DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1346–F]

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Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System—Update for Rate Year Beginning July 1, 2011 (RY 2012)

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

ACTION: Final rule.

SUMMARY: This final rule updates the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs) for discharges occurring during the rate year (RY) beginning July 1, 2011 through September 30, 2012. The final rule also changes the IPF prospective payment system (PPS) payment rate update period to a RY that coincides with a fiscal year (FY). In addition, the rule implements policy changes affecting the IPF PPS teaching adjustment. It also rebases and revises the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket, and makes some clarifications and corrections to terminology and regulations text.

DATES: These regulations are effective on July 1, 2011.

FOR FURTHER INFORMATION CONTACT:

Dorothy Myrick or Jana Lindquist, (410) 786–4533 (for general information).

Mary Carol Barron, (410) 786–7943, or Bridget Dickensheets, (410) 786–8670, (for information regarding the market basket and labor-related share).

Theresa Bean, (410) 786–2287 (for information regarding the regulatory impact analysis).

SUPPLEMENTARY INFORMATION:

Table of Contents

To assist readers in referencing sections contained in this document, we are providing the following table of contents.

I. Background
A. Annual Requirements for Updating the IPF PPS
B. Overview of the Legislative Requirements of the IPF PPS
C. General Overview of the IPF PPS
D. Transition Period for Implementation of the IPF PPS
II. Provisions of the Proposed Rule and Responses to Public Comments
III. Changing the IPF PPS Payment Rate Update Period From a Rate Year to a Fiscal Year
IV. Rebasing and Revising of the Rehabilitation, Psychiatric, and Long-Term Care (RPL) Market Basket for Inpatient Psychiatric Facilities
A. Background
B. Overview of the FY 2008-Based RPL Market Basket
C. Rebasing and Revising of the RPL Market Basket
1. Development of Cost Categories and Weights
a. Medicare Cost Reports
b. Other Data Sources
2. Final Cost Category Computation
3. Selection of Price Proxies
a. Wages and Salaries
b. Employee Benefits
c. Electricity
d. Fuel, Oil, and Gasoline
e. Water and Sewage
f. Professional Liability Insurance
g. Pharmaceuticals
h. Food: Direct Purchases
i. Food: Contract Services
j. Chemicals
k. Medical Instruments
l. Photographic Supplies
m. Rubber and Plastics
n. Paper and Printing Products
o. Apparel
p. Machinery and Equipment
q. Miscellaneous Products
r. Professional Fees: Labor-Related
s. Administrative and Business Support Services
t. All Other: Labor-Related Services
u. Professional Fees: Nonlabor-Related
v. Financial Services
w. Telephone Services
x. Postage
y. All Other: Nonlabor-Related Services
4. Methodology for Capital Portion of the RPL Market Basket
5. RY 2012 Market Basket Update
6. Labor-Related Share
V. Updates to the IPF PPS for RY Beginning July 1, 2011
A. Determining the Standardized Budget-Neutral Federal Per Diem Base Rate
1. Standardization of the Federal Per Diem Base Rate and Electroconvulsive Therapy (ECT) Rate
2. Calculation of the Budget Neutrality Adjustment
a. Outlier Adjustment
b. Stop-Loss Provision Adjustment
c. Behavioral Offset
B. Update of the Federal Per Diem Base Rate and Electroconvulsive Therapy Rate
VI. Update of the IPF PPS Adjustment Factors
A. Overview of the IPF PPS Adjustment Factors
B. Patient-Level Adjustments
1. Adjustment for MS–DRG Assignment
2. Payment for Comorbid Conditions
3. Patient Age Adjustments
4. Variable Per Diem Adjustments
C. Facility-Level Adjustments
1. Wage Index Adjustment
a. Background
b. Wage Index for RY 2012
c. OMB Bulletins
2. Adjustment for Rural Location
3. Teaching Adjustment
a. Temporary Adjustment to FTE Cap to Reflect Residents Affected by Hospital Closure
b. Temporary Adjustment to FTE Cap to Reflect Residents Affected By Residency Program Closure
4. Cost of Living Adjustment for IPFs Located in Alaska and Hawaii
5. Adjustment for IPFs with a Qualifying Emergency Department (ED)
D. Other Payment Adjustments and Policies
1. Outlier Payments
a. Update to the Outlier Fixed Dollar Loss Threshold Amount
b. Statistical Accuracy of Cost-to-Charge Ratios
2. Expiration of the Stop-Loss Provision
3. Future Refinements
VII. Regulations Text Corrections
VIII. Collection of Information Requirements
IX. Regulatory Impact Analysis
Regulations Text
Addenda

Acronyms

Because of the many terms to which we refer by acronym in this final rule, we are listing the acronyms used and their corresponding meanings 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
CAH Critical access hospital
DSM–IV–TR Diagnostic and Statistical Manual of Mental Disorders Fourth Edition—Text Revision
DRGs Diagnosis-related groups
FY Federal fiscal year (October 1 through September 30)
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
RPL Rehabilitation, Psychiatric, and Long-Term Care
RY Rate Year (July 1 through June 30)
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 inpatient psychiatric facilities (IPF) prospective payment system (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). However, in this final rule, we are changing the payment rate update period to a rate year (RY) that coincides with a fiscal year (FY) update. Therefore, future update notices will be published in the **Federal Register** in the summer. We discuss this change in more detail in section III of this final rule.

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 Social Security Act (the Act) for each year (effective from the implementation period until June 30, 2006).
- 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.
- 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 International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM) coding and diagnosis-related groups (DRGs) 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 IPF PPS annual update occurred in the April 30, 2010 **Federal Register** notice (75 FR 23106) (hereinafter referred to as the April 2010 IPF PPS notice) that set forth updates to the IPF PPS payment rates for RY 2011. This notice updated the IPF PPS per diem payment rates that were published in the May 2009 IPF PPS notice in accordance with our established policies.

Since implementation of the IPF PPS, we have 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 include as much information as possible regarding the patient-level characteristics of the population that each IPF serves. Since we are now approximately 5 years into the system, we believe that we have enough data to begin that process. Therefore, we have begun the necessary analysis in order to make future refinements. While we did not propose to make refinements in this rulemaking, as explained in section V.D.3 below, we believe that in the next rulemaking, for FY 2013, we will be ready to propose potential refinements.

B. Overview of the Legislative Requirements of the IPF PPS

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) 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 site *http://www.cms.hhs.gov/InpatientPsychFacilPPS/*.

Section 3401(f) of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by section 10319(e) of that Act and by section 1105(d) of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (hereafter referred to as "The Affordable Care Act") added subsection (s) to section 1886 of the Act.

Section 1886(s)(1) is titled "Reference to Establishment and Implementation of System" and it refers to section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, which relates to the establishment of the IPF PPS.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 and each subsequent RY. Section 1886(s)(2)(A)(ii) of the Act requires the application of an "other adjustment" that reduces any update to an IPF PPS base rate by percentages specified in section 1886(s)(3) of the Act for rate years beginning in 2010 through the RY beginning in 2019. For the RY beginning in 2011, the reduction is 0.25 percentage point. We are implementing that provision for RY 2012 in this RY 2012 IPF PPS final rule.

Section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in RY 2014.

C. General Overview of the IPF PPS

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 (the 18-month period from January 1, 2005 through June 30, 2006), and it 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 payment policies for: Outlier cases; stop-loss protection (which was 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, we implemented the IPF PPS using the following update strategy:

- 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.
- Use a July 1 through June 30 annual update cycle.
- Allow the IPF PPS first update to be effective for discharges on or after July 1, 2006 through June 30, 2007.

D. Transition Period for Implementation of the IPF PPS

In the November 2004 IPF PPS final rule, we provided for a 3-year transition period. During this 3-year transition period, an IPF's total payment under the PPS was based on an increasing percentage of the Federal rate with a corresponding decreasing percentage of the IPF PPS payment that is based on reasonable cost concepts. However, effective for cost reporting periods beginning on or after January 1, 2008, IPF PPS payments are based on 100 percent of the Federal rate.

II. Provisions of the Proposed Rule and Responses to Public Comments

On January 27, 2011, we published a proposed rule that appeared in the **Federal Register** (76 FR 4998) entitled, "Inpatient Psychiatric Facilities Prospective Payment System—Update for Rate Year Beginning July 1, 2011 (RY 2012)." The January 2011 proposed rule (hereinafter referred to as the RY 2012 IPF PPS proposed rule) set forth the proposed annual update to the proposed PPS for IPFs for discharges occurring during the RY beginning July 1, 2011.

In addition to the annual rate update, we proposed to—

- Switch the annual update period for the IPF PPS from a RY that begins on July 1 and goes through June 30 to one that coincides with a FY, that is, that begins on October 1 and goes through September 30. For the update period that begins in 2012, that is, FY 2013, we would refer to the update period as a FY. In order to make this switch, we proposed that RY 2012 be a 15-month period, from July 1, 2011 through September 30, 2012.
- Rebase and revise the FY 2002-based RPL market basket to a FY 2008-based RPL market basket. Apply a 0.25 percentage point reduction to the market basket update as required by section 1886(s)(3) of the Act.
- Adopt IPF policies similar to such IPPS graduate medical education (GME) policies providing for temporary adjustments to an IPF's FTE cap to reflect residents added due to the closure of an IPF or an IPF's residency training program.
- Update the fixed dollar loss threshold amount in order to maintain the appropriate outlier percentage.
- Update the ECT adjustment by a factor specified by CMS.
- Update the national urban and rural cost-to-charge ratio medians and ceilings.
- Update the cost of living adjustment factors for IPFs located in Alaska and Hawaii, if appropriate.
- Describe the ICD–9–CM and MS–DRG classification changes discussed in the annual update to the hospital inpatient prospective payment system regulations.
- Use 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.
- Retain the 17 percent adjustment for IPFs located in rural areas, the 1.31 adjustment for IPFs with a qualifying ED, the 0.5150 teaching adjustment to the Federal per diem rate, and the MS–DRG adjustment factor currently being paid to IPFs for RY 2011.
- Update the MS–DRG listing and comorbidity categories to reflect the ICD–9–CM revisions effective October 1, 2010.

In addition, we proposed to make clarifying changes to the regulations text. We noted that these proposed changes would not impact policy.

We provided for a 60 day comment period on the RY 2012 IPF PPS proposed rule. We received 12 public comments from hospital associations and psychiatric hospitals and units. In general, many of the commenters strongly supported our proposed policy changes, including changes to the payment rate update cycle and the teaching policy. A few commenters expressed concern regarding the proposed decrease in the labor-related share. Several commenters recommended that we explore the creation of an inpatient rehabilitation and psychiatric facilities (RP) market basket. Summaries of the public comments received and our responses to those comments are provided in the appropriate sections in the preamble of this final rule.

III. Changing the IPF PPS Payment Rate Update Period From a Rate Year to a Fiscal Year

In the RY 2012 IPF PPS proposed rule, we proposed to change the current period for the annual updates of the IPF PPS Federal payment rates. Specifically, we proposed to revise the IPF PPS payment rate update period by switching from a RY that begins on July 1 and goes through June 30 to a period that coincides with a FY, that is, October 1 through September 30. We proposed to refer to the update period as a FY beginning with the update period that begins in 2012, that is, FY 2013. We specified that this change in the annual update period would allow us to consolidate Medicare publications by aligning the IPF PPS update with the annual update of the ICD–9–CM codes, which are effective on October 1 of each year. Currently, in addition to our annual proposed and final rulemaking documents, we publish a change request transmittal every August updating the ICD–9–CM codes related to the DRG and comorbidity adjustments. By proposing to align the IPF PPS with the same update period as the ICD–9–CM codes,

we aimed to eliminate the need to publish a transmittal off-cycle.

We maintain the same diagnostic coding and DRG classification for IPFs that are used under the IPPS for providing the psychiatric care. When the IPF PPS was implemented, we adopted the same diagnostic code set and DRG patient classification systems (that is, the CMS DRGs) that were utilized at the time under the hospital IPPS. Every year, changes to the ICD–9–CM coding system are addressed in the IPPS proposed and final rules. These changes are effective October 1 of each year and must be used by acute care hospitals as well as other providers to report diagnostic and procedure information. The IPF PPS has always incorporated ICD–9–CM coding changes made in the annual IPPS update. This proposed change to the annual payment rate update period would allow the annual update to the rates and the ICD–9–CM coding update to occur on the same schedule and appear in the same **Federal Register** document.

Our intent in making the change in the payment rate update schedule is to place the IPF PPS on the same update cycle as other PPSs, making it administratively efficient. In order to smoothly transition to a payment update period that runs from October 1 through September 30, we proposed that the RY 2012 period run from July 1, 2011 to September 30, 2012 such that RY 2012 would be 15 months. As proposed and for this final rule, after RY 2012, the rate update period for the IPF PPS payment rates and other policy changes will begin on October 1 and go through September 30. The next update to the IPF PPS rates after RY 2012 would be the FY 2013 update cycle, which will begin on October 1, 2012 and go through September 30, 2013. In addition, we proposed to make a change to the regulations at § 412.402 to add the term "IPF Prospective Payment System Rate Year" which would mean October 1 through September 30. We proposed that the RY would be referred to as a FY. For a discussion of the proposed 15-month market basket update for the proposed 2012 RY, we refer readers to the RY 2012 IPF PPS proposed rule (76 FR 4998).

Public comments and our responses on the switch from a RY to a FY are summarized below.

Comment: A few commenters supported moving the payment rate update period from a RY to a FY. They supported a 15-month update for RY 2012 in order to transition to a FY update period.

Response: We appreciate the commenters' support to move the IPF PPS payment rate update period to a period that begins on October 1 and goes through the following September, with a 15-month update for RY 2012 in order to transition to a FY. We are adopting as final, without modification, the proposal to revise the IPF PPS payment period to a FY with a 15-month update for RY 2012 in order to transition to a FY update period.

Final Rule Action: In summary, for RY 2012, we are revising the IPF PPS payment rate update period by switching the RY period from July 1 through June 30 to a period that coincides with a FY. In order to transition to a FY update period, RY 2012 is a 15-month period. We are also making a change to § 412.402 to add the term "IPF Prospective Payment System Rate Year" which means October 1 through September 30 will be referred to as a Fiscal year.

IV. Rebasing and Revising of the Rehabilitation, Psychiatric, and Long-Term Care (RPL) Market Basket for Inpatient Psychiatric Facilities

A. Background

The input price index (that is, the market basket) that was used to develop the IPF PPS was the Excluded Hospital with Capital market basket. This 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 hospitals, and children's hospitals. Although "market basket" technically describes the mix of goods and services used in providing hospital care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket. Accordingly, the term "market basket" as used in this document refers to a hospital input price index.

Beginning with the May 2006 IPF PPS final rule (71 FR 27046 through 27054), IPF PPS payments were updated using a FY 2002-based market basket reflecting the operating and capital cost structures for IRFs, IPFs, and LTCHs (hereafter referred to as the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket).

We excluded cancer and children's hospitals from the RPL market basket because these hospitals are not reimbursed through a PPS; rather, 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. Moreover, the FY 2002 cost structures for cancer and children's hospitals are noticeably different than the cost structures of the IRFs, IPFs, and LTCHs. A complete discussion of the FY 2002-based RPL market basket appears in the May 2006 IPF PPS final rule (71 FR 27046 through 27054).

In the May 1, 2009 IPF PPS notice (74 FR 20362), we expressed our interest in exploring the possibility of creating a stand-alone IPF market basket that reflects the cost structures of only IPF providers. We noted that, of the available options, one would be to join the Medicare cost report data from freestanding IPF providers (presently incorporated into the FY 2002-based RPL market basket) with data from hospital-based IPF providers. We indicated that an examination of the Medicare cost report data comparing freestanding and hospital-based IPFs revealed considerable differences between the two with respect to cost levels and cost structures. At that time, we were unable to fully understand the differences between these two types of IPF providers. As a result, we felt that further research was required and we solicited public comment for additional information that might help us to better understand the reasons for the variations in costs and cost structures, as indicated by the cost report data, between freestanding and hospital-based IPFs (74 FR 20376).

We summarized the public comments we received and our responses in the April 2010 IPF PPS notice (75 FR 23111 through 23113). Despite receiving comments from the public on this issue, we remain unable to sufficiently understand the observed differences in costs and cost structures between hospital-based and freestanding IPFs, and therefore we do not feel it is appropriate at this time to incorporate data from hospital-based IPFs with those of freestanding IPFs to create a stand-alone IPF market basket.

Although we do not feel it would be appropriate to propose a stand-alone IPF market basket, we are currently exploring the viability of creating two separate market baskets from the current RPL, one of which would include freestanding IPFs and freestanding IRFs and would be used to update payments under both the IPF and IRF payment systems. The other would be a stand-alone LTCH market basket. Depending on the outcome of our research, we anticipate the possibility of proposing a rehabilitation and psychiatric (RP) market basket in the next update cycle. In the RY 2012 IPF PPS proposed rule, we welcomed public comment on the possibility of using this type of market

basket to update IPF payments in the future.

For this update cycle, we proposed to rebase and revise the FY 2002-based RPL market basket by creating a proposed FY 2008-based RPL market basket. For this RY 2012 IPF PPS final rule, we are finalizing the FY 2008-based RPL market basket as proposed. In the following section, we provide an overview of the market basket and describe the methodologies we proposed to use, and are finalizing in this final rule, for purposes of determining the operating and capital portions of the FY 2008-based RPL market basket.

Public comments and our responses on the rebasing and revising of the RPL market basket for IPFs are summarized below.

Comment: One commenter, while generally supporting use of the RPL market basket at the time of implementation, stated that it has its limitations, and recommended that CMS explore the creation of an RP market basket. Several commenters supported CMS' efforts to determine if a separate market basket for inpatient psychiatric and rehabilitation facilities is appropriate.

Response: CMS will continue its efforts to investigate the viability of an alternative market basket to update IPF providers. Any possible changes to the market basket used to update IPF payments would appear in a future rulemaking and be subject to public comment.

Comment: Several commenters expressed concern regarding a recent trend in facility closures of hospital-based IPFs and stated that hospital-based IPF facilities are a vital component in preserving access to care for patients suffering from mental illness, particularly those who have coexisting physical conditions or experience a crisis and enter the emergency department for treatment. Therefore, the commenters recommended that CMS continue exploring reasons behind the differences in costs and cost structures between freestanding and hospital-based providers.

Response: We are continuing to analyze the Medicare cost report data in order to better understand the differences between freestanding and hospital-based IPF providers.

B. Overview of the FY 2008-Based RPL Market Basket

The FY 2008-based RPL market basket is a fixed weight, Laspeyres-type price index. A Laspeyres price index measures the change in price, over time, of the same mix of goods and services purchased in the base period. Any changes in the quantity or mix of goods and services (that is, intensity) purchased over time are not measured.

The index itself is constructed in three steps. First, a base period is selected (in this final rule, the base period is FY 2008) and total base period expenditures are estimated for a set of mutually exclusive and exhaustive spending categories with the proportion of total costs that each category represents being calculated. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price or wage variable, referred to as a price proxy. In nearly every instance, these price proxies are derived from publicly available statistical series that are published on a consistent schedule (preferably at least on a quarterly basis). Finally, the expenditure weight for each cost category is multiplied by the level of its respective price proxy. The sum of these products (that is, the expenditure weights multiplied by their price levels) for all cost categories yields the composite index level of the market basket in a given period. Repeating this step for other periods produces a series of market basket levels over time. Dividing an index level for a given period by an index level for an earlier period produces a rate of growth in the input price index over that timeframe.

As noted above, the market basket is described as a fixed-weight index because it represents the change in price over time of a constant mix (quantity and intensity) of goods and services needed to furnish hospital services. The effects on total expenditures resulting from changes in the mix of goods and services purchased subsequent to the base period are not measured. For example, a hospital hiring more nurses to accommodate the needs of patients would increase the volume of goods and services purchased by the hospital, but would not be factored into the price change measured by a fixed-weight hospital market basket. Only when the index is rebased would changes in the quantity and intensity be captured, with those changes being reflected in the cost weights. Therefore, we rebase the market basket periodically so the cost weights reflect recent changes in the mix of goods and services that hospitals purchase (hospital inputs) to furnish inpatient care between base periods.

C. Rebasing and Revising of the RPL Market Basket

In the RY 2012 IPF PPS proposed rule, we proposed to rebase and revise the market basket used to update the IPF PPS. We solicited public comments on our proposed methodological changes to the RPL market basket. We did not receive any specific comments on these proposed changes. Therefore, we are finalizing the methodology for calculating the rebased and revised FY 2008-based market basket as proposed. The methodology is described in more detail below.

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, in this final rule, we are shifting the base year cost structure for the RPL market basket from FY 2002 to FY 2008). "Revising" means changing data sources, price proxies, or methods, used to derive the input price index.

1. Development of Cost Categories and Weights

a. Medicare Cost Reports

As proposed, and in this final rule, the FY 2008-based RPL market basket consists of several major cost categories derived from the FY 2008 Medicare cost reports for freestanding IRFs, freestanding IPFs, and LTCHs, including wages and salaries, pharmaceuticals, professional liability insurance, capital, and a residual. These FY 2008 cost reports include providers whose cost reporting periods began on or after October 1, 2007 and before October 1, 2008. We choose to use FY 2008 as the base year because we believe that the Medicare cost reports for this year represent the most recent, complete set of Medicare cost report data available for IRFs, IPFs, and LTCHs. However, for the FY 2008 cost reports, IRFs, IPFs, and LTCHs were not required to complete the Medicare cost report worksheet for benefits and contract labor (Worksheet S–3, part II). As a result, less than 30 percent of providers reported data for these categories, and we do not expect these FY 2008 data to improve over time. Furthermore, the issue of incomplete Medicare cost report data for benefits and contract labor also existed when we finalized the FY 2002-based RPL market basket, since, at that time, IRFs, IPFs and LTCHs were not required to submit data for Worksheet S–3, part II in the FY 2002 cost reporting year. Due to the incomplete benefits and contract labor data for IRFs, IPFs, and LTCHs, for these cost weights, rather than using IRF/IPF/LTCH cost report data, we instead used FY 2008 IPPS hospital cost report data (similar to the method that was used for the FY 2002-

based RPL market basket). Additional detail is provided later in this section.

Since our goal is to measure cost shares that are reflective of case mix and practice patterns associated with providing services to Medicare beneficiaries, we limited our selection of Medicare cost reports to those from hospitals that have a Medicare average length of stay (LOS) that is within a comparable range of their total facility average LOS. We believe this provides a more accurate reflection of the structure of costs for Medicare covered days. We used the cost reports of IRFs and LTCHs with Medicare average LOS within 15 percent (that is, 15 percent higher or lower) of the total facility average LOS for the hospital. This is the same edit applied to derive the FY 2002-based RPL market basket and generally includes those LTCHs and IRFs with Medicare LOS within approximately 5 days of the facility average LOS of the hospital.

We used a less stringent measure of Medicare LOS for IPFs. For this provider-type, and in order to produce a robust sample size, we used those facilities' Medicare cost reports whose average LOS is within 30 or 50 percent (depending on the total facility average LOS) of the total facility average LOS. This is the same edit applied to derive the FY 2002-based RPL market basket.

We applied these LOS edits to first obtain a set of cost reports for facilities that have a Medicare LOS within a comparable range of their total facility LOS. Using this set of Medicare cost reports, we then calculated cost weights for four cost categories directly from the FY 2008 Medicare cost reports for freestanding IRFs, freestanding IPFs, and LTCHs (found in Table 1 below). These Medicare cost report cost weights were then supplemented with information obtained from other data sources (explained in more detail below) to derive the final FY 2008-based RPL market basket cost weights.

TABLE 1—MAJOR COST CATEGORIES AND THEIR RESPECTIVE COST WEIGHTS AS CALCULATED DIRECTLY FROM FY 2008 MEDICARE COST REPORTS

Major cost categories	FY 2008–based RPL market basket (percent)
Wages and salaries	47.371
Professional Liability Insurance (Malpractice)	0.764
Pharmaceuticals	6.514
Capital	8.392
All other	36.959

b. Other Data Sources

In addition to the IRF, IPF and LTCH Medicare cost reports for freestanding IRFs and freestanding IPFs, and LTCHs, the other data sources we used to develop the FY 2008-based RPL market basket cost weights were the FY 2008 IPPS Medicare cost reports and the 2002 Benchmark Input-Output (I–O) Tables created by the Bureau of Economic Analysis (BEA), U.S. Department of Commerce. The FY 2008 Medicare cost reports include providers whose cost reporting periods began on or after October 1, 2007 and before October 1, 2008.

As noted above, the FY 2008-based RPL cost weights for benefits and contract labor were derived using FY 2008-based IPPS Medicare cost reports. We used these Medicare cost reports to calculate cost weights for Wages and Salaries, Benefits, and Contract Labor for IPPS hospitals for FY 2008. For the Benefits cost weight for the FY 2008-based RPL market basket, the ratio of the FY 2008 IPPS Benefits cost weight to the FY 2008 IPPS Wages and Salaries cost weight was applied to the RPL Wages and Salaries cost weight. Similarly, the ratio of the FY 2008 IPPS Contract Labor cost weight to the FY 2008 IPPS Wages and Salaries cost weight was applied to the RPL Wages and Salaries cost weight to derive a Contract Labor cost weight for the FY 2008-based RPL market basket.

The All Other cost category is divided into other hospital expenditure category shares using the 2002 BEA Benchmark I–O data following the removal of the portions of the All Other cost category provided in Table 1 that are attributable to Benefits and Contract Labor. The BEA Benchmark I–O data are scheduled for publication every 5 years. The most recent data available are for 2002. BEA also produces Annual I–O estimates; however, the 2002 Benchmark I–O data represent a much more comprehensive and complete set of data that are derived from the 2002 Economic Census. The Annual I–O is simply an update of the Benchmark I–O tables. For the FY 2002-based RPL market basket, we used the 1997 Benchmark I–O data. Therefore, we used the 2002 Benchmark I–O data in the FY 2008-based RPL market basket, and instead of using the less detailed Annual I–O data, we aged the 2002 Benchmark I–O data forward to 2008. The methodology we used to age the data forward involves applying the annual price changes from the respective price proxies to the appropriate cost categories. We repeated this practice for each year.

The All Other cost category expenditure shares are determined as being equal to each category's proportion to total "all other" in the aged 2002 Benchmark I–O data. For instance, if the cost for telephone services represented 10 percent of the sum of the "all other" Benchmark I–O hospital expenditures, then telephone services would represent 10 percent of the RPL market basket's All Other cost category.

2. Final Cost Category Computation

As stated previously, for this rebasing we used the FY 2008 Medicare cost reports for IRFs, IPFs, and LTCHs to derive four major cost categories. The FY 2008-based RPL market basket includes two additional cost categories that were not broken out separately in the FY 2002-based RPL market basket: "Administrative and Business Support Services" and "Financial Services". The inclusion of these two additional cost categories, which are derived using the Benchmark I–O data, is consistent with the addition of these two cost categories to the FY 2006-based IPPS market basket (74 FR 43845). We chose to break out both categories so we can better match their respective expenses with more appropriate price proxies. Also, the FY 2008-based RPL market basket excludes one cost category: Photo Supplies. The 2002 Benchmark I–O weight for this category is considerably smaller than the 1997 Benchmark I–O weight, presently accounting for less than one-tenth of one percentage point of the RPL market basket. Therefore, we included the photo supplies costs in the Chemical cost category weight with other similar chemical products.

We did not change our definition of the labor-related share. However, we renamed our aggregate cost categories from "labor-intensive" and "nonlabor-intensive" services to "labor-related" and "nonlabor-related" services. This is consistent with the FY 2006-based IPPS market basket (74 FR 43845). As discussed in more detail below and similar to the FY 2002-based RPL market basket, we classify a cost category as labor-related and include it in the labor-related share if the cost

category is defined as being labor-intensive and its cost varies with the local labor market. In previous regulations, we grouped cost categories that met both of these criteria into labor-intensive services. We believe the new labels more accurately reflect the concepts that they are intended to convey. Therefore, we did not change our definition of the labor-related share because we continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

3. Selection of Price Proxies

After computing the FY 2008 cost weights for the rebased RPL market basket, it was necessary to select appropriate wage and price proxies to reflect the rate of price change for each expenditure category. With the exception of the proxy for Professional Liability Insurance, all of the proxies for the operating portion of the FY 2008-based RPL market basket are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in markets other than the retail market. PPIs are preferable price proxies for goods and services that hospitals purchase as inputs because these PPIs better reflect the actual price changes faced by hospitals. For example, we use a special PPI for prescription drugs, rather than the Consumer Price Index (CPI) for prescription drugs, because hospitals generally purchase drugs directly from a wholesaler. The PPIs that we use measure price changes at the final stage of production.

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

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

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 CPIs, PPIs, and ECIs selected meet these criteria.

Table 2 sets forth the final FY 2008-based RPL market basket including cost categories, and their respective weights and price proxies. For comparison purposes, the corresponding FY 2002-based RPL market basket cost weights are listed, as well. For example, Wages and Salaries are 49.447 percent of total costs in the FY 2008-based RPL market basket compared to 52.895 percent for the FY 2002-based RPL market basket. Employee Benefits are 12.831 percent in the FY 2008-based RPL market basket compared to 12.982 percent for the FY 2002-based RPL market basket. As a result, compensation costs (Wages and Salaries plus Employee Benefits) for the FY 2008-based RPL market basket are 62.278 percent of total costs compared to 65.877 percent for the FY 2002-based RPL market basket.

Following Table 2 is a summary outlining the choice of the proxies used for the operating portion of the FY 2008-based RPL market basket. The price proxies used for the capital portion are described in more detail in the capital methodology section (see section IV.c.4 of this final rule).

We note that the proxies for the operating portion of the FY 2008-based RPL market basket are the same as those used for the FY 2006-based IPPS operating market basket. Because these proxies meet our criteria of reliability, timeliness, availability, and relevance, we believe they are the best measures of price changes for the cost categories. For further discussion on the FY 2006-based IPPS market basket, see the IPPS final rule published in the **Federal Register** on August 27, 2009 (74 FR 43843).

TABLE 2—FY 2008-BASED RPL MARKET BASKET COST CATEGORIES, WEIGHTS, AND PRICE PROXIES WITH FY 2002-BASED RPL MARKET BASKET COST WEIGHTS INCLUDED FOR COMPARISON

Cost categories	FY 2002-based RPL market basket cost weights	FY 2008-based RPL market basket cost weights	FY 2008-based RPL market basket price proxies
1. Compensation	65.877	62.278	
A. Wages and Salaries [1]	52.895	49.447	ECI for Wages and Salaries, Civilian Hospital Workers.
B. Employee Benefits [1]	12.982	12.831	ECI for Benefits, Civilian Hospital Workers.
2. Utilities	0.656	1.578	
A. Electricity	0.351	1.125	PPI for Commercial Electric Power.
B. Fuel, Oil, and Gasoline	0.108	0.371	PPI for Petroleum Refineries.
C. Water and Sewage	0.197	0.082	CPI–U for Water & Sewerage Maintenance.
3. Professional Liability Insurance	1.161	0.764	CMS Hospital Professional Liability Insurance Premium Index.
4. All Other Products and Services	22.158	26.988	
A. All Other Products	13.325	15.574	
(1.) Pharmaceuticals	5.103	6.514	PPI for Pharmaceutical Preparations for Human Use(Prescriptions).
(2.) Food: Direct Purchases	0.873	2.959	PPI for Processed Foods & Feeds.
(3.) Food: Contract Services	0.620	0.392	CPI–U for Food Away From Home.
(4.) Chemicals [2]	1.100	1.100	Blend of Chemical PPIs.
(5.) Medical Instruments	1.014	1.795	PPI for Medical, Surgical, and Personal Aid Devices.
(6.) Photographic Supplies	0.096	—	

TABLE 2—FY 2008-BASED RPL MARKET BASKET COST CATEGORIES, WEIGHTS, AND PRICE PROXIES WITH FY 2002-BASED RPL MARKET BASKET COST WEIGHTS INCLUDED FOR COMPARISON—Continued

Cost categories	FY 2002-based RPL market basket cost weights	FY 2008-based RPL market basket cost weights	FY 2008-based RPL market basket price proxies
(7.) Rubber and Plastics	1.052	1.131	PPI for Rubber & Plastic Products.
(8.) Paper and Printing Products	1.000	1.021	PPI for Converted Paper & Paperboard Products.
(9.) Apparel	0.207	0.210	PPI for Apparel.
(10.) Machinery and Equipment	0.297	0.106	PPI for Machinery & Equipment.
(11.) Miscellaneous Products	1.963	0.346	PPI for Finished Goods less Food and Energy.
B. All Other Services	8.833	11.414	
(1.) Labor-related Services	5.111	4.681	
(a.) Professional Fees: Labor-related.[3]	2.892	2.114	ECI for Compensation for Professional and Related Occupations.
(b.) Administrative and Business Support Services.[4]	n/a	0.422	ECI for Compensation for Office and Administrative Services.
(c.) All Other: Labor-Related Services[4]	2.219	2.145	ECI for Compensation for Private Service Occupations.
(2.) Nonlabor-Related Services	3.722	6.733	
(a.) Professional Fees: Nonlabor-Related[3]	n/a	4.211	ECI for Compensation for Professional and Related Occupations.
(b.) Financial Services[5]	n/a	0.853	ECI for Compensation for Financial Activities.
(c.) Telephone Services	0.240	0.416	CPI–U for Telephone Services.
(d.) Postage	0.682	0.630	CPI–U for Postage.
(e.) All Other: Nonlabor-Related Services[5]	2.800	0.623	CPI–U for All Items less Food and Energy.
5. Capital-Related Costs	10.149	8.392	
A. Depreciation	6.187	5.519	
(1.) Fixed Assets	4.250	3.286	BEA chained price index for nonresidential construction for hospitals and special care facilities—vintage weighted (26 years).
(2.) Movable Equipment	1.937	2.233	PPI for Machinery and Equipment—vintage weighted (11 years).
B. Interest Costs	2.775	1.954	
(1.) Government/Nonprofit	2.081	0.653	Average yield on domestic municipal bonds (Bond Buyer 20 bonds)—vintage-weighted (26 years).
(2.) For Profit	0.694	1.301	Average yield on Moody's Aaa bonds—vintage-weighted (26 years).
C. Other Capital-Related Costs	1.187	0.919	CPI–U for Residential Rent.
Total	100.000	100.000	

Note: Detail may not add to total due to rounding.

[1] Contract Labor is distributed to Wages and Salaries and Employee Benefits based on the share of total compensation that each category represents.

[2] To proxy the Chemicals cost category, we used a blended PPI composed of the PPI for Industrial Gases, the PPI for Other Basic Inorganic Chemical Manufacturing, the PPI for Other Basic Organic Chemical Manufacturing, and the PPI for Soap and Cleaning Compound Manufacturing. For more detail about this proxy, see section IV.C.3.j. of the preamble of this final rule.

[3] The Professional Fees: Labor-related and Professional Fees: Nonlabor-related cost categories were included in one cost category called Professional Fees in the FY 2002-based RPL market basket. For more detail about how these new categories were derived, we refer readers to sections IV.C.6. of the preamble of this final rule, on the labor-related share.

[4] The Administrative and Business Support Services cost category was contained within All Other: Labor-intensive Services cost category in the FY 2002-based RPL market basket. The All Other: Labor-intensive Services cost category is renamed the All Other: Labor-related Services cost category for the FY 2008-based RPL market basket.

[5] The Financial Services cost category was contained within the All Other: Non-labor Intensive Services cost category in the FY 2002-based RPL market basket. The All Other: Non-labor Intensive Services cost category is renamed the All Other: Nonlabor-related Services cost category for the FY 2008-based RPL market basket.

a. Wages and Salaries

We use the ECI for Wages and Salaries for Hospital Workers (All Civilian) (BLS series code CIU1026220000000I) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

b. Employee Benefits

We use the ECI for Employee Benefits for Hospital Workers (All Civilian) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

c. Electricity

We use the PPI for Commercial Electric Power (BLS series code WPU0542) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

d. Fuel, Oil, and Gasoline

For the FY 2002-based RPL market basket, this category only included expenses classified under North American Industry Classification System (NAICS) 21 (Mining). We proxied this category using the PPI for Commercial Natural Gas (BLS series code WPU0552). For the FY 2008-based market basket, we added costs to this category that had previously been grouped in other categories. The added costs include petroleum-related expenses under NAICS 324110 (previously captured in the miscellaneous category), as well as petrochemical manufacturing classified under NAICS 325110 (previously captured in the chemicals category). These added costs represent 80 percent

of the hospital industry's fuel, oil, and gasoline expenses (or 80 percent of this category). Because the majority of the industry's fuel, oil, and gasoline expenses originate from petroleum refineries (NAICS 324110), we use the PPI for Petroleum Refineries (BLS series code PCU324110324110) as the proxy for this cost category.

e. Water and Sewage

We use the CPI for Water and Sewerage Maintenance (All Urban Consumers) (BLS series code CUUR0000SEHG01) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

f. Professional Liability Insurance

We proxy price changes in hospital professional liability insurance premiums (PLI) using percentage changes as estimated by the CMS Hospital Professional Liability Index. To generate these estimates, we collect commercial insurance premiums for a fixed level of coverage while holding nonprice factors constant (such as a change in the level of coverage). This method is also used to proxy PLI price changes in the Medicare Economic Index (75 FR 73268). This same proxy was used in the FY 2002-based RPL market basket.

g. Pharmaceuticals

We use the PPI for Pharmaceuticals for Human Use, Prescription (BLS series code WPUSI07003) to measure the price growth of this cost category. We note that we are not making a change to the PPI that is used to proxy this cost category. There was a recent change to the BLS naming convention for this series; however this is the same proxy that was used in the FY 2002-based RPL market basket.

h. Food: Direct Purchases

We use the PPI for Processed Foods and Feeds (BLS series code WPU02) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

i. Food: Contract Services

We use the CPI for Food Away From Home (All Urban Consumers) (BLS series code CUUR0000SEFV) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

j. Chemicals

We use a blended PPI composed of the PPI for Industrial Gas Manufacturing (NAICS 325120) (BLS series code PCU325120325120P), the PPI for Other Basic Inorganic Chemical Manufacturing (NAICS 325180) (BLS series code PCU32518–32518–), the PPI for Other Basic Organic Chemical Manufacturing (NAICS 325190) (BLS series code PCU32519–32519–), and the PPI for Soap and Cleaning Compound Manufacturing (NAICS 325610) (BLS series code PCU32561–32561–). Using the 2002 Benchmark I–O data, we found that these NAICS industries accounted for approximately 90 percent of the hospital industry's chemical expenses.

Therefore, we use this blended index because we believe its composition better reflects the composition of the purchasing patterns of hospitals than does the PPI for Industrial Chemicals (BLS series code WPU061), the proxy used in the FY 2002-based RPL market basket. Table 3 below shows the weights for each of the four PPIs used to create the blended PPI, which we determined using the 2002 Benchmark I–O data.

TABLE 3—BLENDED CHEMICAL PPI WEIGHTS

Name	Weights (in percent)	NAICS
PPI for Industrial Gas Manufacturing	35	325120
PPI for Other Basic Inorganic Chemical Manufacturing	25	325180
PPI for Other Basic Organic Chemical Manufacturing	30	325190
PPI for Soap and Cleaning Compound Manufacturing	10	325610

k. Medical Instruments

We use the PPI for Medical, Surgical, and Personal Aid Devices (BLS series code WPU156) to measure the price growth of this cost category. In the 1997 Benchmark I–O data, approximately half of the expenses classified in this category were for surgical and medical instruments. Therefore, we used the PPI for Surgical and Medical Instruments and Equipment (BLS series code WPU1562) to proxy this category in the FY 2002-based RPL market basket. The 2002 Benchmark I–O data show that surgical and medical instruments now represent only 33 percent of these expenses and that the largest expense category is surgical appliance and supplies manufacturing (corresponding to BLS series code WPU1563). Due to this reallocation of costs over time, we use as the price proxy for this cost category the more aggregated PPI for Medical, Surgical, and Personal Aid Devices.

l. Photographic Supplies

We eliminated the cost category specific to photographic supplies for the FY 2008-based RPL market basket. These costs are now included in the Chemicals cost category because the costs are presently reported as all other chemical products. Notably, although we are eliminating the specific cost category, these costs are still accounted for within the RPL market basket.

m. Rubber and Plastics

We use the PPI for Rubber and Plastic Products (BLS series code WPU07) to measure price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

n. Paper and Printing Products

We use the PPI for Converted Paper and Paperboard Products (BLS series code WPU0915) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

o. Apparel

We use the PPI for Apparel (BLS series code WPU0381) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

p. Machinery and Equipment

We use the PPI for Machinery and Equipment (BLS series code WPU11) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

q. Miscellaneous Products

We use the PPI for Finished Goods Less Food and Energy (BLS series code WPUSOP3500) to measure the price growth of this cost category. Using this index removes the double-counting of food and energy prices, which are already captured elsewhere in the market basket. This same proxy was used in the FY 2002-based RPL market basket.

r. Professional Fees: Labor-Related

We use the ECI for Compensation for Professional and Related Occupations (Private Industry) (BLS series code CIS2020000120000I) to measure the price growth of this category. It includes occupations such as legal, accounting, and engineering services. This same proxy was used in the FY 2002-based RPL market basket.

s. Administrative and Business Support Services

We use the ECI for Compensation for Office and Administrative Support Services (Private Industry) (BLS series code CIU2010000220000I) to measure the price growth of this category. Previously these costs were included in the All Other: Labor-intensive category (now renamed the All Other: Labor-related Services category), and were proxied by the ECI for Compensation for Service Occupations. We believe that this compensation index better reflects the changing price of labor associated with the provision of administrative services and its incorporation represents a technical improvement to the market basket.

t. All Other: Labor-Related Services

We use the ECI for Compensation for Service Occupations (Private Industry) (BLS series code CIU2010000300000I) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

u. Professional Fees: Nonlabor-Related

We use the ECI for Compensation for Professional and Related Occupations (Private Industry) (BLS series code CIS2020000120000I) to measure the price growth of this category. This is the same price proxy that we are using for the Professional Fees: Labor-related cost category.

v. Financial Services

We use the ECI for Compensation for Financial Activities (Private Industry) (BLS series code CIU201520A000000I) to measure the price growth of this cost category. Previously these costs were included in the All Other: Nonlabor-intensive category (now renamed the All Other: Nonlabor-related Services category), and were proxied by the CPI for All Items. We believe that this compensation index better reflects the changing price of labor associated with the provision of financial services and its incorporation represents a technical improvement to the market basket.

w. Telephone Services

We use the CPI for Telephone Services (BLS series code CUUR0000SEED) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

x. Postage

We use the CPI for Postage (BLS series code CUUR0000SEEC01) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

y. All Other: Nonlabor-Related Services

We use the CPI for All Items Less Food and Energy (BLS series code CUUR0000SA0L1E) to measure the price growth of this cost category. Previously these costs were proxied by the CPI for All Items in the FY 2002-based RPL market basket. We believe that using the CPI for All Items Less Food and Energy removes the double counting of changes in food and energy prices, as they are already captured elsewhere in the market basket. Consequently, we believe that the incorporation of this proxy represents a technical improvement to the market basket.

4. Methodology for Capital Portion of the RPL Market Basket

In the FY 2002-based RPL market basket, we did not have IRF, IPF, and LTCH 2002 Medicare cost report data for the capital cost weights, due to a change in the 2002 reporting requirements. Therefore, we used these hospitals' 2001 expenditure data for the capital cost categories of depreciation, interest, and other capital expenses, and aged the data to a 2002 base year using relevant price proxies.

For the FY 2008-based RPL market basket, we calculated weights for the RPL market basket capital costs using the same set of FY 2008 Medicare cost reports used to develop the operating share for IRFs, IPFs, and LTCHs. To calculate the total capital cost weight, we first apply the same LOS edits as applied prior to calculating the operating cost weights as described above in section IV.C.3. The resulting capital weight for the FY 2008 base year is 8.392 percent.

Lease expenses are unique in that they are not broken out as a separate cost category in the RPL market basket, but rather are proportionally distributed amongst the cost categories of Depreciation, Interest, and Other, reflecting the assumption that the underlying cost structure of leases is similar to that of capital costs in general. As was done in the FY 2002-based RPL market basket, we first assumed 10 percent of lease expenses represents overhead and assigned those costs to the Other Capital-Related Costs category accordingly. The remaining lease expenses were distributed across the three cost categories based on the respective weights of depreciation, interest, and other capital not including lease expenses.

Depreciation contains two subcategories: (1) Building & Fixed Equipment; and (2) Movable Equipment. The apportionment between building & fixed equipment and movable equipment was determined using the FY 2008 Medicare cost reports for freestanding IRFs, IPFs, and LTCHs. This methodology was also used to compute the apportionment used in the FY 2002-based RPL market basket (70 FR 47912).

The total Interest expense cost category is split between government/nonprofit interest and for-profit interest. The FY 2002-based RPL market basket allocated 75 percent of the total Interest cost weight to government/nonprofit interest and proxied that category by the average yield on domestic municipal bonds. The remaining 25 percent of the Interest cost weight was allocated to for-profit interest and was proxied by the average yield on Moody's Aaa bonds (70 FR 47912). This was based on the FY 2002-based IPPS capital input price index (70 FR 23406) due to insufficient Medicare cost report data for IPFs, IRFs, and LTCHs. For the FY 2008-based RPL market basket, we derived the split using the relative FY 2008 Medicare cost report data on interest expenses for government/nonprofit and for-profit IRFs, IPFs, and LTCHs. Based on these data, we calculated a 33/67 split between government/nonprofit and for-profit interest. We believe it is important that this split reflects the latest relative cost structure of interest expenses for RPL providers. As stated above, we first apply the LOS edits (as described in section IV.C.3.) prior to calculating this split. Therefore, we are using Medicare cost reports that are reflective of case mix and practice patterns associated with providing services to Medicare beneficiaries. Using data specific to government/nonprofit and for-profit IRFs, IPFs, and LTCHs as well as the application of these LOS edits are the primary reasons for the difference in this split relative to the FY 2002-based RPL market basket.

Because capital is acquired and paid for over time, capital expenses in any given year are determined by both past and present purchases of physical and financial capital. The vintage-weighted capital portion of the FY 2008-based RPL market basket is intended to capture the long-term consumption of capital, using vintage weights for

depreciation (physical capital) and interest (financial capital). These vintage weights reflect the proportion of capital purchases attributable to each year of the expected life of building & fixed equipment, movable equipment, and interest. We use the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense.

Vintage weights are an integral part of the FY 2008-based RPL market basket. Capital costs are inherently complicated and are determined by complex capital purchasing decisions, over time, based on such factors as interest rates and debt financing. In addition, capital is depreciated over time instead of being consumed in the same period it is purchased. The capital portion of the FY 2008-based RPL market basket would reflect the annual price changes associated with capital costs, and would be a useful simplification of the actual capital investment process. By accounting for the vintage nature of capital, we are able to provide an accurate and stable annual measure of price changes. Annual nonvintage price changes for capital are unstable due to the volatility of interest rate changes and, therefore, do not reflect the actual annual price changes for Medicare capital-related costs. The capital component of the FY 2008-based RPL market basket would reflect the underlying stability of the capital acquisition process and provides hospitals with the ability to plan for changes in capital payments.

To calculate the vintage weights for depreciation and interest expenses, we needed a time series of capital purchases for building & fixed equipment and movable equipment. We found no single source that provides a uniquely best time series of capital purchases by hospitals for all of the above components of capital purchases. The early Medicare cost reports did not have sufficient capital data to meet this need. Data we obtained from the American Hospital Association (AHA) do not include annual capital purchases. However, AHA does provide a consistent database back to 1963. We used data from the AHA Panel Survey and the AHA Annual Survey to obtain a time series of total expenses for hospitals. We then used data from the AHA Panel Survey supplemented with the ratio of depreciation to total hospital expenses obtained from the Medicare cost reports to derive a trend of annual depreciation expenses for 1963 through 2008.

In order to estimate capital purchases using data on depreciation expenses, the expected life for each cost category (building & fixed equipment, movable equipment, and interest) is needed to calculate vintage weights. For the FY 2002-based RPL market basket, due to insufficient Medicare cost report data for IRFs, IPFs, and LTCHs, we used 2001 Medicare Cost Reports for IPPS hospitals to determine the expected life of building & fixed equipment and movable equipment (70 FR 47913). The FY 2002-based RPL market basket was based on an expected life of building & fixed equipment of 23 years. It used 11 years as the expected life for movable equipment. We believed that this data source reflected the latest relative cost structure of depreciation expenses for hospitals at the time and was analogous to IRFs, IPFs, and LTCHs.

The expected life of any piece of equipment can be determined by dividing the value of the asset (excluding fully depreciated assets) by its current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation were to continue at current year levels, assuming straight-line depreciation. Following a similar method to what was applied for the FY 2002-based RPL market basket, we use an expected life of building & fixed equipment equal to 26 years, and an expected life of movable equipment of 11 years for the FY 2008-based RPL market basket. These expected lives are calculated using FY 2008 Medicare cost reports for IPPS hospitals since we are currently unable to obtain robust measures of the expected lives for building & fixed equipment and movable equipment using the Medicare cost reports from IRFs, IPFs, and LTCHs.

We used the building & fixed equipment and movable equipment weights derived from FY 2008 Medicare cost reports for IRFs, IPFs, and LTCHs to separate the depreciation expenses into annual amounts of building & fixed equipment depreciation and movable equipment depreciation. Year-end asset costs for building & fixed equipment and movable equipment were determined by multiplying the annual depreciation amounts by the expected life calculations. We then calculated a time series, back to 1963, of annual capital purchases by subtracting the previous year asset costs from the current year asset costs. From this capital purchase time series, we were able to calculate the vintage weights for building & fixed equipment and for movable equipment. Each of these sets of vintage weights is explained in more detail below.

For the building & fixed equipment vintage weights, we used the real annual capital purchase amounts for building & fixed equipment to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual purchase amount for building & fixed equipment was produced by deflating the nominal annual purchase amount by the building & fixed equipment price proxy, BEA's chained price index for nonresidential construction for hospitals and special care facilities. Because building & fixed equipment have an expected life of 26 years, the vintage weights for building & fixed equipment are deemed to represent the average purchase pattern of building & fixed equipment over 26-year periods. With real building & fixed equipment purchase estimates available from 2008 back to 1963, we averaged twenty 26-year periods to determine the average vintage weights for building & fixed equipment that are representative of average building & fixed equipment purchase patterns over time. Vintage weights for each 26-year period are calculated by dividing the real building & fixed capital purchase amount in any given year by the total amount of purchases in the 26-year period. This calculation is done for each year in the 26-year period, and for each of the twenty 26-year periods. We used the average of each year across the twenty 26-year periods to determine the average building & fixed equipment vintage weights for the FY 2008-based RPL market basket.

For the movable equipment vintage weights, the real annual capital purchase amounts for movable equipment were used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment was calculated by deflating the nominal annual purchase amounts by the movable equipment price proxy, the PPI for Machinery and Equipment. This is the same proxy used for the FY 2002-based RPL market basket. Based on our determination that movable equipment has an expected life of 11 years, the vintage weights for movable equipment represent the average expenditure for movable equipment over an 11-year period. With real movable equipment purchase estimates available from 2008 back to 1963, thirty-five 11-year periods were averaged to determine the average vintage weights for movable equipment that are representative of average movable equipment purchase patterns over time. Vintage weights for each 11-year period are calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 11-

year period. This calculation was done for each year in the 11-year period and for each of the thirty-five 11-year periods. We used the average of each year across the thirty-five 11-year periods to determine the average movable equipment vintage weights for the FY 2008-based RPL market basket.

For the interest vintage weights, the nominal annual capital purchase amounts for total equipment (building & fixed, and movable) were used to capture the value of the debt instrument. Because we have determined that hospital debt instruments have an expected life of 26 years, the vintage weights for interest are deemed to represent the average purchase pattern of total equipment over 26-year periods. With nominal total equipment purchase estimates available from 2008 back to 1963, twenty 26-year periods were averaged to determine the average vintage weights for interest that are representative of average capital purchase patterns over time. Vintage weights for each 26-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 26-year period. This calculation is done for each year in the 26-year period and for each of the twenty 26-year periods. We used the average of each year across the twenty 26-year periods to determine the average interest vintage weights for the FY 2008-based RPL market basket. The vintage weights for the capital portion of the FY 2002-based RPL market basket and the FY 2008-based RPL market basket are presented in Table 4.

TABLE 4—FY 2002 AND FY 2008 VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Year	Building & fixed equipment		Movable equipment		Interest	
	FY 2002 23 years	FY 2008 26 years	FY 2002 11 years	FY 2008 11 years	FY 2002 23 years	FY 2008 26 years
1	0.021	0.021	0.065	0.071	0.010	0.010
2	0.022	0.023	0.071	0.075	0.012	0.012
3	0.025	0.025	0.077	0.080	0.014	0.014
4	0.027	0.027	0.082	0.083	0.016	0.016
5	0.029	0.028	0.086	0.085	0.019	0.018
6	0.031	0.030	0.091	0.089	0.023	0.020
7	0.033	0.031	0.095	0.092	0.026	0.021
8	0.035	0.033	0.100	0.098	0.029	0.024
9	0.038	0.035	0.106	0.103	0.033	0.026
10	0.040	0.037	0.112	0.109	0.036	0.029
11	0.042	0.039	0.117	0.116	0.039	0.033
12	0.045	0.041	.....	.....	0.043	0.035
13	0.047	0.042	.....	.....	0.048	0.038
14	0.049	0.043	.....	.....	0.053	0.041
15	0.051	0.044	.....	.....	0.056	0.043
16	0.053	0.045	.....	.....	0.059	0.046
17	0.056	0.046	.....	.....	0.062	0.049
18	0.057	0.047	.....	.....	0.064	0.052
19	0.058	0.047	.....	.....	0.066	0.053
20	0.060	0.045	.....	.....	0.070	0.053
21	0.060	0.045	.....	.....	0.071	0.055
22	0.061	0.045	.....	.....	0.074	0.056
23	0.061	0.046	.....	.....	0.076	0.060
24	.....	0.046	.....	.....	.....	0.063
25	.....	0.045	.....	.....	.....	0.064
26	.....	0.046	.....	.....	.....	0.068
Total	1.000	1.000	1.000	1.000	1.000	1.000

Note: Numbers may not add to total due to rounding.

After the capital cost category weights were computed, it was necessary to select appropriate price proxies to reflect the rate-of-increase for each expenditure category. As proposed, and in this final rule, we use the same price proxies for the capital portion of the FY 2008-based RPL market basket that were used in the FY 2002-based RPL market basket, with the exception of the Boeckh Construction Index. We replaced the Boeckh Construction Index with BEA's chained price index for nonresidential construction for hospitals and special care facilities. The BEA index represents construction of facilities such as hospitals, nursing homes, hospices, and rehabilitation centers. Although these price indices move similarly over time, we believe that it is more technically appropriate to use an index that is more specific to the hospital industry. We believe these are the most appropriate proxies for hospital capital costs that meet our selection criteria of relevance, timeliness, availability, and reliability.

The price proxies (prior to any vintage weighting) for each of the capital cost categories are the same as those used for the FY 2006-based Capital Input Price Index as described in the IPPS FY 2010 final rule (74 FR at 43857).

5. RY 2012 Market Basket Update

As proposed, and in this final rule, for RY 2012 (that is, beginning July 1, 2011 through September 30, 2012), we derived a 15-month estimate of the FY 2008-based RPL market basket based on the best available data. To determine a 15-month market basket update for RY 2012, we calculate the 5-quarter moving average index level for July 1, 2011 through September 30, 2012 and the 4-quarter moving average index level for July 1, 2010 through June 30, 2011. The percent change in these two values represents the 15-month market basket update.

Consistent with historical practice, we estimate the RPL market basket update for the IPF PPS based on IHS Global Insight's forecast using the most recent available data. IHS Global Insight, Inc.

is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets. In the RY 2012 IPF PPS proposed rule, we proposed a market basket update based on the 4th quarter 2010 forecast with history through the 3rd quarter of 2010. We also proposed that if more recent data subsequently became available (for example, a more recent estimate of the market basket) we would use such data, if appropriate, to determine the RY 2012 update in the final rule. Based on IHS Global Insight's 1st quarter 2011 forecast with history through the 4th quarter of 2010, the projected 15-month market basket update for the 15-month RY 2012 (July 1, 2011 through September 30, 2012) is 3.2 percent.

The most recent estimate of the FY 2008-based RPL market basket update for July 1, 2011 through June 30, 2012, based on IHS Global Insight's 1st quarter 2011 forecast with history through the 4th quarter of 2010, is 2.8 percent. We determined this 12-month market basket update by calculating the 4-quarter moving average index level for July 1, 2011 through June 30, 2012 and the 4-quarter moving average index level for July 1, 2010 through June 30, 2011. The percent change in these two values represents the 12-month market basket update. Consistent with our historical practice of using market basket estimates based on the most recent available data, if we were not extending the 2012 IPF PPS RY by 3 months, the market basket update for a 12-month RY 2012 would be 2.8 percent, based on the most recent estimate of the 12-month RPL market basket update for July 1, 2011 through June 30, 2012.

Using the FY 2002-based RPL market basket and IHS Global Insight's 1st quarter 2011 forecast for the market basket components, the 15-month RY 2012 update would be 3.3 percent. The 12-month RY 2012 update would be 2.9 percent.

As proposed, for this RY 2012 IPF PPS final rule we have determined the RY 2012 update based on the most recent market basket estimate for the 15-month period. The current estimates of the FY 2002-based and FY 2008-based RPL market baskets are based on IHS Global Insight's first quarter 2011 forecast with historical data through fourth quarter 2010. Table 5 below compares the FY 2008-based RPL market basket and the FY 2002-based RPL market basket percent changes.

TABLE 5—FY 2002-BASED AND FY 2008-BASED RPL MARKET BASKET PERCENT CHANGES, RY 2006 THROUGH FY 2014

Rate year (RY) or fiscal year (FY)	FY 2002-based RPL market basket index percent change	FY 2008-based RPL market basket index percent change
Historical data:		
RY 2006 [1]	3.8	3.7
RY 2007 [1]	3.5	3.5
RY 2008 [1]	3.5	3.6
RY 2009 [1]	3.1	3.3
RY 2010 [1]	2.2	2.1
Average 2006–2010	3.2	3.2
Forecast:		
RY 2011 [1]	2.4	2.5
RY 2012 [2]	3.3	3.2
FY 2013 [3]	2.9	2.9
FY 2014 [3]	3.0	3.0
Average 2011–2014	2.9	2.9

[1] RY 2006 through RY 2011 represent 12-month updates, which include July 1 through June 30.
[2] RY 2012 represents a 15-month update, which includes July 1, 2011 through September 30, 2012.
[3] FY 2013 through FY 2014 represent 12-month updates, which include October 1 through September 30.
Note that these market basket percent changes do not include any further adjustments as may be statutorily required.
Source: IHS Global Insight, Inc. 1st quarter 2011 forecast.

The 15-month RY 2012 market basket update using the FY 2008-based RPL market basket is 0.1 percentage point lower than the market basket update using the FY 2002-based RPL market basket. This is due to slightly offsetting factors. The lower total compensation weight in the FY 2008-based RPL market basket (62.278 percent) relative to the FY 2002-based RPL market basket (65.877 percent), absent other factors, would have resulted in a slightly lower market basket update using the FY 2008-based RPL market basket. This impact, however, is partially offset by the larger weight associated with the Professional Fees category. In both market baskets, these expenditures are proxied by the ECI for Compensation for Professional and Related Services. The weight for Professional Fees in the FY 2002-based RPL market basket is 2.892 percent compared to 6.325 percent in the FY 2008-based RPL market basket.

We did not receive any public comments on the market basket updates in the RY 2012 IPF PPS proposed rule.

6. Labor-Related Share

As described in section VI.C.1. of this final rule, due to the variations in costs and geographic wage levels, we proposed that payment rates under the IPF PPS continue to be adjusted by a geographic wage index. This wage index would apply 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 total costs that are related to, influenced by, or vary with the local labor market. As proposed, and for this final rule, we continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market. Given this, based on our definition of the labor-related share, we proposed to include in the labor-related share the sum of the relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Business Support Services, All Other: Labor-

related Services (previously referred to in the FY 2002-based RPL market basket as labor-intensive), and a portion of the Capital-Related cost weight.

Consistent with previous rebasings, the All Other: Labor-related Services cost category is mostly comprised of building maintenance and security services (including, but not limited to, commercial and industrial machinery and equipment repair, nonresidential maintenance and repair, and investigation and security services). Because these services tend to be labor-intensive and are mostly performed at the hospital facility (and, therefore, unlikely to be purchased in the national market), we believe that they meet our definition of labor-related services.

As stated in the April 2010 IPF PPS notice (75 FR 23110), the labor-related share was defined as 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. Therefore, to determine the labor-related share for the IPF PPS for RY 2011, we used the FY 2002-based RPL market basket cost weights relative importance to determine the labor-related share for the IPF PPS.

For the proposed FY 2008-based RPL market basket rebasing, the proposed inclusion of the Administrative and Business Support Services cost category into the labor-related share remained consistent with the current labor-related share because this cost category was previously included in the Labor-intensive cost category. As previously stated, we established a separate Administrative and Business Support Service cost category so that we can use the ECI for Compensation for Office and Administrative Support Services to more precisely proxy these specific expenses.

For the FY 2002-based RPL market basket, we assumed that all nonmedical professional services (including accounting and auditing services, engineering services, legal services, and management and consulting services) were purchased in the local labor market and, therefore, all of their associated fees varied with the local labor market. As a result, we previously included 100 percent of these costs in the labor-related share. In an effort to more accurately determine the share of professional fees that should be included in the labor-related share, we surveyed hospitals regarding the proportion of those fees that go to companies that are located beyond their own local labor market (the results are discussed below).

We continue to look for ways to refine our market basket approach to more accurately account for the proportion of costs influenced by the local labor market. To that end, we conducted a survey of hospitals to empirically determine the proportion of contracted professional services purchased by the industry that are attributable to local firms and the proportion that are purchased from national firms. We notified the public of our intent to conduct this survey on December 9, 2005 (70 FR 73250) and received no comments (71 FR 8588).

With approval from the Office of Management and Budget (OMB), we contacted a sample of IPPS hospitals and received responses to our survey from 108 hospitals. We believe that these data serve as an appropriate proxy for the purchasing patterns of professional services for IPFs as they are also institutional providers of health care services. Using data on FTEs to allocate responding hospitals across strata (region of the country and urban/rural status), we calculated poststratification weights. Based on these weighted results, we determined that hospitals purchase, on average, the following portions of contracted professional services outside of their local labor market:

- 34 percent of accounting and auditing services.
- 30 percent of engineering services.
- 33 percent of legal services.
- 42 percent of management consulting services.

We applied each of these percentages to its respective Benchmark I–O cost category underlying the professional fees cost category. This is the methodology that we used to separate the FY 2008-based RPL market basket professional fees category into Professional Fees: Labor-related and Professional Fees: Nonlabor-related cost categories. In addition to the professional services listed above, we also classified expenses under NAICS 55, Management of Companies and Enterprises, into the Professional Fees cost category as was done in previous rebasings. The NAICS 55 data are mostly comprised of corporate, subsidiary, and regional managing offices, or otherwise referred to as home offices. Formerly, all of the expenses within this category were considered to vary with, or be influenced by, the local labor market and were thus included in the labor-related share. Because many hospitals are not located in the same geographic area as their home office, we analyzed data from a variety of sources in order to determine what proportion of these costs should be appropriately included in the labor-related share.

Using data primarily from the Medicare cost reports and a CMS database of Home Office Medicare Records (HOMER) (a database that provides city and state information (addresses) for home offices), we were able to determine that 19 percent of the total number of freestanding IRFs, freestanding IPFs, and LTCHs that had home offices had those home offices located in their respective local labor markets—defined as being in the same Metropolitan Statistical Area (MSA).

The Medicare cost report requires hospitals to report their home office provider numbers. Using the HOMER database to determine the home office location for each home office provider number, we compared the location of the provider with the location of the hospital's home office. We then placed providers into one of the following three groups:

- Group 1—Provider and home office are located in different States.
- Group 2—Provider and home office are located in the same State and same city.
- Group 3—Provider and home office are located in the same State and different city.

We found that 63 percent of the providers with home offices were classified into Group 1 (that is, different State) and, thus, these providers were determined to not be located in the same local labor market as their home office. Although there were a very limited number of exceptions (that is, providers located in different States but the same MSA as their home office), the 63 percent estimate was unchanged.

We found that 9 percent of all providers with home offices were classified into Group 2 (that is, same State and same city and, therefore, the same MSA). Consequently, these providers were determined to be located in the same local labor market as their home offices.

We found that 27 percent of all providers with home offices were classified into Group 3 (that is, same State and different city). Using data from the Census Bureau to determine the specific MSA for both the provider and its home office, we found that 10 percent of all providers with home offices were identified as being in the same State, a different city, but the same MSA.

Pooling these results, we were able to determine that approximately 19 percent of providers with home offices had home offices located within their local labor market (that is, 9 percent of providers with home offices had their

home offices in the same State and city (and, thus, the same MSA), and 10 percent of providers with home offices had their home offices in the same State, a different city, but the same MSA). We proposed to apportion the NAICS 55 expense data by this percentage. Thus, we proposed to classify 19 percent of these costs into the Professional Fees: Labor-related cost category and the remaining 81 percent into the Professional Fees: Nonlabor-related Services cost category.

We received several comments on our proposal to revise the labor-related share. These comments and our responses are provided below.

Comment: One commenter recommended that CMS move forward with this proposal, and stated a belief that the labor-related share has been overstated in the past, resulting in reduced payments to facilities in areas with low wage indices.

Response: We thank the commenter for this comment. We believe comments on prior years' labor-related shares would have been addressed in those rulemakings.

Comment: Several commenters objected to the proposed change in the treatment of professional fees in the calculation of the labor-related share, and recommended maintaining the current methodology. One commenter questioned the sample size (108 hospitals) for estimating the allocation of professional fees. Several commenters believed that professional services, whether purchased within or outside the local labor market, are substitutes for hospital-employed staff and should be included as labor costs.

Response: We disagree with the request to reject the proposed change in the calculation of the labor-related share. A method that distributes professional fees based on empirical research and data represents a technical improvement to the construction of the market basket, where previously all professional fees were assumed to vary with the local labor market. In response to the concern about the sample of 108 hospitals, we provided more detail on that survey conducted below. We note that these same survey results were used in the IPPS market basket rebasing for the FY 2010 IPPS final rule (74 FR 43853).

The survey's methods unfolded in the following manner: Through an independent contractor, a small sample of 12 hospitals were initially pre-tested in order to ensure the understandability of the survey questions. The survey prompted sample institutions to select from multiple choice answers the proportions of their professional fees that are purchased from firms located outside of their respective local labor market. The multiple choice answers for each type of professional service included the following options: 0 percent of fees; 1–20 percent of fees; 21–40 percent of fees; 41–60 percent of fees; 61–80 percent of fees; 81–99 percent of fees; and 100 percent of fees. All respondents were assured that the information they provided would be kept strictly confidential.

Understanding that larger, urban-based hospitals (and those located in areas with area wage indexes greater than 1.0) are most likely to be impacted by the survey's results, we used data on full-time equivalents (FTEs) to represent the sizes of hospitals and selected hospitals with probability proportional to their sizes across strata when drawing the full sample. Strata were formed by Census Region and Urban/Rural Status. The distributions of the hospital population, as well as weighted distributions for the responders, by Urban/Rural Status (including data on hospital size) and Census Region were as follows:

	All hospitals percent distribution & average FTE size	Responding hospitals percent distribution & average FTE size
Total	100%/994	100%/1,156
Total Rurals	30%/388	25%/449
Total Urbans	70%/1,255	75%/1,460
Total Northeast Region	15%/1,442	20%/1,078
Total Mid-West Region	23%/1,062	24%/1,656
Total South Region	42%/843	37%/944
Total West Region	20%/899	19%/1,081

Sample weights were calculated as the inverse of the selection probability and were subsequently adjusted for nonresponse bias by strata and post-stratified to derive final weights. This type of application represents a common survey approach and is based on valid and widely-accepted statistical techniques.

For the estimates of the nationwide proportion of nonmedical professional services fees purchased outside of the local labor market, we first examined the data on multiple levels. First, we found that fewer than 30 percent of the responding hospitals paid 100 percent of their professional fees to vendors located within their local labor market. Conversely, we found that roughly 20 percent of responding hospitals reported 81 percent or more of their professional services fees are paid to vendors located outside of their local labor market.

In determining the specific and appropriate proportions of professional fees to consider labor-related and nonlabor-related, we generated weighted averages from the data in the following manner:

- For any multiple choice answer where the standard error associated with the weighted counts for that answer was less than 30 percent, we multiplied the weighted counts associated with that answer by the midpoint of the range within that answer. For example, for Accounting and Auditing services, if a weighted count of 500 hospitals responded that they pay "1 to 20 percent" of their professional fees for these services to firms located outside of their local labor market, we would multiply 500 times 10 percent. We repeat this for each possible multiple choice answer.
- For any multiple choice answer where the standard error associated with the weighted counts for that answer exceeded 30 percent, we multiplied the weighted hospital counts by the low point of the range. Using a similar example as above, if a weighted count of 300 hospitals responded that they pay "1 to 20 percent" of their professional fees for these services to firms located outside of their local labor market, and the standard error on that estimate was greater than 30 percent, we would multiply 300 times 1 percent.
- After applying one of these two techniques to each answer, dependent on its associated standard error, we took a weighted average of the results to determine the final proportion to be excluded from the labor-related share

for each of the four types of professional services surveyed.

Given the information provided above, we believe that the estimates based on this survey are valid. In response to the commenters' statement that professional services should be included as labor-related costs no matter where they are purchased, we again note that the purpose of the labor-related share is to determine the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We define the labor-related share as not only those expenses that are labor-intensive but those that also vary with, or are influenced by, the local labor market. By application of this definition, it is relevant where these professional services are purchased. To the extent these services are not purchased in the local labor market, they are not included in the labor-related share.

After consideration of the public comments received, in this final rule we are finalizing our methodology for calculating the labor-related share for RY 2012. Using the same methodology that was proposed in the RY 2012 IPF PPS proposed rule, we calculated a labor-related share for RY 2012 using the most recent data available at the time of this final rule. This estimate of the RY 2012 labor-related share is based on IHS Global Insight Inc.'s first quarter 2011 forecast, which is the same forecast used to derive the RY 2012 market basket update.

Table 6 below shows the RY 2012 relative importance labor-related share using the FY 2008-based RPL market basket and the FY 2002-based RPL market basket.

TABLE 6—COMPARISON OF THE RY 2011 (12-MONTH) RELATIVE IMPORTANCE LABOR-RELATED SHARE BASED ON THE FY 2002-BASED RPL MARKET BASKET AND THE RY 2012 (15-MONTH) RELATIVE IMPORTANCE LABOR-RELATED SHARE BASED ON THE FY 2008-BASED RPL MARKET BASKET

	RY 2011 relative importance labor-related share [1]	Final RY 2012 relative importance labor-related share [2]
Wages and Salaries	52.600	49.049
Employee Benefits	13.935	13.036
Professional Fees: Labor-Related	2.853	2.073
Administrative and Business Support Services		0.416
All Other: Labor-Related Services	2.118	2.094
Subtotal	71.506	66.668
Labor-Related Portion of Capital Costs (46%)	3.894	3.649
Total Labor-Related Share	75.400	70.317

[1] Published in the RY 2011 IPF PPS notice (75FR 23110–23111) and based on the IHS Global Insight, Inc. first quarter 2010 forecast of the 2002-based RPL market basket.

[2] Based on IHS Global Insight, Inc. first quarter 2011 forecast of the 2008-based RPL market basket.

The labor-related share for RY 2012 is the sum of the RY 2012 relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2008) and RY 2012. The sum of the relative importance for RY 2012 for operating costs (Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Business Support Services, and All Other: Labor-related Services) is 66.668 percent, as shown in Table 6 above. The portion of Capital that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage applied to the FY 2002-based RPL market basket. Since the relative importance for Capital-Related Costs is 7.932 percent of the FY 2008-based RPL market basket in RY 2012, we take 46 percent of 7.932 percent to determine the labor-related share of Capital for RY 2012. The result is 3.649 percent, which we add to 66.668 percent for the operating cost amount to determine the total labor-related share for RY 2012. Therefore, the labor-related share for the IPF PPS in RY 2012 is 70.317 percent. This labor-related share is determined using the same methodology as employed in calculating all previous IPF labor-related shares (69 FR 66952). The wage index and the labor-related share are reflected in budget neutrality adjustments.

V. Updates to the IPF PPS for RY Beginning July 1, 2011

The IPF PPS is based on a standardized Federal per diem base rate calculated from IPF average per diem costs and adjusted for budget-neutrality in the implementation year. The Federal per diem base rate is used as the standard payment per day under the IPF PPS and is adjusted by 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 Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) 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 (ECT) 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 was completed in RY 2009, the stop-loss provision is no longer applicable, and for cost reporting periods beginning on or after January 1, 2008, IPFs were paid 100 percent PPS.

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 until we analyze IPF PPS data.

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 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

As described in the November 2004 IPF PPS final rule (69 FR 66931), the average per diem cost was updated to the midpoint of the implementation year. 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 increase in the per diem base rate for RY 2009 included the 0.39 percent increase due to the removal of the stop-loss provision. We indicated in the November 2004 IPF PPS final rule (69 FR 66932) that we would remove this 0.39 percent reduction to the Federal per diem base rate after the transition. As discussed in section IV.D.2. of the May 2008 IPF PPS notice, we increased the Federal per diem base rate and the ECT base rate by 0.39 percent in RY 2009. Therefore for RY 2009 and beyond, the stop-loss provision has ended and is no longer a part of budget neutrality.

In accordance with section 1886(s)(2)(A)(ii) of the Act, which requires the application of an "other adjustment," described in section 1886(s)(3) of the Act (specifically, section 1886(s)(3)(A) for RYs 2011 and 2012) that reduces the update to the IPF PPS base rate for the RY beginning in Calendar Year (CY) 2011, we are adjusting the IPF PPS update by a 0.25 percentage point reduction for RY 2012. For this final rule, we are applying the 15-month 2008-based RPL market basket increase for RY 2012 of 3.2 percent, as adjusted by the "other adjustment" of −0.25 percentage point, and the wage index budget neutrality factor of 0.9995 to the RY 2011 Federal per diem base rate of $665.71 yielding a Federal per diem base rate of $685.01 for RY 2012. Similarly, we are applying the market basket increase, as adjusted by the "other adjustment", and the wage index budget neutrality factor to the RY 2011 ECT base rate, yielding an ECT base rate of $294.91 for RY 2012.

Final Rule Action: In summary, for the RY 2012, we received no public comments concerning the "other adjustment"; therefore, we will apply the 15-month FY 2008-based RPL market basket increase of 3.2 percent with the "other adjustment" of −0.25 percent and the wage index budget neutrality factor to the RY 2011 ECT and Federal per diem base rates to yield the RY 2012 ECT base rate of $294.91 and Federal per diem base rate of $685.01.

VI. 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. For the proposed rule, we used the same results of the regression analysis used to implement the November 2004 IPF PPS final rule. For a more detailed description of the data file used for the regression analysis, see the November 2004 IPF PPS final rule (69 FR 66935 through 66936). While we have since used more recent claims data to set the fixed dollar loss threshold amount, we used the same results of this regression analysis to update the IPF PPS for RY 2011 and we proposed to use these same results for RY 2012. Now that we are approximately 5 years into the IPF PPS, we believe that we have enough data to begin looking at the process of refining the IPF PPS as appropriate. We believe that in the next rulemaking, for FY 2013, we will be ready to propose potential refinements to the system.

As we stated previously, we do not plan to update the regression analysis until we are able to analyze IPF PPS claims and cost report data. However, we continue to monitor claims and payment data independently from cost report data to assess issues, to determine whether changes in case-mix or payment shifts have occurred among freestanding governmental, non-profit and private psychiatric hospitals, and psychiatric units of general hospitals, and CAHs and other issues of importance to IPFs.

B. Patient-Level Adjustments

In the April 2010 IPF PPS notice (75 FR 23113 through 23117), we announced payment adjustments for the following patient-level characteristics: Medicare Severity diagnosis related groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments.

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. The IPF PPS recognizes the MS–DRGs. The DRG 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 Chapter Five ("Mental Disorders") of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM)" or in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, (DSM–IV–TR). IPF claims with a principal diagnosis included in Chapter Five of the ICD–9–CM or the DSM–IV–TR are 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 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 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 were 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 as well as other providers to report diagnostic and procedure information. The IPF PPS has always incorporated ICD–9–CM coding changes made in the annual IPPS update. We publish coding changes in a Transmittal/Change Request, similar to how coding changes are announced by the IPPS and LTCH PPS. Those ICD–9–CM coding changes are also published in the following IPF PPS RY update, in either the IPF PPS proposed and final rules, or in an IPF PPS update notice.

In the May 2008 IPF PPS notice (73 FR 25709), we discussed CMS' effort to better recognize resource use and the severity of illness among patients. CMS adopted the new MS–DRGs for the IPPS in the FY 2008 IPPS final rule with comment period (72 FR 47130). We believe 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).

In the May 2008 IPF PPS notice, the IPF PPS recognized the MS–DRGs. A crosswalk, to reflect changes that were made to the DRGs under the IPF PPS to the new MS–DRGs was provided (73 FR 25716). Since then, we have referred to the IPF PPS DRGs as MS–DRGs. In the RY 2012 IPF PPS proposed rule, we proposed that all references to the MS–DRGs used for the IPF PPS would be to MS–IPF–DRGs. This would only be a change in terminology. We proposed to revise § 412.402 to add the definition of MS–IPF–DRG.

Comment: One Commenter suggested for consistency sake, that the DRG name of MS–DRG should remain the same in this rule as it is in the IPPS rule. The commenter believes that the name change to MS–IPF–DRGs suggest that there are two separate and distinct DRG classification systems.

Response: We understand the commenter's concern that the name change from MS–DRG to MS–IPF–DRG could suggest that there are two separate DRG classification systems. Although we proposed to simply change the

terminology only and this change does not mean two separate and distinct DRG classification systems, we will retain the MS–DRG name for consistency sake and to avoid confusion. Therefore, we will not finalize the revision of § 412.402 to add the definition of MS–IPF–DRG. All references to the DRG name of MS–DRGs for the IPF PPS will remain the same.

All of the ICD–9–CM coding changes are reflected in the FY 2011 GROUPER, Version 28.0, effective for IPPS discharges occurring on or after October 1, 2010 through September 30, 2011. The GROUPER Version 28.0 software package assigns each case to an MS–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) 27.0 uses the new ICD–9–CM codes to validate coding for IPPS discharges on or after October 1, 2010. For additional information on the GROUPER Version 28.0 and MCE 27.0, see Transmittal 2060 (Change Request 7134), dated October 1, 2010. 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 28.0 and MCE 27.0 on October 1, 2010, also became effective for the IPF PPS for discharges occurring on or after October 1, 2010.

The impact of the new MS–DRGs on the IPF PPS was negligible. Mapping to the MS–DRGs resulted in the current 17 MS–DRGs, instead of the original 15, for which the IPF PPS provides an adjustment. 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 updates are reflected in Tables 7 and 8. For a detailed description of the mapping changes from the original DRG adjustment categories to the current MS–DRG adjustment categories we refer readers to the May 2008 IPF PPS notice (73 FR 25714).

The official version of the ICD–9–CM is available on CD–ROM from the U.S. Government Printing Office. The FY 2009 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 2011 Rates" in the August 16, 2010 **Federal Register** (75 FR 50042) and at Tables 7 and 8 below list the FY 2011 new and revised ICD–9–CM diagnosis codes that group to one of the 17 MS–DRGs for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2011 changes and do 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 7—FY 2011 NEW DIAGNOSIS CODES

Diagnosis code	MS–DRG descriptions	MS–DRG
799.51	Attention or concentration deficit	886
799.52	Cognitive communication deficit	884
799.54	Psychomotor deficit	884
799.55	Frontal lobe and executive function deficit	884
799.59	Other signs and symptoms involving cognition	884

TABLE 8—FY 2011 REVISED DIAGNOSIS CODE

Diagnosis code	MS–DRG description	MS–DRG
307.0	Adult onset fluency disorder	887

Because we do not plan to update the regression analysis until we are able to analyze IPF PPS data, we proposed that the MS–IPF–DRG adjustment factors (as shown in Table 9) would continue to be paid for discharges occurring in RY 2012.

TABLE 9—RY 2012 CURRENT MS–IPF–DRGS APPLICABLE FOR THE PRINCIPAL DIAGNOSIS ADJUSTMENT

MS–DRG	MS–DRG descriptions	Adjustment factor
056	Degenerative nervous system disorders w/MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
080	Nontraumatic stupor & coma w/MCC	1.07
081	Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w/principal diagnoses of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.02

TABLE 9—RY 2012 CURRENT MS–IPF–DRGS APPLICABLE FOR THE PRINCIPAL DIAGNOSIS ADJUSTMENT—Continued

MS–DRG	MS–DRG descriptions	Adjustment factor
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w/rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Final Rule Action: In summary, we received one public comment objecting to our proposed change to § 412.402 to change the terminology from MS–DRG to MS–IPF–DRG. Therefore, we will not revise § 412.402 to add the definition of MS–IPF–DRG. Instead, we will retain the MS–DRG name for consistency sake and in order to avoid confusion. All references to the DRG name of MS–DRG for the IPF PPS will remain the same. In addition, we are adopting the MS–DRG adjustments currently in effect and as shown in Table 9.

2. Payment for Comorbid Conditions

The intent of the comorbidity adjustments 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 April 2010 IPF PPS notice (75 FR 23114), 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 comorbid condition payment adjustment under the IPF PPS for RY 2011 (75 FR 23115).

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 must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, length of stay (LOS), or 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 and impact the treatment provided.

The comorbidity adjustments were determined based on the regression analysis using the diagnoses reported by IPFs in FY 2002. The principal diagnoses were used to establish the DRG adjustments 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 April 2010 IPF PPS notice (75 FR 23115), 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 MS–DRG section, where we proposed that all references to MS–DRGs used for the IPF PPS be to MS–IPF–DRGs (as previously stated, we are not finalizing that proposal), 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 10 below lists the FY 2011 new ICD diagnosis codes that impact the comorbidity adjustments under the IPF PPS. Table 10 is not a list of all currently valid ICD codes applicable for the IPF PPS comorbidity adjustments.

TABLE 10—FY 2011 NEW ICD CODES APPLICABLE FOR THE COMORBIDITY ADJUSTMENT

Diagnosis code	Description	Comorbidity category
237.73	Schwannomatosis	Oncology.
237.79	Other neurofibromatosis	Oncology.

For RY 2012, we are applying the seventeen comorbidity categories for which we are providing an adjustment, their respective codes, including the new FY 2011 ICD–9–CM codes, and their respective adjustment factors in Table 11 below.

TABLE 11—RY 2012 DIAGNOSIS CODES AND ADJUSTMENT FACTORS FOR COMORBIDITY CATEGORIES

Description of comorbidity	Diagnoses codes	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

TABLE 11—RY 2012 DIAGNOSIS CODES AND ADJUSTMENT FACTORS FOR COMORBIDITY CATEGORIES—Continued

Description of comorbidity	Diagnoses codes	Adjustment factor
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

Final Rule Action: In summary, we are adopting the comorbidity adjustments currently in effect and as shown in Table 11 above for RY 2012 beginning on July 1, 2011.

3. Patient Age Adjustments

As explained in the November 2004 IPF PPS final rule (69 FR 66922), 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 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.

We do not plan to update the regression analysis until we are able to analyze IPF PPS data. Therefore, for RY 2012, we proposed to continue to use the patient age adjustments currently in effect as shown in Table 12 below.

TABLE 12—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
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15

TABLE 12—AGE GROUPINGS AND ADJUSTMENT FACTORS—Continued

Age	Adjustment factor
80 and over	1.17

Final Rule Action: We received no comments on the RY 2012 IPF PPS proposed rule concerning the age adjustment. We are adopting the age adjustment currently in effect and as shown in Table 12 above for RY 2012.

4. Variable Per Diem Adjustments

We explained in the November 2004 IPF PPS final rule (69 FR 66946) that the regression analysis indicated that per diem cost declines as the LOS increases. 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 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 V.C.5 of this final rule.

For RY 2012, we proposed to continue to use the variable per diem adjustment factors currently in effect as shown in Table 13 below. A complete discussion of the variable per diem adjustments appears in the November 2004 IPF PPS final rule (69 FR 66946).

TABLE 13—VARIABLE PER DIEM ADJUSTMENTS

Day-of-stay	Adjustment factor
Day 1—IPF Without a Qualifying ED	1.19
Day 1—IPF With a Qualifying 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

TABLE 13—VARIABLE PER DIEM ADJUSTMENTS—Continued

Day-of-stay	Adjustment factor
After Day 21	0.92

Final Rule Action: In response to the RY 2012 IPF PPS proposed rule, we received no public comments concerning the variable per diem adjustment. We are adopting the variable per diem adjustment currently in effect and as shown in Table 13 above.

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

a. Background

As discussed in the May 2006 IPF PPS final rule and in the May 2008 and May 2009 IPF PPS notices, in providing an adjustment for geographic wage levels, the labor-related portion of an IPF's payment is adjusted using an appropriate wage index. Currently, an IPF's geographic 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 § 412.64(C).

b. Wage Index for RY 2012

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 2012. We apply the wage index adjustment to the labor-related portion of the Federal rate, which is 70.317 percent. This percentage reflects the labor-related relative importance of the FY 2008-based RPL market basket for RY 2012 (see section IV.C.6 of this final rule). 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 2012, we proposed to apply the most recent hospital wage index (that is, the FY 2011 pre-floor, pre-reclassified hospital wage index because this is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data (that is, data from hospital cost reports for the cost reporting period beginning during FY 2007), 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 2011 using the applicable wage index value divided by the total estimated IPF PPS payments in RY 2012 using the most recent wage index. The estimated payments are based on FY 2009 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 2012 in addition to the market basket described in section IV.C.5 of this final rule. The wage index budget neutrality factor for RY 2012 is 0.9995.

The wage index applicable for RY 2012 appears in Table 1 and Table 2 in Addendum B of this final rule. As explained in the May 2006 IPF PPS final rule for RY 2007 (71 FR 27061), the IPF PPS applies the hospital wage index without a hold-harmless policy, and without an out-commuting adjustment or out-migration adjustment because the statutory authority for these policies applies only to the IPPS.

Also 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 CBSA-based wage index.

As was the case in RY 2011, for RY 2012 we proposed to continue to use the CBSA-based wage index values as presented in Tables 1 and 2 in Addendum B of this final rule. A complete discussion of the CBSA labor market definitions appears in the May 2006 IPF PPS final rule (71 FR 27061 through 27067).

In summary, for RY 2012 we proposed to use the FY 2011 wage index data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2007) to adjust IPF PPS payments beginning July 1, 2011.

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 2008 IPF PPS notice, we incorporated 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 (73 FR 25721). We will continue 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*.

Final Rule Action: We are finalizing our proposal to use FY 2011 wage index data to adjust IPF PPS payments beginning July 1, 2011.

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 2012, we proposed to apply a 17 percent payment adjustment for IPFs located in a rural area as defined at § 412.64(b)(1)(ii)(C). As 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 are able to analyze IPF PPS data. A complete discussion of the adjustment for rural locations appears in the November 2004 IPF PPS final rule (69 FR 66954).

Final Rule Action: In summary, we are adopting the 17 percent rural adjustment in effect for RY 2012.

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 hospitals. The teaching adjustment accounts for the higher indirect operating costs experienced by hospitals that participate in GME programs. The payment adjustments are made based on the number of full-time equivalent (FTE) interns and residents training in the IPF and the IPF's average daily census.

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 a PPS, and those paid under the TEFRA rate-of-increase limits. 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 does not make separate payments for indirect medical education costs because payments to these hospitals are based on the hospitals' reasonable costs which already include these higher indirect costs that may be associated with teaching programs.

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 FTE residents training in the IPF (subject to limitations described below) to the IPF's average daily census (ADC).

We established the teaching adjustment in a manner that limited the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. We imposed a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. The cap limits the number of FTE residents that teaching IPFs may count for the purpose of calculating the IPF PPS teaching adjustment, not the number of residents teaching institutions can hire or train. We calculated the number of FTE residents that trained in the IPF during a "base year" and used that FTE resident number as the cap. An IPF's FTE resident cap is ultimately determined based on the final settlement of the IPF's most recent cost report filed before November 15, 2004 (that is, the publication date of the IPF PPS final rule).

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, in this final rule, for RY 2012, 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 2008 IPF PPS notice (73 FR 25721).

FTE Intern and Resident Cap Adjustment

CMS has been asked to reconsider the current IPF teaching policy and permit a temporary increase in the FTE resident cap when the IPF increases the number of FTE residents it trains due to the acceptance of displaced residents (residents that are training in an IPF or a program before the IPF or program closed) when another IPF closes or closes its medical residency training program.

To help us assess how many IPFs have been, or expect to be adversely affected by their inability to adjust their caps under § 412.424(d)(1) and under these situations, we specifically requested public comment from IPFs in the May 1, 2009 IPF PPS notice (74 FR 20376 through 20377). A summary of the comments and our response can be reviewed in the April 30, 2010 IPF PPS notice (75 FR 23106, 23117). All of the commenters recommended that CMS modify the IPF PPS teaching adjustment policy, supporting a policy change that would permit the IPF PPS residency cap to be temporarily adjusted when that IPF trains displaced residents due to closure of an IPF or closure of an IPF's medical residency training program(s). The commenters recommended a temporary resident cap adjustment policy similar to such policies applied in similar contexts for acute care hospitals.

We agree with the commenters that, when a hospital temporarily takes on residents because another hospital closes or discontinues its program, a temporary adjustment to the cap would be appropriate for rotation that occurs in an IPF setting (freestanding or units). In these situations, residents may have partially completed a medical residency training program at the hospital that has closed its training program and may be unable to complete their training at another hospital that is already training residents up to or in excess of its cap. We believe that it is appropriate to allow temporary adjustments to the FTE caps for an IPF that provides residency training to medical residents who have partially completed a residency training program at an IPF that closes or at an IPF that discontinues training residents in a residency training program(s) (also referred to as a "closed" program throughout this preamble). For this reason, we proposed to adopt the following temporary resident cap adjustment policies, similar to the temporary adjustments to the FTE cap used for acute care hospitals. We proposed that the cap adjustment would be temporary because it is resident specific and would only apply to the displaced resident(s) until the resident(s) completes training in that specialty. We proposed that, as under the IPPS policy for displaced residents, the IPF PPS temporary cap adjustment would apply only to residents that were still training at the IPF at the time the IPF closed or at the time the IPF ceased training residents in the residency training program(s). Residents who leave the IPF, for whatever reason, before the closure of the IPF hospital or medical residency training program would not be considered displaced residents for purposes of the IPF temporary cap adjustment policy. Similarly, as under the IPPS policy, we proposed that medical students who match to a program at an IPF but the IPF or medical residency training program closes before the individual begins training at that IPF are also not considered displaced residents for purposes of the IPF temporary cap adjustments. For detailed information on these acute care hospital GME/IME payment policies, see 66 FR 39899 (August 1, 2001), 64 FR 41522 (July 30 1999), and 64 FR 24736 (May 7 1999). We note that although we proposed to adopt a policy under the IPF PPS that is consistent with the policy applicable under the IPPS, the actual caps under the two payment systems may not be commingled.

a. Temporary Adjustment to the FTE Cap To Reflect Residents Added Due to Hospital Closure

We proposed to allow an IPF to receive a temporary adjustment to the FTE cap to reflect residents added because of another IPF's closure. This adjustment is intended to account for medical residents who would have partially completed a medical residency training program at the hospital that has closed and may be unable to complete their training at another hospital because that hospital is already training residents up to or in excess of its cap. We proposed this change because IPFs have indicated a reluctance to accept additional residents from a closed IPF without a temporary adjustment to their caps. For purposes of this policy on IPF closure, we proposed to adopt the IPPS definition of "closure of a hospital" in 42 CFR 413.79(h) to mean the IPF terminates its Medicare provider agreement as specified in 42 CFR 489.52. Therefore, we proposed to add a new § 412.424(d)(1)(iii)(F)(*1*) to allow a temporary adjustment to an IPF's FTE cap to reflect residents added because of

an IPF's closure on or after July 1, 2011 to be effective for cost reporting periods beginning on or after July 1, 2011. We would allow an adjustment to an IPF's FTE cap if the IPF meets the following criteria: (a) The IPF is training displaced residents from an IPF that closed on or after July 1, 2011; and (b) the IPF that is training the displaced residents from the closed IPF submits a request for a temporary adjustment to its FTE cap to its Medicare contractor no later than 60 days after the hospital first begins training the displaced residents, and documents that the IPF is eligible for this temporary adjustment to its FTE cap by identifying the residents who have come from the closed IPF and have caused the IPF to exceed its cap, (or the IPF may already be over its cap), and specifies the length of time that the adjustment is needed. After the displaced residents leave the IPF's training program or complete their residency program, the IPF's cap would revert to its original level. This means that the temporary adjustment to the FTE cap would be available to the IPF only for the period of time necessary for the displaced residents to complete their training. Further, as under the IPPS policy, we also proposed that the total amount of temporary cap adjustment that can be distributed to all receiving hospitals cannot exceed the cap amount of the IPF that closed.

We also note that section 5506 of the Affordable Care Act, "Preservation of Resident Cap Positions from Closed Hospitals," does not apply to IPFs that closed. Section 5506 only amends sections 1886(d) and (h) of the Act with respect to direct GME and IPPS IME payments. Therefore, the IME FTE cap redistributions under section 5506 only apply to "subsection (d)" IPPS hospitals. Section 5506 has no applicability to the IME teaching adjustments under the IPF PPS (or the IRF PPS, for that matter).

b. Temporary Adjustment to FTE Cap To Reflect Residents Affected by Residency Program Closure

We proposed that if an IPF that ceases training residents in a residency training program(s) agrees to temporarily reduce its FTE cap, another IPF may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another IPF's residency training program. For purposes of this policy on closed residency programs, we proposed to adopt the IPPS definition of "closure of a hospital residency training program" to mean that the hospital ceases to offer training for residents in a particular approved medical residency training program as specified in § 413.79(h). The methodology for adjusting the caps for the "receiving IPF" and the "IPF that closed its program" is described below.

i. Receiving IPF

We proposed that an IPF(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another IPF's residency training program for cost reporting periods beginning on or after July 1, 2011 if—

- The IPF is training additional residents from the residency training program of an IPF that closed its program on or after July 1, 2011; and
- No later than 60 days after the IPF begins to train the residents, the IPF submits to its Medicare Contractor a request for a temporary adjustment to its FTE cap, documents that the IPF is eligible for this temporary adjustment by identifying the residents who have come from another IPF's closed program and have caused the IPF to exceed its cap,(or the IPF may already be in excess of its cap), specifies the length of time the adjustment is needed, and, as explained in more detail below, submits to its Medicare contractor a copy of the FTE cap reduction statement by the IPF closing the residency training program.

In general, the temporary adjustment criteria established for closed medical residency training programs at IPFs is similar to the criteria established for closed IPFs. More than one IPF may be eligible to apply for the temporary adjustment because residents from one closed program may migrate to different IPFs, or they may complete their training at more than one IPF. Also, only to the extent to which an IPF would exceed its FTE cap by training displaced residents would it be eligible for the temporary adjustment.

Finally, we proposed that IPFs that meet the proposed criteria would be eligible to receive temporary adjustments to their FTE caps for cost reporting periods beginning on or after July 1, 2011.

ii. IPF That Closed Its Program(s)

We proposed that an IPF that agrees to train residents who have been displaced by the closure of another IPF's resident teaching program may receive a temporary FTE cap adjustment only if the IPF with the closed program meets the following criteria—

- Temporarily reduces its FTE cap by the number of FTE residents in each program year, training in the program at the time of the program's closure. The yearly reduction would be determined by deducting the number of those residents who would have been training in the program during the year of the closure, had the program not closed; and
- No later than 60 days after the residents who were in the closed program begin training at another IPF, submits to its Medicare contractor a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the IPF training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were training at the time of the program's closure; identifies the IPFs to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

Unlike the proposed closed IPF policy at § 412.424(d) (1)(iii)(F)(1), we proposed under this closed program policy that in order for the receiving IPF(s) to qualify for a temporary adjustment to their FTE cap, the IPFs that are closing their programs would need to reduce their FTE cap for the duration of time the displaced residents would need to finish their training. We proposed this because the IPF that closes the program still retains the FTE slots in its cap, even if the IPF chooses not to fill the slots with residents. We believe it is inappropriate to allow an increase to the receiving IPF's cap without an attendant decrease to the cap of the IPF with the closed program, because the IPF that closed a program(s) could fill these slots with residents from other programs even if the increase and related decrease is only temporary.

We proposed that the cap reduction for the IPF with the closed program would be based on the number of FTE residents in each program year who were in the program at the IPF at the time of the program's closure, and who begin training at another IPF.

Comment: The majority of the commenters strongly supported the proposed policy to allow a temporary adjustment to the resident cap when an IPF closes or closes its residency teaching program. However, a few of the commenters urged CMS to modify the regulations to allow IPFs to receive the temporary cap adjustment if they are training displaced residents as of July 1, 2011. One commenter requested the amendment at § 412.424(d)(1)(iii)(F)(*I*)(*i*) be modified to state, "The IPF is training additional residents as of July 1, 2011 from an IPF that closed." The commenter also requested that we modify § 412.424(d)(1)(iii)(*I*)(*ii*) to state, "No later than 60 days after the IPF begins to train the resident or in the case where an IPF is training the residents as

of July 1,2011, by August 31, 2011, the IPF submits. * * * ”

Response: We share the commenters' concern for those FTE residents who have been displaced before July 1, 2011 due to closure of an IPF. We carefully considered the commenters' request that CMS modify the IPF temporary cap adjustment policy to allow IPFs that volunteered to train displaced residents before July 1, 2011, to receive the temporary cap adjustment. We realize that at present, IPFs provide this important service to displaced residents without extra compensation. However, this is a new policy that was proposed rather than a correction to an existing policy, and as such the effective date of the IPF closure policy must be applied prospectively. Therefore, as proposed, we are finalizing the IPF PPS temporary cap adjustment to apply where an IPF is training additional residents from an IPF that closed or closed its' residency program on or after July 1, 2011. The policy is effective for cost reporting periods beginning on or after July 1, 2011. We appreciate the support for the proposed policies to allow a temporary adjustment to the resident cap when an IPF closes or closes its residency teaching program. We are finalizing these policies as proposed.

Comment: Several commenters expressed concern about the caps on the number of FTE residents that can be used to calculate the teaching adjustment. These commenters believe that the current cap is based on a snapshot of activity freezing the status of residency education at a random point in time-2004. The commenters stated that they continue to advocate for a substantial increase in the total number of residency training positions supported by the Federal Government.

One commenter expressed concern about having caps in general since the current cap is based on 2004 data. Several commenters pointed out that the demand for health care services will continue with the growing needs of 78 million “baby boomers” that started retirement in 2010 and with the passage of Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008. These commenters stated that the U.S. already faces a shortage of psychiatrist, and these factors could potentially elevate what is now a problem to what could be a crisis.

Response: We established the teaching adjustment in a manner that limited the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. We imposed a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment, similar to that established by sections 4621 (IME FTE cap for IPPS hospitals) and 4623 (direct GME FTE cap for all hospitals) of the BBA. The cap limits the number of residents that teaching IPFs may count for purposes of calculating the teaching adjustment, not the number of residents that teaching institutions can hire or train.

We acknowledge that the cap on the number of FTE residents that may be counted under the IPF PPS teaching adjustment is based on 2004 data and the cap freezes the number of residents that Medicare will recognize for payment under the IPF PPS teaching adjustment to that year. This policy is intended to exercise our statutory responsibility under the BBA to prevent any erosion of the resident caps established under the IPPS that could result from incentives created by the facility adjustment for teaching hospitals under the IPF PPS. In addition, we wanted to avoid creating incentives to artificially expand residency training in IPFs, and ensure that the resident base used to determine payments is related to the care needs in IPF institutions. We provided a detailed discussion in the November 15, 2004 **Federal Register** (69 FR 66954–66955) of the BBA cap. We are continually monitoring the impact of our policies to assess the appropriateness of the policies and will continue to monitor the impact of this policy closely and consider the appropriateness of our FTE cap for future refinements for the RY 2013.

Comment: One commenter recommended that CMS work with the Congress to provide a permanent distribution of the resident cap for IPFs that close, similar to the Affordable Care Act for acute care hospital closures.

Response: We believe the commenter is referring to section 5506 of the Affordable Care Act, “Preservation of Resident Cap Positions from Closed Hospitals,” which does not apply to IPFs that closed. In the absence of such authority, we are finalizing the temporary adjustment to the FTE resident caps for when an IPF closes or closes its residency teaching program, as described above.

Final Rule Action: In summary, we are adding § 412.424(d)(1)(iii)(F)(1) and § 412.424(d)(1)(iii)(F)(2) to implement policies related to temporary adjustments to FTE caps to reflect residents added due to closure of an IPF or an IPFs medical residency training program respectfully.

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.

A COLA adjustment for IPFs located in Alaska and Hawaii is made by multiplying the nonlabor-related portion of the Federal per diem base rate by the applicable COLA factor based on the COLA area in which the IPF is located.

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.

As previously stated in the November 2004 IPF PPS final rule, we update the COLA factors according to updates established by the U.S. Office of Personnel Management (OPM).

Sections 1911 through 1919 of the Nonforeign Area Retirement Equity Assurance Act, as contained in subtitle B of title XIX of the National Defense Authorization Act (NDAA) for Fiscal Year 2010 (Pub. L. 111–84, October 28, 2009), transitions the Alaska and Hawaii COLAs to locality pay. Under section 1914 of Public Law 111–84, locality pay is being phased in over a 3-year period beginning in January 2010, with COLA rates frozen as of the date of enactment, October 28, 2009, and then

proportionately reduced to reflect the phase-in of locality pay.

When we published the proposed COLA adjustment factors in the January 2011 proposed rule, we inadvertently selected the FY 2010 COLA rates. The FY 2010 COLA rates were reduced rates to account for the phase-in of locality pay. We did not intend to propose reduced COLA rates, and we do not believe it is appropriate to finalize the reduced COLAs that we showed in our proposed rule. The 2009 COLA rates do not reflect the phase-in of locality pay. Therefore, we are finalizing the FY 2009 COLA rates, which are the same rates that were in effect for both RY 2010 and RY 2011. We plan to address COLA in the future refinement process in FY 2013.

TABLE 14—COLA FACTORS FOR ALASKA AND HAWAII IPFS

Area	Cost of living adjustment factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

(The above factors are based on data obtained from the U.S. Office of Personnel Management Web site at: *http://www.opm.gov/oca/cola/rates.asp*.)

Final Rule Action: In summary, although we did not propose the FY 2009 COLAs, in order to provide a full COLA, we are adopting the FY 2009 COLA rates obtained from the OPM Web site and as shown in Table 14 above.

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 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 incurred by a freestanding psychiatric hospital with a qualifying ED or a distinct part psychiatric unit of an acute hospital or a CAH 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)(2)) and the overhead cost of maintaining the ED. This payment is a facility-level adjustment that applies to all IPF admissions (with one exception 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 critical access hospital (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, as stated in the November 2004 IPF PPS final rule (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 2012, we proposed to retain 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).

Final Rule Action: We are retaining the 1.31 adjustment factor for IPFs with qualifying EDs for RY 2012.

D. Other Payment Adjustments and Policies

For RY 2012, the IPF PPS includes 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 $6,372 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 proposed to update 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 an analysis of the latest available data (that is, FY 2009 IPF claims) and rate increases indicates that 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 will continue to use this process for RY 2012. We begin by simulating aggregate payments with and without an outlier policy, and applying an iterative process to determine an outlier fixed dollar loss threshold amount that will result in outlier payments being equal to 2 percent of total estimated payments under the simulation. Based on this process, using the FY 2009 claims data, we estimate that IPF outlier payments as a percentage of total estimated payments are approximately 2.2 percent in RY 2011. Thus, for this final rule, we are updating the RY 2012 IPF outlier threshold amount to ensure that estimated RY 2012 outlier payments are approximately 2 percent of total estimated IPF payments. The outlier fixed dollar loss threshold amount of $6,372 for RY 2011 will be changed to $7,340 for RY 2012 to reduce estimated outlier payments and thereby maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for RY 2012.

Final Rule Action: In this final rule, we are adopting $7,340 as the fixed dollar loss threshold for RY 2012.

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 2012 is 1.8199 for rural IPFs, and 1.7643 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 apply the national CCRs to the following situations:

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

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

++ Other IPFs for which 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 or final settled cost report.

We are not making any changes to the procedures for ensuring the statistical accuracy of CCRs in RY 2012. However, we are updating the national urban and rural CCRs (ceilings and medians) for IPFs for RY 2012 based on the CCRs entered in the latest available IPF PPS Provider Specific File.

Specifically, for RY 2012, and to be used in each of the three situations listed above, we estimate the national average CCR to be 0.6435 for rural IPFs and the national average CCR of 0.5055 for urban IPFs. 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. Expiration of the Stop-Loss Provision

In the November 2004 IPF PPS final rule, we implemented a stop-loss policy that reduced financial risk to IPFs projected to experience substantial reductions in Medicare payments during the period of transition to the IPF PPS. This stop-loss policy guaranteed that each facility received total IPF PPS payments that were no less than 70 percent of its TEFRA payments had the IPF PPS not been implemented. This policy was applied to the IPF PPS portion of Medicare payments during the 3-year transition.

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. As described in the May 2008 IPF PPS notice for RY 2009, we increased 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.

The stop-loss provision ended during RY 2009 (that is for discharges occurring on or after July 1, 2008 through June 30,

2009). The stop-loss policy is no longer applicable under the IPF PPS.

3. Future Refinements

As we have noted throughout the RY 2012 IPF PPS proposed rule as well as in this final rule, we have delayed making refinements to the IPF PPS until we have adequate IPF PPS data on which to base those decisions. Now that we are approximately 5 years into the system, we believe that we have enough data to begin that process. We have begun the necessary analysis to better understand IPF industry practices so that we may refine the IPF PPS as appropriate. While we did not propose to make the following refinements in the RY 2012 IPF PPS proposed rulemaking, we believe that in the rulemaking for FY 2013 we will be ready to present the results of our analysis.

Specifically, with the change from ICD–9–CM to ICD–10–CM coming in FY 2013, we are analyzing the comorbidity categories and related codes for utilization and continued suitability. While we would continue to provide for comorbidity adjustments, we are analyzing whether the current groupings and codes continue to be warranted and whether other appropriate codes should be added. Also, we are analyzing our current policies for interrupted stays, readmissions, same-day transfers, and length of stays in order to assess whether these policies continue to be appropriate. Additionally, in accordance with section 1886(s)(4) of the Act, which was added by section 10322 of the Affordable Care Act, IPFs must submit data on quality measures, as specified by the Secretary, for each RY beginning in RY 2014. If data is not submitted, any annual update to a Federal base rate for discharges for the payments shall be reduced by 2 percentage points. Quality measures are currently being developed to effectuate this requirement. Lastly, for the first time MedPAC will become involved in evaluating facility margins and will likely make recommendations regarding the appropriate payment update to IPFs based on their findings. CMS is interested in gaining feedback on these areas for future refinements and therefore we invite comments on these issues described in this section at this time.

Comment: A few commenters strongly supported the need to develop and implement quality measures for the IPF PPS. They strongly encouraged CMS to review and consider the Hospital-Based Inpatient Psychiatric Services (HBIPS) core measures as a foundation for quality measures for the IPF PPS. They pointed out that these quality measures are now in effect for all Joint Commission-accredited psychiatric hospitals and are available for use by psychiatric units in acute care hospitals.

Response: We appreciate the support for the development and implementation of quality measures, as well as the recommendation regarding the Hospital-Based Inpatient Psychiatric Services (HBIPS) core measures for IPFs. In accordance with section 1886(s)(4) of the SSA (the Act), which was added by section 10322 of the Affordable Care Act, IPFs must submit data on quality measures as specified by the Secretary, for each RY (that coincides with a FY) beginning in FY 2014. Quality measures are currently being developed to effectuate this requirement. To implement this, a Technical Expert Panel (TEP) has been assembled to develop quality measures for inpatient psychiatric hospitals and psychiatric units. The TEP consists of a wide cross-section of today's learned scholars and experts in the field including the Joint Commission on Hospital and Accreditation (formerly Joint Commission on Accreditation of Healthcare Organizations), to provide valued input on quality measure development. The TEP is charged with identifying measures that reflect current knowledge regarding effective, evidenced-based treatments for psychiatric disorders; addressing the range of treatments and care processes provided at IPFs; and identifying measures applicable to all Medicare beneficiaries treated in IPFs. Therefore, consistent with the views of these commenters, CMS is reviewing and taking into consideration those HBIPS core measures to help form a foundation for quality measures as directed under the Act.

Comment: A few commenters stated that although the core adjustments to the system, such as age, length of stay, and comorbidities have been effective in addressing the variability in the costs of treating Medicare patients with psychiatric disorders, they recommend that the key adjustments (such as age, comorbidities, and length of stays) be analyzed to determine if any changes are warranted.

Response: We agree with the commenters on the need to analyze patient characteristics such as age, comorbidities, and length of stays when we refine the IPF PPS system. As explained in the RY 2012 IPF PPS proposed rule, in preparation for the migration from ICD–9–CM to ICD–10–CM in FY 2013, we plan to analyze the comorbidity categories and related codes for utilization and continued suitability. We will make determinations as to whether the current groupings and codes continue to be warranted and whether other appropriate codes should also be added. We are also analyzing our current policies on interrupted stays, readmissions, same-day transfers, and length of stays in order to assess whether these policies continue to be appropriate. We welcome the support by these commenters for such future refinements.

VII. Regulations Text Corrections

We proposed several minor corrections to the regulations text to address typographical errors. We noted that these proposed changes do not impact policy. We proposed to correct typographical errors at § 412.404, "Conditions for payment" under the prospective payment system for inpatient hospital services of psychiatric facilities; § 412.422, "Basis of payment;" and § 412.426, "Transition period." In addition to these corrections, we proposed to add clarifying language at § 412.426 and § 412.432(d), "Method of payment under the inpatient psychiatric facility prospective payment system." The proposed revisions are described below.

Section 412.404(a)(1)

Under § 412.404, in paragraph (a)(1), "General requirements," we proposed to delete the word "in" between the words "furnished" and "to Medicare".

Section 412.422(b)(2)

Under § 412.422, in paragraph (b)(2), we proposed to correct the reference to § 413.80 to § 413.89. The regulations covered at § 413.89 include bad debts, charity, and courtesy allowances.

Section 412.426(a)

Under § 412.426, in paragraph (a), "Duration of transition period and composition of the blended transition payment," we proposed to replace "Except as provided in paragraph (d) of this section" with "Except as provided in paragraph (c) of this section." There is no paragraph (d); this exception should refer to paragraph (c), "Treatment of new inpatient psychiatric facilities."

Also in paragraph (a), we proposed to add the words "of this part" after "as specified in § 412.424(d)" and "of this section" after "as specified under paragraph (b)." This regulatory language is required by the **Federal Register**.

In each of paragraphs § 412.426(a)(1) through (a)(3), we proposed to delete the words "on or" directly before the words "before January". For example, paragraph (a)(1) currently states, "For

cost reporting periods beginning on or after January 1, 2005 and on or before January 1, 2006 * * *" We proposed that this statement read: "For cost reporting periods beginning on or after January 1, 2005 and before January 1, 2006 * * *" This correction does not represent a change in policy. Rather, it is a correction to conform the regulation text to our policy, which was established in our final rule that appeared in the **Federal Register** on November 15, 2004 (69 FR 66980) (which was subsequently corrected on April 1, 2005 (70 FR 16729)). It is clear that the current regulation text is incorrect. The same January date (for example, January 1, 2007) cannot be both the date on which a new transition period begins and the date on which the previous transition period ends. Our policy, since we established the transition, has been to begin a transition period on or after a January 1 date and to end that transition period before the next transition period begins. Because our regulation text does not accurately reflect our actual policy, we proposed this correction.

At § 412.426(a)(4), we proposed to replace the statement, "For cost reporting periods beginning on or after July 1, 2008, payment is based entirely on the Federal per diem payment amount" with the following statement: "For cost reporting periods beginning on or after January 1, 2008, payment is based entirely on the Federal per diem payment amount." The transition period during which payment was based on a combination of the Federal per diem payment amount and TEFRA payments, ended on January 1, 2008, not July 1, 2008.

Comment: Two commenters expressed serious concern that CMS is making retroactive policy changes to the regulations text for the 3-year transition period for the IPF PPS rather than minor corrections to address typographical errors.

Response: We disagree with the commenters. We are simply making minor corrections to the regulations at § 412.426 covering the transition period to address typographical errors to the IPF PPS. In the November 2004 IPF PPS final rule, we provided for a 3-year transition period. During this 3-year transition period, an IPF's total payment under the PPS was based on an increasing percentage of the Federal rate with a corresponding decreasing percentage of the IPF PPS payment that was based on reasonable cost concepts. However, effective for cost reporting periods beginning on or after January 1, 2008, IPF PPS payments are based on 100 percent of the Federal rate. This correction does not represent a policy change, and therefore is not a retroactive change. Rather, it is a correction to conform the regulation text to our policy, which was established in our final rule that appeared in the **Federal Register** on November 15, 2004 (69 FR 66980) (which was subsequently corrected on April 1, 2005 (70 FR 16729)). It is clear that the current regulation text is incorrect. The same January date (for example, January 1, 2007) cannot be both the date on which a new transition period begins and the date on which the previous transition period ends. Our policy, since we established the transition, has been to begin a transition period on or after a January 1 date and to end that transition period before the next transition period begins. Because our regulation text does not accurately reflect our actual policy, we proposed this correction.

In addition for § 412.426, in paragraph (a), "Duration of transition period and composition of the blended transition payment," we intended to propose, but did not, to replace "on or after January 1, 2005 through January 1, 2008" with "on or after January 1, 2005 through December 31,2007". Here again, this correction does not represent a policy change; it is merely a correction to conform the regulation text to our policy, and it is consistent with the other typographical errors we are correcting in § 412.426.

Section 412.432(d)

Under § 412.432, in paragraph (d), "Outlier payments," we proposed to add the words "of this part" after "subject to the cost report settlement specified in § 412.84(i) and § 412.84(m)." This regulatory language is required by the **Federal Register** and clarifies that § 412.84(i) and § 412.84(m) refer to 42 CFR part 412, "Prospective Payment Systems for Inpatient Hospital Services."

VIII. Collection of Information Requirements

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).

IX. Regulatory Impact Analysis

A. Statement of Need

This final rule will update the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities for discharges occurring during the RY beginning July 1, 2011 through September 30, 2012. We are applying the 15-month FY 2008-based RPL market basket increase of 3.2 percent, adjusted by the 0.25 percentage point reduction, as required by section 1886(s)(3)(A) of the Act. In addition, the rule implements policy changes affecting the IPF PPS teaching adjustment, as well as makes some clarifications and corrections to terminology and regulations text.

B. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct 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). This final rule has been designated an "economically" significant rule, under section 3(f) (1) of Executive Order 12866 and a major rule under the Congressional Review Act. Accordingly, the rule has been reviewed by the Office of Management and Budget.

We estimate that the total impact of these changes for estimated RY 2012 payments compared to estimated RY 2011 payments would be an increase of approximately $120 million (this reflects a $130 million increase from the update to the payment rates and a $10 million decrease due to the update to the outlier threshold amount to decrease outlier payments from approximately 2.2 percent in RY 2011 to 2.0 percent in RY 2012).

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small

governmental jurisdictions. Most IPFs and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7 million to $34.5 million in any one year (for details, refer to the SBA Small Business Size Standards found at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2465b064ba6965cc1fbd2eae60854b11&rgn=div8&view=text&node=13:1.0.1.1.16.1.266.9&idno=13*). 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. The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA.

As shown in Table 15, we estimate that the revenue impact of this final rule on all IPFs is to increase estimated Medicare payments by about 2.74 percent, with rural IPFs estimated to receive an increase in estimated Medicare payments greater than 3 percent (an aggregate 3.80 percent). As a result, the Secretary has determined that this final rule will not have a significant impact on a substantial number of small entities. Medicare fiscal intermediaries, Medicare Administrative Contractors, and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity. We solicited comment on the above analysis.

In addition, section 1102(b) of the Social Security 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. As discussed in detail below, the rates and policies set forth in this final rule will not have an adverse impact on the rural hospitals based on the data of the 320 rural units and 67 rural hospitals in our database of 1,653 IPFs for which data were available. Therefore, the Secretary has determined that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (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 2011, that threshold is approximately $136 million. This final rule will not impose spending costs on State, local, or Tribal governments in the aggregate, or by the private sector, of $136 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. As stated above, this final rule would not have a substantial effect on State and local governments.

C. Anticipated Effects of the Final Rule

We discuss below the historical background of the IPF PPS and the impact of this final rule 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. As discussed in the May 2008 IPF PPS notice (73 FR 25711), the stop-loss adjustment is no longer applicable under the IPF PPS.

In accordance with § 412.424(c)(3)(ii), we indicated that we would 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 reassess the accuracy of all of the factors impacting budget neutrality. In addition, as discussed in section IV.C.6 of this final rule, we are using the wage index and labor-related share in a budget neutral manner by applying a wage index budget neutrality factor to the Federal per diem and ECT base rates. Therefore, the budgetary impact to the Medicare program of this final rule will be due to the 15-month market basket update for RY 2012 of 3.2 percent (see section IV.C.5 of this final rule) as adjusted by the "other adjustment" of −0.25 percentage point according to section 1886(s)(3)(A) of the Act, and the update to the outlier fixed dollar loss threshold amount.

We estimate that the RY 2012 impact would be a net increase of $120 million in payments to IPF providers. This reflects an estimated $130 million increase from the update to the payment rates and a $10 million decrease due to the update to the outlier threshold amount to decrease estimated outlier payments from approximately 2.2 percent in RY 2011 to 2.0 percent in RY 2012.

2. Impact on Providers

To understand the impact of the changes to the IPF PPS on providers, discussed in this final rule, it is necessary to compare estimated payments under the IPF PPS rates and factors for RY 2012 versus those under RY 2011. The estimated payments for RY 2011 and RY 2012 will be 100 percent of the IPF PPS payment, since the transition period has ended and stop-loss payments are no longer paid. We determined the percent change of estimated RY 2012 IPF PPS payments to RY 2011 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 update to the outlier fixed dollar loss threshold amount, the labor-related share and wage index changes for the RY 2012 IPF PPS, and the 15-month market basket update for RY 2012, as adjusted by the "other adjustment" according to section 1886(s)(3)(A) of the Act.

To illustrate the impacts of the RY 2012 changes in this final rule, our analysis begins with a RY 2011 baseline simulation model based on FY 2009 IPF payments inflated to the midpoint of RY 2011 using IHS Global Insight's most recent forecast of the market basket update (see section IV.C.5 of this final rule); the estimated outlier payments in RY 2011; the CBSA designations for IPFs based on OMB's MSA definitions after June 2003; the FY 2010 pre-floor, pre-reclassified hospital wage index; the RY 2011 labor-related share; and the RY 2011 percentage amount of the rural adjustment. During the simulation, the total estimated outlier payments are maintained at 2 percent of total IPF 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 update to the outlier fixed dollar loss threshold amount.
- The FY 2011 pre-floor, pre-reclassified hospital wage index and RY 2012 labor-related share.
- The 15-month market basket update for RY 2012 of 3.2 percent adjusted by the 0.25 percentage point reduction in accordance with section 1886(s)(3)(A) of the Act.

Our final comparison illustrates the percent change in payments from RY 2011 (that is, July 1, 2010 to June 30, 2011) to RY 2012 (that is, July 1, 2011 to September 30, 2012) including all the changes in this final rule.

TABLE 15—IPF Impact Table for RY 2012

Projected Impacts (Percent Change for RY 2012)					
Facility by Type	Number of Facilities	Outlier	CBSA Wage Index & Labor Share	Adjusted Market Basket Update[1]	Total Percent Change[2]
(1)	(2)	(3)	(4)	(5)	(6)
All Facilities	1,653	-0.21	0.00	2.95	2.74
Total Urban	1,266	-0.21	-0.16	2.95	2.57
Total Rural	387	-0.18	1.02	2.95	3.80
Urban DPU	854	-0.28	-0.23	2.95	2.43
Urban CAH unit	10	-0.84	-0.20	2.95	1.86
Urban hospital	402	-0.06	-0.05	2.95	2.84
Rural DPU	267	-0.24	1.05	2.95	3.77
Rural CAH unit	53	-0.13	0.64	2.95	3.47
Rural hospital	67	-0.06	1.10	2.95	4.02
Freestanding IPF					
By Type of Ownership:					
Urban Psychiatric Hospitals					
Government	169	-0.08	-0.34	2.95	2.52
Non-Profit	117	-0.07	0.01	2.95	2.88
For-Profit	116	-0.04	0.20	2.95	3.12
Rural Psychiatric Hospitals					
Government	43	-0.07	0.61	2.95	3.51
Non-Profit	9	-0.01	1.03	2.95	4.00
For-Profit	15	-0.03	2.25	2.95	5.23
IPF Units					
By Type of Ownership:					
Urban DPU					
Government	148	-0.43	-0.30	2.95	2.21
Non-Profit	589	-0.27	-0.28	2.95	2.38
For-Profit	117	-0.17	0.07	2.95	2.84
Urban CAH					
Government	4	-1.57	-0.18	2.95	1.09
Non-Profit	6	-0.31	-0.21	2.95	2.41
Rural DPU					
Government	64	-0.25	1.05	2.95	3.76
Non-Profit	153	-0.22	0.97	2.95	3.71
For-Profit	50	-0.27	1.28	2.95	3.97
Rural CAH					
Government	21	-0.08	0.42	2.95	3.28
Non-Profit	28	-0.15	0.78	2.95	3.59
For-Profit	4	-0.20	0.85	2.95	3.61
By Teaching Status:					
Non-teaching	1,428	-0.19	0.12	2.95	2.88
Less than 10% interns and residents to beds	130	-0.18	-0.53	2.95	2.22
10% to 30% interns and residents to beds	66	-0.43	-0.35	2.95	2.16
More than 30% interns and residents to beds	29	-0.40	-0.39	2.95	2.15
By Region:					
New England	117	-0.23	-0.91	2.95	1.78
Mid-Atlantic	273	-0.19	-0.74	2.95	2.00
South Atlantic	233	-0.17	0.19	2.95	2.96
East North Central	274	-0.24	0.22	2.95	2.93
East South Central	166	-0.16	0.62	2.95	3.43
West North Central	149	-0.21	0.04	2.95	2.77
West South Central	228	-0.18	1.18	2.95	3.97
Mountain	87	-0.17	0.03	2.95	2.80
Pacific	126	-0.29	-0.43	2.95	2.19
By Bed Size:					
Psychiatric Hospitals					
Under 12 beds	12	-0.43	0.02	2.95	2.52
Beds: 12-24	71	-0.13	1.08	2.95	3.93
Beds: 25-49	70	-0.15	0.32	2.95	3.11
Beds: 50-75	72	-0.05	0.16	2.95	3.06
Over 75 beds	244	-0.04	-0.12	2.95	2.78
Psychiatric Units					
Under 12 beds	189	-0.34	0.75	2.95	3.34
Beds: 12-24	515	-0.26	0.15	2.95	2.83
Beds: 25-49	313	-0.28	-0.15	2.95	2.50
Beds: 50-75	105	-0.27	-0.05	2.95	2.62
Over 75 beds	62	-0.27	-0.57	2.95	2.11

[1] This column reflects the impact of the 15-month market basket update for RY 2012 of 3.2 percent, reduced by 0.25 percentage point in accordance with section 1886(s)(3)(A) of the Act.

[2] Percent changes in estimated payments from RY 2011 to RY 2012 include all changes of this rule. Note, the products of these impacts may be different from the percentage changes shown here due to rounding effects.

3. Results

Table 15 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 1,653 IPFs included in this analysis.

In column 3, we present the effects of the update to the outlier fixed dollar loss threshold amount. We estimate that IPF outlier payments as a percentage of total IPF payments are 2.2 percent in RY 2011. Therefore, we are adjusting the outlier threshold amount from $6,372 in RY 2011 to $7,340 in RY 2012 in order to set total estimated outlier payments equal to 2 percent of total payments in RY 2012. The estimated change in total IPF payments for RY 2012, therefore, includes an approximate 0.2 percent decrease in payments because the outlier portion of total payments is expected to decrease from approximately 2.2 percent to 2 percent.

The overall aggregate effect of this outlier adjustment update (as shown in column 3 of table 15), across all hospital groups, is to decrease total estimated payments to IPFs by 0.21 percent. We do not estimate that any group of IPFs will experience an increase in payments from this update. The largest decrease in payments is estimated to reflect a 1.57 percent decrease in payments to urban government IPF units located in CAHs which is due to the small number of IPFs of that type and the high volume of outlier payments made to those IPFs.

In column 4, 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 2012 payments under the FY 2011 hospital wage index under CBSA classification and associated labor-related share to the simulated RY 2011 payments under the FY 2010 hospital wage index under CBSA classifications and associated labor-related share. We note that there is no projected change in aggregate payments to IPFs, as indicated in the first row of column 4. However, there will be distributional effects among different categories of IPFs. For example, we estimate a 1.02 percent increase in overall payments to rural IPFs, with the largest increase in payments of 2.25 percent for rural, for-profit freestanding psychiatric hospitals. In addition, we estimate the largest decrease in payments to be a 0.91 percent decrease for IPFs in the New England region.

Column 5 shows the estimated effect of the update to the IPF PPS payment rates, which includes a 3.2 percent 15-month market basket update adjusted by the 0.25 percentage point reduction in accordance with section 1886(s)(3)(A).

Column 6 compares our estimates of the changes reflected in this final rule for RY 2012, to our payments for RY 2011 (without these changes). This column reflects all RY 2012 changes relative to RY 2011. The average estimated increase for all IPFs is approximately 2.74 percent. This estimated net increase includes the effects of the 3.2 percent 15-month market basket update adjusted by the "other adjustment" of −0.25 percentage point, as required by section 1886(s)(3)(A) of the Act. It also includes the overall estimated 0.2 percent decrease in estimated IPF outlier payments from the update to the outlier fixed dollar loss threshold amount. Since we are making the updates to the IPF labor-related share and wage index in a budget-neutral manner, they will not affect total estimated IPF payments in the aggregate. However, they will affect the estimated distribution of payments among providers.

Overall, no IPFs are estimated to experience a net decrease in payments as a result of the updates in this rule. IPFs in urban areas will experience a 2.57 percent increase and IPFs in rural areas will experience a 3.80 percent increase. The largest payment increase is estimated at 5.23 percent for rural, for-profit freestanding psychiatric hospitals. This is due to the larger than average positive effect of the FY 2011 CBSA wage index and labor-related share updates for rural IPFs in this category.

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 shown in Table 16 below.

TABLE 16—ESTIMATED PAYMENTS

Rate year	Dollars in millions
July 1, 2011 to June 30, 2012	$4,615
July 1, 2012 to June 30, 2013	4,945
July 1, 2013 to June 30, 2014	5,330
July 1, 2014 to June 30, 2015	5,775
July 1, 2015 to June 30, 2016	6,273

These estimates are based on the current forecast of the increases in the RPL market basket, including an adjustment for productivity, for the RY beginning in 2012 and each subsequent RY, as required by section 1886(s)(3)(A) of the Act, as follows:

- 2.8 percent for rate years beginning in 2011 (RY 2012).
- 1.7 percent for rate years beginning in 2012 (RY 2013).
- 2.0 percent for rate years beginning in 2013 (RY 2014).
- 2.2 percent for rate years beginning in 2014 (RY 2015).
- 2.4 percent for rate years beginning in 2015 (RY 2016).

The estimates in Table 16 also include the application of the "other adjustment," as required by section 1886(s)(3)(A) of the Act, as follows:

- −0.25 percentage point for rate years beginning in 2011.
- −0.1 percentage point for rate years beginning in 2012.
- −0.1 percentage point for rate years beginning in 2013.
- −0.3 percentage point for rate years beginning in 2014.
- −0.2 percentage point for rate years beginning in 2015.

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

- 3.3 percent in RY 2012.
- 3.7 percent in RY 2013.
- 4.3 percent in RY 2014.
- 4.9 percent in RY 2015.
- 5.6 percent in RY 2016.

5. Effect on Beneficiaries

Under the IPF PPS, IPFs would 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 2012 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.

D. 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 using the methodology published in the November 2004 IPF PPS final rule.

We note that this final rule initiates policy changes with regard to the IPF PPS, and it also provides an update to the rates for RY 2012. We considered making refinements to the IPF PPS in this final rule. However, more time is required to assess the data and will therefore once again delay running the regression analysis until we have adequate IPF PPS data. We have initiated the necessary analysis to better understand IPF industry practices. We did not consider rebasing the IPF PPS for concerns that rebasing would be too costly (re-calculate the cost-per-day) and time consuming.

E. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 17 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. This table provides our best estimate of the increase in Medicare payments under the IPF PPS as a result of the proposed changes presented in this final rule and based on the data for 1,653 IPFs in our database. All expenditures are classified as transfers to IPF Medicare providers.

TABLE 17—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2011 IPF PPS RY TO THE 2012 IPF PPS RY

[In millions]

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

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

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 continues to read as follows:

Authority: Secs 1102, 1862, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395y, and 1395hh).

Subpart N—Prospective Payment System for Inpatient Hospital Services of Inpatient Psychiatric Facilities

■ 2. In § 412.402, the definition of "*Inpatient psychiatric facilities prospective payment system rate year*" is added in alphabetical order to read as follows:

§ 412.402 Definitions.

* * * * *

Inpatient psychiatric facilities prospective payment system rate year means—

(1) Through June 30, 2011, the 12-month period of July 1 through June 30.

(2) Beginning July 1, 2011, the 15-month period of July 1, 2011 through September 30, 2012.

(3) Beginning October 1, 2012, the 12-month period of October 1 through September 30, referred to as Fiscal Year (FY).

* * * * *

■ 3. Section 412.404 is amended by revising paragraph (a)(1) to read as follows:

§ 412.404 Conditions for payment under the prospective payment system for inpatient hospital services of psychiatric facilities.

(a) * * *

(1) Effective for cost reporting periods beginning on or after January 1, 2005, an inpatient psychiatric facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

* * * * *

■ 4. Section 412.422 is amended by revising paragraph (b)(2) to read as follows:

§ 412.422 Basis of payment.

* * * * *

(b) * * *

(2) In addition to the Federal per diem payment amounts, inpatient psychiatric facilities receive payment for bad debts of Medicare beneficiaries, as specified in § 413.89 of this chapter.

■ 5. Section 412.424 is amended by adding a new paragraph (d)(1)(iii)(F) to read as follows:

§ 412.424 Methodology for calculating the Federal per diem payment amount.

* * * * *

(d) * * *

(1) * * *

(iii) * * *

(F) *Closure of an IPF.* (*1*) For cost reporting periods beginning on or after July 1, 2011, an IPF may receive a temporary adjustment to its FTE cap to reflect residents added because of another IPF's closure if the IPF meets the following criteria:

(*i*) The IPF is training additional residents from an IPF that closed on or after July 1, 2011.

(*ii*) No later than 60 days after the IPF begins to train the residents, the IPF submits a request to its Medicare contractor for a temporary adjustment to its cap, documents that the IPF is eligible for this temporary adjustment by identifying the residents who have come from the closed IPF and have caused the IPF to exceed its cap, and specifies the length of time the adjustment is needed.

(*2*) *Closure of an IPF's residency training program.* If an IPF that closes its residency training program on or after July 1, 2011, agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (d)(1)(iii)(F)(*2*)(*ii*) of this section, another IPF(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in paragraph (d)(1)(iii)(F)(*2*)(*i*) of this section are met.

(*i*) *Receiving IPF(s).* For cost reporting periods beginning on or after July 1, 2011, an IPF may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another IPF's residency training program if the IPF is training additional residents from the residency training program of an IPF that closed a program; and if no later than 60 days after the IPF begins to train the residents, the IPF submits to its Medicare Contractor a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from another IPF's closed program and have caused the IPF to exceed its cap, specifies the length of time the adjustment is needed, and submits to its Medicare contractor a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (d)(1)(iii)(F)(*2*)(*ii*) of this section.

(*ii*) *IPF that closed its program.* An IPF that agrees to train residents who have been displaced by the closure of another IPF's program may receive a

temporary FTE cap adjustment only if the hospital with the closed program temporarily reduces its FTE cap based on the FTE residents in each program year training in the program at the time of the program's closure. This yearly reduction in the FTE cap will be determined based on the number of those residents who would have been training in the program during that year had the program not closed. No later than 60 days after the residents who were in the closed program begin training at another hospital, the hospital with the closed program must submit to its Medicare contractor a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the IPF training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were in training at the time of the program's closure; identifies the IPFs to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

* * * * *

■ 6. Section 412.426 is amended by revising paragraph (a) to read as follows:

§ 412.426 Transition period.

(a) *Duration of transition period and composition of the blended transition payment.* Except as provided in paragraph (c) of this section, for cost reporting periods beginning on or after January 1, 2005 through December 31, 2007, an inpatient psychiatric facility receives a payment comprised of a blend of the estimated Federal per diem payment amount, as specified in § 412.424(d) of this subpart and a facility-specific payment as specified under paragraph (b) of this section.

(1) For cost reporting periods beginning on or after January 1, 2005 and before January 1, 2006, payment is based on 75 percent of the facility-specific payment and 25 percent is based on the Federal per diem payment amount.

(2) For cost reporting periods beginning on or after January 1, 2006 and before January 1, 2007, payment is based on 50 percent of the facility-specific payment and 50 percent is based on the Federal per diem payment amount.

(3) For cost reporting periods beginning on or after January 1, 2007 and before January 1, 2008, payment is based on 25 percent of the facility-specific payment and 75 percent is based on the Federal per diem payment amount.

(4) For cost reporting periods beginning on or after January 1, 2008, payment is based entirely on the Federal per diem payment amount.

* * * * *

■ 7. Section 412.432 is amended by revising paragraph (d) to read as follows:

§ 412.432 Method of payment under the inpatient psychiatric facility prospective payment system.

* * * * *

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. Outlier payments are made based on the submission of a discharge bill and represents final payment subject to the cost report settlement specified in § 412.84(i) and § 412.84(m) of this part.

* * * * *

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

Dated: April 21, 2011.

Donald Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: April 26, 2011.

Kathleen Sebelius,

Secretary.

Note: The following Addendums will not appear in the Code of Federal Regulations.

BILLING CODE 4120–01–P

Addendum A—Rate and Adjustment Factors

Per Diem Rate:

Federal Per Diem Base Rate	$685.01
Labor Share (0.70317)	$481.68
Non-Labor Share (0.29683)	$203.33

Fixed Dollar Loss Threshold Amount:

$7,340

Wage Index Budget Neutrality Factor:

0.9995

Facility Adjustments:

Rural Adjustment Factor	1.17
Teaching Adjustment Factor	0.5150
Wage Index	Pre-reclass Hospital Wage Index (FY2011)

Cost of Living Adjustments (COLAs):

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Patient Adjustments:

ECT – Per Treatment	$294.91

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:

MS-DRG	MS-DRG Descriptions	Adjustment Factor
056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnoses of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
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 2012 CBSA Wage Index Tables

In this addendum, we provide the wage index tables referred to in the preamble to this notice. Tables 1 and 2 display the CBSA-based wage index values for urban and rural providers.

Table 1–RY 2012 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	0.8003
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	0.3471
10420	Akron, OH Portage County, OH Summit County, OH	0.8843
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9036

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8653
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9456
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.7995
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9194
11020	Altoona, PA Blair County, PA	0.8620
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8644
11180	Ames, IA Story County, IA	0.9970
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.1964
11300	Anderson, IN Madison County, IN	0.9192
11340	Anderson, SC Anderson County, SC	0.8691
11460	Ann Arbor, MI Washtenaw County, MI	1.0124
11500	Anniston-Oxford, AL Calhoun County, AL	0.7918
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9361
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9001
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9659
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	0.9549
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1129
12220	Auburn-Opelika, AL Lee County, AL	0.7190

CBSA Code	Urban Area (Constituent Counties)	Wage Index
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9538
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9514
12540	Bakersfield, CA Kern County, CA	1.1707
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0255
12620	Bangor, ME Penobscot County, ME	0.9777
12700	Barnstable Town, MA Barnstable County, MA	1.2823
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8583
12980	Battle Creek, MI Calhoun County, MI	0.9656
13020	Bay City, MI Bay County, MI	0.9221
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8488
13380	Bellingham, WA Whatcom County, WA	1.1390
13460	Bend, OR Deschutes County, OR	1.1372
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0525
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8674
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8719
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	0.8611
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7348
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8314
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8989
14060	Bloomington-Normal, IL McLean County, IL	0.9439
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9273
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2178

CBSA Code	Urban Area (Constituent Counties)	Wage Index
14500	Boulder, CO Boulder County, CO	1.0065
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8666
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0667
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2547
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9173
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9209
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9530
15500	Burlington, NC Alamance County, NC	0.8863
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9947
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1250
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0386
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8749
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9195
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.8983
16180	Carson City, NV Carson City, NV	1.0465
16220	Casper, WY Natrona County, WY	0.9655
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8844
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0235
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.7895
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9354
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9420
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9342
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8829
16940	Cheyenne, WY Laramie County, WY	0.9392

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	1.0593
17020	Chico, CA Butte County, CA	1.1533
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	0.9699
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.7888
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.7731
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9050
17660	Coeur d'Alene, ID Kootenai County, ID	0.9364
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9588
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9481
17860	Columbia, MO Boone County, MO Howard County, MO	0.8282
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8733
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9027
18020	Columbus, IN Bartholomew County, IN	0.9434
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	1.0141
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8585
18700	Corvallis, OR Benton County, OR	1.0455
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa County, FL	0.8842
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8186

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	0.9860
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8622
19180	Danville, IL Vermilion County, IL	0.9693
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8168
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8400
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9140
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7621
19500	Decatur, IL Macon County, IL	0.7916
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8736
19740	Denver-Aurora-Broomfield, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.0718
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9621
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9699
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7435
20100	Dover, DE Kent County, DE	0.9921
20220	Dubuque, IA Dubuque County, IA	0.8774
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0565
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9664
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9639
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1006
20940	El Centro, CA Imperial County, CA	0.9258
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8449
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9465
21300	Elmira, NY Chemung County, NY	0.8445

CBSA Code	Urban Area (Constituent Counties)	Wage Index
21340	El Paso, TX El Paso County, TX	0.8475
21500	Erie, PA Erie County, PA	0.8360
21660	Eugene-Springfield, OR Lane County, OR	1.1384
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8433
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1080
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3883
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8064
22140	Farmington, NM San Juan County, NM	0.9339
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9323
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8616
22380	Flagstaff, AZ Coconino County, AZ	1.2443
22420	Flint, MI Genesee County, MI	1.1496
22500	Florence, SC Darlington County, SC Florence County, SC	0.8252
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8144
22540	Fond du Lac, WI Fond du Lac County, WI	0.9223
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9892
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0160
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7599
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9362
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9474
23420	Fresno, CA Fresno County, CA	1.1422
23460	Gadsden, AL Etowah County, AL	0.7180
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9160
23580	Gainesville, GA Hall County, GA	0.9223
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9084
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8507
24140	Goldsboro, NC Wayne County, NC	0.9067
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7717

CBSA Code	Urban Area (Constituent Counties)	Wage Index
24300	Grand Junction, CO Mesa County, CO	0.9850
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9169
24500	Great Falls, MT Cascade County, MT	0.8289
24540	Greeley, CO Weld County, CO	0.9496
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9586
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.8882
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9370
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9644
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3686
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8877
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9254
25260	Hanford-Corcoran, CA Kings County, CA	1.1205
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9296
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9158
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.0927
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7714
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8693
25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.8958
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8632
26180	Honolulu, HI Honolulu County, HI	1.1807
26300	Hot Springs, AR Garland County, AR	0.9151
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7852
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	0.9824
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.8953

CBSA Code	Urban Area (Constituent Counties)	Wage Index
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9191
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9663
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	0.9672
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9657
27060	Ithaca, NY Tompkins County, NY	0.9842
27100	Jackson, MI Jackson County, MI	0.9155
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8042
27180	Jackson, TN Chester County, TN Madison County, TN	0.8404
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.8884
27340	Jacksonville, NC Onslow County, NC	0.7807
27500	Janesville, WI Rock County, WI	0.9415
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8434
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.8105
27780	Johnstown, PA Cambria County, PA	0.8090
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7757
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8214
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0292
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0619
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	0.9652
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9976
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8798

CBSA Code	Urban Area (Constituent Counties)	Wage Index
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7588
28740	Kingston, NY Ulster County, NY	0.9075
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7842
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9130
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9803
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9289
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8489
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8196
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0781
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0235
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8447
29540	Lancaster, PA Lancaster County, PA	0.9344
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0298
29700	Laredo, TX Webb County, TX	0.7914
29740	Las Cruces, NM Dona Ana County, NM	0.9296
29820	Las Vegas-Paradise, NV Clark County, NV	1.2099
29940	Lawrence, KS Douglas County, KS	0.8533
30020	Lawton, OK Comanche County, OK	0.8285
30140	Lebanon, PA Lebanon County, PA	0.7807
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9358
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.8903
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.8817
30620	Lima, OH Allen County, OH	0.9271
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9617
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	0.8546
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8794
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8563

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31020	Longview, WA Cowlitz County, WA	1.0296
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2130
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	0.8896
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8847
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8694
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9202
31460	Madera-Chowchilla, CA Madera County, CA	0.7986
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1294
31700	Manchester-Nashua, NH Hillsborough County, NH	0.9869
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.7847
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9083
31900	Mansfield, OH Richland County, OH	0.8918
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3640
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.8837
32780	Medford, OR Jackson County, OR	1.0061
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	0.9268
32900	Merced, CA Merced County, CA	1.2359
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0128
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9470
33260	Midland, TX Midland County, TX	0.9711
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0183

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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	1.1143
33540	Missoula, MT Missoula County, MT	0.8921
33660	Mobile, AL Mobile County, AL	0.7960
33700	Modesto, CA Stanislaus County, CA	1.2104
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7993
33780	Monroe, MI Monroe County, MI	0.8684
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8442
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8137
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7041
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0363
34620	Muncie, IN Delaware County, IN	0.8206
34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.9809

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34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8738
34900	Napa, CA Napa County, CA	1.4604
34940	Naples-Marco Island, FL Collier County, FL	0.9698
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	0.9457
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2315
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1460
35300	New Haven-Milford, CT New Haven County, CT	1.1515
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	0.9070

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35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.2955
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8872
35840	North Port-Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	0.9481
35980	Norwich-New London, CT New London County, CT	1.1215
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6354
36100	Ocala, FL Marion County, FL	0.8468
36140	Ocean City, NJ Cape May County, NJ	1.0879
36220	Odessa, TX Ector County, TX	0.9436
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9267
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	0.8877
36500	Olympia, WA Thurston County, WA	1.1269
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	0.9583
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9163
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9566
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8370
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2377
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9211
37380	Palm Coast, FL Flagler County, FL	0.8405
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.7954
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7455
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8299
37764	Peabody, MA Essex County, MA	1.0979
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8254

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37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9149
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0803
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0642
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8012
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8605
38340	Pittsfield, MA Berkshire County, MA	1.0371
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9507
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4326
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9899
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	1.1476
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.0723
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1354
39140	Prescott, AZ Yavapai County, AZ	1.2234
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	1.0714
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9321
39380	Pueblo, CO Pueblo County, CO	0.8721
39460	Punta Gorda, FL Charlotte County, FL	0.8759
39540	Racine, WI Racine County, WI	1.0580
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9811
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0442
39740	Reading, PA Berks County, PA	0.8904
39820	Redding, CA Shasta County, CA	1.4134
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0419

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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	0.9661
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1570
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8827
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.0942
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8595
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0033
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0026
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9034
40660	Rome, GA Floyd County, GA	0.8635
40900	Sacramento-Arden-Arcade-Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4053
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8728
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1042
41100	St. George, UT Washington County, UT	0.9133
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0302
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9090
41420	Salem, OR Marion County, OR Polk County, OR	1.1133
41500	Salinas, CA Monterey County, CA	1.5686
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9005

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41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9266
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8303
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.8998
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1979
41780	Sandusky, OH Erie County, OH	0.8686
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5733
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4560
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6703
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.4296
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.2915
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2162
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.1909

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42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6740
42140	Santa Fe, NM Santa Fe County, NM	1.0847
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6143
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.8907
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8238
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1556
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9097
43100	Sheboygan, WI Sheboygan County, WI	0.9233
43300	Sherman-Denison, TX Grayson County, TX	0.8279
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8536
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9091
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9299
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9948
43900	Spartanburg, SC Spartanburg County, SC	0.9383
44060	Spokane, WA Spokane County, WA	1.0571
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9130
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0251
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8371
44220	Springfield, OH Clark County, OH	0.9234
44300	State College, PA Centre County, PA	0.8779
44600	Steubenville-Weirton, OH-WV Jefferson County, OH Brooke County, WV Hancock County, WV	0.7315
44700	Stockton, CA San Joaquin County, CA	1.2644
44940	Sumter, SC Sumter County, SC	0.7860
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9905
45104	Tacoma, WA Pierce County, WA	1.1343
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8806
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9054

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45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9205
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.7748
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9432
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8952
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0150
46060	Tucson, AZ Pima County, AZ	0.9480
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8793
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8843
46340	Tyler, TX Smith County, TX	0.8065
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8471
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.7941
46700	Vallejo-Fairfield, CA Solano County, CA	1.4931
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8219
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0534
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	0.8961
47300	Visalia-Porterville, CA Tulare County, CA	1.0738
47380	Waco, TX McLennan County, TX	0.8403
47580	Warner Robins, GA Houston County, GA	0.8028
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9648

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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	1.0723
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8462
48140	Wausau, WI Marathon County, WI	0.9563
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	0.9615
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9934
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6675
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8898
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9566
48700	Williamsport, PA Lycoming County, PA	0.7256
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0580
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9202
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0002
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8939
49340	Worcester, MA Worcester County, MA	1.1012
49420	Yakima, WA Yakima County, WA	1.0067
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3536
49620	York-Hanover, PA York County, PA	0.9983
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8625
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1043
49740	Yuma, AZ Yuma County, AZ	0.9283

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

Table 2—RY 2012 WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

State Code	Nonurban Area	Wage Index
1	Alabama	0.7380
2	Alaska	1.2626
3	Arizona	0.9095
4	Arkansas	0.7222
5	California	1.2056
6	Colorado	0.9933
7	Connecticut	1.1128
8	Delaware	0.9757
10	Florida	0.8409
11	Georgia	0.7566
12	Hawaii	1.1189
13	Idaho	0.7556
14	Illinois	0.8343
15	Indiana	0.8391
16	Iowa	0.8545
17	Kansas	0.7981
18	Kentucky	0.7830
19	Louisiana	0.7712
20	Maine	0.8588
21	Maryland	0.9175
22	Massachusetts[1]	1.1769
23	Michigan	0.8555
24	Minnesota	0.9038
25	Mississippi	0.7620
26	Missouri	0.7655
27	Montana	0.8517
28	Nebraska	0.8911
29	Nevada	0.9350
30	New Hampshire	1.0207
31	New Jersey[1]	-----
32	New Mexico	0.8911
33	New York	0.8185
34	North Carolina	0.8359
35	North Dakota	0.6831
36	Ohio	0.8561
37	Oklahoma	0.7860
38	Oregon	1.0029
39	Pennsylvania	0.8480
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	-----
42	South Carolina	0.8413
43	South Dakota	0.8536
44	Tennessee	0.7886
45	Texas	0.7806
46	Utah	0.8649
47	Vermont	0.9591
48	Virgin Islands	0.7993
49	Virginia	0.7841
50	Washington	1.0184
51	West Virginia	0.7474
52	Wisconsin	0.9186
53	Wyoming	0.9528
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 FY 2011. The rural Massachusetts wage index is calculated as the average of all contiguous CBSAs. The Puerto Rico wage index is the same as FY 2010.

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