and 75 percent is IPF PPS payments, which are guaranteed to be at least 70 percent of the TEFRA payments. The resulting 77.5 percent of TEFRA payments is the sum of 25 percent and 75 percent times 70 percent (which equals 52.5 percent).

In the implementation year, the 70 percent of TEFRA payment stop-loss policy required a reduction in the standardized Federal per diem and ECT base rates of 0.39 percent in order to make the stop-loss payments budget neutral.

For the RY 2009 (that is for discharges occurring on or after July 1, 2008 through June 30, 2009), we are not making any changes to the stop-loss policy for IPFs continuing to transition. However, beginning January 1, 2009, the stop-loss provision will have ended for all IPFs because it was implemented to be effective for the duration of the transition period, and the transition period will be completed beginning January 1, 2009. As indicated in ''Section III. A.2.6 of this notice for RY 2009, we are increasing the Federal per diem base rate and ECT rate by 0.39 percent because these rates were reduced by 0.39 percent in the implementation year to ensure stop-loss payments were budget neutral.

V. Waiver of Proposed Rulemaking

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

We find it is unnecessary to undertake notice and comment rulemaking for the update in this notice because the update does not make any substantive changes in policy, but merely reflects the application of previously established methodologies. Therefore, under 5 U.S.C 553(b)(3)(B), for good cause, we waive notice and comment procedures.

VI. Collection of Information Requirement

This document does not impose any information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

VII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), 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 (as amended) 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). For purposes of Title 5, United States Code, section 804(2), we estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking on the 1,669 IPFs.

The updates to the IPF labor-related share and wage indices are made in a budget neutral manner and thus have no effect on estimated costs to the Medicare program. Therefore, the estimated increased cost to the Medicare program is due to the updated IPF payment rates, which results in a $140 million increase in payments, and the transition from 75 percent PPS/25 percent TEFRA payments to 100 percent PPS payments, which results in a $20 million decrease in payments. The sunset of the stop-loss provision has a minimal impact on IPF payments in RY 2009. The distribution of these impacts is summarized in Table 13. The effect of the updates described in this notice result in an overall $120 million increase in payments from RY 2008 to RY 2009.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that the great majority of IPFs are small entities as that term is used in the RFA (include small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $6.5 million to $31.5 million in any 1 year) (For details, see the Small Business Administration's Interim final rule that set forth size standards at 70 FR 72577, December 6, 2005.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IPFs or the proportion of IPFs' revenue that is derived from Medicare payments. Therefore, we assume that all IPFs are considered small entities. As shown in Table 13, we estimate that the net revenue impact of this notice on all IPFs is to increase payments by about 2.5 percent. Thus, we anticipate that this notice will not have a significant impact on a substantial number of small entities. Medicare contractors are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule 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 604 of the RFA. 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. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). However, under the new labor market definitions, we no longer employ NECMAs to define urban areas in New England. For purposes of this analysis, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. Therefore, the Secretary certifies that this notice has a significant impact on the operations of a substantial number of small rural hospitals.

We have determined that this notice will have a significant and positive impact on substantial number of hospitals classified as located in rural areas. Since the impact on rural hospitals is positive, we did not consider alternatives to reduce burden on these IPFs.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) 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. In 2008, that threshold is approximately $130 million. This notice will not impose spending costs on State, local, or tribal governments in the aggregate, or by the private sector, of $130 million Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this notice under the criteria set forth in Executive Order 13132 and have determined that the notice will not have any substantial impact on the rights, roles, and responsibilities of State, local, or tribal governments.

B. Anticipated Effects

We discuss below the historical background of the IPF PPS and the impact of this notice on the Federal Medicare budget and on IPFs.

1. Budgetary Impact

As discussed in the November 2004 and May 2006 IPF PPS final rules, we applied a budget neutrality factor to the Federal per diem and ECT base rates to ensure that total estimated payments under the IPF PPS in the implementation period would equal the amount that would have been paid if the IPF PPS had not been implemented. The budget neutrality factor includes the following components: Outlier adjustment, stop-loss adjustment, and the behavioral offset. In accordance with § 412.424(c)(3)(ii), we will evaluate the accuracy of the budget neutrality adjustment within the first 5 years after implementation of the payment system. We may make a one-time prospective adjustment to the Federal per diem and ECT base rates to account for differences between the historical data on cost-based TEFRA payments (the basis of the budget neutrality adjustment) and estimates of TEFRA payments based on actual data from the first year of the IPF PPS. As part of that process, we will re-assess the accuracy of all of the factors impacting budget neutrality.

In addition, as discussed in section IV.C.1. of this notice, we are using the wage index and labor market share in a budget neutral manner by applying a wage index budget neutrality factor to the Federal per diem and ECT base rates. Thus, the budgetary impact to the Medicare program by the update of the IPF PPS will be due to the market basket updates (see section III.B. of this notice) and the planned update of the payment blend discussed below.

2. Impacts on Providers

To understand the impact of the changes to the IPF PPS discussed in this notice on providers, it is necessary to compare estimated payments under the IPF PPS rates and factors for RY 2009 to estimated payments under the IPF PPS rates and factors for RY 2008. The estimated payments for RY 2008 are a blend of: 25 percent of the facility-specific TEFRA payment and 75 percent of the IPF PPS payment with stop-loss payment. The estimated payments for the RY 2009 IPF PPS will be 100 percent of the IPF PPS payment and the stop-loss payment will no longer be applied. We determined the percent change of estimated RY 2009 IPF PPS payments to estimated RY 2008 IPF PPS payments for each category of IPFs. In addition, for each category of IPFs, we have included the estimated percent change in payments resulting from the wage index changes for the RY 2009 IPF PPS, the market basket update to IPF PPS payments, and the transition blend for the RY 2009 IPF PPS payment and the facility-specific TEFRA payment.

To illustrate the impacts of the final RY 2009 changes in this update notice, our analysis begins with a RY 2008 baseline simulation model based on FY 2006 IPF payments inflated to the midpoint of RY 2008 using Global Insight's most recent forecast of the market basket update (see section III.B. of this notice); the estimated outlier payments in RY 2008; the estimated stop-loss payments in RY 2008; the CBSA designations for IPFs based on OMB's MSA definitions after June 2003; the FY 2007 pre-floor, pre-reclassified hospital wage index; the RY 2008 labor-market share; and the RY 2008 percentage amount of the rural adjustment. During the simulation, the outlier payment is maintained at the target of 2 percent of total PPS payments.

Each of the following changes is added incrementally to this baseline model in order for us to isolate the effects of each change:

- The FY 2008 pre-floor, pre-reclassified hospital wage index and RY 2009 final labor-related share.
- A market basket update of 3.2 percent resulting in an update to the IPF PPS base rates.
- The transition to 100 percent IPF PPS payments.
- The removal of the stop-loss provision.
- Our final comparison illustrates the percent change in payments from RY 2008 (that is, July 1, 2007 to June 30, 2008) to RY 2009 (that is, July 1, 2008 to June 30, 2009).

TABLE 13.—PROJECTED IMPACTS

Facility by type	Number of facilities	CBSA wage index and labor share (percent)	Market basket (percent)	Transition blend (percent)	Stop-loss (percent)	Total (percent)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
All Facilities	1,669	0.0	3.2	−0.5	−0.1	2.5
Urban	1,301	0.0	3.2	−0.5	0.0	2.6
Rural	368	0.0	3.2	−0.6	−0.3	2.1
Urban unit	931	0.0	3.2	−2.6	−0.1	0.4
Rural unit	308	0.0	3.2	−2.4	−0.5	0.1
Freestanding IPF By Type of Ownership:						
Urban Psychiatric Hospitals:						
Government	141	0.1	3.2	6.7	0.3	10.5
Non-Profit	83	0.0	3.2	0.2	−0.1	3.3
For-Profit	145	−0.1	3.2	5.6	0.1	9.0
Rural Psychiatric Hospitals:						
Government	40	−0.1	3.2	8.3	0.4	12.1
Non-Profit	7	0.2	3.2	0.9	0.4	4.5
For-Profit	14	−0.4	3.2	5.5	0.4	8.4

TABLE 13.—PROJECTED IMPACTS

Facility by type	Number of facilities	CBSA wage index and labor share (percent)	Market basket (percent)	Transition blend (percent)	Stop-loss (percent)	Total (percent)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
By Teaching Status:						
Non-teaching	1,424	0.0	3.2	−0.4	−0.1	2.6
Less than 10% interns and residents to beds	137	0.0	3.2	−0.4	0.3	3.1
10% to 30% interns and residents to beds	73	0.0	3.2	−2.0	−0.1	1.0
More than 30% interns and residents to beds	35	0.0	3.2	−1.6	−0.5	1.1
By Region:						
New England	121	0.4	3.2	−2.4	0.0	1.2
Mid-Atlantic	284	−0.1	3.2	1.9	0.2	5.2
South Atlantic	226	0.0	3.2	−0.5	0.1	2.8
East North Central	292	−0.2	3.2	−2.3	−0.3	0.3
East South Central	164	−0.4	3.2	−0.2	0.0	2.5
West North Central	141	0.1	3.2	−1.7	−0.2	1.4
West South Central	228	−0.1	3.2	−1.1	−0.5	1.3
Mountain	74	−0.3	3.2	−1.7	−0.7	0.5
Pacific	132	0.5	3.2	0.4	0.0	4.2
By Bed Size:						
Psychiatric Hospitals:						
Less than 12 beds	24	−0.1	3.2	−1.9	0.0	1.1
12 to 25 beds	62	−0.1	3.2	1.2	0.1	4.2
25 to 50 beds	94	−0.2	3.2	2.4	−0.5	4.9
50 to 75 beds	77	0.0	3.2	5.1	0.2	8.6
More than 75 beds	174	0.1	3.2	6.5	0.4	10.4
Psychiatric Units:						
Less than 12 beds	489	0.0	3.2	−4.6	−0.7	−2.4
12 to 25 beds	430	0.1	3.2	−2.9	−0.3	0.0
25 to 50 beds	217	0.0	3.2	−2.0	0.2	1.3
50 to 75 beds	55	−0.1	3.2	−1.8	0.3	1.4
More than 75 beds	47	0.0	3.2	0.7	0.3	4.2

3. Results

Table 1 above displays the results of our analysis. The table groups IPFs into the categories listed below based on characteristics provided in the Provider of Services (POS) file, the IPF provider specific file, and cost report data from HCRIS:

- Facility Type
- Location
- Teaching Status Adjustment
- Census Region
- Size

The top row of the table shows the overall impact on the 1,669 IPFs included in the analysis.

In column 3, we present the effects of the budget-neutral update to the labor-related share and the wage index adjustment under the CBSA geographic area definitions announced by OMB in June 2003. This is a comparison of the simulated RY 2009 payments under the FY 2008 hospital wage index under CBSA classification and associated labor-related share to the simulated RY 2008 payments under the FY 2007 hospital wage index under CBSA classifications and associated labor-related share. There is no projected change in aggregate payments to IPFs, as indicated in the first row of column 3. There would, however, be small distributional effects among different categories of IPFs. For example, rural for-profit IPFs and IPFs located in the East South Central region will experience a 0.4 percent decrease in payments. IPFs located in the Pacific region will receive the largest increase of 0.5 percent.

In column 4, we present the effects of the market basket update to the IPF PPS payments by applying the TEFRA and PPS updates to payments under the revised budget neutrality factor and labor-related share and wage index under CBSA classification. In the aggregate this update is projected to be a 3.2 percent increase in overall payments to IPFs.

In column 5, we present the effects of the payment change in transition blend percentages to the final year of the transition (TEFRA Rate Percentage = 0 percent, IPF PPS Federal Rate Percentage = 100 percent) from the third year of the transition (TEFRA Rate Percentage = 25 percent, IPF PPS Federal Rate Percentage = 75 percent) of the IPF PPS under the revised budget neutrality factor, labor-related share and wage index under CBSA classification, and TEFRA and PPS updates to RY 2008. The overall aggregate effect, across all hospital groups, is projected to be a 0.5 percent decrease in payments to IPFs. There are distributional effects of these changes among different categories of IPFs. Government psychiatric hospitals will receive the largest increase, with rural government hospitals receiving an 8.3 percent increase and urban government hospitals receiving a 6.7 percent increase. In addition, psychiatric hospitals with more than 75 beds will receive a 6.5 percent increase. Alternatively, psychiatric units with fewer than 12 beds will receive the largest decrease of 4.6 percent.

In column 6, we present the effects of the removal of the stop-loss provision. Stop-loss payments are no longer applicable when payments are 100 percent IPF PPS payments. However, all IPFs will receive an increase in the rates of 0.39 percent. The overall aggregate effect, across all hospital groups, is projected to be a 0.1 percent decrease in payments to IPFs. While stop-loss payments were intended to be budget neutral, we slightly underestimated the percentage by which we needed to decrease the Federal per diem base rate in the implementation year. Therefore,

the aggregate impact of removing the stop-loss provision is a 0.1 percent decrease in payments instead of 0.0 percent. There are distributional effects of these changes among different categories of IPFs. Rural freestanding psychiatric hospitals will receive the largest increases, with rural government hospitals, rural non-profit hospitals, and rural for-profit hospitals each receiving a 0.4 percent increase. Alternatively, psychiatric units with fewer than 12 beds and IPFs located in the Mountain region will receive the largest decrease of 0.7 percent.

Column 7 compares our estimates of the changes reflected in this notice for RY 2009, to our estimates of payments for RY 2008 (without these changes). This column reflects all RY 2009 changes relative to RY 2008 (as shown in columns 3 through 6). The average increase for all IPFs is approximately 2.5 percent. This increase includes the effects of the market basket update resulting in a 3.2 percent increase in total RY 2009 payments, a 0.5 percent decrease in RY 2009 payments for the transition blend, and a 0.1 percent decrease in RY 2009 payments for the removal of the stop-loss provision.

Overall, the largest payment increase is projected to be among government IPFs. Rural government psychiatric hospitals will receive a 12.1 percent increase and urban government psychiatric hospitals will receive a 10.5 percent increase. In addition, psychiatric hospitals with more than 75 beds will receive a 10.4 percent increase. Psychiatric units with fewer than 12 beds will receive a 2.4 percent decrease.

4. Effect on the Medicare Program

Based on actuarial projections resulting from our experience with other PPSs, we estimate that Medicare spending (total Medicare program payments) for IPF services over the next 5 years would be as follows:

TABLE 14.—ESTIMATED PAYMENTS

Rate year	Dollars in millions
July 1, 2008 to June 30, 2009	$4,584

TABLE 14.—ESTIMATED PAYMENTS—Continued

Rate year	Dollars in millions
July 1, 2009 to June 30, 2010	4,799
July 1, 2010 to June 30, 2011	5,055
July 1, 2011 to June 30, 2012	5,373
July 1, 2012 to June 30, 2013	5,722

These estimates are based on the current estimate of increases in the RPL market basket as follows:

- 3.2 percent for RY 2009;
- 2.9 percent for RY 2010;
- 3.0 percent for RY 2011;
- 3.2 percent for RY 2012; and
- 3.2 percent for RY 2013.

We estimate that there would be a change in fee-for-service Medicare beneficiary enrollment as follows:

- −0.3 percent in RY 2009;
- 0.2 percent in RY 2010;
- 0.5 percent in RY 2011;
- 1.5 percent in RY 2012; and
- 2.5 percent in RY 2013.

5. Effect on Beneficiaries

Under the IPF PPS, IPFs will receive payment based on the average resources consumed by patients for each day. We do not expect changes in the quality of care or access to services for Medicare beneficiaries under the RY 2009 IPF PPS. In fact, we believe that access to IPF services will be enhanced due to the patient and facility level adjustment factors, all of which are intended to adequately reimburse IPFs for expensive cases. Finally, the outlier policy is intended to assist IPFs that experience high-cost cases.

C. Alternatives Considered

The statute does not specify an update strategy for the IPF PPS and is broadly written to give the Secretary discretion in establishing an update methodology. Therefore, we are updating the IPF PPS similar to the update approach used in other hospital PPSs and as published in the November 15, 2004, final rule. We note that this notice does not initiate any policy changes with regard to the IPF PPS; rather, it simply provides an update to the rates for RY 2009. Therefore, no other options were considered.

D. Accounting Statement

As required by OMB Circular A–4 (available at: *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf)*, in Table 15 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this notice. This table provides our best estimate of the increase in Medicare payments under the IPF PPS as a result of the changes presented in this notice based on the data for 1,669 IPFs in our database. All expenditures are classified as transfers to Medicare providers (that is, IPFs).

TABLE 15.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2008 IPF PPS RY TO THE 2009 IPF PPS RY

[in Millions]

Category	Transfers
Annualized Monetized Transfers.	$120.
From Whom To Whom?	Federal Government To IPFs Medicare Providers.

E. Conclusion

This notice does not initiate any policy changes with regard to the IPF PPS; rather, it simply provides an update to the rates for RY 2009 using established methodologies. In accordance with the provisions of Executive Order 12866, this rule was previously reviewed by OMB.

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

Dated: March 14, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: April 4, 2008.

Michael O. Leavitt,

Secretary.

Addendum A--Rate and Adjustment Factors

Per Diem Rate:

Federal Per Diem Base Rate	$637.78
Labor Share (0.75631)	$482.36
Non-Labor Share (0.24369)	$155.42

Fixed Dollar Loss Threshold Amount:

$6,113

Wage Index Budget Neutrality Factor:

1.0010

Facility Adjustments:

Rural Adjustment Factor	1.17
Teaching Adjustment Factor	0.5150
Wage Index	Pre-Reclassified Hospital Wage Index (FY2008)

Cost of Living Adjustments (COLAs):

Alaska	
Anchorage	1.24
Fairbanks	1.24
Juneau	1.24
Rest of Alaska	1.25
Hawaii	
Honolulu County	1.25
Hawaii County	1.17
Kauai County	1.25
Maui County	1.25
Kalawao County	1.25

Patient Adjustments:

ECT – Per Treatment	$274.58

Variable Per Diem Adjustments:

	Adjustment Factor
Day 1 -- Facility Without a Qualifying Emergency Department	1.19
Day 1 -- Facility With a Qualifying Emergency Department	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00
Day 10	1.00
Day 11	0.99
Day 12	0.99
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
After Day 21	0.92

Age Adjustments:

Age (in years)	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

DRG Adjustments:

(v24) DRG Prior to 10/01/07	(v25) MS-DRG After 10/01/07	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521-522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
523	896 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Comorbidity Adjustments:

Comorbidity	Adjustment Factor
Developmental Disabilities	1.04
Coagulation Factor Deficit	1.13
Tracheostomy	1.06
Eating and Conduct Disorders	1.12
Infectious Diseases	1.07
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Diabetes Mellitus	1.05
Severe Protein Malnutrition	1.13
Drug/Alcohol Induced Mental Disorders	1.03
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings – Digestive & Urinary	1.08
Severe Musculoskeletal & Connective Tissue Diseases	1.09
Poisoning	1.11

Addendum B – RY 2009 CBSA Wage Index Tables

In this addendum, we provide Tables 1 and 2 which indicate the CBSA-based wage index values for urban and rural providers.

Table 1-- RY 2009 Wage Index for Urban Areas Based On CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.7957
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	0.3448
10420	Akron, OH Portage County, OH Summit County, OH	0.8794
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8514
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8588
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9554
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.7979
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9865
11020	Altoona, PA Blair County, PA	0.8618
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9116
11180	Ames, IA Story County, IA	1.0046
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.1913
11300	Anderson, IN Madison County, IN	0.8827
11340	Anderson, SC Anderson County, SC	0.9086
11460	Ann Arbor, MI Washtenaw County, MI	1.0539
11500	Anniston-Oxford, AL Calhoun County, AL	0.7926
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9598
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9185
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	1.0517

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	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	
12060	Walton County, GA	0.9828
	Atlantic City, NJ	
12100	Atlantic County, NJ	1.2198
	Auburn-Opelika, AL	
12220	Lee County, AL	0.8090
	Augusta-Richmond County, GA-SC	
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
12260	Edgefield County, SC	0.9645

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Austin-Round Rock, TX	
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
12420	Williamson County, TX	0.9544
	Bakersfield, CA	
12540	Kern County, CA	1.1051
	Baltimore-Towson, MD	
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
12580	Baltimore City, MD	1.0134
	Bangor, ME	
12620	Penobscot County, ME	0.9978
	Barnstable Town, MA	
12700	Barnstable County, MA	1.2603
	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	
12940	West Feliciana Parish, LA	0.8034
	Battle Creek, MI	
12980	Calhoun County, MI	1.0179
	Bay City, MI	
13020	Bay County, MI	0.8897
	Beaumont-Port Arthur, TX	
	Hardin County, TX	
	Jefferson County, TX	
13140	Orange County, TX	0.8531
	Bellingham, WA	
13380	Whatcom County, WA	1.1474
	Bend, OR	
13460	Deschutes County, OR	1.0942
	Bethesda-Gaithersburg-Frederick, MD	
	Frederick County, MD	
13644	Montgomery County, MD	1.0511

CBSA Code	Urban Area (Constituent Counties)	Wage Index
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8666
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8949
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	0.8898
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7225
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8192
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8915
14060	Bloomington-Normal, IL McLean County, IL	0.9325
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9465
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.1792
14500	Boulder, CO Boulder County, CO	1.0426
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8159
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0904
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2735
15180	Brownsville-Harlingen, TX Cameron County, TX	0.8914
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9475
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9568
15500	Burlington, NC Alamance County, NC	0.8747
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9660
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1215
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0411
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8935
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9396
16180	Carson City, NV Carson City, NV	1.0003
16220	Casper, WY Natrona County, WY	0.9385
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8852
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9392

CBSA Code	Urban Area (Constituent Counties)	Wage Index
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8289
16700	Charleston-North Charleston, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9124
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9520
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9277
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8994
16940	Cheyenne, WY Laramie County, WY	0.9308
16974	Chicago-Naperville-Joliet, 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	1.0715
17020	Chico, CA Butte County, CA	1.1290
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	0.9784
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8251
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8052
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9339
17660	Coeur d'Alene, ID Kootenai County, ID	0.9532
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9358
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9719
17860	Columbia, MO Boone County, MO Howard County, MO	0.8658

CBSA Code	Urban Area (Constituent Counties)	Wage Index
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8800
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8729
18020	Columbus, IN Bartholomew County, IN	0.9537
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	1.0085
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8588
18700	Corvallis, OR Benton County, OR	1.0959
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8294
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	0.9915
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8760
19180	Danville, IL Vermilion County, IL	0.8957
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8240
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8830
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9190
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7885
19500	Decatur, IL Macon County, IL	0.8074
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9031
19740	Denver-Aurora, 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	1.0718
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9226
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9999

CBSA Code	Urban Area (Constituent Counties)	Wage Index
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7270
20100	Dover, DE Kent County, DE	1.0099
20220	Dubuque, IA Dubuque County, IA	0.9058
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	0.9975
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9816
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9475
20764	Edison, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1181
20940	El Centro, CA Imperial County, CA	0.8914
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8711
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9611
21300	Elmira, NY Chemung County, NY	0.8264
21340	El Paso, TX El Paso County, TX	0.8989
21500	Erie, PA Erie County, PA	0.8495
21660	Eugene-Springfield, OR Lane County, OR	1.0932
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8662
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1050
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4375
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8042
22140	Farmington, NM San Juan County, NM	0.9587
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9368
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8742
22380	Flagstaff, AZ Coconino County, AZ	1.1687
22420	Flint, MI Genesee County, MI	1.1220
22500	Florence, SC Darlington County, SC Florence County, SC	0.8249
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7680
22540	Fond du Lac, WI Fond du Lac County, WI	0.9667
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9897
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0229

CBSA Code	Urban Area (Constituent Counties)	Wage Index
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7933
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8743
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9284
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9693
23420	Fresno, CA Fresno County, CA	1.0993
23460	Gadsden, AL Etowah County, AL	0.8159
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9196
23580	Gainesville, GA Hall County, GA	0.9216
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9224
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8256
24140	Goldsboro, NC Wayne County, NC	0.9288
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7881
24300	Grand Junction, CO Mesa County, CO	0.9864
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9315
24500	Great Falls, MT Cascade County, MT	0.8675
24540	Greeley, CO Weld County, CO	0.9658
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9727
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9010
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9402
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9860
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3064
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8773
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9013
25260	Hanford-Corcoran, CA Kings County, CA	1.0499
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9280
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.8867

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25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.0959
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7366
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9028
25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.9251
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9006
26180	Honolulu, HI Honolulu County, HI	1.1556
26300	Hot Springs, AR Garland County, AR	0.9109
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7892
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	0.9939
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9041
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9146
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9264
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	0.9844
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9568
27060	Ithaca, NY Tompkins County, NY	0.9630
27100	Jackson, MI Jackson County, MI	0.9329
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8011
27180	Jackson, TN Chester County, TN Madison County, TN	0.8676
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9021
27340	Jacksonville, NC Onslow County, NC	0.8079
27500	Janesville, WI Rock County, WI	0.9702
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8478

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27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7677
27780	Johnstown, PA Cambria County, PA	0.7543
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7790
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8951
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0433
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0238
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	0.9504
28420	Kennewick-Richland-Pasco, WA Benton County, WA Franklin County, WA	1.0075
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8249
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7658
28740	Kingston, NY Ulster County, NY	0.9556
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8036
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9591
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9685
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.8869
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8247
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7777
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0603
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	0.9333
29460	Lakeland, FL Polk County, FL	0.8661
29540	Lancaster, PA Lancaster County, PA	0.9252
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0119
29700	Laredo, TX Webb County, TX	0.8093

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29740	Las Cruces, NM Dona Ana County, NM	0.8676
29820	Las Vegas-Paradise, NV Clark County, NV	1.1799
29940	Lawrence, KS Douglas County, KS	0.8227
30020	Lawton, OK Comanche County, OK	0.8025
30140	Lebanon, PA Lebanon County, PA	0.8192
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9454
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9193
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9191
30620	Lima, OH Allen County, OH	0.9424
30700	Lincoln, NE Lancaster County, NE Seward County, NE	1.0051
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	0.8863
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9183
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8717
31020	Longview, WA Cowlitz County, WA	1.0827
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.1771
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9065
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8680
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8732
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9541
31460	Madera, CA Madera County, CA	0.8069
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.0935
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0273
31900	Mansfield, OH Richland County, OH	0.9271
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3711
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9123

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32780	Medford, OR Jackson County, OR	1.0318
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	0.9250
32900	Merced, CA Merced County, CA	1.2120
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0002
33140	Michigan City-La Porte, IN LaPorte County, IN	0.8914
33260	Midland, TX Midland County, TX	1.0017
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0214
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	1.1093
33540	Missoula, MT Missoula County, MT	0.8953
33660	Mobile, AL Mobile County, AL	0.8033
33700	Modesto, CA Stanislaus County, CA	1.1962
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7832
33780	Monroe, MI Monroe County, MI	0.9414
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8088
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8321
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7388
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0529
34620	Muncie, IN Delaware County, IN	0.8214
34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.9836
34820	Myrtle Beach-Conway-North Myrtle Beach, SC Horry County, SC	0.8634
34900	Napa, CA Napa County, CA	1.4476
34940	Naples-Marco Island, FL Collier County, FL	0.9487
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	0.9689

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35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2640
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1862
35300	New Haven-Milford, CT New Haven County, CT	1.1871
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	0.8897
35644	New York-Wayne-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	1.3115
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9141
35980	Norwich-New London, CT New London County, CT	1.1432
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.5685
36100	Ocala, FL Marion County, FL	0.8627
36140	Ocean City, NJ Cape May County, NJ	1.0988
36220	Odessa, TX Ector County, TX	1.0042
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9000
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	0.8815
36500	Olympia, WA Thurston County, WA	1.1512
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	0.9561
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9226
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9551
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8652
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.1852
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9325
37380	Palm Coast, FL Flagler County, FL	0.8945
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8313

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37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8105
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8647
37764	Peabody, MA Essex County, MA	1.0650
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8281
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9299
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0925
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0264
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7839
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8525
38340	Pittsfield, MA Berkshire County, MA	1.0091
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9465
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4450
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0042
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1498
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.0016
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.0982
39140	Prescott, AZ Yavapai County, AZ	1.0020
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	1.0574
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9557
39380	Pueblo, CO Pueblo County, CO	0.8851
39460	Punta Gorda, FL Charlotte County, FL	0.9254
39540	Racine, WI Racine County, WI	0.9498
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9839

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39660	Rapid City, SD Meade County, SD Pennington County, SD	0.8811
39740	Reading, PA Berks County, PA	0.9356
39820	Redding, CA Shasta County, CA	1.3541
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0715
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	0.9425
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1100
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8691
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.0755
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8858
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9814
40484	Rockingham County, NH Rockingham County, NH Strafford County, NH	1.0111
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9001
40660	Rome, GA Floyd County, GA	0.9042
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.3505
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8812
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.0549
41100	St. George, UT Washington County, UT	0.9358
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	0.8762

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	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	
41180	St. Louis City, MO	0.9024
	Salem, OR	
	Marion County, OR	
41420	Polk County, OR	1.0572
	Salinas, CA	
41500	Monterey County, CA	1.4775
	Salisbury, MD	
	Somerset County, MD	
41540	Wicomico County, MD	0.8994
	Salt Lake City, UT	
	Salt Lake County, UT	
	Summit County, UT	
41620	Tooele County, UT	0.9399
	San Angelo, TX	
	Irion County, TX	
41660	Tom Green County, TX	0.8579
	San Antonio, TX	
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
41700	Wilson County, TX	0.8834
	San Diego-Carlsbad-San Marcos, CA	
41740	San Diego County, CA	1.1492

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Sandusky, OH	
41780	Erie County, OH	0.8822
	San Francisco-San Mateo-Redwood City, CA	
	Marin County, CA	
	San Francisco County, CA	
41884	San Mateo County, CA	1.5195
	San Germán-Cabo Rojo, PR	
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
41900	San Germán Municipio, PR	0.4729
	San Jose-Sunnyvale-Santa Clara, CA	
	San Benito County, CA	
41940	Santa Clara County, CA	1.5735

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	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	
41980	Yabucoa Municipio, PR	0.4528
	San Luis Obispo-Paso Robles, CA	
42020	San Luis Obispo County, CA	1.2488
	Santa Ana-Anaheim-Irvine, CA	
42044	Orange County, CA	1.1766
	Santa Barbara-Santa Maria-Goleta, CA	
42060	Santa Barbara County, CA	1.1714
	Santa Cruz-Watsonville, CA	
42100	Santa Cruz County, CA	1.6122
	Santa Fe, NM	
42140	Santa Fe County, NM	1.0734
	Santa Rosa-Petaluma, CA	
42220	Sonoma County, CA	1.4696
	Sarasota-Bradenton-Venice, FL Manatee County, FL	
42260	Sarasota County, FL	0.9933
	Savannah, GA Bryan County, GA Chatham County, GA	
42340	Effingham County, GA	0.9131
	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA	
42540	Wyoming County, PA	0.8457
	Seattle-Bellevue-Everett, WA King County, WA	
42644	Snohomish County, WA	1.1572
	Sebastian-Vero Beach, FL	
42680	Indian River County, FL	0.9412
	Sheboygan, WI	
43100	Sheboygan County, WI	0.8975
	Sherman-Denison, TX	
43300	Grayson County, TX	0.8320
	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA	
43340	De Soto Parish, LA	0.8476
	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE	
43580	Union County, SD	0.9251
	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD	
43620	Turner County, SD	0.9563

CBSA Code	Urban Area (Constituent Counties)	Wage Index
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9617
43900	Spartanburg, SC Spartanburg County, SC	0.9422
44060	Spokane, WA Spokane County, WA	1.0455
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.8944
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0366
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8695
44220	Springfield, OH Clark County, OH	0.8694
44300	State College, PA Centre County, PA	0.8768
44700	Stockton, CA San Joaquin County, CA	1.1855
44940	Sumter, SC Sumter County, SC	0.8599
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9910
45104	Tacoma, WA Pierce County, WA	1.1055
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.9025
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9020
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.8805
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.7770
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9431
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8538
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0699
46060	Tucson, AZ Pima County, AZ	0.9245
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8340
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8303
46340	Tyler, TX Smith County, TX	0.9114
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8486
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8098

CBSA Code	Urban Area (Constituent Counties)	Wage Index
46700	Vallejo-Fairfield, CA Solano County, CA	1.4666
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8302
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0133
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	0.8818
47300	Visalia-Porterville, CA Tulare County, CA	1.0091
47380	Waco, TX McLennan County, TX	0.8518
47580	Warner Robins, GA Houston County, GA	0.9128
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0001
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	1.0855
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8519
48140	Wausau, WI Marathon County, WI	0.9679
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.7924
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	1.1469
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9728
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6961
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9062

CBSA Code	Urban Area (Constituent Counties)	Wage Index
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.7920
48700	Williamsport, PA Lycoming County, PA	0.8043
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0824
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9410
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9913
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9118
49340	Worcester, MA Worcester County, MA	1.1287
49420	Yakima, WA Yakima County, WA	1.0267
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3284
49620	York-Hanover, PA York County, PA	0.9359
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9002
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.0756
49740	Yuma, AZ Yuma County, AZ	0.9488

[1] At this time, there are no hospitals located in this urban area on which to base a wage index.

Table 2-- FY 2008 WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

CBSA Code	Nonurban Area	Wage Index
1	Alabama	0.7533
2	Alaska	1.2109
3	Arizona	0.8479
4	Arkansas	0.7371
5	California	1.2023
6	Colorado	0.9704
7	Connecticut	1.1119
8	Delaware	0.9727
10	Florida	0.8465
11	Georgia	0.7659
12	Hawaii	1.0612
13	Idaho	0.7920
14	Illinois	0.8335
15	Indiana	0.8576
16	Iowa	0.8566
17	Kansas	0.7981
18	Kentucky	0.7793
19	Louisiana	0.7373
20	Maine	0.8476
21	Maryland	0.9034
22	Massachusetts[1]	1.1644
23	Michigan	0.8953
24	Minnesota	0.9079
25	Mississippi	0 7700
26	Missouri	0.7930
27	Montana	0.8379
28	Nebraska	0.8849
29	Nevada	0.9272
30	New Hampshire	1.0470
31	New Jersey[1]	------
32	New Mexico	0.8940
33	New York	0.8268
34	North Carolina	0.8603
35	North Dakota	0.7182
36	Ohio	0.8714
37	Oklahoma	0.7492

CBSA Code	Nonurban Area	Wage Index
35	North Dakota	0.7182
36	Ohio	0.8714
37	Oklahoma	0.7492
38	Oregon	0.9906
39	Pennsylvania	0.8385
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	------
42	South Carolina	0.8656
43	South Dakota	0.8549
44	Tennessee	0.7723
45	Texas	0.7968
46	Utah	0.8116
47	Vermont	0.9919
48	Virgin Islands	0.6830
49	Virginia	0.7896
50	Washington	1.0259
51	West Virginia	0.7454
52	Wisconsin	0.9667
53	Wyoming	0.9287
65	Guam	0.9611

[1] All counties within the State are classified as urban, with the exception of Massachusetts and Puerto Rico. Massachusetts and Puerto Rico have areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for RY 2009. The rural Massachusetts wage index is calculated as the average of all contiguous CBSAs. The Puerto Rico wage index is the same as RY 2008.

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BILLING CODE 4120–01–C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2008–N–0272]

Agency Information Collection Activities; Proposed Collection; Comment Request; Guidance for Industry: Notification of a Health Claim or Nutrient Content Claim Based on an Authoritative Statement of a Scientific Body

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 the collection of information associated with the submission of notifications of health claims or nutrient content claims based on authoritative statements of scientific bodies of the U.S. Government.

DATES: Submit written or electronic comments on the collection of information by July 7, 2008.

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: Jonna Capezzuto, Office of the Chief Information Officer (HFA–250), Food and Drug Administration,5600 Fishers Lane, Rockville, MD 20857, 301–827–4659.

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.

Guidance for Industry: Notification of a Health Claim or Nutrient Content Claim Based on an Authoritative Statement of a Scientific Body (OMB Control Number 0910–0374)—Extension

Section 403(r)(2)(G) and (r)(3)(C) of the Federal Food, Drug and Cosmetic Act (the act) (21 U.S.C. 343(r)(2)(G) and (r)(3)(C)), as amended by the FDA