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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1474–F]

RIN 0938–AL95

Medicare Program; Changes to the Inpatient Rehabilitation Facility Prospective Payment System and Fiscal Year 2004 Rates

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

ACTION: Final rule.

SUMMARY: In this final rule, we are establishing the prospective payment rates for inpatient hospital services furnished under Medicare by inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2004, as required under section 1886(j)(3)(C) of the Social Security Act (the Act). As required by law and regulations, we are specifying the classification and weighting factors for the IRF case-mix groups and providing a description of the methodology and data used in computing the prospective payment rates for FY 2004. These rates are applicable to discharges occurring on or after October 1, 2003 and before October 1, 2004.

In addition, we are revising and clarifying policies governing the payment for inpatient hospital services furnished by IRFs under the IRF PPS.

DATES: Effective: October 1, 2003. The updated IRF prospective payment rates are applicable for discharges on or after October 1, 2003 and on or before September 30, 2004 (FY 2004).

FOR FURTHER INFORMATION CONTACT: Robert Kuhl, (410) 786–4597 (General information) Pete Diaz (410) 786–1235 (Patient assessment instrument and other patient assessment issues); Nora Hoban, (410) 786–0675 (Payment system, calculation of IRF payment rates, update factors, relative weights/case-mix index, and payment adjustments).

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

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Acronyms

BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
CMGs Case-mix groups
CMI Case-mix index
CMP Competitive medical plan
CMS Centers for Medicare & Medicaid Services
FY Federal fiscal year
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
HMO Health maintenance organization
IPPS Acute care hospital inpatient prospective payment system
IRF Inpatient rehabilitation facility
IRF PAI Inpatient rehabilitation patient assessment instrument
IRF PPS Inpatient rehabilitation facility prospective payment system
JCAH Joint Commission on Accreditation of Hospitals
JCAHO Joint Commission on Accreditation of Hospital Organizations
LTCH Long-term care hospital
MedPAR Medicare Provider Analysis and Review File

PPS Prospective payment system
RIC Rehabilitation impairment category
SNF Skilled nursing facility

I. Background

A. Overview of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

Section 1886(j) of the Social Security Act (the Act) provides for the implementation of a prospective payment system under Medicare for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit of a hospital (referred to as an inpatient rehabilitation facility (IRF)). Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act give the Secretary of Health and Human Services (the Secretary) discretion in defining a rehabilitation hospital and rehabilitation unit of a hospital. The regulations at 42 CFR 412.23(b), 412.25, and 412.29, specify the criteria for a hospital to be classified as a rehabilitation hospital or rehabilitation unit. Hospitals and units meeting such criteria are eligible to be paid on a prospective payment basis as an IRF under the IRF PPS.

Payments made under the IRF PPS cover inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs), but not costs of approved educational activities, bad debts, and other services or items outside the scope of the IRF PPS. Covered rehabilitation services include services for which benefits are provided under Medicare Part A (Hospital Insurance).

Payments under the IRF PPS are made on a per discharge basis. A patient classification system is used to classify patients in IRFs into case-mix groups (CMGs). The IRF PPS uses Federal prospective payment rates across distinct CMGs. A majority of the CMGs are constructed using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). Special CMGs are constructed to account for very short stays, and for patients who expire in the IRF.

For each CMG, we develop relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors account for the relative difference in resource use across all CMGs. Within each CMG, the weighting factors are ''tiered'' based on the estimated effect that the existence of certain comorbidities have on resource use.

The Federal prospective payment rates are established using a standard payment amount (also referred to as the budget neutral conversion factor). For each of the tiers within a CMG, the relative weighting factors are applied to the budget neutral conversion factor to compute the unadjusted Federal prospective payment rates.

Adjustments that account for geographic variations in wages (wage index), for the percentage of low-income patients, and for facilities located in a rural area are applied to the unadjusted Federal prospective payment rates. In addition, adjustments are made for early transfers of patients, interrupted stays, and high-cost outliers (cases with unusually high costs).

(We note that, for cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, IRFs either transitioned into the prospective payment system and received a ''blended payment,'' or elected to be paid 100 percent of the Federal IRF PPS rate. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), the transition methodology has expired and payments for all IRFs are now based on 100 percent of the adjusted Federal prospective payment under the IRF PPS.)

Implementing regulations for the IRF PPS are located in 42 CFR part 412, subpart P. Regulations governing the requirements for classification of hospitals as IRFs are located in 42 CFR 412.22, 412.23, 412.25 and 412.29.

A complete discussion of the development of the IRF PPS is included in the August 7, 2001 final rule (66 FR 41316). We also have established a CMS Web site that contains useful information regarding the IRF PPS. The Web site URL is *http://www.cms.hhs.gov/providers/irfpps/default.asp* and may be accessed to download or view publications, software, and other information pertinent to the IRF PPS.

B. Requirements for Updating the Prospective Payment Rates Under the IRF PPS

Section 412.628 of the regulations requires us to publish information pertaining to the IRF prospective payment rates in the **Federal Register**, on or before August 1 of the preceding fiscal year. We are required to include in the **Federal Register** document the classifications of the IRF case-mix groups (CMGs), the weighting factors that are applied to the CMG in determining the payment rate, and a description of the methodology and data used to compute the prospective payment rates for the applicable fiscal year.

The initial FY 2002 IRF prospective payment rates were established on August 7, 2001 in a final rule entitled ''Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities (CMS–1069–F)'' in the **Federal Register** (66 FR 41316) and were effective for cost reporting periods beginning on or after January 1, 2002. On August 1, 2002, we published a notice in the **Federal Register** (67 FR 49928) that updated the IRF Federal prospective payment rates from FY 2002 to FY 2003 using the methodology specified in § 412.624 of the regulations. On July 1, 2002, we also published in the **Federal Register** (67 FR 44073) a correcting amendment to the August 1, 2001 final rule. Therefore, any reference in this final rule to the August 7, 2001 final rule includes the provisions effective in the correcting amendment.

As discussed in section II of this preamble, on May 16, 2003, we issued a proposed rule in the **Federal Register** (68 FR 26786) to update the IRF Federal prospective payment rates from FY 2003 to FY 2004, to be effective for discharges occurring on or after October 1, 2003 and before October 1, 2004. For the proposed FY 2004 updates, we used the same classifications and weighting factors that were used for the IRF CMGs set forth in the August 7, 2001 final rule to update the IRF Federal prospective payment rates from FY 2002 to FY 2003.

C. Operational Overview of the IRF PPS

In accordance with existing regulations at § 412.606, upon the admission and discharge of a Medicare Part A fee-for-service patient, the IRF is required to complete the appropriate sections of a patient assessment instrument. CMS has established the Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF-PAI) for this purpose. All required data must be electronically encoded into the IRF's PAI software product. Generally, the software product includes patient grouping programming called the GROUPER software. The GROUPER software uses specific PAI data elements to classify (or group) a patient into a distinct CMG and account for the existence of any relevant comorbidities. The GROUPER software produces a 5-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last 4 digits represent the distinct CMG number. (Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available at the CMS Web site at *http://*

www.cms.hhs.gov/providers/irfpps/default.asp).

When a patient is discharged, the IRF completes the Medicare claim (UB–92 or its equivalent) using the 5-digit CMG number and sends it to the appropriate Medicare fiscal intermediary. (Claims submitted to Medicare must comply with the electronic claim requirements found at *http://www.cms.hhs.gov/providers/edi/default.asp.* All submitted claims must also be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) program claim memoranda issued by us and also published at that website, and as listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600. Instructions for the limited number of claims submitted to Medicare on paper are located in Part 3 section 3604 of the Medicare Intermediary Manual.) The Medicare fiscal intermediary processes the claim through its software system. This software system includes pricing programming called the PRICER software. The PRICER software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths. The PRICER software also applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments.

D. Issuance of Proposed Rule on the FY 2004 Updates

On May 16, 2003, we issued in the **Federal Register** (68 FR 26788) a proposed rule in which we proposed to update the Federal prospective payments rates under the IRF PPS and to make revisions and clarifying changes to the policies governing the implementation of the IRF PPS. A summary of our proposal follows:

We proposed to use FY 1999 acute care hospital wage data to compute the IRF wage indices for FY 2004. (For FY 2003, we used FY 1997 acute care hospital wage data to compute the IRF wage indices.) We believe that the FY 1999 acute care hospital data are the best available because they are currently the most recent complete final data. However, any adjustments or updates made under section 1886(j)(6) of the Act must be made in a budget neutral manner. Therefore, we proposed to apply the methodology to update the wage indices for FY 2004, using 1999 acute care hospital data in a budget neutral manner.

We also proposed to update the underlying data used to compute the IRF market basket index. As explained in Appendix D of the August 7, 2001 final rule, we used 1992 cost report data as the underlying data to develop the excluded hospital with capital market basket that formed the basis of the FY 2002 and FY 2003 IRF market basket index. We proposed to use 1997 cost report data, which are the most recent data available to form the basis of the FY 2004 IRF market basket index.

We further proposed to modify or clarify certain criteria for a hospital or a hospital unit to be classified as an IRF. As stated in the August 7, 2001 final rule, we did not change the survey and certification procedures applicable to entitled seeking classification as an IRF. Currently, to be paid under the IRF PPS, a hospital or unit of a hospital must first be deemed excluded from the diagnosis-related group (DRG)-based acute care hospital PPS (IPPS) under the general requirements in subpart B of part 412 of the regulations. Second, the excluded hospital or unit must meet the conditions for payment under the IRF PPS at § 412.604 of the regulations.

Lastly, we proposed to modify or clarify existing provisions of the IRF PPS relating to the patient assessment process and the transmission of patient data to CMS. However, we note that we did not propose any refinements or changes to the FY 2002 case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments, due to the lack of available data to make such changes.

We received more than 6,900 timely items of correspondence containing multiple comments on the May 16, 2003 proposed rule. Major issues addressed by commenters included the following: enforcement of the 75 percent rule (as discussed below); definition of a discharge; waiver of the penalty for late transmission of the IRF-PAI; and changes to the outlier policies. Summaries of the public comments received and our responses to those comments are set forth below under the appropriate subject headings.

Many commenters did not agree with our stated intention to enforce the existing regulations at § 412.23(b) whereby at least 75 percent of an IRF's patient population must receive intensive rehabilitation services for treatment of one or more of ten conditions specified in regulations for the facility to be classified as an IRF (also known as the 75 percent rule). In addition, on May 19, 2003, we hosted an IRF Town Hall meeting in Baltimore, MD where patients, providers, and other interested parties presented their views on the May 16, 2003 proposed rule. We received numerous suggestions concerning changes to the 75 percent rule. Based on the level of public interest generated by this issue, we have decided to revisit our policies concerning the 75 percent rule. In the very near future, we will be issuing a proposed rule in the **Federal Register** that will contain a full discussion of our proposed changes to the existing 75 percent rule.

II. Requirements and Conditions for Payment Under the IRF PPS

A. Background

Existing regulations at § 412.604 describe the conditions that must be met for an IRF to be paid under the IRF PPS. Section 412.604(a) states the general requirements for payment to be made under the IRF PPS and the effects on Medicare payment if the conditions described the section are not met. Section 412.604(b) states the existing regulatory provisions that must be met for a hospital or unit of a hospital to be excluded from the IPPS and to be classified as an IRF. Section 412.604(c) requires an IRF to complete a patient assessment instrument for each Medicare Part A fee-for-service patient admitted. Section 412.604(d) describes the limitations on IRFs for charging beneficiaries who receive Medicare covered services. Section 412.604(e) describes the requirements associated with furnishing inpatient hospital services directly or under arrangement. Section 412.604(f) states the reporting and recordkeeping requirements that IRFs must meet.

B. Provisions of the May 16, 2003 Proposed Rule

In the May 16,2003 proposed rule, we described several proposed changes to the conditions or underlying requirements of § 412.604. Below we discuss the proposed change to the general conditions and requirements. The specific changes relating to classification criteria are addressed under section II.C. of this preamble.

As stated earlier, under § 412.604(a), we specify the general conditions for payment to be made under the IRF PPS and the effects on Medicare payment if the conditions are not met. We proposed to make a change in paragraph (a)(2) relating to the entity that takes the action if the IRF fails to comply with the conditions of the section; that is to withhold (in full or in part) or reduce Medicare payment to the IRF until the facility provides adequate assurances of compliance, or to classify the IRF as an inpatient hospital that is subject to the conditions of 42 CFR part 412, subpart

C and is paid under the prospective payment systems specified in § 412.1(a)(1). We proposed to specify that either CMS or the Medicare fiscal intermediary may take such action, as appropriate.

Comment: We did not receive any comments concerning this proposed change.

Response: We are therefore adopting the proposed change to § 412.604(a)(2) to indicate that CMS or the Medicare fiscal intermediary may take actions if the IRF does not meet the conditions specified in the section.

C. Classification Criteria for IRFs Subject to the IRF PPS

Section 412.604(b) states that, subject to the special payment provisions of § 412.22(c), an IRF must meet the general criteria set forth in § 412.22 and the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in § 412.23(b), § 412.25, and § 412.29 for exclusion from the IPPS specified in § 412.1(a)(1). These general criteria are located under 42 CFR part 412, subpart B of the regulations. In the August 7, 2001 final rule implementing the IRF PPS, we did not make any changes to the exclusion criteria and requirements to be classified as an IRF under subpart B of part 412. Since the implementation of the IRF PPS, a number of questions have been raised on the application of some of these requirements and the necessity of other criteria.

Below, we discuss each requirement as it relates to the classification of an IRF, the proposed changes, if any, included in the May 16, 2003 proposed rule, the public comments received, and the provisions of this final rule.

1. Relationship to IPPS

Section 1886 to the Act established a PPS for acute care inpatient hospital services for cost reporting periods beginning on or after October 1, 1983. Under section 1886(d)(1)(B) of the Act, several types of hospitals and units of hospitals are excluded from the IPPS. Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act specify that rehabilitation hospitals and units (as defined by the Secretary) are excluded from the IPPS. The Secretary has defined rehabilitation hospitals and units in regulations at 42 CFR part 412 subpart B.

Extensive discussion and public comments on developing the criteria under which a hospital or unit of a hospital can be excluded from the IPPS as an IRF began with the September 1, 1983 publication of the interim final rule with comment period in the **Federal Register** (48 FR 39752). (That interim final rule discussed the provisions necessary to implement section 1886 of the Act.) On January 3, 1984, we published in the **Federal Register** a final rule (49 FR 234) that responded to public comments on the provisions of the September 1, 1983 interim final rule and established the initial set of criteria that must be met by a hospital or unit of a hospital seeking exclusion from the IPPS as an IRF. Since the publication of these earlier rules, the criteria to be an IRF have been revised and codified at 42 CFR part 412, subpart B of the existing Medicare regulations.

2. IRF Hospital Services Furnished to HMOs or CMP Enrollees

Section 412.20(b) of the existing regulations state that covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet the conditions of § 412.604 are paid under the IRF PPS described in subpart P of 42 CFR part 412.

In the May 16, 2003 proposed rule, we proposed to redesignate existing § 412.20(b) as § 412.20(b)(1) and add § 412.20(b)(2) to ensure that inpatient hospital services will not be paid under the IRF PPS if the services are paid by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not to have CMS make payments to an IRF for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees under 42 CFR Part 417. This provision is similar to the provision at § 412.20(d)(3) that prohibits payments under the IPPS for similar HMO or CMP services.

Comment: We did not receive any comments concerning this proposed change.

Response: Therefore, we are adopting the proposed redesignation of existing § 412.20(b) as § 412.20(b)(1) and add § 412.20(b)(2) to ensure that inpatient hospital services will not be paid under the IRF PPS if the services are paid by a HMO or CMP that elects not to have CMS make payments to an IRF for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees under 42 CFR part 417.

3. Bed-Number Criteria for Freestanding Satellite IRFs

Section 412.22(h) describes the requirements to be a satellite facility of a hospital that is excluded from the IPPS. The following describes our proposed changes in the May 16, 2003 proposed rule to eliminate the provision that limits the bed size of a satellite IRF.

In the July 30, 1999 **Federal Register** (64 FR 41540), we revised § 412.22(h) to require that in order to be excluded from the acute care hospital inpatient PPS, a satellite of a hospital: (1) Effective for cost reporting periods beginning on or after October 1, 2002, is not under the control of the governing body or chief executive officer of the hospital in which it is located, and furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located; (2) must maintain admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available; (3) cannot commingle beds with beds of the hospital in which it is located; (4) must be serviced by the same FI as the hospital of which it is a part; (5) must be treated as a separate cost center of the hospital of which it is a part; (6) for cost reporting and apportionment purposes, must use an accounting system that properly allocates costs and maintains adequate data to support the basis of allocation; and (7) must report costs in the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part. In addition, the satellite facility must independently comply with the qualifying criteria for exclusion from the IPPS. Lastly, the total number of State-licensed and Medicare-certified beds (including those of the satellite facility) for a hospital (other than a children's hospital) that was excluded from the IPPS for the most recent cost reporting period beginning before October 1, 1997, may not exceed the hospital's number of beds on the last day of that cost reporting period.

In § 412.22(h)(1), we define a satellite as ''a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.'' Satellite arrangements exist when an existing hospital that is excluded from the IPPS and that is either a freestanding hospital or a hospital-within-a-hospital under § 412.22(e) shares space in a building or on a campus occupied by another hospital in order to establish an additional location for the excluded hospital. The July 30, 1999 IPPS final rule (64 FR 41532–41534) includes a detailed discussion of our policies regarding Medicare payments for satellite facilities of hospitals excluded from the IPPS.

In accordance with section 1886(b) of the Act, as amended by sections 4414 and 4416 of Pub. L. 105–33, we established two different target limits on payments to excluded hospitals, depending upon when the IRF was established. The target amount limit for an IRF with a cost reporting period beginning before October 1, 1997 was set at the 75th percentile of the target amounts of IRFs, as specified in § 413.40(c)(4)(iii), updated to the applicable cost reporting period. For IRFs with a cost reporting period beginning on or after October 1, 1997, under section 4416 of Pub. L. 105–33, the payment amount for the hospital's first two 12-month cost reporting periods, as specified at § 413.40(f)(2)(ii)(A) and (B), could not exceed 110 percent of the national median of target amounts of IRFs for cost reporting periods ending during FY 1996, updated by the hospital market basket increase percentage to the first cost reporting period in which the IRF receives payment.

Because we were concerned that a number of pre-1997 excluded hospitals (including IRFs), governed by § 413.40(c)(4)(iii), would seek to create satellite arrangements in order to avoid the effect of the lower payment caps that would apply to new hospitals under § 413.40(f)(2)(ii), we established rules regarding the exclusion of and payments to satellites of existing facilities. If the number of beds in the hospital or unit (including both the base hospital or unit and the satellite location) exceeds the number of State-licensed and Medicare-certified beds in the hospital or unit on the last day of the hospital's or unit's last cost reporting period beginning before October 1, 1997, the facility would be paid under the IPPS. Therefore, while an excluded hospital or unit could ''transfer'' bed capacity from a base facility to a satellite, if it increased total bed capacity beyond the level it had in the most recent cost reporting period before October 1, 1997 (*see* 64 FR 41532–41533, July 30, 1999), the hospital will not be paid as a hospital excluded from the IPPS. However, no similar limitation was imposed with respect to the number of total beds in excluded hospitals and units and satellite facilities of those excluded hospitals and units established after October 1, 1997, since those excluded hospitals and units were subject to the lower payment limits of section 4416 of Pub. L. 105–33, and would, therefore, not benefit from the higher payment cap on target amounts under § 413.40(c)(4) by creating a satellite facility.

On March 22, 2002, we published a proposed rule in the **Federal Register** (67 FR 13416) that set forth the proposed Medicare PPS for long-term care hospitals (LTCHs). Discussion of the comments received on that LTCH proposed rule and our responses were published in a final rule on August 30, 2002 **Federal Register** (67 FR 55954). Specific comments received were discussed on page 56013 of the LTCH final rule that urged us to eliminate the bed-number criteria in § 412.22(h)(2)(i) for pre-1997 IRFs since the applicable PPS is fully phased in. The rationale for the bed-number criteria provision at § 412.22(h)(2)(i) was the potential for circumventing the PPS by creating a satellite location that could have their payment based on a higher TEFRA target amount cap. However, once an IRF's payment under the IRF PPS does not include a TEFRA-based payment (referred to as the facility-specific payment under the transition period described in § 412.626) and is based on 100 percent of the Federal prospective payment rate, we believe that the need for the bed-number criteria does not exist because IRF prospective payments will be the same regardless of when the IRF was established. Because all IRFs now will be paid 100 percent of the Federal prospective payment rates, in the May 16, 2003 proposed rule, we proposed to eliminate the bed-number criteria by revising § 412.22(h) relating to freestanding satellite IRFs. We also proposed to eliminate the bed-number criteria for IRF satellite units of a hospital by revising § 412.25(e) to conform to the proposed change in § 412.22(h).

Comment: We received a number of comments in support of the proposed elimination of the bed-number criteria. However, one commenter was concerned with the increase in paperwork burden.

Response: We are adopting the proposed elimination of the bed-number criteria by revising § 412.22(h) for freestanding IRFs and § 412.25(e) for IRF units. The commenter was not specific on how this change would increase paperwork burden. We believe that this change makes the policy of creating a satellite IRF less restrictive and less burdensome to verify that the bed-number criteria were met. Accordingly, we do not believe that this change increases paperwork burden and, thus, we did not include an estimate of time associated with eliminating the bed-number criteria in the Collection of Information section of the May 16, 2003 proposed rule.

4. Technical Changes

a. *Excluded Rehabilitation Units:* Additional Requirements:

Under § 412.29(a), an IRF unit must have met either the requirements for new units or converted units under § 412.30. Section 412.29(a)(2) contains an incorrect reference to the requirements for converted units as ''§ 412.30(b).'' The correct reference to the requirements for converted units is § 412.30(c). Accordingly, we proposed to make a technical correction by changing the reference in § 412.29(a)(2) to state ''Converted units under § 412.30(c).''

Comment: We did not receive any comments concerning this proposed technical correction.

Response: We are adopting the proposed technical correction to § 412.29(a)(2) to state ''Converted units under § 412.30(c).''

b. *Exclusion of New Rehabilitation Units and Expansion of Units Already Excluded:*

Under § 412.30(b)(2), a hospital that seeks exclusion of a new IRF unit may provide written certification that the inpatient population the hospital intends the unit to serve meets the requirements of § 412.23(b)(2). Section 412.30(b)(3) contains an incorrect reference to the required written certification described in ''paragraph (a)(2)'' of this section. The correct reference to the written certification is described in paragraph (2) of § 412.30(b). Accordingly, we proposed to make a technical correction by changing the current reference to § 412.30(a)(2) in § 412.30(b)(3) to state ''The written certification described in paragraph (b)(2) * * *.'' In the proposed rule, we incorrectly stated that the reference to § 412.23(a)(2) was in § 412.23(b)(3). It should have read that the reference to § 412.30(a)(2) was in § 412.30(b)(3).

Comment: We did not receive any comments concerning this proposed technical correction.

Response: We are adopting the proposed technical correction to § 412.30(b)(3) to state ''The written certification described in paragraph (b)(2) * * *.''

Section 412.30(d)(1) defines new bed capacity for the purposes of expanding an existing excluded IRF unit. Section § 412.30(d)(2)(i) contains an incorrect reference to the definition of new bed capacity under ''paragraph (c)(1)'' of this section. The correct reference to the definition of new bed capacity is paragraph (d)(1). Accordingly, we proposed a technical correction to change the current reference to

paragraph (c)(1) under paragraph (d)(2)(i) to state ''under paragraph (d)(1) of this section.''

Comment: We did not receive any comments concerning this proposed technical correction.

Response: We are adopting the proposed technical correction to change the current reference to paragraph (c)(1) under paragraph (d)(2)(i) to state ''under paragraph (d)(1) of this section.''

III. Research To Support Case-Mix Refinements to the IRF PPS

A. Research on IRFs

As described in the August 7, 2001 final rule, we contracted with the RAND Corporation (RAND) to analyze IRF data to support our efforts in developing the CMG patient classification system and the IRF PPS. As discussed below, we are continuing our contract with RAND to support us in developing refinements to the classification and PPS, and in developing a system to monitor the effects of the IRF PPS. In addition, under a separate contract, we are developing and defining measures to monitor the quality of care and services provided to Medicare beneficiaries receiving care in an IRF.

B. RAND Research Background

In 1995, the RAND Corporation (RAND) began extensive CMS-sponsored research to assist us in developing a per discharge-based inpatient rehabilitation PPS model using the patient classification system known as Functional Independence Measures-Functional Related Groups (FIM–FRGs) using 1994 data. Initial results of RAND's earliest research were revealed in September 1997 and are contained in two reports available through the National Technical Information Service (NTIS). The reports are entitled ''Classification System for Inpatient Rehabilitation Patients—A Review and Proposed Revisions to the Functional Independence Measure-Function Related Groups,'' NTIS order number PB98–105992INZ; and ''Prospective Payment System for Inpatient Rehabilitation,'' NTIS order number PB98–106024INZ.

In summarizing these reports, RAND found in the research based on 1994 data that, with limitations, the FIM–FRGs were effective predictors of resource use based on the proxy measurement: length of stay. FRGs based upon FIM motor score, cognitive scores, and age remained stable over time. Researchers at RAND developed, examined, and evaluated a model payment system based upon FIM–FRG classifications that explains approximately 50 percent of patient costs and approximately 60 percent to 65 percent of the costs at the facility level. Based on this earlier analysis, RAND concluded that an IRF PPS using this model is feasible.

In July 1999, we contracted with RAND to update the earlier study. The update used their earlier research and included an analysis of FIM data, the FRGs, and the model rehabilitation PPS using more recent data from a greater number of IRFs. The purpose of updating the earlier research was to develop the underlying data necessary to support the Medicare IRF PPS based on case-mix groups for the original IRF PPS proposed rule. RAND expanded the scope of their earlier research to include the examination of several payment elements, such as comorbidities, facility-level adjustments, and implementation issues, including evaluation and monitoring. This research was used in our development of the IRF PPS. RAND issued a report on its research which can be found on our Web site at *http://cms.hhs.gov/providers/irfpps/research.asp.*

C. Continuing Research

RAND's data efforts over the past year were concentrated on archiving data from the first phase of the project, constructing the analytic files for monitoring special studies, and preparing for post-IRF PPS data that will be used for monitoring and for refinement. RAND's monitoring effort seeks to measure changes in IRF care, post-IRF care, and postacute care following implementation of the IRF PPS. The refinement effort necessitates that the methods used to create the initial set of CMGs weights and facility adjustments be applied to more recent IRF data.

Section 125(b) of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act (BBRA), Pub. L. 106–113, provides that the Secretary shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the IRF prospective payment system. A report on the study must be submitted to the Congress not later than 3 years after the date the IRF prospective payment system is first implemented. Accordingly, to continue RAND's research, data from other health care settings are needed to assess the impact on utilization and beneficiary access to services because the IRF PPS can have an impact among other settings that deliver rehabilitative services. If we only analyzed data from IRFs, our assessment of utilization and access would not be complete. In addition to the data obtained from the IRF Medicare claims, functional measures from the IRF PAI, and cost reports, other data are required to show the utilization and access of rehabilitative services delivered in other settings, such as SNFs, LTCHs, home health agencies, and outpatient rehabilitation facilities. Analysis of these data may show changes in utilization of inpatient rehabilitation services and if the types or severity of patients treated in IRFs differs significantly from the data used to create the CMGs, case-mix refinements may be needed.

In the next phase of their research, RAND will be developing and testing possible improvements to the payment system using existing data. This analysis will focus on potential improvements to the methods used to establish the CMGs, facility adjustments (such as, teaching, rural, and low-income adjustments), and comorbidities.

In constructing the CMGs for the IRF PPS, one of our primary goals was to develop a payment methodology that would match payment to resource use as closely as possible. It is important to continue to examine the IRF PPS to ensure that the system remains a good predictor of resource use over time. Further, more complete data will be available in which we can assess the reliability and validity of the IRF PPS. We also expect improvements with certain data elements. For example, prior to implementation of the IRF PPS, IRFs were not required to code comorbidities. As a result of implementing the IRF PPS, we expect that IRFs will improve coding comorbidities because collection of this information may affect their payment amount. These improved data will allow us to determine the effects various conditions have on the cost of a case.

RAND will use post-IRF PPS data when they become available, as well as existing data to support their research. RAND research includes: analyses of methodological improvements in the creation of CMGs, methodological improvements to the statistical approaches used to derive payment adjustments and characterizing IRFs into groups based on their case-mix. Currently, RAND does not have enough post-IRF PPS data to analyze potential modifications to the classification and payment systems. Further, we will need a sufficient amount of these data to be able to determine if future refinements are needed. Because IRFs began to be paid under the IRF PPS based on their cost report start date that occurred on or after January 1, 2002, sufficient data will not be available for those facilities

whose cost report start date occurs later in the calendar year. Therefore, in this final rule, we are not changing the CMG classification system or the facility-level and case-level adjustments, other than the wage adjustment. The adopted changes for the wage adjustment are discussed in detail in section VI. of this final rule.

D. Staff Time Measurement Data

As described in the August 7, 2001 final rule, we contracted with Aspen Systems Corporation (ASPEN) to collect actual resource use or staff time measurement (STM) data in a sample of IRFs. Data were collected using the MDS–PAC patient assessment instrument. FIM data were collected at the same time. We believe that these data, which measure actual nursing and therapy time spent on patient care, may be used to enhance our ability to refine the CMGs.

RAND received ASPEN's analytical database in early spring 2002. After a brief period of working with the data, RAND discovered that their study required details that were not in this summary database. Specifically, about half of the cases within the analytic database had data for only the first part of the patient's stay. RAND needed to have explicit data that tracked how staff time usage changed throughout a patient's stay and the analytic database contained only the averages of the observed portions of the patient's stay. RAND also needed data on patients during the second part of their stay.

In late July 2002, RAND received the backup data, but did not assess it until late August 2002. Further technical questions about the data still exist and must be answered before the modeling of the data can occur.

E. Monitoring

A greater part of the ongoing work to be performed by RAND is an analysis to develop a potential system of indicators to monitor the impact and performance of the IRF PPS. As part of their analysis, RAND will case-mix adjust these measures and distinguish between those that will track the direct impact of PPS on IRFs and IRF patients, and those that will track changes in the pool of potential IRF patients. We anticipate that RAND will develop a set of possible indicators needed to monitor the IRF PPS, develop potential access to care models and measures, and define a possible measure of outcomes.

F. Need To Develop Quality Indicators for IRFs

The IRF PAI is the data collection instrument for IRFs. It contains a blend of FIM items and quality and medical needs questions. The quality and medical needs questions (which are currently collected on a voluntary basis) may need to be modified to encapsulate those data necessary for calculation of a quality indicator in the future. One of the primary tasks of the RAND contract is to identify quality indicators pertinent to the inpatient rehabilitation setting and determine what information is necessary to calculate those quality indicators. These tasks include reviewing literature and other sources for existing rehabilitation quality indicators. It also involves identifying organizations involved in measuring or monitoring quality of care in the inpatient rehabilitation setting. RAND will convene a technical expert panel to identify a series of quality indicators that can be measured using the IRF–PAI. In addition, quality indicators and data elements must be developed for calculation as well as the independent testing of the developed indicators.

We note that the National Library of Medicine, which is part of the National Institutes of Health within the Department of Health and Human Services, has entered into an agreement with the College of American Pathologists to license the Systematized Nomenclature of Medicine—Clinical Terms (SNOMED CT). SNOMED CT provides a common language that enables a consistent way of capturing, sharing, and aggregating health care data across specialties and sites of care. If in the future, CMS makes changes to the IRF PAI, we will consider whether SNOMED CT includes IRF PAI data terminology and we will consider including SNOMED CT terms. For further information, please visit SNOMED's Web site at *http://www.snomed.org* or the National Library of Medicine Web site at *http://www.nlm.hih.gov*.

IV. The IRF PPS Patient Assessment Process

A. Background

In the August 7, 2001 IRF PPS final rule (66 FR 41316), we described how an IRF would use the IRF Patient Assessment Instrument (PAI) to assess an IRF patient. Training on the IRF–PAI assessment process was conducted in Baltimore, Maryland, Chicago, Illinois, San Francisco, California, and Atlanta, Georgia during the fall of 2001. We also created videotapes of the training that we made available to IRFs free of charge. IFRs were instructed to go to the CMS IRF PPS website to request copies of the videotapes and to access electronic copies of the IRF–PAI manual, which contained detailed instructions regarding the completion of the IRF–PAI.

B. Patient Rights

Section 412.608 of the existing regulations specifies that prior to performing the IRF–PAI assessment, and in order to receive payment from Medicare, the IRF must inform the patient of the rights contained in this section. These rights are as follows:

(1) The right to be informed of the purpose of the patient assessment data collection;

(2) The right to have the patient assessment information collected kept confidential and secure;

(3) The right to be informed that the patient assessment information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(4) The right to refuse to answer patient assessment questions; and

(5) The right to see, review, and request changes on the patient assessment instrument.

In addition to the rights specified in § 412.608, a patient has privacy rights under the Privacy Act of 1974 (5 U.S.C 552a(e)(3)), and 45 CFR 5b.4(a)(3). We have elaborated on these privacy rights in this Preamble statement in order to avoid any confusion. The Privacy Act and 45 CFR 5b.4(a)(3) require that an individual be informed of the following: the authority by which individually identifiable information is being collected by a Federal agency and maintained in a system of records; whether providing the information is voluntary or mandatory; the principal purpose for collecting the information; the routine uses for release of the information; and the effect refusal to provide requested information may have on the individual. The Federal agency should be identified, as well as the location of the system of records. In order to ensure compliance with the Privacy Act of 1974 and 45 CFR 5b.4(a)(3), in the May 16, 2003 proposed rule, we proposed to revise § 412.608 to specify that, prior to performing the IRF–PAI assessment, an IRF clinician must give each Medicare inpatient specific privacy information forms.

We published these proposed privacy forms in Appendix B of the May 16, 2003 proposed rule (and are including them under the Appendix of this final rule). The first proposed form, entitled ''Privacy Act Statement—Health Care Records,'' is a detailed description of the patient's privacy rights under the Privacy Act of 1974. The second proposed form, entitled ''Data

Collection Information Summary for Patients in Inpatient Rehabilitation Facilities'' is the simplified plain language summary of the Privacy Act Statement—Health Care Records. We proposed to require that both of these forms be given to a patient before beginning the IRF–PAI assessment. These actions on the part of an IRF would fulfill the requirement that the patient be informed of the five rights specified in § 412.608. In addition, in this final rule, we have made technical changes to the proposed § 412.608. We have deleted proposed § 412.608(c) because it was redundant of proposed § 412.608(a)(2), and have redesignated proposed § 412.608(d) as § 412.608(c) and proposed § 412.608(e) as § 412.608(d). We note that when an IRF clinician gives a patient the forms entitled ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities'' and the ''Privacy Act Statement-Health Care Records'' prior to performing an assessment, these forms do not satisfy the privacy provisions contained in the HIPAA Privacy Rule (65 FR 82462 as modified by 67 FR 53182). For example, these forms do not meet the privacy notice requirements of the HIPAA Privacy Rule (*see* 45 CFR 164.520).

Health plans and health care providers must meet the notice requirements of the HIPAA Privacy Rule by giving a Notice of Privacy Practices to their patients. The Notice of Privacy Practices describes a health plan or health care provider's uses and disclosures of protected health information and the individual rights that patients have with respect to their protected health information.

Comment: One commenter suggested adding the text, ''simplified plain language,'' to the subtitle of the form entitled ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities.''

Response: We agree with the commenter and have revised the title of the ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities'' to include the phrase ''Simplified Plain Language'' as a subtitle.

Comment: One commenter requested that the two patient rights forms be posted on the IRF PPS website and that they also be made available in Spanish.

Response: We agree with the commenter and will post the two privacy forms on the IRF PPS website and make them available in Spanish.

Comment: We received one comment concerning patients' rights. The commenter supported the proposed change, however, several members of the commenter's organization have raised concerns about an additional paperwork burden.

Response: We disagree with the commenter and estimate that it will take no more than one minute to document the fact that the IRF has given a patient a copy of his or her rights, even assuming that the rights statement is the only handout. We anticipate that the rights statement will be one of several handouts that a patient would receive and that as a matter of prudent business and medical procedures, facilities have a mechanism in place to document that patients have been given all the necessary paperwork.

C. When the IRF–PAI Must Be Completed

Under existing § 412.606(b), an IRF must use the IRF–PAI to assess Medicare Part A fee-for-service inpatients. Section 412.610(c)(1)(i)(A) specifies that the admission assessment covers the first 3 calendar days of the inpatient's current IRF Medicare Part A fee-for-service hospitalization. Section 412.610(c)(1)(i)(B) specifies that the admission assessment reference date is the third day of the 3-day admission assessment time period. Section 412.610(c)(1)(i)(C) specifies that the IRF–PAI for the admission assessment must be completed on the calendar day that follows the admission assessment reference day.

We are concerned that IRFs are interpreting § 412.610(c)(1)(i)(C) to mean that they may not start to record data on the IRF–PAI before the calendar day that follows the admission assessment reference day. This interpretation is not our intent. The ''completion requirement'' of the IRF–PAI indicates the date that the IRF's staff must have completed its recording on the IRF–PAI of the assessment data that the IRF's clinical staff obtained during an assessment of the inpatient that was performed during the admission assessment time period. In other words, the date when the IRF–PAI must be completed is the deadline date when the process of recording data on the IRF–PAI must be finished. The IRF's staff is permitted to enter assessment data on the IRF–PAI prior to the deadline date.

D. Recording IRF-Data Based on a Patient's Performance

How data are recorded on the IRF–PAI is specified in the IRF–PAI item-by-item guide, entitled the ''IRF–PAI Training Manual Revised 01/16/02.'' The instructions contained in the IRF–PAI item-by-item guide are, when possible, very similar to the rules for coding the patient assessment instrument that we used as the model for the IRF–PAI. The model for the IRF–PAI was the patient assessment instrument published by Uniform Data System for Medical Rehabilitation (UDSmr).

The UDSmr rules for coding their assessment instrument specify that an item's score should reflect an inpatient's lowest level of functioning. Consequently, in order to be consistent with how an inpatient's functional performance was scored on the UDSmr patient assessment instrument, the IRF–PAI item-by-item guide, likewise, specifies that a patient's assessment must indicate the patient's lowest level of functioning.

During the admission assessment, an IRF clinician records different types of data on the IRF–PAI. We believe that the sources of the data recorded in the categories of the IRF–PAI entitled ''Identification Information,'' ''Admission Information,'' and ''Payer Information'' allows an IRF to quickly obtain and record these data. For these categories of data, the source of the data may be the patient, the patient's medical record, other patient documents, the patient's family, or a person that has personal knowledge of the patient.

In order to complete the data for the IRF–PAI categories entitled ''Function Modifiers'' and ''FIM™ Instrument,'' the clinician observes the patient's functional performance over the admission assessment time period, and makes clinical judgments regarding the patient's performance. Consequently, due to how the data for the Function Modifiers and FIM™ categories are obtained, we believe it is the time span that it takes to assess the patient's functional performance that will usually determine how long it takes to complete the admission assessment.

Page III–3 of the IRF–PAI manual states that when determining the level of a patient's functional performance, the clinician is to ''record the lowest (most dependent) score.'' We believe that the patient's functional performance improves in the time span between the patient's admission and discharge from the IRF. We also believe that on the patient's admission day and for the following next few days, a patient's functional performance is poor in comparison to functional performance on subsequent days of the patient's current IRF hospitalization. Therefore, during the part of the admission assessment that is the first or second day of the patient's current IRF hospitalization, we believe that a patient's functional performance will usually be scored as indicating the most

dependence or the lowest level of functioning.

As stated previously, the IRF's clinical staff is permitted to record assessment data on the IRF–PAI at any time during the admission assessment process. Also, as stated previously, we believe it is the scoring of a patient's functional performance that will determine how long it takes to complete the admission assessment. The combination of: (1) Being able to record assessment data at any time during the admission assessment, (2) the requirement that the lowest level of functional performance be recorded, and (3) the lowest level of functional performance that will usually occur on the first or second day of the admission assessment, makes it possible to finish obtaining and recording all the assessment data before the day that follows the admission assessment reference date. However, in accordance with § 412.610(c)(1)(i)(C), an IRF has until the day following the admission assessment reference day to complete the IRF–PAI.

In order to clarify that § 412.610(c)(1)(i)(C) does not prohibit the IRF from recording any or all of the data on the IRF–PAI before the day that follows the admission assessment reference day, in the May 16, 2003 proposed rule we proposed to revise § 412.610(c)(1)(i)(C) to indicate that the IRF–PAI must be completed by the calendar day that follows the admission assessment reference day.

Comment: A commenter expressed agreement with the proposed change.

Response: We are adopting the proposed change as final without modification.

E. Transmission of IRF–PAI Data

As specified in § 412.606(b), ''Patient assessment instrument,'' an IRF must use the IRF–PAI to assess Medicare Part A fee-for-service inpatients. There are nine categories of IRF–PAI assessment data. The nine categories are entitled ''identification information, admission information, payer information, medical information, medical needs, function modifiers, the FIM™ instrument, discharge information, and quality indicators''. The data from some of these categories are used to classify a patient into a CMG.

It is the CMG classification code, not the IRF–PAI raw data itself, that is part of the claim data the IRF submits to its fiscal intermediary when the IRF submits data in order to be paid for the services it furnished to the inpatient. We believe that an IRF's clinical staff will initially use the paper version of the IRF–PAI to record its assessment data. In accordance with § 412.610(d), the IRF would use the data that it recorded on the paper version of the IRF–PAI to enter the IRF–PAI data into an electronic version of the document. The electronic version of the IRF–PAI uses the patient assessment data to classify a patient into a CMG. Under the IRF PPS, it is the CMG payment code, along with other information that the IRF submits to the fiscal intermediary that will determine the payment the IRF receives for the services the IRF furnished to a Medicare Part A fee-for-service beneficiary.

Section 412.614 specifies that an IRF must transmit to us the IRF–PAI assessment data for each Medicare Part A fee-for-service inpatient. It is the electronic version of the IRF–PAI that enables an IRF to transmit the IRF–PAI data to us. We require that IRFs transmit IRF–PAI data so that we have the IRF–PAI data that are associated with the CMG payment code that the IRF submitted to its fiscal intermediary.

In most cases, an IRF will submit claims data, including the patient's CMG, to the fiscal intermediary in order to be paid for the services it furnished to a Medicare Part A fee-for-service inpatient. However, there are situations when the IRF would submit claims data to its fiscal intermediary, but the submission of the claims data is not for the purpose of being paid for any of the services the IRF furnished to a Medicare Part A fee-for-service inpatient.

In these situations, Medicare operational procedures that were in effect before implementation of the IRF PPS require an IRF to send claims data to the FI. The purpose of the IRF sending claims data to the FI in these situations is to enable Medicare to monitor a beneficiary's period of entitlement. For instance, an IRF must still send the fiscal intermediary claims data even if the inpatient's non-Medicare primary payer paid for all of the IRF services that the IRF furnished to the Medicare Part A fee-for-service inpatient. Another instance when the IRF must still send the FI claims data is when an inpatient's non-Medicare primary payer does not pay for any of the services, and these services also do not qualify for payment under the IRF PPS.

We want to relieve the IRF of the burden of transmitting IRF–PAI data to us when the IRF is not requesting that Medicare pay for any of the services the IRF furnished to a Medicare Part A fee-for-service inpatient. Accordingly, in the May 16, 2003 proposed rule, we proposed to revise § 412.614 to specify that paragraph (a) is a general rule.

We also proposed to further revise § 412.614 by adding a new § 412.614(a)(3) to specify that the IRF is not required to, but may, transmit the IRF–PAI data for a Medicare Part A fee-for-service inpatient when Medicare will not be paying the IRF for any of the services the IRF furnished to that inpatient.

Comment: We received one public comment supporting the proposed change.

Response: We are adopting the proposed change as final without modification.

F. Revision of the Definition of Discharge

Existing § 412.602 specifies that a discharge has occurred when the patient has been formally released from the hospital, or has died in the hospital, or when the patient stops receiving Medicare-covered Part A inpatient rehabilitation services. Our intention in specifying this definition of when a discharge has occurred under the IRF PPS was to try to ensure that Medicare paid an IRF only for furnishing an IRF level of services to the Medicare Part A fee-for-service inpatient. However, in contrast to when a patient is formally released from the IRF or dies, the time when a patient stops receiving Medicare-covered Part A IRF services may be subject to different interpretations, resulting in different determinations of when a discharge has occurred.

Various determinations of when a discharge has occurred can lead to inconsistencies in determining the discharge date. In these situations, IRFs furnishing the same services for the same period of time may be paid differently, because the discharge date determines a patient's length-of-stay. The patient's length-of-stay is one of the factors that determines the amount of the CMG payment. For example, under § 412.624(f), a patient's length-of-stay as determined by the inpatient's discharge date may affect the amount of the IRF's CMG payment when a patient is transferred from an IRF to another site of care.

In addition, there may be cases when an IRF believes an inpatient no longer has a medical need for Medicare-covered Part A inpatient rehabilitation services, but the IRF believes that the inpatient has a medical need for an SNF level of services. However, due to circumstances beyond the IRF's control, the IRF is unable to formally release the patient, because the IRF cannot place the patient in an SNF setting. In that situation, according to section 1861(v)(1)(G)(i) of the Act and

§ 424.13(b), a physician may certify or recertify that the patient needs to continue to be hospitalized in the IRF. The effect of the physician's certification or recertification is that under Medicare the patient is not considered discharged until the patient is formally released from the IRF.

In consideration of what can occur when discharge is defined as being when the inpatient stops receiving Medicare-covered Part A inpatient rehabilitation services, in the May 16, 2003 proposed rule, we proposed to revise the definition of ''discharge'' under § 412.602 by removing the phrase ''(2) The patient stops receiving Medicare-covered Part A inpatient rehabilitation services, unless the patient qualifies for continued hospitalization under § 424.13(b) of this chapter; or''. Under the proposed revised definition, discharge would mean a Medicare patient in an inpatient rehabilitation facility is considered discharged when (1) the patient is formally released from the inpatient rehabilitation facility; or (2) the patient dies in the inpatient rehabilitation facility.

Comment: We received a comment requesting that CMS not revise the definition of discharge as specified in § 412.503 that applies to patients in an LTCH similar to how we are revising the definition of a discharge from an IRF.

Response: The commenter's concern did not relate to our proposed change to the definition of discharge in the IRF context and we are adopting the proposed change without modification.

G. Waiver of the Penalty for Late Transmittal of the IRF–PAI Data

Section 412.614(c), ''transmission dates,'' states that the admission and discharge assessment data must be transmitted together. The discharge assessment is completed after the admission assessment has been completed. Therefore, the date when the IRF–PAI data must be transmitted is determined by when the IRF–PAI discharge assessment is completed.

Section 412.610(d) specifies that after the discharge assessment has been completed, the data must be entered into the electronic version of the IRF–PAI, a process which § 412.602 defines as encoding the data. Section 412.610(d) specifies that the IRF has 7 calendar days to encode the discharge assessment. Section 412.614(d)(2) specifies that, in order for the IRF–PAI data not to be considered as having been transmitted late, the IRF–PAI data must be transmitted to us no later than 10 calendar days from the date specified in § 412.614(c).

The date specified in § 412.614(c) is the 7th calendar day of the applicable encoding time period specified in § 412.610(d). The 7th calendar day of the applicable encoding date specified in § 412.610(d) is the end of the discharge assessment encoding time period because none of the data can be transmitted until the discharge assessment has been encoded. The following example, which is very similar to the Chart 3 on page 41332 of the August 7, 2001 final rule (66 FR 41316), is intended to clarify when CMS will determine that the IRF–PAI data were transmitted late.

CHART 1–2.—EXAMPLE OF APPLYING THE PATIENT ASSESSMENT INSTRUMENT DISCHARGE ASSESSMENT AND TRANSMISSION DATES

Assessment type	Discharge date	Assessment reference date	IRF–PAI completed by	IRF–PAI encoded by	IRF–PAI data transmitted by	Date when IRF–PAI data transmission is late
Discharge Assessment	10/16/03	10/16/03	10/20/03	10/26/03	11/01/03	11/12/03*

*Or any day after 11/12/03.

If IRF–PAI data are transmitted later than 10 calendar days from the transmission date specified in § 412.614(c), § 412.614(d)(2) specifies that we will assess a penalty by deducting 25 percent from the CMG payment that is associated with the IRF–PAI data that were transmitted late. However, we believe that an IRF may encounter an extraordinary situation, which is beyond its control, and that extraordinary situation could render the IRF unable to comply with § 412.614(c). The IRF must fully describe in the appropriate inpatient's clinical record, or by use of another documentation method as selected by the IRF, the extraordinary situation which the IRF encountered that resulted in the IRF being unable to comply with § 412.614(c). Although an IRF may believe that the facility has encountered an extraordinary situation, the IRF's belief does not mean that CMS is obligated to also automatically determine that the situation was of an extraordinary nature.

CMS has the discretion to determine whether the situation described by the IRF is extraordinary. An extraordinary situation may be, but does not have to be, due to the occurrence of an unusual event. Examples of unusual events include, but are not limited to, fire, flood, earthquake, or other similar incidents that inflict extensive damage to an IRF.

Another example of an extraordinary situation is the inability of an IRF to transmit any IRF–PAI data for an extended time period, because during that entire time period there was a problem with the data transmission system that was beyond the control of the IRF. An example of a data transmission system problem that is beyond the control of the IRF is the inability of an IRF to transmit its IRF–PAI data because the computer used by CMS to receive and process the data is malfunctioning.

A further example of a data transmission system problem that is beyond the control of the IRF is the existence of a flaw in the software that was distributed by CMS to IRFs, or a flaw in the software specifications made available by CMS to vendors that prevent the IRF from transmitting its IRF–PAI data. In addition, an extraordinary situation may include a situation in which a facility has correctly followed CMS policies and procedures in order to be classified as an IRF and obtain an IRF provider number, but has experienced a delay in attaining an IRF provider number.

In light of these possibilities, in the May 16, 2003 proposed rule, we proposed to add a new § 412.614(e) to specify that CMS may waive the penalty specified in § 412.614(d) when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data in accordance with § 412.614(c).

We also proposed that ''only CMS can determine if a situation encountered by an IRF is extraordinary and qualifies as a situation for waiver of the penalty specified in § 412.614(d)(2) of this

section. An extraordinary situation may be due to, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflict extensive damage to an inpatient rehabilitation facility. An extraordinary situation may be one that produces a data transmission problem that is beyond the control of the inpatient rehabilitation facility, as well as other situations determined by CMS to be beyond the control of the inpatient rehabilitation facility.''

Lastly, we proposed that ''an extraordinary situation must be fully documented by the inpatient rehabilitation facility.''

Comment: The comments we received supported the proposed revision.

Response: We are adopting the proposed change as final without modification.

H. General Information Regarding the IRF–PAI Assessment Process

We have received many questions regarding the IRF–PAI assessment process policies. We have posted the answers to most of these questions on the IRF PPS Web site.

1. The IRF PPS Web Site Address

The current Internet address for the IRF PPS Web site is *http://www.cms.hhs.gov/providers/irfpps/.* Due to changes in CMS' Internet policies during 2002, the current website address is different from the one we published in the August 7, 2001 final rule.

2. Exceptions to the IRF–PAI Admission and Discharge Assessment Time Period General Rules

Section 412.610(c)(1)(i) states the general rule that the time span covered during the admission assessment is calendar days 1 through 3 of the patient's current Medicare Part A fee-for-service IRF hospitalization. Section 412.610(c)(2)(i) states the general rule that the discharge assessment time period is a span of time that covers 3 calendar days, which includes the inpatient's discharge date, which is the same date as the discharge assessment reference date, and the 2 calendar days before the discharge date. We want to remind IRFs that, as specified in § 412.610(c)(1)(ii) and § 412.610(c)(2)(iii), we may use the IRF–PAI item-by-item guide and other instructions to identify items that have a different admission or discharge assessment time period. We may specify different admission and discharge assessment time periods in order to capture patient information for payment and quality of care monitoring objectives appropriately.

Miscellaneous Comments: We received several comments regarding IRF PPS implementation operational issues. For example, some commenters requested that we post on the IRF PPS website the questions asked of the IRF PAI Help Desk and the associated answers. Some commenters requested that we revise the instructions in the IRF–PAI manual regarding the coding of the patient during the discharge assessment. Some commenters requested that CMS publish a list of all the ICD–9–CM codes associated with every impairment group. Some commenters requested that we synchronize the discharge codes used in IRF–PAI with the patient status codes used in the claim data. Some commenters requested that we synchronize the methodology used to determine the IRF–PAI etiologic diagnosis code with the methodology used to determine the principal or admitting diagnosis on the claim.

Response: These comments are related to functions that are administrative and operational and are not specifically related to our proposed changes to the IRF PPS. We will take these comments into consideration as we continue to refine implementation of the IRF PPS.

V. Patient Classification System for the IRF PPS

As previously stated, in this final rule we are adopting the same case-mix classification system that was set forth in the August 7, 2001 final rule. It is our intention to pursue the development of possible refinements to the case-mix classification system that will continue to improve the ability of the PPS to accurately pay IRFs. We have awarded a contract to the RAND Corporation (RAND) to conduct additional research that will, in the initial stages, provide us with the data necessary to address the feasibility of developing and proposing refinements. When the study has been completed, we plan to review various approaches so that we can propose an appropriate methodology to develop and apply refinements. Any specific refinement proposal resulting from this research will be published in the **Federal Register**.

Table 1.—Relative Weights for Case-Mix Groups (CMGs) in the Addendum to this final rule presents the CMGs, the comorbidity tiers, and the corresponding Federal relative weights. We also present the average length of stay for each CMG. As we discussed in the August 7, 2001 final rule (66 FR 41353), the average length of stay for each CMG, along with the discharge destination, is used to determine when an IRF discharge meets the definition of a transfer, which results in a per diem case level adjustment (66 FR 41354). Because these data elements are not changing as a result of this final rule, Table 1 in this final rule is identical to Table 1 that was published in the August 7, 2001 final rule (66 FR 41394 through 41396). The relative weights reflect the inclusion of cases with an interruption of stay (patient returns on day of discharge or either of the next 2 days). The methodology we used to construct the data elements in Table 1 is described in detail in the August 7, 2001 final rule (66 FR 41350 through 41353).

VI. Fiscal Year 2004 Federal Prospective Payment Rates

A. Expiration of the IRF PPS Transition Period

Section 1886(j)(1) of the Act and § 412.626 of the regulations provides that the transition period for IRFs expires for cost reporting periods beginning on or after October 1, 2002 (FY 2003 and beyond). Accordingly, the payment for discharges during FY 2004 will be based entirely on the adjusted FY 2004 IRF Federal PPS rates in this final rule.

B. Description of the IRF Standardized Payment Amount

In the August 7, 2001 final rule, we established a standard payment amount referred to as the budget neutral conversion factor under § 412.624(c). In accordance with the methodology described in § 412.624(c)(3)(i), the budget neutral conversion factor for FY 2002, as published in the August 7,2001 final rule, was $11,838.00. Under § 412.624(c)(3)(i), this amount reflects, as appropriate, any adjustments for outlier payments, budget neutrality, and coding and classification changes as described in § 412.624(d).

The budget neutral conversion factor is a standardized payment amount and the amount reflects the budget neutrality adjustment for FY 2002, as described in § 412.624(d)(2). The statute requires a budget neutrality adjustment only for FYs 2001 and 2002. Accordingly, we believe it is more consistent with the statute to refer to the standardized payment as the standardized payment conversion factor, rather than refer to it as a budget neutral conversion factor.

As we proposed in the May 16, 2003 proposed rule, after careful consideration, in this final rule we are changing all references to the budget neutral conversion factor in §§ 412.624(c) and 412.624(d) to the

''standard payment conversion factor.'' We believe that the standard payment conversion factor better describes the standardized payment amount especially in those fiscal years where a budget neutrality adjustment is not made.

Under § 412.624(c)(3)(i), the standard payment conversion factor for FY 2002 of $11,838.00 reflected the budget neutrality adjustment described in § 412.624(d)(2). Under the then existing § 412.624(c)(3)(ii), we updated the FY 2002 standard payment conversion factor ($11,838.00) to FY 2003 by applying an increase factor (the IRF market basket index) of 3.0 percent, as described in the update notice published in the August 1, 2002 **Federal Register** (67 FR 49931). This yielded the FY 2003 standard payment conversion factor of $12,193.00 that was published in the August 1, 2002 update notice (67 FR 49931). The FY 2003 standard payment conversion factor is the basis of the updated FY 2004 standard payment conversion factor that also reflects the adjustments described below.

C. Adjustments To Determine the FY 2004 Standard Payment Conversion Factor

1. IRF Market Basket Index

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in IRF services paid for under the IRF PPS, which is referred to as the IRF market basket index. Accordingly, in updating the FY 2004 payment rates set forth in this final rule, we will apply an appropriate increase factor, that is equal to the IRF market basket, to the FY 2003 IRF standardized payment amount.

Beginning with the implementation of the IRF PPS in FY 2002 and with the FY 2003 IRF PPS update, the 1992-based excluded hospital with capital market basket has been used to determine the IRF market basket factor for updating payments to rehabilitation facilities. The 1992-based market basket reflected the distribution of costs in 1992 for Medicare-participating freestanding rehabilitation, long-term care, psychiatric, cancer, and children's hospitals. This information was derived from the 1992 Medicare cost reports. A full discussion of the methodology and data sources used to construct the 1992-based excluded hospital with capital market basket is available in Appendix D of the IRF PPS final rule published in the August 7, 2001 **Federal Register** (66 FR 41427).

2. The Excluded Hospital and the Capital Market Basket

In this final rule, we are revising and rebasing the excluded hospital with capital market basket to a 1997 base year. We believe that using 1997 data, rather than 1992 data, to construct the IRF market basket allows us to more appropriately estimate increases in the costs of IRF goods and services from year to year. We believe the use of more recent data will ensure that our estimates more closely approximate the current costs of goods and services provided in IRFs.

The operating portion of the 1997-based excluded hospital with capital market basket is derived from the 1997-based excluded hospital market basket. The methodology used to develop the excluded hospital market basket operating portion was described in the August 1, 2002 **Federal Register** (67 FR 50042–50044). In brief, the operating cost category weights in the 1997-based excluded market basket added to 100.0. These weights were determined from the Medicare cost reports, the 1997 Business Expenditure Survey from the Bureau of the Census, and the 1997 Annual Input-Output data from the Bureau of Economic Analysis. In using the 1997 data, we made two methodological revisions to the 1997-based excluded hospital market basket: (1) Changing the wage and benefit price proxies to use the Employment Cost Index (ECI) wage and benefit data for hospital workers, and (2) adding a cost category for blood and blood products.

Previously we used a combination of several occupational ECIs in the 1992-based index such as the professional and technical workers, service workers, etc. We believe the ECI for hospital workers better represents the movement of hospital wages, salaries, and benefits and it is more reflective of current labor market conditions. For the 1992-based market baskets we were unable to find an adequate data source for the blood cost category.

For the 1997-based excluded hospital market basket, we were able to obtain these data from Medicare cost reports. As discussed in the IPPS August 1, 2002 final rule (67 FR 50035), BIPA required that we adequately reflect the price of blood and blood products in the hospital market basket when it was rebased and revised, which was done for the FY 2003 IPPS payment rates. We believe this revision is also appropriate for the excluded hospital with capital market basket because it results in a more precise measure of the cost category for blood and blood products.

When we add the weight for capital costs to the excluded hospital market basket, the sum of the operating and capital weights must still equal 100.0. Because capital costs account for 8.968 percent of total costs for excluded hospitals in 1997, it holds that operating costs must account for 91.032 percent. Each operating cost category weight from the August 1, 2002 **Federal Register** (67 FR 50442–50444) was rebased to the 1997-based excluded hospital with capital market basket by multiplying by 0.91032 to determine its weight in the 1997-based excluded hospital with capital market basket.

The aggregate capital component of the 1997-based excluded hospital market basket (8.968 percent) was determined from the same set of Medicare cost reports used to derive the operating component. The detailed capital cost categories of depreciation, interest, and other capital expenses were also determined using the Medicare cost reports. As explained below, two sets of weights for the capital portion of the revised and rebased market basket needed to be determined. The first set of weights identifies the proportion of capital expenditures attributable to each capital cost category, while the second set represents relative vintage weights for depreciation and interest. The vintage weights identify the proportion of capital expenditures that is attributable to each year over the useful life of capital assets within a cost category (see IPPS final rule published in the August 1, 2002 **Federal Register** (67 FR 50046–50047) for a discussion of how vintage weights are determined).

The cost categories, price proxies, and base-year FY 1992 and FY 1997 weights for the excluded hospital with capital market basket are presented in Chart 3 ''Excluded Hospital With Capital Input Price Index (FY 1992 and FY 1997) Structure and Weights.'' Chart 4 ''Excluded Hospital with Capital Input Price Index (FY 1997) Vintage Weights'' presents the vintage weights for the 1997-based excluded hospital with capital market basket.

CHART 3.—EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1992 AND FY 1997) STRUCTURE AND WEIGHTS [1, 2]

Cost category	Price wage variable	Weights (%) base-year 1992	Weights (%) base-year 1997
Total		100.000	100.000
Compensation		57.935	57.579
Wages and Salaries	ECI—Wages and Salaries, Civilian Hospital Workers	47.417	47.335
Employee Benefits	ECI—Benefits, Civilian Hospital Workers	10.519	10.244
Professional fees: Non-Medical	ECI—Compensation: Prof. & Technical	1.908	4.423
Utilities		1.524	1.180
Electricity	WPI—Commercial Electric Power	0.916	0.726
Fuel Oil, Coal, etc.	WPI—Commercial Natural Gas	0.365	0.248
Water and Sewerage	CPI–U—Water & Sewage	0.243	0.206
Professional Liability Insurance	HCFA—Professional Liability Premiums	0.983	0.733
All Other Products and Services		28.571	27.117
All Other Products		22.027	17.914
Pharmaceuticals	WPI—Prescription Drugs	2.791	6.318
Food: Direct Purchase	WPI—Processed Foods	2.155	1.122
Food: Contract Service	CPI–U—Food Away from Home	0.998	1.043
Chemicals	WPI—Industrial Chemicals	3.413	2.133
Blood and Blood Products	WPI—Blood and Derivatives		0.748
Medical Instruments	WPI—Med. Inst. & Equipment	2.868	1.795
Photographic Supplies	WPI—Photo Supplies	0.364	0.167
Rubber and Plastics	WPI—Rubber & Plastic Products	4.423	1.366
Paper Products	WPI—Convert. Paper and Paperboard	1.984	1.110
Apparel	WPI—Apparel	0.809	0.478
Machinery and Equipment	WPI—Machinery & Equipment	0.193	0.852
Miscellaneous Products	WPI—Finished Goods excluding Food and Energy	2.029	0.783
All Other Services		6.544	9.203
Telephone	CPI–U—Telephone Services	0.574	0.348
Postage	CPI–U—Postage	0.268	0.702
All Other: Labor	ECI—Compensation: Service Workers	4.945	4.453
All Other: Non-Labor Intensive	CPI–U—All Items (Urban)	0.757	3.700
Capital-Related Costs		9.080	8.968
Depreciation		5.611	5.586
Fixed Assets	Boeckh-Institutional Construction: 23 Year Useful Life	3.570	3.503
Movable Equipment	WPI—Machinery & Equipment: 11 Year Useful Life	2.041	2.083
Interest Costs		3.212	2.682
Non-profit	Avg. Yield Municipal Bonds: 23 Year Useful Life	2.730	2.280
For-profit	Avg. Yield AAA Bonds: 23 Year Useful Life	0.482	0.402
Other Capital-Related Costs	CPI–U—Residential Rent	0.257	0.699

[1] The operating cost category weights in the excluded hospital market basket described in the August 1, 2002 FEDERAL REGISTER (67 FR 50442 through 50444) add to 100.0.
[2] Due to rounding, weights sum to 1.000.

When we add an additional set of cost category weights (total capital weight = 8.968 percent) to this original group, the sum of the weights in the new index must still add to 100.0. Because capital costs account for 8.968 percent of the market basket, then operating costs account for 91.032 percent. Each weight in the 1997-based excluded hospital market basket from the IPPS final rule published in the August 1, 2002 **Federal Register** (67 FR 50442–50444) was multiplied by 0.91032 to determine its weight in the 1997-based excluded hospital with capital market basket.

CHART 4.—EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1997) VINTAGE WEIGHTS

Year from farthest to most to most recent	Fixed assets (23-year weights)	Movable assets (11-year weights)	Interest: capital-related (23-year weights)
1	0.018	0.063	0.007
2	0.021	0.068	0.009
3	0.023	0.074	0.011
4	0.025	0.080	0.012
5	0.026	0.085	0.014
6	0.028	0.091	0.016
7	0.030	0.096	0.019
8	0.032	0.101	0.022
9	0.035	0.108	0.026
10	0.039	0.114	0.030
11	0.042	0.119	0.035
12	0.044		0.039
13	0.047		0.045

CHART 4.—EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1997) VINTAGE WEIGHTS—Continued

Year from farthest to most to most recent	Fixed assets (23-year weights)	Movable assets (11-year weights)	Interest: capital-related (23-year weights)
14	0.049		0.049
15	0.051		0.053
16	0.053		0.059
17	0.057		0.065
18	0.060		0.072
19	0.062		0.077
20	0.063		0.081
21	0.065		0.085
22	0.064		0.087
23	0.065		0.090
Total*	1.0000	1.0000	1.0000

*Due to rounding, weights sum to 1.000.

Comment: One commenter asked about the derivation of the professional liability cost weight. The commenter believed the reduction in the professional liability weight (shown in Chart 3) from the 1992-based excluded with capital market basket (.983) to the 1997-based excluded with capital market basket (.733) was inconsistent with the trends in professional liability insurance.

Response: Recent trends show professional liability insurance growing faster than our market basket but in the post 1997 period. This growth is reflected in the movement of the professional liability insurance price proxy.

The professional liability cost weight used in the 1997-based excluded with capital market basket was derived from a survey conducted by ANASYS under contract to CMS (Contract Number 500–98–005). This survey attempted to estimate hospital malpractice insurance costs over time at the national level for years 1996 and 1997 using a statistical sample. The statistical sample was drawn from a population universe of non-Federal short-term, acute care prospective payment system hospitals. CMS applied the results—more specifically the relationship between professional liability and other hospital costs—to the excluded hospital with capital market basket. (More results about this survey are published in the May 9, 2002 IPPS Hospital Proposed Rule (90 FR 31440)).

We believe the reduction in the professional liability insurance weight from 1992 to 1997 does reflect the actual conditions facing hospitals at that time. The relevant professional liability insurance price proxy shows a decline in prices from 1990 to 1998 while the overall market basket shows an increase. In the most recent five years, the professional liability insurance price proxy has been accelerating, resulting in an increasing relative importance of its weight in the market basket. This is consistent with recent trends.

Chart 5 ''Percent Changes in the 1992-based and 1997-based Excluded Hospital with Capital Market Baskets, FY 1999–2004'' compares the 1992-based excluded hospital with capital market basket to the 1997-based excluded hospital with capital market basket. As is shown, the rebased and revised market basket grows slightly faster over the 1999–2001 period than the 1992-based market basket. The major reason for this was the switching of the previous wage and benefit proxies to the ECI for hospital workers from the previous occupational blend. We believe that the ECI is the best most appropriate price proxy for measuring changes in wage data facing IRFs. This wage series reflects actual wage data reported by civilian hospitals to the Bureau of Labor Statistics that is more reflective of current trends in hospitals than is the blended wage previously used. The ECIs are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. They are appropriately not affected by shifts in skill mix. This differs from the proxy used in the FY 1992-based index in which a blended occupational wage index was used. The blended occupational wage proxy used in the FY 1992-based index and the ECI for wages and salaries for hospitals both reflect a fixed distribution of occupations within a hospital. The major difference between the two proxies is in the treatment of professional and technical wages (legal, accounting, management, and consulting services from outside the facility). In the blended occupational wage proxy, the professional and technical category was blended evenly between the ECI for wages and salaries for hospitals and the ECI for wages and salaries for professional and technical occupations in the overall economy. The ECI for hospitals reflects, instead of hospital-specific occupations as reflected in the ECI for hospitals. This revision had a similar impact on the hospital PPS and excluded market baskets, as described in the IPPS final rule published in the August 1, 2001 **Federal Register**. The FY 2004 increase in the 1997-based excluded hospital with capital market basket is 3.2 percent.

CHART 5.—PERCENT CHANGES IN THE 1992-BASED AND 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKETS, FY 1999–2004

Fiscal year	Percent change, FY 1992-based market basket	Percent change, FY 1997-based market basket
Actual Historical % Increase (FY 1999–2002)		
1999	2.3	2.7

CHART 5.—PERCENT CHANGES IN THE 1992-BASED AND 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKETS, FY 1999–2004—Continued

Fiscal year	Percent change, FY 1992-based market basket	Percent change, FY 1997-based market basket
2000	3.4	3.1
2001	3.9	4.0
2002	2.7	3.6
Average historical	3.1	3.4
Forecasts (FY 2003–2004)		
2003	3.4	3.8
2004	2.9	3.2
Average forecast	3.2	3.5

Section 1886(j)(3)(c) requires that the increase in the IRF PPS payment rate be based on an ''appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).'' To date, we have used a market basket based on the cost structure of all excluded hospitals to satisfy this requirement, and have discussed in prior IRF rules why we feel this market basket provides a reasonable measure of the price changes facing exempt hospitals.

3. Research and Analysis

In its March 2002 Report, the Medicare Payment Advisory Commission (MedPAC) recommended the development of a market basket specific to IRF services. As we mentioned in the August 7, 2001 final rule, we researched the feasibility of developing such a market basket. This research included analyzing data sources for cost category weights, specifically the Medicare cost reports, and investigating other data sources on cost, expenditure, and price information specific to IRFs. As described in greater detail below, based on this research, we are not developing a market basket specific to IRF services at this time.

Our analysis of the Medicare cost reports indicates that the distribution of costs among major cost report categories (wages, pharmaceuticals, capital) for IRFs is not substantially different from the 1997-based excluded hospital with capital market basket we have used. In addition, the only data available to us were for these cost categories (wages, pharmaceuticals, and capital) presenting a potential problem since no other major cost category would be based on IRF data.

We conducted a sensitivity analysis of annual percent changes in the market basket when the IRF weights for wages, pharmaceuticals, and capital were substituted into the excluded hospital with capital market basket. Other cost categories were recalibrated using ratios available from the inpatient PPS hospital market basket. On average, between the years 1995 through 2002, the excluded hospital with capital market basket increased at essentially the same average annual rate (2.9 percent) as the market basket with IRF weights for wages, pharmaceuticals, and capital (2.8 percent). In addition, in almost any individual year the difference was 0.1 percentage point or less, which is less than the 0.25 percentage point criterion that is used under the IPPS update framework to determine whether a forecast error adjustment is warranted.

The 0.25 percentage point criterion that determines whether a forecast error adjustment is warranted has been used in the IPPS update framework since the implementation of the IPPS. It serves as a guideline for the level of forecast accuracy, since any forecast is likely to contain enough imprecision that differences of one tenth or two-tenths of a percentage point are not thought to be significant. Thus, in this case if the forecast error is not at least greater than two-tenths of a percentage point, it is thought to be similar enough to the actual data as not to warrant an adjustment.

Based on the analysis described above, we continue to believe that the excluded hospital with capital market basket is doing an adequate job of reflecting the price changes facing IRFs. As additional cost data are being collected under the IRF PPS we hope that we will eventually be able to develop a market basket derived specifically from IRF data.

As shown in Chart 5, for the payment rates set forth in this final rule, the FY 2004 IRF market basket increase factor using 1997 data is 3.2 percent. Thus, we apply the 3.2 percent increase, in addition to the budget neutral wage adjustment factor described below, to the FY 2003 standard payment conversion factor ($12,193.00) to determine the 2004 standard payment conversion factor.

4. Updated Labor-Related Share

In implementing the FY 2002 and FY 2003 IRF PPS, we used the 1992 market basket data to determine the labor-related share (72.395 percent). As stated above, we are updating the 1992 market basket data to 1997. Doing so allows us to use the 1997-based excluded hospital market basket with capital costs to determine the FY 2004 labor-related share.

We calculated the FY 2004 labor-related share as the sum of the weights for those cost categories contained in the 1997-based excluded hospital with capital market basket that are influenced by local labor markets. These cost categories include wages and salaries, employee benefits, professional fees, labor-intensive services and a 46 percent share of capital-related expenses. The labor-related share for FY 2004 is the sum of the FY 2004 relative importance of each labor-related cost category, and reflects the different rates of price change for these cost categories between the base year (FY 1997) and FY 2004. The sum of the relative importance for FY 2004 for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) is 69.028 percent, as shown in Chart 6 ''FY 2004 Labor-Related Share Relative Importance.'' The portion of capital that is influenced by local labor markets is estimated to be 46 percent. Because the relative importance of capital is 7.604 percent of the 1997-based excluded hospital with capital market basket in FY 2004, we take 46 percent of 7.604 percent to

determine the labor-related share of capital for FY 2004. The result is 3.498 percent, which we then add to the 69.028 percent calculated for operating costs to determine the total labor-related relative importance for FY 2004. The resulting labor-related share that we are using for IRFs in FY 2004 is 72.526 percent.

CHART 6.—FY 2004 LABOR-RELATED SHARE RELATIVE IMPORTANCE

Cost category	Relative importance 1992-based market basket FY 2004	Relative importance 1997-based market basket FY 2004
Wages and salaries	50.180	48.906
Employee benefits	11.980	11.081
Professional fees	2.041	4.500
Postage	0.257	.....
All other labor intensive services	5.214	4.541
Subtotal	69.672	69.028
Labor-related share of capital	3.370	3.498
Total	73.042	72.526

Chart 6 above shows that rebasing the excluded hospital with capital market basket lowers the increase in labor share that we used in FY 2004 relative to what it would have been had we not rebased the excluded hospital with capital market basket. As we previously stated, we are using a labor-related share of 72.526 percent for the FY 2004 IRF PPS payment rates set forth in this final rule.

5. Budget Neutral Wage Adjustment Update Methodology

As stated above, for FY 2004, we are updating the FY 2003 IRF wage indices by using FY 1999 acute care hospital wage data and updating the labor-related share by using the 1997 market basket data. Because any adjustment or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget neutral manner as required by statute, we are amending the regulation at § 412.624(e)(1), as proposed, to reflect this requirement. We also determined a budget neutral wage adjustment factor based on an adjustment or update to the wage data to apply to the standard payment conversion factor.

In addition, as we proposed in the May 16, 2003 proposed rule, we use the following steps to ensure that the FY 2004 IRF standard payment conversion factor reflects the update to the wage indices and to the labor-related share in a budget neutral manner:

Step 1. We determine the total amount of the FY 2003 IRF PPS rates using the FY 2003 standardized payment amount and the labor-related share and the wage indices from FY 2003 (as published in the August 1, 2002 notice).

Step 2. We then calculate the total amount of IRF PPS payments using the FY 2003 standardized payment amount and the updated FY 2004 labor-related share and wage indices described above.

Step 3. We divide the amount calculated in step 1 by the amount calculated in step 2, which equals the FY 2004 budget neutral wage adjustment factor of 0.9954.

Step 4. We then apply the FY 2004 budget neutral wage adjustment factor from step 3 to the FY 2003 IRF PPS standard payment conversion factor after the application of the market basket update, described above, to determine the FY 2004 standardized payment amount.

Comment: A commenter noted that the update factor used to develop the FY 2003 IRF PPS payment rates should have been higher than 3 percent.

Response: In order to update the IRF PPS payment rates, section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services, which is referred to as a market basket index.

Accordingly, in the November 2, 2000 proposed rule we described our proposed methodology for constructing an appropriate IRF market basket, the 1992-based excluded hospital with capital market basket. We invited comments on the proposed construction of this market basket and eventually adopted the proposed methodology in the August 7, 2001 final rule. At the time we proposed this methodology, we used the best data that were available. Further, in finalizing this method we also used the best data available at the time we developed the August 7, 2001 final rule.

In updating the FY 2003 IRF PPS payment rates, we issued a notice in the **Federal Register** using the methodology finalized in the August 7, 2001 final rule. Therefore, we used an appropriate update factor for the FY 2003 IRF PPS payment rates based on the best data available at the time the August 1, 2002 update notice was developed.

D. Update of Payment Rates Under the IRF PPS for FY 2004

Once we calculate the IRF market basket increase factor and determine the budget neutral wage adjustment factor, this calculation enables us to determine the updated Federal prospective payments for FY 2004. In this final rule, we apply the IRF market basket increase factor of 3.2 percent to the standard payment conversion factor for FY 2003 ($12,193) that equals $12,583. Then, we apply the budget neutral wage adjustment of 0.9954 to $12,583, which resulted in a final updated standard payment conversion factor for FY 2004 of $12,525.

Consistent with the proposed rule, this final rule provides that the FY 2004 standard payment conversion factor is applied to each CMG weight shown in Table 1 to compute the unadjusted IRF prospective payment rates for FY 2004 shown in Table 2.

Table 2.—FY 2004 Federal Prospective Payments for Case-Mix Groups (CMGs) for FY 2004 displays the CMGs, the comorbidity tiers, and the corresponding unadjusted IRF prospective payment rates for FY 2004.

E. Examples of Computing the Total Adjusted IRF Prospective Payments

In general, under § 412.624(e), we adjust the Federal prospective payment amount associated with a CMG, shown

in Table 2, to account for an IRF's geographic wage variation, low-income patients and, if applicable, location in a rural area.

The adjustment for an IRF's geographic wage variation includes the FY 2004 labor-related share adjustment of 72.526 percent and the FY 2004 IRF urban or rural wage indices in Tables 3A and 3B of the Addendum of this final rule, respectively.

The adjustment for low-income patients is based on the formula used to account for the cost of furnishing care to low-income patients as discussed in the August 7, 2001 IRF PPS final rule (67 FR 41360). The formula to calculate the low-income patient or LIP adjustment is as follows:

$$(1 + \text{DSH}) \text{ raised to the power of } (.4838)$$

$$\text{Where DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

The adjustment for IRFs located in rural areas is an increase to the Federal prospective payment amount of 19.14 percent. This percentage increase is the same as the one described in the August 7, 2002 IRF PPS final rule (67 FR 41359).

To illustrate the methodology that we use to adjust the Federal prospective payments, we provide an example in Chart 7 below.

One beneficiary is in Facility A, an IRF located in rural Maryland, and another beneficiary is in Facility B, an IRF located in the New York City metropolitan statistical area (MSA). Facility A's disproportionate share hospital (DSH) adjustment is 5 percent, with a low-income patient adjustment of (1.0239) and a wage index of (0.8946), and the rural area adjustment (19.14 percent) applies. Facility B's DSH is 15 percent, with a LIP adjustment of (1.0700) and a wage index of (1.4414).

Both Medicare beneficiaries are classified to CMG 0112 (without comorbidities). To calculate each IRF's total adjusted Federal prospective payment, we compute the wage-adjusted Federal prospective payment and multiply the result by the appropriate low-income patient adjustment and the rural adjustment (if applicable). Chart 7 illustrates the components of the adjusted payment calculation.

CHART 7.—EXAMPLE OF COMPUTING AN IRF'S FEDERAL PROSPECTIVE PAYMENT

	Facility A	Facility B
Federal Prospective Payment	$25,068.79	$25,068.79
Labor Share	×0.72526	×0.72526
Labor Portion of Federal Payment	18,181.39	18,181.39
Wage Index (shown in Tables 3A or 3B)	×0.8946	×1.4414
Wage-Adjusted Amount	=$16,265.07	=$26,206.65
Nonlabor Amount	+$6,887.40	+$6,887.40
Wage-Adjusted Federal Payment	=$23,152.47	=$33,094.05
Rural Adjustment	×1.1914	×1.0000
Subtotal	=$27,583.85	=$33,094.05
LIP Adjustment	×1.0239	×1.0700
Total FY 2004 Adjusted Federal Prospective Payment	=$28,243.11	=$35,410.64

Thus, the adjusted payment for facility A will be $28,243.11, and the adjusted payment for facility B will be $35,410.64.

F. Computing Total Payments Under the IRF PPS for the Transition Period

Under section 1886(j)(1) of the Act and § 412.626 of the regulations, payment for all IRFs with cost reporting periods beginning on or after October 1, 2002, will consist of 100 percent of the FY 2004 adjusted Federal prospective payment (plus any applicable outlier payments under § 412.624(e)(4)) and there will not be any blended payments. Accordingly, the FY 2004 IRF PPS rates set forth in this final rule will apply to all discharges on or after October 1, 2003 and before October 1, 2004.

G. IRF-Specific Wage Data

On page 41358 of the August 7, 2001 IRF PPS final rule, we responded to comments regarding the development of a separate wage index for IRFs. Our response indicated that we were unable to develop a separate wage index for rehabilitation facilities. Specifically, we responded to these comments as follows:

''At this time, we are unable to develop a separate wage index for rehabilitation facilities. There is a lack of specific IRF wage and staffing data necessary to develop a separate IRF wage index accurately. Further, in order to accumulate the data needed for such an effort, we would need to make modifications to the cost report. In the future, we will continue to research a wage index specific to IRF facilities. Because we do not have an IRF specific wage index that we can compare to the hospital wage index, we are unable to determine at this time the degree to which the acute care hospital data fully represent IRF wages. However, we believe that a wage index based on acute care hospital wage data is the best and most appropriate wage index to use in adjusting payments to IRFs, since both acute care hospitals and IRFs compete in the same labor markets.''

At the current time, we still do not have any IRF-specific wage data to determine the feasibility of developing an IRF-specific wage index or of developing an adjustment to refine the acute care hospital wage data to reflect inpatient rehabilitation services. We continue to look into alternative ways to collect, analyze, develop, and audit IRF-specific wage data that would reflect the

wages and wage-related costs attributable to rehabilitation facilities.

We believe that the best source to collect IRF-specific wage data is the Medicare cost report—the same source for the acute care hospital wage data. These data must be accurate and reliable; thus, collecting these data would increase the recordkeeping and reporting burden on IRFs. Initially, this burden would be imposed to collect data just to determine the feasibility of developing an IRF-specific wage index or development of an adjustment to the current IRF wage index.

In addition, as stated earlier in this section of this final rule, any adjustment or update to the wage index must be made in a budget neutral manner in accordance with section 1886(j)(6) of the Act. Thus, the PPS rates for any one IRF could be affected in a positive or negative direction, due to the application of the updates to the labor-related share and wage indices in a budget neutral manner. Accordingly, given the current trend of reducing the Medicare cost reporting burden of collecting data and given that any change to the wage index be budget neutral, in the May 16, 2003 proposed rule, we did not propose to require facilities to record additional information at this time, however we solicited comments on possible ways to adjust or refine the current IRF wage index, given those restraints.

Comment: One commenter offered to meet with us to discuss the feasibility and effort involved with developing an IRF-based wage index.

Response: We appreciate the commenter's willingness to meet and we will contact them to arrange a meeting in the future.

In this final rule, we are not imposing the burden of collecting these data and we will continue to explore options to adjust or refine the current IRF wage index, given the restraints previously discussed.

Since IRFs and hospitals compete in the same labor markets, we will continue to use the acute care hospital wage data to develop the IRF wage index as described earlier in this section of this final rule.

Comment: One commenter requested that we reconsider the decision in the August 7, 2001 final rule to use pre-reclassification wage data to determine a facilities wage adjustment and suggested the use of the post-reclassification wage index. The commenter asserted that using the pre-reclassification wage index disadvantages IRFs because they must compete in the same labor market as their affiliated acute care hospital for the same pool of highly trained personnel.

Response: In the November 2, 2000 proposed rule, we proposed to use the pre-reclassification wage index. In the August 7, 2001 final rule, we addressed comments that we received regarding the use of the post-reclassification wage index. In the August 7, 2001 final rule we stated that we believe the actual location of an IRF as opposed to the location of affiliated providers is most appropriate for determining the wage adjustment because the data support the premise that the prevailing wages in the area in which the facility is located influence the cost of a case. We also stated that IRFs provide services that are considered part of the post-acute continuum of care and in order to be consistent with the area wage adjustments made to other post-acute care providers (that is, under the existing SNF and HHA prospective payment systems), we are using the inpatient acute care hospital wage data without regard to any approved geographic reclassifications under section 1886(d)(8) or 1886(d)(10) of the Act. Therefore, for all of the reasons stated above, we will continue to use the pre-reclassification wage index to adjust an IRF's PPS payments and base this payment adjustment on the facility's actual location.

We would also like to point out that on June 6, 2003, the Office of Management and Budget (OMB) issued ''OMB Bulletin No.03–04,'' announcing revised definitions of Metropolitan Statistical Areas, and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. A copy of the Bulletin may be obtained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/b03–04.html*. These new definitions will not be applied to the FY 2004 IRF wage index. However, we will be studying the new definitions and their impact and, if warranted, may adopt them at a later point in time using the appropriate administrative processes. To the extent these definitions are used, the concerns expressed by many for the use of a geographical reclassification system may be mitigated.

H. Adjustment for High-Cost Outliers Under the IRF PPS

In the May 16, 2003 proposed rule, we proposed changes to the methodology for determining IRF payments for high-cost outliers. The intent of the proposed changes was to ensure that outlier payments are paid only for truly high-cost cases. Further, we indicated that these proposed changes would allow us to create policies that are consistent among the various Medicare prospective payment systems when appropriate.

We have become aware that under the IPPS, some hospitals have taken advantage of two features in the IPPS outlier policy to maximize their outlier payments. The first is the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report. Second, statewide average cost-to-charge ratios are used in those instances in which an acute care hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. We set forth these parameters and the statewide cost-to-charge ratios in the annual notices of prospective payment rates that are published by August 1 of each year in accordance with § 412.8(b). Currently, these parameters represent 3.0 standard deviations (plus or minus) from the geometric mean of cost-to-charge ratios for all hospitals. In some cases, hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of the cost-to-charge ratio and a higher statewide average cost-to-charge ratio is applied to determine if the acute care hospital should receive an outlier payment. This disparity results in their cost-to-charge ratios being set too high, which in turn results in an overestimation of their current costs per case.

We believe the Congress intended that outlier payments under both the IPPS and the IRF PPS would be made only in situations where the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. Under the IPPS outlier methodology, if hospitals' charges are not sufficiently comparable in magnitude to their costs, the legislative purpose underlying the outlier regulations is thwarted. Thus, on March 4, 2003, we published in the **Federal Register** a proposed rule ''Proposed Changes in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System'' (68 FR 10420–10429) with an extensive discussion proposing new regulations to ensure outlier payments are paid for truly high-cost cases under the IPPS. This policy was finalized in a final regulation on June 9, 2003 (68 FR 34494), effective August 8, 2003.

We believe the use of these parameters is appropriate in determining cost-to-charge ratios to ensure these values are reasonable and outlier payments can be made in the most equitable manner possible.

Further, we believe the methodology of computing IRF outlier payments is susceptible to the same payment enhancement practices identified under the IPPS and, therefore, merit similar revisions. Accordingly, as discussed below, in this final rule we are making revisions as proposed in the May 16, 2003 proposed rule, to the IRF outlier payment methodology to be effective for discharges on or after October 1, 2003.

1. Current Outlier Payment Provision Under the IRF PPS

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. In the August 7, 2001 IRF PPS final rule, we codified at § 412.624(e)(4) of the regulations the provision to make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the IRF PPS in determining resource costs at the patient and facility level. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients.

Under § 412.624(e)(4), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount ($11,211 which is then adjusted for each IRF by the facilities wage adjustment, its low-income patient adjustment, and its rural adjustment, if applicable). We calculate the estimated cost of a case by multiplying the IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. In accordance with § 412.624(e)(4), we pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted IRF PPS payment for the CMG and the adjusted threshold amount).

On November 1, 2001, we published a Program Memorandum (Transmittal A–01–131) with detailed intermediary instructions for calculating the cost-to-charge ratios for the purposes of determining outlier payments under the IRF PPS. We stated the following:

''Intermediaries will use the latest available settled cost report and associated data in determining a facility's overall Medicare cost-to-charge ratio specific to freestanding IRFs and for IRFs that are distinct part units of acute care hospitals. Intermediaries will calculate updated ratios each time a subsequent cost report settlement is made. Further, retrospective adjustments to the data used in determining outlier payments will not be made. If the overall Medicare cost-to-charge ratio appears to be substantially out-of-line with similar facilities, the intermediary should ensure that the underlying costs and charges are properly reported. We are evaluating the use of upper and lower cost-to-charge ratio thresholds (similar with the outlier policy for acute care hospitals) in the future to ensure that the distribution of outlier payments remains equitable.''

In the May 16, 2003 proposed rule, we proposed to continue to use the $11,211 threshold amount.

Comment: A commenter asserted that CMS should consider dropping the outlier threshold similar to the IPPS.

Response: As we stated in the May 16, 2003 proposed rule, the threshold amount was used in the FY 2003 IRF PPS payment rates and we believe that the threshold amount of $11,211 that was used remains appropriate because the data that was used to calculate this amount was not comprised of data that were inappropriately influenced by the incentives the current IRF PPS may create.

Specifically we used the IRF cost and charge data from the previous cost-based reimbursement system to establish the outlier threshold. These data were not inappropriately influenced by incentives to inflate charges that are created with the existence of an outlier policy. There is no need to inflate charges under cost-based reimbursement because a provider is paid their costs subject to certain applicable limits. This is unlike the outlier situation in IPPS, which used post-PPS data to update its annual threshold amount. The IPPS data reflected the practices that we believe erroneously created inappropriate outlier payments. Namely, that hospitals take advantage of the time lag between current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report. Specifically, using historical cost-to-charge ratios may not reflect actual charges in the cost reporting period when the discharge occurred. This can result in an over-estimation of costs that in turn may result in inappropriate outlier payments. In addition to the time lag vulnerability, some hospitals increase their charges so far above costs that their cost-to-charge ratios fall below a floor resulting in an over-estimation of a hospital's cost per case. Again, this over-estimation of costs can possibly result in inappropriate outlier payments. As discussed in the November 3, 2000 proposed rule, the outlier threshold amount of $11,211 was calculated by simulating aggregate payments with and without an outlier policy, and applying an iterative process to determine a threshold that would result in outlier payments being projected to equal 3 percent of total payments under the simulation. Once we have adequate post-IRF PPS data, we will be able to examine whether the threshold amount needs to be updated. Specifically, we will assess the extent to which total estimated outlier payment approximates 3 percent of total payments and whether the threshold amount needs to be updated. As we previously stated, the data used to develop the IRF PPS outlier threshold amount were not inappropriately influenced by these incentives, therefore, we are adopting as final the continued use of the $11,211 threshold amount.

We will also continue to make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount ($11,211 which is then adjusted for each IRF by the facility's wage adjustment, its low-income patient adjustment, and its rural adjustment, if applicable). We will calculate the estimated cost of a case by multiplying an IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. However, we are applying a ceiling to an IRF's cost-to-charge ratios, which is discussed below. In accordance with § 412.624(e)(4), we will continue to pay outlier cases at 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted IRF PPS payment for the CMG and the adjusted threshold amount). In addition, under the existing methodology described in the preamble to the August 7, 2001 IRF PPS final rule (66 FR 41363), we will continue to assign the applicable national average for new IRFs.

2. Changes to the IRF Outlier Payment Methodology

Statistical accuracy of cost-to-charge ratios. We believe that there is a need to ensure that the cost-to-charge ratio used to compute an IRF's estimated costs should be subject to a statistical measure of accuracy. Removing aberrant data from the calculation of outlier payments will allow us to enhance the extent to which outlier payments are equitably distributed and continue to reduce incentives for IRFs to underserve patients who require more costly care. Further, we stated in the May 16, 2003 IRF proposed rule that using a statistical

measure of accuracy to address aberrant cost-to-charge ratios would also allow us to be consistent with the proposed outlier policy changes for the acute care hospital IPPS discussed in the March 4, 2003 Cost Outlier proposed rule, (68 FR 10420). In the May 16, 2003 proposed rule, we proposed the following:

(1) To apply a ceiling to IRF's cost-to-charge ratio if a facility's cost-to-charge ratio is above a ceiling. We would calculate two national ceilings, one for IRFs located in rural areas and one for facilities located in urban areas. We proposed to compute this ceiling by first calculating the national average and the standard deviation of the cost-to-charge ratio for both urban and rural IRFs. (Because of the small number of IRF's compared to the number of acute care hospitals, we believe that statewide averages for IRFs, as proposed and adopted as final under the IPPS, would not be statistically valid. Thus, we proposed to use national average cost-to-charge ratios in place of statewide averages.)

However, we believe that using only a national average may not adequately address the differences among the various types of IRFs, like the use of statewide averages would under the IPPS. Therefore, we believe using two national ceilings, one for IRFs in urban areas and one for IRFs in rural areas would be more appropriate than just using one national ceiling for IRFs. In the August 7, 2001 final rule, we discussed our policy to adjust IRF PPS payments to IRFs located in rural areas, in large part, because IRFs in rural areas have significantly higher costs than other facilities. Similarly, we believe using an average cost-to-charge ratio specifically targeted for rural facilities will allow us to more accurately estimate costs that are used to determine outlier payments for IRFs in rural areas. Therefore, we are adopting as final the use of two national ceilings, one for IRFs in urban areas and one for IRFs in rural areas.

To determine the rural and urban ceiling, we proposed to multiply each of the standard deviations by 3 and add the result to the appropriate national cost-to-charge ratio average (rural and urban). We believe this method results in statistically valid ceilings. If an IRF's cost-to-charge ratio is above the applicable ceiling it would be considered to be statistically inaccurate and we would assign the national (either rural or urban) average cost-to-charge ratio to the IRF. Cost-to-charge ratios above this ceiling are probably due to faulty data reporting or entry, and, therefore, should not be used to identify and make payments for outlier cases because such data are most likely erroneous and therefore should not be relied upon. We proposed to update the ceiling and averages using this methodology every year and indicated that we would publish these amounts in future program memoranda.

Comment: We received no comments on this proposal.

Response: We are adopting this proposed policy as final.

(2) Not assign the applicable national average cost-to-charge ratio when an IRF's cost-to-charge ratio falls below a floor. We proposed this policy because, as is the case for acute care hospitals, we believe IRFs could arbitrarily increase their charges in order to maximize outlier payments. Even though this arbitrary increase in charges should result in a lower cost-to-charge ratio in the future (due to the lag time in cost report settlement), if we use a floor, the IRF's cost-to-charge ratio would be raised to the applicable national average. This application of the national average could result in inappropriately higher outlier payments. Accordingly, we proposed to apply the IRF's actual cost-to-charge ratio to determine the cost of the case rather than creating and applying a floor. Applying an IRF's actual cost-to-charge ratio to charges in the future to determine the cost of a case will result in more appropriate outlier payments because it does not overstate the actual cost-to-charge ratio.

Comment: Some commenters disagreed with the proposal to assign a national ceiling and not a national floor when an IRF's own ratio falls below the floor. A commenter asserted that this did not seem equitable.

Response: We disagree with the commenters and believe the elimination of a floor while maintaining a ceiling is fair and appropriate. The proposed policy not to use a floor under the IRF PPS is appropriate because use of a floor results in cost-to-charge ratios being set too high relative to an IRF's own cost-to-charge ratio, which in turn results in an over-estimation of an IRF's current costs per case. We also note that not using a floor is consistent with the IPPS finalized outlier policies as discussed in the June 9, 2003 final rule. This policy was established in response to a specific problem associated with hospitals under the IPPS, with some hospitals intentionally taking advantage of our policy to assign cost-to-charge ratios when a hospital's own ratio fell below the floor. We are finalizing our decision not to use a floor in our outlier policy as it would aid in appropriately identifying those cases that warrant outlier payments. In addition, the proposed policy to maintain a ceiling under IRF PPS is fair because we believe that if an IRF has a cost-to-charge ratio above 3 standard deviations from the mean, then the cost-to-charge ratio is probably due to faulty data reporting or entry and should not be used to identify and pay for outliers.

3. Adjustment of IRF Outlier Payments

Under the existing methodology for computing IRF outlier payments as described in the preamble of the August 7, 2001 IRF PPS final rule (66 FR 41363) and in the November 1, 2001 Program Memorandum discussed above, we specify that the cost-to-charge ratio used to compute estimated costs are obtained from the most recent settled Medicare cost report. Further, we provided for no retroactive adjustment to the outlier payments to account for differences between the cost-to-charge ratio from the latest settled cost report and the actual cost-to-charge ratio for the cost reporting period in which the outlier payment is made. This policy is consistent with the existing outlier payment policy for acute care hospitals under the IPPS. However, as discussed in the IPPS March 4, 2003 Cost Outlier proposed rule (68 FR 10423), we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because we became aware that payment vulnerabilities exist in the current IPPS outlier policy. Because we believe the IRF outlier payment methodology is likewise susceptible to the same payment vulnerabilities, we proposed the following:

(1) As proposed for acute care hospitals under the IPPS at proposed § 412.84(i) in the March 4, 2003 proposed rule (68 FR 10420), we proposed under § 412.624(e)(4), by cross-referencing proposed § 412.84(i), that fiscal intermediaries would use more recent data when determining an IRF's cost-to-charge ratio. Specifically, under § 412.84(i), we proposed that fiscal intermediaries would use either the most recent settled IRF cost report or the most recent tentative settled IRF cost report (whichever is later) to obtain the applicable IRF cost-to-charge ratio. In addition, as proposed under § 412.84(i), any reconciliation of outlier payments would be based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(2) As proposed for acute care hospitals under the IPPS at proposed § 412.84(m) in the March 4, 2003 proposed rule (68 FR 10420), we proposed under § 412.624(e)(4), by

cross-referencing proposed § 412.84(m), that IRF outlier payments may be adjusted to account for the time value of money which is the value of money during the time period it was inappropriately held by the IRF as an ''overpayment.'' We also proposed to adjust outlier payments for the time value of money for cases that are ''underpaid'' to the IRF. In these cases, the adjustment would result in additional payments to the IRF. We proposed that any adjustment would be based upon a widely available index to be established in advance by the Secretary, and would be applied from the midpoint of the cost reporting period to the date of reconciliation.

Comment: A few commenters disagreed with the proposed policy to adjust outlier payments to account for the time value of money.

Response: Outlier payments are extremely susceptible to manipulation because hospitals set their own level of charges and are able to change their charges without notification to, or review by, their fiscal intermediary. Such changes by a hospital directly affect its level of outlier payments. Therefore, even though money may be recouped if the outlier payments are reconciled, the hospital would essentially be able to unilaterally increase its charges and acquire an interest-free loan in the meantime. For that reason, we believe it is appropriate and we are finalizing our policy to apply an adjustment for the time value of ''overpayments'' or ''underpayments'' identified at the cost report reconciliation.

Comment: Some commenters believe that the adjustment for the time value of money should be set at a point other than the midpoint of the cost reporting period

Response: We believe using the midpoint of the cost reporting year is an appropriate point to base an adjustment, as proposed, and results in an average ''overpayment'' or ''underpayment'' that would be fair to use as part of the adjustment calculation. Specifically, using the midpoint of the cost reporting period as the point to base an adjustment for all discharges that occur during a given cost reporting period is appropriate given that the midpoint is the median of the time period for all discharges. As we stated in the proposed rule, we proposed that IRF outlier payments may be adjusted to account for the time value of money which is the value of money during the time period it was inappropriately held by the IRF as an ''overpayment.'' We also stated that we may adjust outlier payments for the time value of money for cases that are ''underpaid'' to the IRF. In these ''underpayment'' cases, the adjustment will result in additional payments to the IRF. Because this adjustment will be applicable to IRFs that were ''overpaid,'' as well as those IRFs that were ''underpaid,'' we believe applying adjustments from the midpoint of the cost reporting period to the date of reconciliation is reasonable. Further, this policy is consistent with the final outlier policy stated in the June 9, 2003 IPPS outlier final rule.

We proposed to add a provision to our regulations to provide that outlier payments would become subject to reconciliation when hospitals' cost reports are settled. Under this policy, outlier payments would be processed throughout the year using facility cost-to-charge ratios based on the best information available at that time. We proposed that when the cost report is settled, any reconciliation of outlier payments by fiscal intermediaries would be based on facility cost-to-charge ratios calculated on a ratio of costs to charges computed from the cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

This process would require some degree of recalculating outlier payments for individual claims. It is not possible to distinguish, on an aggregate basis, how much a hospital's outlier payments would change due to a change in its cost-to-charge ratios. This is because, in the event of a decline in a cost-to-charge ratio, some cases may no longer qualify for any outlier payments while other cases may qualify for lower outlier payments. Therefore, the only way to determine accurately the net effect of a decrease in cost-to-charge ratios on a hospital's total outlier payments is to assess the impact on a claim-by-claim basis. Because under our proposal, outlier payments would be based on the relationship between the hospital's costs and charges at the time a discharge occurred, the proposed methodology would ensure that when the final outlier payments were made, they would reflect an accurate assessment of the actual costs the hospital incurred. Therefore, we are adopting this proposal as final.

4. Change to the Methodology for Calculating the Federal Prospective Payment Outlier Payment

Under § 412.624(e)(4), we provide for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients and for rural locations) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at § 412.84(i) except that national averages will be used instead of statewide averages. Also effective for discharges on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at § 412.84(m).

Comment: A commenter was concerned about the discretion given to the fiscal intermediaries that would allow them to reconcile a provider's outlier payments if they believe the outlier payments are significantly inaccurate.

Response: Although CMS understands the commenter's concerns about discretion given to the fiscal intermediaries, we believe that it is important for CMS to have the flexibility to respond appropriately in the future if unforeseen evidence of manipulation of other prospective payments similar to that of IPPS comes to light. Therefore, we will provide guidance to the fiscal intermediaries with respect to their scope of discretion, as well as, provide them with instructions to implement all revisions to the outlier policy contained in this final rule.

I. Miscellaneous Comment

Comment: We received a comment expressing a concern that some providers believe that recreational therapy services are not covered by Medicare and that the costs of providing recreational therapy services are not included in the IRF PPS rates.

Response: This comment is not specifically related to our proposed changes to the IRF PPS. We responded to similar comments in the IPPS January 3, 1984 final rule (49 FR 242) by stating that ''Neither the implementation of the prospective payment system nor the criteria for excluding certain hospitals and units from it will prohibit the provision of recreational therapy services to hospital inpatients. In particular, the absence of these services from the list of rehabilitative services in rehabilitation hospitals and units does not indicate that Medicare will no longer pay for them in those hospitals and units that provide them. On the contrary, these services will continue to be covered to the same extent they always have been under the existing Medicare policies.'' Since the publication of the January 3, 1984 final

rule, we have not made any changes to our policies that would preclude recreational therapy services from those covered by Medicare. In particular the introduction of the IRF PPS does not change this fact. Accordingly, since recreational therapy services were provided in the IRF base period, the costs of providing these covered services are included in standardized payment amount upon which the IRF PPS rates are based.

VII. Provisions of the Final Rule

The provisions of this final rule reflect the provisions of the May 16, 2003 proposed rule, except as noted elsewhere in this preamble. Following is a summary of the major changes that we have made in this final rule, either in consideration of public comments received or to more effectively implement the FY 2004 IRF PPS.

- In the proposed rule we proposed a market basket increase factor of 3.3 percent for FY 2004 IRF 1997 data. In this final rule, the payment rates set forth for the FY 2004 IRF market basket increase factor is 3.2 percent using 1997 data.
- As indicated in the May 16, 2003 proposed rule, in this final rule we are using updated FY 2004 IRF market basket index data from 1992 through 1997 and an updated FY 2004 IRF labor-related share and wage indices to update the IRF PPS rates to FY 2004. Because any adjustment or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget neutral manner as required by statute, we amend our regulation at § 412.624(e)(1).
- As indicated in the May 16, 2003 proposed rule, we finalize changes to the methodology for determining IRF payments for high-cost outliers to conform our policies to other Medicare prospective payment systems as appropriate. In this final rule we revise the IRF outlier payment methodology effective for discharges on or after October 1, 2003 and adopt as final the continued use of the $11,211 threshold amount. However, a ceiling will be applied to an IRF's cost-to-charge ratios in accordance with § 412.624(e)(4). We will continue to pay outlier cases at 80 percent of the difference between the estimated cost of the case and the outlier threshold and assign the applicable national average for new IRFs.
- Under § 412.624(e)(4), we provide for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients and for rural locations) as specified by us. Effective for discharges on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at § 412.84(i) except that national averages will be used instead of statewide averages. Also effective for discharges on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at § 412.84(m).

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 30-day notice in the **Federal Register** and solicit public comment when a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are therefore soliciting public comment on each of these issues for the proposed information collection requirements discussed below.

Section 412.608 Patients' Rights Regarding the Collection of Patient Assessment Data

Under this section, before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient the form entitled ''Privacy Act Statement—Health Care Records'' and the simplified plain language description of the Privacy Act Statement—Health Care Records, which is a form entitled ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities;'' the inpatient rehabilitation facility must document in the Medicare inpatient's clinical record that the Medicare inpatient has been given the documents specified in this section.

The burden associated with this section is the time it will take to document that the patient has been given the requisite forms. We estimate that it will take no more than a minute per patient. There will be an estimated 390,000 admissions per year, for a total of 6,500 hours per year.

Section 412.614 Transmission of Patient Assessment Data

1. The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service inpatient.

These information collection requirements associated with the IRF PPS are currently approved by OMB through July 31, 2005 under OMB number 0938–0842.

2. Under paragraph (e), *Exemption to being assessed a penalty for transmitting the IRF–PAI data late,* CMS may waive the penalty specified in paragraph (d) of this section. To assist CMS in determining if a waiver is appropriate the inpatient rehabilitation facility must fully document the circumstances surrounding the occurrence.

Given that it is estimated that fewer than 10 instances will occur on an annual basis to necessitate a waiver, this requirement is not subject to the PRA as stipulated under 5 CFR 1320.3(c).

We have submitted a copy of this final rule to OMB for its review of the information collection requirements in § 412.608 and § 412.614. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies to CMS within 30 days of this publication date directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Office of Regulations Development and Issuances, Reports Clearance Officer, 7500 Security Boulevard, Baltimore, MD 21244–1850. Attn: Julie Brown, CMS–1474–P; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

Comments submitted to OMB may also be emailed to the following address: E-mail: *baguilar@omb.eop.gov;* or faxed to OMB at (202) 395–6974.

IX. Regulatory Impact Analysis

A. Introduction

The August 7, 2001 IRF PPS final rule (66 FR 41316) established the IRF PPS for the payment of inpatient hospital services furnished by a rehabilitation

hospital or rehabilitation unit of a hospital with cost reporting periods beginning on or after January 1, 2002. We incorporated a number of elements into the IRF PPS, such as case-level adjustments, a wage adjustment, an adjustment for the percentage of low-income patients, a rural adjustment, and outlier payments. The August 1, 2002 IRF PPS notice (67 FR 49928) set forth updates of the IRF PPS rates contained in the August 7, 2001 IRF PPS final rule. The purpose of the August 1, 2002 IRF PPS notice was only to provide an update to the IRF payment rates for discharges during FY 2003. This final rule provides updated IRF PPS rates for discharges that occur during FY 2004 as well as makes policy changes in the IRF PPS system.

In constructing these impacts, we do not attempt to predict behavioral responses, and we do not make adjustments for future changes in such variables as discharges or case-mix. We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors due to other changes in the forecasted impact time period. Some examples of such possible events are newly legislated general Medicare program funding changes by the Congress, or changes specifically related to IRFs. In addition, changes to the Medicare program may continue to be made as a result of new statutory provisions. Although these changes may not be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA), (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

B. Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more).

In this final rule, we are using an updated FY 2004 IRF market basket index and an updated FY 2004 IRF labor-related share and wage indices to update the IRF PPS rates to FY 2004, as described in section VII. of this final rule. By updating the IRF PPS rates to FY 2004, we estimate that the overall cost to the Medicare program for IRF services in FY 2004 will increase by $187.3 million over FY 2003 levels. The updates to the IRF labor-related share and wage indices are made in a budget neutral manner. Thus, updating the IRF labor-related share and the wage indices to FY 2004 have no overall effect on estimated costs to the Medicare program. Therefore, this estimated cost to the Medicare program is due to the application of the updated IRF market basket of 3.2 percent. Because the combined distributional effects and the cost to the Medicare program are greater than $100 million, this final rule is considered a major rule as defined above.

C. Regulatory Flexibility Act (RFA) and Impact on Small Hospitals

The RFA requires agencies to analyze the economic impact of our regulations on small entities. If we determine that the regulation will impose a significant burden on a substantial number of small entities, we must examine options for reducing the burden. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and governmental agencies. Most hospitals are considered small entities, either by nonprofit status or by having receipts of $6 million to $29 million in any 1 year. (For details, see the Small Business Administration's regulation at 65 FR 69432 that set forth size standards for health care industries.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs. Therefore, we assume that all IRFs are considered small entities for the purpose of the analysis that follows. Medicare fiscal intermediaries and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

The provisions of this final rule represent a 3.2 percent increase to the Federal PPS rates. We do not expect an incremental increase of 3.2 percent to the Medicare Federal rates to have a significant effect on the overall revenues of IRFs. Most IRFs are units of hospitals that provide many different types of services (for example, acute care, outpatient services) and the rehabilitation component of their business is relatively minor in comparison. In addition, IRFs provide services to (and generate revenues from) patients other than Medicare beneficiaries. Accordingly, we certify that this final rule will not have a significant impact on small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that will have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. 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 (MSA) and has fewer than 100 beds.

This final rule will not have a significant impact on the operations of small rural hospitals. As indicated above, the provisions of this final rule represent a 3.2 percent increase to the Federal PPS rates. In addition, we do not expect an incremental increase of 3.2 percent to the Federal rates to have a significant effect on overall revenues or operations since most rural hospitals provide many different types of services (for example, acute care, outpatient services) and the rehabilitation component of their business is relatively minor in comparison. Accordingly, we certify that this final rule will not have a significant impact on the operations of small rural hospitals.

D. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of at least $110 million. This final rule will not have a substantial effect on the governments mentioned nor will it affect private sector costs.

E. Executive Order 13132

We examined this final rule in accordance with Executive Order 13132 and determined that it will not have a substantial impact on the rights, roles, or responsibilities of State, local, or tribal governments.

F. Overall Impact

For the reasons stated above, we have not prepared an analysis under the RFA and section 1102(b) of the Act because we have determined that this final rule will not have a significant impact on small entities or the operations of small rural hospitals.

G. Anticipated Effects of the Final Rule

We discuss below the impacts of this final rule on the Federal budget and on IRFs.

1. Budgetary Impact

Section 1886(j)(3)(C) of the Act requires annual updates to the IRF PPS payment rates. Section 1886(j)(6) of the Act requires the Secretary to adjust or update the labor-related share and the wage indices or the labor-related share and the wage indices applicable to IRFs not later than October 1, 2001 and at least every 36 months thereafter. We project that updating the IRF PPS for discharges occurring on or after October 1, 2003 and before October 1, 2004, will cost the Medicare program $187.3 million. The updates to the IRF labor-related share and wage indices are made in a budget neutral manner. Thus, updating the IRF labor-related share and the wage indices to FY 2004 will have no overall effect on estimated costs to the Medicare program. Therefore, this estimated cost to the Medicare program is due to the application of the updated IRF market basket of 3.2 percent.

2. Impact on Providers

For the impact analyses shown in the August 7, 2001 IRF PPS final rule, we simulated payments for 1,024 facilities. To construct the impact analyses set forth in this final rule, we use the latest available data. For the most part, we used 1998 and 1999 Medicare claims and FIM data for the same facilities that were used in constructing the impact analyses provided in the August 7, 2001 IRF PPS final rule (66 FR 41364 through 41365, and 41372) which was effective for cost reporting periods beginning on or after January 1, 2002. We do not have enough post-IRF PPS data to develop the distributional impact on providers. Further, we will need a sufficient amount of these data to be able to rely on them as the basis for the impact analysis. Because IRFs began to be paid under the IRF PPS based on their cost report start date that occurred on or after January 1, 2002, sufficient Medicare claims data will not be available for those facilities whose cost report start date occurs later in the calendar year. The estimated distributional impacts among the various classifications of IRFs for discharges occurring on or after October 1, 2003 and before October 1, 2004 is reflected in Chart 8.—Projected Impact of FY 2004 Update—of this final rule. These impacts reflect the updated IRF wage adjustment and the application of the 3.2 percent IRF market basket increase.

3. Calculation of the Estimated FY 2003 IRF Prospective Payments

To estimate payments under the IRF PPS for FY 2003, we multiplied each facility's case-mix index by the facility's number of Medicare discharges, the FY 2003 standardized payment amount, the applicable FY 2003 labor-related share and wage indices, a low-income patient adjustment, and a rural adjustment (if applicable). The adjustments include the following:

The wage adjustment, calculated as follows:

(.27605 + (.72395 × FY 2003 Wage Index)).

The disproportionate share adjustment, calculated as follows:

(1 + Disproportionate Share Percentage) raised to the power of .4838).

The rural adjustment, if applicable, calculated by multiplying payments by 1.1914.

4. Calculation of the Proposed Estimated FY 2004 IRF Prospective Payments

To calculate FY 2004 payments, we use the payment rates described in this final rule that reflect the 3.2 percent market basket increase factor using the FY 2004 labor-related share and wage indices, a low-income patient adjustment, and a rural adjustment (if applicable). The adjustments include the following:

The wage adjustment, calculated as follows:

(.27474 + (.72526 × FY 2004 Wage Index)).

The disproportionate share adjustment, calculated as follows:

(1 + Disproportionate Share Percentage) raised to the power of .4838).

The rural adjustment, if applicable, calculated by multiplying payments by 1.1914.

Chart 8.—Projected Impact of FY 2004 Update illustrates the aggregate impact of the estimated FY 2004 updated payments among the various classifications of facilities compared to the estimated IRF PPS payment rates applicable for FY 2003. The first column, Facility Classification, identifies the type of facility. The second column identifies the number of facilities for each classification type, and the third column lists the number of cases. The fourth column indicates the impact of the budget neutral wage adjustment. The last column reflects the combined changes including the update to the FY 2003 payment rates by 3.2 percent and the budget neutral wage adjustment (including the FY 2004 labor-related share and the FY 2004 wage indices).

CHART 8.—PROJECTED IMPACT OF FY 2004 UPDATE

Facility classification	Number of facilities	Number of cases	Budget neutral wage adjustment (in percent)	Total change (in percent)
Total				
	1,024	347,809	0.0	3.2
Urban unit	725	206,926	−0.5	2.7
Rural unit	131	26,507	0.2	3.4
Urban hospital	156	109,691	0.9	4.2
Rural hospital	12	4,685	−1.3	1.8
Total urban	881	316,617	0.0	3.2
Total rural	143	31,192	0.0	3.1
Urban by Region				
New England	32	15,039	0.1	3.3
Middle Atlantic	133	64,042	−1.5	1.6
South Atlantic	112	52,980	0.5	3.7
East North Central	171	55,071	−0.5	2.6
East South Central	41	23,434	0.9	4.1

CHART 8.—PROJECTED IMPACT OF FY 2004 UPDATE—Continued

Facility classification	Number of facilities	Number of cases	Budget neutral wage adjustment (in percent)	Total change (in percent)
West North Central	70	18,087	0.6	3.8
West South Central	154	52,346	1.5	4.7
Mountain	56	14,655	1.1	4.3
Pacific	112	20,963	−0.7	2.5
Rural by Region				
New England	4	829	−0.2	3.0
Middle Atlantic	10	2,424	−1.3	1.8
South Atlantic	20	6,192	−0.8	2.4
East North Central	29	5,152	−0.5	2.7
East South Central	10	3,590	0.2	3.4
West North Central	22	3,820	1.7	4.9
West South Central	32	7,317	0.6	3.8
Mountain	9	1,042	−0.3	2.9
Pacific	7	826	−1.2	2.0

As Chart 8 illustrates, all IRFs are expected to benefit from the 3.2 percent market basket increase that will be applied to FY 2003 IRF PPS payment rates to develop the FY 2004 rates. However, there may be distributional impacts among various IRFs due to the application of the updates to the labor-related share and wage indices in a budget neutral manner.

To summarize, this final rule provides that all facilities will receive a 3.2 percent increase in their unadjusted IRF PPS payments. The estimated positive impact among all IRFs reflected in Chart 8 are due to the effect of the update to the IRF market basket index.

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

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, part 412 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 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

■ 2. In § 412.20, the following changes are made:

■ A. Redesignate paragraph (b) as paragraph (b)(1).

■ B. Add paragraph (b)(2) to read as follows:

§ 412.20 Hospital services subject to the prospective payment systems.

* * * * *

(b) * * *

(2) CMS will not pay for services under Subpart P of this part if the services are paid for by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not to have CMS make payments to an inpatient rehabilitation facility for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees, as provided under part 417 of this chapter.

* * * * *

■ 3. In § 412.22, the following changes are made:

■ A. Revise paragraph (h)(2) introductory text.

■ B. Remove and reserve paragraph (h)(6).

■ C. Add paragraph (h)(7).

The revisions and addition read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(h) * * *

(2) Except as provided in paragraphs (h)(3), (h)(6), and (h)(7) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

* * * * *

(6) [Reserved]

(7) The provisions of paragraph (h)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.

■ 4. In § 412.25, the following changes are made:

■ A. Revise paragraph (e)(2) introductory text.

■ B. Add paragraph (e)(5).

The revision and addition read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(e) * * *

(2) Except as provided in paragraphs (e)(3) and (e)(5) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

* * * * *

(5) The provisions of paragraph (e)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for

cost reporting periods beginning on or after October 1, 2003.

* * * * *

■ 5. In § 412.29, revise paragraph (a)(2) to read as follows:

§ 412.29 Excluded rehabilitation units: Additional requirements.

(a) * * *

(2) Converted units under § 412.30(c).

* * * * *

■ 6. In § 412.30, the following changes are made:

■ A. Revise paragraph (b)(3).

■ B. Revise paragraph (d)(2)(i).

§ 412.30 Exclusion of new rehabilitation units and expansion of units already excluded.

(b) * * *

(3) The written certification described in paragraph (b)(2) of this section is effective for the first full cost reporting period during which the unit is used to provide hospital inpatient care.

* * * * *

(d) * * *

(2) *Conversion of existing bed capacity.*

(i) Bed capacity is considered to be existing bed capacity if it does not meet the definition of new bed capacity under paragraph (d)(1) of this section.

* * * * *

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

■ 7. In § 412.602, republish the introductory text and revise the definition of ''Discharge'' to read as follows:

§ 412.602 Definitions.

As used in this subpart—

* * * * *

Discharge. A Medicare patient in an inpatient rehabilitation facility is considered discharged when—

(1) The patient is formally released from the inpatient rehabilitation facility; or

(2) The patient dies in the inpatient rehabilitation facility.

* * * * *

■ 8. In § 412.604(a)(2), revise the introductory text to read as follows:

§ 412.604 General requirements.

(a) * * *

(2) If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare Part A fee-for-service beneficiaries, CMS or its Medicare fiscal intermediary may, as appropriate—

* * * * *

■ 9. Section 412.608 is revised to read as follows:

§ 412.608 Patients' rights regarding the collection of patient assessment data.

(a) Before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient—

(1) The form entitled ''Privacy Act Statement—Health Care Records''; and

(2) The simplified plain language description of the Privacy Act Statement—Health Care Records which is a form entitled ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities.''

(b) The inpatient rehabilitation facility must document in the Medicare inpatient's clinical record that the Medicare inpatient has been given the documents specified in paragraph (a) of this section.

(c) By giving the Medicare inpatient the forms specified in paragraph (a) of this section the inpatient rehabilitation facility will inform the Medicare patient of—

(1) Their privacy rights under the Privacy Act of 1974 and 45 CFR 5b.4(a)(3); and

(2) The following rights:

(i) The right to be informed of the purpose of the collection of the patient assessment data;

(ii) The right to have the patient assessment information collected be kept confidential and secure;

(iii) The right to be informed that the patient assessment information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(iv) The right to refuse to answer patient assessment questions; and

(v) The right to see, review, and request changes on his or her patient assessment.

(d) The patient rights specified in this section are in addition to the patient rights specified in § 82.13 of this chapter.

■ 10. In § 412.610, revise paragraph (c)(1)(i)(C) to read as follows:

§ 412.610 Assessment schedule.

* * * * *

(c) * * *

(1) * * *

(i) * * *

(C) Must be completed by the calendar day that follows the admission assessment reference day.

* * * * *

■ 11. In § 412.614, the following changes are made:

■ A. Revise the introductory text to paragraph (a).

■ B. Add a new paragraph (a)(3).

■ C. Add a new paragraph (e).

The revision and additions read as follows:

§ 412.614 Transmission of patient assessment data.

(a) *Data format. General rule.* The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service inpatient—

* * * * *

(3) *Exception to the general rule.* When the inpatient rehabilitation facility does not submit claim data to Medicare in order to be paid for any of the services it furnished to a Medicare Part A fee-for-service inpatient, the inpatient rehabilitation facility is not required to, but may, transmit to Medicare the inpatient rehabilitation facility patient assessment data associated with the services furnished to that same Medicare Part A fee-for-service inpatient.

* * * * *

(e) *Exemption to being assessed a penalty for transmitting the IRF–PAI data late.* CMS may waive the penalty specified in paragraph (d) of this section when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data in accordance with paragraph (c) of this section. Only CMS can determine if a situation encountered by an inpatient rehabilitation facility is extraordinary and qualifies as a situation for waiver of the penalty specified in paragraph (d)(2) of this section. An extraordinary situation may be due to, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflict extensive damage to an inpatient rehabilitation facility. An extraordinary situation may be one that produces a data transmission problem that is beyond the control of the inpatient rehabilitation facility, as well as other situations determined by CMS to be beyond the control of the inpatient rehabilitation facility. An extraordinary situation must be fully documented by the inpatient rehabilitation facility.

■ 12. In § 412.624, the following changes are made:

■ A. Revise paragraph (c).

■ B. Revise paragraph (d).

■ C. Revise paragraph (e)(1).

■ D. Revise paragraph (e)(4).

The revisions read as follows:

§ 412.624 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) *Determining the Federal prospective payment rates.* (1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard payment conversion factor. The standard payment conversion factor is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments, and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, CMS estimates the payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the standard payment conversion factor.* The standard payment conversion factor is computed as follows:

(i) *For fiscal year 2002.* Based on the updated costs per discharge and estimated payments for fiscal year 2002 determined in paragraph (c)(2) of this section, CMS computes a standard payment conversion factor for fiscal year 2002, as specified by CMS, that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The standard payment conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(4) *Determining the Federal prospective payment rate for each case-mix group.* The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in § 412.620(b) and the standard payment conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard payment conversion factor.* The standard payment conversion factor described in paragraph (c)(3) of this section will be adjusted for the following:

(1) *Outlier payments.* CMS determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(4) of this section.

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for fiscal year 2002 so that aggregate payments under the prospective payment system, excluding any additional payments associated with elections not to be paid under the transition period methodology under § 412.626(b), are estimated to equal the amount that would have been made to inpatient rehabilitation facilities under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Coding and classification changes.* CMS adjusts the standard payment conversion factor for a given year if CMS determines that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that those revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(e) *Calculation of the adjusted Federal prospective payment.*

(1) *Adjustment for area wage levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.602. Adjustments or updates to the wage data used to adjust a facility's Federal prospective payment rate under paragraph (e)(1) of this section will be made in a budget neutral manner. CMS determines a budget neutral wage adjustment factor, based on any adjustment or update to the wage data, to apply to the standard payment conversion factor.

* * * * *

(4) *Adjustment for high-cost outliers.* CMS provides for an additional payment to an inpatient rehabilitation facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients and for rural locations) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at § 412.84(i), except that national averages will be used instead of statewide averages. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at § 412.84(m).

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

Dated: July 16, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 22, 2003.

Tommy G. Thompson,

Secretary.

BILLING CODE 4120–01–P

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS STATEMENT GIVES YOU NOTICE REQUIRED BY LAW (the Privacy Act of 1974).

THIS STATEMENT IS NOT A CONSENT FORM. IT WILL NOT BE USED TO RELEASE OR TO USE YOUR HEALTH CARE INFORMATION.

I. AUTHORITY FOR COLLECTION OF YOUR INFORMATION, INCLUDING YOUR SOCIAL SECURITY NUMBER, AND WHETHER OR NOT YOU ARE REQUIRED TO PROVIDE INFORMATION FOR THIS ASSESSMENT. Sections 1102(a), 1154, 1861(z), 1864, 1865, 1866, 1871, 1886(j) of the Social Security Act.

Medicare participating inpatient rehabilitation facilities must do a complete assessment that accurately reflects your current clinical status and includes information that can be used to show your progress toward your rehabilitation goals. The inpatient rehabilitation facility must use the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IFR-PAI) as part of that assessment, when evaluating your clinical status. The IRF-PAI must be used to assess every Medicare Part A fee-for-service inpatient, and it may be used to assess other types of inpatients. This information will be used by the Centers for Medicare & Medicaid Services (CMS) to be sure that the inpatient rehabilitation facility is paid appropriately for the services that they furnish you, and to help evaluate that the inpatient rehabilitation facility meets quality standards and gives appropriate health care to its patients. You have the right to refuse to provide information to the inpatient rehabilitation facility for the assessment. Information provided to the federal government for this assessment is protected under the Federal Privacy Act of 1974 and the IRF-PAI System of Records. You have the right to see, copy, review, and request correction of inaccurate or missing personal health information in the IRF-PAI System of Records.

II. PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

The information collected will be entered into the IRF-PAI System No. 09-70-1518. Your health care information in the IRF-PAI System of Records will be used for the following purposes:

- support the IRF prospective payment system (PPS) for payment of the IRF Medicare Part A fee-for-services furnished by the IRF to Medicare beneficiaries;
- help validate and refine the Medicare IRF-PPS
- study and help ensure the quality of care provided by IRFs;
- enable CMS and its agents to provide IRFs with data for their quality assurance and ultimately quality improvement activities;
- support agencies of the State government , deeming organizations or accrediting agencies to determine, evaluate and assess overall effectiveness and quality of IRF services provided in the State;
- provide information to consumers to allow them to make better informed selections of providers;
- support regulatory and policy functions performed within the IRF or by a contractor or consultant;
- support constituent requests made to a Congressional representative;
- support litigation involving the facility;
- support research on the utilization and quality of inpatient rehabilitation services; as well as, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health for understanding and improving payment systems.

III. ROUTINE USES

These "routine uses" specify the circumstances when the Centers for Medicare & Medicaid Services may release your information from the IRF-PAI System of Records without your consent. Each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of protected health information authorized by these routine uses may be made only if, and as, permitted or required by the 'Standards for Privacy of Individually Identifiable Health Information.' (45 CFR Parts 160 and 164). Disclosures of the information may be to:

1. To agency contractors or consultants who have been contracted by the agency to assist in the performance of a service related to this system of records and who need to have access to the records in order to perform the activity;
2. To a Peer Review Organization (PRO) in order to assist the PRO to perform Title XI and Title XVIII functions relating to assessing and improving IRF quality of care. PROs will work with IRFs to implement quality improvement programs, provide consultation to CMS, its contractors, and to State agencies;
3. To another Federal or State agency:
    a. To contribute to the accuracy of CMS's proper payment of Medicare benefits,
    b. To enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds, or

   c. To improve the state survey process for investigation of complains related to health and safety or quality of care and to implement a more outcome oriented survey and certification program.
4. To an individual or organization for a research, evaluation, or epidemiological projects related to the prevention of disease or disability, the restoration or maintenance of health epidemiological or for understanding and improving payment projects.
5. To a member of Congress or to a congressional staff member in response to a inquiry of the Congressional Office made at the written request of the constituent about whom the record is maintained.
6. To the Department of Justice (DOJ), court or adjudicatory body when:
   a. The agency or any component thereof; or
   b. Any employee of the agency in his or her official capacity; or
   c. Any employee of the agency in his or her individual capacity where the employee; or
   d. The United States Government; is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.
7. To a CMS contractor (including, but not necessarily limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program.
8. To another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in whole or part by Federal funds, when disclosure is deemed reasonable necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat frauds or abuse in such programs;
9. To a national accrediting organization that has been approved for deeming authority for Medicare requirements for inpatient rehabilitation services (i.e., the Joint Commission for the Accreditation of Healthcare Organizations, the American Osteopathic Association and the Commission of Accreditation of Rehabilitation Facilities). Data will be released to these organizations only for those facilities that participate in Medicare by virtue of their accreditation status.
10. To insurance companies, third party administrators (TPA), employers, self-insurers, manage care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, group health plans (i.e., health maintenance organizations (HMO) or a competitive medical plan (CMP)) with a Medicare contract, or a Medicare-approved health care prepayment plan (HCPP), directly or through a contractor, and other groups providing protection for their enrollees. Information to be disclosed shall be limited to Medicare entitlement data. In order to receive the information, they must agree to:
    a. Certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a third party administrator;
    b. Utilize the information solely for the purpose of processing the individual's insurance claims; and
    c. Safeguard the confidentiality of the data and prevent unauthorized access.

IV. EFFECT ON YOU IF YOU DO NOT PROVIDE INFORMATION

The inpatient rehabilitation facility needs the information contained in the IRF-PAI in order to comply with the Medicare regulations. Your inpatient rehabilitation facility will also use the IRF-PAI to assist in providing you with quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it difficult to evaluate if the facility is giving you quality services. If you choose not to provide information, there is no federal requirement for the inpatient rehabilitation facility to refuse you services.

CONTACT INFORMATION

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy or request correction of inaccurate or missing personal health information which that Federal agency maintains in its IRF-PAI System of Records:

Call 1-800-MEDICARE, toll free, for assistance in contacting the IRF-PAI System of Records Manager.

TTY for the hearing and speech impaired: 1-800-820-1202

Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities

This notice is a simplified plain language summary of the information contained in the attached "Privacy Act Statement-Health Care Records"

As a hospital rehabilitation inpatient, you have the privacy rights listed below.

- **You have the right to know why we need to ask you questions.**
  - We are required by federal law to collect health information to make sure:
    1) you get quality health care, and
    2) payment for Medicare patients is correct.
- **You have the right to have your personal health care information kept confidential and secure.**
  - You will be asked to tell us information about yourself so that we can provide the most appropriate, comprehensive services for you.
  - We keep anything we learn about you confidential and secure. This means only those who are legally permitted to use or obtain the information collected during this assessment will see it.
- **You have the right to refuse to answer questions.**
  - You do not have to answer any questions to get services.
- **You have the right to look at your personal health information.**
  - We know how important it is that the information we collect about you is correct.
  - You may ask to review the information you provided. If you think we made a mistake, you can ask us to correct it.

In addition, you may ask the Centers for Medicare & Medicaid Services to see, review, copy or request correction of inaccurate or missing personal identifying health information which this Federal agency maintains in its IRF-PAI System of Records. For CONTACT INFORMATION or a detailed description of your privacy rights, refer to the attached PRIVACY ACT STATEMENT – HEALTH CARE RECORDS.
Note: The rights listed above are in concert with the rights listed in the hospital conditions of participation and the rights established under the Federal Privacy Rule.

This is a Medicare & Medicaid Approved Notice.

Table 1. – Relative Weights for Case-Mix Groups (CMGs)

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0101	Stroke M=69-84 and C=23-35	0.4778	0.4279	0.4078	0.3859	10	9	6	8
0102	Stroke M=59-68 and C=23-35	0.6506	0.5827	0.5553	0.5255	11	12	10	10
0103	Stroke M=59-84 and C=5-22	0.8296	0.7430	0.7080	0.6700	14	12	12	12
0104	Stroke M=53-58	0.9007	0.8067	0.7687	0.7275	17	13	12	13
0105	Stroke M=47-52	1.1339	1.0155	0.9677	0.9158	16	17	15	15
0106	Stroke M=42-46	1.3951	1.2494	1.1905	1.1267	18	18	18	18
0107	Stroke M=39-41	1.6159	1.4472	1.3790	1.3050	17	20	21	21
0108	Stroke M=34-38 and A>=83	1.7477	1.5653	1.4915	1.4115	25	27	22	23
0109	Stroke M=34-38 and A<=82	1.8901	1.6928	1.6130	1.5265	24	24	22	24
0110	Stroke M=12-33 and A>=89	2.0275	1.8159	1.7303	1.6375	29	25	27	26
0111	Stroke M=27-33 and A=82-88	2.0889	1.8709	1.7827	1.6871	29	26	24	27
0112	Stroke M=12-26 and A=82-88	2.4782	2.2195	2.1149	2.0015	40	33	30	31
0113	Stroke M=27-33 and A<=81	2.2375	2.0040	1.9095	1.8071	30	27	27	28
0114	Stroke M=12-26 and A<=81	2.7302	2.4452	2.3300	2.2050	37	34	32	33
0201	Traumatic brain injury M=52-84 and C=24-35	0.7689	0.7276	0.6724	0.6170	13	14	14	11
0202	Traumatic brain injury M=40-51 and C=24-35	1.1181	1.0581	0.9778	0.8973	18	16	17	16
0203	Traumatic brain injury M=40-84 and C=5-23	1.3077	1.2375	1.1436	1.0495	19	20	19	18
0204	Traumatic brain injury M=30-39	1.6534	1.5646	1.4459	1.3269	24	23	22	22
0205	Traumatic brain injury M=12-29	2.5100	2.3752	2.1949	2.0143	44	36	35	31
0301	Non-traumatic brain injury M=51-84	0.9655	0.8239	0.7895	0.7195	14	14	12	13
0302	Non-traumatic brain injury M=41-50	1.3678	1.1672	1.1184	1.0194	19	17	17	16
0303	Non-traumatic brain injury M=25-40	1.8752	1.6002	1.5334	1.3976	23	23	22	22
0304	Non-traumatic brain injury M=12-24	2.7911	2.3817	2.2824	2.0801	44	32	34	31
0401	Traumatic spinal cord injury M=50-84	0.9282	0.8716	0.8222	0.6908	15	15	16	14
0402	Traumatic spinal cord injury M=36-49	1.4211	1.3344	1.2588	1.0576	21	18	22	19
0403	Traumatic spinal cord injury M=19-35	2.3485	2.2052	2.0802	1.7478	32	32	31	30

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0404	Traumatic spinal cord injury M=12-18	3.5227	3.3078	3.1203	2.6216	46	43	62	40
0501	Non-traumatic spinal cord injury M=51-84 and C=30-35	0.7590	0.6975	0.6230	0.5363	12	13	10	10
0502	Non-traumatic spinal cord injury M=51-84 and C=5-29	0.9458	0.8691	0.7763	0.6683	15	17	10	12
0503	Non-traumatic spinal cord injury M=41-50	1.1613	1.0672	0.9533	0.8206	17	17	15	14
0504	Non-traumatic spinal cord injury M=34-40	1.6759	1.5400	1.3757	1.1842	23	21	21	19
0505	Non-traumatic spinal cord injury M=12-33	2.5314	2.3261	2.0778	1.7887	31	31	29	28
0601	Neurological M=56-84	0.8794	0.6750	0.6609	0.5949	14	13	12	12
0602	Neurological M=47-55	1.1979	0.9195	0.9003	0.8105	15	15	14	15
0603	Neurological M=36-46	1.5368	1.1796	1.1550	1.0397	21	18	18	18
0604	Neurological M=12-35	2.0045	1.5386	1.5065	1.3561	31	24	25	23
0701	Fracture of lower extremity M=52-84	0.7015	0.7006	0.6710	0.5960	13	13	12	11
0702	Fracture of lower extremity M=46-51	0.9264	0.9251	0.8861	0.7870	15	15	16	14
0703	Fracture of lower extremity M=42-45	1.0977	1.0962	1.0500	0.9326	18	17	17	16
0704	Fracture of lower extremity M=38-41	1.2488	1.2471	1.1945	1.0609	14	20	19	18
0705	Fracture of lower extremity M=12-37	1.4760	1.4740	1.4119	1.2540	20	22	22	21
0801	Replacement of lower extremity joint M=58-84	0.4909	0.4696	0.4518	0.3890	9	9	8	8
0802	Replacement of lower extremity joint M=55-57	0.5667	0.5421	0.5216	0.4490	10	10	9	9
0803	Replacement of lower extremity joint M=47-54	0.6956	0.6654	0.6402	0.5511	9	11	11	10
0804	Replacement of lower extremity joint M=12-46 and C=32-35	0.9284	0.8881	0.8545	0.7356	15	14	14	12
0805	Replacement of lower extremity joint M=40-46 and C=5-31	1.0027	0.9593	0.9229	0.7945	16	16	14	14
0806	Replacement of lower extremity joint M=12-39 and C=5-31	1.3681	1.3088	1.2592	1.0840	21	20	19	18
0901	Other orthopedic M=54-84	0.6988	0.6390	0.6025	0.5213	12	11	11	11
0902	Other orthopedic M=47-53	0.9496	0.8684	0.8187	0.7084	15	15	14	13

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0903	Other orthopedic M=38-46	1.1987	1.0961	1.0334	0.8942	18	18	17	16
0904	Other orthopedic M=12-37	1.6272	1.4880	1.4029	1.2138	23	23	23	21
1001	Amputation, lower extremity M=61-84	0.7821	0.7821	0.7153	0.6523	13	13	12	13
1002	Amputation, lower extremity M=52-60	0.9998	0.9998	0.9144	0.8339	15	15	14	15
1003	Amputation, lower extremity M=46-51	1.2229	1.2229	1.1185	1.0200	18	17	17	18
1004	Amputation, lower extremity M=39-45	1.4264	1.4264	1.3046	1.1897	20	20	19	19
1005	Amputation, lower extremity M=12-38	1.7588	1.7588	1.6086	1.4670	21	25	23	23
1101	Amputation, non-lower extremity M=52-84	1.2621	0.7683	0.7149	0.6631	18	11	13	12
1102	Amputation, non-lower extremity M=38-51	1.9534	1.1892	1.1064	1.0263	25	18	17	18
1103	Amputation, non-lower extremity M=12-37	2.6543	1.6159	1.5034	1.3945	33	23	22	25
1201	Osteoarthritis M=55-84 and C=34-35	0.7219	0.5429	0.5103	0.4596	13	10	11	9
1202	Osteoarthritis M=55-84 and C=5-33	0.9284	0.6983	0.6563	0.5911	16	11	13	13
1203	Osteoarthritis M=48-54	1.0771	0.8101	0.7614	0.6858	18	15	14	13
1204	Osteoarthritis M=39-47	1.3950	1.0492	0.9861	0.8882	22	19	16	17
1205	Osteoarthritis M=12-38	1.7874	1.3443	1.2634	1.1380	27	21	21	20
1301	Rheumatoid, other arthritis M=54-84	0.7719	0.6522	0.6434	0.5566	13	14	13	11
1302	Rheumatoid, other arthritis M=47-53	0.9882	0.8349	0.8237	0.7126	16	14	14	14
1303	Rheumatoid, other arthritis M=36-46	1.3132	1.1095	1.0945	0.9469	20	18	16	17
1304	Rheumatoid, other arthritis M=12-35	1.8662	1.5768	1.5555	1.3457	25	25	29	22
1401	Cardiac M=56-84	0.7190	0.6433	0.5722	0.5156	15	12	11	11
1402	Cardiac M=48-55	0.9902	0.8858	0.7880	0.7101	13	15	13	13
1403	Cardiac M=38-47	1.2975	1.1608	1.0325	0.9305	21	19	16	16
1404	Cardiac M=12-37	1.8013	1.6115	1.4335	1.2918	30	24	21	20
1501	Pulmonary M=61-84	0.8032	0.7633	0.6926	0.6615	15	13	13	13
1502	Pulmonary M=48-60	1.0268	0.9758	0.8855	0.8457	17	17	14	15

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1503	Pulmonary M=36-47	1.3242	1.2584	1.1419	1.0906	21	20	18	18
1504	Pulmonary M=12-35	2.0598	1.9575	1.7763	1.6965	30	28	30	26
1601	Pain syndrome M=45-84	0.8707	0.8327	0.7886	0.6603	15	14	13	13
1602	Pain syndrome M=12-44	1.3320	1.2739	1.2066	1.0103	21	20	20	18
1701	Major multiple trauma without brain or spinal cord injury M=46-84	0.9996	0.9022	0.8138	0.7205	16	14	11	13
1702	Major multiple trauma without brain or spinal cord injury M=33-45	1.4755	1.3317	1.2011	1.0634	21	21	20	18
1703	Major multiple trauma without brain or spinal cord injury M=12-32	2.1370	1.9288	1.7396	1.5402	33	28	27	24
1801	Major multiple trauma with brain or spinal cord injury M=45-84 and C=33-35	0.7445	0.7445	0.6862	0.6282	12	12	12	10
1802	Major multiple trauma with brain or spinal cord injury M=45-84 and C=5-32	1.0674	1.0674	0.9838	0.9007	16	16	16	16
1803	Major multiple trauma with brain or spinal cord injury M=26-44	1.6350	1.6350	1.5069	1.3797	22	25	20	22
1804	Major multiple trauma with brain or spinal cord injury M=12-25	2.9140	2.9140	2.6858	2.4589	41	29	40	40
1901	Guillian Barre M=47-84	1.1585	1.0002	0.9781	0.8876	15	15	16	15
1902	Guillian Barre M=31-46	2.1542	1.8598	1.8188	1.6505	27	27	27	24
1903	Guillian Barre M=12-30	3.1339	2.7056	2.6459	2.4011	41	35	30	40
2001	Miscellaneous M=54-84	0.8371	0.7195	0.6705	0.6029	12	13	11	12
2002	Miscellaneous M=45-53	1.1056	0.9502	0.8855	0.7962	15	15	14	14
2003	Miscellaneous M=33-44	1.4639	1.2581	1.1725	1.0543	20	18	18	18
2004	Miscellaneous M=12-32 and A>=82	1.7472	1.5017	1.3994	1.2583	30	22	21	22
2005	Miscellaneous M=12-32 and A<=81	2.0799	1.7876	1.6659	1.4979	33	25	24	24
2101	Burns M=46-84	1.0357	0.9425	0.8387	0.8387	18	18	15	16
2102	Burns M=12-45	2.2508	2.0482	1.8226	1.8226	31	26	26	29
5001	Short-stay cases, length of stay is 3 days or fewer				0.1651				3
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.4279				8

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
5102	Expired, orthopedic, length of stay is 14 days or more				1.2390				23
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.5436				9
5104	Expired, not orthopedic, length of stay is 16 days or more				1.7100				28

TABLE 2.— Fiscal Year 2004 Federal Prospective Payments for Case-Mix Groups (CMGs)

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidities
0101	$5,984.45	$5,359.45	$5,107.70	$4,833.40
0102	8,148.77	7,298.32	6,955.13	6,581.89
0103	10,390.74	9,306.08	8,867.70	8,391.75
0104	11,281.27	10,103.92	9,627.97	9,111.94
0105	14,202.10	12,719.14	12,120.44	11,470.40
0106	17,473.63	15,648.74	14,911.01	14,111.92
0107	20,239.15	18,126.18	17,271.98	16,345.13
0108	21,889.94	19,605.38	18,681.04	17,679.04
0109	23,673.50	21,202.32	20,202.83	19,119.41
0110	25,394.44	22,744.15	21,672.01	20,509.69
0111	26,163.47	23,433.02	22,328.32	21,130.93
0112	31,039.46	27,799.24	26,489.12	25,068.79
0113	28,024.69	25,100.10	23,916.49	22,633.93
0114	34,195.76	30,626.13	29,183.25	27,617.63
0201	9,630.47	9,113.19	8,421.81	7,727.93
0202	14,004.20	13,252.70	12,246.95	11,238.68
0203	16,378.94	15,499.69	14,323.59	13,144.99
0204	20,708.84	19,596.62	18,109.90	16,619.42
0205	31,437.75	29,749.38	27,491.12	25,229.11
0301	12,092.89	10,319.35	9,888.49	9,011.74
0302	17,131.70	14,619.18	14,007.96	12,767.99
0303	23,486.88	20,042.51	19,205.84	17,504.94
0304	34,958.53	29,830.79	28,587.06	26,053.25
0401	11,625.71	10,916.79	10,298.06	8,652.27
0402	17,799.28	16,713.36	15,766.47	13,246.44
0403	29,414.96	27,620.13	26,054.51	21,891.20
0404	44,121.82	41,430.20	39,081.76	32,835.54

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidities
0501	9,506.48	8,736.19	7,803.08	6,717.16
0502	11,846.15	10,885.48	9,723.16	8,370.46
0503	14,545.28	13,366.68	11,940.08	10,278.02
0504	20,990.65	19,288.50	17,230.64	14,832.11
0505	31,705.79	29,134.40	26,024.45	22,403.47
0601	11,014.49	8,454.38	8,277.77	7,451.12
0602	15,003.70	11,516.74	11,276.26	10,151.51
0603	19,248.42	14,774.49	14,466.38	13,022.24
0604	25,106.36	19,270.97	18,868.91	16,985.15
0701	8,786.29	8,775.02	8,404.28	7,464.90
0702	11,603.16	11,586.88	11,098.40	9,857.18
0703	13,748.69	13,729.91	13,151.25	11,680.82
0704	15,641.22	15,619.93	14,961.11	13,287.77
0705	18,486.90	18,461.85	17,684.05	15,706.35
0801	6,148.52	5,881.74	5,658.80	4,872.23
0802	7,097.92	6,789.80	6,533.04	5,623.73
0803	8,712.39	8,334.14	8,018.51	6,902.53
0804	11,628.21	11,123.45	10,702.61	9,213.39
0805	12,558.82	12,015.23	11,559.32	9,951.11
0806	17,135.45	16,392.72	15,771.48	13,577.10
0901	8,752.47	8,003.48	7,546.31	6,529.28
0902	11,893.74	10,876.71	10,254.22	8,872.71
0903	15,013.72	13,728.65	12,943.34	11,199.86
0904	20,380.68	18,637.20	17,571.32	15,202.85
1001	9,795.80	9,795.80	8,959.13	8,170.06
1002	12,522.50	12,522.50	11,452.86	10,444.60
1003	15,316.82	15,316.82	14,009.21	12,775.50
1004	17,865.66	17,865.66	16,340.12	14,900.99
1005	22,028.97	22,028.97	20,147.72	18,374.18
1101	15,807.80	9,622.96	8,954.12	8,305.33
1102	24,466.34	14,894.73	13,857.66	12,854.41
1103	33,245.11	20,239.15	18,830.09	17,466.11
1201	9,041.80	6,799.82	6,391.51	5,756.49
1202	11,628.21	8,746.21	8,220.16	7,403.53
1203	13,490.68	10,146.50	9,536.54	8,589.65
1204	17,472.38	13,141.23	12,350.90	11,124.71
1205	22,387.19	16,837.36	15,824.09	14,253.45
1301	9,668.05	8,168.81	8,058.59	6,971.42
1302	12,377.21	10,457.12	10,316.84	8,925.32

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidities
1303	16,447.83	13,896.49	13,708.61	11,859.92
1304	23,374.16	19,749.42	19,482.64	16,854.89
1401	9,005.48	8,057.33	7,166.81	6,457.89
1402	12,402.26	11,094.65	9,869.70	8,894.00
1403	16,251.19	14,539.02	12,932.06	11,654.51
1404	22,561.28	20,184.04	17,954.59	16,179.80
1501	10,060.08	9,560.33	8,674.82	8,285.29
1502	12,860.67	12,221.90	11,090.89	10,592.39
1503	16,585.61	15,761.46	14,302.30	13,659.77
1504	25,799.00	24,517.69	22,248.16	21,248.66
1601	10,905.52	10,429.57	9,877.22	8,270.26
1602	16,683.30	15,955.60	15,112.67	12,654.01
1701	12,519.99	11,300.06	10,192.85	9,024.26
1702	18,480.64	16,679.54	15,043.78	13,319.09
1703	26,765.93	24,158.22	21,788.49	19,291.01
1801	9,324.86	9,324.86	8,594.66	7,868.21
1802	13,369.19	13,369.19	12,322.10	11,281.27
1803	20,478.38	20,478.38	18,873.92	17,280.74
1804	36,497.85	36,497.85	33,639.65	30,797.72
1901	14,510.21	12,527.51	12,250.70	11,117.19
1902	26,981.36	23,294.00	22,780.47	20,672.51
1903	39,252.10	33,887.64	33,139.90	30,073.78
2001	10,484.68	9,011.74	8,398.01	7,551.32
2002	13,847.64	11,901.26	11,090.89	9,972.41
2003	18,335.35	15,757.70	14,685.56	13,205.11
2004	21,883.68	18,808.79	17,527.49	15,760.21
2005	26,050.75	22,389.69	20,865.40	18,761.20
2101	12,972.14	11,804.81	10,504.72	10,504.72
2102	28,191.27	25,653.71	22,828.07	22,828.07
5001				2,067.88
5101				5,359.45
5102				15,518.48
5103				6,808.59
5104				21,417.75

BILLING CODE 4120–01–C

TABLE 3A.—URBAN WAGE INDEX

MSA	Urban area (constituent counties or county equivalents)	Wage index
0040	Abilene, TX	0.7792
	Taylor, TX	
0060	Aguadilla, PR	0.4587
	Aguada, PR	
	Aguadilla, PR	
	Moca, PR	
0080	Akron, OH	0.9600
	Portage, OH	
	Summit, OH	
0120	Albany, GA	1.0594
	Dougherty, GA	
	Lee, GA	
0160	Albany-Schenectady-Troy, NY	0.8384
	Albany, NY	
	Montgomery, NY	
	Rensselaer, NY	
	Saratoga, NY	
	Schenectady, NY	
	Schoharie, NY	
0200	Albuquerque, NM	0.9315
	Bernalillo, NM	
	Sandoval, NM	
	Valencia, NM	
0220	Alexandria, LA	0.7859
	Rapides, LA	
0240	Allentown-Bethlehem-Easton, PA	0.9735
	Carbon, PA	
	Lehigh, PA	
	Northampton, PA	
0280	Altoona, PA	0.9225
	Blair, PA	
0320	Amarillo, TX	0.9034
	Potter, TX	
	Randall, TX	
0380	Anchorage, AK	1.2358
	Anchorage, AK	
0440	Ann Arbor, MI	1.1103
	Lenawee, MI	
	Livingston, MI	
	Washtenaw, MI	
0450	Anniston, AL	0.8044
	Calhoun, AL	
0460	Appleton-Oshkosh-Neenah, WI	0.8997
	Calumet, WI	
	Outagamie, WI	
	Winnebago, WI	
0470	Arecibo, PR	0.4337
	Arecibo, PR	
	Camuy, PR	
	Hatillo, PR	
0480	Asheville, NC	0.9876
	Buncombe, NC	
	Madison, NC	
0500	Athens, GA	1.0211
	Clarke, GA	
	Madison, GA	
	Oconee, GA	
0520	Atlanta, GA	0.9991
	Barrow, GA	
	Bartow, GA	
	Carroll, GA	
	Cherokee, GA	
	Clayton, GA	
	Cobb, GA	
	Coweta, GA	
	De Kalb, GA	
	Douglas, GA	
	Fayette, GA	
	Forsyth, GA	
	Fulton, GA	

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Gwinnett, GA	
	Henry, GA	
	Newton, GA	
	Paulding, GA	
	Pickens, GA	
	Rockdale, GA	
	Spalding, GA	
	Walton, GA	
0560	Atlantic City-Cape May, NJ	1.1017
	Atlantic City, NJ	
	Cape May, NJ	
0580	Auburn-Opelika, AL	0.8325
	Lee, AL	
0600	Augusta-Aiken, GA–SC	1.0264
	Columbia, GA	
	McDuffie, GA	
	Richmond, GA	
	Aiken, SC	
	Edgefield, SC	
0640	Austin-San Marcos, TX	0.9637
	Bastrop, TX	
	Caldwell, TX	
	Hays, TX	
	Travis, TX	
	Williamson, TX	
0680	Bakersfield, CA	0.9899
	Kern, CA	
0720	Baltimore, MD	0.9929
	Anne Arundel, MD	
	Baltimore, MD	
	Baltimore City, MD	
	Carroll, MD	
	Harford, MD	
	Howard, MD	
	Queen Annes, MD	
0733	Bangor, ME	0.9664
	Penobscot, ME	
0743	Barnstable-Yarmouth, MA	1.3202
	Barnstable, MA	
0760	Baton Rouge, LA	0.8294
	Ascension, LA	
	East Baton Rouge	
	Livingston, LA	
	West Baton Rouge, LA	
0840	Beaumont-Port Arthur, TX	0.8324
	Hardin, TX	
	Jefferson, TX	
	Orange, TX	
0860	Bellingham, WA	1.2282
	Whatcom, WA	
0870	Benton Harbor, MI	0.9042
	Berrien, MI	
0875	Bergen Passaic, NJ	1.2150
	Bergen, NJ	
	Passaic, NJ	
0880	Billings, MT	0.9022
	Yellowstone, MT	
0920	Biloxi-Gulfport-Pascagoula, MS	0.8757
	Hancock, MS	
	Harrison, MS	
	Jackson, MS	
0960	Binghamton, NY	0.8341
	Broome, NY	
	Tioga, NY	
1000	Birmingham, AL	0.9222
	Blount, AL	
	Jefferson, AL	
	St. Clair, AL	
	Shelby, AL	
1010	Bismarck, ND	0.7972

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Burleigh, ND	
	Morton, ND	
1020	Bloomington, IN	0.8907
	Monroe, IN	
1040	Bloomington-Normal, IL	0.9109
	McLean, IL	
1080	Boise City, ID	0.9310
	Ada, ID	
	Canyon, ID	
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1235
	Bristol, MA	
	Essex, MA	
	Middlesex, MA	
	Norfolk, MA	
	Plymouth, MA	
	Suffolk, MA	
	Worcester, MA	
	Hillsborough, NH	
	Merrimack, NH	
	Rockingham, NH	
	Strafford, NH	
1125	Boulder-Longmont, CO	0.9689
	Boulder, CO	
1145	Brazoria, TX	0.8535
	Brazoria, TX	
1150	Bremerton, WA	1.0944
	Kitsap, WA	
1240	Brownsville-Harlingen-San Benito, TX	0.8880
	Cameron, TX	
1260	Bryan-College Station, TX	0.8821
	Brazos, TX	
1280	Buffalo-Niagara Falls, NY	0.9365
	Erie, NY	
	Niagara, NY	
1303	Burlington, VT	1.0052
	Chittenden, VT	
	Franklin, VT	
	Grand Isle, VT	
1310	Caguas, PR	0.4371
	Caguas, PR	
	Cayey, PR	
	Cidra, PR	
	Gurabo, PR	
	San Lorenzo, PR	
1320	Canton-Massillon, OH	0.8932
	Carroll, OH	
	Stark, OH	
1350	Casper, WY	0.9690
	Natrona, WY	
1360	Cedar Rapids, IA	0.9056
	Linn, IA	
1400	Champaign-Urbana, IL	1.0635
	Champaign, IL	
1440	Charleston-North Charleston, SC	0.9235
	Berkeley, SC	
	Charleston, SC	
	Dorchester, SC	
1480	Charleston, WV	0.8898
	Kanawha, WV	
	Putnam, WV	
1520	Charlotte-Gastonia-RockHill, NC–SC	0.9850
	Cabarrus, NC	
	Gaston, NC	
	Lincoln, NC	
	Mecklenburg, NC	
	Rowan, NC	
	Stanly, NC	
	Union, NC	
	York, SC	
1540	Charlottesville, VA	1.0438

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Albemarle, VA	
	Charlottesville City, VA	
	Fluvanna, VA	
	Greene, VA	
1560	Chattanooga, TN–GA	0.8976
	Catoosa, GA	
	Dade, GA	
	Walker, GA	
	Hamilton, TN	
	Marion, TN	
1580	Cheyenne, WY	0.8628
	Laramie, WY	
1600	Chicago, IL	1.1044
	Cook, IL	
	DeKalb, IL	
	DuPage, IL	
	Grundy, IL	
	Kane, IL	
	Kendall, IL	
	Lake, IL	
	McHenry, IL	
	Will, IL	
1620	Chico-Paradise, CA	0.9745
	Butte, CA	
1640	Cincinnati, OH–KY–IN	0.9381
	Dearborn, IN	
	Ohio, IN	
	Boone, KY	
	Campbell, KY	
	Gallatin, KY	
	Grant, KY	
	Kenton, KY	
	Pendleton, KY	
	Brown, OH	
	Clermont, OH	
	Hamilton, OH	
	Warren, OH	
1660	Clarksville-Hopkinsville, TN–KY	0.8406
	Christian, KY	
	Montgomery, TN	
1680	Cleveland-Lorain-Elyria, OH	0.9670
	Ashtabula, OH	
	Geauga, OH	
	Cuyahoga, OH	
	Lake, OH	
	Lorain, OH	
	Medina, OH	
1720	Colorado Springs, CO	0.9916
	El Paso, CO	
1740	Columbia MO	0.8496
	Boone, MO	
1760	Columbia, SC	0.9307
	Lexington, SC	
	Richland, SC	
1800	Columbus, GA–AL	0.8374
	Russell, AL	
	Chattanoochee, GA	
	Harris, GA	
	Muscogee, GA	
1840	Columbus, OH	0.9751
	Delaware, OH	
	Fairfield, OH	
	Franklin, OH	
	Licking, OH	
	Madison, OH	
	Pickaway, OH	
1880	Corpus Christi, TX	0.8729
	Nueces, TX	
	San Patricio, TX	
1890	Corvallis, OR	1.1453

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Benton, OR	
1900	Cumberland, MD–WV	0.7847
	Allegany, MD	
	Mineral, WV	
1920	Dallas, TX	0.9998
	Collin, TX	
	Dallas, TX	
	Denton, TX	
	Ellis, TX	
	Henderson, TX	
	Hunt, TX	
	Kaufman, TX	
	Rockwall, TX	
1950	Danville, VA	0.8859
	Danville City, VA	
	Pittsylvania, VA	
1960	Davenport-Moline-Rock Island, IA–IL	0.8835
	Scott, IA	
	Henry, IL	
	Rock Island, IL	
2000	Dayton-Springfield, OH	0.9282
	Clark, OH	
	Greene, OH	
	Miami, OH	
	Montgomery, OH	
2020	Daytona Beach, FL	0.9062
	Flagler, FL	
	Volusia, FL	
2030	Decatur, AL	0.8973
	Lawrence, AL	
	Morgan, AL	
2040	Decatur, IL	0.8055
	Macon, IL	
2080	Denver, CO	1.0601
	Adams, CO	
	Arapahoe, CO	
	Broomfield, CO	
	Denver, CO	
	Douglas, CO	
	Jefferson, CO	
2120	Des Moines, IA	0.8791
	Dallas, IA	
	Polk, IA	
	Warren, IA	
2160	Detroit, MI	1.0448
	Lapeer, MI	
	Macomb, MI	
	Monroe, MI	
	Oakland, MI	
	St. Clair, MI	
	Wayne, MI	
2180	Dothan, AL	0.8137
	Dale, AL	
	Houston, AL	
2190	Dover, DE	0.9356
	Kent, DE	
2200	Dubuque, IA	0.8795
	Dubuque, IA	
2240	Duluth-Superior, MN–WI	1.0368
	St. Louis, MN	
	Douglas, WI	
2281	Dutchess County, NY	1.0684
	Dutchess, NY	
2290	Eau Claire, WI	0.8952
	Chippewa, WI	
	Eau Claire, WI	
2320	El Paso, TX	0.9265
	El Paso, TX	
2330	Elkhart-Goshen, IN	0.9722
	Elkhart, IN	

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
2335	Elmira, NY	0.8416
	Chemung, NY	
2340	Enid, OK	0.8376
	Garfield, OK	
2360	Erie, PA	0.8925
	Erie, PA	
2400	Eugene-Springfield, OR	1.0944
	Lane, OR	
2440	Evansville-Henderson, IN–KY	0.8177
	Posey, IN	
	Vanderburgh, IN	
	Warrick, IN	
	Henderson, KY	
2520	Fargo-Moorhead, ND–MN	0.9684
	Clay, MN	
	Cass, ND	
2560	Fayetteville, NC	0.8889
	Cumberland, NC	
2580	Fayetteville-Springdale-Rogers, AR	0.8100
	Benton, AR	
	Washington, AR	
2620	Flagstaff, AZ–UT	1.0682
	Coconino, AZ	
	Kane, UT	
2640	Flint, MI	1.1135
	Genesee, MI	
2650	Florence, AL	0.7792
	Colbert, AL	
	Lauderdale, AL	
2655	Florence, SC	0.8780
	Florence, SC	
2670	Fort Collins-Loveland, CO	1.0066
	Larimer, CO	
2680	Ft. Lauderdale, FL	1.0297
	Broward, FL	
2700	Fort Myers-Cape Coral, FL	0.9680
	Lee, FL	
2710	Fort Pierce Port-St. Lucie, FL	0.9823
	Martin, FL	
	St.Lucie, FL	
2720	Fort Smith, AR–OK	0.7895
	Crawford, AR	
	Sebastian, AR	
	Sequoyah, OK	
2750	Fort Walton Beach, FL	0.9693
	Okaloosa, FL	
2760	Fort Wayne, IN	0.9457
	Adams, IN	
	Allen, IN	
	DeKalb, IN	
	Huntington, IN	
	Wells, IN	
	Whitley, IN	
2800	Forth Worth-Arlington, TX	0.9446
	Hood, TX	
	Johnson, TX	
	Parker, TX	
	Tarrant, TX	
2840	Fresno, CA	1.0216
	Fresno, CA	
	Madera, CA	
2880	Gadsden, AL	0.8505
	Etowah, AL	
2900	Gainesville, FL	0.9871
	Alachua, FL	
2920	Galveston-Texas City, TX	0.9465
	Galveston, TX	
2960	Gary, IN	0.9584
	Lake, IN	
	Porter, IN	

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
2975	Glens Falls, NY	0.8281
	Warren, NY	
	Washington, NY	
2980	Goldsboro, NC	0.8892
	Wayne, NC	
2985	Grand Forks, ND–MN	0.8897
	Polk, MN	
	Grand Forks, ND	
2995	Grand Junction, CO	0.9456
	Mesa, CO	
3000	Grand Rapids-Muskegon-Holland, MI	0.9525
	Allegan, MI	
	Kent, MI	
	Muskegon, MI	
	Ottawa, MI	
3040	Great Falls, MT	0.8950
	Cascade, MT	
3060	Greeley, CO	0.9237
	Weld, CO	
3080	Green Bay, WI	0.9502
	Brown, WI	
3120	Greensboro-Winston Salem-High Point, NC	0.9282
	Alamance, NC	
	Davidson, NC	
	Davie, NC	
	Forsyth, NC	
	Guilford, NC	
	Randolph, NC	
	Stokes, NC	
	Yadkin, NC	
3150	Greenville, NC	0.9100
	Pitt, NC	
3160	Greenville-Spartanburg-Anderson, SC	0.9122
	Anderson, SC	
	Cherokee, SC	
	Greenville, SC	
	Pickens, SC	
	Spartanburg, SC	
3180	Hagerstown, MD	0.9268
	Washington, MD	
3200	Hamilton-Middletown, OH	0.9418
	Butler, OH	
3240	Harrisburg-Lebanon-Carlisle, PA	0.9223
	Cumberland, PA	
	Dauphin, PA	
	Lebanon, PA	
	Perry, PA	
3283	Hartford, CT	1.1549
	Hartford, CT	
	Litchfield, CT	
	Middlesex, CT	
	Tolland, CT	
3285	Hattiesburg, MS	0.7659
	Forrest, MS	
	Lamar, MS	
3290	Hickory-Morganton-Lenoir, NC	0.9028
	Alexander, NC	
	Burke, NC	
	Caldwell, NC	
	Catawba, NC	
3320	Honolulu, HI	1.1457
	Honolulu, HI	
3350	Houma, LA	0.8385
	Lafourche, LA	
	Terrebonne, LA	
3360	Houston, TX	0.9892
	Chambers, TX	
	Fort Bend, TX	
	Harris, TX	
	Liberty, TX	

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Montgomery, TX	
	Waller, TX	
3400	Huntington-Ashland, WV–KY–OH	0.9636
	Boyd, KY	
	Carter, KY	
	Greenup, KY	
	Lawrence, OH	
	Cabell, WV	
	Wayne, WV	
3440	Huntsville, AL	0.8903
	Limestone, AL	
	Madison, AL	
3480	Indianapolis, IN	0.9717
	Boone, IN	
	Hamilton, IN	
	Hancock, IN	
	Hendricks, IN	
	Johnson, IN	
	Madison, IN	
	Marion, IN	
	Morgan, IN	
	Shelby, IN	
3500	Iowa City, IA	0.9587
	Johnson, IA	
3520	Jackson, MI	0.9532
	Jackson, MI	
3560	Jackson, MS	0.8607
	Hinds, MS	
	Madison, MS	
	Rankin, MS	
3580	Jackson, TN	0.9275
	Chester, TN	
	Madison, TN	
3600	Jacksonville, FL	0.9381
	Clay, FL	
	Duval, FL	
	Nassau, FL	
	St. Johns, FL	
3605	Jacksonville, NC	0.8239
	Onslow, NC	
3610	Jamestown, NY	0.7976
	Chautaqua, NY	
3620	Janesville-Beloit, WI	0.9849
	Rock, WI	
3640	Jersey City, NJ	1.1190
	Hudson, NJ	
3660	Johnson City-Kingsport-Bristol, TN–VA	0.8268
	Carter, TN	
	Hawkins, TN	
	Sullivan, TN	
	Unicoi, TN	
	Washington, TN	
	Bristol City, VA	
	Scott, VA	
	Washington, VA	
3680	Johnstown, PA	0.8329
	Cambria, PA	
	Somerset, PA	
3700	Jonesboro, AR	0.7749
	Craighead, AR	
3710	Joplin, MO	0.8613
	Jasper, MO	
	Newton, MO	
3720	Kalamazoo-Battlecreek, MI	1.0595
	Calhoun, MI	
	Kalamazoo, MI	
	Van Buren, MI	
3740	Kankakee, IL	1.0790
	Kankakee, IL	
3760	Kansas City, KS–MO	0.9736

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Johnson, KS	
	Leavenworth, KS	
	Miami, KS	
	Wyandotte, KS	
	Cass, MO	
	Clay, MO	
	Clinton, MO	
	Jackson, MO	
	Lafayette, MO	
	Platte, MO	
	Ray, MO	
3800	Kenosha, WI	0.9686
	Kenosha, WI	
3810	Killeen-Temple, TX	1.0399
	Bell, TX	
	Coryell, TX	
3840	Knoxville, TN	0.8970
	Anderson, TN	
	Blount, TN	
	Knox, TN	
	Loudon, TN	
	Sevier, TN	
	Union, TN	
3850	Kokomo, IN	0.8971
	Howard, IN	
	Tipton, IN	
3870	La Crosse, WI–MN	0.9400
	Houston, MN	
	La Crosse, WI	
3880	Lafayette, LA	0.8475
	Acadia, LA	
	Lafayette, LA	
	St. Landry, LA	
	St. Martin, LA	
3920	Lafayette, IN	0.9278
	Clinton, IN	
	Tippecanoe, IN	
3960	Lake Charles, LA	0.7965
	Calcasieu, LA	
3980	Lakeland-Winter Haven, FL	0.9357
	Polk, FL	
4000	Lancaster, PA	0.9078
	Lancaster, PA	
4040	Lansing-East Lansing, MI	0.9726
	Clinton, MI	
	Eaton, MI	
	Ingham, MI	
4080	Laredo, TX	0.8472
	Webb, TX	
4100	Las Cruces, NM	0.8745
	Dona Ana, NM	
4120	Las Vegas, NV–AZ	1.1521
	Mohave, AZ	
	Clark, NV	
	Nye, NV	
4150	Lawrence, KS	0.7923
	Douglas, KS	
4200	Lawton, OK	0.8315
	Comanche, OK	
4243	Lewiston-Auburn, ME	0.9179
	Androscoggin, ME	
4280	Lexington, KY	0.8581
	Bourbon, KY	
	Clark, KY	
	Fayette, KY	
	Jessamine, KY	
	Madison, KY	
	Scott, KY	
	Woodford, KY	
4320	Lima, OH	0.9483

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Allen, OH	
	Auglaize, OH	
4360	Lincoln, NE	0.9892
	Lancaster, NE	
4400	Little Rock-North Little, AR	0.9097
	Faulkner, AR	
	Lonoke, AR	
	Pulaski, AR	
	Saline, AR	
4420	Longview-Marshall, TX	0.8629
	Gregg, TX	
	Harrison, TX	
	Upshur, TX	
4480	Los Angeles-Long Beach, CA	1.2001
	Los Angeles, CA	
4520	Louisville, KY–IN	0.9276
	Clark, IN	
	Floyd, IN	
	Harrison, IN	
	Scott, IN	
	Bullitt, KY	
	Jefferson, KY	
	Oldham, KY	
4600	Lubbock, TX	0.9646
	Lubbock, TX	
4640	Lynchburg, VA	0.9219
	Amherst, VA	
	Bedford City, VA	
	Bedford, VA	
	Campbell, VA	
	Lynchburg City, VA	
4680	Macon, GA	0.9204
	Bibb, GA	
	Houston, GA	
	Jones, GA	
	Peach, GA	
	Twiggs, GA	
4720	Madison, WI	1.0467
	Dane, WI	
4800	Mansfield, OH	0.8900
	Crawford, OH	
	Richland, OH	
4840	Mayaguez, PR	0.4914
	Anasco, PR	
	Cabo Rojo, PR	
	Hormigueros, PR	
	Mayaguez, PR	
	Sabana Grande, PR	
	San German, PR	
4880	McAllen-Edinburg-Mission, TX	0.8428
	Hidalgo, TX	
4890	Medford-Ashland, OR	1.0498
	Jackson, OR	
4900	Melbourne-Titusville-Palm Bay, FL	1.0253
	Brevard, FL	
4920	Memphis, TN–AR–MS	0.8920
	Crittenden, AR	
	De Soto, MS	
	Fayette, TN	
	Shelby, TN	
	Tipton, TN	
4940	Merced, CA	0.9837
	Merced, CA	
5000	Miami, FL	0.9802
	Dade, FL	
5015	Middlesex-Somerset-Hunterdon, NJ	1.1213
	Hunterdon, NJ	
	Middlesex, NJ	
	Somerset, NJ	
5080	Milwaukee-Waukesha, WI	0.9893

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Milwaukee, WI	
	Ozaukee, WI	
	Washington, WI	
	Waukesha, WI	
5120	Minneapolis-St. Paul, MN–WI	1.0903
	Anoka, MN	
	Carver, MN	
	Chisago, MN	
	Dakota, MN	
	Hennepin, MN	
	Isanti, MN	
	Ramsey, MN	
	Scott, MN	
	Sherburne, MN	
	Washington, MN	
	Wright, MN	
	Pierce, WI	
	St. Croix, WI	
5140	Missoula, MT	0.9157
	Missoula, MT	
5160	Mobile, AL	0.8108
	Baldwin, AL	
	Mobile, AL	
5170	Modesto, CA	1.0498
	Stanislaus, CA	
5190	Monmouth-Ocean, NJ	1.0674
	Monmouth, NJ	
	Ocean, NJ	
5200	Monroe, LA	0.8137
	Ouachita, LA	
5240	Montgomery, AL	0.7734
	Autauga, AL	
	Elmore, AL	
	Montgomery, AL	
5280	Muncie, IN	0.9284
	Delaware, IN	
5330	Myrtle Beach, SC	0.8976
	Horry, SC	
5345	Naples, FL	0.9754
	Collier, FL	
5360	Nashville, TN	0.9578
	Cheatham, TN	
	Davidson, TN	
	Dickson, TN	
	Robertson, TN	
	Rutherford, TN	
	Sumner, TN	
	Williamson, TN	
	Wilson, TN	
5380	Nassau-Suffolk, NY	1.3357
	Nassau, NY	
	Suffolk, NY	
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2408
	Fairfield, CT	
	New Haven, CT	
5523	New London-Norwich, CT	1.1767
	New London, CT	
5560	New Orleans, LA	0.9046
	Jefferson, LA	
	Orleans, LA	
	Plaquemines, LA	
	St. Bernard, LA	
	St. Charles, LA	
	St. James, LA	
	St. John The Baptist, LA	
	St. Tammany, LA	
5600	New York, NY	1.4414
	Bronx, NY	
	Kings, NY	
	New York, NY	

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Putnam, NY	
	Queens, NY	
	Richmond, NY	
	Rockland, NY	
	Westchester, NY	
5640	Newark, NJ	1.1381
	Essex, NJ	
	Morris, NJ	
	Sussex, NJ	
	Union, NJ	
	Warren, NJ	
5660	Newburgh, NY–PA	1.1387
	Orange, NY	
	Pike, PA	
5720	Norfolk-Virginia Beach-Newport News, VANC	0.8574
	Currituck, NC	
	Chesapeake City, VA	
	Gloucester, VA	
	Hampton City, VA	
	Isle of Wight, VA	
	James City, VA	
	Mathews, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
	York, VA	
5775	Oakland, CA	1.5072
	Alameda, CA	
	Contra Costa, CA	
5790	Ocala, FL	0.9402
	Marion, FL	
5800	Odessa-Midland, TX	0.9397
	Ector, TX	
	Midland, TX	
5880	Oklahoma City, OK	0.8900
	Canadian, OK	
	Cleveland, OK	
	Logan, OK	
	McClain, OK	
	Oklahoma, OK	
	Pottawatomie, OK	
5910	Olympia, WA	1.0960
	Thurston, WA	
5920	Omaha, NE–IA	0.9978
	Pottawattamie, IA	
	Cass, NE	
	Douglas, NE	
	Sarpy, NE	
	Washington, NE	
5945	Orange County, CA	1.1474
	Orange, CA	
5960	Orlando, FL	0.9640
	Lake, FL	
	Orange, FL	
	Osceola, FL	
	Seminole, FL	
5990	Owensboro, KY	0.8344
	Daviess, KY	
6015	Panama City, FL	0.8865
	Bay, FL	
6020	Parkersburg-Marietta, WV–OH	0.8127
	Washington, OH	
	Wood, WV	
6080	Pensacola, FL	0.8645
	Escambia, FL	
	Santa Rosa, FL	

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
6120	Peoria-Pekin, IL	0.8739
	Peoria, IL	
	Tazewell, IL	
	Woodford, IL	
6160	Philadelphia, PA–NJ	1.0713
	Burlington, NJ	
	Camden, NJ	
	Gloucester, NJ	
	Salem, NJ	
	Bucks, PA	
	Chester, PA	
	Delaware, PA	
	Montgomery, PA	
	Philadelphia, PA	
6200	Phoenix-Mesa, AZ	0.9820
	Maricopa, AZ	
	Pinal, AZ	
6240	Pine Bluff, AR	0.7962
	Jefferson, AR	
6280	Pittsburgh, PA	0.9365
	Allegheny, PA	
	Beaver, PA	
	Butler, PA	
	Fayette, PA	
	Washington, PA	
	Westmoreland, PA	
6323	Pittsfield, MA	1.0235
	Berkshire, MA	
6340	Pocatello, ID	0.9372
	Bannock, ID	
6360	Ponce, PR	0.5169
	Guayanilla, PR	
	Juana Diaz, PR	
	Penuelas, PR	
	Ponce, PR	
	Villalba, PR	
	Yauco, PR	
6403	Portland, ME	0.9794
	Cumberland, ME	
	Sagadahoc, ME	
	York, ME	
6440	Portland-Vancouver, OR–WA	1.0667
	Clackamas, OR	
	Columbia, OR	
	Multnomah, OR	
	Washington, OR	
	Yamhill, OR	
	Clark, WA	
6483	Providence-Warwick-Pawtucket, RI	1.0854
	Bristol, RI	
	Kent, RI	
	Newport, RI	
	Providence, RI	
	Washington, RI	
6520	Provo-Orem, UT	0.9984
	Utah, UT	
6560	Pueblo, CO	0.8820
	Pueblo, CO	
6580	Punta Gorda, FL	0.9218
	Charlotte, FL	
6600	Racine, WI	0.9334
	Racine, WI	
6640	Raleigh-Durham-Chapel Hill, NC	0.9990
	Chatham, NC	
	Durham, NC	
	Franklin, NC	
	Johnston, NC	
	Orange, NC	
	Wake, NC	
6660	Rapid City, SD	0.8846

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Pennington, SD	
6680	Reading, PA	0.9295
	Berks, PA	
6690	Redding, CA	1.1135
	Shasta, CA	
6720	Reno, NV	1.0648
	Washoe, NV	
6740	Richland-Kennewick-Pasco, WA	1.1491
	Benton, WA	
	Franklin, WA	
6760	Richmond-Petersburg, VA	0.9477
	Charles City County, VA	
	Chesterfield, VA	
	Colonial Heights City, VA	
	Dinwiddie, VA	
	Goochland, VA	
	Hanover, VA	
	Henrico, VA	
	Hopewell City, VA	
	New Kent, VA	
	Petersburg City, VA	
	Powhatan, VA	
	Prince George, VA	
	Richmond City, VA	
6780	Riverside-San Bernardino, CA	1.1365
	Riverside, CA	
	San Bernardino, CA	
6800	Roanoke, VA	0.8614
	Botetourt, VA	
	Roanoke, VA	
	Roanoke City, VA	
	Salem City, VA	
6820	Rochester, MN	1.2139
	Olmsted, MN	
6840	Rochester, NY	0.9194
	Genesee, NY	
	Livingston, NY	
	Monroe, NY	
	Ontario, NY	
	Orleans, NY	
	Wayne, NY	
6880	Rockford, IL	0.9625
	Boone, IL	
	Ogle, IL	
	Winnebago, IL	
6895	Rocky Mount, NC	0.9228
	Edgecombe, NC	
	Nash, NC	
6920	Sacramento, CA	1.1500
	El Dorado, CA	
	Placer, CA	
	Sacramento, CA	
6960	Saginaw-Bay City-Midland, MI	0.9650
	Bay, MI	
	Midland, MI	
	Saginaw, MI	
6980	St. Cloud, MN	0.9700
	Benton, MN	
	Stearns, MN	
7000	St. Joseph, MO	0.8021
	Andrews, MO	
	Buchanan, MO	
7040	St. Louis, MO–IL	0.8855
	Clinton, IL	
	Jersey, IL	
	Madison, IL	
	Monroe, IL	
	St. Clair, IL	
	Franklin, MO	
	Jefferson, MO	

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Lincoln, MO	
	St. Charles, MO	
	St. Louis, MO	
	St. Louis City, MO	
	Warren, MO	
	Sullivan City, MO	
7080	Salem, OR	1.0367
	Marion, OR	
	Polk, OR	
7120	Salinas, CA	1.4623
	Monterey, CA	
7160	Salt Lake City-Ogden, UT	0.9945
	Davis, UT	
	Salt Lake, UT	
	Weber, UT	
7200	San Angelo, TX	0.8374
	Tom Green, TX	
7240	San Antonio, TX	0.8753
	Bexar, TX	
	Comal, TX	
	Guadalupe, TX	
	Wilson, TX	
7320	San Diego, CA	1.1131
	San Diego, CA /	
7360	San Francisco, CA	1.4142
	Marin, CA	
	San Francisco, CA	
	San Mateo, CA	
7400	San Jose, CA	1.4145
	Santa Clara, CA	
7440	San Juan-Bayamon, PR	0.4741
	Aguas Buenas, PR	
	Barceloneta, PR	
	Bayamon, PR	
	Canovanas, PR	
	Carolina, PR	
	Catano, PR	
	Ceiba, PR	
	Comerio, PR	
	Corozal, PR	
	Dorado, PR	
	Fajardo, PR	
	Florida, PR	
	Guaynabo, PR	
	Humacao, PR	
	Juncos, PR	
	Los Piedras, PR	
	Loiza, PR	
	Luguillo, PR	
	Manati, PR	
	Morovis, PR	
	Naguabo, PR	
	Naranjito, PR	
	Rio Grande, PR	
	San Juan, PR	
	Toa Alta, PR	
	Toa Baja, PR	
	Trujillo Alto, PR	
	Vega Alta, PR	
	Vega Baja, PR	
	Yabucoa, PR	
7460	San Luis Obispo-Atascadero-Paso Robles, CA	1.1271
	San Luis Obispo, CA	
7480	Santa Barbara-Santa Maria-Lompoc, CA	1.0481
	Santa Barbara, CA	
7485	Santa Cruz-Watsonville, CA	1.3646
	Santa Cruz, CA	
7490	Santa Fe, NM	1.0712
	Los Alamos, NM	
	Santa Fe, NM	

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
7500	Santa Rosa, CA	1.3046
	Sonoma, CA	
7510	Sarasota-Bradenton, FL	0.9425
	Manatee, FL	
	Sarasota, FL	
7520	Savannah, GA	0.9376
	Bryan, GA	
	Chatham, GA	
	Effingham, GA	
7560	Scranton-Wilkes Barre-Hazleton, PA	0.8599
	Columbia, PA	
	Lackawanna, PA	
	Luzerne, PA	
	Wyoming, PA	
7600	Seattle-Bellevue-Everett, WA	1.1474
	Island, WA	
	King, WA	
	Snohomish, WA	
7610	Sharon, PA	0.7869
	Mercer, PA	
7620	Sheboygan, WI	0.8697
	Sheboygan, WI	
7640	Sherman-Denison, TX	0.9255
	Grayson, TX	
7680	Shreveport-Bossier City, LA	0.8987
	Bossier, LA	
	Caddo, LA	
	Webster, LA	
7720	Sioux City, IA-NE	0.9046
	Woodbury, IA	
	Dakota, NE	
7760	Sioux Falls, SD	0.9257
	Lincoln, SD	
	Minnehaha, SD	
7800	South Bend, IN	0.9802
	St. Joseph, IN	
7840	Spokane, WA	1.0852
	Spokane, WA	
7880	Springfield, IL	0.8659
	Menard, IL	
	Sangamon, IL	
7920	Springfield, MO	0.8424
	Christian, MO	
	Greene, MO	
	Webster, MO	
8003	Springfield, MA	1.0927
	Hampden, MA	
	Hampshire, MA	
8050	State College, PA	0.8941
	Centre, PA	
8080	Steubenville-Weirton, OH–WV	0.8804
	Jefferson, OH	
	Brooke, WV	
	Hancock, WV	
8120	Stockton-Lodi, CA	1.0506
	San Joaquin, CA	
8140	Sumter, SC	0.8273
	Sumter, SC	
8160	Syracuse, NY	0.9714
	Cayuga, NY	
	Madison, NY	
	Onondaga, NY	
	Oswego, NY	
8200	Tacoma, WA	1.0940
	Pierce, WA	
8240	Tallahassee, FL	0.8504
	Gadsden, FL	
	Leon, FL	
8280	Tampa-St. Petersburg-Clearwater, FL	0.9065
	Hernando, FL	

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Hillsborough, FL	
	Pasco, FL	
	Pinellas, FL	
8320	Terre Haute, IN	0.8599
	Clay, IN	
	Vermillion, IN	
	Vigo, IN	
8360	Texarkana, AR-Texarkana, TX	0.8088
	Miller, AR	
	Bowie, TX	
8400	Toledo, OH	0.9810
	Fulton, OH	
	Lucas, OH	
	Wood, OH	
8440	Topeka, KS	0.9199
	Shawnee, KS	
8480	Trenton, NJ	1.0432
	Mercer, NJ	
8520	Tucson, AZ	0.8911
	Pima, AZ	
8560	Tulsa, OK	0.8332
	Creek, OK	
	Osage, OK	
	Rogers, OK	
	Tulsa, OK	
	Wagoner, OK	
8600	Tuscaloosa, AL	0.8130
	Tuscaloosa, AL	
8640	Tyler, TX	0.9521
	Smith, TX	
8680	Utica-Rome, NY	0.8465
	Herkimer, NY	
	Oneida, NY	
8720	Vallejo-Fairfield-Napa, CA	1.3354
	Napa, CA	
	Solano, CA	
8735	Ventura, CA	1.1096
	Ventura, CA	
8750	Victoria, TX	0.8756
	Victoria, TX	
8760	Vineland-Millville-Bridgeton, NJ	1.0031
	Cumberland, NJ	
8780	Visalia-Tulare-Porterville, CA	0.9429
	Tulare, CA	
8800	Waco, TX	0.8073
	McLennan, TX	
8840	Washington, DC–MD–VA–WV	1.0851
	District of Columbia, DC	
	Calvert, MD	
	Charles, MD	
	Frederick, MD	
	Montgomery, MD	
	Prince Georges, MD	
	Alexandria City, VA	
	Arlington, VA	
	Clarke, VA	
	Culpepper, VA	
	Fairfax, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fauquier, VA	
	Fredericksburg City, VA	
	King George, VA	
	Loudoun, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Prince William, VA	
	Spotsylvania, VA	
	Stafford, VA	
	Warren, VA	

TABLE 3A.—URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Berkeley, WV	
	Jefferson, WV	
8920	Waterloo-Cedar Falls, IA	0.8069
	Black Hawk, IA	
8940	Wausau, WI	0.9782
	Marathon, WI	
8960	West Palm Beach-Boca Raton, FL	0.9939
	Palm Beach, FL	
9000	Wheeling, OH–WV	0.7670
	Belmont, OH	
	Marshall, WV	
	Ohio, WV	
9040	Wichita, KS	0.9520
	Butler, KS	
	Harvey, KS	
	Sedgwick, KS	
9080	Wichita Falls, TX	0.8498
	Archer, TX	
	Wichita, TX	
9140	Williamsport, PA	0.8544
	Lycoming, PA	
9160	Wilmington-Newark, DE–MD	1.1173
	New Castle, DE	
	Cecil, MD	
9200	Wilmington, NC	0.9640
	New Hanover, NC	
	Brunswick, NC	
9260	Yakima, WA	1.0569
	Yakima, WA	
9270	Yolo, CA	0.9434
	Yolo, CA	
9280	York, PA	0.9026
	York, PA	
9320	Youngstown-Warren, OH	0.9358
	Columbiana, OH	
	Mahoning, OH	
	Trumbull, OH	
9340	Yuba City, CA	1.0276
	Sutter, CA	
	Yuba, CA	
9360	Yuma, AZ	0.8589
	Yuma, AZ	

TABLE 3B.—RURAL WAGE INDEX

Nonurban area	Wage index
Alabama	0.7660
Alaska	1.2293
Arizona	0.8493
Arkansas	0.7666
California	0.9840
Colorado	0.9015
Connecticut	1.2394
Delaware	0.9128
Florida	0.8814
Georgia	0.8230
Guam	0.9611
Hawaii	1.0255
Idaho	0.8747
Illinois	0.8204
Indiana	0.8755
Iowa	0.8315
Kansas	0.7923
Kentucky	0.8079
Louisiana	0.7567
Maine	0.8874
Maryland	0.8946

TABLE 3B.—RURAL WAGE INDEX—Continued

Nonurban area	Wage index
Massachusetts	1.1288
Michigan	0.9000
Minnesota	0.9151
Mississippi	0.7680
Missouri	0.8021
Montana	0.8481
Nebraska	0.8204
Nevada	0.9577
New Hampshire	0.9796
New Jersey [1]	.....
New Mexico	0.8872
New York	0.8542
North Carolina	0.8666
North Dakota	0.7788
Ohio	0.8613
Oklahoma	0.7590
Oregon	1.0303
Pennsylvania	0.8462
Puerto Rico	0.4356
Rhode Island [1]	.....

TABLE 3B.—RURAL WAGE INDEX—Continued

Nonurban area	Wage index
South Carolina	0.8607
South Dakota	0.7815
Tennessee	0.7877
Texas	0.7821
Utah	0.9312
Vermont	0.9345
Virginia	0.8504
Virgin Islands	0.7845
Washington	1.0179
West Virginia	0.7975
Wisconsin	0.9162
Wyoming	0.9007

[1] All counties within the State are classified urban.

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