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Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; and Changes to the Long Term Care Hospital Prospective Payment System and Rate Years 2010 and 2009 Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 415, 485, and 489

[CMS–1406–F and IFC; CMS–1493–F; CMS–1337–F]

RIN 0938–AP33; RIN 0938–AP39; RIN 0938–AP76

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; and Changes to the Long-Term Care Hospital Prospective Payment System and Rate Years 2010 and 2009 Rates

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

ACTION: Final rules and interim final rule with comment period.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems, and to implement certain provisions made by the TMA, Abstinence Education, and QI Program Extension Act of 2007, the Medicare Improvements for Patients and Providers Act of 2008, and the American Recovery and Reinvestment Act of 2009. In addition, in the Addendum to this final rule, we describe the changes to the amounts and factors used to determine the rates for Medicare acute care hospital inpatient services for operating costs and capital-related costs. These changes are applicable to discharges occurring on or after October 1, 2009. We also are setting forth the update to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The updated rate-of-increase limits are effective for cost reporting periods beginning on or after October 1, 2009.

Second, we are updating the payment policy and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for rate year (RY) 2010, including responding to public comments received on a June 3, 2009 supplemental proposed rule relating to the proposed RY 2010 Medicare Severity Long-Term Care Diagnosis-Related Groups (MS–LTC–DRG) relative weights and the proposed RY 2010 high-cost outlier (HCO) fixed-loss amount. In the Addendum to this final rule, we also set forth the changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for RY 2010. These changes are applicable to discharges occurring on or after October 1, 2009. In addition, we are responding to public comments received on and finalizing a June 3, 2009 interim final rule with comment period that revised the MS–LTC–DRG relative weights for payments under the LTCH PPS for the remainder of FY 2009 (that is, from June 3, 2009, through September 30, 2009).

Third, in this final rule, we are responding to public comments we received on, and finalizing, two May 2008 interim final rules with comment period that implemented certain provisions of section 114 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, Pub. L. 110–173) relating to payments to LTCHs and LTCH satellite facilities, the establishment of LTCHs and LTCH satellite facilities, and increases in beds in existing LTCHs and LTCH satellite facilities under the LTCH PPS.

Fourth, through an interim final rule with comment period as part of this document, we are implementing those provisions of the ARRA that amended certain provisions of section 114 of the MMSEA relating to payments to LTCHs and LTCH satellite facilities and increases in beds in existing LTCHs and LTCH satellite facilities under the LTCH PPS.

DATES: *Effective Dates:* These final rules are effective on October 1, 2009, with the following exceptions:

The provisions of §§ 412.534(c) through (e) and (h) and 412.536(a)(2) are effective for cost reporting periods beginning on or after July 1, 2007, or October 1, 2007, as applicable. In accordance with sections 1871(e)(1)(A)(i) and (ii) of the Social Security Act, the Secretary has determined that retroactive application of the provisions of §§ 412.534(c) through (e) and (h) and 412.5536(a)(2) is necessary to comply with the statute and that failure to apply the changes retroactively would be contrary to public interest.

Comment Period: To be assured consideration, comments on the interim final rule with comment period (CMS–1406–IFC) that appears as section XI. of the preamble of this document must be received at one of the addresses provided below, no later than 5 p.m. E.S.T. on October 26, 2009.

ADDRESSES: When commenting on issues presented in the interim final rule with comment period, please refer to file code CMS–1406–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation at *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' and enter the file code CMS–1406–IFC to submit comments on this interim final rule.

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–1406–IFC, P.O. Box 8011, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–1406–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses: a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.) b. 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION, CONTACT: Tzvi Hefter, (410) 786–4487, and Ing-Jye Cheng, (410) 786–4548, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Capital Prospective Payment, Excluded Hospitals, Direct and Indirect Graduate Medical Education Payments, Disproportionate Share Hospital (DSH), Critical Access Hospital (CAH), EMTALA Hospital Emergency Services, and Hospital-within-Hospital Issues.

Michele Hudson, (410) 786–4487, and Judith Richter, (410) 786–2590, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights for FYs 2009 and 2010 Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

James Poyer, (410) 786–2261, Quality Data for Annual Payment Update Issues.

Lisa Grabert, (410) 786–6827, Hospital-Acquired Conditions.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions at that Web site to view public comments.

Comments received timely will also be available for public inspection, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Acronyms

3M 3M Health Information System
AAHKS American Association of Hip and Knee Surgeons
AAMC Association of American Medical Colleges
ACGME Accreditation Council for Graduate Medical Education
AHA American Hospital Association
AHIC American Health Information Community
AHIMA American Health Information Management Association
AHRQ Agency for Healthcare Research and Quality
ALOS Average length of stay
ALTHA Acute Long Term Hospital Association
AMA American Medical Association
AMGA American Medical Group Association
AOA American Osteopathic Association
APR DRG All Patient Refined Diagnosis Related Group System
ARRA American Recovery and Reinvestment Act of 2009, Public Law 111–5
ASC Ambulatory surgical center
ASCA Administrative Simplification Compliance Act of 2002, Public Law 107–105
ASITN American Society of Interventional and Therapeutic Neuroradiology
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106–554
BLS Bureau of Labor Statistics
CAH Critical access hospital
CARE [Medicare] Continuity Assessment Record & Evaluation [Instrument]
CART CMS Abstraction & Reporting Tool
CBSAs Core-based statistical areas
CC Complication or comorbidity
CCR Cost-to-charge ratio
CDAC [Medicare] Clinical Data Abstraction Center
CDAD *Clostridium difficile*-associated disease
CIPI Capital input price index
CMI Case-mix index
CMS Centers for Medicare & Medicaid Services
CMSA Consolidated Metropolitan Statistical Area
COBRA Consolidated Omnibus Reconciliation Act of 1985, Public Law 99–272
COLA Cost-of-living adjustment
CoP [Hospital] condition of participation
CPI Consumer price index
CY Calendar year
DPP Disproportionate patient percentage
DRA Deficit Reduction Act of 2005, Public Law 109–171
DRG Diagnosis-related group
DSH Disproportionate share hospital
ECI Employment cost index
EMR Electronic medical record
EMTALA Emergency Medical Treatment and Labor Act of 1986, Public Law 99–272
FAH Federation of Hospitals
FDA Food and Drug Administration
FFY Federal fiscal year
FHA Federal Health Architecture
FIPS Federal information processing standards
FQHC Federally qualified health center
FTE Full-time equivalent
FY Fiscal year
GAAP Generally Accepted Accounting Principles
GAF Geographic Adjustment Factor
GME Graduate medical education
HACs Hospital-acquired conditions
HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems
HCFA Health Care Financing Administration
HCO High-cost outlier
HCRIS Hospital Cost Report Information System
HHA Home health agency
HHS Department of Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996, Public Law 104–191
HIPC Health Information Policy Council
HIS Health information system
HIT Health information technology
HMO Health maintenance organization
HPMP Hospital Payment Monitoring Program
HSA Health savings account
HSCRC [Maryland] Health Services Cost Review Commission
HSRV Hospital-specific relative value
HSRVcc Hospital-specific relative value cost center
HQA Hospital Quality Alliance
HQI Hospital Quality Initiative
HwH Hospital-within-a-hospital
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification
ICD–10–CM International Classification of Diseases, Tenth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Revision, Procedure Coding System
ICR Information collection requirement
IHS Indian Health Service
IME Indirect medical education
I–O Input-Output
IOM Institute of Medicine
IPF Inpatient psychiatric facility
IPPS [Acute care hospital] inpatient prospective payment system
IRF Inpatient rehabilitation facility
LAMCs Large area metropolitan counties
LOS Length of stay
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MA Medicare Advantage
MAC Medicare Administrative Contractor

MCC Major complication or comorbidity
MCE Medicare Code Editor
MCO Managed care organization
MCV Major cardiovascular condition
MDC Major diagnostic category
MDH Medicare-dependent, small rural hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare Provider Analysis and Review File
MEI Medicare Economic Index
MGCRB Medicare Geographic Classification Review Board
MIEA–TRHCA Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006, Public Law 109–432
MIPPA Medicare Improvements for Patients and Providers Act of 2008, Public Law 110–275
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 110–173
MPN Medicare provider number
MRHFP Medicare Rural Hospital Flexibility Program
MRSA Methicillin-resistant *Staphylococcus aureus*
MSA Metropolitan Statistical Area
MS–DRG Medicare severity diagnosis-related group
MS–LTC–DRG Medicare severity long-term care diagnosis-related group
NAICS North American Industrial Classification System
NALTH National Association of Long Term Hospitals
NCD National coverage determination
NCHS National Center for Health Statistics
NCQA National Committee for Quality Assurance
NCVHS National Committee on Vital and Health Statistics
NECMA New England County Metropolitan Areas
NQF National Quality Forum
NTIS National Technical Information Service
NTTAA National Technology Transfer and Advancement Act of 1991 (Pub. L. 104–113)
NVHRI National Voluntary Hospital Reporting Initiative
OACT [CMS'] Office of the Actuary
OBRA 86 Omnibus Budget Reconciliation Act of 1996, Public Law 99–509
OES Occupational employment statistics
OIG Office of the Inspector General
OMB Executive Office of Management and Budget
OPM U.S. Office of Personnel Management
O.R. Operating room
OSCAR Online Survey Certification and Reporting [System]
PIP Periodic interim payment
PLI Professional liability insurance
PMSAs Primary metropolitan statistical areas
POA Present on admission
PPI Producer price index
PPS Prospective payment system
PRM Provider Reimbursement Manual
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
PSF Provider-Specific File
PS&R Provider Statistical and Reimbursement (System)
QIG Quality Improvement Group, CMS
QIO Quality Improvement Organization
RCE Reasonable compensation equivalent
RHC Rural health clinic
RHQDAPU Reporting hospital quality data for annual payment update
RNHCI Religious nonmedical health care institution
RPL Rehabilitation psychiatric long-term care (hospital)
RRC Rural referral center
RTI Research Triangle Institute, International
RUCAs Rural-urban commuting area codes
RY Rate year
SAF Standard Analytic File
SCH Sole community hospital
SFY State fiscal year
SIC Standard Industrial Classification
SNF Skilled nursing facility
SOCs Standard occupational classifications
SOM State Operations Manual
SSO Short-stay outlier
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248
TEP Technical expert panel
TMA TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007, Public Law 110–90
TJA Total joint arthroplasty
UHDDS Uniform hospital discharge data set

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I. Background

A. Summary

1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system (PPS). Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. If the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS, known as the indirect medical education (IME) adjustment. This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies or medical services that have been approved for special add-on payments. To qualify, a new technology or medical service must demonstrate that it is a substantial clinical improvement over technologies or services otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any eligible outlier payment is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology or medical service add-on adjustments.

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital-specific rate based on their costs in a base year. For example, sole community hospitals (SCHs) receive the higher of a hospital-specific rate based on their costs in a base year (the highest of FY 1982, FY 1987, FY 1996, or FY 2006) or the IPPS Federal rate based on the

standardized amount. Through and including FY 2006, a Medicare-dependent, small rural hospital (MDH) received the higher of the Federal rate or the Federal rate plus 50 percent of the amount by which the Federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. As discussed below, for discharges occurring on or after October 1, 2007, but before October 1, 2011, an MDH will receive the higher of the Federal rate or the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987, or FY 2002 hospital-specific rate. SCHs are the sole source of care in their areas, and MDHs are a major source of care for Medicare beneficiaries in their areas. Specifically, section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that is located more than 35 road miles from another hospital or that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of hospital inpatient services reasonably available to Medicare beneficiaries. In addition, certain rural hospitals previously designated by the Secretary as essential access community hospitals are considered SCHs. Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area, has not more than 100 beds, is not an SCH, and has a high percentage of Medicare discharges (not less than 60 percent of its inpatient days or discharges in its cost reporting year beginning in FY 1987 or in two of its three most recently settled Medicare cost reporting years). Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital IPPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Capital IPPS payments are also adjusted for IME and DSH, similar to the adjustments made under the operating IPPS. In addition, hospitals may receive outlier payments for those cases that have unusually high costs.

The existing regulations governing payments to hospitals under the IPPS are located in 42 CFR part 412, subparts A through M.

2. Hospitals and Hospital Units Excluded From the IPPS

Under section 1886(d)(1)(B) of the Act, as amended, certain hospitals and hospital units are excluded from the IPPS. These hospitals and units are: Rehabilitation hospitals and units; long-term care hospitals (LTCHs); psychiatric hospitals and units; children's hospitals; and cancer hospitals. Religious nonmedical health care institutions (RNHCIs) are also excluded from the IPPS. Various sections of the Balanced Budget Act of 1997 (BBA, Pub. L. 105–33), the Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA, Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, Pub. L. 106–554) provide for the implementation of PPSs for rehabilitation hospitals and units (referred to as inpatient rehabilitation facilities (IRFs)), LTCHs, and psychiatric hospitals and units (referred to as inpatient psychiatric facilities (IPFs)). (We note that the annual updates to the LTCH PPS are now included as part of the IPPS annual update document (for RY 2010, in this final rule). Updates to the IRF PPS and IPF PPS are issued as separate documents.) Children's hospitals, cancer hospitals, and RNHCIs continue to be paid solely under a reasonable cost-based system subject to a rate-of-increase ceiling on inpatient operating costs per discharge.

The existing regulations governing payments to excluded hospitals and hospital units are located in 42 CFR parts 412 and 413.

3. Long-Term Care Hospital Prospective Payment System (LTCH PPS)

The Medicare prospective payment system (PPS) for LTCHs applies to hospitals described in section 1886(d)(1)(B)(iv) effective for cost reporting periods beginning on or after October 1, 2002. The LTCH PPS was established under the authority of sections 123(a) and (c) of Public Law 106–113 and section 307(b)(1) of Public Law 106–554. During the 5-year (optional) transition period, a LTCH's payment under the PPS was based on an increasing proportion of the LTCH Federal rate with a corresponding decreasing proportion based on reasonable cost principles. Effective for cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the Federal rate. The existing regulations governing payment under the LTCH PPS are located in 42 CFR part 412, subpart O. Beginning with RY 2010, we are issuing the annual updates to the LTCH PPS in the same documents that update the IPPS (73 FR 26797 through 26798).

4. Critical Access Hospitals (CAHs)

Under sections 1814(l), 1820, and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services are generally based on 101 percent of reasonable cost. Reasonable cost is determined under the provisions of section 1861(v)(1)(A) of the Act and existing regulations under 42 CFR parts 413 and 415.

5. Payments for Graduate Medical Education (GME)

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act. The amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year. The existing regulations governing payments to the various types of hospitals are located in 42 CFR part 413.

B. Provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

Section 148 of the MIPPA (Pub. L. 110–275) changes the payment rules regarding outpatient clinical diagnostic laboratory tests furnished by a CAH. The statutory change applies to services furnished on or after July 1, 2009. In section VII.C.2. of the preamble of the proposed rule, we discussed our proposal to codify policies in the Medicare regulations to implement this provision. In section VII.C.2. of this final rule, we finalize our policies in the Medicare regulations to implement this provision.

C. Provisions of the American Recovery and Reinvestment Act of 2009 (ARRA)

Section 4301(b) of the American Recovery and Reinvestment Act of 2009 (AARA), Pub. Law 111–5, enacted on February 17, 2009, requires that the phase-out of the capital IPPS teaching adjustment at § 412.322(c) (that is, the 50-percent reduction for FY 2009) shall be applied, as if such paragraph had not been in effect. That is, discharges occurring on or after October 1, 2008,

through September 30, 2009, receive the full capital IPPS teaching adjustment as determined under § 412.322(b) of the regulations. We note that, in this final rule, in response to public comments on our proposed implementation of section 4301(b) of the ARRA, we are deleting § 412.322(d) of the existing regulations which currently eliminates the teaching adjustment beginning in FY 2010. We discuss the implementation of these provisions in sections VI.A. and E.2. of the preamble of this final rule.

Section 4302 of the ARRA included several amendments to provisions of section 114 of the MMSEA relating to: (1) The 3-year delay in the application of certain provisions of the payment adjustments for short-stay outliers and revision to the RY 2008 standard Federal rate for LTCHs; and (2) the 3-year moratorium on the establishment of new LTCHs and LTCH satellite facilities and on increases in beds in existing LTCHs and LTCH satellite facilities. We discuss the final implementation of these provisions in sections I.E., VIII., and XI. of the preamble of this final rule.

D. Issuance of a Notice of Proposed Rulemaking

On May 22, 2009, we published in the **Federal Register** (74 FR 24080) a proposed rule that set forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs of acute care hospitals in FY 2010. We also set forth proposed changes relating to payments for IME costs and payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis. In addition, we set forth proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for RY 2010. On June 3, 2009, we published in the **Federal Register** (74 FR 26600) a supplemental proposed rule (hereafter referred to as the ''RY 2010 LTCH PPS supplemental proposed rule'') that presented both proposed RY 2010 MS–LTC–DRG relative weights and a proposed RY 2010 high-cost outlier (HCO) fixed-loss amount based on the revised FY 2009 MS–LTC–DRG relative weights presented in an interim final rule with comment period published also on June 3, 2009 in the **Federal Register** (74 FR 26546).

Below is a summary of the major changes that we proposed to make:

1. Proposed Changes to MS–DRG Classifications and Recalibrations of Relative Weights

In section II. of the preamble of this final rule, we included—

- Proposed changes to MS–DRG classifications based on our yearly review.
- Proposed application of the documentation and coding adjustment to hospital-specific rates for FY 2010 resulting from implementation of the MS–DRG system.
- A discussion of the Research Triangle International, Inc. (RTI) and RAND Corporation reports and recommendations relating to charge compression, including a solicitation of public comments on the ''over'' standardization of hospital charges.
- Proposed recalibrations of the MS–DRG relative weights.

We also presented a listing and discussion of hospital-acquired conditions (HACs), including infections, that are subject to the statutorily required quality adjustment in MS–DRG payments for FY 2010.

We presented our evaluation and analysis of the FY 2010 applicants for add-on payments for high-cost new medical services and technologies (including public input, as directed by Pub. L. 108–173, obtained in a town hall meeting).

2. Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

In section III. of the preamble to the proposed rule, we proposed revisions to the wage index for acute care hospitals and the annual update of the wage data. Specific issues addressed include the following:

- Second year of the 3-year transition from national to within-State budget neutrality for the rural floor and imputed floor.
- Final year of the 2-year transition for changes in the average hourly wage criterion for geographic reclassifications.
- Changes to the CBSA designations.
- The proposed FY 2010 wage index update using wage data from cost reporting periods that began during FY 2007.
- Analysis and implementation of the proposed FY 2010 occupational mix adjustment to the wage index for acute care hospitals, including the use of data from the 2007–2008 occupational mix survey.
- Proposed revisions to the wage index for acute care hospitals based on hospital redesignations and reclassifications.
- The proposed adjustment to the wage index for acute care hospitals for FY 2010 based on commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index.
- The timetable for reviewing and verifying the wage data used to compute the proposed FY 2010 wage index for acute care hospitals.

3. Proposed Rebasing and Revision of the Hospital Market Baskets for Acute Care Hospitals

In section IV. of the preamble of the proposed rule, we proposed to rebase and revise the acute care hospital operating and capital market baskets to be used in developing the FY 2010 update factor for the operating and capital prospective payment rates and the FY 2010 update factor for the excluded hospital rate-of-increase limits. We also set forth the data sources used to determine the proposed revised market basket relative weights.

4. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs

In section V. of the preamble of the proposed rule, we discussed a number of the provisions of the regulations in 42 CFR parts 412, 413, and 489, including the following:

- The reporting of hospital quality data as a condition for receiving the full annual payment update increase.
- Discussion of applying the correct budget neutrality adjustment for the FY 2002-based hospital-specific rates for MDHs.
- The proposed updated national and regional case-mix values and discharges for purposes of determining RRC status.
- The statutorily-required IME adjustment factor for FY 2010.
- Proposed changes to the policies governing payments to Medicare disproportionate share hospitals, including proposed policies relating to the inclusion of labor and delivery patient days in the calculation of the DSH payment adjustment, calculation of inpatient days in the Medicaid fraction for the Medicare DSH calculation, and exclusion of observation beds and patient days from the Medicare DSH calculation and from the bed count for the IME adjustment.
- Proposed changes to the policies governing payment for direct GME.
- Proposed changes to policies on hospital emergency services under EMTALA relating to the applicability of sanctions under EMTALA.
- Discussion of the implementation of the Rural Community Hospital Demonstration Program in FY 2010.
- Proposed technical correction to the regulations governing the calculation of the Federal rate under the IPPS.

5. FY 2010 Policy Governing the IPPS for Capital-Related Costs

In section VI. of the preamble to the proposed rule, we discussed the payment policy requirements for capital-related costs and capital payments to hospitals for FY 2010. We also proposed to remove a section of the regulations relating to the phase-out of the capital IME adjustment for FY 2009 to implement the provisions of section 4301(b) of the ARRA.

6. Proposed Changes to the Payment Rates for Certain Excluded Hospitals: Rate-of-Increase Percentages

In section VII. of the preamble of the proposed rule, we discussed—

- Proposed changes to payments to excluded hospitals.
- Proposed changes to the regulations governing satellite facilities of hospitals.
- Proposed changes relating to payments to CAHs, including payment for clinical laboratory tests furnished by CAHs and payment for outpatient facility services when a CAH elects the optional payment method.
- Proposed changes to the rules governing provider-based status of facilities and a proposed technical correction to the regulations governing provider-based entities.

7. Proposed Changes to the LTCH PPS

In section VIII.A. through C. and F. of the preamble of the proposed rule, we set forth proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for RY 2010, including the annual update of the MS–LTC–DRG classifications and relative weights for use under the LTCH PPS for RY 2010, the proposed use of the FY 2002-based RPL market basket for LTCHs, and proposed technical corrections to the LTCH PPS regulations.

In section VIII.D. of the preamble of the proposed rule, we discussed our ongoing monitoring protocols under the LTCH PPS. In section VIII.E. of the preamble of the proposed rule, we discussed the Research Triangle Institute, International (RTI) Phase III Report on its evaluation of the feasibility of establishing facility and patient criteria for LTCHs, as recommended by MedPAC in its June 2004 Report to Congress.

We note that, because we did not propose any policy changes relating to our present activities in monitoring and updates on the RTI contract, we are not republishing these section discussions in this final rule. We did receive several public comments on specific aspects of the summary of RTI's most recent work. These commenters urged CMS not to finalize any proposals based on RTI's Phase III report until the public has had the opportunity to review the report and comment on its findings. We regret that RTI's Phase III report was not posted on the CMS Web site, as we had indicated in our proposed rule. The report will be available in the near future at *http://www.cms.hhs.gov/LongTermCareHopitalPPS/02a_RTIReports.asp#TopOfPage*. Although we did not propose any policies based on that report, we can assure the readers that any policies that we believe are appropriate for implementation would be subject to the notice-and-comment rulemaking process.

8. Determining Proposed Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits for Acute Care Hospitals

In the Addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the proposed FY 2010 prospective payment rates for operating costs and capital-related costs for acute care hospitals. We also established the proposed threshold amounts for outlier cases. In addition, we addressed the proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2010 for hospitals excluded from the IPPS.

9. Determining Proposed Prospective Payment Rates for LTCHs

In the Addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the proposed RY 2010 prospective standard Federal rate. We also established the proposed adjustments for wage levels, the labor-related share, the cost-of-living adjustment, and high-cost outliers, including the fixed-loss amount, and the LTCH cost-to-charge ratios (CCRs) under the LTCH PPS.

10. Impact Analysis

In Appendix A of the proposed rule, we set forth an analysis of the impact that the proposed changes would have on affected acute care hospitals and LTCHs.

11. Recommendation of Update Factors for Operating Cost Rates of Payment for Hospital Inpatient Services

In Appendix B of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provided our recommendations of the appropriate percentage changes for FY 2010 for the following:

- A single average standardized amount for all areas for hospital inpatient services paid under the IPPS for operating costs of acute care hospitals (and hospital-specific rates applicable to SCHs and MDHs).
- Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by certain hospitals excluded from the IPPS.
- The standard Federal rate for hospital inpatient services furnished by LTCHs.

12. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, MedPAC is required to submit a report to Congress, no later than March 1 of each year, in which MedPAC reviews and makes recommendations on Medicare payment policies. MedPAC's March 2008 recommendations concerning hospital inpatient payment policies address the update factor for hospital inpatient operating costs and capital-related costs under the IPPS, for hospitals and distinct part hospital units excluded from the IPPS, and for LTCHs. We addressed these recommendations in Appendix B of the proposed rule. For further information relating specifically to the MedPAC March 2008 report or to obtain a copy of the report, contact MedPAC at (202) 220–3700 or visit MedPAC's Web site at: *http://www.medpac.gov*.

We received approximately 525 timely pieces of correspondence from the public in response to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule and the supplemental proposed rule. We summarize these public comments and present our responses under the specific subject areas of this final rule.

E. Finalization of Interim Final Rule With Comment Period That Revised the FY 2009 MS–LTC–DRG Relative Weights

On June 3, 2009, we issued in the **Federal Register** an interim final rule with comment period that revised the MS–LTC–DRG relative weights for payments under the LTCH PPS. We revised the MS–LTC–DRG relative weights for FY 2009 due to the misapplication of our established methodology in the calculation of the budget neutrality factor. The revised relative weights are effective for the remainder of FY 2009 (that is, from June 3, 2009 through September 30, 2009). We received 11 timely pieces of correspondence from the public in response to this interim final rule with comment period. In section IX. of the preamble of this final rule, we summarize these public comments, present our responses, and finalize the

provisions of the interim final rule with comment period.

F. Finalization of Two LTCH PPS Interim Final Rules With Comment Period Issued in May 2008

On May 6, 2008 and May 22, 2008, we issued in the **Federal Register** two interim final rules with comment period relating to the LTCH PPS (73 FR 24871 and 73 FR 29699, respectively), which implement section 114 of Public Law 110–173 (MMSEA). The May 6, 2008 interim final rule with comment period implemented provisions of section 114 of Public Law 110–173 relating to a 3-year delay in the application of certain provisions of the payment adjustment for short-stay outliers and revisions to the RY 2008 standard Federal rate for LTCHs. The May 22, 2008 interim final rule with comment period implemented certain provisions of section 114 of Public Law 110–173 relating to a 3-year moratorium on the establishment of new LTCHs and LTCH satellite facilities and on increases in beds in existing LTCHs and LTCH satellite facilities. The May 22, 2008 interim final rule with comment period also implemented a 3-year delay in the application of certain payment policies that apply to payment adjustments for discharges from LTCHs and LTCH satellite facilities that were admitted from certain referring hospitals in excess of various percentage thresholds.

We received six timely pieces of correspondence from the public in response to the May 6, 2008 interim final rule with comment period. We received 30 timely pieces of correspondence from the public in response to the May 22, 2008 interim final rule with comment period. In section X. of the preamble of this final rule, we summarize these public comments, present our responses, and finalize the provisions of both interim final rules with comment period, as appropriate.

G. Interim Final Rule With Comment Period That Implements Certain Provisions of the ARRA Relating to Payments to LTCHs and LTCH Satellite Facilities

Section 4302 of the American Recovery and Reinvestment Act of 2009 (ARRA, Pub. L. 111–5) included several amendments to section 114 of Public Law 110–173 (MMSEA) relating to payments to LTCHs and LTCH satellite facilities that are discussed under section X. of the preamble of this final rule. These amendments are effective as if they were enacted as part of section 114 of Public Law 110–173 (MMSEA). We issued instructions to the fiscal intermediaries and Medicare administrative contractors (MACs) to interpret these amendments (Change Request 6444). In section XI. of this document, we implement the provisions of section 4302 of Public Law 111–5 through an interim final rule with comment period. Comments on this interim final rule with comment period may be submitted as specified in the **DATES** and Comment Period sections of this document.

II. Changes to Medicare Severity Diagnosis-Related Group (MS–DRG) Classifications and Relative Weights

A. Background

Section 1886(d) of the Act specifies that the Secretary shall establish a classification system (referred to as DRGs) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

B. MS–DRG Reclassifications

1. General

As discussed in the preamble to the FY 2008 IPPS final rule with comment period (72 FR 47138), we focused our efforts in FY 2008 on making significant reforms to the IPPS consistent with the recommendations made by MedPAC in its ''Report to the Congress, Physician-Owned Specialty Hospitals'' in March 2005. MedPAC recommended that the Secretary refine the entire DRG system by taking severity of illness into account and applying hospital-specific relative value (HSRV) weights to DRGs.[1] We began this reform process by adopting cost-based weights over a 3-year transition period beginning in FY 2007 and making interim changes to the DRG system for FY 2007 by creating 20 new CMS DRGs and modifying 32 other DRGs across 13 different clinical areas involving nearly 1.7 million cases. As described in more detail below, these refinements were intermediate steps towards comprehensive reform of both the relative weights and the DRG system as we undertook further study. For FY 2008, we adopted 745 new Medicare Severity DRGs (MS–DRGs) to replace the CMS DRGs. We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full detailed discussion of how the MS–DRG system, based on severity levels of illness, was established (72 FR 47141).

Currently, cases are classified into MS–DRGs for payment under the IPPS based on the following information reported by the hospital: the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay. In a small number of MS–DRGs, classification is also based on the age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM).

The process of developing the MS–DRGs was begun by dividing all possible principal diagnoses into mutually exclusive principal diagnosis areas, referred to as Major Diagnostic Categories (MDCs). The MDCs were formulated by physician panels to ensure that the DRGs would be clinically coherent. The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. Thus, in order to maintain the requirement of clinical coherence, no final MS–DRG could contain patients in different MDCs. For example, MDC 6 is Diseases and Disorders of the Digestive System. This approach is used because clinical care is generally organized in accordance with the organ system affected. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)). For FY 2009, cases are assigned to one of 746 MS–DRGs in 25 MDCs. The table below lists the 25 MDCs.

[1] Medicare Payment Advisory Commission: *Report to the Congress, Physician-Owned Specialty Hospitals,* March 2005, page viii.

MAJOR DIAGNOSTIC CATEGORIES (MDCS)

1	Diseases and Disorders of the Nervous System.
2	Diseases and Disorders of the Eye.
3	Diseases and Disorders of the Ear, Nose, Mouth, and Throat.
4	Diseases and Disorders of the Respiratory System.
5	Diseases and Disorders of the Circulatory System.
6	Diseases and Disorders of the Digestive System.
7	Diseases and Disorders of the Hepatobiliary System and Pancreas.
8	Diseases and Disorders of the Musculoskeletal System and Connective Tissue.
9	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast.
10	Endocrine, Nutritional and Metabolic Diseases and Disorders.
11	Diseases and Disorders of the Kidney and Urinary Tract.
12	Diseases and Disorders of the Male Reproductive System.

MAJOR DIAGNOSTIC CATEGORIES (MDCS)—Continued

13	Diseases and Disorders of the Female Reproductive System.
14	Pregnancy, Childbirth, and the Puerperium.
15	Newborns and Other Neonates with Conditions Originating in the Perinatal Period.
16	Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders.
17	Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms.
18	Infectious and Parasitic Diseases (Systemic or Unspecified Sites).
19	Mental Diseases and Disorders.
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
21	Injuries, Poisonings, and Toxic Effects of Drugs.
22	Burns.
23	Factors Influencing Health Status and Other Contacts with Health Services.

MAJOR DIAGNOSTIC CATEGORIES (MDCS)—Continued

24	Multiple Significant Trauma.
25	Human Immunodeficiency Virus Infections.

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to an MS–DRG. However, under the most recent version of the Medicare GROUPER (Version 26.0), there are 13 MS–DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These MS–DRGs are for heart transplant or implant of heart assist systems; liver and/or intestinal transplants; bone marrow transplants; lung transplants; simultaneous pancreas/kidney transplants; pancreas transplants; and tracheostomies. Cases are assigned to these MS–DRGs before they are classified to an MDC. The table below lists the 13 current pre-MDCs.

PRE-MAJOR DIAGNOSTIC CATEGORIES (PRE-MDCS)

MS–DRG 001	Heart Transplant or Implant of Heart Assist System with MCC.
MS–DRG 002	Heart Transplant or Implant of Heart Assist System without MCC.
MS–DRG 003	ECMO or Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnosis with Major O.R.
MS–DRG 004	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnosis with Major O.R.
MS–DRG 005	Liver Transplant with MCC or Intestinal Transplant.
MS–DRG 006	Liver Transplant without MCC.
MS–DRG 007	Lung Transplant.
MS–DRG 008	Simultaneous Pancreas/Kidney Transplant.
MS–DRG 009	Bone Marrow Transplant.
MS–DRG 010	Pancreas Transplant.
MS–DRG 011	Tracheostomy for Face, Mouth, and Neck Diagnoses with MCC.
MS–DRG 012	Tracheostomy for Face, Mouth, and Neck Diagnoses with CC.
MS–DRG 013	Tracheostomy for Face, Mouth, and Neck Diagnoses without CC/MCC.

Once the MDCs were defined, each MDC was evaluated to identify those additional patient characteristics that would have a consistent effect on hospital resource consumption. Because the presence of a surgical procedure that required the use of the operating room would have a significant effect on the type of hospital resources used by a patient, most MDCs were initially divided into surgical DRGs and medical DRGs. Surgical DRGs are based on a hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. Medical DRGs generally are differentiated on the basis of diagnosis and age (0 to 17 years of age or greater than 17 years of age). Some surgical and medical DRGs are further differentiated based on the presence or absence of a complication or comorbidity (CC) or a major complication or comorbidity (MCC).

Generally, nonsurgical procedures and minor surgical procedures that are not usually performed in an operating room are not treated as O.R. procedures. However, there are a few non-O.R. procedures that do affect MS–DRG assignment for certain principal diagnoses. An example is extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones. Lithotripsy procedures are not routinely performed in an operating room. Therefore, lithotripsy codes are not classified as O.R. procedures. However, our clinical advisors believe that patients with urinary stones who undergo extracorporeal shock wave lithotripsy should be considered similar to other patients who undergo O.R. procedures. Therefore, we treat this group of patients similar to patients undergoing O.R. procedures.

Once the medical and surgical classes for an MDC were formed, each diagnosis class was evaluated to determine if complications or comorbidities would consistently affect hospital resource consumption. Each diagnosis was categorized into one of three severity levels. These three levels include a major complication or comorbidity (MCC), a complication or comorbidity (CC), or a non-CC. Physician panels classified each diagnosis code based on a highly iterative process involving a combination of statistical results from test data as well as clinical judgment. As stated earlier, we refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full detailed discussion of how the MS–DRG system was established based on severity levels of illness (72 FR 47141).

A patient's diagnosis, procedure, discharge status, and demographic information is entered into the Medicare claims processing systems and subjected to a series of automated screens called

the Medicare Code Editor (MCE). The MCE screens are designed to identify cases that require further review before classification into an MS–DRG.

After patient information is screened through the MCE and any further development of the claim is conducted, the cases are classified into the appropriate MS–DRG by the Medicare GROUPER software program. The GROUPER program was developed as a means of classifying each case into an MS–DRG on the basis of the diagnosis and procedure codes and, for a limited number of MS–DRGs, demographic information (that is, sex, age, and discharge status).

After cases are screened through the MCE and assigned to an MS–DRG by the GROUPER, the PRICER software calculates a base MS–DRG payment. The PRICER calculates the payment for each case covered by the IPPS based on the MS–DRG relative weight and additional factors associated with each hospital, such as IME and DSH payment adjustments. These additional factors increase the payment amount to hospitals above the base MS–DRG payment.

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible MS–DRG classification changes and to recalibrate the MS–DRG weights. However, in the FY 2000 IPPS final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for us to consider using particular non-MedPAR data, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the non-MedPAR data submitted. Generally, however, a significant sample of the non-MedPAR data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule. This date allows us time to test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

As we indicated above, for FY 2008, we made significant improvements in the DRG system to recognize severity of illness and resource usage by adopting MS–DRGs that were reflected in the FY 2008 GROUPER, Version 25.0, and were effective for discharges occurring on or after October 1, 2007. Our MS–DRG analysis for the FY 2009 final rule was based on data from the March 2008 update of the FY 2007 MedPAR file, which contained hospital bills received through March 31, 2008, for discharges occurring through September 30, 2007. For this final rule, for FY 2010, our MS–DRG analysis is based on data from the March 2009 update of the FY 2008 MedPAR file, which contains hospital bills received through September 30, 2008, for discharges occurring through September 30, 2008.

2. Yearly Review for Making MS–DRG Changes

Many of the changes to the MS–DRG classifications we make annually are the result of specific issues brought to our attention by interested parties. We encourage individuals with comments about MS–DRG classifications to submit these comments no later than early December of each year so they can be carefully considered for possible inclusion in the annual proposed rule and, if included, may be subjected to public review and comment. Therefore, similar to the timetable for interested parties to submit non-MedPAR data for consideration in the MS–DRG recalibration process, comments about MS–DRG classification issues should be submitted no later than early December in order to be considered and possibly included in the next annual proposed rule updating the IPPS.

The actual process of forming the MS–DRGs was, and will likely continue to be, highly iterative, involving a combination of statistical results from test data combined with clinical judgment. In the FY 2008 IPPS final rule (72 FR 47140 through 47189), we described in detail the process we used to develop the MS–DRGs that we adopted for FY 2008. In addition, in deciding whether to make further modification to the MS–DRGs for particular circumstances brought to our attention, we considered whether the resource consumption and clinical characteristics of the patients with a given set of conditions are significantly different than the remaining patients in the MS–DRG. We evaluated patient care costs using average charges and lengths of stay as proxies for costs and relied on the judgment of our medical advisors to decide whether patients are clinically distinct or similar to other patients in the MS–DRG. In evaluating resource costs, we considered both the absolute and percentage differences in average charges between the cases we selected for review and the remainder of cases in the MS–DRG. We also considered variation in charges within these groups; that is, whether observed average differences were consistent across patients or attributable to cases that were extreme in terms of charges or length of stay, or both. Further, we considered the number of patients who will have a given set of characteristics and generally preferred not to create a new MS–DRG unless it would include a substantial number of cases.

C. Adoption of the MS–DRGs in FY 2008

In the FY 2006, FY 2007, and FY 2008 IPPS final rules, we discussed a number of recommendations made by MedPAC regarding revisions to the DRG system used under the IPPS (70 FR 47473 through 47482; 71 FR 47881 through 47939; and 72 FR 47140 through 47189). As we noted in the FY 2006 IPPS final rule, we had insufficient time to complete a thorough evaluation of these recommendations for full implementation in FY 2006. However, we did adopt severity-weighted cardiac DRGs in FY 2006 to address public comments on this issue and the specific concerns of MedPAC regarding cardiac surgery DRGs. We also indicated that we planned to further consider all of MedPAC's recommendations and thoroughly analyze options and their impacts on the various types of hospitals in the FY 2007 IPPS proposed rule.

For FY 2007, we began this process. In the FY 2007 IPPS proposed rule, we proposed to adopt Consolidated Severity DRGs (CS DRGs) for FY 2008 (if not earlier). Based on public comments received on the FY 2007 IPPS proposed rule, we decided not to adopt the CS DRGs. In the FY 2007 IPPS final rule (71 FR 47906 through 47912), we discussed several concerns raised by commenters regarding the proposal to adopt CS DRGs. We acknowledged the many comments suggesting the logic of Medicare's DRG system should continue to remain in the public domain as it has since the inception of the PPS. We also acknowledged concerns about the impact on hospitals and software vendors of moving to a proprietary system. Several commenters suggested that CMS refine the existing DRG classification system to preserve the many policy decisions that were made over the last 20 years and were already incorporated into the DRG system, such as complexity of services and new device technologies. Consistent with the concerns expressed in the public comments, this option had the advantage of using the existing DRGs as a starting point (which was already familiar to the public) and retained the benefit of many DRG decisions that were made in recent years. We stated our belief that the suggested approach of incorporating severity measures into the

existing DRG system was a viable option that would be evaluated.

Therefore, we decided to make interim changes to the existing DRGs for FY 2007 by creating 20 new DRGs involving 13 different clinical areas that would significantly improve the CMS DRG system's recognition of severity of illness. We also modified 32 DRGs to better capture differences in severity. The new and revised DRGs were selected from 40 existing CMS DRGs that contained 1,666,476 cases and represented a number of body systems. In creating these 20 new DRGs, we deleted 8 existing DRGs and modified 32 existing DRGs. We indicated that these interim steps for FY 2007 were being taken as a prelude to more comprehensive changes to better account for severity in the DRG system by FY 2008.

In the FY 2007 IPPS final rule (71 FR 47898), we indicated our intent to pursue further DRG reform through two initiatives. First, we announced that we were in the process of engaging a contractor to assist us with evaluating alternative DRG systems that were raised as potential alternatives to the CMS DRGs in the public comments. Second, we indicated our intent to review over 13,000 ICD–9–CM diagnosis codes as part of making further refinements to the current CMS DRGs to better recognize severity of illness based on the work that CMS (then HCFA) did in the mid-1990's in connection with adopting severity DRGs. We describe below the progress we have made on these two initiatives and our actions for FYs 2008, 2009, and 2010 based on our continued analysis of reform of the DRG system. We note that the adoption of the MS–DRGs to better recognize severity of illness has implications for the outlier threshold, the application of the postacute care transfer policy, the measurement of real case-mix versus apparent case-mix, and the IME and DSH payment adjustments. We discuss these implications for FY 2010 in other sections of this preamble and in the Addendum to this final rule.

In the FY 2007 IPPS proposed rule, we discussed MedPAC's recommendations to move to a cost-based HSRV weighting methodology using HSRVs beginning with the FY 2007 IPPS proposed rule for determining the DRG relative weights. Although we proposed to adopt the HSRV weighting methodology for FY 2007, we decided not to adopt the proposed methodology in the final rule after considering the public comments we received on the proposal. Instead, in the FY 2007 IPPS final rule, we adopted a cost-based weighting methodology without the HSRV portion of the proposed methodology. The cost-based weights were adopted over a 3-year transition period in ⅓ increments between FY 2007 and FY 2009. In addition, in the FY 2007 IPPS final rule, we indicated our intent to further study the HSRV-based methodology as well as other issues brought to our attention related to the cost-based weighting methodology adopted in the FY 2007 final rule. There was significant concern in the public comments that our cost-based weighting methodology does not adequately account for charge compression—the practice of applying a higher percentage charge markup over costs to lower cost items and services and a lower percentage charge markup over costs to higher cost items and services. Further, public commenters expressed concern about potential inconsistencies between how costs and charges are reported on the Medicare cost reports and charges on the Medicare claims. In the FY 2007 IPPS final rule, we used costs and charges from the cost report to determine departmental level cost-to-charge ratios (CCRs) which we then applied to charges on the Medicare claims to determine the cost-based weights. The commenters were concerned about potential distortions to the cost-based weights that would result from inconsistent reporting between the cost reports and the Medicare claims. After publication of the FY 2007 IPPS final rule, we entered into a contract with RTI International (RTI) to study both charge compression and to what extent our methodology for calculating DRG relative weights is affected by inconsistencies between how hospitals report costs and charges on the cost reports and how hospitals report charges on individual claims. Further, as part of its study of alternative DRG systems, the RAND Corporation analyzed the HSRV cost-weighting methodology. We refer readers to section II.E. of the preamble of this final rule for discussion of the issue of charge compression and the cost-weighting methodology for FY 2010.

We believe that revisions to the DRG system to better recognize severity of illness and changes to the relative weights based on costs rather than charges are improving the accuracy of the payment rates in the IPPS. We agree with MedPAC that these refinements should be pursued. Although we continue to caution that any prospective payment system based on grouping cases will always present some opportunities for providers to specialize in cases they believe have higher margins, we believe that the changes we have adopted and the continuing reforms we are adoptimg in this final rule for FY 2010 will improve payment accuracy and reduce financial incentives to create specialty hospitals.

We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full discussion of how the MS–DRG system was established based on severity levels of illness (72 FR 47141).

D. FY 2010 MS–DRG Documentation and Coding Adjustment, Including the Applicability to the Hospital-Specific Rates and the Puerto Rico-Specific Standardized Amount

1. Background on the Prospective MS–DRG Documentation and Coding Adjustments for FY 2008 and FY 2009 Authorized by Public Law 110–90

As we discussed earlier in this preamble, we adopted the MS–DRG patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008 (currently, 746 DRGs, which include 1 additional MS–DRG created in FY 2009). By increasing the number of DRGs and more fully taking into account patients' severity of illness in Medicare payment rates for acute care hospitals, the use of MS–DRGs encourage hospitals to improve their documentation and coding of patient diagnoses. In the FY 2008 IPPS final rule with comment period (72 FR 47175 through 47186), we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule with comment period, we exercised our authority under section 1886(d)(3)(A)(vi) of the Act, which authorizes us to maintain budget neutrality by adjusting the national standardized amount to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. Our actuaries estimated that maintaining budget neutrality required an adjustment of −4.8 percent to the national standardized amount. We phased in this −4.8 percent adjustment over 3 years. Specifically, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010.

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007, Public Law 110–90. Section 7(a) of Public Law 110–90 reduced the documentation and coding adjustment made as a result of the MS–DRG system that we adopted in the FY 2008 IPPS final rule with comment period to −0.6 percent for FY 2008 and −0.9 percent for FY 2009. Section 7(a) of Public Law 110–90 did not adjust the FY 2010 −1.8 percent documentation and coding adjustment promulgated in the FY 2008 IPPS final rule with comment period. To comply with section 7(a) of Public Law 110–90, we promulgated a final rule on November 27, 2007 (72 FR 66886) that modified the IPPS documentation and coding adjustment for FY 2008 to −0.6 percent, and revised the FY 2008 payment rates, factors, and thresholds accordingly. These revisions were effective on October 1, 2007.

For FY 2009, section 7(a) of Public Law 110–90 required a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment established in the FY 2008 IPPS final rule with comment period. As discussed in the FY 2009 IPPS final rule (73 FR 48447) and required by statute, we applied a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amount. The documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period, as amended by Public Law 110–90, are cumulative. As a result, the −0.9 percent documentation and coding adjustment for FY 2009 was in addition to the −0.6 percent adjustment for FY 2008, yielding a combined effect of −1.5 percent.

2. Prospective Adjustment to the Average Standardized Amounts Required by Section 7(b)(1)(A) of Public Law 110–90

Section 7(b)(1)(A) of Public Law 110–90 requires that if the Secretary determines that implementation of the MS–DRG system resulted in changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 or FY 2009 that are different than the prospective documentation and coding adjustments applied under section 7(a) of Public Law 110–90, the Secretary shall make an appropriate adjustment under section 1886(d)(3)(A)(vi) of the Act. Section 1886(d)(3)(A)(vi) of the Act authorizes adjustments to the average standardized amounts for subsequent fiscal years in order to eliminate the effect of such coding or classification changes. These adjustments are intended to ensure that future annual aggregate IPPS payments are the same as the payments that otherwise would have been made had the prospective adjustments for documentation and coding applied in FY 2008 and FY 2009 reflected the change that occurred in those years.

3. Recoupment or Repayment Adjustments in FYs 2010 Through 2012 Required by Public Law 110–90

If, based on a retroactive evaluation of claims data, the Secretary determines that implementation of the MS–DRG system resulted in changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 or FY 2009 that are different from the prospective documentation and coding adjustments applied under section 7(a) of Public Law 110–90, section 7(b)(1)(B) of Public Law 110–90 requires the Secretary to make an additional adjustment to the standardized amounts under section 1886(d) of the Act. This adjustment must offset the estimated increase or decrease in aggregate payments for FYs 2008 and 2009 (including interest) resulting from the difference between the estimated actual documentation and coding effect and the documentation and coding adjustment applied under section 7(a) of Public Law 110–90. This adjustment is in addition to making an appropriate adjustment to the standardized amounts under section 1886(d)(3)(A)(vi) of the Act as required by section 7(b)(1)(A) of Public Law 110–90. That is, these adjustments are intended to recoup (or repay) spending in excess of (or less than) spending that would have occurred had the prospective adjustments for changes in documentation and coding applied in FY 2008 and FY 2009 precisely matched the changes that occurred in those years. Public Law 110–90 requires that the Secretary make these recoupment or repayment adjustments for discharges occurring during FYs 2010, 2011, and 2012.

4. Retrospective Evaluation of FY 2008 Claims Data

In order to implement the requirements of section 7 of Public Law 110–90, we indicated in the FY 2009 IPPS final rule (73 FR 48450) that we planned a thorough retrospective evaluation of our claims data. We stated that the results of this evaluation would be used by our actuaries to determine any necessary payment adjustments to the standardized amounts under section 1886(d) of the Act beginning in FY 2010 to ensure the budget neutrality of the MS–DRGs implementation for FY 2008 and FY 2009, as required by law. In the FY 2009 IPPS proposed rule (73 FR 23541 through 23542), we described our preliminary plan for a retrospective analysis of inpatient hospital claims data and invited public input on our proposed methodology.

In that proposed rule, we indicated that we intended to measure and corroborate the extent of the overall national average changes in case-mix for FY 2008 and FY 2009. We expected that the two largest parts of this overall national average change would be attributable to underlying changes in actual patient severity and to documentation and coding improvements under the MS–DRG system. In order to separate the two effects, we planned to isolate the effect of shifts in cases among base DRGs from the effect of shifts in the types of cases within base DRGs.

The MS–DRGs divide the base DRGs into three severity levels (with MCC, with CC and without CC); the previously used CMS DRGs had only two severity levels (with CC and without CC). Under the CMS DRG system, the majority of hospital discharges had a secondary diagnosis which was on the CC list, which led to the higher severity level. The MS–DRGs significantly changed the code lists of what was classified as an MCC or a CC. Many codes that were previously classified as a CC are no longer included on the MS–DRG CC list because the data and clinical review showed these conditions did not lead to a significant increase in resource use. The addition of a new level of high severity conditions, the MCC list, also provided a new incentive to code more precisely in order to increase the severity level. We anticipated that hospitals would examine the MS–DRG MCC and CC code lists and then work with physicians and coders on documentation and coding practices so that coders could appropriately assign codes from the highest possible severity level. We note that there have been numerous seminars and training sessions on this particular coding issue. The topic of improving documentation practices in order to code conditions on the MCC list was also discussed extensively by participants at the March 11–12, 2009 ICD–9–CM Coordination and Maintenance Committee meeting. Participants discussed their hospitals' efforts to encourage physicians to provide more precise documentation so that coders could appropriately assign codes that would lead to a higher

severity level. Because we expected most of the documentation and coding changes under the MS–DRG system would occur in the secondary diagnoses, we believed that the shifts among base DRGs were less likely to be the result of the MS–DRG system and the shifts within base DRGs were more likely to be the result of the MS–DRG system. We also anticipated evaluating data to identify the specific MS–DRGs and diagnoses that contributed significantly to the documentation and coding payment effect and to quantify their impact. This step entailed analysis of the secondary diagnoses driving the shifts in severity within specific base DRGs.

In that same proposed rule, we also stated that, while we believe that the data analysis plan described previously will produce an appropriate estimate of the extent of case-mix changes resulting from documentation and coding changes, we might decide, if feasible, to use historical data from our Hospital Payment Monitoring Program (HPMP) to corroborate the within-base DRG shift analysis. The HPMP is supported by the Medicare Clinical Data Abstraction Center (CDAC).

In the FY 2009 IPPS proposed rule, we solicited public comments on the analysis plans described above, as well as suggestions on other possible approaches for performing a retrospective analysis to identify the amount of case-mix changes that occurred in FY 2008 and FY 2009 that did not reflect real increases in patients' severity of illness.

A few commenters, including MedPAC, expressed support for the analytic approach described in the FY 2009 IPPS proposed rule. A number of other commenters expressed concerns about certain aspects of the approach and/or suggested alternate analyses or study designs. In addition, one commenter recommended that any determination or retrospective evaluation by the actuaries of the impact of the MS–DRGs on case-mix be open to public scrutiny prior to the implementation of the payment adjustments beginning in FY 2010.

We took these comments into consideration as we developed our proposed analysis plan (described in greater detail below) and in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24092 through 24101) solicited public comment on our methodology and analysis. For the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we performed a retrospective evaluation of the FY 2008 data for claims paid through December 2008. Based on this evaluation, our actuaries determined that implementation of the MS–DRG system resulted in a 2.5 percent change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008. In the FY 2010 IPPS/RY 2010 LTCH proposed rule, we also stated that we would update the results from the proposed analysis plan with data extracted from FY 2008 Medicare claims that were paid through March 2008 [sic] for the FY 2010 IPPS final rule. (We note that the March 2008 date for the updated data that appeared in the proposed rule should have been March 2009.)

In performing the analysis for the proposed rule, we first divided the case-mix index (CMI) obtained by grouping the FY 2008 claims data through the FY 2008 GROUPER (Version 25.0) by the CMI obtained by grouping these same FY 2008 claims through the FY 2007 GROUPER (Version 24.0). This resulted in a value of 1.028. Because these cases are the same FY 2008 cases grouped using Versions 24.0 and 25.0 of the GROUPER, we attribute this increase primarily to two factors: (1) The effect of changes in documentation and coding under the MS–DRG system; and (2) the measurement effect from the calibration of the GROUPER. We estimated the measurement effect from the calibration of the GROUPER by dividing the CMI obtained by grouping cases in the FY 2007 claims data through the FY 2008 GROUPER by the CMI obtained by grouping cases in these same claims through the FY 2007 GROUPER. This resulted in a value of 1.003. In order to isolate the documentation and coding effect, we then divided the combined effect of the changes in documentation and coding and measurement (1.028) by the measurement effect (1.003) to yield 1.025. Therefore, our estimate of the documentation and coding increase was 2.5 percent.

We then sought to corroborate this 2.5 percent estimate by examining the increases in the within-base DRGs as compared to the increases in the across base DRGs as described earlier in our analysis plan. In other words, we looked for improvements in code selection that would lead to a secondary diagnosis increasing the severity level to either a CC or an MCC level.

In the analysis of data for the proposed rule, we found that the within-base DRG increases were almost entirely responsible for the case-mix change, supporting our conclusion that the 2.5 percent estimate was an accurate reflection of the FY 2008 effect of changes in documentation and coding under the MS–DRG system. In fact, almost every base DRG that was split into different severity levels under the MS–DRG system experienced increases in the within-base DRGs.

We then further analyzed the changes in the within-base DRGs to determine which MS–DRGs had the highest contributions to this increase. Consistent with the expectations of our medical coding experts concerning areas with potential for documentation and coding improvements, the top contributors were heart failure, chronic obstructive pulmonary disease, and simple pneumonia and pleurisy. In fact, the coding of heart failure was discussed extensively at the March 11–12, 2009 ICD–9–CM Coordination and Maintenance Committee meeting. Heart failure is a very common secondary diagnosis among Medicare hospital admissions. The heart failure codes are assigned to all three severity levels. Some codes are classified as non-CCs, while other codes are on the CC and MCC lists. By changing physician documentation to more precisely identify the type of heart failure, coders are able to appropriately change the severity level of cases from the lowest level (non-CC) to a higher severity level (CC or MCC). This point was stressed repeatedly at the March 11–12, 2009 ICD–9–CM Coordination and Maintenance Committee meeting as coders discussed their work with physicians on this coding issue. Many of the participants indicated that additional work was still needed with their physicians in order to document conditions in the medical record more precisely.

The results of the analysis for the proposed rule provided additional support for our conclusion that the proposed 2.5 percent estimate accurately reflected the FY 2008 increases in documentation and coding under the MS–DRG system.

While we attempted to use the CDAC data to distinguish real increase in case-mix growth from documentation and coding in the overall case-mix number, we found aberrant data and significant variation across the FY 1999–FY 2007 analysis period. It was not possible to distinguish changes in documentation and coding from changes in real case-mix in the CDAC data. Therefore, we concluded that the CDAC data would not support analysis of real case-mix growth that could be used in our retrospective evaluation of the FY 2008 claims data.

Although we could not use the CDAC data, we did examine the overall growth in case-mix using the FY 2007 claims data in which we grouped cases using the FY 2007 GROUPER and the FY 2008 data in which we grouped cases using

the FY 2008 GROUPER. We found the overall growth in case-mix was 1.9 percent. The implication of overall FY 2008 case-mix growth of 1.9 percent relative to our estimate of the FY 2008 documentation and coding effect and the GROUPER measurement effect is that real case-mix declined between FY 2007 and FY 2008. After additional data analysis, our actuaries determined that the 1.9 percent growth in overall case-mix was consistent with our 2.5 percent estimate of the FY 2008 documentation and coding effect for reasons that included: (1) Our mathematical model for determining the 2.5 percent documentation and coding effect was corroborated by the amount of case-mix growth attributed to within-DRG improvements in secondary coding of MCCs and CCs; (2) our data analysis confirmed the substitution of specified diagnosis for unspecified diagnoses for such common conditions as heart failure and chronic obstructive pulmonary disease; and (3) there was a relative decline in above average cost short-stay surgical cases that can be performed on an outpatient basis, such as certain high volume pacemaker procedures.

We also examined the differences in case-mix between the FY 2008 claims data in which cases were grouped through the FY 2008 GROUPER (Version 25.0) and the FY 2009 GROUPER (Version 26.0). This was to help inform analysis of the potential for increase in the documentation and coding effect in FY 2009. In FY 2008, we were transitioning to the fully implemented MS–DRG relative weights and the fully implemented cost-based weights. We found that the use of the transition weights mitigated the FY 2008 documentation and coding effect on expenditures. Using the FY 2009 relative weights, the documentation and coding effect would have been an estimated 3.2 percent in FY 2008 instead of our estimated 2.5 percent. Even assuming no continued improvement in documentation and coding in FY 2009, we estimated that the use of the FY 2009 relative weights would result in an additional 0.7 percent documentation and coding effect in FY 2009. After taking into account the results of our FY 2008 analysis and the expertise of our coding staff, our actuaries continue to estimate that the cumulative overall effect of documentation and coding improvements under the MS–DRG system will be 4.8 percent. However, our actuaries estimate that these improvements will be substantially complete by the end of FY 2009. Therefore, our estimate of the FY 2009 MS–DRG documentation and coding effect for the proposed rule was 2.3 percent.

As in prior years, the FY 2008 MedPAR files were available to the public to allow independent analysis of the FY 2008 documentation and coding effect. Interested individuals may still order these files by going to the Web site at *http://www.cms.hhs.gov/LimitedDataSets/* and clicking on MedPAR Limited Data Set (LDS)-Hospital (National). This Web page describes the file and provides directions and further detailed instructions for how to order.

Persons placing an order must send the following: a Letter of Request, the LDS Data Use Agreement and Research Protocol (refer to the Web site for further instructions), the LDS Form, and a check for $3,655 to:

Mailing address if using the U.S. Postal Service: Centers for Medicare & Medicaid Services, RDDC Account, Accounting Division, P.O. Box 7520, Baltimore, MD 21207–0520.

Mailing address if using express mail: Centers for Medicare & Medicaid Services, OFM/Division of Accounting—RDDC, 7500 Security Boulevard, C3–07–11, Baltimore, MD 21244–1850.

Comment: MedPAC commented that its analysis of 2008 claims confirmed the CMS finding that documentation and coding improvements increased case-mix by 2.5 percent in 2008, which resulted in overpayments of 1.9 percent. With regard to CMS' projection that by the end of 2009, hospitals' documentation and coding improvements will have increased case-mix by a cumulative total of 4.8 percent, MedPAC stated that, while all documentation and coding improvement projections are subject to uncertainty, 4.8 percent appears to be a reasonable estimate, given MedPAC's own examination of recent experience in Maryland.

Response: We agree with MedPAC's comment that changes in documentation and coding increased case-mix by 2.5 percent in FY 2008. Using more recent FY 2008 claims data updated through March 2009, our actuaries' estimate of the effect of changes in documentation and coding continues to be 2.5 percent. Our actuaries also continue to estimate that by the end of FY 2009, changes in documentation and coding will have increased case-mix by 4.8 percent, consistent with MedPAC's comment.

Comment: Most commenters questioned CMS' methodology for the retrospective evaluation of FY 2008 claims data and CMS' finding that real case-mix growth in FY 2008 was negative. These comments were generally similar to the comments from the AHA, which read:

''In its analysis of documentation and coding changes, CMS concludes that from FY 2007 to FY 2008, there was a decline in real case mix; in contrast, our analysis found that there is a historical pattern of steady annual increases of 1.2 to 1.3 percent in real case mix and we are concerned that CMS' conclusion is incorrect. Further, because CMS' conclusion that real case-mix declined is an inference based on its analysis of documentation and coding-related increases, we are concerned that the 1.9 percent proposed cut also is inaccurate and overstated.''

The commenters also raised concerns that CMS' estimate did not fully consider other potential causes of increased case-mix, such as patients requiring less complex services receiving care in other settings and ''healthier'' patients enrolling in Medicare Advantage plans in increasing numbers. Other commenters indicated that factors such as the changes in the CC/MCC definitions, limitations on the number of codes used by CMS for payment and ratesetting, resequencing of secondary diagnoses, the transition to the cost-based weights, less use of ''not otherwise specified'' codes, and increases in real case-mix due to health reform efforts also resulted in an inaccurate documentation and coding analysis. One commenter indicated that, of the overall case-mix increase, 1.0 percent to 1.5 percent is ''real'' case-mix increase, while 1.0 percent to 1.5 percent is due to documentation and coding or other increases.

Response: The assertion that there is a historical pattern of steady annual increases of 1.2 to 1.3 percent in real case-mix is predicated on the assumption that there was little documentation and coding effect in those historical years. In considering these comments concerning historical real case-mix, we calculated overall increases in case-mix for the period from FY 2000 to FY 2007 using the cases from each year and the GROUPER and relative weights applicable for each year. The results are shown in the following chart:

OVERALL CASE-MIX INCREASES FOR FY 2000 TO FY 2007

Year	Overall case-mix change from prior year (in percent)
FY 2000	−0.7
FY 2001	−0.4
FY 2002	1.0
FY 2003	1.4
FY 2004	1.0
FY 2005	0.9
FY 2006	1.2
FY 2007	−0.2

Overall case-mix growth is predominately comprised of three factors: real case-mix growth; a documentation and coding effect; and a measurement effect. Under the reasonable assumption that there has been a relatively small measurement effect in those years, the assertion that there is a historical pattern of steady annual increases of 1.2 to 1.3 percent in real case-mix implies that the documentation and coding effect in many of those years was negative. For example, as described earlier, we estimated a recent measurement effect of +0.3 percent. The overall case-mix growth of −0.2 percent in FY 2007 net of a measurement effect of +0.3 percent results in growth of +0.1 percent. A real case-mix growth of +1.2 percent in FY 2007, therefore, implies a negative documentation and coding effect of approximately −1.1 percent. It is not obvious why documentation and coding would have had such a large negative effect in FY 2007, or in any other year where the overall case-mix change is significantly less than the commenter's claimed average annual trend, calling into question the assertion that real case-mix growth is a steady 1.2 to 1.3 percent per year.

Our current estimate of the overall case-mix growth for FY 2008 based on more recent data than the data used in the proposed rule is 2.0 percent, still less than our actuaries' estimate of a 2.5 percent documentation and coding increase. With respect to the concerns raised by commenters about our finding of negative real case-mix growth in FY 2008, a finding of negative real case-mix growth is consistent with the fact that, in some years, overall case-mix growth has been negative, as shown in the chart presented above in this response. Some commenters were particularly focused on our statement in the proposed rule regarding a relative decline in above average cost short-stay surgical cases. We did not state that the decline in real case-mix was entirely attributable to the relative decline in above average cost short-stay outliers. We stated that—

''After additional data analysis, our actuaries determined that the 1.9 percent growth in overall case-mix was consistent with our 2.5 percent estimate of the FY 2008 documentation and coding effect for reasons that included: (1) Our mathematical model for determining the 2.5 percent documentation and coding effect was corroborated by the amount of case-mix growth attributed to within-DRG improvements in secondary coding of MCCs and CCs; (2) our data analysis confirmed the substitution of specified diagnosis for unspecified diagnoses for such common conditions as heart failure and chronic obstructive pulmonary disease; and (3) there was a relative decline in above average cost short-stay surgical cases that can be performed on an outpatient basis, such as certain high-volume pacemaker procedures.''

The decline in above average cost short-stay surgical cases was one factor in our actuaries' determination that the 1.9 percent growth in overall case-mix was consistent with our 2.5 percent documentation and coding estimate. It was not the only factor. Our current estimate of the overall case-mix growth between FY 2007 and FY 2008 based on more recent data than the data used in the proposed rule is 2.0 percent. We observed numerous small changes for a number of base DRGs that drive the difference between this overall case mix growth estimate of 2.0 percent and our documentation and coding estimate of 2.5 percent, including the relative decline in above average cost surgical stay cases that can be performed on an outpatient basis that we cited in the proposed rule. These other base DRGs include MS–DRGs 193, 194, and 195 (Simple Pneumonia and Pleurisy with MCC, with CC, and without CC or MCC, respectively); MS–DRGs 246 and 247 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with MCC or Four or More (4+) Vessels/Stents and without MCC, respectively); MS–DRGs 233 and 234 (Coronary Bypass with Cardiac Catheterization with MCC and without MCC, respectively); MS–DRGs 235 and 236 (Coronary Bypass without Cardiac Catheterization with MCC and without MCC, respectively); MS–DRGs 252, 253, and 254 (Other Vascular Procedures with MCC, with CC, and without CC or MCC, respectively); MS–DRGs 291, 292, and 293 (Heart Failure and Shock with MCC, with CC, and without CC or MCC, respectively); MS–DRG 313 (Chest Pain); and MS–DRGs 391 and 392 (Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders with MCC and without MCC, respectively). It is reasonable that the cumulative impact of small changes across a number of base DRGs could result in a difference of 0.5 percentage points between the overall growth in case-mix and our documentation and coding estimate.

With respect to the commenters who raised concerns that our estimate did not fully consider other potential causes of increased real case-mix, such as patients requiring less-complex services receiving care in other settings, ''healthier'' patients enrolling in MA plans in increasing numbers, and health reform efforts, we note that our methodology for estimating documentation and coding does not, by definition, include real case-mix, regardless of the actual real case-mix level. As MedPAC stated in its comment:

''Our analysis of hospital claims for fiscal year 2008 confirms CMS's findings. To see how much the aggregate CMI and payments increased in 2008 due solely to hospitals' DCI, we used fiscal year 2008 claims—from the December 2008 update of the 2008 MedPAR file—to calculate the national aggregate CMI based on the 2008 MS–DRGs and weights. Using the same claims, we also calculated the aggregate CMI based on the 2007 DRGs and weights. The difference between the two CMIs is 2.8 percent. By definition, this change in reported case mix is not real because the cases are the same.''

The question is how much of the 2.8 percent increase is due to a documentation and coding effect and how much is due to a measurement effect. Both MedPAC and our actuaries, based on prior year data, estimate the measurement effect to be 0.3 percent, yielding our 2.5 percent FY 2008 documentation and coding effect.

With respect to the commenter who indicated that real case-mix growth was 1.0 percent to 1.5 percent, the primary reason cited was the interaction of the resequencing of secondary diagnoses, changes in MS–DRG definitions, and limitations on the number of codes used by CMS for payment and ratesetting. There is a yearly review for making MS–DRG changes. As we note in section II.B.2. of this preamble, the actual process of forming MS–DRGs is highly iterative and involves statistical results from test data and clinical judgment. In addition, while hospitals may submit up to 25 diagnosis codes and 25 procedure codes on the claim, our payment system uses only the first 9 diagnosis code positions and the first 6 procedure code positions for payment purposes. The commenter observed that the

combination of this system limitation with the yearly review of MS–DRGs has a sequencing effect. The commenter did not believe that the resequencing of secondary diagnoses was a documentation and coding effect. We disagree. Resequencing is merely a change in the hospital's ordering of the codes that will be used for payment purposes. It causes a payment change unrelated to any change in the underlying condition of a patient. As we have stated on numerous occasions, we do not believe that these types of documentation and coding changes are the result of inappropriate behavior on the part of hospitals. However, to the extent resequencing occurs, it is appropriately included in our documentation and coding increase.

Comment: Multiple commenters were disappointed that CMS was unable to obtain relevant findings based on CDAC data to quantify real case-mix change.

Response: As we stated in the proposed rule, when we attempted to use the CDAC data to distinguish increase in real case-mix growth from increases due to documentation and coding in the overall case-mix number, we found aberrant data and significant inconsistency across the FY 1999–FY 2007 analysis period. It was not possible to distinguish changes in documentation and coding from changes in real case-mix in the CDAC data. Therefore, we concluded that the CDAC data would not support analysis of real case-mix growth that could be used in our retrospective evaluation of the FY 2008 claims data. While we acknowledge the disappointment of the commenters, we note that we did not receive any alternative analysis directly measuring real case-mix growth that did not rely on assumptions with respect to the other factors that influence overall case-mix growth.

Comment: Some commenters suggested that rural providers are typically presented with less complex cases and have fewer opportunities to benefit from improved coding opportunities.

Response: As MedPAC stated in its comment, ''In addition, we estimated the 2008 DCI effect using the same methods for various subgroups of hospitals. Although the DCI estimates varied somewhat among the groups, the variation was generally small. Thus, the DCI response appears to be widely consistent among all types of hospitals.'' Our own analyses confirm MedPAC's finding that the documentation and coding response appears to be generally consistent among different types of hospitals, including urban and rural hospitals. Using the same methodology described earlier, the difference in the DCI response between urban and rural hospitals was not significant, similar to our findings discussed elsewhere that the differences for MDHs and SCHs were not significant.

We also note that we discussed the issue of a uniform adjustment for DCI response in the FY 2008 IPPS final rule (72 FR 47184), published prior to the TMA, Abstinence Education, and QI Programs Extension Act of 2007. In that discussion, we noted that ''While improvements in documentation and coding that increase case mix may be variable, section 1886(d)(3)(A)(vi) of the Act only allows us to apply the adjustments that are a result of changes in the coding or classification of discharges that do not reflect real changes in case mix to the standardized amounts.''

Section 7 of the TMA, Abstinence Education, and QI Programs Extension Act of 2007 specifically references section 1886(d)(3)(A)(vi), stating that the Secretary shall ''make an appropriate adjustment under paragraph (3)(A)(vi) of such section 1886(d).'' Section 1886(d)(3)(A)(iv)(II) of the Act directed CMS to eliminate separate standardized amounts for large urban areas and other areas beginning in FY 2004, creating the current uniform standardized amount that is applicable to all hospitals. Therefore, even if the data did indicate a different DCI response for urban and rural hospitals, the law continues to only allow us to apply the prospective adjustments that are a result of changes in the coding or classification of discharges that do not reflect real changes in case-mix to the standardized amount.

5. Adjustments for FY 2010 and Subsequent Years Authorized by Section 7(b)(1)(A) of Public Law 110–90 and Section 1886(d)(3)(vi) of the Act

Based on our most current evaluation of FY 2008 Medicare claims data, the estimated 2.5 percent change in FY 2008 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 exceeds the −0.6 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 by 1.9 percentage points. Under section 7(b)(1)(A) of Public Law 119–90, the Secretary is required to make an appropriate adjustment under section 1886(d)(3)(A)(vi) of the Act to the average standardized amounts for subsequent fiscal years in order to eliminate the full effect of the documentation and coding changes on future payments. In addition, we note that the Secretary has the authority to make this prospective adjustment in FY 2010 under section 1886(d)(3)(A)(vi) of the Act. As we have consistently stated since the initial implementation of the MS–DRG system, we do not believe it is appropriate for expenditures to increase due to MS–DRG-related changes in documentation and coding that do not reflect real changes in case-mix.

We also estimate that the additional change in case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2009 will be 2.3 percent, which would exceed by 1.4 percentage points the −0.9 percent prospective documentation and coding adjustment for FY 2009 applied under section 7(a) of Public Law 100–90. We have the statutory authority to adjust the FY 2010 rates for this estimated 1.4 percentage point increase. However, given that Public Law 100–90 requires a retrospective claims evaluation for the additional adjustments described in section II.D.6. of this preamble, we stated in the proposed rule that we believed our evaluation of the extent of the overall national average changes in case-mix for FY 2009 should also be based on a retrospective evaluation of all FY 2009 claims data. Because we do not receive all FY 2009 claims data prior to publication of this final rule, we indicated we would address any difference between the additional increase in FY 2009 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 in the FY 2011 rulemaking cycle.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24096), we solicited public comment on the proposed −1.9 percent prospective adjustment to the standardized amounts under section 1886(d) of the Act to address the effects of documentation and coding changes unrelated to changes in real case-mix in FY 2008. In addition, we solicited public comments on addressing in the FY 2011 rulemaking cycle any differences between the increase in FY 2009 case-mix due to changes in documentation and coding changes that do not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90. We present below a summation of the

public comments we received on these issues and our responses.

Comment: MedPAC summarized its comments on when CMS should reduce payment rates to prevent further overpayments and to recover overpayments occurring in 2008 and 2009 as follows: ''We support CMS's proposal to reduce IPPS payments in 2010 by 1.9 percent to prevent further overpayments. While we and the CMS actuaries believe that a 1.9 percent reduction will not fully prevent overpayments from continuing in 2010, this is a reasonable first step toward reducing overpayments.''

Response: While we agree with MedPAC's comment that our proposed −1.9 percent adjustment would be a reasonable first step with respect to the documentation and coding increases associated with the implementation of the MS–DRGs, nevertheless, as discussed below, we believe that it would be more prudent to delay implementation of the documentation and coding adjustment to allow for a more complete analysis of FY 2009 claims data. If the estimated documentation and coding effect determined based on a full analysis of FY 2009 claims data is more or less than our current estimates, it would change, possibly lessen, the anticipated cumulative adjustments that we currently estimate we would have to make for FY 2008 and FY 2009 combined adjustment.

Comment: Most commenters opposed the proposed −1.9 percent prospective FY 2010 adjustment for FY 2008 documentation and coding increases, but supported the proposal not to apply a FY 2010 prospective adjustment for estimated FY 2009 documentation and coding increases. The commenters expressed concern over the financial impact of the proposed −1.9 percent adjustment and the methodology for calculating the adjustment. The comments on the financial impact were generally similar to those contained in the comment from the AHA, which stated that ''The proposed rule includes a 1.9 percent cut to both operating and capital payments in FY 2010 and beyond—$23 billion over 10 years—to correct the base rate for payments made in FY 2008 that CMS claims are the effect of documentation and coding changes that do not reflect real changes in case mix. In combination with other policy changes, this cut results in hospitals being paid $1 billion less in FY 2010 than in FY 2009 * * * We recognize that CMS could have taken action to reduce payments more than proposed in this rule. We appreciate that CMS did not propose cuts for documentation and coding changes in FY 2009 or cuts to recoup the estimated documentation and coding overpayments in FY 2008. However, given the severity of the 1.9 percent proposed cut, and in light of the fact that our analysis shows real increases in patient severity, we ask that the agency significantly mitigate its proposed documentation and coding cut.''

Other commenters recommended that CMS seek to extend the timeframe beyond 2 years to phase in the estimated −6.6 percent adjustment to the standardized amount.

Response: Our actuaries have determined, and MedPAC has confirmed, that the implementation of the MS–DRG system resulted in changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008. The impact of these changes exceeds the −0.6 percent prospective documentation and coding adjustments applied under section 7(a) of Public Law 110–90. As described earlier, analysis of more recent claims data confirms that the difference is −1.9 percent. We addressed the comments on our methodology in the section II.D.4. of this preamble.

We fully understand that our proposed adjustment of −1.9 percent would reduce the increase in payments that affected hospitals would have received in FY 2009 in the absence of the adjustment. Although we are required to make a prospective adjustment to eliminate the full effect of coding or classification changes that did not reflect real changes in case-mix for discharges occurring during FY 2008, we believe we have some discretion regarding when to implement this adjustment. Section 7(b)(1)(A) of Public Law 110–90 requires that if the Secretary determines that implementation of the MS–DRG system resulted in changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 or FY 2009 that are different than the prospective documentation and coding adjustments applied under section 7(a) of Public Law 110–90, the Secretary shall make an ''appropriate'' adjustment under section 1886(d)(3)(A)(vi) of the Act.

After consideration of the public comments we received on these issues, we have determined that it would be appropriate to postpone adopting documentation and coding adjustments as authorized under section 7(a) of Public Law 110–90 and section 1886(d)(3)(A)(vi) of the Act until a full analysis of case-mix changes can be completed. While we have the statutory authority to make this 1.9 percent prospective adjustment entirely in FY 2010, we believe it would be prudent to wait until we have complete data on the magnitude of the documentation and coding effect in FY 2009. If the documentation and coding effect were less in FY 2009 than our current estimates, it could lessen the anticipated adjustment that we currently estimate we would have to make for FY 2008 and FY 2009 combined. In future rulemaking, we will consider applying a prospective adjustment based upon a complete analysis of FY 2008 and FY 2009 claims data over an extended time period, such as 5 years, beginning in FY 2011. During this phase-in period, we intend to address any difference between the increase in FY 2009 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 in the FY 2011 rulemaking cycle.

We appreciate the commenters' support of our decision not to apply a FY 2010 prospective adjustment for estimated FY 2009 documentation and coding increases until we have performed a retrospective evaluation of the FY 2009 claims data.

6. Additional Adjustment for FY 2010 Authorized by Section 7(b)(1)(B) of Public Law 110–90

As indicated above, the estimated 2.5 percent change (estimated from analysis of more recent data than the data used for the proposed rule) due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 exceeds the −0.6 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 by 1.9 percentage points. Our actuaries currently estimate that this 1.9 percentage point increase resulted in an increase in aggregate payments of approximately $2.2 billion. As described earlier, section 7(b)(1)(B) of Public Law 110–90 requires an additional adjustment for discharges occurring in FYs 2010, 2011, and/or 2012 to offset the estimated amount of this increase in aggregate payments (including interest).

Although section 7(b)(1)(B) of Public Law 110–90 requires us to make this adjustment in FYs 2010, 2011, and/or 2012, we have discretion as to when during this 3 year period we will apply the adjustment. For example, we could make adjustments to the standardized amounts under section 1886(d) of the

Act in FY 2010, 2011, and 2012. Alternatively, we could delay offsetting the increase in FY 2008 aggregate payments by applying the adjustment required under section 7(b)(1)(B) of Public Law 110–90 only to FYs 2011 and 2012.

We did not propose to make an adjustment to the FY 2010 average standardized amounts to offset, in whole or in part, the estimated increase in aggregate payments for discharges occurring in FY 2008, but stated in the proposed rule that we intended to address this issue in future rulemaking for FYs 2011 and 2012. That is, we stated we would address recouping the additional expenditures that occurred in FY 2008 as a result of the 1.9 percentage point difference between the actual changes in documentation and coding that do not reflect real changes in case-mix, or 2.5 percent, and the −0.6 percent adjustment applied under Public Law 110–90 in FY 2011 and/or FY 2012, as required by law. We indicated that, while we have the statutory authority to make this −1.9 percent recoupment adjustment entirely in FY 2010, we are delaying the adjustment until FY 2011 and FY 2012 because we do not have any data yet on the magnitude of the documentation and coding effect in FY 2009. If the documentation and coding effect were less in FY 2009 than our current estimates, it could lessen the anticipated recoupment adjustment that we currently estimate we would have to make for FY 2008 and FY 2009 combined. As we have the authority to recoup the aggregate effect of this 1.9 percentage point difference in FY 2008 IPPS payments in FY 2011 or FY 2012 (with interest), delaying this adjustment would have no effect on Federal budget outlays. In the proposed rule, we indicated that we intended to wait until we have a complete year of data on the FY 2009 documentation and coding effect before applying a recoupment adjustment for IPPS spending that occurred in FY 2008 or we estimate will occur in FY 2009.

As discussed above, section 7(b)(1)(B) of Public Law 110–90 requires the Secretary to make an additional adjustment to the standardized amounts under section 1886(d) of the Act to offset the estimated increase or decrease in aggregate payments for FY 2009 (including interest) resulting from the difference between the estimated actual documentation and coding effect and the documentation and coding adjustments applied under section 7(a) of Public Law 110–90. This determination must be based on a retrospective evaluation of claims data. Because we will not receive all FY 2009 claims data prior to publication of this final rule, as we indicate in the proposed rule, we intend to address any increase or decrease in FY 2009 payments in future rulemaking for FY 2011 and 2012 after we perform a retrospective evaluation of the FY 2009 claims data. Our actuaries currently estimate that this adjustment will be approximately −3.3 percent. This reflects the difference between the estimated 4.8 percent cumulative actual documentation and coding changes for FY 2009 (2.5 percent for FY 2008 and an additional 2.3 percent for FY 2009) and the cumulative −1.5 percent documentation and coding adjustments applied under section 7(a) of Public Law 110–90 (−0.6 percent in FY 2008 and −0.9 percent in FY 2009). We note that the actual adjustments are multiplicative and not additive. This more recent estimated 4.8 percent cumulative actual documentation and coding changes for FY 2009 includes the impact of the changes in documentation and coding first occurring in FY 2008 because we believe hospitals will continue these changes in documentation and coding in subsequent fiscal years. Consequently, these documentation and coding changes will continue to impact payments under the IPPS absent a prospective adjustment to account for the effect of these changes.

We note that, unlike the −1.9 adjustment to the standardized amounts under section 7(b)(1)(A) of Public Law 110–90 described earlier, any adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90 would not be cumulative, but would be removed for subsequent fiscal years once we have offset the increase in aggregate payments for discharges for FY 2008 expenditures and FY 2009 expenditures, if any.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24096), we solicited public comment on our proposal not to offset the 1.9 percent increase in aggregate payments (including interest) for discharges occurring in FY 2008 resulting from the adoption of the MS–DRGs, but to instead address this issue in future rulemaking for FYs 2011 and 2012.

Comment: MedPAC stated in its comments on the adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90: ''In addition, it would be desirable for CMS to minimize year-to-year changes in payment adjustments it must make to recover overpayments that were made in 2008 and 2009. To achieve this goal, CMS should consider spreading the recovery of 2008 overpayments over 3 years, beginning in 2010.''

Response: We appreciate MedPAC's comment that it would be desirable to minimize year-to-year changes in payment adjustments due to the recoupment adjustments. However, as we stated in the proposed rule, we continue to believe it would be more appropriate to examine the FY 2009 claims data fully before making a determination as to the appropriate timing of the FY 2008 recoupment adjustment. Postponing this adjustment until a retrospective evaluation of the claims data from both FY 2008 and FY 2009 are available would allow us to make annual adjustments more appropriately in FY 2011 and FY 2012.

Comment: As noted above, some commenters recommended that CMS seek to extend the timeframe beyond 2 years to phase in the estimated −6.6 percent adjustment to the standardized amount. The commenters asked CMS to seek necessary legislative action to accommodate such a policy.

Response: As discussed in the proposed rule, we are required under section 7(b)(1)(B) of Public Law 110–90 to recapture the difference of actual documentation and coding effect in FY 2008 and FY 2009 that is greater than the prior adjustments. This retrospective recoupment process must be completed by the end of FY 2012. The large majority of the remaining adjustment to the standardized amount reflects retrospective adjustment. At this time, we have no plans to seek legislative action to change the time period for this adjustment.

Comment: Most commenters expressed concern with the significant negative financial impacts that would be incurred by providers if CMS adopted that proposed −1.9 percent documentation and coding adjustment in FY 2010. The commenters cited providers' already small or negative margins for Medicare payments, and requested that CMS not further reduce payments during the current period of economic instability and reduced State funding. Other commenters indicated that it would be appropriate to delay any adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90 until after CMS has the opportunity to fully examine the FY 2009 claims data.

Response: We recognize that any adjustment to account for the documentation and coding effect observed in the FY 2008 and FY 2009 claims data may result in significant future payment reduction for providers. However, as discussed in the proposed rule, we are required under section

7(b)(1)(B) of Public Law 110–90 to recapture the difference of actual documentation and coding effect in FY 2008 and FY 2009 that is greater than the prior adjustments. We agree with the commenters who requested that CMS delay any adjustment and, for the reasons stated above, expect to address this issue through the FY 2011 rulemaking.

7. Background on the Application of the Documentation and Coding Adjustment to the Hospital-Specific Rates

Under section 1886(d)(5)(D)(i) of the Act, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge. Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate based on the greatest of the FY 1982, FY 1987, or FY 2002 costs per discharge. In the FY 2008 IPPS final rule with comment period (72 FR 47152 through 47188), we established a policy of applying the documentation and coding adjustment to the hospital-specific rates. In that final rule with comment period, we indicated that because SCHs and MDHs use the same DRG system as all other hospitals, we believe they should be equally subject to the budget neutrality adjustment that we are applying for adoption of the MS–DRGs to all other hospitals. In establishing this policy, we relied on section 1886(d)(3)(A)(vi) of the Act, which provides us with the authority to adjust ''the standardized amount'' to eliminate the effect of changes in coding or classification that do not reflect real change in case-mix.

However, in the final rule that appeared in the **Federal Register** on November 27, 2007 (72 FR 66886), we rescinded the application of the documentation and coding adjustment to the hospital-specific rates retroactive to October 1, 2007. In that final rule, we indicated that, while we still believe it would be appropriate to apply the documentation and coding adjustment to the hospital-specific rates, upon further review, we decided that the application of the documentation and coding adjustment to the hospital-specific rates is not consistent with the plain meaning of section 1886(d)(3)(A)(vi) of the Act, which only mentions adjusting ''the standardized amount'' under section 1886(d) of the Act and does not mention adjusting the hospital-specific rates.

In the FY 2009 IPPS proposed rule (73 FR 23540), we indicated that we continued to have concerns about this issue. Because hospitals paid based on the hospital-specific rate use the same MS–DRG system as other hospitals, we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. In section 1886(d)(3)(A)(vi) of the Act, Congress stipulated that hospitals paid based on the standardized amount should not receive additional payments based on the effect of documentation and coding changes that do not reflect real changes in case-mix. Similarly, we believe that hospitals paid based on the hospital-specific rates should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. While we continue to believe that section 1886(d)(3)(A)(vi) of the Act does not provide explicit authority for application of the documentation and coding adjustment to the hospital-specific rates, we believe that we have the authority to apply the documentation and coding adjustment to the hospital-specific rates using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. The special exceptions and adjustment provision authorizes us to provide ''for such other exceptions and adjustments to [IPPS] payment amounts * * * as the Secretary deems appropriate.'' In the FY 2009 IPPS final rule (73 FR 48448 through 48449), we indicated that, for the FY 2010 rulemaking, we planned to examine our FY 2008 claims data for hospitals paid based on the hospital-specific rate. We further indicated that if we found evidence of significant increases in case-mix for patients treated in these hospitals that do not reflect real changes in case-mix, we would consider proposing application of the documentation and coding adjustments to the FY 2010 hospital-specific rates under our authority in section 1886(d)(5)(I)(i) of the Act.

In response to public comments received on the FY 2009 IPPS proposed rule, we stated in the FY 2009 IPPS final rule that we would consider whether such a proposal is warranted for FY 2010. To gather information to evaluate these considerations, we indicated that we planned to perform analyses on FY 2008 claims data to examine whether there has been a significant increase in case-mix for hospitals paid based on the hospital-specific rate. If we found that application of the documentation and coding adjustment to the hospital-specific rates for FY 2010 is warranted, we indicated that we would include a proposal to do so in the FY 2010 IPPS proposed rule.

8. Documentation and Coding Adjustment to the Hospital-Specific Rates for FY 2010 and Subsequent Fiscal Years

In the FY 2010 IPPS/RY 2010 LTCH proposed rule (74 FR 24098 through 24100), we discussed our performance of a retrospective evaluation of the FY 2008 claims data for SCHs and MDHs using the same methodology described earlier for other IPPS hospitals. We found that, independently for both SCHs and MDHs, the change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 slightly exceeded the proposed 2.5 percent result discussed earlier, but did not significantly differ from that result.

Again, for the proposed rule, we found that the within-base DRG increases were almost entirely responsible for the case-mix change. In the proposed rule, we presented two Figures to display our results.

Therefore, consistent with our statements in prior IPPS rules, we proposed to use our authority under section 1886(d)(5)(I)(i) of the Act to prospectively adjust the hospital-specific rates by the proposed −2.5 percent in FY 2010 to account for our estimated documentation and coding effect in FY 2008 that does not reflect real changes in case-mix. We proposed to leave this adjustment in place for subsequent fiscal years in order to ensure that changes in documentation and coding resulting from the adoption of the MS–DRGs do not lead to an increase in aggregate payments for SCHs and MDHs not reflective of an increase in real case-mix. The proposed −2.5 percent adjustment to the hospital-specific rates exceeded the −1.9 percent adjustment to the national standardized amount under section 7(b)(1)(A) of Public Law 110–90 because, unlike the national standardized rates, the FY 2008 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24100), we

solicited public comment on the proposed −2.5 percent prospective adjustment to the hospital-specific rates under section 1886(d)(5)(I)(i) of the Act and our proposal to address in the FY 2011 rulemaking cycle any changes in FY 2009 case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2009. We also indicated that we intended to update our analysis with FY 2008 data on claims paid through March 2008 [sic] for the FY 2010 IPPS final rule. (We note that the March 2008 update claims paid data date in the proposed rule should have been March 2009.)

Consistent with our approach for IPPS hospitals discussed earlier, we are also delaying adoption of a documentation and coding adjustment to the hospital-specific rate until FY 2011. Similar to our approach for IPPS hospitals, we will consider, through future rulemaking, phasing in the documentation and coding adjustment over an appropriate period. As we indicated earlier, we also will address, through future rulemaking, any changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2009. We noted that, unlike the national standardized rates, the FY 2009 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs. However, as we note earlier with regard to IPPS hospitals, if the estimated documentation and coding effect determined based on a full analysis of FY 2009 claims data is more or less than our current estimates, it would change, possibly lessen, the anticipated cumulative adjustments that we currently estimate we would have to make for the FY 2008 and FY 2009 combined adjustment. Therefore, we believe that it would be more prudent to delay implementation of the documentation and coding adjustment to allow for a more complete analysis of FY 2009 claims data for hospitals receiving hospital-specific rates.

Comment: One commenter request that CMS rescind the documentation and coding adjustment for SCHs and MDHs. The commenter contended that, due to the special recognition and protection afforded to these provider types by the Medicare program, CMS should more closely reexamine any negative payment adjustment that may threaten the viability of these providers. Commenters also questioned the statutory authority to apply this adjustment to SCHs and MDHs. The commenters argued that because Congress included specific statutory authority to adjust the standardized amount in section 1886(d)(3)(A)(vi) of the Act, CMS is precluded from using the broader ''adjustments'' language in section 1886(d)(5)(I)(i) of the Act to apply those same adjustments to the hospital-specific rate.

Response: We disagree with the commenter that the Secretary's broad authority to make exceptions and adjustment to payment amounts under section 1886(d)(3)(A)(vi) of the Act cannot be applied in this instance. We have discussed the basis for applying such an adjustment in prior rules (in the FY 2009 proposed rule (73 FR 23540), the FY 2009 final rule (73 FR 48448), and the FY 2010 proposed rule (74 FR 24098)) and do not agree that the language in section 1886(d)(3)(A)(vi) of the Act limits our authority under section 1886(d)(5)(I)(i) of the Act to make such an adjustment. We recognize that SCHs and MDHs are entitled through legislation to receive the hospital-specific rate in order to compensate for their unique service requirements in the provider community. Similar to our approach with IPPS hospitals, through future rulemaking, we will consider a phase-in of the documentation and coding adjustment over an appropriate period, beginning in FY 2011, and will continue to separately analyze SCH and MDH claims data to assure that any future adjustment is appropriate for these provider types.

9. Background on the Application of the Documentation and Coding Adjustment to the Puerto Rico-Specific Standardized Amount

Puerto Rico hospitals are paid based on 75 percent of the national standardized amount and 25 percent of the Puerto Rico-specific standardized amount. As noted previously, the documentation and coding adjustment we adopted in the FY 2008 IPPS final rule with comment period relied upon our authority under section 1886(d)(3)(A)(vi) of the Act, which provides the Secretary the authority to adjust ''the standardized amounts computed under this paragraph'' to eliminate the effect of changes in coding or classification that do not reflect real changes in case-mix. Section 1886(d)(3)(A)(vi) of the Act applies to the national standardized amounts computed under section 1886(d)(3) of the Act, but does not apply to the Puerto Rico-specific standardized amount computed under section 1886(d)(9)(C) of the Act. In calculating the FY 2008 payment rates, we made an inadvertent error and applied the FY 2008 −0.6 percent documentation and coding adjustment to the Puerto Rico-specific standardized amount, relying on our authority under section 1886(d)(3)(A)(vi) of the Act. However, section 1886(d)(3)(A)(vi) of the Act authorizes application of a documentation and coding adjustment to the national standardized amount and does not apply to the Puerto Rico specific standardized amount. In the FY 2009 IPPS final rule (73 FR 48449), we corrected this inadvertent error by removing the −0.6 percent documentation and coding adjustment from the FY 2008 Puerto Rico-specific rates.

While section 1886(d)(3)(A)(vi) of the Act is not applicable to the Puerto Rico-specific standardized amount, we believe that we have the authority to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. Similar to SCHs and MDHs that are paid based on the hospital-specific rate, we believe that Puerto Rico hospitals that are paid based on the Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. Consistent with the approach described for SCHs and MDHs, in the FY 2009 IPPS final rule (73 FR 48449), we indicated that we planned to examine our FY 2008 claims data for hospitals in Puerto Rico. We indicated in the FY 2009 IPPS proposed rule (73 FR 23541) that if we found evidence of significant increases in case-mix for patients treated in these hospitals, we would consider proposing application of the documentation and coding adjustments to the FY 2010 Puerto Rico-specific standardized amount under our authority in section 1886(d)(5)(I)(i) of the Act.

10. Documentation and Coding Adjustment to the Puerto Rico-Specific Standardized Amount

For the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we performed a retrospective evaluation of the FY 2008 claims data for Puerto Rico hospitals using the same methodology described earlier for IPPS hospitals paid under the national standardized amounts under section 1886(d) of the Act. We found that, for Puerto Rico hospitals, the increase in payments for discharges occurring during FY 2008 due to documentation and coding that did not reflect real changes in case-mix for

discharges occurring during FY 2008 was approximately 1.1 percent. When we calculated the within-base DRG changes and the across-base DRG changes for Puerto Rico hospitals, we found that responsibility for the case-mix change between FY 2007 and FY 2008 is much more evenly shared. Across-base DRG shifts accounted for 44 percent of the changes, and within-base DRG shifts accounted for 56 percent. Thus, the change in the percentage of discharges with an MCC was not as large as that for other IPPS hospitals. In Figure 4 in the proposed rule, we showed that, for Puerto Rico hospitals, there was a 3 percentage point increase in the discharges with an MCC from 22 percent to 25 percent and a corresponding decrease of 3 percentage points from 58 percent to 55 percent in discharges without a CC or an MCC.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24101), we solicited public comment on the proposed −1.1 percent prospective adjustment to the hospital-specific rates under section 1886(d)(5)(I)(i) of the Act and our intent to address in the FY 2011 rulemaking cycle any changes in FY 2009 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009. We also stated that we intended to update our analysis with FY 2008 data on claims paid through March 2009 for the FY 2010 IPPS final rule.

Given these documentation and coding increases, consistent with our statements in prior IPPS rules, we will use our authority under section 1886(d)(5)(I)(i) of the Act to adjust the Puerto Rico-specific rate. However, in parallel to our decision to postpone adjustments to the Federal standardized amount, we are adopting a similar policy for the Puerto Rico-specific rate and will consider the phase-in of this adjustment over an appropriate time period through future rulemaking. The adjustment would be applied to the Puerto Rico-specific rate that accounts for 25 percent of payments to Puerto Rico hospitals, with the remaining 75 percent based on the national standardized amount. Consequently, the overall reduction to the payment rates for Puerto Rico hospitals to account for documentation and coding changes will be slightly less than the reduction for IPPS hospitals paid based on 100 percent of the national standardized amount. We note that, as with the hospital-specific rates, the Puerto Rico-specific standardized amount had not previously been reduced based on estimated changes in documentation and coding associated with the adoption of the MS–DRGs. However, as we note earlier for IPPS hospitals and hospitals receiving hospital-specific rates, if the estimated documentation and coding effect determined based on a full analysis of FY 2009 claims data is more or less than our current estimates, it would change, possibly lessen, the anticipated cumulative adjustments that we currently estimate we would have to make for the FY 2008 and FY 2009 combined adjustment. Therefore, we believe that it would be more prudent to delay implementation of the documentation and coding adjustment to allow for a more complete analysis of FY 2009 claims data for Puerto Rico hospitals.

Consistent with our approach for IPPS hospitals discussed above, we will address in the FY 2011 rulemaking cycle any change in FY 2009 case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2009. We note that, unlike the national standardized rates, the FY 2009 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs.

E. Refinement of the MS–DRG Relative Weight Calculation

1. Background

In the FY 2009 IPPS final rule (73 FR 48450), we continued to implement significant revisions to Medicare's inpatient hospital rates by completing our 3-year transition from charge-based relative weights to cost-based relative weights. Beginning in FY 2007, we implemented relative weights based on cost report data instead of based on charge information. We had initially proposed to develop cost-based relative weights using the hospital-specific relative value cost center (HSRVcc) methodology as recommended by MedPAC. However, after considering concerns expressed in the public comments we received on the proposal, we modified MedPAC's methodology to exclude the hospital-specific relative weight feature. Instead, we developed national CCRs based on distinct hospital departments and engaged a contractor to evaluate the HSRVcc methodology for future consideration. To mitigate payment instability due to the adoption of cost-based relative weights, we decided to transition cost-based weights over 3 years by blending them with charge-based weights beginning in FY 2007. (We refer readers to the FY 2007 IPPS final rule for details on the HSRVcc methodology and the 3-year transition blend from charge-based relative weights to cost-based relative weights (71 FR 47882 through 47898).)

In FY 2008, we adopted severity-based MS–DRGs, which increased the number of DRGs from 538 to 745. Many commenters raised concerns as to how the transition from charge-based weights to cost-based weights would continue with the introduction of new MS–DRGs. We decided to implement a 2-year transition for the MS–DRGs to coincide with the remainder of the transition to cost-based relative weights. In FY 2008, 50 percent of the relative weight for each DRG was based on the CMS DRG relative weight and 50 percent was based on the MS–DRG relative weight.

In FY 2009, the third and final year of the transition from charge-based weights to cost-based weights, we calculated the MS–DRG relative weights based on 100 percent of hospital costs. We refer readers to the FY 2007 IPPS final rule (71 FR 47882) for a more detailed discussion of our final policy for calculating the cost-based DRG relative weights and to the FY 2008 IPPS final rule with comment period (72 FR 47199) for information on how we blended relative weights based on the CMS DRGs and MS–DRGs.

a. Summary of the RTI Study of Charge Compression and CCR Refinement

As we transitioned to cost-based relative weights, some commenters raised concerns about potential bias in the weights due to ''charge compression,'' which is the practice of applying a higher percentage charge markup over costs to lower cost items and services, and a lower percentage charge markup over costs to higher cost items and services. As a result, the cost-based weights would undervalue high-cost items and overvalue low-cost items if a single CCR is applied to items of widely varying costs in the same cost center. To address this concern, in August 2006, we awarded a contract to RTI to study the effects of charge compression in calculating the relative weights and to consider methods to reduce the variation in the CCRs across services within cost centers. RTI issued an interim draft report in January 2007 with its findings on charge compression (which was posted on the CMS Web site at: *http://www.cms.hhs.gov/reports/downloads/Dalton.pdf*). In that report, RTI found that a number of factors contribute to charge compression and affect the accuracy of the relative weights. RTI's findings demonstrated that charge compression exists in

several CCRs, most notably in the Medical Supplies and Equipment CCR.

In its interim draft report, RTI offered a number of recommendations to mitigate the effects of charge compression, including estimating regression-based CCRs to disaggregate the Medical Supplies Charged to Patients, Drugs Charged to Patients, and Radiology cost centers, and adding new cost centers to the Medicare cost report, such as adding a ''Devices, Implants and Prosthetics'' line under ''Medical Supplies Charged to Patients'' and a ''CT Scanning and MRI'' subscripted line under ''Radiology-Diagnostics''. (For more details on RTI's findings and recommendations, we refer readers to the FY 2009 IPPS final rule (73 FR 48452).) Despite receiving public comments in support of the regression-based CCRs as a means to immediately resolve the problem of charge compression, particularly within the Medical Supplies and Equipment CCR, we did not adopt RTI's recommendation to create additional regression-based CCRs for several reasons. We were concerned that RTI's analysis was limited to charges on hospital inpatient claims, while typically hospital cost report CCRs combine both inpatient and outpatient services. Further, because both the IPPS and the OPPS rely on cost-based weights, we preferred to introduce any methodological adjustments to both payment systems at the same time. RTI's analysis of charge compression has since been expanded to incorporate outpatient services. RTI evaluated the cost estimation process for the OPPS cost-based relative weights, including a reassessment of the regression-based CCR models using both outpatient and inpatient charge data. This interim report was made available in April 2008 during the public comment period on the FY 2009 IPPS proposed rule and can be found on RTI's Web site at: *http://www.rti.org/reports/cms/HHSM–500–2005–0029I/PDF/Refining_Cost_to_Charge_Ratios_200804.pdf.* The IPPS-specific chapters, which were separately displayed in the April 2008 interim report, as well as the more recent OPPS chapters, were included in the July 3, 2008 RTI final report entitled, ''Refining Cost-to-Charge Ratios for Calculating APC [Ambulatory Payment Classification] and DRG Relative Payment Weights,'' that became available at the time of the development of the FY 2009 IPPS final rule. The RTI final report can be found on RTI's Web site at: *http://www.rti.org/reports/cms/HHSM–500–2005–0029I/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf.*

RTI's final report distinguished between two types of research findings and recommendations: those pertaining to the accounting or cost report data and those related to statistical regression analysis. Importantly, RTI found that, under the IPPS and the OPPS, accounting improvements to the cost reporting data reduce some of the sources of aggregation bias without having to use regression-based adjustments. In general, with respect to the regression-based adjustments, RTI confirmed the findings of its March 2007 report that regression models are a valid approach for diagnosing potential aggregation bias within selected services for the IPPS and found that regression models are equally valid for setting payments under the OPPS. RTI also suggested that regression-based CCRs could provide a short-term correction until accounting data could be sufficiently refined to support more accurate CCR estimates under both the IPPS and the OPPS.

RTI also noted that cost-based weights are only one component of a final prospective payment rate. There are other rate adjustments (wage index, IME, and DSH) to payments derived from the revised cost-based weights and the cumulative effect of these components may not improve the ability of final payment to reflect resource cost. With regard to APCs and MS–DRGs that contain substantial device costs, RTI cautioned that the other rate adjustments largely offset the effects of charge compression among hospitals that receive these adjustments. RTI endorsed short-term regression-based adjustments, but also concluded that more refined and accurate accounting data are the preferred long-term solution to mitigate charge compression and related bias in hospital cost-based weights.

As a result of this research, RTI made 11 recommendations. For a more detailed summary of RTI's findings, recommendations, and public comments we received on the report, we refer readers to the FY 2009 IPPS final rule (73 FR 48452 through 48453).

b. Summary of the RAND Corporation Study of Alternative Relative Weight Methodologies

One of the reasons that we did not implement regression-based CCRs at the time of the FY 2008 IPPS final rule with comment period was our inability to investigate how regression-based CCRs would interact with the implementation of MS–DRGs. In the FY 2008 final rule with comment period (72 FR 47197), we stated that we engaged the RAND Corporation as the contractor to evaluate the HSRV methodology in conjunction with regression-based CCRs, and that we would consider its analysis as we prepared for the FY 2009 IPPS rulemaking process. In the FY 2009 IPPS final rule (73 FR 48453 through 48457), we provided a summary of the RAND report and the public comments we received in response to the FY 2009 IPPS proposed rule. The report may be found on RAND's Web site at: *http://www.rand.org/pubs/working_papers/WR560/.*

RAND evaluated six different methods that could be used to establish relative weights, CMS' current relative weight methodology of 15 national CCRs and 5 alternatives, including a method in which the 15 national CCRs are disaggregated using the regression-based methodology, and a method using hospital-specific CCRs for the 15 cost center groupings. In addition, RAND analyzed our standardization methodologies that account for systematic cost differences across hospitals. The purpose of standardization is to eliminate systematic facility-specific differences in cost so that these cost differences do not influence the relative weights. The three standardization methodologies analyzed by RAND include: The ''hospital payment factor'' methodology currently used by CMS, under which a hospital's wage index factor, and IME and/or DSH factor, are divided out of its estimated DRG cost; the HSRV methodology, which standardizes the cost for a given discharge by the hospital's own costliness rather than by the effect of the systematic cost differences across groups of hospitals; and the HSRVcc methodology, which removes hospital-level cost variation by calculating hospital-specific charge-based relative values for each DRG at the cost center level and standardizing them for differences in case-mix. Under the HSRVcc methodology, a national average charge-based relative weight is calculated for each cost center.

Overall, RAND found that none of the alternative methods of calculating the relative weights represented a marked improvement in payment accuracy over the current method, and there was little difference across methods in their ability to predict cost at either the discharge-level or the hospital-level. In their regression analysis, RAND found that after controlling for hospital payment factors, the relative weights are compressed (that is, understated). However, RAND also found that the hospital payment factors are overstated and increase more rapidly than cost.

Therefore, while the relative weights are compressed, these payment factors offset the compression such that total payments to hospitals increase more rapidly than hospitals' costs.

RAND found that relative weights using the 19 national disaggregated regression-based CCRs result in significant redistributions in payments among hospital groupings. However, RAND did not believe the regression-based charge compression adjustments significantly improve payment accuracy. With regard to standardization methodologies, while RAND found that there is no clear advantage to the HSRV method or the HSRVcc method of standardizing cost compared to the current hospital payment factor standardization method, its analysis did reveal significant limitations of CMS' current hospital payment factor standardization method. The current standardization method has a larger impact on the relative weights and payment accuracy than any of the other alternatives that RAND analyzed because the method ''over-standardizes'' by removing more variability for hospitals receiving a payment factor than can be empirically supported as being cost-related (particularly for IME and DSH). RAND found that instead of increasing proportionately with cost, the payment factors CMS currently uses (some of which are statutory), increase more rapidly than cost, thereby reducing payment accuracy. RAND concluded that further analysis is needed to isolate the cost-related component of the IPPS payment adjustments (some of which has already been done by MedPAC), use them to standardize cost, and revise the analysis of payment accuracy to reflect only the cost-related component.

2. Summary of FY 2009 Changes and Discussion for FY 2010

In the FY 2009 IPPS final rule (73 FR 48458 through 48467), in response to the RTI's recommendations concerning cost report refinements, and because of RAND's finding that regression-based adjustments to the CCRs do not significantly improve payment accuracy, we discussed our decision to pursue changes to the cost report to split the cost center for Medical Supplies Charged to Patients into one line for ''Medical Supplies Charged to Patients'' and another line for ''Implantable Devices Charged to Patients.'' We acknowledged, as RTI had found, that charge compression occurs in several cost centers that exist on the Medicare cost report. However, as we stated in the final rule, we focused on the CCR for Medical Supplies and Equipment because RTI found that the largest impact on the MS–DRG relative weights could result from correcting charge compression for devices and implants. In determining what should be reported in these respective cost centers, we adopted the commenters' recommendation that hospitals should use revenue codes established by AHA's National Uniform Billing Committee to determine what should be reported in the ''Medical Supplies Charged to Patients'' and the ''Implantable Devices Charged to Patients'' cost centers.

When we developed the FY 2009 IPPS final rule, we considered all of the public comments we received both for and against adopting regression-based CCRs. Also noteworthy is RAND's belief that regression-based CCRs may not significantly improve payment accuracy, and that it is equally, if not more, important to consider revisions to the current IPPS hospital payment factor standardization method in order to improve payment accuracy. We continue to believe that, ultimately, improved and more precise cost reporting is the best way to minimize charge compression and improve the accuracy of the cost weights. Accordingly, we did not propose to adopt regression-based CCRs for the calculation of the FY 2010 IPPS relative weights.

However, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24103), we expressed our concern about RAND's finding that there are significant limitations of CMS' current hospital payment factor standardization method. As summarized above, RAND found that the current standardization method ''over-standardizes'' by removing more variability for hospitals receiving a payment factor than can be empirically supported as being cost-related (particularly for IME and DSH). RAND found that instead of increasing proportionately with cost, the payment factors CMS currently uses (some of which are statutory), increase more rapidly than cost, thereby reducing payment accuracy. Further analysis is needed to isolate the cost-related component of the IPPS payment adjustments, use them to standardize cost, and revise the analysis of payment accuracy to reflect only the cost-related component. However, RAND cautioned that ''re-estimating'' these payment factors ''raises important policy issues that warrant additional analyses'' (page 49 of RAND's report, which is available on the Web site at: *http://www.rand.org/pubs/working_papers/WR560/*), particularly to ''determine the analytically justified levels using the MS–DRGs'' (page 86 of the RAND report). In addition, we noted that RTI, in its July 2008 final report, also observed that the adjustment factors under the IPPS (the wage index, IME, and DSH adjustments) complicate the determination of cost and these factors ''within the rate calculation may offset the effects of understated weights due to charge compression'' (page 109 of RTI's final report, which is available at the Web site at: *http://www.rti.org/reports/cms/HHSM-500-2005-0029I/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf*). While it may be more accurate to standardize using the empirically justified levels of the IME and DSH adjustments, consideration needs to be given to the extent to which these payment factors offset the compression of the relative weights.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24103 and 24104), we stated that we understood that MedPAC performed an analysis to identify empirically justifiable formulas for determining appropriate IME and DSH adjustments. For example, in its March 2007 report (and reiterated in its March 2009 report), MedPAC asserts that the current level of the IME adjustment factor, 5.5 percent for every 10 percent increase in resident-to-bed ratio, overstates IME payments by more than twice the empirically justified level, resulting in approximately $3 billion in overpayments. The empirical level of the IME adjustment is estimated to be 2.2 percent for every 10 percent increase in the resident-to-bed ratio. We stated that we cannot propose to change the IME and DSH factors used for actual payment under the IPPS because these factors are mandated by law. However, under section 1886(d)(4) of the Act, we have the authority to determine the appropriate weighting factor for each MS–DRG (including which factors or method we will employ in making annual adjustments to the MS–DRGs so as to reflect changes in the relative use of hospital resources). In addition, section 1886(d)(7)(B) of the Act precludes judicial review of our methodology for determining the appropriate weighting factors. Therefore, we do have some flexibility in what factors may be used for standardization purposes. For purposes of standardization only, we stated that one option may be for CMS to use the empirically justified IME adjustment of 2.2 percent, such that only the cost-related component of teaching hospitals is removed from the claim charges prior to calculating the relative weights. Similarly, for the DSH adjustment, in its March 2007 report, MedPAC found that costs per case increase about 0.4 percent

for each 10 percent increase in the low-income patient percentage. This is significantly less than the percentage increase expressed by the current factors used in the DSH payment formulas. (According to MedPAC, in FY 2004, about $5.5 billion in DSH payments were made above the empirically justified level.) In looking only at urban hospitals with greater than 100 beds, which manifest the strongest positive correlation between cost and low income patient share, MedPAC found that costs increase about 1.4 percent for every 10 percent increment of the low-income patient percentage. MedPAC did not find a positive cost relationship between low-income patient percentage and costs per case for urban hospitals with less than 100 beds and/or for rural hospitals. Therefore, for purposes of standardizing for the DSH adjustment, we stated that an option we may consider is to incorporate an adjustment factor of 1.4 percent for urban hospitals with greater than 100 beds, and to remove the DSH payment adjustment altogether for other hospitals that otherwise currently qualify for DSH payment. We also noted that while we cannot predict the effect of using the empirical factors for IME and DSH in the standardized methodology on the relative weights without further analysis, dividing out (that is, excluding) reduced IME and DSH payment factors from a hospital's total payment would result in a greater share of teaching and DSH hospitals' costs used in calculating the relative weights. With respect to the wage index, because there are multiple wage index factors, one for each geographic area, determining the true cost associated with geographic location and standardizing for those costs is much more challenging. While we did not propose changes for FY 2010, in light of the previous discussion of the current IME and DSH adjustments in the standardization process, we solicited public comments as to how the standardization process can be improved to more precisely remove cost differences across hospitals, thereby improving the accuracy of the relative weights in subsequent fiscal years.

Charge Compression

Comment: Commenters continue to oppose the regression-based CCR approach to calculate the relative weights. The commenters cited the results of the RAND report on alternative relative weight methodologies in which RAND found that ''none of the alternative weight methodologies represent a marked improvement over the current system.'' In addition, the commenters noted the RTI study, which concluded that more refined and accurate accounting data would be the preferred long-term solution to mitigate charge compression.

Some commenters also continue to support our policy finalized in the FY 2009 IPPS final rule to address charge compression (that is, the creation of separate cost centers for Implantable Devices Charged to Patients and Medical Supplies Charged to Patients).

Response: We appreciate the comments with respect to regression-based CCRs and the use of refined cost report data. However, we note that we have not proposed any changes to the existing cost-based relative weight methodology for FY 2010.

Comment: Some commenters sought clarification on which revenue codes should be used to report various implantable devices. Some commenters disagreed with the definition of a high-cost device that only applied to implantables because the commenters believed that there are other high-cost devices that are not implantable, but should be included in the device cost center.

Response: We did not propose any policy changes with respect to the use of revenue codes or alternative ways for identifying high-cost devices. Therefore, we are not responding to these comments at this time. We refer readers to the discussion in the FY 2009 IPPS final rule concerning our current policy on these matters (73 FR 48462 and 48462).

Comment: Commenters responded to our solicitation for options on possibly revising the current standardization methodology. MedPAC supported the option of standardizing hospitals' service charges using the empirical estimates of DSH and IME rather than their actual payment amounts. MedPAC also expressed support for the use of the HSRV methodology for calculating relative weights because it would obviate the need to standardize hospitals' charges and it would allow for costs to be comparable across hospitals. Other commenters continue to oppose the HSRV methods of standardization. These commenters believe that the HSRV methodology is inappropriate for a cost-based methodology and only applicable in charge-based systems that account for mark-up practices. Some of these commenters expressed general concern about revising the current standardization methodology because CMS has implemented numerous changes to the relative weights and DRGs in recent years, including moving to cost-based relative weights and to MS–DRGs, making it difficult for hospitals to predict their payments. Commenters suggested that, because hospitals have been dealing with other Medicare payment changes, such as quality reporting, and in light of health reform legislation, CMS wait before modifying the relative weight methodology to allow payments under the cost-based relative weights to stabilize and to allow hospitals to better predict their payments.

Response: In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we expressed our concerns regarding RAND's finding that there are significant limitations of CMS' current hospital payment factor standardization method. As summarized above, RAND found that the current standardization method ''over-standardizes'' by removing more variability for hospitals receiving a payment factor than can be empirically supported as being cost-related (particularly for IME and DSH). We further stated that given MedPAC's analysis that identifies empirically justifiable formulas for determining appropriate IME and DSH adjustments, perhaps one option for improving the accuracy of the standardization process is to use the empirically justified IME and DSH factors. We did not propose any changes for FY 2010, although we solicited public comments as to how the standardization process can be changed to improve the accuracy of the relative weights in subsequent fiscal years. Therefore, the commenters need not be concerned that we are introducing yet another significant change to the calculation of the relative weights or the MS–DRGs for FY 2010. We appreciate the public comments received, and we will consider the commenters' concerns as we continue to study the issue.

Comment: One commenter expressed concern regarding the effects of standardizing the relative weights by only removing the empirical costs of DSH and IME, rather than removing the entire effects of DSH and IME. The commenter was concerned that, by removing the empirical costs of DSH and IME in setting the relative weights, the non-DSH and nonteaching hospitals would be adversely affected by lower relative weights and a lower standardized amount. The commenter requested that thorough analysis be done and shared with the industry before CMS proposed any changes to the standardization method.

Response: As we stated in the proposed rule, we cannot predict the effect of using the empirical factors for IME and DSH in the standardized methodology on the relative weights without further analysis. We

acknowledge that dividing out (that is, excluding) reduced IME and DSH payment factors from a hospital's total payment would result in a greater share of teaching and DSH hospitals' payments being characterized as costs that would then be used in calculating the relative weights. We also are unsure as to whether a change in the relative weights would affect the standardized amount. In any case, should we propose changes to the current standardization process, we will make our analysis and impacts available to the public for comment, in accordance with our general practice.

3. Timeline for Revising the Medicare Cost Report

As mentioned in the FY 2009 IPPS final rule (73 FR 48467), we are currently in the process of comprehensively reviewing the Medicare hospital cost report, and the finalized policy from the FY 2009 IPPS final rule to split the current cost center for Medical Supplies Charged to Patients into one line for ''Medical Supplies Charged to Patients'' and another line for ''Implantable Devices Charged to Patients,'' as part of our initiative to update and revise the hospital cost report. Under an effort initiated by CMS to update the Medicare hospital cost report to eliminate outdated requirements in conjunction with provisions of the Paperwork Reduction Act (PRA), we stated that we have been planning to propose the actual changes to the cost reporting form, the attending cost reporting software, and the cost reporting instructions in Chapter 40 of the Medicare Provider Reimbursement Manual (PRM), Part II. Under the effort to update the cost report and eliminate outdated requirements in conjunction with the provisions of the PRA, we stated that changes to the cost reporting form and cost reporting instructions would be made available to the public for comment. Thus, the public would have an opportunity to suggest comprehensive reforms (which they had advocated in the FY 2009 IPPS final rule in response to our proposals), and would similarly be able to make suggestions for ensuring that these reforms are made in a manner that is not disruptive to hospitals' billing and accounting systems, and are first and foremost within the guidelines of GAAP, which are consistent with the Medicare principles of reimbursement, and sound accounting practices.

In the FY 2009 IPPS final rule (73 FR 48468), we stated that we expect the revised cost reporting forms that reflect one cost center for ''Medical Supplies Charged to Patients'' and one cost center for ''Implantable Devices Charged to Patients'' would not be available until cost reporting periods beginning after the Spring of 2009. At the time the proposed rule was issued, we anticipated that the transmittal to create this new cost center would be issued in June 2009. Because there is approximately a 3-year lag between the availability of cost report data for IPPS and OPPS ratesetting purposes in a given fiscal year or calendar year, we stated that we may be able to derive two distinct CCRs, one for medical supplies and one for devices, for use in calculating the FY 2013 IPPS relative weights and the CY 2013 OPPS relative weights. Until the revised cost reporting forms are published, we stated that hospitals must include costs and charges of separately chargeable medical supplies and implantable medical devices in the cost center for ''Medical Supplies Charged to Patients'' (section 2202.8 of the PRM–I), and effective for cost reporting periods specified in the revised cost reporting forms, hospitals must include costs and charges of separately chargeable medical supplies in the cost center for ''Medical Supplies Charged to Patients'' and of separately chargeable implantable medical devices in the new ''Implantable Devices Charged to Patients'' cost center.

Comment: A number of commenters addressed the new cost reporting forms in which implantable device costs that had been reported on Medical Supplies Charged to Patients under the current cost reporting forms will now be reported on a new line for ''Implantable Devices Charged to Patients''. The commenters recommended that CMS specifically mandate in the cost reporting instructions that hospitals report their medical supplies and implantable devices separately to ensure that hospitals will report their costs in both cost centers.

Response: In the revised Form CMS–2552–96 and the new Form CMS–2552–10 cost reporting instructions, we will clearly indicate that low cost medical supplies should be reported on the line for Medical Supplies Charged to Patients, and that high cost medical devices should be reported on the Implantable Devices Charged to Patients line. The cost reporting instructions will provide further guidance on differentiating between high cost items and low cost items.

Comment: Several commenters urged CMS to work with the hospital industry as CMS revises the Medicare hospital cost report. The commenters expressed disappointment that CMS has not worked with the hospital industry at the outset of revising the Medicare hospital cost report. The commenters urged CMS not to make piecemeal changes to the Medicare hospital cost report; rather, CMS should make changes that align with hospitals' protocols and payment methodologies to improve the accuracy of the cost-based MS–DRG relative weights. The commenters requested that the public have the opportunity to comment on cost reporting forms and instructions before they are implemented. In addition, the commenters urged that CMS work with the National Uniform Billing Committee (NUBC) to develop standards for the use of revenue codes and to mandate standardized cost centers.

Response: In the FY 2009 IPPS proposed and final rules (73 FR 23546 and 73 FR 48461), we stated that we began a comprehensive review of the Medicare hospital cost report, and splitting the current cost center for Medical Supplies Charged to Patients into one line for ''Medical Supplies Charged to Patients'' and another line for ''Implantable Devices Charged to Patients'' is part of that initiative to update and revise the cost report. We also stated that under the effort to update the cost report and eliminate outdated requirements in conjunction with the PRA, changes to the cost report form and cost report instructions would be made available to the public for comment. Thus, the public would have an opportunity to suggest the more comprehensive reforms that they are advocating, and would similarly be able to make suggestions for ensuring that these reforms are made in a manner that is not disruptive to hospitals' billing and accounting systems, and are within the guidelines of GAAP, which are consistent with the Medicare principles of reimbursement, and sound accounting practices. In fact, the new draft hospital cost report Form CMS–2552–10 went on public display through the **Federal Register** on July 2, 2009, for a 60-day review and comment period, which ends August 31, 2009. Those wishing to review and comment on the document can do so at *http://www.cms.hhs.gov/PaperworkReductionActof1995*. We are willing to work with and consider comments from finance and cost report experts from the hospital community as we work to improve and modify the hospital cost report and standardize the use of revenue codes. The cost center for Implantable Devices Charged to Patients will be available for use for cost reporting periods beginning on or after May 1, 2009. The revised hospital cost report Form CMS–2552–10 will be

available for cost reporting periods beginning on or after February 1, 2010.

Comment: Some comments that expressed concerns with the delay of the cost reporting changes which would, in turn, delay the ability to use supply and device CCRs in the ratesetting process. The commenters stated that, in the FY 2009 IPPS final rule, CMS had anticipated using the revised CCR for the FY 2012 rule. However, due to delays in the issuance of instructions on cost reporting, CMS now believes that new CCRs for Medical Supplies Charged to Patients and Implantable Devices Charged to Patients may be used in the FY 2013 IPPS proposed and final rules. The commenters urged CMS to issue instructions to hospitals on a timely basis so that the new cost centers may be implemented as quickly as possible for FY 2013 ratesetting purposes. The commenters also suggested that, if CMS anticipates further delays in implementing the new cost centers, CMS implement regression-based CCRs as a short-term solution to address charge compression until data from the new cost centers become available. The commenters were also concerned that the new cost center may not be implemented consistently across hospitals and urged CMS to use analytical methods to test and supplement hospital cost center data in rate setting. For example, the commenters suggested that CMS use regression-based CCRs to measure the accuracy of the device cost center for the FY 2013 relative weights.

Response: We are sympathetic to the commenters' concerns and regret the delay in the issuance of the revised cost reporting forms. However, we are making progress on this front. As we stated in response to a previous comment, the new draft hospital cost report Form CMS–2552–10 went on display at the **Federal Register** on July 2, 2009, for a 60-day review and comment period, which ends August 31, 2009. Those wishing to review and comment on the document can do so at *http://www.cms.hhs.gov/PaperworkReductionActof1995*. After the revised cost report is available for use by all hospitals, and we begin to use the data to create CCRs for use in the calculation of the relative weights, we will analyze and monitor how hospitals are reporting their data and what effect the data are having on the separate CCRs for medical supplies and implantable devices. Comparison of the CCRs derived from the revised cost report to regression-based CCRs might be one method of gauging the accuracy and effectiveness of the separate cost centers for Medical Supplies Charged to Patients and Implantable Devices Charged to Patients.

Comment: Several commenters asked for clarification on the new ''Implantable Devices Charged to Patients'' cost center that was finalized in the FY 2009 IPPS final rule and will be part of the new Medicare Hospital Cost Report form. The commenters asked that CMS clarify the statement in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule that ''hospitals must include costs and charges of separately chargeable medical supplies and implantable medical devices in the cost center for 'Medical Supplies Charged to Patients' '' as referenced in PRM–I Section 2202.8. The commenters were confused by the reference to PRM–I Section 2202.8 because that section defines ancillary services, with no mention of medical supplies. In addition, one commenter noted the hospitals are currently testing their systems to report costs and charges for implantable devices and asked whether it would be acceptable for hospitals to establish a cost center for ''Implantable Devices Charged to Patients'' at line 55.01 of the current cost report until the revised cost report is available. The commenter understood that the subscripted cost center would be rolled up into Line 55 for the purposes of calculating the relative weights until the new cost report is available.

Response: We included the reference to Section 2202.8 of the PRM–I, which defines ancillary services, to remind hospitals that any items reported in the Medical Supplies Charged to Patients cost center are items (high cost or low cost) that are *separately chargeable* ancillary services. In accordance with Section 2202.8 of the PRM–I, ancillary services are those services for which a separate charge is customarily made in addition to the routine service charge. With respect to subscripting Line 55 to establish a cost center for Implantable Devices Charged to Patients, we have provided Line 55.30 to report Implantable Devices Charged to Patients on Form CMS–2552–96 and Line 69 on the proposed new Form CMS–2552–10.

Comment: Some commenters suggested that CMS engage in outreach and educational activities to hospitals on the changes to the cost report and reporting of charges with respect to the medical device and medical supply cost centers so that hospitals can appropriately report data. The commenters recommended that the outreach activities go beyond the ''distribution of bulletins that are used to inform providers about changes to the Medicare program.''

Response: Although it is a bit early to plan specific outreach activities at this point, given that the proposed rule for the revised cost reporting forms has only been released on July 2, 2009, we agree that such educational activities are important, and we have been considering some options for educating the provider community involving the fiscal intermediaries and MACs and the cost report vendors. We look forward to working with the provider community in these initiatives.

Accordingly, we are not implementing any changes to the relative weight calculation for FY 2010. We will continue to focus on possible ways to improve the weights through cost reporting and look forward to reviewing the comments received on the draft revised cost reporting forms. In addition, we will continue to think about possible ways to refine the standardization process as a means to improve the accuracy of the relative weights. As stated above, any further changes we decide to make to any portion of the relative weights calculation will be promulgated first through notice and comment rulemaking, which will allow the public sufficient opportunity to review relevant analyses and impacts of such potential changes.

F. Preventable Hospital-Acquired Conditions (HACs), Including Infections

1. Statutory Authority

Section 1886(d)(4)(D) of the Act addresses certain hospital-acquired conditions (HACs), including infections. By October 1, 2007, the Secretary was required to select, in consultation with the Centers for Disease Control (CDC), at least two conditions that: (a) are high cost, high volume, or both; (b) are assigned to a higher paying MS–DRG when present as a secondary diagnosis (that is, conditions under the MS–DRG system that are CCs or MCCs); and (c) could reasonably have been prevented through the application of evidence-based guidelines. The list of conditions can be revised, again in consultation with CDC, from time to time as long as the list contains at least two conditions.

Medicare continues to assign a discharge to a higher paying MS–DRG if a selected HAC is present on admission (POA). However, since October 1, 2008, Medicare no longer assigns an inpatient hospital discharge to a higher paying MS–DRG if a selected condition is not POA. Thus, if a selected HAC that was not present on admission manifests during the hospital stay, the case is paid as though the secondary diagnosis was not present. However, if any

nonselected CC/MCC appears on the claim, the claim will be paid at the higher MS–DRG rate; to cause a lower MS–DRG payment, all CCs/MCCs on the claim must be selected conditions for the HAC payment provision.

Since October 1, 2007, hospitals have been required to submit information on Medicare claims specifying whether diagnoses were POA. The POA indicator reporting requirement and the HAC payment provision apply to IPPS hospitals only. Non-IPPS hospitals, including CAHs, LTCHs, IRFs, IPFs, cancer hospitals, children's hospitals, hospitals in Maryland operating under waivers, rural health clinics, federally qualified health centers, RNHCIs, and Department of Veterans Affairs/ Department of Defense hospitals, are exempt from POA reporting and the HAC payment provision. Throughout this section, the term ''hospital'' refers to an IPPS hospital.

2. HAC Selection Process

In the FY 2007 IPPS proposed rule (71 FR 24100), we sought public input regarding conditions with evidence-based prevention guidelines that should be selected in implementing section 1886(d)(4)(D) of the Act. The public comments we received were summarized in the FY 2007 IPPS final rule (71 FR 48051 through 48053).

In the FY 2008 IPPS proposed rule (72 FR 24716 through 24726), we sought public comment on conditions that we proposed to select. In the FY 2008 IPPS final rule with comment period (72 FR 47200 through 47218), we selected 8 categories to which the HAC payment provisions would apply.

In the FY 2009 IPPS proposed rule (73 FR 23547), we proposed several additional candidate HACs as well as refinements to the previously selected HACs. In the FY 2009 IPPS final rule (73 FR 48471), we expanded and refined several of the previously selected HACs, and we selected 2 additional categories of HACs. A complete list of the 10 current categories of HACs is included in section II.F.4. of this preamble.

3. Collaborative Process

CMS experts have worked closely with public health and infectious disease professionals from across the Department of Health and Human Services, including CDC, AHRQ, and the Office of Public Health and Science, to identify the candidate preventable HACs, review comments, and select HACs. CMS and CDC have also collaborated on the process for hospitals to submit a POA indicator for each diagnosis listed on IPPS hospital Medicare claims and on the payment implications of the various POA reporting options.

On December 17, 2007, CMS and CDC hosted a jointly-sponsored HAC and POA Listening Session to receive input from interested organizations and individuals. On December 18, 2008, CMS, CDC, and AHRQ hosted a second jointly-sponsored HAC and POA Listening Session to receive input from interested organizations and individuals. The agenda, presentations, audio file, and written transcript of the December 18, 2008 Listening Session are available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalAcqCond/07_EducationalResources.asp#TopOfPage*.

4. Selected HAC Categories

The following table lists the current HACs.

HAC	CC/MCC (ICD–9–CM code)
Foreign Object Retained After Surgery	998.4 (CC), 998.7 (CC).
Air Embolism	999.1 (MCC).
Blood Incompatibility	999.6 (CC).
Pressure Ulcer Stages III & IV	707.23 (MCC), 707.24 (MCC).
Falls and Trauma:	Codes within these ranges on the CC/MCC list:
—Fracture	800–829.
—Dislocation	830–839.
—Intracranial Injury	850–854.
—Crushing Injury	925–929.
—Burn	940–949.
—Electric Shock	991–994.
Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC). Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC).
Vascular Catheter-Associated Infection	999.31 (CC).
Manifestations of Poor Glycemic Control	250.10–250.13 (MCC), 250.20–250.23 (MCC), 251.0 (CC), 249.10–249.11 (MCC), 249.20–249.21 (MCC).
Surgical Site Infections	
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG).	519.2 (MCC). And one of the following procedure codes: 36.10–36.19.
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC), 998.59 (CC). And one of the following procedure codes: 81.01–81.08, 81.23–81.24, 81.31–81.38, 81.83, 81.85.
Surgical Site Infection Following Bariatric Surgery for Obesity	*Principal Diagnosis*—278.01, 998.59 (CC) And one of the following procedure codes: 44.38, 44.39, or 44.95.
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures.	415.11 (MCC), 415.19 (MCC), 453.40–453.42 (CC). And one of the following procedure codes: 00.85–00.87, 81.51–81.52, or 81.54.

We refer readers to section II.F.6. of the FY 2008 IPPS final rule with comment period (72 FR 47202 through 47218) and to section II.F.7. of the FY 2009 IPPS final rule (73 FR 48474 through 48486) for detailed analyses

supporting the selection of each of these HACs.

The list of selected HAC categories is dependent upon CMS' list of diagnoses designated as CC/MCCs. As changes and/or new diagnosis codes are proposed and finalized to the list of CC/MCCs, these changes need to be reflected in the list of selected HAC categories. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24106), we proposed the addition of ICD–9–CM codes 813.46 (Torus fracture of ulna) and 813.47 (Torus fracture of radius and ulna) to more precisely define the previously selected HAC category of falls and trauma. We refer readers to Table 6A in the Addendum to this final rule for the adoption of ICD–9–CM codes 813.46 and 813.47 as CCs.

Comment: Commenters supported the addition of ICD–9–CM codes 813.46 and 813.47 to more precisely define the falls and trauma HAC category.

Response: We appreciate the commenters' support of a more precise definition of the falls and trauma category. We are finalizing the addition of ICD–9–CM codes 813.46 and 813.47 to more precisely define the falls and trauma HAC category.

5. Public Input Regarding Selected and Potential Candidate HACs

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24104 through 24106), we did not propose to add or remove categories of HACs. However, we indicated that we continue to encourage public dialogue about refinements to the HAC list. During and after the December 18, 2008 Listening Session, we received many oral and written stakeholder comments about both previously selected and potential candidate HACs. In response to the Listening Session, commenters strongly supported using information gathered from early experience with the HAC payment provision to inform maintenance of the HAC list and consideration of future potential candidate HACs. Further, commenters emphasized the need for a robust program evaluation prior to modifying the HAC list. Strong support was also expressed for a program evaluation in response to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24106).

Comment: Commenters overwhelmingly expressed strong support for a robust program evaluation before modifying the HAC list. Many commenters stated that CMS' approach to employ a studied program analysis during FY 2010 allows hospitals additional time to develop processes for improving performance on previously selected HACs.

Response: We appreciate the support we have received for our decision to undertake a program evaluation. The Medicare HAC policy aims to ensure patients are receiving high quality care, and the program evaluation will enable us to understand the impact of the program.

Comment: Several commenters made specific suggestions for the program evaluation. A number of commenters suggested that the program evaluation should consider assessing the policy's impact on patient treatment and potential unintended consequences. Some commenters indicated that CMS should validate POA indicator data and explore how information learned from POA coding could be used to better understand and prevent certain HACs. Commenters encouraged CMS to examine the extent to which the program is increasing adherence to evidence-based guidelines. Commenters also encouraged CMS to ensure transparency in the development of its program evaluation and to allow for public comment at various stages of the evaluation. Some commenters requested that the final program evaluation results be shared publicly.

Response: We appreciate the specific suggestions provided regarding the program evaluation. These recommendations will be taken into consideration as the program evaluation is developed. We agree with commenters that monitoring unintended consequences and assessing adherence to evidence-based guidelines should be a priority for the program evaluation. We also agree that validation of POA coding, as well as examining each POA indicator, are areas of critical importance for the program evaluation. We appreciate the public's interest in the program evaluation and plan to include updates and findings from the evaluation on CMS' Hospital-Acquired Conditions and Present on Admission Indicator Web site available at: *http://www.cms.hhs.gov/HospitalAcqCond/*.

6. POA Indicator Reporting

Collection of POA indicator data is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision as well as for broader public health uses of Medicare data. Through Change Request No. 5679 (released on June 20, 2007), CMS issued instructions requiring IPPS hospitals to submit POA indicator data for all diagnosis codes on Medicare claims. CMS also issued Change Request No. 6086 (released on June 13, 2008) regarding instructions for processing non-IPPS claims. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the *ICD–9–CM Official Guidelines for Coding and Reporting*, available on the CDC Web site at: *http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf* (the POA reporting guidelines begin on page 92). Additional information regarding POA indicator reporting and application of the POA reporting options is available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalAcqCond*. CMS has historically not provided coding advice. Rather, CMS collaborates with the American Hospital Association (AHA) through the *Coding Clinic for ICD–9–CM*. CMS has been collaborating with the AHA to promote the *Coding Clinic for ICD–9–CM* as the source for coding advice about the POA indicator.

There are five POA indicator reporting options, as defined by the *ICD–9–CM Official Guidelines for Coding and Reporting:*

Indicator	Descriptor
Y	Indicates that the condition was present on admission.
W	Affirms that the hospital has determined based on data and clinical judgment that it is not possible to document when the onset of the condition occurred.
N	Indicates that the condition was not present on admission.
U	Indicates that the documentation is insufficient to determine if the condition was present at the time of admission.
1	Signifies exemption from POA reporting. CMS established this code as a workaround to blank reporting on the electronic 4010A1. A list of exempt ICD–9–CM diagnosis codes is available in the *ICD–9–CM Official Guidelines for Coding and Reporting*.

In the FY 2009 IPPS final rule (73 FR 48486 through 48487), we adopted as final our proposal to: (1) Pay the CC/MCC MS–DRGs for those HACs coded with ''Y'' and ''W'' indicators; and (2) not pay the CC/MCC MS–DRGs for those

HACs coded with ''N'' and ''U'' indicators. Though we did not make any proposals regarding the HAC POA payment determinations in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, commenters addressed this aspect of the HAC payment provision.

Comment: Commenters suggested that CMS should consider paying for HACs coded with the ''U'' indicator.

Response: We adopted a policy of not paying for the ''U'' option because we believe that this approach encourages documentation and will ensure more accurate public health data. We refer readers to the FY 2009 IPPS final rule (73 FR 48486 through 48487) for further discussion of our coding policy. In addition, as part of CMS' program evaluation of the HAC payment provision, we intend to analyze the ''U'' POA reporting options (section II.F.4. of this preamble).

In addition to providing specific suggestions on what CMS should consider for the program evaluation, commenters also offered suggestions on how to address POA data beyond the program evaluation.

Comment: A few commenters recommended that AHRQ continue to develop strategies to improve the accuracy of documenting POA.

Response: Through the collaborative partnership that CMS has developed with AHRQ around the program evaluation, we will continue to work with AHRQ to identify strategies to improve the accuracy of documenting POA reporting.

Comment: Some comments suggested that CMS consider publicly releasing aggregate POA data to decrease the incidence of preventable HACs. The commenters indicated that one effective approach for decreasing the incidence of preventable HACs would be to provide each hospital with aggregate POA rates based on peer comparisons.

Response: We agree with the suggestion that the public release of aggregate POA data should be considered as one prong in a multi-pronged strategy to decrease the incidence of preventable HACs. We refer readers to the FY 2009 IPPS final rule (73 FR 48488) for a detailed discussion regarding public reporting of POA indicator data.

7. Additional Considerations Addressing the HAC and POA Payment Provision

In addition to receiving comments on the program evaluation (II.F.5) and uses of POA indicator data (II.F.6), we also received comments addressing many other topics related to HAC and POA. This section summarizes those topics and provides responses.

Comment: Commenters suggested that CMS consider the evaluation of new technologies that detect, prevent, and treat HACs as a research priority.

Response: We agree with commenters that evaluating all methods to reduce preventable HACs, including new technologies, is a top priority for CMS. We refer readers to section II.I. of this preamble for additional information on CMS' new technology add-on payment policy.

Comment: Some commenters addressed expansion of the principles behind the HAC payment provision to other settings of care and other entitlement benefits, beyond fee-for-service Medicare. One commenter specifically expressed concern that the Medicare HAC policy may have unintended consequences for the pediatric population, as similar policies are being adopted by State Medicaid agencies. The commenter suggested that these Medicaid policies may discourage physicians from treating complicated pediatric patients for whom the risk of certain HACs cannot be eliminated using evidence-based guidelines.

Response: The Medicare HAC policy applies only to hospitals that are subject to the IPPS. While CMS does not develop or implement individual State Medicaid policies, we do endorse alignment of incentives across all systems of care and between the Medicare and Medicaid programs.

Comment: Commenters recommended that CMS clarify how hospitals may appeal a HAC payment determination for a particular patient who is not eligible for higher payment through assignment to the higher CC/MCC level of the MS–DRG.

Response: We thank the commenters for seeking clarification regarding appeals and the HAC payment provision. We refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47216) for further information on existing procedures for review of HAC payment adjustments.

Comment: Several commenters believed that some of CMS' selected HACs may not be fully preventable and recommended that CMS' payment methodology include risk adjustment.

Response: We agree with the commenters that a risk adjustment methodology may lead to greater precision of HAC payment determinations and refer readers to the FY 2009 IPPS final rule (73 FR 48487 through 48488) for a detailed discussion of HACs and risk adjustment at both the individual and population levels.

Comment: A few commenters urged CMS to focus on more global hospital-wide assessments of harm, such as rate-based measurement of HACs, rather than targeting individual HAC events.

Response: We agree with the commenters that capturing rates of HACs may more accurately assess the level of harm within a given institution and refer readers to the FY 2009 IPPS final rule (73 FR 48488) for a detailed discussion of the advantages and disadvantages of rate-based measurement of HACs.

Comment: Commenters expressed support for expansion of the HAC list to include categories such as ventilator-associated pneumonia, failure to rescue, surgical site infection following implantation of devices, *Clostridium difficile*-associated disease, and malnutrition.

Response: We thank the commenters for their continued engagement and monitoring of candidate HACs. We will continue to monitor these conditions as an aspect of the program evaluation and may consider discussion of these candidate HACs in future rulemaking.

Comment: A few commenters encouraged CMS to adopt a pay-for-performance initiative that is complementary to the current HAC program and incorporates specific initiatives outlined in the *HHS Action Plan to Prevent Healthcare-Associated Infections*. One commenter suggested that mandatory reporting of case rates should be incorporated into pay-for-performance initiatives.

Response: We agree with the commenters that pay-for-performance and value-based purchasing (VBP) programs may be one of several payment tools for reducing preventable HACs and refer readers to the FY 2009 IPPS final rule (73 FR 48487 through 48488) for a detailed discussion of how VBP initiatives such as the Hospital VBP Plan Report to Congress can address preventable HACs.

G. Changes to Specific MS–DRG Classifications

1. MDC 5 (Diseases and Disorders of the Circulatory System): Intraoperative Fluorescence Vascular Angiography (IFVA)

As we discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24106 through 24107) we received a request to reassign cases reporting the use of intraoperative fluorescence vascular angiography (IFVA) with coronary artery bypass graft (CABG) procedures from MS–DRGs 235 and 236 (Coronary Bypass without Cardiac Catheterization with and without MCC,

respectively) into MS–DRG 233 (Coronary Bypass with Cardiac Catheterization with MCC) and MS–DRG 234 (Coronary Bypass with Cardiac Catheterization without MCC). Effective October 1, 2007, procedure code 88.59 (Intra-operative fluorescence vascular angiography (IFVA)) describes this technology.

IFVA technology consists of a mobile device imaging system with software. The technology is used to test cardiac graft patency and technical adequacy at the time of coronary artery bypass grafting (CABG). While this system does not involve fluoroscopy or cardiac catheterization, it has been suggested by the manufacturer and clinical studies that it yields results that are similar to those achieved with selective coronary arteriography and cardiac catheterization. Intraoperative coronary angiography provides information about the quality of the anastomosis, blood flow through the graft, distal perfusion and durability. For additional detailed information regarding IFVA technology, we refer readers to the September 28–29, 2006 ICD–9–CM Coordination and Maintenance Committee meeting handout at the following Web site: *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp#TopOfPage.*

We examined data on cases identified by procedure code 88.59 in MS–DRGs 233, 234, 235, and 236 in the FY 2008 MedPAR file. As shown in the table below, for both MS–DRGs 235 and 236, the cases utilizing IFVA technology identified by procedure code 88.59 have a shorter length of stay and lower average costs compared to all cases in MS–DRGs 235 and 236. There were a total of 10,312 cases in MS–DRG 235 with an average length of stay of 11.12 days with average costs of $33,846. There were 88 cases in MS–DRG 235 identified by procedure code 88.59 with an average length of stay of 9.82 days with average costs of $29,258. In MS–DRG 236, there were a total of 24,799 cases with an average length of stay of 6.52 days and average costs of $22,329. There were 159 cases in MS–DRG 236 identified by procedure code 88.59 with an average length of stay of 6.30 days and average costs of $20,404. The data clearly demonstrate that the IFVA cases identified by procedure code 88.59 are assigned appropriately to MS–DRGs 235 and 236. We also examined data on cases identified by procedure code 88.59 in MS–DRGs 233 and 234. Similarly, in MS–DRGs 233 and 234, cases identified by procedure code 88.59 reflect shorter lengths of stay and lower average costs compared to all of the other cases in those MS–DRGs. There were a total of 17,453 cases in MS–DRG 233 with an average length of stay of 13.65 days with average costs of $41,199. There were 60 cases in MS–DRG 233 identified by procedure code 88.59 with an average length of stay of 12.82 days and average costs of $38,842. In MS–DRG 234, there were a total of 27,003 cases with an average length of stay of 8.70 days and average costs of $28,327. There were 69 cases in MS–DRG 234 identified by procedure code 88.59 with an average length of stay of 8.75 days and average costs of $25,308. As a result of our analysis, the data demonstrate that the IFVA cases identified by procedure code 88.59 are appropriately assigned to MS–DRGs 233 and 234.

MS–DRG	Number of cases	Average length of stay	Average cost*
235—All cases	10,312	11.12	$33,846
235—Cases with code 88.59	88	9.82	29,258
235—Cases without code 88.59	10,224	11.14	33,886
236—All cases	24,799	6.52	22,329
236—Cases with code 88.59	159	6.30	20,404
236—Cases without code 88.59	24,640	6.52	22,341

MS–DRG	Number of cases	Average length of stay	Average cost*
233—All cases	17,453	13.65	41,199
233—Cases with code 88.59	60	12.82	38,842
233—Cases without code 88.59	17,393	13.65	41,207
234—All cases	27,003	8.70	28,327
234—Cases with code 88.59	69	8.75	25,308
234—Cases without code 88.59	26,934	8.70	28,334

* In the FY 2007 IPPS final rule (71 FR 47882), we adopted a cost-based weighting methodology. The cost-based weights were adopted over a 3-year transition period in ⅓ increments between FY 2007 and FY 2009. The average cost represents the average standardized charges on the claims reduced to cost using the cost center-specific CCRs for a specific DRG. The standardization process includes adjustments for IME, DSH, and wage index as applied to individual hospitals. This estimation of cost is the same method used in the computation of the relative weights. We are using cost-based data instead of our historical charge-based data to evaluate proposed MS–DRG classification changes.

We believe that if the cases identified by procedure code 88.59 were proposed to be reassigned from MS–DRGs 235 and 236 to MS–DRGs 233 and 234, they would be significantly overpaid. In addition, because the cases in MS–DRGs 235 and 236 did not actually have a cardiac catheterization performed, a proposal to reassign cases identified by procedure code 88.59 would result in lowering the relative weights of MS–DRGs 233 and 234 where a cardiac catheterization is truly performed.

In summary, the data do not support moving IFVA cases identified by procedure code 88.59 from MS–DRGs 235 and 236 into MS–DRGs 233 and 234.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we invited the public to submit comments on our proposal not to make any MS–DRG modifications for cases reporting procedure code 88.59 for FY 2010. Below, we provide a summation of the public comments we received and our responses.

Comment: A number of commenters believed that the use of IFVA in conjunction with CABG procedures leads to positive outcomes. Many of the commenters stated that they had performed IFVA and that, by using IFVA along with the CABG procedure, they were able to reduce their patients' lengths of stay and reduce complications, which in turn reduced hospitals costs. The commenters stated that the CMS published data indicated that patients who undergo a CABG procedure along with IFVA ''showed consistently shortened length of stay and the resulting cost savings.'' The commenters stated that, despite cost savings from the routine treatment of CABG patients with IFVA, their facilities were not prepared to purchase this technology unless there were additional Medicare payments.

The commenters did not dispute the fact that the CMS data showed IFVA cases used considerably less resources than cases undergoing a cardiac catheterization. However, the commenters expressed concern that CMS did not suggest a mechanism to encourage hospitals to invest in the IFVA equipment by providing additional payment for the utilization of IFVA.

Some commenters urged CMS to explore alternative methods of payment to facilities for utilizing the IFVA technology.

Another commenter representing a specialty society indicated that several of its members, who are cardiothoracic surgeons, had differing opinions on the value of IFVA as an adjunctive procedure to CABG surgery. This commenter stated that, due to a lack of information regarding the efficacy of IFVA within its cardiac surgery database, the commenter was unable to appropriately assess the effectiveness of the technology.

Response: We appreciate and acknowledge the commenters' concerns. We would like to point out that the costs associated with the IFVA technology, when utilized with coronary artery bypass (CABG) procedures, are already accounted for within the MS–DRGs for the CABG procedure. In other words, cases reporting procedure code 88.59, when performed with a CABG procedure, are currently grouped to one of the MS–DRGs describing a CABG procedure. Our claims data indicate that IFVA cases have average costs very similar to other cases within the MS–DRGs to which they are currently assigned. Our data do not support classifying code 88.59 as a cardiac catheterization so that all cases where IFVA is performed would be assigned to the CABG DRGs with cardiac catheterization (MS–DRGs 233 and 234). The cardiac catheterization cases have consistently higher costs than cases that only utilize IFVA with CABG.

In response to concerns that CMS did not provide an alternative for facilities to account for costs associated with IFVA use in conjunction with CABG surgery, in our evaluation of data for possible proposals for modifications to the MS–DRGs, we did not find data to support a MS–DRG change for IFVA. The request we received was to reassign cases reporting the use of IFVA with CABG procedures from MS–DRGs 235 and 236 into MS–DRG 233 and MS–DRG 234. To make this change, we would have to add the IFVA procedure to the list of cardiac catheterization procedures listed under MS–DRGs 233 and 234. As the commenters noted in its own submitted comments, the data presented in the FY 2010 proposed rule (74 FR 24107), for cases where IFVA (code 88.59) was reported with a CABG procedure, demonstrated that these cases resulted in shorter lengths of stay and lower average costs compared to all cases within the specified CABG MS–DRGs. As such, it would be inappropriate to reassign cases reporting the use of IFVA to higher weighted MS–DRGs merely as an incentive for hospitals to invest in the IFVA technology.

With regards to the commenter's suggestion that CMS give consideration to the utilization of the cardiac surgery database to analyze IFVA, we refer the commenter and readers to section V.A.1–5 of the FY 2010 proposed rule (74 FR 24165 through 24176) for a discussion of CMS' Hospital Value-Based Purchasing (VBP) Plan, a policy that strives to align payment incentives with the quality of care as well as the resources used to deliver care to encourage high-value health care.

In conclusion, many commenters expressed support for the limited MS–DRG changes proposed for FY 2010, given the major changes that took place with the recent implementation of the MS–DRG system. Our analysis of claims data indicates that IFVA cases have average costs very similar to other cases within the MS–DRGs to which they are currently assigned, and the data do not support the request to classify IFVA as a cardiac catheterization at this time. Therefore, as final policy for FY 2010, we are finalizing our proposal to not make any changes to MS–DRGs 233, 234, 235, or 236 for cases reporting the use of intraoperative fluorescence vascular angiography (IFVA), procedure code 88.59.

2. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Infected Hip and Knee Replacements

As discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24107 through 24109), we received a request that we examine the issue of patients who have undergone hip or knee replacement procedures that have subsequently become infected and who are then admitted for inpatient services for removal of the prosthesis. The requestor stated that these patients are presented with devastating complications and require extensive resources to treat. The infection often results in the need for multiple re-operations, prolonged use of intravenous and oral antibiotics, extended rehabilitation, and frequent followups. Furthermore, the requestor stated that, even with extensive treatment, the outcomes can still be poor for some of these patients. The requestor stated that patients who are admitted for inpatient services with an infected hip or knee prosthesis must first undergo a procedure to remove the prosthesis and to insert an antibiotic spacer to treat the infection and maintain a space for the new prosthesis. The new prosthesis cannot be inserted until after the infection has been treated. Patients who are admitted for inpatient services with a hip or knee infection and then undergo a removal of the prosthesis are captured by the following procedure codes:

- 80.05 (Arthrotomy for removal of prosthesis, hip)
- 80.06 (Arthrotomy for removal of prosthesis, knee)

In addition, code 84.56 (Insertion or replacement of (cement) spacer)) would be used for any insertion of a spacer that would be reported if an antibiotic spacer were inserted.

The issue of hip and knee infections and revisions was discussed in the FY 2009 IPPS final rule (73 FR 48498 through 48507) in response to a more complicated request that we received involving the creation and modification of several joint DRGs. Because data did not support the requestor's suggested changes, we did not make any modifications to the joint DRGs at that time.

The current requestor asked that we move cases involving the removal of hip and knee prostheses (procedure codes 80.05 and 80.06) from their current assignment in MS–DRGs 480, 481, and 482 (Hip and Femur Procedures Except Major Joint with MCC, with CC, without CC/MCC, respectively) and in MS–DRGs 495, 496, and 497 (Local Excision of

Internal Fixation Device Except Hip and Femur with MCC, with CC, and with CC/MCC, respectively) and assign them to MS–DRGs 463, 464, and 465 (Wound Debridement and Skin Graft Except Hand, for Musculo-Connective Tissue Disease with MCC, with CC, without CC/MCC, respectively). MS–DRGs 463, 464, and 465 include cases that are treated with a debridement for infection. The requestor stated that these cases are clinically similar to those captured by procedure codes 80.05 and 80.06 where the prosthesis is removed and a new prosthesis is not inserted because of an infection.

The requestor specifically asked that we remove the hip arthrotomy code 80.05 from MS–DRGs 480, 481, and 482, and assign it to MS–DRGs 463, 464, and 465. The requestor also recommended that we remove the knee arthrotomy code 80.06 from MS–DRGs 495, 496, and 497 and assign it to MS–DRGs 463, 464, and 465.

If we were to accept the requestor's suggestion, joint replacement cases in which the patients were admitted for inpatient services to remove the prosthesis because of an infection would be assigned to the higher paying debridement MS–DRGs (MS–DRGs 463, 464, and 465). As mentioned earlier, these MS–DRGs contain other cases involving treatment for infections.

For the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we examined hip replacement cases identified by procedure code 80.05 in MS–DRGs 480, 481, and 482, and knee replacement cases identified by procedure code 80.06 in MS–DRGs 495, 496, and 497 using the FY 2008 MedPAR file. Our data from the FY 2008 MedPAR file support the requestor's suggestion that these cases have similar costs to those in MS–DRGs 463, 464, and 465, and that they are significantly more expensive to treat than those in their current MS–DRG assignments. The following table summarizes those findings:

MS–DRG	Number of cases	Average length of stay	Average cost*
463—All Cases	4,834	16.59	$26,696
464—All Cases	4,934	9.52	15,065
465—All Cases	1,696	5.45	9,041
480—All Cases	31,181	8.89	17,168
480—Cases with code 80.05	643	13.35	26,053
480—Cases without code 80.05	30,538	8.80	16,981
481—All Cases	72,406	5.68	11,259
481—Cases with code 80.05	871	8.34	17,202
481—Cases without code 80.05	71,535	5.65	11,187
482—All Cases	37,443	4.65	9,320
482—Cases with code 80.05	282	6.82	13,718
482—Cases without code 80.05	37,161	4.63	9,287
495—All Cases	2,140	10.40	18,729
495—Cases with code 80.06	513	11.53	23,508
495—Cases without code 80.06	1,627	10.04	17,432
496—All Cases	5,518	5.73	10,827
496—Cases with code 80.06	1,346	6.67	14,454
496—Cases without code 80.06	4,172	5.42	9,657
497—All Cases	5,856	2.84	7,148
497—Cases with code 80.06	688	5.08	12,234
497—Cases without code 80.06	5,168	2.54	6,470

* In the FY 2007 IPPS final rule (71 FR 47882), we adopted a cost-based weighting methodology. The cost-based weights were adopted over a 3-year transition period in ⅓ increments between FY 2007 and FY 2009. The average cost represents the average standardized charges on the claims reduced to cost using the cost center-specific CCRs for a specific DRG. The standardization process includes adjustments for IME, DSH, and wage index as applied to individual hospitals. This estimation of cost is the same method used in the computation of the relative weights. We are using cost-based data instead of our historical charge-based data to evaluate proposed MS–DRG classification changes.

The data show that hip replacement cases with procedure code 80.05 in MS–DRGs 480, 481, and 482 have average costs of $26,053, $17,202, and $13,718, respectively, compared to overall average costs of $17,168 in MS–DRG 480; $11,259 in MS–DRG 481; and $9,320 in MS–DRG 482. The data also show that knee replacement cases with procedure code 80.06 in MS–DRGs 495, 496, and 497 have average costs of $23,508, $14,454, and $12,234, respectively, compared to average costs of all cases of $18,729 in MS–DRG 495, $10,827 in MS–DRG 496, and $7,148 in MS–DRG 497. All cases in MS–DRGs 463, 464, and 465 had average costs of $26,696, $15,065, and $9,041, respectively.

The results of this analysis of data support the reassignment of procedure codes 80.05 and 80.06 to MS–DRGs 463, 464, and 465. Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24107 through 24109), we proposed to move procedure codes 80.05 and 80.06 from their current assignments in MS–DRGs 480, 481, and 482 and 495, 496, and 497, and assign them to MS–DRGs 463, 464, and 465. We also proposed to revise the code title of procedure code 80.05 to read ''Arthrotomy for removal of prosthesis without replacement, hip'' and the title of procedure code 80.06 to read ''Arthrotomy for removal of prosthesis without replacement, knee'', effective October 1, 2009, as in shown in Table 6F of the Addendum to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule.

Comment: A number of commenters supported our recommendation to move codes 80.05 and 80.06 from their current assignments in MS–DRGs 480, 481, and 482 and 495, 496, and 497 and assign them to MS–DRGs 463, 464, and 465. The commenters also supported the proposed changes to the code titles for both codes 80.05 and 80.06, effective October 1, 2009.

One commenter supported this MS–DRG change for the treatment of infection following hip and knee arthroplasty patients because, according to the commenter, considerable resources are required to care for these patients whose deep infections are one of the most devastating complications

associated with hip and knee arthroplasty. The commenter further stated that the current hospital payment rate provides a disincentive for hospitals to admit patients with infected total joint replacements and creates an economic burden on tertiary care referral centers treating these patients. Several other commenters also agreed that these cases are significantly more expensive to treat than other cases in the current MS–DRG assignments. One commenter stated that this reassignment will more accurately reflect the costs associated with treating the removal of hip and knee prostheses.

Some of the commenters who supported the proposed changes stated that, given the recent major changes to the MS–DRGs, it was appropriate for CMS to propose a limited number of MS–DRG classification changes for FY 2010. The commenters had no objections to the proposal to move codes 80.05 and 80.06 to MS–DRGs 463, 464, and 465.

Response: We appreciate the support of the commenters and agree that it is appropriate to move codes 80.05 and 80.06 to MS–DRGs 463, 464, and 465.

Comment: Several commenters who supported this proposed MS–DRG assignment change also recommended that CMS consider revising the titles for MS–DRGs 463, 464, and 465 to reflect the proposed reassignment change. The commenters suggested the following MS–DRG titles for MS–DRGs 463, 464, and 465: ''Wound Debridement, Skin Graft, and/or Removal of Infected Prosthesis Except hand for Musculoskeletal-Connective Tissue Disease with MCC, with CC, or without CC/MCC,'' respectively.

Response: The MS–DRG titles are general in nature and usually do not describe all the diagnoses and procedure codes included in each MS–DRG. We do not use the full MS–DRG titles within the IPPS. Rather, we use abbreviated titles, as is shown in Table 5 of the Addendum to this FY 2010 IPPS/RY 2010 LTCH PPS final rule. Our abbreviated titles are constrained by the fact that they must be 68 characters long. The current abbreviated title for MS–DRG 465 is already 68 characters long. The MS–DRG 465 abbreviated title is as follows: Wnd debrid & skn graft exc hand, for musculo-conn tiss dis w/o CC/MM. As a result, we are unable to accommodate the commenter's suggestion by making a clear MS–DRG abbreviated title that includes all of the recommended language within our 68 character limitation. We also note that not all prosthesis removals are being moved to MS–DRGs 463, 364, and 465. We are only moving knee and hip prosthesis removals to these MS–DRGs. Therefore, we believe that the suggested new title may be misleading because it implies all types of prosthesis removals are in these MS–DRGs. Therefore, we are maintaining the current titles for MS–DRGs 463, 464, and 465.

After consideration of the public comments we received, we are finalizing our proposal to move procedure codes 80.05 and 80.06 to MS–DRGs 463, 464, and 465. We are also finalizing our proposal to revise the titles of procedure codes 80.05 and 80.06. The revised title for procedure code 80.05 is ''Arthrotomy for removal of prosthesis without replacement, hip''. The revised title for procedure code 80.06 is ''Arthrotomy for removal of prosthesis without replacement, knee''. These modifications and revisions are effective October 1, 2009, as reflected in Table 6F of the Addendum to this final rule.

3. Medicare Code Editor (MCE) Changes

As explained under section II.B.1. of the preamble of this final rule, the Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into a DRG. In the FY 2020 IPPS/LTCH PPS proposed rule (74 FR 24109 through 24110), for FY 2010, we proposed to make the following changes to the MCE edits:

a. Diagnoses Allowed for Males Only Edit

There are four diagnosis codes that were inadvertently left off of the MCE edit titled ''Diagnoses Allowed for Males Only.'' These codes are located in the chapter of the ICD–9–CM diagnosis codes entitled ''Diseases of Male Genital Organs.'' In the FY 2009 IPPS final rule, we indicated that we were adding the following four codes to this MCE edit:

- 603.0 (Encysted hydrocele)
- 603.1 (Infected hydrocele)
- 603.8 (Other specified types of hydrocele)
- 603.9 (Hydrocele, unspecified).

We had no reported problems or confusion with the omission of these codes from this section of the MCE, but in order to have an accurate product, we indicated that we were adding these codes for FY 2009. However, through an oversight, we failed to implement the indicated FY 2009 changes to the MCE by adding codes 603.0, 603.1, 603.8, and 603.9 to the MCE edit of diagnosis allowed for males only. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we acknowledged this omission and again proposed to make the changes.

We did not receive any public comments on the proposed changes to the edit for Diagnosis Allowed for Males Only. Therefore, we are finalizing our proposal to add diagnosis codes 603.0, 603.1, 603.8, and 603.9 to this MCE edit for FY 2010.

b. Manifestation Codes as Principal Diagnosis Edit

Manifestation codes describe the manifestation of an underlying disease, not the disease itself. Therefore, manifestation codes should not be used as a principal diagnosis. The National Center for Health Statistics (NCHS) has removed the advice ''code first associated disorder'' from three codes, thereby making them acceptable principal diagnosis codes. These codes are:

- 365.41 (Glaucoma associated with chamber angle anomalies)
- 365.42 (Glaucoma associated with anomalies of iris)
- 365.43 (Glaucoma associated with other anterior segment anomalies)

In order to make conforming changes to the MCE, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24109), we proposed to remove codes 365.41, 365.42, and 365.43 from the Manifestation Code as Principal Diagnosis Edit.

We did not receive any public comments on the proposed changes to the edit for Manifestation Codes as Principal Diagnosis. Therefore, we are finalizing our proposal to remove manifestation codes 365.41, 365.42, and 365.43 from the principal diagnosis edit. These codes will be acceptable as principal diagnosis, effective October 1, 2010.

c. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis, including the admitting diagnosis, and each procedure against a table of valid ICD–9–CM codes. If an entered code does not agree with any code on the list, it is assumed to be invalid or that the 4th or 5th digit of the code is invalid or missing.

An error was discovered in this edit. ICD–9–CM code 00.01 (Therapeutic ultrasound of vessels of head and neck) was inadvertently left out of the MCE tables. The inclusion of this code in the MCE tables would have generated an error message at the Medicare contractor level, but we had instructed the

Medicare contractors to override this edit for discharges on or after October 1, 2008. To make a conforming change to the MCE, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24109), we proposed to add code 00.01 to the table of valid codes.

We did not receive any public comments on our proposed changes to the edit for Invalid Diagnosis or Procedure Codes. Therefore, we are finalizing our proposal to add code 00.01 to the table of valid codes for FY 2010.

d. Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance that influences an individual's health status but not a current illness or injury and codes that are not specific manifestations but may describe illnesses due to an underlying cause. These codes are considered unacceptable as a principal diagnosis.

For FY 2008, a series of diagnostic codes were created at subcategory 209, Neuroendocrine Tumors. An instructional note under this subcategory stated that coders were to ''Code first any associated multiple endocrine neoplasia syndrome (258.01–258.03)''. Medicare contractors had interpreted this note to mean that none of the codes in subcategory 209 were acceptable principal diagnoses and had entered these codes on the MCE edit for unacceptable principal diagnoses. We later deemed this interpretation to be incorrect. We had not intended that the series of codes at subcategory 209 were only acceptable as secondary diagnoses.

To avoid future misinterpretation, in the FY 2010 IPPS/RY 2919 LTCH PPS proposed rule (74 FR 24109 through 24110), we proposed to remove the following codes from the MCE edit for unacceptable principal diagnoses.

- 209.00 (Malignant carcinoid tumor of the small intestine, unspecified portion)
- 209.01 (Malignant carcinoid tumor of the duodenum)
- 209.02 (Malignant carcinoid tumor of the jejunum)
- 209.03 (Malignant carcinoid tumor of the ileum)
- 209.10 (Malignant carcinoid tumor of the large intestine, unspecified portion)
- 209.11 (Malignant carcinoid tumor of the appendix)
- 209.12 (Malignant carcinoid tumor of the cecum)
- 209.13 (Malignant carcinoid tumor of the ascending colon)
- 209.14 (Malignant carcinoid tumor of the transverse colon)
- 209.15 (Malignant carcinoid tumor of the descending colon)
- 209.16 (Malignant carcinoid tumor of the sigmoid colon)
- 209.17 (Malignant carcinoid tumor of the rectum)
- 209.20 (Malignant carcinoid tumor of unknown primary site)
- 209.21 (Malignant carcinoid tumor of the bronchus and lung)
- 209.22 (Malignant carcinoid tumor of the thymus)
- 209.23 (Malignant carcinoid tumor of the stomach)
- 209.24 (Malignant carcinoid tumor of the kidney)
- 209.25 (Malignant carcinoid tumor of foregut, not otherwise specified)
- 209.26 (Malignant carcinoid tumor of midgut, not otherwise specified)
- 209.27 (Malignant carcinoid tumor of hindgut, not otherwise specified)
- 209.29 (Malignant carcinoid tumor of other sites)
- 209.30 (Malignant poorly differentiated neuroendocrine carcinoma, any site)
- 209.40 (Benign carcinoid tumor of the small intestine, unspecified portion)
- 209.41 (Benign carcinoid tumor of the duodenum)
- 209.42 (Benign carcinoid tumor of the jejunum)
- 209.43 (Benign carcinoid tumor of the ileum)
- 209.50 (Benign carcinoid tumor of the large intestine, unspecified portion)
- 209.51 (Benign carcinoid tumor of the appendix)
- 209.52 (Benign carcinoid tumor of the cecum)
- 209.53 (Benign carcinoid tumor of the ascending colon)
- 209.54 (Benign carcinoid tumor of the transverse colon)
- 209.55 (Benign carcinoid tumor of the descending colon)
- 209.56 (Benign carcinoid tumor of the sigmoid colon)
- 209.57 (Benign carcinoid tumor of the rectum)
- 209.60 (Benign carcinoid tumor of unknown primary site)
- 209.61 (Benign carcinoid tumor of the bronchus and lung)
- 209.62 (Benign carcinoid tumor of the thymus)
- 209.63 (Benign carcinoid tumor of the stomach)
- 209.64 (Benign carcinoid tumor of the kidney)
- 209.65 (Benign carcinoid tumor of foregut, not otherwise specified)
- 209.66 (Benign carcinoid tumor of midgut, not otherwise specified)
- 209.67 (Benign carcinoid tumor of hindgut, not otherwise specified)
- 209.69 (Benign carcinoid tumor of other sites)

In the meantime, CMS has issued instructions in the form of an internal working document called a joint signature memorandum to the Medicare contractors to override this edit and process claims containing codes from the subcategory 209 series as acceptable principal diagnoses.

We acted quickly to negate the effects of this edit, as it was an erroneous edit to the MCE resulting in unintended consequences. We did not receive any public comments on the proposed change to the edit for Unacceptable Principal Diagnosis. Therefore, we are finalizing our proposal to remove the codes listed above (that is, codes 209.00 through 209.69) from the MCE edit for Unacceptable Principal Diagnosis.

e. Creation of New Edit Titled ''Wrong Procedure Performed''

On January 15, 2009, CMS issued three National Coverage Decision memoranda on the coverage of erroneous surgeries on Medicare patients: Wrong Surgical or Other Invasive Procedure Performed on a Patient (CAG–00401N); Surgical or Other Invasive Procedure Performed on the Wrong Body Part (CAG–00402N); and Surgical or Other Invasive Procedure Performed on the Wrong Patient (CAG–00403N). We refer readers to the following CMS Web sites to view the memoranda in their entirety: For the decision memorandum on surgery on the wrong body part: *https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=222.* For the decision memorandum on surgery on the wrong patient: *https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=221.* For the decision memorandum on the wrong surgery performed on a patient: *https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=223.*

To conform to these new coverage decisions, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24110), we proposed to create a new edit to identify cases in which wrong surgeries occurred. The NCHS has revised the title of one E-code and created two new E-codes to identify cases in which incorrect surgeries have occurred. The revised E-code title is:

- E876.5 (Performance of wrong operation (procedure) on correct patient).

The two new E-codes are as follows:

- E876.6 (Performance of operation (procedure) on patient not scheduled for surgery).
- E876.7 (Performance of correct operation (procedure) on wrong side/body part).

For the benefit of the reader, we are providing the following brief background information on external causes of injury and poisoning codes (E-

codes). E-codes are intended to provide data for injury research and evaluation of injury prevention strategies. E-codes capture how the injury or poisoning happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), and the place where the event occurred. The use of E-codes is supplemental to the ICD–9–CM diagnosis codes. The National Center for Health Statistics (NCHS)/CDC has created and maintains the *ICD–9–CM Official Guidelines for Coding and Reporting,* including instructions concerning E-codes, and has made these guidelines available on the Web site at: *http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf.* The guidelines are a national HIPAA standard. The guidelines are being updated effective October 1, 2009, to recognize the fact that CMS requires the reporting of E-codes as part of its wrong procedure performed national coverage decision. The fourth quarter issue of *Coding Clinic for ICD–9–CM* will also include information on the new wrong surgery codes as well as the updated Coding Guidelines.

A complete list of all of the E-codes that will be implemented on October 1, 2009, can be found on the CMS Web site home page at: *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage* in the download titled ''New, Deleted, and Invalid Diagnosis and Procedure Codes.''

Currently, an E-code used as a principal diagnosis will receive the MCE Edit ''E-code as principal diagnosis''. This edit will remain in effect. However, we proposed a change to the MCE so that E-codes E876.5 through E876.7, whether they are in the principal or secondary diagnosis position, will trigger the ''Wrong Procedure Performed'' edit. Any claim with this edit will be rejected.

Comment: Several commenters requested that CMS clarify its policy on reporting of E-codes, stating that CMS has never required the reporting of these codes prior to the proposed rule. The commenters also stated that an edit for codes E876.5 through E876.7 should not be applied to claims in which one of these E-codes was listed as the principal diagnosis as there is already an MCE edit that addresses E-codes in this position. One commenter agreed that eliminating the ''E-code as Principal Diagnosis'' edit that is currently in place will address many issues for reporting E-codes as principal diagnosis.

Response: The commenters are correct that the reporting of E-codes has not previously been required for reporting to CMS. However, as noted above, the E-codes are used for many purposes and are often required by institutions in order to describe a complete patient encounter with health services. We believe that any of the three aforementioned wrong surgery situations presents such an egregious scenario that hospitals will capture this information through the use of the applicable E-codes.

The commenters are correct that E-codes in the principal diagnosis position on the claim will trigger an edit in which claims will be returned to the provider. However, we did not propose to delete this edit; this edit will remain in place along with the Wrong Procedure Performed edit. Claims with E-codes other than codes E876.5 through E876.7 reported in the principal diagnosis position will be subject to the longstanding Principal Diagnosis edit. Claims with codes E876.5 through E876.7 reported in either the principal or secondary diagnosis position will be subject to the Wrong Procedures Performed edit. These claims will be rejected.

Comment: Commenters suggested that the Wrong Procedure Performed edit should be triggered if the E-code is reported in either the E-code position on the claim or in the secondary diagnosis position.

Response: We agree that the edit should be triggered no matter in what position it is reported. However, we encourage reporting of the E-codes in the secondary diagnosis position.

Comment: One commenter suggested that if codes E876.5 through E876.7 were to be reported in the principal diagnosis position, the ''E-code as Principal Diagnosis'' edit should be invoked and the claim returned to the provider so that the claim could then be resubmitted listing the codes in the correct sequence. The commenter further suggested that the Wrong Procedure Performed edit should only be triggered when the E-codes are reported in the correct position on the claim.

Response: We do not believe this suggestion is in the best interest of the hospital industry. Performance of the wrong surgery is not a reasonable and necessary treatment for the Medicare beneficiary, and these claims will be rejected. To cause the Medicare contractor (the fiscal intermediary or the A/B MAC) to return the claim to the provider, have the provider correct the sequencing of the codes on the claim and return it to the contractor, only to ultimately have the claim be rejected, add steps to a process that results in the same outcome.

Comment: One commenter suggested that updated coding guidance should address the definition of operation/procedure, and [define] what constitutes a wrong procedure for consistent assignment [of the codes] to coincide with industry definitions.

Response: We take this opportunity to point out that the definition of an operation or procedure is a longstanding description, dating from the Uniform Hospital Discharge Data Set promulgated by the Secretary of the U.S. Department of Health, Education, and Welfare in 1974. In addition, with regard to the suggestion that there need to be guidelines regarding the performance of a wrong surgery in any of the three cases described by these codes, we believe that any of these three scenarios are so flagrant that the average individual could determine that a wrong surgery had taken place. Therefore, we do not believe we should wait for a determination by the industry of what constitutes the definition of a wrong surgery.

Comment: One commenter urged CMS to work closely with the other Cooperating Parties for ICD–9–CM to provide guidance for coding, reporting, and sequencing of codes E876.5 through E876.7. Several commenters suggested that CMS begin processing all of the reported diagnosis and procedure codes.

Response: We acknowledge the current CMS system limitations that allow us to process only the first nine diagnosis codes and six procedure codes reported on the hospital bills and that do not allow us to process codes from the external cause of injury field when making an MS–DRG assignment. We have discussed these internal CMS system limitations in previous rules. In anticipation of the implementation of ICD–10 on October 1, 2013, CMS is undertaking extensive efforts to update its systems. These system updates include plans to begin processing up to 25 diagnosis codes and 25 procedure codes as well as the ability to process codes reported in the external cause of injury field. With these system updates, we believe the concerns expressed by commenters concerning CMS' limited processing of reported codes will be resolved. In the meantime, hospitals should continue their current and longstanding practice of reporting the ICD–9–CM diagnosis and procedure codes which affect the MS–DRG assignment among the first nine diagnosis and first six procedure coding fields.

As stated below, CMS will implement a wrong surgery (Wrong Procedure Performed) coverage edit in the MCE on October 1, 2009, that will lead to any

claim with a wrong surgery E-code triggering this edit to be rejected.

Should hospitals perform any of the three wrong surgeries and submit claims on which the E-code is omitted or is listed in a field that we do not currently process for the MS–DRG assignment (the code is not reported among the first nine diagnosis codes or the code is reported in the External Cause of Injury field), the case may be subject to retrospective review by the Recovery Audit Contractor (RAC) and then subsequently denied. Patterns of apparent coding abuse may be referred to the Office of Inspector General for HHS for additional investigation.

We also have referred this new Wrong Procedure Performed national coverage decision to the Cooperating Parties for ICD–9–CM who update and maintain the *Official ICD–9–CM Coding Guidelines*. These guidelines are a national HIPAA standard. The guidelines are being updated effective October 1, 2009, to recognize the fact that CMS requires the reporting of E-codes as part of its wrong procedure performed national coverage decision. The fourth quarter issue of *Coding Clinic for ICD–9–CM* will also include information on the new wrong surgery codes as well as the updated Coding Guidelines. We believe the clarity provided by the national coverage decisions, the MCE edits, the updated *Official ICD–9–CM Coding Guidelines*, and the *Fourth Quarter Coding Clinic* article on the new wrong surgery codes should make clear how the codes are to be used and reported.

After consideration of the public comments we received, we are finalizing our proposal to change the MCE so the E-codes E876.5 through E876.7, whether they are in the principal or secondary diagnosis position, will trigger the ''Wrong Procedure Performed'' edit. Therefore, any claim with this edit will be rejected, effective October 1, 2009.

f. Procedures Allowed for Females Only Edit

It has come to our attention that code 75.37 (Amnioinfusion) and code 75.38 (Fetal pulse oximetry) were inadvertently omitted from the MCE edit ''Procedures Allowed for Females Only.'' In order to correct this omission, in the FY 2010 IPPS/RY 2010 LTCH proposed rule (74 FR 24110 through 24111), we proposed to add codes 75.37 and 75.38 to the edit for procedures allowed for females only.

We did not receive any public comments on our proposal. Therefore, for FY 2010, we are adding codes 75–37 and 75.38 to the Procedures Allowed for Females Only edit.

4. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different MS–DRG within the MDC to which the principal diagnosis is assigned. Therefore, it is necessary to have a decision rule within the GROUPER by which these cases are assigned to a single MS–DRG. The surgical hierarchy, an ordering of surgical classes from most resource-intensive to least resource-intensive, performs that function. Application of this hierarchy ensures that cases involving multiple surgical procedures are assigned to the MS–DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of MS–DRG reclassification and recalibrations, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications and recalibrations, to determine if the ordering of classes coincides with the intensity of resource utilization.

A surgical class can be composed of one or more MS–DRGs. For example, in MDC 11, the surgical class ''kidney transplant'' consists of a single MS–DRG (MS–DRG 652) and the class ''major bladder procedures'' consists of three MS–DRGs (MS–DRGs 653, 654, and 655). Consequently, in many cases, the surgical hierarchy has an impact on more than one MS–DRG. The methodology for determining the most resource-intensive surgical class involves weighting the average resources for each MS–DRG by frequency to determine the weighted average resources for each surgical class. For example, assume surgical class A includes MS–DRGs 1 and 2 and surgical class B includes MS–DRGs 3, 4, and 5. Assume also that the average costs of MS–DRG 1 is higher than that of MS–DRG 3, but the average costs of MS–DRGs 4 and 5 are higher than the average costs of MS–DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average costs of each MS–DRG in the class by frequency (that is, by the number of cases in the MS–DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other O.R. procedures'' as discussed below.

This methodology may occasionally result in assignment of a case involving multiple procedures to the lower-weighted MS–DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER search for the procedure in the most resource-intensive surgical class, in cases involving multiple procedures, this result is sometimes unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average cost is ordered above a surgical class with a higher average cost. For example, the ''other O.R. procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the average costs for the MS–DRG or MS–DRGs in that surgical class may be higher than those for other surgical classes in the MDC. The ''other O.R. procedures'' class is a group of procedures that are only infrequently related to the diagnoses in the MDC, but are still occasionally performed on patients in the MDC with these diagnoses. Therefore, assignment to these surgical classes should only occur if no other surgical class more closely related to the diagnoses in the MDC is appropriate.

A second example occurs when the difference between the average costs for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy because, as a result of reassigning cases on the basis of the hierarchy change, the average costs are likely to shift such that the higher-ordered surgical class has a lower average costs than the class ordered below it.

For FY 2010, we did not propose any revisions to the surgical hierarchy.

We did not receive any public comments on our proposal not to make any revisions to the surgical hierarchy and, therefore, are finalizing our proposed decision in this final rule.

5. Complications or Comorbidity (CC) Exclusions List

a. Background

As indicated earlier in the preamble of this final rule, under the IPPS DRG classification system, we have developed a standard list of diagnoses that are considered CCs. Historically, we developed this list using physician panels that classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial

complication or comorbidity. A substantial complication or comorbidity was defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least 1 day in at least 75 percent of the patients. We refer readers to section II.D.2. and 3. of the preamble of the FY 2008 IPPS final rule with comment period for a discussion of the refinement of CCs in relation to the MS–DRGs we adopted for FY 2008 (72 FR 47121 through 47152).

b. CC Exclusions List for FY 2010

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered valid CCs in combination with a particular principal diagnosis. We created the CC Exclusions List for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. As we indicated above, we developed a list of diagnoses, using physician panels, to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the list of CCs, either by adding new CCs or deleting CCs already on the list.

In the May 19, 1987 proposed notice (52 FR 18877) and the September 1, 1987 final notice (52 FR 33154), we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another.
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for the same condition should not be considered CCs for one another.
- Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- Codes for the same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. We have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC.[2]

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24111 through 24112), we proposed to make limited revisions to the CC Exclusions List for FY 2010 to take into account the changes made in the ICD–9–CM diagnosis coding system effective October 1, 2009. (We refer readers to section II.G.7. of the preamble of this final rule for a discussion of ICD–9–CM changes.) We proposed to make these changes in accordance with the principles established when we created the CC Exclusions List in 1987. In addition, we indicated on the CC Exclusions List some changes as a result of updates to the ICD–9–CM codes to reflect the exclusion of codes from being MCCs under the MS–DRG system that we adopted in FY 2008.

Comment: One comment asked CMS if it would be reasonable to consider modifying future GROUPER logic so that patients with multiple secondary diagnoses classified as CCs would be assigned to the MCC level. In other words, the commenter stated, multiple CCs would be considered the same as having an MCC.

Response: We believe this comment is outside the scope of the proposed rule because we did not propose significant revisions to the MS–DRGs. Moreover, as discussed earlier, we made significant refinements to the inpatient payment system when we implemented the MS–DRG system in FY 2008. We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full discussion of how the MS–DRG system was established based on severity levels of illness (72 FR 47141). As we noted earlier, we received a number of comments recognizing the recent major changes to the MS–DRGs. The commenters stated that, given these recent major changes, it is appropriate for CMS to make only a limited number of MS–DRG classification changes for FY 2010. We believe that reclassifying a case with two or more CCs as an MCC would have a major impact on the MS–DRG system because 51 percent of the cases in the MedPAR file have more than one CC (5,980,824 of 11,801,371 cases in FY 2008). Therefore, we have decided not to modify the GROUPER logic to classify a case with multiple CCs as an MCC for FY 2010.

Comment: Several commenters recommended that CMS consider making further adjustments to the MS–DRG assignments based on obesity. The commenters stated that higher Body Mass Index (BMI) ratings add to the complexity of care for patients, such as those patients undergoing orthopedic procedures. The commenters recommended the following changes to the list of MCCs and CCs.

One commenter recommended that CMS add the following codes to the CC list. Another commenter recommended that CMS add these same codes to the MCC list.

- 731.3 (Major osseous defects)
- V85.35 (Body mass index 35.0–35.9, adult)
- V85.36 (Body mass index 36.0–36.9, adult)
- V85.37 (Body mass index 37.0–37.9, adult)

Both commenters recommended that CMS add the following codes to the MCC list:

- V85.38 (Body mass index 38.0–38.9, adult)
- V85.39 (Body mass index 39.0–39.9, adult)
- V85.40 (Body mass index 40 and over, adult)

Response: We believe this comment is outside the scope of the specific proposal in the proposed rule because we did not propose significant revisions to the MS–DRGs. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24091), we stated that we were encouraging individuals with comments about MS–DRG classifications to submit these comments no later than early December of each year so they can be carefully considered for possible

[2] *See* the FY 1989 final rule (53 FR 38485, September 30, 1988), for the revision made for the discharges occurring in FY 1989; the FY 1990 final rule (54 FR 36552, September 1, 1989), for the FY 1990 revision; the FY 1991 final rule (55 FR 36126, September 4, 1990), for the FY 1991 revision; the FY 1992 final rule (56 FR 43209, August 30, 1991) for the FY 1992 revision; the FY 1993 final rule (57 FR 39753, September 1, 1992), for the FY 1993 revision; the FY 1994 final rule (58 FR 46278, September 1, 1993), for the FY 1994 revisions; the FY 1995 final rule (59 FR 45334, September 1, 1994), for the FY 1995 revisions; the FY 1996 final rule (60 FR 45782, September 1, 1995), for the FY 1996 revisions; the FY 1997 final rule (61 FR 46171, August 30, 1996), for the FY 1997 revisions; the FY 1998 final rule (62 FR 45966, August 29, 1997) for the FY 1998 revisions; the FY 1999 final rule (63 FR 40954, July 31, 1998), for the FY 1999 revisions; the FY 2001 final rule (65 FR 47064, August 1, 2000), for the FY 2001 revisions; the FY 2002 final rule (66 FR 39851, August 1, 2001), for the FY 2002 revisions; the FY 2003 final rule (67 FR 49998, August 1, 2002), for the FY 2003 revisions; the FY 2004 final rule (68 FR 45364, August 1, 2003), for the FY 2004 revisions; the FY 2005 final rule (69 FR 49848, August 11, 2004), for the FY 2005 revisions; the FY 2006 final rule (70 FR 47640, August 12, 2005), for the FY 2006 revisions; the FY 2007 final rule (71 FR 47870) for the FY 2007 revisions; the FY 2008 final rule (72 FR 47130) for the FY 2008 revisions, and the FY 2009 final rule (73 FR 48510). In the FY 2000 final rule (64 FR 41490, July 30, 1999, we did not modify the CC Exclusions List because we did not make any changes to the ICD–9–CM codes for FY 2000.

inclusion in the annual proposed rule and, if included, may be subjected to public review and comment. Therefore, we are not adding these codes to the MCC list or the CC list for FY 2010. We may consider their appropriateness for inclusion in next year's annual IPPS proposed rule.

After consideration of the public comments received, we are adopting the proposed limited revisions to the CC Exclusion List as final for FY 2010 without change.

Tables 6G and 6H, Additions to and Deletions from the CC Exclusion List, respectively, which are effective for discharges occurring on or after October 1, 2009, are not being published in this final rule because of the length of the two tables. Instead, we are making them available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS*. Each of these principal diagnoses for which there is a CC exclusion is shown in Tables 6G and 6H with an asterisk, and the conditions that will not count as a CC, are provided in an indented column immediately following the affected principal diagnosis.

A complete updated MCC, CC, and Non-CC Exclusions List is also available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS*. Beginning with discharges on or after October 1, 2009, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

To assist readers in identifying the changes to the MCC and CC lists that occurred as a result of updates to the ICD–9–CM codes, as described in Tables 6A, 6C, and 6E of the Addendum to this final rule, we are providing the following summaries of those MCC and CC changes.

SUMMARY OF ADDITIONS TO THE MS–DRG MCC LIST—TABLE 6I.1

Code	Description
277.88	Tumor lysis syndrome.
670.22	Puerperal sepsis, delivered, with mention of postpartum complication.
670.24	Puerperal sepsis, postpartum condition or complication.
670.32	Puerperal septic thrombophlebitis, delivered, with mention of postpartum complication.
670.34	Puerperal septic thrombophlebitis, postpartum condition or complication.
670.80	Other major puerperal infection, unspecified as to episode of care or not applicable.
670.82	Other major puerperal infection, delivered, with mention of postpartum complication.
670.84	Other major puerperal infection, postpartum condition or complication.
756.72	Omphalocele.
756.73	Gastroschisis.
768.73	Severe hypoxic-ischemic encephalopathy.
779.32	Bilious vomiting in newborn.

SUMMARY OF DELETIONS FROM THE MS–DRG MCC LIST—TABLE 6I.2

Code	Description
768.7	Hypoxic-ischemic encephalopathy (HIE).

SUMMARY OF ADDITIONS TO THE MS–DRG CC LIST—TABLE 6J.1

Code	Description
209.71	Secondary neuroendocrine tumor of distant lymph nodes.
209.72	Secondary neuroendocrine tumor of liver.
209.73	Secondary neuroendocrine tumor of bone.
209.74	Secondary neuroendocrine tumor of peritoneum.
209.79	Secondary neuroendocrine tumor of other sites.
416.2	Chronic pulmonary embolism.
453.50	Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity.
453.51	Chronic venous embolism and thrombosis of deep vessels of proximal lower extremity.
453.52	Chronic venous embolism and thrombosis of deep vessels of distal lower extremity.
453.6	Venous embolism and thrombosis of superficial vessels of lower extremity.
453.71	Chronic venous embolism and thrombosis of superficial veins of upper extremity.
453.72	Chronic venous embolism and thrombosis of deep veins of upper extremity.
453.73	Chronic venous embolism and thrombosis of upper extremity, unspecified.
453.74	Chronic venous embolism and thrombosis of axillary veins.
453.75	Chronic venous embolism and thrombosis of subclavian veins.
453.76	Chronic venous embolism and thrombosis of internal jugular veins.
453.77	Chronic venous embolism and thrombosis of other thoracic veins.
453.79	Chronic venous embolism and thrombosis of other specified veins.
453.81	Acute venous embolism and thrombosis of superficial veins of upper extremity.
453.82	Acute venous embolism and thrombosis of deep veins of upper extremity.
453.83	Acute venous embolism and thrombosis of upper extremity, unspecified.
453.84	Acute venous embolism and thrombosis of axillary veins.
453.85	Acute venous embolism and thrombosis of subclavian veins.
453.86	Acute venous embolism and thrombosis of internal jugular veins.
453.87	Acute venous embolism and thrombosis of other thoracic veins.
453.89	Acute venous embolism and thrombosis of other specified veins.
569.71	Pouchitis.
569.79	Other complications of intestinal pouch.
670.10	Puerperal endometritis, unspecified as to episode of care or not applicable.

SUMMARY OF ADDITIONS TO THE MS–DRG CC LIST—TABLE 6J.1—Continued

Code	Description
670.12	Puerperal endometritis, delivered, with mention of postpartum complication.
670.14	Puerperal endometritis, postpartum condition or complication.
670.20	Puerperal sepsis, unspecified as to episode of care or not applicable.
670.30	Puerperal septic thrombophlebitis, unspecified as to episode of care or not applicable.
768.70	Hypoxic-ischemic encephalopathy, unspecified.
768.71	Mild hypoxic-ischemic encephalopathy.
768.72	Moderate hypoxic-ischemic encephalopathy.
813.46	Torus fracture of ulna (alone).
813.47	Torus fracture of radius and ulna.

SUMMARY OF DELETIONS FROM THE MS–DRG CC LIST—TABLE 6J.2

Code	Description
453.8	Other venous embolism and thrombosis of other specified veins.

These summary lists are the same as those lists included in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24111 through 24112).

Comment: One commenter supported the CC designations for new codes 813.46 (Torus fracture of ulna (alone)) and 813.47 (Torus fracture of radius and ulna).

Response: We appreciate the commenter's support.

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current MS–DRG Definitions Manual, Version 26.0, is available for $250.00, which includes shipping and handling. Version 26.0 of the manual is also available on a CD for $200.00; a combination hard copy and CD is available for $400.00. Version 27.0 of this manual, which will include the final FY 2010 MS–DRG changes, will be available in CD only for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303, or by obtaining an order form at the Web site: *http://www.3MHIS.com.* Please specify the revision or revisions requested.

6. Review of Procedure Codes in MS DRGs 981 Through 983; 984 Through 986; and 987 Through 989

Each year, we review cases assigned to former CMS DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), CMS DRG 476 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis), and CMS DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among these CMS DRGs. Under the MS–DRGs that we adopted for FY 2008, CMS DRG 468 was split three ways and became MS–DRGs 981, 982, and 983 (Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC). CMS DRG 476 became MS–DRGs 984, 985, and 986 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC). CMS DRG 477 became MS–DRGs 987, 988, and 989 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC).

MS–DRGs 981 through 983, 984 through 986, and 987 through 989 (formerly CMS DRGs 468, 476, and 477, respectively) are reserved for those cases in which none of the O.R. procedures performed are related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. MS–DRGs 984 through 986 (previously CMS DRG 476) are assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

- 60.0, Incision of prostate
- 60.12, Open biopsy of prostate
- 60.15, Biopsy of periprostatic tissue
- 60.18, Other diagnostic procedures on prostate and periprostatic tissue
- 60.21, Transurethral prostatectomy
- 60.29, Other transurethral prostatectomy
- 60.61, Local excision of lesion of prostate
- 60.69, Prostatectomy, not elsewhere classified
- 60.81, Incision of periprostatic tissue
- 60.82, Excision of periprostatic tissue
- 60.93, Repair of prostate
- 60.94, Control of (postoperative) hemorrhage of prostate
- 60.95, Transurethral balloon dilation of the prostatic urethra
- 60.96, Transurethral destruction of prostate tissue by microwave thermotherapy
- 60.97, Other transurethral destruction of prostate tissue by other thermotherapy
- 60.99, Other operations on prostate

All remaining O.R. procedures are assigned to MS–DRGs 981 through 983 and 987 through 989, with MS–DRGs 987 through 989 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis.[3]

[3] The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the FY 1989 final rule (53 FR 38591). As part of the FY 1991 final rule (55 FR 36135), the FY 1992 final rule (56 FR 43212), the FY 1993 final rule (57 FR 23625), the FY 1994 final rule (58 FR 46279), the FY 1995 final rule (59 FR 45336), the FY 1996 final rule (60 FR 45783), the FY 1997 final rule (61 FR 46173), and the FY 1998 final rule (62 FR 45981), we moved several other procedures from DRG 468 to DRG 477, and some procedures from DRG 477 to DRG 468. No procedures were moved in FY 1999, as noted in the final rule (63 FR 40962); in FY 2000 (64 FR 41496); in FY 2001 (65 FR 47064); or in FY 2002 (66 FR 39852). In the FY 2003 final rule (67 FR 49999) we did not move any procedures from DRG 477. However, we did move procedure codes from DRG 468 and placed them in more clinically coherent DRGs. In the FY 2004 final rule (68 FR 45365), we moved several procedures from DRG 468 to DRGs 476 and 477 because the procedures are nonextensive. In the FY 2005 final rule (69 FR 48950), we moved one procedure from DRG 468 to 477. In addition, we added several existing procedures to DRGs 476 and 477. In the FY 2006 (70 FR 47317), we moved one procedure from DRG 468 and assigned it to DRG 477. In FY 2007, we moved one procedure from DRG 468 and assigned it to DRGs 479, 553, and 554. In FYs 2008 and 2009, no procedures were moved, as noted in the FY 2008

Continued

For FY 2010, we did not propose to change the procedures assigned among these MS–DRGs. We did not receive any public comments on our proposal not to change the procedures assigned among the cited MS–DRGs and, therefore, are adopting it as final for FY 2010 in this final rule.

a. Moving Procedure Codes From MS–DRGs 981 Through 983 or MS–DRGs 987 Through 989 to MDCs

We annually conduct a review of procedures producing assignment to MS–DRGs 981 through 983 (formerly CMS DRG 468) or MS–DRGs 987 through 989 (formerly CMS DRG 477) on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these MS–DRGs into one of the surgical MS–DRGs for the MDC into which the principal diagnosis falls. The data are arrayed in two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. For FY 2010, we did not propose to remove any procedures from MS–DRGs 981 through 983 or MS–DRGs 987 through 989. We did not receive any public comments on our proposal and, therefore, are adopting it as final for FY 2010 in this final rule.

b. Reassignment of Procedures Among MS–DRGs 981 Through 983, 984 Through 986, and 987 Through 989

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to MS–DRGs 981 through 983, 984 through 986, and 987 through 989 (formerly, CMS DRGs 468, 476, and 477, respectively), to ascertain whether any of those procedures should be reassigned from one of these three MS–DRGs to another of the three MS–DRGs based on average charges and the length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting MS–DRG assignment illogical. If we find these shifts, we would propose to move cases to keep the MS–DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data.

For FY 2010, we did not propose to move any procedure codes among these MS–DRGs. We did not receive any public comments on our proposal and, therefore, are adopting it as final for FY 2010 in this final rule.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on our review this year, we did not propose to add any diagnosis codes to MDCs for FY 2010. We did not receive any public comments on this subject.

7. Changes to the ICD–9–CM Coding System

As described in section II.B.1. of the preamble of this final rule, the ICD–9–CM is a coding system used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS), the Centers for Disease Control and Prevention, and CMS, charged with maintaining and updating the ICD–9–CM system. The Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The Official Version of the ICD–9–CM contains the list of valid diagnosis and procedure codes. (The Official Version of the ICD–9–CM is available from the Government Printing Office on CD–ROM for $19.00 by calling (202) 512–1800.) Complete information on ordering the CD–ROM is also available at: *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/05_CDROM.asp#TopOfPage.* The Official Version of the ICD–9–CM is no longer available in printed manual form from the Federal Government; it is only available on CD–ROM. Users who need a paper version are referred to one of the many products available from publishing houses.

The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases,* while CMS has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures.*

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), and various physician specialty groups, as well as individual physicians, health information management professionals, and other members of the public, to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for implementation in FY 2010 at a public meeting held on September 24–25, 2008 and finalized the coding changes after consideration of comments received at the meetings and in writing by December 5, 2008. Those coding changes are announced in Tables 6A through 6F in the Addendum to this final rule. The Committee held its 2009 meeting on March 11–12, 2009. New codes for which there was a consensus of public support and for which complete tabular and indexing changes are made by May 2009 will be included in the October 1, 2009 update to ICD–9–CM. Code revisions that were discussed at the March 11–12, 2009 Committee meeting but that could not be finalized in time to include them in the Addendum to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule are included in Tables 6A through 6F of this final rule and are marked with an asterisk (*).

Copies of the minutes of the procedure codes discussions at the Committee's September 24–25, 2008 meeting and March 11–12, 2009 meeting can be obtained from the CMS Web site at: *http://cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.* The minutes of the diagnosis codes discussions at the September 24–25, 2008 meeting and March 11–12, 2009 meeting are found at: *http://www.cdc.gov/nchs/icd9.htm.* Paper copies of these minutes are no longer available and the mailing list has been discontinued. These Web sites also provide detailed information about the Committee, including information on

final rule with comment period (72 FR 46241), and in the FY 2009 final rule (73 FR 48513).

requesting a new code, attending a Committee meeting, and timeline requirements and meeting dates.

We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, NCHS, Room 2402, 3311 Toledo Road, Hyattsville, MD 20782. Comments may be sent by E-mail to: *dfp4@cdc.gov.*

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. Comments may be sent by E-mail to: *patricia.brooks2@cms.hhs.gov.*

The ICD–9–CM code changes that have been approved will become effective October 1, 2009. The new ICD–9–CM codes are listed, along with their MS–DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this final rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24114), we solicited comments on the proposed classification of these new codes. We did not receive any public comments on the proposed MS–DRG assignments for the new diagnosis and procedure codes. Therefore, in this final rule, we are adopting as final without modification the MS–DRG classifications for the new codes for FY 2010 that were included in the proposed rule and the new codes that were discussed at the spring but were not finalized in time to be included in the proposed rule.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A in the Addendum to this final rule. New procedure codes are shown in Table 6B in the Addendum to this final rule. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes) in the Addendum to this final rule. These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2009. Table 6D in the Addendum to this final rule contains invalid procedure codes. These invalid procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2009. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles) in the Addendum to this final rule, which also includes the MS–DRG assignments for these revised codes. Table 6F in the Addendum to this final rule includes revised procedure code titles for FY 2010.

In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include proposals for procedure codes that would describe new technology discussed and approved at the Spring meeting as part of the code revisions effective the following October. As stated previously, ICD–9–CM codes discussed at the March 11–12, 2009 Committee meeting that receive consensus and that were finalized by May 2009 are included in Tables 6A through 6F in the Addendum to this final rule.

Section 503(a) of Public Law 108–173 included a requirement for updating ICD–9–CM codes twice a year instead of a single update on October 1 of each year. This requirement was included as part of the amendments to the Act relating to recognition of new technology under the IPPS. Section 503(a) amended section 1886(d)(5)(K) of the Act by adding a clause (vii) which states that the ''Secretary shall provide for the addition of new diagnosis and procedure codes on April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement improves the recognition of new technologies under the IPPS system by providing information on these new technologies at an earlier date. Data will be available 6 months earlier than would be possible with updates occurring only once a year on October 1.

While section 1886(d)(5)(K)(vii) of the Act states that the addition of new diagnosis and procedure codes on April 1 of each year shall not require the Secretary to adjust the payment, or DRG classification, under section 1886(d) of the Act until the fiscal year that begins after such date, we have to update the DRG software and other systems in order to recognize and accept the new codes. We also publicize the code changes and the need for a mid-year systems update by providers to identify the new codes. Hospitals also have to obtain the new code books and encoder updates, and make other system changes in order to identify and report the new codes.

The ICD–9–CM Coordination and Maintenance Committee holds its meetings in the spring and fall in order to update the codes and the applicable payment and reporting systems by October 1 of each year. Items are placed on the agenda for the ICD–9–CM Coordination and Maintenance Committee meeting if the request is received at least 2 months prior to the meeting. This requirement allows time for staff to review and research the coding issues and prepare material for discussion at the meeting. It also allows time for the topic to be publicized in meeting announcements in the **Federal Register** as well as on the CMS Web site. The public decides whether or not to attend the meeting based on the topics listed on the agenda. Final decisions on code title revisions are currently made by March 1 so that these titles can be included in the IPPS proposed rule. A complete addendum describing details of all changes to ICD–9–CM, both tabular and index, is published on the CMS and NCHS Web sites in May of each year. Publishers of coding books and software use this information to modify their products that are used by health care providers. This 5-month time period has proved to be necessary for hospitals and other providers to update their systems.

A discussion of this timeline and the need for changes are included in the December 4–5, 2005 ICD–9–CM Coordination and Maintenance Committee minutes. The public agreed that there was a need to hold the fall meetings earlier, in September or October, in order to meet the new implementation dates. The public provided comment that additional time would be needed to update hospital systems and obtain new code books and coding software. There was considerable concern expressed about the impact this new April update would have on providers.

In the FY 2005 IPPS final rule, we implemented section 1886(d)(5)(K)(vii) of the Act, as added by section 503(a) of Public Law 108–173, by developing a mechanism for approving, in time for the April update, diagnosis and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We also established the following process for making these determinations. Topics considered during the Fall ICD–9–CM Coordination and Maintenance Committee meeting are considered for

an April 1 update if a strong and convincing case is made by the requester at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at the meeting and those reviewing the Committee meeting summary report are provided the opportunity to comment on this expedited request. All other topics are considered for the October 1 update. Participants at the Committee meeting are encouraged to comment on all such requests. There were no requests approved for an expedited April 1, 2009 implementation of an ICD–9–CM code at the September 24–25, 2008 Committee meeting. Therefore, there were no new ICD–9–CM codes implemented on April 1, 2009.

Current addendum and code title information is published on the CMS Web site at: *http://www.cms.hhs.gov/icd9ProviderDiagnosticCodes/01_overview.asp#TopofPage.* Information on ICD–9–CM diagnosis codes, along with the Official ICD–9–CM Coding Guidelines, can be found on the Web site at: *http://www.cdc.gov/nchs/icd9.htm.* Information on new, revised, and deleted ICD–9–CM codes is also provided to the AHA for publication in the *Coding Clinic for ICD–9–CM.* AHA also distributes information to publishers and software vendors.

CMS also sends copies of all ICD–9–CM coding changes to its Medicare contractors for use in updating their systems and providing education to providers.

These same means of disseminating information on new, revised, and deleted ICD–9–CM codes will be used to notify providers, publishers, software vendors, contractors, and others of any changes to the ICD–9–CM codes that are implemented in April. The code titles are adopted as part of the ICD–9–CM Coordination and Maintenance Committee process. Thus, although we publish the code titles in the IPPS proposed and final rules, they are not subject to comment in the proposed or final rules. We will continue to publish the October code updates in this manner within the IPPS proposed and final rules. For codes that are implemented in April, we will assign the new procedure code to the same DRG in which its predecessor code was assigned so there will be no DRG impact as far as DRG assignment. Any midyear coding updates will be available through the Web sites indicated above and through the *Coding Clinic for ICD–9–CM.* Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software systems. We will strive to have the April 1 updates available through these Web sites 5 months prior to implementation (that is, early November of the previous year), as is the case for the October 1 updates.

Comment: A number of commenters addressed concerns regarding the implementation of ICD–10 and the processing more than nine diagnosis and six procedure codes in anticipation of the implementation of ICD–10. Several commenters recommended that CMS begin processing all reported diagnosis and procedure codes on claims, even before the planned implementation of ICD–10–CM and ICD–10–PCS on October 1, 2013. Other commenters recommended that CMS be transparent during all steps of ICD–10 implementation and make provisions for stakeholder comments and input during the transition. One commenter recommended that the final ICD–10 version of MS–DRGs be adopted using notice and comment rulemaking.

Response: We did not address the planned implementation of ICD–10 in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule and, therefore, consider these comments beyond the scope of the proposed rule. Therefore, we will not address them in this final rule. We refer readers to the separate CMS final rule published in the **Federal Register** that announced the implementation of modifications to medical data code set standards to adopt ICD–10–CM and ICD–10–PCS (74 FR 3328 through 3362). CMS is currently undergoing extensive efforts to update its Medicare payment systems as part of the move to ICD–10. Part of these system efforts will involve the expansion of our ability to process more diagnosis and procedure codes. Information on ICD–10 can be found on the CMS Web site at: *http://www.cms.hhs.gov/ICD10.* The final ICD–10 version of MS–DRGs will be adopted under the formal rulemaking process as part of our annual IPPS updates.

8. Other Issues Not Addressed in the Proposed Rule

We received a number of public comments on issues that were not the subject of proposals in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule.

a. Administration of Tissue Plasminogen Activator (tPA) (rtPA)

We received a public comment requesting that CMS conduct an analysis of diagnosis code V45.88 (Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility) under MDC 1 (Diseases and Disorders of the Nervous System). This code was created for use beginning October 1, 2008, and the commenter believes that the use of this code during FY 2009 and FY 2010 could potentially result in a new MS–DRG or set of MS–DRGs in FY 2011. The commenter believed that an expedited analysis would help show if the code is being used.

This comment is outside the scope of the proposed rule, as we did not propose any MS–DRG changes based on data analysis of cases including diagnosis code V45.88. Therefore, we will not undertake an evaluation of code V45.88 at this time for FY 2010. As we stated in FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24091), we encourage individuals with comments about MS–DRG classifications to submit these comments no later than early December of each year so they can be carefully considered for possible inclusion in the annual proposed rule and, if included, may be subjected to public review and comment.

b. Coronary Artery Bypass Graft (CABG) With Intraoperative Angiography

We received a number of comments that recommended creating new MS–DRGs to separately identify the use of intraoperative angiography, by any method, in CABG surgery under MDC 5 (Diseases and Disorders of the Circulatory System). Intraoperative angiography is used to assess bypass graft patency. The commenters acknowledged that imaging in the operating room is a fairly new concept. However, the commenters stated that there is a movement to encourage greater use of this technology in conjunction with CABG procedures to identify and correct any technical issues with the graft(s) at the time of surgery. According to the commenters, intraoperative angiography would reduce graft failure complications and hospital readmissions while improving patient care outcomes.

The commenters expressed concern that the costs related to intraoperative angiography are not fully realized in the current structure of the MS–DRGs. One commenter suggested creating four new MS–DRGs to identify the use of intraoperative angiography when performed with CABG surgery. The commenter stated that in the current MS–DRG scheme, there is not a mechanism to determine when intraoperative angiography is performed. Angiography is commonly performed as a separate procedure in a catheterization laboratory and the ICD–9–CM procedure codes do not distinguish between preoperative,

intraoperative, and postoperative angiography. Procedure code 88.59 (Intraoperative fluorescence vascular angiography (IFVA)), is one intraoperative angiography technique that allows visualization of the coronary vasculature. The commenter proposed four new MS–DRGs in addition to the existing MS–DRGs for CABG in an attempt to differentiate the utilization of resources between intraoperative angiography and IFVA when utilized with CABG.

Another commenter suggested that CMS should consider completely separating CABG procedures from cardiac catheterization. This commenter indicated that the concept is ''worthy of serious consideration because of its relationship to much larger issues in management of coronary artery disease.'' Other commenters recommended that CMS assign IFVA cases to the ''Other Cardiovascular MS–DRGs,'' MS–DRGs 228, 229, and 230.

We believe the requests to create new MS–DRGs in FY 2010 for CABG cases with intraoperative angiography and IFVA are outside the scope of the issues addressed in the proposed rule. The recommendation to move IFVA cases to Other Cardiovascular MS–DRGs 228, 229, and 230 is also out of scope issues addressed in the proposed rule. Therefore, we are not providing responses to these public comments in this final rule. We will consider the requests for new MS–DRGs regarding this topic during the FY 2011 rulemaking process.

c. Insertion of Gastrointestinal Stent

We received a public comment requesting that CMS analyze the need to create new MS–DRGs in FY 2011 to better capture patients who undergo the insertion of a gastrointestinal stent under MDC 6 (Diseases and Disorders of the Digestive System). The stents are inserted in the esophagus, duodenum, biliary tract, or the colon in order to reestablish or maintain patency of these vessels to allow swallowing, drainage, or passage of waste. The commenter requested that the new MS–DRGs be subdivided into three severity levels (with MCC, with CC, and without CC/MCC). The commenter stated it had data that showed cases with gastrointestinal stent insertions have higher costs than other cases within the same MS–DRGs. The commenter also stated that there are a small number of these cases, and acknowledged that there may be some concern about the need to establish new DRGs for such a small number of cases.

This comment relating to a request to create new MS–DRGs in FY 2011 for cases with gastrointestinal stents is outside the scope of the FY 2010 proposed rule. We will consider this request alone with other timely received requests for updates to the FY 2011 MS–DRGs during the FY 2011 rulemaking process. As we stated above, we encourage individuals with comments about MS–DRG classifications to submit these comments no later than early December of each year so they can be carefully considered for possible inclusion in the annual proposed rule and, if included, may be subjected to public review and comment.

H. Recalibration of MS–DRG Weights

In section II.E. of the preamble of this final rule, we state that we fully implemented the cost-based DRG relative weights for FY 2009, which was the third year in the 3-year transition period to calculate the relative weights at 100 percent based on costs. In the FY 2008 IPPS final rule with comment period (72 FR 47267), as recommended by RTI, for FY 2008, we added two new CCRs for a total of 15 CCRs: one for ''Emergency Room'' and one for ''Blood and Blood Products,'' both of which can be derived directly from the Medicare cost report.

As we proposed, in developing the FY 2010 system of weights, we used two data sources: claims data and cost report data. As in previous years, the claims data source is the MedPAR file. This file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2008 MedPAR data used in this final rule include discharges occurring on October 1, 2007, through September 30, 2008, based on bills received by CMS through March 31, 2009, from all hospitals subject to the IPPS and short-term, acute care hospitals in Maryland (which are under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2008 MedPAR file used in calculating the relative weights includes data for approximately 11,283,982 Medicare discharges from IPPS providers. Discharges for Medicare beneficiaries enrolled in a Medicare Advantage managed care plan are excluded from this analysis. The data exclude CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken. The second data source used in the cost-based relative weighting methodology is the FY 2007 Medicare cost report data files from HCRIS (that is, cost reports beginning on or after October 1, 2006, and before October 1, 2007), which represents the most recent full set of cost report data available. We used the March 31, 2009 update of the HCRIS cost report files for FY 2007 in setting the relative cost-based weights.

The methodology we used to calculate the DRG cost-based relative weights from the FY 2008 MedPAR claims data and FY 2007 Medicare cost report data is as follows:

- To the extent possible, all the claims were regrouped using the FY 2010 MS–DRG classifications discussed in sections II.B. and G. of the preamble of this final rule.
- The transplant cases that were used to establish the relative weights for heart and heart-lung, liver and/or intestinal, and lung transplants (MS–DRGs 001, 002, 005, 006, and 007, respectively) were limited to those Medicare-approved transplant centers that have cases in the FY 2008 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average cost for each MS–DRG and before eliminating statistical outliers.
- Claims with total charges or total lengths of stay less than or equal to zero were deleted. Claims that had an amount in the total charge field that differed by more than $10.00 from the sum of the routine day charges, intensive care charges, pharmacy charges, special equipment charges, therapy services charges, operating room charges, cardiology charges, laboratory charges, radiology charges, other service charges, labor and delivery charges, inhalation therapy charges, emergency room charges, blood charges, and anesthesia charges were also deleted.
- At least 95.9 percent of the providers in the MedPAR file had charges for 10 of the 15 cost centers. Claims for providers that did not have charges greater than zero for at least 10 of the 15 cost centers were deleted.
- Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the total charges per case and the total charges per day for each MS–DRG.
- Effective October 1, 2008, because hospital inpatient claims include a POA indicator field for each diagnosis

present on the claim, the POA indicator field was reset to ''Y'' for ''Yes'' just for relative weight-setting purposes for all claims that otherwise have an ''N'' (No) or a ''U'' (documentation insufficient to determine if the condition was present at the time of inpatient admission) in the POA field.

Under current payment policy, the presence of specific HAC codes, as indicated by the POA field values, can generate a lower payment for the claim. Specifically, if the particular condition is present on admission (that is, a ''Y'' indicator is associated with the diagnosis on the claim), then it is not a ''HAC,'' and the hospital is paid with the higher severity (and, therefore, the higher weighted MS–DRG). If the particular condition is *not* present on admission (that is, an ''N'' indicator is associated with the diagnosis on the claim) and there are no other complicating conditions, the DRG GROUPER assigns the claim to a lower severity (and, therefore, the lower weighted MS–DRG) as a penalty for allowing a Medicare inpatient to contract a ''HAC.'' While this meets policy goals of encouraging quality care and generates program savings, it presents an issue for the relative weight-setting process. Because cases identified as HACs are likely to be more complex than similar cases that are not identified as HACs, the charges associated with HACs are likely to be higher as well. Thus, if the higher charges of these HAC claims are grouped into lower severity MS–DRGs prior to the relative weight-setting process, the relative weights of these particular MS–DRGs would become artificially inflated, potentially skewing the relative weights. In addition, we want to protect the integrity of the budget neutrality process by ensuring that, in estimating payments, no increase to the standardized amount occurs as a result of lower overall payments in a previous year that stem from using weights and case-mix that are based on lower severity MS–DRG assignments. If this would occur, the anticipated cost savings from the HAC policy would be lost.

To avoid these problems, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24116), we proposed to reset the POA indicator field to ''Y'' just for relative weight-setting purposes for all claims that otherwise have an ''N'' or a ''U'' in the POA field. This ''forces'' the more costly HAC claims into the higher severity MS–DRGs as appropriate, and the relative weights calculated for each MS–DRG more closely reflect the true costs of those cases.

We did not receive any public comments on our proposal to reset the POA indicator field to ''Y'' for relative weight-setting purposes for all claims that otherwise have an ''N'' or a ''U'' in the POA field. We are finalizing this proposal for FY 2010 accordingly.

Once the MedPAR data were trimmed and the statistical outliers were removed, the charges for each of the 15 cost groups for each claim were standardized to remove the effects of differences in area wage levels, IME and DSH payments, and for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment. Because hospital charges include charges for both operating and capital costs, we standardized total charges to remove the effects of differences in geographic adjustment factors, cost-of-living adjustments, and DSH payments under the capital IPPS as well. Charges were then summed by MS–DRG for each of the 15 cost groups so that each MS–DRG had 15 standardized charge totals. These charges were then adjusted to cost by applying the national average CCRs developed from the FY 2007 cost report data.

The 15 cost centers that we used in the relative weight calculation are shown in the following table. The table shows the lines on the cost report and the corresponding revenue codes that we used to create the 15 national cost center CCRs.

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Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
Routine Days	Private Room Charges	011X and 014X		Adults & Pediatrics (General Routine Care)	C_1_C5_25	C_1_C6_25	D4_HOS_C2_25
	Semi-Private Room Charges	010X, 012X, 013X and 016X-019X				C_1_C7_25	D4_HOS_C2_26
	Ward Charges	015X					
Intensive Days	Intensive Care Charges	020X		Intensive Care Unit	C_1_C5_26	C_1_C6_26	D4_HOS_C2_26
						C_1_C7_26	
	Coronary Care Charges	021X		Coronary Care Unit	C_1_C5_27	C_1_C6_27	D4_HOS_C2_27
						C_1_C7_27	
				Burn Intensive Care Unit	C_1_C5_28	C_1_C6_28	D4_HOS_C2_28
						C_1_C7_28	
				Surgical Intensive Care Unit	C_1_C5_29	C_1_C6_29	D4_HOS_C2_29
						C_1_C7_29	
				Other Special Care Unit	C_1_C5_30	C_1_C6_30	D4_HOS_C2_30
						C_1_C7_30	
Drugs	Pharmacy Charges	025X, 026X and 063X		Intravenous Therapy	C_1_C5_48	C_1_C6_48	D4_HOS_C2_48

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
						C_1_C7_48	
				Drugs Charged To Patient	C_1_C5_56	C_1_C6_56	D4_HOS_C2_56
						C_1_C7_56	
Supplies and Equipment	Medical/Surgical Supply Charges	027X and 062X		Medical Supplies Charged to Patients	C_1_C5_55	C_1_C6_55	D4_HOS_C2_55
						C_1_C7_55	
	Durable Medical Equipment Charges	0290, 0291, 0292 and 0294-0299		DME-Rented	C_1_C5_66	C_1_C6_66	D4_HOS_C2_66
						C_1_C7_66	
	Used Durable Medical Charges	0293		DME-Sold	C_1_C5_67	C_1_C6_67	D4_HOS_C2_67
						C_1_C7_67	
Therapy Services	Physical Therapy Charges	042X		Physical Therapy	C_1_C5_50	C_1_C6_50	D4_HOS_C2_50
						C_1_C7_50	
	Occupational Therapy Charges	043X		Occupational Therapy	C_1_C5_51	C_1_C6_51	D4_HOS_C2_51
						C_1_C7_51	
	Speech Pathology Charges	044X and 047X		Speech Pathology	C_1_C5_52	C_1_C6_52	D4_HOS_C2_52

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
					C_1_C7_52	
Inhalation Therapy	Inhalation Therapy Charges	041X and 046X	Respiratory Therapy	C_1_C5_49	C_1_C6_49 C_1_C7_49	D4_HOS_C2_49
Operating Room For all DRGs but Labor & Delivery	Operating Room Charges	036X, 071X and 072X	Operating Room	C_1_C5_37	C_1_C6_37 C_1_C7_37	D4_HOS_C2_37
			Recovery Room	C_1_C5_38	C_1_C6_38 C_1_C7_38	D4_HOS_C2_38
Labor & Delivery **ONLY FOR THE 6 Labor & Delivery DRGs** **370, 371, 372, 373, 374, 375**	Operating Room Charges	036X, 071X and 072X	Delivery Room and Labor Room	C_1_C5_39	C_1_C6_39 C_1_C7_39	D4_HOS_C2_39
	Clinic Charges	051X	Obstetrics Clinic	C_1_C5_63	C_1_C6_63 C_1_C7_63	D4_HOS_C2_63
Anesthesia	Anesthesia Charges	037X	Anesthesi-ology	C_1_C5_40	C_1_C6_40	D4_HOS_C2_40

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
					C_1_C7_40	
Cardiology	Cardiology Charges	048X and 073X	Electro-cardiology	C_1_C5_53	C_1_C6_53	D4_HOS_C2_53
					C_1_C7_53	
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X	Laboratory	C_1_C5_44	C_1_C6_44	D4_HOS_C2_44
					C_1_C7_44	
			PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45	D4_HOS_C2_45
					C_1_C7_45	
			Electro-encep halography	C_1_C5_54	C_1_C6_54	D4_HOS_C2_54
					C_1_C7_54	
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X	Radiology - Diagnostic	C_1_C5_41	C_1_C6_41	D4_HOS_C2_41
					C_1_C7_41	
	MRI Charges	061X	Radiology - Therapeutic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42
			Radioisotope	C_1_C5_43	C_1_C6_43	D4_HOS_C2_43

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
						C_1_C7_43	
Emergency Room	Emergency Room Charges	045x		Emergency	C_1_C5_61	C_1_C6_61	D4_HOS_C2_61
						C_1_C7_61	
Blood and Blood Products	Blood Charges	038x		Whole Blood & Packed Red Blood Cells	C_1_C5_46	C_1_C6_46	D4_HOS_C2_46
						C_1_C7_46	
	Blood Storage / Processing	039x		Blood Storing, Processing, & Transfusing	C_1_C5_47	C_1_C6_47	D4_HOS_C2_47
						C_1_C7_47	
Other Services	Lithotripsy Charge	079X					
	Other Service Charge	0002-0099, 022X, 023X, 024X,052X,053X 055X-060X, 064X-070X, 076X-078X, 090X-095X and 099X					
				ASC (Non Distinct Part)	C_1_C5_58	C_1_C6_58	D4_HOS_C2_58
						C_1_C7_58	
	Outpatient Service Charges	049X and 050X		Other Ancillary	C_1_C5_59	C_1_C6_59	D4_HOS_C2_59
						C_1_C7_59	

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
				Clinic	C_1_C5_60	C_1_C6_60 C_1_C7_60	D4_HOS_C2_60
	Ambulance Charges	054X					
	ESRD Revenue Setting Charges	080X and 082X-088X		Observation beds	C_1_C5_62	C_1_C6_62 C_1_C7_62	D4_HOS_C2_62
	Clinic Visit Charges (excluding Labor & Delivery DRGs)	051X		Observation beds	C_1_C5_6201	C_1_C6_6201 C_1_C7_6201	D4_HOS_C2_6201
				Rural Health Clinic	C_1_C5_6350	C_1_C6_6350 C_1_C7_6350	D4_HOS_C2_6350
	Professional Fees Charges	096X, 097X, and 098X					
				FQHC	C_1_C5_6360	C_1_C6_6360 C_1_C7_6360	D4_HOS_C2_6360
				Home Program Dialysis	C_1_C5_64	C_1_C6_64 C_1_C7_64	D4_HOS_C2_64
				Ambulance	C_1_C5_65	C_1_C6_65 C_1_C7_65	D4_HOS_C2_65

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Worksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Worksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Worksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Worksheet D-4, Column & line number)
				Other Reimbursable	C_1_C5_68	C_1_C6_68 C_1_C7_68	D4_HOS_C2_68

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We developed the national average CCRs as follows:

Taking the FY 2007 cost report data, we removed CAHs, Indian Health Service hospitals, all-inclusive rate hospitals, and cost reports that represented time periods of less than 1 year (365 days). We included hospitals located in Maryland as we are including their charges in our claims database. We then created CCRs for each provider for each cost center (see prior table for line items used in the calculations) and removed any CCRs that were greater than 10 or less than 0.01. We normalized the departmental CCRs by dividing the CCR for each department by the total CCR for the hospital for the purpose of trimming the data. We then took the logs of the normalized cost center CCRs and removed any cost center CCRs where the log of the cost center CCR was greater or less than the mean log plus/minus 3 times the standard deviation for the log of that cost center CCR. Once the cost report data were trimmed, we calculated a Medicare-specific CCR. The Medicare-specific CCR was determined by taking the Medicare charges for each line item from Worksheet D–4 and deriving the Medicare-specific costs by applying the hospital-specific departmental CCRs to the Medicare-specific charges for each line item from Worksheet D–4. Once each hospital's Medicare-specific costs were established, we summed the total Medicare-specific costs and divided by the sum of the total Medicare-specific charges to produce national average, charge-weighted CCRs.

After we multiplied the total charges for each MS–DRG in each of the 15 cost centers by the corresponding national average CCR, we summed the 15 ''costs'' across each MS–DRG to produce a total standardized cost for the MS–DRG. The average standardized cost for each MS–DRG was then computed as the total standardized cost for the MS–DRG divided by the transfer-adjusted case count for the MS–DRG. The average cost for each MS–DRG was then divided by the national average standardized cost per case to determine the relative weight.

The new cost-based relative weights were then normalized by an adjustment factor of 1.54381 so that the average case weight after recalibration was equal to the average case weight before recalibration. The normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS, as required by section 1886(d)(4)(C)(iii) of the Act.

The 15 national average CCRs for FY 2010 are as follows:

Group	CCR
Routine Days	0.553
Intensive Days	0.480
Drugs	0.200
Supplies & Equipment	0.348
Therapy Services	0.415
Laboratory	0.163
Operating Room	0.282
Cardiology	0.181
Radiology	0.161
Emergency Room	0.278
Blood and Blood Products	0.424
Other Services	0.426
Labor & Delivery	0.462
Inhalation Therapy	0.201
Anesthesia	0.136

As we explained in section II.E. of the preamble of this final rule, we have completed our 2-year transition to the MS–DRGs. For FY 2008, the first year of the transition, 50 percent of the relative weight for an MS–DRG was based on the two-thirds cost-based weight/one-third charge-based weight calculated using FY 2006 MedPAR data grouped to the Version 24.0 (FY 2007) DRGs. The remaining 50 percent of the FY 2008 relative weight for an MS–DRG was based on the two-thirds cost-based weight/one-third charge-based weight calculated using FY 2006 MedPAR grouped to the Version 25.0 (FY 2008) MS–DRGs. In FY 2009, the relative weights were based on 100 percent cost weights computed using the Version 26.0 (FY 2009) MS–DRGs.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24123), we proposed to use that same case threshold in recalibrating the MS–DRG weights for FY 2010. Using the FY 2008 MedPAR data set, there are 8 MS–DRGs that contain fewer than 10 cases. Under the MS–DRGs, we have fewer low-volume DRGs than under the CMS DRGs because we no longer have separate DRGs for patients age 0 to 17 years. With the exception of newborns, we previously separated some DRGs based on whether the patient was age 0 to 17 years or age 17 years and older. Other than the age split, cases grouping to these DRGs are identical. The DRGs for patients age 0 to 17 years generally have very low volumes because children are typically ineligible for Medicare. In the past, we have found that the low volume of cases for the pediatric DRGs could lead to significant year-to-year instability in their relative weights. Although we have always encouraged non-Medicare payers to develop weights applicable to their own patient populations, we have heard frequent complaints from providers about the use of the Medicare relative weights in the pediatric population. We believe that eliminating this age split in the MS–DRGs will provide more stable payment for pediatric cases by determining their payment using adult cases that are much higher in total volume. Newborns are unique and require separate MS–DRGs that are not mirrored in the adult population. Therefore, it remains necessary to retain separate MS–DRGs for newborns. All of the low-volume MS–DRGs listed below are for newborns. In FY 2010, because we do not have sufficient MedPAR data to set accurate and stable cost weights for these low-volume MS–DRGs, we proposed to compute weights for the

low-volume MS–DRGs by adjusting their FY 2009 weights by the percentage change in the average weight of the cases in other MS–DRGs. The crosswalk table is shown below:

Low-volume MS–DRG	MS–DRG title	Crosswalk to MS–DRG
768	Vaginal Delivery with O.R. Procedure Except Sterilization and/or D&C.	FY 2009 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
789	Neonates, Died or Transferred to Another Acute Care Facility	FY 2009 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate.	FY 2009 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
791	Prematurity with Major Problems	FY 2009 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
792	Prematurity without Major Problems	FY 2009 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
793	Full-Term Neonate with Major Problems	FY 2009 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
794	Neonate with Other Significant Problems	FY 2009 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
795	Normal Newborn	FY 2009 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).

Comment: Some commenters questioned whether Medicare Advantage claims were used to calculate the MS–DRG relative weights for FY 2010 in the proposed rule. The commenters noted that CMS' policy has been to exclude Medicare Advantage claims from the relative weights calculation, but believed that CMS may have inadvertently included those claims in the calculation in the proposed rule. The commenters believed that if the Medicare Advantage claims were included, the amount paid under the IPPS will be overstated. The commenters recommended that CMS ensure that Medicare Advantage claims are excluded from the relative weights calculation. However, the commenters requested that CMS continue to include the Medicare Advantage claims in the MedPAR dataset for analysis purposes.

Response: Historically, we have excluded data from Medicare Advantage claims from the calculation of the relative weights. As has been stated in the preamble of previous IPPS rules and, most recently, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24115), ''Discharges for Medicare beneficiaries enrolled in a Medicare Advantage managed care plan are excluded from this analysis.'' Consistent with this language, in the FY 2010 proposed rule, we intended to exclude Medicare Advantage claims from the calculation of the relative weights for FY 2010 as well. However, the December 2008 update of the FY 2008 MedPAR data that was used as the source for calculating the relative weights contained a significant number of Medicare Advantage claims. This inclusion is a result of hospitals being required to submit informational only claims for all Medicare Advantage patients they treated for discharges occurring on or after October 1, 2006, under Change Request 5647, Transmittal 1311. As a result, we inadvertently included claims from discharges of patients enrolled in Medicare Advantage plans in the calculation of the proposed FY 2010 relative weights. We have corrected this oversight in the calculation of the final FY 2010 relative weights and, therefore, no Medicare Advantage claims data are included in the calculations in this final rule. Specifically, we added an edit to the relative weight calculation to remove any claims that have a GHO_Paid indicator value of ''1,'' which effectively removes Medicare Advantage claims from the relative weights calculations. We are continuing to include Medicare Advantage claims in the Expanded Modified MedPAR file that is available to researchers for purchase under a data use agreement with CMS.

We did not receive any public comments on this section. Therefore, we are adopting the national average CCRs as proposed, with the MS–DRG weights recalibrated based on these CCRs.

I. Add-On Payments for New Services and Technologies

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as ''new technologies'') under the IPPS. Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered new if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the process must apply to a new medical service or technology if, ''based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.'' We note that beginning with FY 2008, CMS transitioned from CMS–DRGs to MS–DRGs.

The regulations implementing these provisions specify three criteria for a new medical service or technology to receive an additional payment: (1) The medical service or technology must be new; (2) the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies. These three criteria are explained below in the ensuing paragraphs in further detail.

Under the first criterion, as reflected in 42 CFR 412.87(b)(2), a specific medical service or technology will be considered ''new'' for purposes of new medical service or technology add-on payments until such time as Medicare data are available to fully reflect the cost of the technology in the MS–DRG weights through recalibration. Typically, there is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market (generally on the date that the technology receives FDA approval/clearance) and when data reflecting the use of the medical service or technology

are used to calculate the MS–DRG weights. For example, data from discharges occurring during FY 2008 are used to calculate the FY 2010 MS–DRG weights in this final rule. Section 412.87(b)(2) of the regulations therefore provides that ''a medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered 'new' under the criterion for this section.''

The 2-year to 3-year period during which a medical service or technology can be considered new would ordinarily begin on the date on which the medical service or technology received FDA approval or clearance. (We note that, for purposes of this section of the final rule, we generally refer to both FDA approval and FDA clearance as FDA ''approval.'') However, in some cases, initially there may be no Medicare data available for the new service or technology following FDA approval. For example, the newness period could extend beyond the 2-year to 3-year period after FDA approval is received in cases where the product initially was generally unavailable to Medicare patients following FDA approval, such as in cases of a national noncoverage determination or a documented delay in bringing the product onto the market after that approval (for instance, component production or drug production has been postponed following FDA approval due to shelf life concerns or manufacturing issues). After the MS–DRGs have been recalibrated to reflect the costs of an otherwise new medical service or technology, the medical service or technology is no longer eligible for special add-on payment for new medical services or technologies (as specified under § 412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2008 and entered the market at that time may be eligible to receive add-on payments as a new technology for discharges occurring before October 1, 2011 (the start of FY 2012). Because the FY 2012 MS–DRG weights would be calculated using FY 2010 MedPAR data, the costs of such a new technology would be fully reflected in the FY 2012 MS–DRG weights. Therefore, the new technology would no longer be eligible to receive add-on payments as a new technology for discharges occurring in FY 2012 and thereafter.

Under the second criterion, § 412.87(b)(3) further provides that, to be eligible for the add-on payment for new medical services or technologies, the MS–DRG prospective payment rate otherwise applicable to the discharge involving the new medical services or technologies must be assessed for adequacy. Under the cost criterion, to assess the adequacy of payment for a new technology paid under the applicable MS–DRG prospective payment rate, we evaluate whether the charges for cases involving the new technology exceed certain threshold amounts. In the FY 2004 IPPS final rule (68 FR 45385), we established the threshold at the geometric mean standardized charge for all cases in the MS–DRG plus 75 percent of 1 standard deviation above the geometric mean standardized charge (based on the logarithmic values of the charges and converted back to charges) for all cases in the MS–DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant MS–DRGs, if the new medical service or technology occurs in more than one MS–DRG).

However, section 503(b)(1) of Public Law 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide that, beginning in FY 2005, CMS will apply ''a threshold * * * that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved.'' (We refer readers to section IV.D. of the preamble to the FY 2005 IPPS final rule (69 FR 49084) for a discussion of the revision of the regulations to incorporate the change made by section 503(b)(1) of Pub. L. 108–173.) Table 10 that was included in the notice published in the **Federal Register** on October 3, 2008, contains the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2010 (73 FR 57888).

We note that section 124 of Public Law 110–275 extended, through FY 2009, wage index reclassifications under section 508 of Public Law 108–173 (the MMA) and special exceptions contained in the final rule promulgated in the **Federal Register** on August 11, 2004 (69 FR 49105 and 49107) and extended under section 117 of Public Law 110–173 (the MMSEA). The wage data affect the standardized amounts (as well as the outlier offset and budget neutrality factors that are applied to the standardized amounts), which we use to compute the cost criterion thresholds. Therefore, the thresholds reflected in Table 10 in the Addendum to the FY 2009 IPPS final rule were tentative. As noted earlier, on October 3, 2008, we published a **Federal Register** notice (73 FR 57888) that contained a new Table 10 with revised thresholds that reflect the wage index rates for FY 2009 as a result of implementation of section 124 of Public Law 110–275. The revised thresholds also were published on the CMS Web site. The revised thresholds published in Table 10 in the October 3, 2008 **Federal Register** notice were used to determine if an applicant for new technology add-on payments discussed in this FY 2010 final rule met the cost criterion threshold for new technology add-on payments for FY 2010.

In the September 7, 2001 final rule that established the new technology add-on payment regulations (66 FR 46917), we discussed the issue of whether the HIPAA Privacy Rule at 45 CFR parts 160 and 164 applies to claims information that providers submit with applications for new technology add-on payments. Specifically, we explained that health plans, including Medicare, and providers that conduct certain transactions electronically, including the hospitals that would be receiving payment under the FY 2001 IPPS final rule, are required to comply with the HIPAA Privacy Rule. We further explained how such entities could meet the applicable HIPAA requirements by discussing how the HIPAA Privacy Rule permitted providers to share with health plans information needed to ensure correct payment, if they had obtained consent from the patient to use that patient's data for treatment, payment, or health care operations. We also explained that, because the information to be provided within applications for new technology add-on payment would be needed to ensure correct payment, no additional consent would be required. The HHS Office for Civil Rights has since amended the HIPAA Privacy Rule, but the results remain. The HIPAA Privacy Rule no longer requires covered entities to obtain consent from patients to use or disclose protected health information for treatment, payment, or health care operations, and expressly permits such entities to use or to disclose protected health information for any of these purposes. (We refer readers to 45 CFR 164.502(a)(1)(ii), and 164.506(c)(1) and (c)(3), and the Standards for Privacy of Individually

Identifiable Health Information published in the **Federal Register** on August 14, 2002, for a full discussion of changes in consent requirements.)

Under the third criterion, § 412.87(b)(1) of our existing regulations provides that a new technology is an appropriate candidate for an additional payment when it represents ''an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.'' For example, a new technology represents a substantial clinical improvement when it reduces mortality, decreases the number of hospitalizations or physician visits, or reduces recovery time compared to the technologies previously available. (We refer readers to the September 7, 2001 final rule for a complete discussion of this criterion (66 FR 46902).)

The new medical service or technology add-on payment policy under the IPPS provides additional payments for cases with relatively high costs involving eligible new medical services or technologies while preserving some of the incentives inherent under an average-based prospective payment system. The payment mechanism is based on the cost to hospitals for the new medical service or technology. Under § 412.88, if the costs of the discharge (determined by applying cost to charge ratios (''CCRs'') as described in § 412.84(h)) exceed the full DRG payment (including payments for IME and DSH, but excluding outlier payments), Medicare will make an add-on payment equal to the lesser of: (1) 50 percent of the estimated costs of the new technology (if the estimated costs for the case including the new technology exceed Medicare's payment); or (2) 50 percent of the difference between the full DRG payment and the hospital's estimated cost for the case. Unless the discharge qualifies for an outlier payment, Medicare payment is limited to the full MS–DRG payment plus 50 percent of the estimated costs of the new technology.

Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual MS–DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, in the past, we accounted for projected payments under the new medical service and technology provision during the upcoming fiscal year, while at the same time estimating the payment effect of changes to the MS–DRG classifications and recalibration. The impact of additional payments under this provision was then included in the budget neutrality factor, which was applied to the standardized amounts and the hospital-specific amounts. However, section 503(d)(2) of Public Law 108–173 provides that there shall be no reduction or adjustment in aggregate payments under the IPPS due to add-on payments for new medical services and technologies. Therefore, following section 503(d)(2) of Public Law 108–173, add-on payments for new medical services or technologies for FY 2005 and later years have not been subjected to budget neutrality.

In the FY 2009 IPPS final rule (73 FR 48561 through 48563), we modified our regulations at § 412.87 to codify our current practice of how CMS evaluates the eligibility criteria for new medical service or technology add-on payment applications. We also amended § 412.87(c) to specify that all applicants for new technology add-on payments must have FDA approval for their new medical service or technology by July 1 of each year prior to the beginning of the fiscal year that the application is being considered.

Applicants for add-on payments for new medical services or technologies for FY 2011 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate that the medical service or technology meets the high-cost threshold. Complete application information, along with final deadlines for submitting a full application, will be posted as it becomes available on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp*. To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2011, the Web site also will list the tracking forms completed by each applicant.

The Council on Technology and Innovation (CTI) at CMS oversees the agency's cross-cutting priority on coordinating coverage, coding and payment processes for Medicare with respect to new technologies and procedures, including new drug therapies, as well as promoting the exchange of information on new technologies between CMS and other entities. The CTI, composed of senior CMS staff and clinicians, was established under section 942(a) of Public Law 108–173. The Council is co-chaired by the Director of the Office of Clinical Standards and Quality (OCSQ) and the Director of the Center for Medicare Management (CMM), who is also designated as the CTI's Executive Coordinator.

The specific processes for coverage, coding, and payment are implemented by CMM, OCSQ, and the local claims-payment contractors (in the case of local coverage and payment decisions). The CTI supplements, rather than replaces, these processes by working to assure that all of these activities reflect the agency-wide priority to promote high-quality, innovative care. At the same time, the CTI also works to streamline, accelerate, and improve coordination of these processes to ensure that they remain up to date as new issues arise. To achieve its goals, the CTI works to streamline and create a more transparent coding and payment process, improve the quality of medical decisions, and speed patient access to effective new treatments. It is also dedicated to supporting better decisions by patients and doctors in using Medicare-covered services through the promotion of better evidence development, which is critical for improving the quality of care for Medicare beneficiaries.

CMS plans to continue its Open Door forums with stakeholders who are interested in CTI's initiatives. In addition, to improve the understanding of CMS' processes for coverage, coding, and payment and how to access them, the CTI has developed an ''innovator's guide'' to these processes. The intent is to consolidate this information, much of which is already available in a variety of CMS documents and in various places on the CMS Web site, in a user-friendly format. This guide was published in August 2008 and is available on the CMS Web site at: *http://www.cms.hhs.gov/CouncilonTechInnov/Downloads/InnovatorsGuide8_25_08.pdf*.

As we indicated in the FY 2009 IPPS final rule (73 FR 48554), we invite any product developers or manufacturers of new medical technologies to contact the agency early in the process of product development if they have questions or concerns about the evidence that would be needed later in the development process for the agency's coverage decisions for Medicare.

The CTI aims to provide useful information on its activities and initiatives to stakeholders, including Medicare beneficiaries, advocates, medical product manufacturers, providers, and health policy experts. Stakeholders with further questions about Medicare's coverage, coding, and payment processes, or who want further

guidance about how they can navigate these processes, can contact the CTI at *CTI@cms.hhs.gov* or from the ''Contact Us'' section of the CTI home page (*http://www.cms.hhs.gov/CouncilonTechInnov/*).

Comment: One commenter recommended that CMS deem a device to be a substantial clinical improvement ''* * * if it has been granted a humanitarian device exemption or priority review based on the fact that it represents breakthrough technologies, that offer significant advantages over existing approved alternatives, for which no alternatives exist, or the availability of which is in the best interests of the patients.''

Response: As stated in the FY 2008 IPPS final rule (72 FR 47302), the FDA provides a number of different types of approvals to devices, drugs and other medical products. At this time, we do not believe that any particular type of FDA approval alone would automatically demonstrate a substantial clinical improvement for the Medicare population. However, as noted in previous final rules, we do take FDA approval into consideration in our evaluation of new technology applications. We note that a Humanitarian Device Exemption (HDE) approval only requires that ''the probable benefit outweighs the risk of injury or illness'' as opposed to the safety and effectiveness standard that exists for pre-market approval (PMA). Among other requirements, the labeling of a humanitarian use device must state that the effectiveness of the device for the specific indication has not been demonstrated. While an HDE approval certainly does not preclude us from considering a technology for an add-on payment, neither does it suggest that the product automatically meets the requirement to be judged a substantial clinical improvement. Under the substantial clinical improvement criterion, we will continue to evaluate a technology with an HDE approval by measuring it against the specific criteria we listed for determining substantial clinical improvement at 66 FR 46914.

Comment: A number of commenters addressed topics relating to the marginal cost factor for the new technology add-on payment, the potential implementation of ICD–10–CM, the use of external data in determining the cost threshold, paying new technology add-on payments for two to three years, mapping new technologies to the appropriate MS–DRG and the use of the date that a ICD–9–CM code is assigned to a technology or the FDA approval date (whichever is later) as the start of the newness period.

Response: We did not request public comments nor propose to make any changes to any of the issues summarized above. Because these comments are outside of the scope of the provisions included in the proposed rule, we are not providing a complete summary of the comments or responding to them in this final rule.

2. Public Input Before Publication of a Notice of Proposed Rulemaking on Add-On Payments

Section 1886(d)(5)(K)(viii) of the Act, as amended by section 503(b)(2) of Public Law 108–173, provides for a mechanism for public input before publication of a notice of proposed rulemaking regarding whether a medical service or technology represents a substantial clinical improvement or advancement. The process for evaluating new medical service and technology applications requires the Secretary to—

- Provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of Medicare beneficiaries;
- Make public and periodically update a list of the services and technologies for which applications for add-on payments are pending;
- Accept comments, recommendations, and data from the public regarding whether a service or technology represents a substantial clinical improvement; and
- Provide, before publication of a proposed rule, for a meeting at which organizations representing hospitals, physicians, manufacturers, and any other interested party may present comments, recommendations, and data regarding whether a new medical service or technology represents a substantial clinical improvement to the clinical staff of CMS.

In order to provide an opportunity for public input regarding add-on payments for new medical services and technologies for FY 2010 prior to publication of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we published a notice in the **Federal Register** on November 28, 2008 (73 FR 72490), and held a town hall meeting at the CMS Headquarters Office in Baltimore, MD, on February 17, 2009. In the announcement notice for the meeting, we stated that the opinions and alternatives provided during the meeting would assist us in our evaluations of applications by allowing public discussion of the substantial clinical improvement criterion for each of the FY 2010 new medical service and technology add-on payment applications before the publication of the FY 2010 IPPS proposed rule.

Approximately 90 individuals registered to attend the town hall meeting in person, while additional individuals listened over an open telephone line. Each of the five FY 2010 applicants presented information on its technology, including a discussion of data reflecting the substantial clinical improvement aspect of the technology. We considered each applicant's presentation made at the town hall meeting, as well as written comments submitted on each applicant's application, in our evaluation of the new technology add-on applications for FY 2010 in the FY 2010 proposed rule and in this final rule.

In response to the published notice and the new technology town hall meeting, we received two written comments regarding applications for FY 2010 new technology add-on payments. We summarized these comments or, if applicable, indicated that there were no comments received, at the end of each discussion of the individual applications in the FY 2010 IPPS/RY LTCH PPS proposed rule. We did not receive any general comments about the application of the substantial clinical improvement criterion.

A further discussion of our evaluation of the applications and the documentation for new technology add-on payments submitted for FY 2010 approval is provided under the specified areas under this section.

3. FY 2010 Status of Technologies Approved for FY 2009 Add-On Payments

We approved one application for new technology add-on payments for FY 2009: CardioWest™ Temporary Total Artificial Heart System (CardioWest™ TAH–t).

SynCardia Systems, Inc. submitted an application for approval of the CardioWest™ temporary Total Artificial Heart system (TAH–t). The TAH–t is a technology that is used as a bridge to heart transplant device for heart transplant-eligible patients with end-stage biventricular failure. The TAH–t pumps up to 9.5 liters of blood per minute. This high level of perfusion helps improve hemodynamic function in patients, thus making them better heart transplant candidates.

The TAH–t was approved by the FDA on October 15, 2004, for use as a bridge to transplant device in cardiac transplant-eligible candidates at risk of imminent death from biventricular failure. The TAH–t is intended to be

used in hospital inpatients. One of the FDA's post-approval requirements is that the manufacturer agrees to provide a post-approval study demonstrating success of the device at one center can be reproduced at other centers. The study was to include at least 50 patients who would be followed up to 1 year, including (but not limited to) the following endpoints: survival to transplant; adverse events; and device malfunction.

In the past, Medicare did not cover artificial heart devices, including the TAH–t. However, on May 1, 2008, CMS issued a final national coverage determination (NCD) expanding Medicare coverage of artificial hearts when they are implanted as part of a study that is approved by the FDA and is determined by CMS to meet CMS' Coverage with Evidence Development (CED) clinical research criteria. (The final NCD is available on the CMS Web site at: *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=211*.)

We indicated in the FY 2009 IPPS final rule (73 FR 48555) that, because Medicare's previous coverage policy with respect to this device had precluded payment from Medicare, we did not expect the costs associated with this technology to be currently reflected in the data used to determine the relative weights of MS–DRGs. As we have indicated in the past, and as we discussed in the FY 2009 IPPS final rule, although we generally believe that the newness period would begin on the date that FDA approval was granted, in cases where the applicant can demonstrate a documented delay in market availability subsequent to FDA approval, we would consider delaying the start of the newness period. This technology's situation represented such a case. We also noted that section 1886(d)(5)(K)(ii)(II) of the Act requires that we provide for the collection of cost data for a new medical service or technology for a period of at least 2 years and no more than 3 years ''beginning on the date on which an inpatient hospital code is issued with respect to the service or technology.'' Furthermore, the statute specifies that the term ''inpatient hospital code'' means any code that is used with respect to inpatient hospital services for which payment may be made under the IPPS and includes ICD–9–CM codes and any subsequent revisions. Although the TAH–t has been described by the ICD–9–CM code(s) since the time of its FDA approval, because the TAH–t had not been covered under the Medicare program (and, therefore, no Medicare payment had been made for this technology), this code could not be ''used with respect to inpatient hospital services for which payment'' is made under the IPPS, and thus we assumed that none of the costs associated with this technology would be reflected in the Medicare claims data used to recalibrate the MS–DRG relative weights for FY 2009. For this reason, as discussed in the FY 2009 IPPS final rule, despite the FDA approval date of the technology, we determined that TAH–t would still be eligible to be considered ''new'' for purposes of the new technology add-on payment because the TAH–t met the newness criterion on the date that Medicare coverage began, consistent with issuance of the final NCD, effective on May 1, 2008.

After evaluation of the newness, costs, and substantial clinical improvement criteria for new technology add-on payments for the TAH–t and consideration of the public comments we received on the FY 2009 IPPS proposed rule, we approved the TAH–t for new technology add-on payments for FY 2009 (73 FR 48557). We indicated that we believed the TAH–t offered a new treatment option that previously did not exist for patients with end-stage biventricular failure. However, we indicated that we recognized that Medicare coverage of the TAH–t is limited to approved clinical trial settings. The new technology add-on payment status does not negate the restrictions under the NCD nor does it obviate the need for continued monitoring of clinical evidence for the TAH–t. We remain interested in seeing whether the clinical evidence demonstrates that the TAH–t continues to be effective. If evidence is found that the TAH–t may no longer offer a substantial clinical improvement, we reserve the right to discontinue new technology add-on payments, even within the 2 to 3 year period that the device may still be considered to be new.

The new technology add-on payment for the TAH–t for FY 2009 is triggered by the presence of ICD–9–CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and the diagnosis code reflecting clinical trial—V70.7 (Examination of participant in clinical trial). For FY 2009, we finalized a maximum add-on payment of $53,000 (that is, 50 percent of the estimated operating costs of the device of $106,000) for cases that involve this technology. As noted above, the TAH–t is still eligible to be considered ''new'' for purposes of the new technology add-on payment because the TAH–t met the newness criterion on the date that Medicare coverage began, consistent with issuance of the final NCD, effective on May 1, 2008.

We did not receive any public comments on our proposal to continue new technology add-on payments for the TAH–t for FY 2010. Therefore, as we proposed, for FY 2010, we are continuing the new technology add-on payments for cases involving the TAH–t in FY 2010 with a maximum add-on payment of $53,000.

4. FY 2010 Applications for New Technology Add-On Payments

We received six applications to be considered for new technology add-on payment for FY 2010. However, one applicant, Emphasys Medical, withdrew its application for the Zephyr® Endobronchial Valve (Zephyr® EBV) prior to the publication of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. Since the Zephyr® EBV application was withdrawn prior to the town hall meeting and publication of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we did not discuss the application in the proposed rule and also will not discuss it in this final rule.

During the public comment period, three additional applicants withdrew their applications from further consideration for FY 2010 new technology add-on payments. A discussion and final determination of the remaining two applications is presented below.

a. The AutoLITT™ System

Monteris Medical submitted an application for new technology add-on payments for FY 2010 for the AutoLITT™. However, the applicant withdrew its application for new technology add-on payments during the public comment period.

Comment: One commenter supported the AutoLITT™ application. The commenter stated that AutoLITT™ represented an advance because it provides the ability to ''steer and rotate the beam to the size and shape of the tumor'' and that such ability is a significant advance from the current non-directional systems. The commenter noted that it had ''no longitudinal or systemic studies to verify precisely the degree of improvement in patient care,'' but that use of the AutoLITT™ had led to a quicker recovery time and fewer complications in its experience with the device. Specifically, the commenter stated that it was able to discharge patients within 24 to 48 hours which is faster than with traditional therapies.

Response: We appreciate the commenter's response to the proposed

rule. We note again that the applicant withdrew its application from consideration for new technology add-on payments for FY 2010. Accordingly, we are not providing a response to the comment.

b. CLOLAR® (Clofarabine) Injection

Genzyme Oncology submitted an application for new technology add-on payments for FY 2010 for CLOLAR® (clofarabine) injection. However, the applicant withdrew its application for new technology add-on payments during the public comment period. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule in section II.I.4.b. of the preamble, we included a detailed discussion relating to our policy for determining whether a new technology is substantially similar to an existing technology in our analysis of whether CLOLAR would meet the newness criterion. Because the CLOLAR application has been withdrawn, we will not make a determination regarding substantially similarity to determine newness for that application. Instead, we have provided our discussion of substantial similarity below and have summarized and responded to comments received on that topic.

Substantial Similarity Discussion

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we stated that the newness criterion is intended to apply to technologies that have been available to Medicare beneficiaries for no more than 2 to 3 years. Therefore, a technology that applies for a supplemental FDA approval must demonstrate that the new approval is not substantially similar to the prior approval.

As discussed above, the new technology add-on payment is available to new medical services or technologies that satisfy the three criteria set forth in our regulations at § 412.87(b) (that is, newness, high-costs, and substantial clinical improvement). Typically, we begin our analysis with an evaluation of whether an applicant's technology meets what we refer to as the ''newness criterion'' under § 412.87(b)(2) (that is, whether Medicare data are available to fully reflect the cost of the technology in the MS–DRG weights through recalibration). Generally, we believe that the costs of a technology begin to be reflected in the hospital charge data used to recalibrate the MS–DRG relative weights when the technology becomes available on the market, usually on or soon after the date on which it receives FDA approval.

Congress provided for the new technology add-on payment in order to ensure that Medicare beneficiaries have access to new technologies. As discussed previously, there often is a lag time of 2 to 3 years before the costs of new technologies are reflected in the recalibration of the relevant MS–DRGs. Because a new technology often has higher costs than existing technologies, during this lag time the current MS–DRG payment may not adequately reflect the costs of the new technology. The new technology add-on payment addresses this concern by ensuring that hospitals receive an add-on payment under the IPPS for costly new technologies that represent a substantial clinical improvement over existing technologies until such time when the cost of the technology is reflected within the MS–DRG relative weights. When an existing technology receives FDA approval for a new indication, similar concerns may arise. If, prior to the FDA approval for the new indication, the technology has not been used to treat Medicare patients for purposes consistent with the new indication, the relevant MS–DRGs may not reflect the cost of the technology. Consequently, Medicare beneficiaries may not have adequate access to the technology when used for purposes consistent with the new indication. Allowing the new technology add-on payment for the technology when used for the new indication would address this concern. For these reasons, we believe that treating an existing technology as ''new'' when approved by the FDA for a new indication may be warranted under certain circumstances.

In the September 7, 2001 final rule (66 FR 46915), we stated that a new use of an existing technology may be eligible for the new technology add-on payment under certain conditions. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we stated that we believe it is appropriate to consider an existing technology for the new technology add-on payments when its new use is not substantially similar to existing uses of the technology. In the FY 2006 IPPS final rule (70 FR 47351), we explained our policy regarding substantial similarity in detail and its relevance for assessing if the hospital charge data used in the development of the relative weights for the relevant DRGs reflect the costs of the technology. In that final rule, we stated that, for determining substantial similarity, we consider (1) whether a product uses the same or a similar mechanism of action to achieve a therapeutic outcome, and (2) whether a product is assigned to the same or a different DRG. We indicated that both of the above criteria should be met in order for a technology to be considered ''substantially similar'' to an existing technology. However, in that same final rule, we also noted that, due to the complexity of issues regarding the substantial similarity component of the newness criterion, it may be necessary to exercise flexibility when considering whether technologies are substantially similar to one another. Specifically, we stated that we may consider additional factors depending on the circumstances specific to each application.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we stated that we believe that in determining whether a new use of an existing technology is substantially similar to existing uses of the technology, it may be relevant to consider not only the two criteria discussed in the FY 2006 IPPS final rule, but also certain additional factors. Specifically, we stated that it may also be appropriate to analyze whether, as compared to existing uses of the technology, the new use involves the treatment of the same or similar type of disease and the same or similar patient population. Accordingly, we proposed to add a third factor of consideration to our analysis of whether a new technology is substantially similar to one or more existing technologies. Specifically, we proposed to consider whether the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population (74 FR 24130) in addition to considering the already established factors described in the FY 2006 IPPS final rule. We explained that if all three components are present and the new use is deemed substantially similar to one or more of the existing uses of the technology (that is beyond the newness period), we would conclude that the technology is not new and, therefore, is not eligible for the new technology add-on payment. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we noted that we considered, but rejected, the inclusion of the third factor in the FY 2006 IPPS final rule on the grounds that we believed that it was more relevant to analyze whether the costs of the technology were already reflected in the relative weights of the MS–DRGs. However, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we stated that upon further consideration, we believe that both the type of disease and patient population for which a technology is used are also relevant in determining whether one indication of a technology is ''substantially similar'' to another.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we noted that the discussion of substantial similarity in the FY 2006 IPPS final rule related to

comparing two separate technologies made by different manufacturers. Nevertheless, we stated that the criteria discussed in the FY 2006 IPPS final rule also are relevant when comparing the similarity between a new use and existing uses of the same technology (or a very similar technology manufactured by the same manufacturer). In other words, we stated that it is necessary to establish that the new indication for which the technology has received FDA approval is not substantially similar to that of the prior indication. We explained that such a distinction is necessary to determine the appropriate start date of the newness period in evaluating whether the technology would qualify for add-on payments (that is, the date of the ''new'' FDA approval or that of the prior approval), or whether the technology could qualify for separate new technology add-on payments under each indication.

Comment: Several commenters supported our proposal to add a third factor of consideration to our analysis of whether a technology is substantially similar to another technology or to a previous version of the same technology with a new FDA indication. The commenters commended CMS for proposing to add the third factor and encouraged CMS to apply all three factors to future decisions regarding proposed new technologies. One commenter encouraged CMS to consider codifying all three substantial similarity factors in the regulations. Another commenter asked that CMS clarify whether the proposed criterion applied both to products that receive a second or follow-on indication as well as to separate and distinct products that have the same or similar mechanism of action, but are intended to treat a separate disease or patient population. The commenter also noted that, in FY 2006, it recommended that CMS include an additional factor when determining whether products were substantially similar, specifically, whether the products conferred the same level of substantial clinical improvement. The commenter asserted that the addition of this would ''ensure that products found to represent a true advancement in clinical care—even if they utilize a similar mechanism of action, could be eligible for new technology add-on payments.''

Response: We thank the commenters for their support of our proposal.

In response to the comment asking for clarification about whether the proposed additional factor under substantial similarity would apply solely to a technology approved for a new indication or to two separate and distinct products, we refer the commenter to our discussion above in which we stated, ''the discussion of substantial similarity in the FY 2006 IPPS final rule related to comparing two separate technologies made by different manufacturers. Nevertheless, we believe the criteria discussed in the FY 2006 IPPS final rule also are relevant when comparing the similarity between a new use and existing uses of the same technology (or a very similar technology manufactured by the same manufacturer). In other words, we believe that it is necessary to establish that the new indication for which the technology has received FDA approval is not substantially similar to that of the prior indication.'' Therefore, all three factors of substantial similarity will apply in both scenarios.

In response to the comment that suggested we analyze whether two products (or one product with two different indications) confer the same level of substantial clinical improvement, we note that substantial similarity is considered under the newness criterion (that is, to determine if a technology may still be considered ''new'' for purposes of the new technology add-on payment). As we stated in FY 2006 final IPPS rule, we base our decisions about new technology add-on payments on a logical sequence of determinations moving from the newness criterion to the cost criterion and finally to the substantial clinical improvement criterion. Specifically, we do not make determinations about substantial clinical improvement unless a product has already been determined to be new and to meet the cost criterion. Therefore, we are reluctant to import substantial clinical improvement considerations into the logical prior decision about whether technologies are new. Furthermore, while we make separate determinations about whether similar products meet the substantial clinical improvement criterion, we do not believe that it would be appropriate to make determinations about whether one product or another is clinically superior.

In response to the comment that suggested that we codify the factors we use to evaluate substantial similarity, we note that we did not propose to amend the new technology add-on regulations in the proposed rule. However, we will consider making such a proposal in a future rulemaking period.

We are finalizing our proposal to add a third factor of consideration to our analysis of whether a new technology is substantially similar to one or more existing technologies. Specifically, in making a determination of whether a new technology is substantially similar to an existing technology, we will consider whether the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population (74 FR 24130), in addition to considering the already established factors described in the FY 2006 IPPS final rule (that is, (1) whether a product uses the same or a similar mechanism of action to achieve a therapeutic outcome; and (2) whether a product is assigned to the same or a different DRG).

c. LipiScan™ Coronary Imaging System

InfraReDx, Inc. submitted an application for new technology add-on payments for FY 2010 for the LipiScan™ Coronary Imaging System (LipiScan™). The LipiScan™ device is a diagnostic tool that uses Intravascular Near Infrared Spectroscopy (INIRS) during a cardiac catheterization to scan the artery wall in order to determine coronary plaque composition. The purpose of the device is to identify lipid-rich areas in the artery because such areas have been shown to be more prone to rupture. The procedure does not require flushing or occlusion of the artery. INIRS identifies the chemical content of plaque by focusing near infrared light at the vessel wall and measuring reflected light at different wavelengths (that is, spectroscopy). The LipiScan™ system collects approximately 1,000 measurements per 12.5 mm of pullback, with each measurement interrogating an area of 1 to 2 mm^2 of lumen surface perpendicular to the longitudinal axis of the catheter. When the catheter is in position, the physician activates the pullback and rotation device and the scan is initiated providing 360 degree images of the length of the artery. The rapid acquisition speed for the image freezes the motion of the heart and permits scanning of the artery in less than 2 minutes. When the catheter pullback is completed, the console displays the scan results, which are referred to as a ''chemogram'' image. The chemogram image requires reading by a trained user, but, according to the applicant, was designed to be simple to interpret.

With regard to the newness criterion, the LipiScan™ received a 510K FDA clearance for a new indication on April 25, 2008, and was available on the market immediately thereafter. On June 23, 2006, InfraReDx, Inc. was granted a 510K FDA clearance for the ''InfraReDx Near Infrared (NIR) Imaging System.'' Both devices are under the common

name of ''Near Infrared Imaging System'' according to the 510K summary document from the FDA. However, the InfraReDx NIR Imaging System device that was approved by the FDA in 2006 was approved ''for the near infrared imaging of the coronary arteries,'' whereas the LipiScan™ device cleared by the FDA in 2008 is for a modified indication. The modified indication specified that LipiScan™ is ''intended for the near-infrared examination of coronary arteries * * *, the detection of lipid-core-containing plaques of interest * * * [and] for the assessment of coronary artery lipid core burden.''

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24132), we expressed our concerns regarding whether LipiScan™ is substantially similar to its predicate device that was approved by FDA in 2006. Specifically, it appears that the two devices, which are manufactured by the same company, do not differ in either design or functionality, according to the approval order documents from the FDA. In the 2008 approval order, the FDA stated, ''The LipiScan Coronary Imaging System utilizes the same basic catheter design as the predicate, the InfraReDx NIR Imaging System (June 23, 2006). These devices have a similar intended use, use the same operating principal, incorporate the same basic catheter design, have the same shelf life, and are packaged using the same materials and processes. The modifications from the InfraReDx NIR Imaging System to the LipiScan Coronary Imaging System are the improved catheter design, improved user interface (including PBR and console), and the additional testing required to support an expanded indication for use.'' Therefore, it appears that the only difference between the two approvals may be a modification of the intended use.

As mentioned earlier in our discussion of substantial similarity in section II.I.4.b. of this final rule, our policy regarding substantial similarity discussed in the FY 2006 final rule (70 FR 47351 through 47532) outlined two criteria as it relates to two separate technologies that are made by different manufacturers that were used to guide our determination of whether two technologies were substantially similar to one another. Although the LipiScan™ is a diagnostic device and not a therapeutic device we believe that the substantial similarity component of the newness criterion still applies.

Both the prior and the new FDA indications for LipiScan™ use the same or a similar mechanism of action to achieve a desired therapeutic outcome, and both treat patients that would generally be assigned to the same MS–DRG. Similarly, both indications of LipiScan™ are intended to treat the same disease in the same patient population. Consequently, in the 2010 IPPS/RY 2010 LTCH PPPS proposed rule, we stated that we have concerns as to whether or not the two intended uses are substantially similar, especially considering that the technologies appear essentially identical. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we welcomed public comment on whether or not the latest 510K FDA clearance should be considered ''substantially similar'' to its predicate technology approved by the FDA in 2006 (74 FR 24133).

Comment: One commenter, the manufacturer, gave comments regarding whether LipiScan™ was substantially similar to its predicate device and whether it met the newness criterion for new technology add-on payments. The manufacturer included the following table to illustrate the differences between the version of the device that was approved in 2006 and the version that was approved in 2008:

	2006 NIRS device	Marketed 2008 LipiScan
Console	No display of results of scan	Results displayed immediately.
Catheter	Saline-filled with microbubble problem obscuring many scans	Air-filled with no microbubble problem.
Algorithm	No algorithmic processing of NIR signals—no means of certifying that lipid core plaque is present.	Algorithm validated in over 1,000 autopsy measurements proving that NIRS can detect lipid core plaque, and providing diagnosis of lipid core plaque to the MD during the case.

In addition, the commenter asserted that the version of the device that was approved by the FDA in 2006 was ''never marketed, donated or sold to hospitals because it had numerous shortcomings that were not overcome until [the date of its second FDA clearance, April 25, 2008].'' Finally, the commenter noted that Medicare claims do not contain any charge for LipiScan™ prior to that date.

Response: Because the manufacturer has provided statements that LipiScan™ was not marketed until after its second FDA clearance, we believe that it is no longer necessary to determine whether the version of the device that was cleared by the FDA in 2008 is substantially similar to that which was cleared in 2006. As noted by the applicant, CMS uses the date of FDA approval or the date that a technology is marketed (if the manufacturer can document there was a delay in bringing the technology to market after FDA approval) and thus available to Medicare beneficiaries as the start of the newness period. In this case, the manufacturer has provided such documentation. Therefore, we believe that based on the evidence that supports that LipiScan™ was not marketed or otherwise available to Medicare beneficiaries until April 25, 2008, LipiScan™ meets the newness criterion.

We note that the LipiScan™ technology is identified by ICD–9–CM procedure code 38.23 (Intravascular spectroscopy), which became effective October 1, 2008, and cases involving the use of this device generally map to MS–DRG 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent(s) with MCC or 4+ Vessels/Stents); MS–DRG 247 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent(s) without MCC); MS–DRG 248 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent(s) with MCC or 4+ Vessels/Stents); MS–DRG 249 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent(s) without MCC); MS–DRG 250 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent with MCC); and MS–DRG 251 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent without MCC).

In an effort to demonstrate that the technology meets the cost criterion, the applicant used the FY 2009 After Outliers Removed (AOR) file (posted on the CMS Web site) for cases potentially eligible for LipiScan™. The applicant believes that every case within DRGs 246, 247, 248, 249, 250, and 251 are eligible for LipiScan™. In addition, the applicant believes that LipiScan™ will be evenly distributed across patients in each of the six MS–DRGs (16.6 percent within each MS–DRG). Using data from the AOR file, the applicant found the average standardized charge per case for MS–DRGs 246, 247, 248, 249, 250, and

251 was $65,364, $42,162, $58,754, $37,048, $61,016, and $35,878 respectively, equating to an average standardized charge per case of $50,037. The applicant indicated that the average standardized charge per case does not include charges related to LipiScan™; therefore, it is necessary to add the charges related to the device to the average standardized charge per case in evaluating the cost threshold criterion. Although the applicant submitted data related to the estimated cost of LipiScan™ per case, the applicant noted that the cost of the device was proprietary information. Based on a sampling of two hospitals that have used the device, the applicant used a markup of 120 percent of the costs and estimates $5,280 in charges related to LipiScan™. Because the applicant lacked a significant sample of cases to determine the charges associated with the device, we expressed our concerns in the proposed rule as to whether or not the estimate of $5,280 in charges related to the device was a valid estimate (74 FR 24133).

Adding the estimated charges related to the drug to the average standardized charge per case (based on the case distribution from the applicant's 2009 AOR analysis) results in a case-weighted average standardized charge per case of $55,317 ($50,037 plus $5,280). Using the FY 2010 thresholds published in Table 10 (73 FR 58008), the case-weighted threshold for MS–DRGs 246, 247, 248, 249, 250, and 251 was $53,847 (all calculations above were performed using unrounded numbers). Because the case-weighted average standardized charge per case for the applicable MS–DRGs exceed the case-weighted threshold amount, the applicant maintains that LipiScan™ would meet the cost criterion. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we invited public comment on whether or not LipiScan™ meets the cost criterion.

Comment: One commenter, the applicant, submitted comments regarding whether LipiScan™ meets the cost criterion. The commenter noted that LipiScan™ is now used in 11 hospitals, 10 of which are non-Department of Veterans Affairs (VA) hospitals. This represented an increase from the two hospitals it noted in its application when the applicant submitted it in November 2008. Based on a sampling of all 10 non-VA hospitals that are actively using the device, the applicant determined that the average charge for the device was $7,497. Using the same methodology from the proposed rule and the AOR file from the FY 2010 proposed rule (posted on the CMS Web site) instead of the FY 2009 final rule AOR file, the applicant determined a case-weighted average standardized charge of $47,059 for MS–DRGs 246–251. Based on charge data from these 10 hospitals, the applicant determined a mean charge of $7,497 for the LipiScan™ device. The applicant added the average charge of the device to the charge per case and determined an average case-weighted charge per case of $54,556 ($47,059 plus $7,497). Based on the Table 10 thresholds published in the proposed rule (74 FR 24570), the case-weighted threshold for MS–DRGs 246–251 was $52,881. Because the case-weighted average standardized charge per case for the applicable MS–DRGs exceed the case-weighted threshold amount, the applicant maintains that based on this analysis the LipiScan™ would meet the cost criterion.

In addition, the applicant stated that it analyzed Hospital Cost Report Information System (''HCRIS'') data from 2007. Specifically, the applicant searched for the 100 cardiac catheterization labs that had the highest volume of cases in the United States. Based on the HCRIS data from these 100 labs, the applicant determined the mean cost-to-charge ratio was 0.204 with a mark-up of 490 percent yielding a charge of $11,760 for LipiScan™. Assuming that the LipiScan™ device was marked-up 490 percent, the case-weighted average standardized charge per case for cases involving the use of LipiScan™ would be $58,819 ($47,059 plus $11,760) across MS–DRGs 246–251. Similar to the above computation, based on the Table 10 thresholds published in the proposed rule (74 FR 24570), the case-weighted threshold for MS–DRGs 246–251 was $52,881. Because the case-weighted average standardized charge per case for the applicable MS–DRGs exceed the case-weighted threshold amount, the applicant maintains that based on this analysis the LipiScan™ would also meet the cost criterion.

Response: We thank the commenter for the updated analyses. As noted above in its comment, the applicant determined the case-weighted threshold using Table 10 thresholds from the proposed rule. The thresholds in Table 10 published in the proposed rule are for applicants for new technology add-on payments for FY 2011. The correct case-weighted threshold to be used to evaluate FY 2010 proposals is the same threshold ($53,847) that the applicant used in its analysis from the proposed rule, which is based on Table 10 thresholds for FY 2010 applicants (as noted in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule). Nevertheless, under the applicant's updated analysis using the Table 10 threshold for FY 2010 applicants, the case-weighted average standardized charge per case in either of the two analyses above (in the applicant's comment) would exceed the case-weighted Table 10 threshold of $53,847.

We reviewed all three analyses that the applicant submitted (one in the proposed rule and two in its comment) and, based on all three analyses, we agree that the applicant meets the cost criterion.

With regard to substantial clinical improvement, the applicant maintains that the device meets this criterion for the following reasons. The applicant noted that the September 1, 2001 final rule states that one facet of the criterion for substantial clinical improvement is ''the device offers the ability to diagnose a medical condition in a patient population where the medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods. There must also be evidence that use of the device to make a diagnosis affects the management of the patient'' (66 FR 46914). The applicant believes that LipiScan™ meets all facets of this criterion. The applicant asserted that the device is able to detect a condition that is not currently detectable. The applicant explained that LipiScan™ is the first device of its kind to be able to detect lipid-core-containing plaques and to assess coronary artery lipid core burden. The applicant further noted that FDA, in its approval documentation, has indicated that ''This is the first device that can help assess the chemical makeup of coronary artery plaques and help doctors identify those of particular concern.''

In addition, the applicant stated that the LipiScan™ chemogram permits a clinician to detect lipid-core-containing plaques in the coronary arteries compared to other currently available devices that do not have this ability. The applicant explained that the angiogram, the conventional test for coronary atherosclerosis, shows only minimal coronary narrowing. However, the applicant indicated that the LipiScan™ chemogram has the ability to reveal when an artery contains extensive lipid-core-containing plaque at an earlier stage.

The applicant also noted that the device has the ability to allow providers to make a diagnosis that better affects the management of the patient. Specifically, the applicant explained that the chemogram results are available to the interventional cardiologist during

the PCI procedure, and have been found to be useful in decision-making. In their application, the applicant stated that physicians have reported changes in therapy based on LipiScan™ findings in 20 to 50 percent of patients. The applicant further stated in their application that the most common use of LipiScan™ results has been for selection of the length of artery to be stented. In some cases a longer stent has been used when there is a lipid-core-containing plaque adjacent to the area that is being stented because a flow-limiting stenosis is present. Therefore, the applicant contends that the use of LipiScan™ by clinicians to select the length of artery to be stented and as an aid in selection of intensity of lipid-altering therapy, demonstrates that LipiScan™ affects the management of patients.

The applicant also submitted commentary from Interventional Cardiologists (a group of clinicians who currently utilize the LipiScan™ device) explaining the clinical benefits of the device. The applicant further noted that the device may have other potential uses that would be of clinical benefit, and studies are currently being conducted to investigate these other potential uses. The applicant explained that LipiScan™ offers promise as a means to enhance progress against the two leading problems in coronary disease management: (1) The unacceptably high rate of second events that occur even after catheterization, revascularization, and the institution of optimal medical therapy; and (2) the failure to diagnose coronary disease early, which results in sudden death or myocardial infarction being the first sign of the disease in most patients. The applicant further stated that the identification of coronary lipid-core-containing plaques, which can most readily be done in those already undergoing catheterization, is likely to be of benefit in the prevention of second events. In the longer term, the applicant stated that the identification of lipid-core-containing plaques by LipiScan™ may contribute to the important goal of primary prevention of coronary events, which, in the absence of adequate diagnostic methods, continue to cause extensive morbidity, mortality and health care expenditures in Medicare beneficiaries and the general population.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we noted that while we recognize that the identification of lipid-rich plaques in the coronary vasculature holds promise in the management of coronary artery disease, we were concerned that statements in the FDA approval documents, as well as statements made by investigators in the literature, suggest that the clinical implications of identifying these lipid-rich plaques are not yet certain and that further studies need to be done to understand the clinical implications of this information (74 FR 24134). We also noted that we were concerned that there are no outcome data regarding the use of the LipiScan™ technology.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we welcomed public comment regarding whether or not the LipiScan™ technology represents a substantial clinical improvement in the Medicare population.

Comment: Two commenters submitted comments regarding whether LipiScan™ represented a substantial clinical improvement. One commenter supported approving LipiScan™ for new technology add-on payments and noted that the statute indicated that either a ''diagnostic device *or* a therapy should be eligible for the add-on payment.'' (emphasis provided) The commenter stated that the device had been studied in detail by the FDA and that the FDA concluded that the device identified lipid core plaques with ''accuracy suitable for clinical use.'' Additionally, the commenter stated that the device ''has already started changing the therapeutic decisionmaking process and has the potential to provide additional benefits in the struggle against the leading cause of death in the United States.''

The applicant stated that it believed that LipiScan™ is a ''substantial clinical improvement'' over existing technologies because it enables the physician to choose the length of artery to be stented as well as the intensity of lipid lowering medical therapy that should be used. The applicant asserted that the detection of lipid core plaque could ultimately be helpful to physicians in managing patient care and improving clinical outcomes because such plaques are prone to sudden rupture. Additionally, the applicant asserted that there were three ways in which it met CMS' regulatory standard for a substantial clinical improvement including:

1. It detects ''a condition that is not currently detectable'' because it is the only device approved to identify the lipid core content in coronary arteries.

2. It ''enables the patient to be diagnosed earlier'' because other available diagnostic tests (including exercise testing and coronary angiography) do not identify lipid core plaque; whereas without this technology, the first sign that a lipid-rich plaque is present may be an acute myocardial infarction.

3. It affects the management of the patient by:

- Affecting the selection of the length of the artery to be stented;
- Affecting the selection of the appropriate target levels for lipid altering pharmacologic therapy;
- The chance that it may eventually be linked to the prevention of peri-stenting myocardial infarction.

As an attachment to its comment, the applicant submitted a legal analysis that stated that neither the statute nor the regulations require that a diagnostic device be linked to improved clinical outcomes; rather, an improvement in diagnosis alone is the only requirement. The legal memorandum also noted that the statute ''references technology that improves either diagnosis or treatment'' and that a new technology ''need not improve both, nor does the statute specify that the diagnostic must be linked to a treatment that improves outcomes.'' Additionally, the legal analysis stated that LipiScan™ has submitted evidence in accord with both the statute and the regulations that it ''provides an improvement in diagnosis of coronary artery disease by identifying the presence of the lipid core plaque'' and asserts that this point is further evidenced by the FDA which stated that the device ''is the first device that can help assess the chemical make-up of coronary artery plaques and help physicians identify those plaques with lipid cores, which may be of particular concern.'' The legal analysis also stated that CMS should not require new diagnostics to be judged by the same criteria that have been applied to judge new therapeutics because ''such an approach would not be in accord with the plain language of the regulation and that statue, both of which envision distinct clinical benefits associated with either a diagnostic or a therapy.''

Finally, the applicant summarized an article that considered the ''effect of diagnostic imaging on decisionmaking.'' Specifically, the applicant summarized the hierarchy of six levels of diagnostic efficacy presented in the article:

''*Level 1:* Technical efficacy, the physics are appropriate for the target of the diagnostic;

Level 2: Diagnostic accuracy, the sensitivity and specificity for the diagnostic target are appropriate;

Level 3: Diagnostic thing efficacy, the physician accepts the diagnostic as capable of identifying the target;

Level 4: Therapeutic efficacy, the physician selects or does not select a given therapy on the basis of the diagnostic outcome;

Level 5: Therapeutic outcome efficacy, the therapy selected on the basis of the results of the diagnostic outcome provides an improvement in the health outcome of the patient;

Level 6: Cost-effectiveness, the benefits to society have a favorable relationship to the costs of the diagnostic.''

The applicant claimed that, applying the analysis from the article, the FDA approval established that Levels 1 and 2 were met which it believed to be consistent with the requirement under 42 CFR 412.87(b)(1). Further, the applicant asserted that the testimony provided by physicians who are using LipiScan demonstrates that physicians are accepting the results to identify lipid core plaque (Level 3) and are utilizing the device to guide therapy (Level 4).

Response: We disagree with the commenters who stated that the statute and regulations require that a diagnostic technology need only ''improve'' diagnosis and that the FDA approval of a diagnostic technology in and of itself meets the regulatory criteria under § 412.87(b)(1). The commenter correctly notes that section 1886(d)(5)(K)(viii) of the Act requires us to provide for public input on whether a new technology ''substantially improves the diagnosis or treatment'' of Medicare beneficiaries. Section 1886(d)(5)(K)(vi) of the Act also authorizes the Secretary to establish through notice-and-comment rulemaking the criteria that a new medical service or technology must meet in order to be eligible for the new technology add-on patient. Under this authority, we established three criteria through notice and comment rulemaking—the newness criterion, the cost criterion, and the substantial clinical improvement criterion (66 FR 46924). Specifically, § 412.87(b)(1) of the regulations provides that a new medical service or technology must ''represent an advance that substantially improves, relating to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.''

As we explained in that rule, we will consider a diagnostic technology to meet the substantial clinical improvement criterion if the technology not only ''offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods,'' but also if ''use of the device to make a diagnosis affects the management of the patient'' (66 FR 46914). Under the commenter's analysis, a diagnostic technology effectively would only need to receive FDA approval and be the only technology approved for a particular diagnostic capability in order to be deemed a ''substantial improvement'' for purposes of new technology add-on payments, regardless of its ability to positively affect patient management. This approach would deem a device leading to the identification of new information (in this case, whether plaques contain a lipid core) as a substantial improvement in diagnosis even if such detection has not been ''demonstrated to represent a substantial improvement in caring for Medicare beneficiaries'' and is not linked to evidence-based, significant, and positive changes in the management of patients or, ultimately, to changes in clinical outcomes. We do not believe this rationale is consistent with our prior statements regarding the substantial clinical improvement criterion of the new technology add-on payment provision. Nor do we believe it would be appropriate to provide additional payments for new diagnostic tools that fail to significantly change the management of patients, thereby improving clinical outcomes.

As to whether LipiScan™ represents a substantial improvement in diagnosis, we considered first, whether LipiScan™ ''offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods,'' and second whether ''use of the device to make a diagnosis affects the management of the patient'' (66 FR 46914). In the case of LipiScan™, the applicant has stated that it believes that LipiScan™ offers the ability to diagnose a condition that is previously undetectable because it allows the detection of lipid-rich plaques in patients with coronary artery disease (CAD). We agree with the applicant that existing technologies may not be able to adequately identify lipid-rich plaques. However, we disagree that use of LipiScan™ affects the management of the patient at this time.

To qualify for the new technology add-on payment, a diagnostic capability must also be linked to ''evidence that use of the device to make a diagnosis affects the management of the patient.'' We believe that this evidence is necessary to determine whether the new technology affords a ''clear improvement over the use of previously available technologies.'' We do not consider any particular type of evidence to be dispositive; instead, we will consider all information presented for each application to determine whether there is evidence to support a conclusion that ''use of the device to make a diagnosis affects the management of the patient'' (in the case of a diagnostic technology). Consequently, we do not consider merely anecdotal claims that a device affects the management of the patient as sufficient evidence to demonstrate that a new diagnostic device affects the management of the patient, particularly where the device could be used for a relatively large patient population. Rather, we will consider whether the peer-reviewed medical literature supports or clinical studies indicate that the diagnostic device should generally be used by providers in guiding the management of their patients. In addition, we will consider evidence demonstrating clinically accepted use of the device in a manner that actually affects the management of patients.

In the case of LipiScan™, we note that other methods exist for diagnosing CAD, including intravascular ultrasound (IVUS) and optical coherence tomography (OCT). In addition, the evidence available to CMS at the time of making a final rule determination consisted of anecdotal claims made by the applicant and one other commenter, that the identification of such plaques affects the management of the patient. A review of the literature yielded no additional evidence to support the applicant's claim. Furthermore, we believe that the prognostic implications of detecting lipid-rich plaque are not yet sufficiently well enough understood and documented in the peer-reviewed evidence to conclude that such identification will lead to significant and evidence-based changes in the management of CAD. In addition, we note that there are relatively few cases in which LipiScan™ has been used relative to the patient population in which it could potentially be used. Specifically, the applicant claims that the device could potentially be used in every patient who undergoes coronary angiography. To date, the device is only in use in 11 hospitals total, and there have been no data published to indicate that management of patients has changed, even in the hospitals where the device has been used. Given the size of the patient population that the manufacturer claims stands to benefit from use of LipiScan™, the fact that so few hospitals are using the technology raises significant concerns regarding whether use of LipiScan™ actually

affects the management of patients in a meaningful manner.

Therefore, while we recognize that LipiScan™ provides the ability to detect lipid-rich plaque which is currently undetectable by any other means, we are nonetheless still concerned that there is significant uncertainty within the clinical community regarding the prognostic implications of obtaining this information. We note that we did not receive any public comment during the public comment period from physicians who may be using the device. We believe the evidence supplied by the applicant that the device is affecting the management of the patient is not able to be validated broadly and is still anecdotal. Further, the discussions of the technology in the scientific studies submitted by the applicant acknowledge the possible potential of the technology to affect treatment in the future, but all stated that additional studies are necessary to determine its actual clinical utility. Specifically, in an editorial published in 2008, the author wrote, ''In conclusion, further studies are warranted to determine if detection of [lipid core plaque of interest] by [near infrared spectroscopy] imaging will contribute to enhanced prediction of outcomes in patients with known CAD.'' (Young, 2008) Also, in a letter to the editor in the Journal of the College of Cardiology, another author wrote about his experience with three patients over a period of three weeks to share his ''initial observations.'' The author wrote that ''* * * preliminary results suggest that intravascular investigation of chemical composition of a coronary plaque has become a clinical reality [but] it remains to be seen whether chemograms would perform better than the ultrasound of whether they will be able to predict adverse events and faciltate development of *clinically effective strategies for management* of vulnerable plaques before it is too late.'' (Maini, 2008) (emphasis added).

We believe that these conclusions, and others, as stated in the literature further support our previously stated view that the prognostic implications of detecting lipid-rich plaque are not well enough understood and therefore the detection of such plaque cannot be reasonably assumed to lead to evidence-based, significant, and positive medical management of patients with CAD that is generally accepted by clinicians, much less lead to improved clinical outcomes. We agree with the commenter and applicant that the identification of lipid-rich plaques may hold promise and ultimately lead to changes in the management of CAD and that LipiScan™ ''has the potential to provide additional benefits in the struggle against the leading cause of death in the United States.'' However, we do not believe the evidence and information available at this time allows us to determine that it meets the substantial clinical improvement criterion.

For these reasons, we are not approving LipiScan™ for new technology add-on payments for FY 2010.

d. Spiration® IBV® Valve System

Spiration, Inc. submitted an application for new technology add-on payments for FY 2010 for the Spiration® IBV® Valve System (Spiration® IBV®). The Spiration® IBV® is a device that is used to place, via bronchoscopy, small, one-way valves into selected small airways in the lung in order to limit airflow into selected portions of lung tissue that have prolonged air leaks following surgery while still allowing mucus, fluids, and air to exit, thereby reducing the amount of air that enters the pleural space. The device is intended to control prolonged air leaks following three specific surgical procedures: lobectomy; segmentectomy; or lung volume reduction surgery. According to the applicant, an air leak that is present on postoperative day 7 is considered ''prolonged'' unless present only during forced exhalation or cough. In order to help prevent valve migration, there are five anchors with tips that secure the valve to the airway. The implanted valves are intended to be removed no later than 6 weeks after implantation.

With regard to the newness criterion, the Spiration® IBV® received a Humanitarian Device Exemption (HDE) approval from the FDA on October 24, 2008. We are unaware of any previously FDA-approved predicate devices, or otherwise similar devices, that could be considered substantially similar to the Spiration® IBV®. However, the applicant asserted that the FDA has precluded the device from being used in the treatment of any patients until Institutional Review Board (IRB) approvals regarding its study sites. Therefore, it would appear that the Spiration® IBV® would meet the newness criterion once it has obtained at least one IRB approval because the device would then be available on the market to treat Medicare beneficiaries. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we welcomed public comments about the date on which the newness period should begin for this technology should it meet the other criteria to be approved for new technology add-on payments (74 FR 24135).

We also noted that the Spiration® IBV® is currently described by ICD–9–CM procedure code 33.71 (Endoscopic insertion or replacement of bronchial valve(s)). At the September 2008 ICD–9–CM Coordination and Maintenance Committee meeting, we discussed a proposal to revise the existing code and create a new code for endoscopic bronchial valve insertion in single and multiple lobes. In the proposed rule, we included the revised title of procedure code 33.71 to ''Endoscopic insertion or replacement of bronchial valve(s), single lobes'' and also the new procedure code 33.73 (Endoscopic insertion or replacement of bronchial valve(s), multiple lobes) in order to distinguish between single and multiple lobes (Table 6F and 6B in the Addendum to the proposed rule (74 FR 24501 and 24494, respectively)).

Comment: The applicant commented that nine hospitals have confirmed receipt of the Spiration® IBV® and the first IRB approval for the Spiration® IBV® was March 12, 2009. The applicant believes that this would confirm that the technology meets the newness criteria.

Another commenter commented that the IRB at the commenter's hospital has made pending approval of the Spiration® IBV® and expects to be able to use the Spiration® IBV® within the next month.

Response: We thank the commenters for providing this information on when the newness period should begin for the Spiration® IBV®. Based on the information above from the applicant, the Spiration® IBV® meets the newness criterion and the newness period for the Spiration® IBV® begins on March 12, 2009.

In an effort to demonstrate that the technology meets the cost criterion, the applicant searched the FY 2007 MedPAR file for cases potentially eligible for use of the Spiration® IBV®. Specifically, the applicant searched for cases with one of the following procedure codes: 32.4 (Lobectomy of lung); 32.3 (Segmental resection of lung); or 32.22 (Long volume reduction surgery). The applicant found 4,225 cases (or 21.6 percent of all cases) in MS–DRG 163 (Major Chest Procedure with MCC), 8,960 cases (or 45.8 percent of all cases) in MS–DRG 164 (Major Chest Procedure with CC), and 6,358 cases (or 32.5 percent of all cases) in MS–DRG 165 (Major Chest Procedure without CC/MCC). The average standardized charge per case was $88,326 for MS–DRG 163, $48,494 for MS–DRG 164, and $38,463 for MS–DRG

165, equating to a case-weighted average standardized charge per case of $53,842.

The average standardized charge per case does not include charges related to the Spiration® IBV®; therefore, it is necessary to add the charges related to the device to the average standardized charge per case in evaluating the cost threshold criterion. Although the applicant submitted data related to the estimated cost of the Spiration® IBV® per case, the applicant noted that the cost of the device was proprietary information. The applicant estimates $21,450 in charges related to the Spiration® IBV® (based on a 100-percent charge markup of the cost of the device). The applicant based this amount on seven actual cases that received the device. Because the applicant lacked a significant sample of cases to determine the charges associated with the device, we expressed our concerns in the proposed rule as to whether or not the $21,450 in charges related to the device is a valid estimate. In addition, based on the seven cases, the applicant determined an estimate of the number of valves used per case (the applicant noted that the number of valves used per case is proprietary). We also expressed concerns that the applicant lacked a significant sample of cases to determine a valid estimate of the number of valves per case. Adding the estimated charges related to the device to the average standardized charge per case (based on the case distribution from the applicant's FY 2007 MedPAR claims data analysis) resulted in a case-weighted average standardized charge per case of $75,292 ($53,842 plus $21,450). Using the FY 2010 thresholds published in Table 10 (73 FR 58008), the case-weighted threshold for MS–DRGs 163, 164, and 165 was $54,715 (all calculations above were performed using unrounded numbers). Because the case-weighted average standardized charge per case for the applicable MS–DRGs exceed the case-weighted threshold amount, the applicant maintains that the Spiration® IBV® would meet the cost criterion.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we invited public comment on whether or not the Spiration® IBV® meets the cost criterion.

Comment: In response to our concerns in the proposed rule, the applicant commented and cited a recent study in Chest,[4] prepublished on line on April 6, 2009 (Travaline 2009). The study reports on use of bronchial valves (not necessarily made by the applicant) for air leaks from a number of etiologies. From December 2002 through January 2007, 40 patients were treated with bronchial valves in 17 centers. The mean number of valves per case was 2.9 for all patients in the study. The mean number of valves was 2.28 for the subset of seven post surgical air leak cases in the study.

We note that the applicant informed us that the information in the proposed rule was incorrect and the number of actual cases where the Spiration® IBV® was used was not seven. The applicant informed CMS that the correct number of actual cases that used the Spiration® IBV® was eight cases. In the proposed rule, the applicant determined an average of 3.9 valves per case (or $21,450 in charges related to the device) for the Spiration® IBV® based on these eight actual cases. However, the applicant explained that if we were to remove one case that they considered to be outlier because it used 10 valves, the average number of valves per case would be 3.0, which is similar to the average amount of valves per case from the Travaline study. The commenter also noted that the lower number of valves used in the Travaline study for post surgical leaks compared to the Spiration® IBV® data can be attributed to the design of the Spiration® IBV® compared to the valve used in the study that limits the sub segmental treatment. The commenter believes that this newly published data supports the conclusion that it is typical to insert multiple valves per case in prolonged air leak cases.

The applicant also commented that since the proposed rule, two additional cases were performed using the Spiration® IBV® (making a total of 10 cases). The applicant included these two additional cases in its revised estimate of the average amount of valves per case. In addition to removing the outlier case above, the applicant also removed an additional case they considered to be an outlier that used four valves and determined an average of 2.5 valves per case (or $13,750 in charges related to the Spiration® IBV®).

The applicant also noted that the case-weighted threshold was $54,715 which is slightly higher than the case-weighted average standardized charge per case of $53,842 (which does not include charges related to the device). The commenter explained that even if we added a charge of $5,550 for only one Spiration® IBV® to the case-weighted average standardized charge per case (for a total case-weighted average standardized charge per case of $59,392), the Spiration® IBV® would still meet the cost criterion since the case-weighted average standardized charge per case ($59,392) exceeds the case-weighted threshold ($53,842).

The commenter also stated the following to strengthen confidence in its MedPAR analysis. The commenter explained that its MedPAR analysis profiled cases identified by the relevant surgical codes since specific ICD–9–CM procedure and diagnosis are not available to identify cases of prolonged air leaks within the FY 2007 MedPAR. The applicant cited peer reviewed clinical literature that was submitted as part of its new technology add-on payment application to demonstrate that patients with prolonged air leaks had a greater length of stay and complication rates compared to patients who did not have a prolonged air leak. Specifically, the applicant noted that one study[5] with 91 post operative patients after pulmonary resection demonstrated that patients with air leaks after 3 days had a greater length of stay (mean of 9.4 days vs. 5.4 days with a p value of $p<0.0001$). The commenter also noted that a study of 552 post operative patients after LVRS in the National Emphysema Treatment Trial[6] demonstrated that patients with air leaks had more complications (57 percent versus 30 percent with a p value of $p=0.0004$) and longer length of stay (11.8 days vs. 7.6 days with a p value of $p=0.0005$). The commenter also cited a retrospective study[7] of 100 patients from a single center that showed the median length of stay for patients with prolonged air leak after radical upper lobectomy procedure was 11 days versus the median of 7 days for patients without prolonged air leak. Based on these clinical data, the applicant concluded that prolonged air leak cases are costlier than cases without prolonged air leak. As a result, the commenter believes that its MedPAR analysis was conservative in evaluating charges for surgical procedures as a whole, without being able to uniquely identify costlier prolonged air leak cases.

Response: We thank the applicant for submitting additional data to determine the amount of charges related to the Spiration® IBV®. In order to determine that the applicant met the cost criteria, in addition to the applicant's analysis, we searched the March update of the FY 2008 MedPAR for the same procedure codes that the applicant searched in their MedPAR analysis. We found 5,501 cases in MS–DRG 163 (or 23.9 percent

[4] Travaline JM et al. Treatment of persistent pulmonary air leaks using endobronchial valves. Chest; Prepublished online; April 6, 2009.

[5] Bardell T, Petiskas D Can Respir J 2003 March, Vol. 10, No 2.

[6] Decamp MM, Ann Thorac Surg. 2006 July; Vol. 82, No. 1.

[7] Abolhoda A et al. Chest 1998; 113:1507–10.

of all cases), 11,151 cases in MS–DRG 164 (or 48.4 percent of all cases), and 6,380 cases in MS–DRG 165 (or 27.7 percent of all cases). The average standardized charge per case was $85,958 for MS–DRG 163, $48,731 for MS–DRG 164, and $37,586 for MS–DRG 165, equating to a case-weighted average standardized charge per case of $54,535. Adding the revised estimate of charges of $13,750 (2.5 valves × $5,550) related to the device to the average standardized charge per case (based on the case distribution from out FY 2008 MedPAR claims data analysis) resulted in a case-weighted average standardized charge per case of $68,285. Using the FY 2010 thresholds published in Table 10 (73 FR 58008), the case-weighted threshold for MS–DRGs 163, 164 and 165 was $55,952 (all calculations above were performed using unrounded numbers). Based on this analysis, the case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount. Additionally, similar to what the applicant stated above, if we only included the amount of charges for one valve, the case-weighted average standardized charge per case of $60,035 ($54,535 plus $5,550) would still exceed the case-weighted threshold of $55,952. Therefore, we believe that the applicant meets the cost criterion.

Additionally, the applicant submitted supplemental data from multiple sources in an effort to determine the average amount of valves that would be used per case. We note that the average number of valves from actual cases involving the Spiration® IBV® (2.5 valves per case) is higher than the average amount of valves (2.28 valves per case) from the seven post surgical air leak cases from the Traveline study (not the Spiration® IBV®). However, we prefer to rely on actual case data when available and the actual case data is a more conservative estimate of the average amount of valves per case compared to those cases in the studies that did not use the Spiration® IBV®.

With respect to how the device would meet the substantial clinical improvement criterion, the applicant submitted information that was based on the Summary of Safety and Probable Benefit (SSPB) from the FDA's HDE approval order for the device. The clinical results indicate the Spiration® IBV® can be deployed in the intended airway reasonably safely with a minimally invasive bronchoscopy procedure. There have been a limited number of device complications and no occurrences of device erosion or migration. The Spiration® IBV® can be removed using a bronchoscope. Laboratory results indicate that the Spiration® IBV® significantly reduces airflow to the lung tissue beyond the treated airway, and a significant reduction in distal airflow is anticipated to augment the resolution of air leaks of the lung. Therefore, the applicant asserts, it is reasonable to conclude that the probable benefit to health associated with using the device for the target population outweighs the risk of illness or injuries, taking into account the probable risks and benefits of currently available devices or alternative forms of treatment when used as indicated in accordance with the directions for use.

We recognize that prolonged air leaks after these types of lung surgery can be a significant problem, and that Spiration® IBV® therapy may represent a new alternative in treating properly selected patients. However, we emphasized our concerns in the proposed rule that the outcome data presented are from a sample set of only seven patients, and the FDA HDE did not require demonstration of either safety or effectiveness. Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we welcomed public comment as to whether or not the Spiration® IBV® represents a substantial clinical improvement for Medicare beneficiaries.

We did not receive any written public comments regarding this application for new technology add-on payments concerning the new technology town hall meeting.

Comment: A number of commenters agreed with the applicant that the Spiration® IBV® meets the substantial clinical improvement criteria. The commenters also recommended the approval of the Spiration® IBV® for new technology add-on payments in FY 2010. One commenter, an association of thoracic surgeons, expressed support for approving the Spiration® IBV® for new technology add-on payments. The commenter explained that the Spiration® IBV® offers a less invasive treatment of the prolonged air leak, whereas the alternative treatment would be a major re-operation which costs more money and poses a greater risk to the patient.

The remaining commenters were physicians who had experience using bronchial valves or had actual experience using the Spiration® IBV®. These commenters noted that excluding the Spiration® IBV®, current treatments for prolonged air leaks include chest tube drainage, occlusion of airways with fibrin ''glue'', and/or re-operation. One of the commenters explained that endobronchial valves offer a unique method for treating prolonged air leaks by temporarily preventing air from flowing into the segment of the lung with the air leak. The commenter noted that the efficacy of the valve can be predicted effectively by occluding the lobe or segment involved with a balloon catheter to determine if the air leak can be stopped. If a balloon is effective in stopping the leak, then a valve can also be effective in stopping the leak. The commenter explained that the advantage of this treatment is that after the leak has completely healed, the valves can be removed with a minimally invasive fiber-optic bronchoscopy. The commenter concluded that the Spiration® IBV® represents a substantial improvement since it offers a valuable, new, unique treatment option for prolonged post thoracotomy air leak and is the only bronchial valve with FDA approval (HDE).

Another commenter stated that using a bronchial valve to treat an air leak, resulted in the air leak ceasing at the end of the procedure. The commenter noted that for safety reasons, chest tubes are left in for 48 hours and patients in its care have been discharged 72 hours after the procedure. The bronchial valve was typically removed within 4–6 weeks after the procedure. The commenter further stated that it was not aware of any randomized clinical trials that prove that bronchial valves make air leaks stop. However, the commenter maintained that based on their experience, air leaks that lasted 14 days or longer which suddenly ceased upon use of a bronchial valve would be strong circumstantial evidence that the therapy works and can shorten hospitalization in appropriately selected patients. The commenter also believes that using a bronchial valve for air leaks still present after five days following surgery would likely result in an overall cost savings since the duration of hospitalization is usually dependent on air leak cessation. The commenter concluded that the Spiration® IBV® represents a substantial clinical improvement and CMS should approve Spiration® IBV® for new technology add-on payments in FY 2010.

One of the commenters noted that in its experience using endobronchial valves, patients with prolonged air leaks who were in the hospital for many weeks with chest tubes in place were discharged and had the chest tubes removed within days upon use of an endobronchial valve. The commenter cited an example of a patient currently treated by the commenter who has undergone numerous procedures with anesthesia in the operating room and requires another two procedures. The commenter believed that this patient

would have been able to be managed in a bronchoscopy suite under moderate sedation with use of an endobronchial valve. As the only bronchial valve with FDA approval (HDE), the commenter believed the Spiration® IBV® represents a substantial clinical improvement and recommended that CMS make new technology add-on payments for the Spiration® IBV® in FY 2010.

Another commenter noted that conservative management of air leaks results in prolonged hospitalization and limited mobilization of patients with a much higher risk of additional complications such as pneumonia, empyema, deep venous thrombosis and pulmonary embolism, and progressive deconditioning. These complications take a toll on patients with prolonged air leaks and result in a significantly worse overall outcomes, prolonged hospital stay, and substantial increase in costs.

The commenter also noted its extensive experience using the Spiration® IBV® valve in clinical trials as a potential therapy for palliation of severe emphysema. Specifically, the commenter stated that the valves are easy to place in desired segments and effectively block distal airflow with a high safety profile in published studies. The commenter further stated that the valves are stable with no incidence of valve migration in over 600 valves placed in emphysema patients with follow-up that included endoscopic and radiologic surveillance. The commenter also noted their extensive experience in valve removal, which is part of the intended therapy for patients that have valve treatment for air leaks (since once the air leaks are resolved the valves will no longer be necessary). The commenter disclosed that it did not have any personal experience in using the Spiration® IBV® for patients with air leaks, but are familiar with the existing literature on similar treatments as well as the case series using the Spiration® IBV® for this indication. With this background, the commenter believed that the Spiration® IBV® has a high likelihood of helping to resolve prolonged postsurgical air leaks and therefore minimizes the duration of chest tube drainage and hospitalization for patients (with an attendant decrease in the risk of complications that accompany prolonged hospitalization). The commenter also believed that the high safety profile and effectiveness of the Spiration® IBV® for occluding segmental airways suggests a very high likelihood of clinical benefit in this group of patients with the indication of prolonged air leak. The commenter concluded that it believed that the Spiration® IBV® represents a substantial improvement to currently available treatment options for patients who have post-surgical prolonged air leaks. The commenter recommended that CMS approve the Spiration® IBV® for new technology add payments so that hospitals are appropriately reimbursed for this new important technology.

Response: We appreciate the commenters submitting their comments in support of the Spiration® IBV®. Many of the commenters described their positive experiences using the Spiration® IBV® or other bronchial valves that resolved cases of air leaks, which improved the clinical outcome of the patient. Furthermore, the commenters suggested that most, if not all, of the cases treated using the Spiration® IBV® and other bronchial valves would have had to have undergone further invasive treatments had the Spiration® IBV® or other bronchial valves not have been available to resolve the air leak. Additionally, the Spiration® IBV® and other bronchial valve provided a quick resolution to these cases of prolonged air leaks. We considered the commenters' positive experiences using the Spiration® IBV® in our determination (below) on whether the Spiration® IBV® represents a substantial clinical improvement.

Comment: The applicant commented that providers have few treatment options for effectively controlling prolonged air leaks. The applicant noted that aside from the Spiration® IBV®, no other bronchoscopic treatments have been clinically accepted or approved by the FDA. Therefore, management of prolonged air leaks due to persistent bronchopleural fistula involves chest drainage and occasionally pleurodesis, with more difficult cases requiring pleurectomy and surgical repair. The applicant further noted that current treatment options for air leaks are associated with risks and complications such as prolonged use of chest tubes which increases the risk of pneumonia, deep venous thrombosis, pulmonary embolus, atelectasis, subcutaneous emphysema and empyema; restricted ambulation due to chest tube which increases the risks associated with inactivity; prolonged requirements for pain medication and extended post operative length of stay which increases the potential for hospital acquired infections.

In response to our concerns in the proposed rule, the applicant acknowledged that there are limited outcomes data associated with the use of the Spiration® IBV® for prolonged air leaks. However, the applicant cited that additional data has been published since the proposed rule regarding the use of a bronchial valve for prolonged air leaks. Specifically, the applicant cited the following clinical benefit data from the Traveline 2009 study for patients who received a bronchial valve for air leaks from multiple causes: following valve placement, the air leaks resolved or decreased in 37 of 40 patients (92.5 percent); 19 patients (47.5 percent) had complete resolution of the air leak acutely, 18 patients (45 percent) had reduction, two patients (5 percent) had no change in air leak status, and one patient (2.5 percent) the immediate change in air leak was not reported.

Additionally, the applicant reported that all 10 procedures performed with the Spiration® IBV® resulted in air leak decrease and/or resolution. The applicant concluded that these results demonstrated the following: Valve placement may reduce or avoid complications associated with current treatments of prolonged air leaks; patients who received bronchial valves experienced air leak resolution or decrease unlike a situation absent bronchial valves where a patient may need to remain in the hospital; patients with a bronchial valve are able to be discharged with the valve thus avoiding risks, complications and costs associated with prolonged lengths of hospitalizations. The applicant believed that these conclusions from the newly published data together with Spiration® data demonstrate that the Spiration® IBV® meets the substantial clinical improvement criteria.

Response: We thank the applicant for providing additional clinical data to demonstrate that the Spiration® IBV® meets the substantial clinical improvement criteria. With respect to substantial clinical improvement, we considered all the case specific clinical information presented by the applicant and the public to determine whether there is evidence to support a conclusion that use of the Spiration® IBV® represents a substantial clinical improvement. Specifically, we considered the peer-reviewed medical literature, clinical studies, and the clinically accepted use of the device. We remain concerned that no prospective comparative data exists to help understand the benefit of the technology versus other modalities. We also do not know what the outcome would have been for the cases presented as examples in the Traveline study (that is, if or when those air leaks might have resolved on their own). Additionally, many of the cases in that study were not for the indicated use (post-operative prolonged air leak management). However, we agree that the Spiration®

IBV® can improve clinical outcomes by providing an alternative treatment that is effective and often a less invasive method of treating prolonged air leaks in a small patient population that is properly and carefully selected (as required by the FDA). Additionally, we received positive comments from a major thoracic society and from physicians who indicated that the Spiration® IBV® and other bronchial valves produced positive clinical outcomes by resolving air leaks. Also, the comments we received from the physicians demonstrated a change to the clinical therapy for cases of air leaks by using a bronchial valve such as the Spiration® IBV® instead of other alternative treatments such as an invasive surgery to resolve the air leak. Furthermore, the Spiration® IBV® is the only device currently approved for the purpose of treating prolonged air leaks following lobectomy, segmentectomy, and LVRS patients in the United States. Without the availability of this device, patients with prolonged air leaks (following lobectomy, segmentectomy, and LVRS) might otherwise remain inpatients in the hospital (and have a longer length of stay than they might otherwise have without the Spiration® IBV®) or might even require additional invasive surgeries to resolve the air leak. We also note that use of the Spiration® IBV® may lead to more rapid beneficial resolution of prolonged air leaks and reduce recovery time following the three lung surgeries mentioned above. Therefore, after reviewing the totality of the evidence, we have determined that the Spiration® IBV® represents a substantial clinical improvement over existing therapies for prolonged air leaks for carefully selected patients.

Accordingly, after consideration of the clinical evidence received, we are approving the Spiration® IBV® for new technology add-on payments in FY 2010. However, we remain interested in seeing whether the clinical evidence continues to find it to be effective. This approval is on the basis of using the Spiration® IBV® consistent with the FDA approval (HDE), and we emphasize the need for appropriate patient selection accordingly. Therefore, we intend to limit the add-on payment to cases involving prolonged air leaks following lobectomy, segmentectomy and LVRS in MS–DRGs 163, 164, and 165. Cases involving the Spiration® IBV® that are eligible for the new technology add-on payment will be identified by assignment to MS–DRGs 163, 164, and 165 with procedure code 33.71 or 33.73 in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41, or 32.49.

The average cost of the Spiration® IBV® is reported as $2,750. Based on the applicant's revised data, the average amount of valves per case is 2.5. Therefore, the total maximum cost for the Spiration® IBV® is expected to be $6,875 per case ($2,750 × 2.5). Under section 412.88(a)(2), new technology add-on payments are limited to the lesser of 50 percent of the average cost of the device or 50 percent of the costs in excess of the MS–DRG payment for the case. As a result, the maximum add-on payment for a case involving the Spiration® IBV® is $3,437.50.

e. TherOx Downstream® System

TherOx, Inc. submitted an application for new technology add-on payments for FY 2010 for the TherOx Downstream® System. However, the applicant withdrew its application for new technology add-on payments during the public comment period.

We did not receive any public comments on this application.

5. Technical Correction to the Regulations

In the FY 2009 IPPS final rule, when we revised the regulations at § 412.87 to incorporate changes relating to the announcement of determinations and deadline for consideration of new medical service or technology applications, we made a change to paragraph (b)(1) (73 FR 48755). In paragraph (b)(1), we inadvertently used the incorrect word ''relating'' in the provision that read ''A new medical service or technology represents an advance that substantially improves, *relating* to technologies previously available, the diagnosis or treatment of Medicare beneficiaries'' (emphasis added). The correct word should have been ''relative.'' We proposed to make a technical correction to § 412.87(b)(1), replacing the word ''relating'' with the word ''relative'' (74 FR 24137). We did not receive any public comments on this proposal. Accordingly, we are finalizing this proposed correction.

III. Changes to the Hospital Wage Index for Acute Care Hospitals

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the FY 2010 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.C. of this preamble.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section of the Act provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The adjustment for FY 2010 is discussed in section II.B. of the Addendum to this final rule.

As discussed below in section III.I. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating IPPS payment amounts. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. The budget neutrality adjustment for FY 2010 is discussed in section II.A.4.b. of the Addendum to this final rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we are applying beginning October 1, 2009 (the FY 2010 wage index) appears under section III.D. of this preamble.

B. Requirements of Section 106 of the MIEA–TRHCA

1. Wage Index Study Required Under the MIEA–TRHCA

a. Legislative Requirement

Section 106(b)(1) of the MIEA–TRHCA (Pub. L. 109–432) required MedPAC to submit to Congress, not later than June 30, 2007, a report on the Medicare wage index classification system applied under the Medicare IPPS. Section 106(b) of MIEA–TRHCA required the report to include any alternatives that MedPAC recommends to the method to compute the wage index under section 1886(d)(3)(E) of the Act.

In addition, section 106(b)(2) of the MIEA–TRHCA instructed the Secretary of Health and Human Services, taking into account MedPAC's recommendations on the Medicare wage index classification system, to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. The Secretary was also to consider each of the following:

- Problems associated with the definition of labor markets for the wage index adjustment.
- The modification or elimination of geographic reclassifications and other adjustments.
- The use of Bureau of Labor of Statistics (BLS) data or other data or methodologies to calculate relative wages for each geographic area.
- Minimizing variations in wage index adjustments between and within MSAs and statewide rural areas.
- The feasibility of applying all components of CMS' proposal to other settings.
- Methods to minimize the volatility of wage index adjustments while maintaining the principle of budget neutrality.
- The effect that the implementation of the proposal would have on health care providers on each region of the country.
- Methods for implementing the proposal(s), including methods to phase in such implementations.
- Issues relating to occupational mix such as staffing practices and any evidence on quality of care and patient safety including any recommendation for alternative calculations to the occupational mix.

In the FY 2009 IPPS final rule (73 FR 48563 through 48567), we discussed the MedPAC's study and recommendations, the CMS contract with Acumen, L.L.C. for assistance with impact analysis and study of wage index reform, and public comments we received on the MedPAC recommendations and the CMS/Acumen study and analysis.

b. Interim and Final Reports on Results of Acumen's Study

(1) Interim Report on Impact Analysis of Using MedPAC's Recommended Wage Index

In the FY 2009 IPPS final rule (73 FR 48566 through 48567), we discussed the analysis conducted by Acumen comparing use of the MedPAC recommended wage indices to the current CMS wage index. We refer readers to section III.B.1.e. of that final rule for a full discussion of the impact analysis as well as to Acumen's interim report available on the Web site: *http://www.acumenllc.com/reports/cms*.

(2) Acumen's Final Report on Analysis of the Wage Index Data and Methodology

Acumen's final report addressing the issues in section 106(b)(2) of the MIEA–TRHCA is divided into two parts. The first part analyzes the strengths and weaknesses of the data sources used to construct the MedPAC and CMS indexes. The first part of Acumen's study is complete and was published on Acumen's Web site after the publication of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. The second part of Acumen's study, which is expected to be released on Acumen's Web site after the publication of this FY 2010 IPPS/RY 2010 LTCH PPS final rule, will focus on the methodology of wage index construction and covers issues related to the definition of wage areas and methods of adjusting for differences among neighboring wage areas, as well as reasons for differential impacts of shifting to a new index.

The following is a description of the analyses for both parts of Acumen's final report.

Part I: Wage Data Analysis

- *Differences between the BLS data and the CMS wage data*—Acumen assessed the strengths and weaknesses of the data used to construct the CMS wage index and the MedPAC compensation index by examining the differences between the BLS and the CMS wage data. Acumen also evaluated the importance of accounting for self-employed workers, part-time workers, and industry wage differences.
- *Employee benefit (wage-related) cost*—Acumen considered whether benefit costs need to be included in the hospital wage index and discussed the differences between Worksheet A benefits data (proposed by MedPAC to use with BLS wage data) and Worksheet S–3 benefit data. Acumen also analyzed the possibility of using BLS' Employer Costs for Employee Compensation (ECEC) series as an alternative to Worksheet A or Worksheet S–3 benefits data that would pose less of a data collection burden for providers.
- *Impact of the fixed national occupational weights*—Acumen assessed MedPAC's and CMS' methods for adjusting for occupational mix differences. While the proposed MedPAC compensation index uses fixed weights for occupations representative of the hospital industry nationally, the CMS wage index incorporates an occupational mix adjustment (OMA) from a separate data collection.
- *Year-to-year volatility in the CMS and BLS wage data*—Acumen calculated the extent of volatility in the CMS and BLS wage indexes using several measures of volatility. Acumen also explored potential causes of volatility, such as the number of hospitals and the annual change in the number of hospitals in a wage area. Finally, Acumen evaluated the impact on annual volatility of using a 2-year rolling average of CMS wage index values.

In the first part of its final report, Acumen suggests that MedPAC's recommended methods for revising the wage index represent an improvement over the existing methods, and that the BLS data should be used so that the MedPAC approach can be implemented.

Comment: Several commenters reiterated their concerns regarding the use of the BLS data for computing the Medicare wage index that they had expressed in public comments on the FY 2009 IPPS final rule (73 FR 48564). The commenters stated that they still have significant concerns about the shortcomings of the BLS data, and they urged CMS to move cautiously in considering MedPAC's and Acumen's findings. Other commenters expressed support for MedPAC's and Acumen's findings and recommendations, although some commenters cautioned that a few refinements may still be needed before adopting these recommendations. MedPAC commented that they look forward to the completion of the Acumen study and to working with CMS on improving the hospital wage index.

Response: As Acumen's study is incomplete at the time of preparation of this final rule, we are making no assessments or conclusions in this rule with regards to Acumen's findings in Part I of its final report. As we mention below, we will consider both of Acumen's final reports and public comments in assessing MedPAC's

recommendations and making future proposals for changes in the wage index.

Part II: Wage Index Construction

- *Alternative wage area definitions*—Acumen will explore the conceptual basis for defining wage areas and investigate alternative wage area definitions that have been considered in prior literature to reduce differences between areas.
- *Differences between and within contiguous wage areas*—Acumen will estimate different methods for smoothing wage index values between geographically proximate areas and examine the justification for and sensitivity to assumptions used by MedPAC in its smoothing method.
- *Reasons for differential impacts of shifting to a new index*—Acumen will analyze the impact on hospitals if CMS were to adopt MedPAC's proposed compensation index, with a focus on hospitals that would no longer qualify for exceptions such as geographic reclassification and the rural floor. Acumen will also determine if there are identifiable reasons for the different impacts.

As mentioned above, Acumen is expected to complete and publish its analysis for the second part of its final report after the publication date of this final rule.

We indicated in the FY 2009 IPPS final rule that, in developing any proposal(s) for additional wage index reform that may be included in the FY 2010 IPPS proposed rule, we would consider all of the public comments on the MedPAC recommendations that we had received in that proposed rulemaking cycle, along with the interim and final reports to be submitted to us by Acumen. As Acumen's study was not complete at the time of issuance of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we did not propose any additional changes to the hospital wage index for acute care hospitals for the FY 2010 IPPS.

2. FY 2009 Policy Changes in Response to Requirements Under Section 106(b) of the MIEA–TRHCA

To implement the requirements of section 106(b) of the MIEA–TRHCA and respond to MedPAC's recommendations in its June 2007 report to Congress, in the FY 2009 IPPS final rule (73 FR 48567 through 48574), we made the following policy changes relating to the hospital wage index. (We refer readers to the FY 2009 IPPS final rule for a full discussion of the basis for the proposals, the public comments received, and the FY 2009 final policy.)

a. Reclassification Average Hourly Wage Comparison Criteria

In the FY 2009 IPPS final rule, we adopted the policy to adjust the reclassification average hourly wage standard, comparing a reclassifying hospital's (or county hospital group's) average hourly wage relative to the average hourly wage of the area to which it seeks reclassification. We provided for a phase-in of the adjustment over 2 years. For applications for reclassification for the first transitional year, FY 2010, the average hourly wage standards were set at 86 percent for urban hospitals and group reclassifications and 84 percent for rural hospitals. For applications for reclassification for FY 2011 (for which the application deadline is September 1, 2009) and for subsequent fiscal years, the average hourly wage standards will be 88 percent for urban and group reclassifications and 86 percent for rural hospitals (§§ 412.230, 412.232, and 412.234 of the regulations). As stated above, these policies were adopted in the FY 2009 IPPS final rule.

In response to our summary of the FY 2009 policy changes in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24139), we received several public comments, which are summarized below.

Comment: Several commenters opposed raising the average hourly wage thresholds to 88 percent for urban and group reclassifications and 86 percent for rural hospitals for applications for FY 2011 and subsequent years.

Response: As we discussed in the FY 2009 IPPS proposed and final rules, section 106(b) of the MIEA–TRHCA required the Secretary to make one or more proposals to revise the wage index adjustment for FY 2009. In the FY 2009 IPPS proposed rule (73 FR 48567 through 48574), we indicated that while we had limited authority to make changes to the nine specific areas of the wage index that the law required us to study, we did carefully review the criteria established in regulations for allowing a hospital to geographically reclassify. Specifically, in the FY 2009 IPPS final rule, we updated the geographic reclassification criteria based on a review of the statistical metrics that were used to establish the original standards in 1993. The original individual standards were set using a methodology that calculated a percentile range of one standard deviation from the mean in which a typical hospital's average hourly wage would be expected to fall relative to its combined labor market average hourly wage. In short, we found that the average hospital average hourly wage as a percentage of its area's wage had increased from approximately 96 percent in FY 1993 to 98 percent in the most recent 3 fiscal years. Further, the standard deviation had been reduced from approximately 12 percent to 10 percent over the same time period. The original criteria were set equal to the average less the standard deviation (96 percent less 12 percentage points). The revised reclassification criteria based on these same statistical metrics led us to change the standard to 88 percent (98 percent less 10 percentage points). By refining our standards, we found that the number of hospitals that are able to reclassify despite not demonstrating average hourly wage levels that truly justify a higher wage index will be reduced.

We considered public comments received in response to the FY 2009 IPPS proposed rule before making this change final in the FY 2009 IPPS final rule (73 FR 48567 through 48574). The change in policy did not affect any 3-year geographic reclassifications that went into effect beginning in FY 2009. Further, in response to public comments on the FY 2009 IPPS proposed rule, we decided to adopt the revised reclassification criteria over a 2-year transitional period. Hospitals will be subject to the 88 percent criteria for urban and group reclassifications (86 percent for rural areas) for 3-year geographic reclassifications beginning for FY 2011 applications due to the MGCRB no later than 5 p.m. (EST) on September 1, 2009.

Finally, in the FY 2009 IPPS final rule and in section III.B.1.b. of the preamble of this final rule, we discuss our contract with Acumen to assist us in studying the wage index and the MedPAC recommendations, and also to assist us in developing other proposals for reforming the wage index. At this time, the study is still in progress and Acumen intends to issue its final report this year. We will consider possible additional changes to the wage index through the formal rulemaking process after our review of Acumen's final report and recommendations.

b. Within-State Budget Neutrality Adjustment for the Rural and Imputed Floors

In the FY 2009 IPPS final rule, we adopted State level budget neutrality (rather than the national budget neutrality adjustment) for the rural and imputed floors, to be effective beginning with the FY 2009 wage index. The transition from the national budget neutrality adjustment to the State level budget neutrality adjustment is being

phased in over a 3-year period. In FY 2009, hospitals received a blended wage index that was 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. In FY 2010, the blended wage index reflects 50 percent of the State level adjustment and 50 percent of the national adjustment. In FY 2011, the adjustment will be completely transitioned to the State level methodology.

In the FY 2009 IPPS final rule, we incorporated this policy in our regulation at § 412.64(e)(4). Specifically, we provided that CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105–33) and the imputed rural floor under § 412.64(h)(4) are made in a manner that ensures that aggregate payments to hospitals are not affected and that, beginning October 1, 2008, CMS would transition from a nationwide adjustment to a statewide adjustment, with a statewide adjustment fully in place by October 1, 2010. We note that the imputed floor expires on September 30, 2011 (as discussed in section III.H. of this preamble).

Comment: Several commenters requested that CMS repeal its decision to apply a State level budget neutrality adjustment for the rural and imputed floors. The commenters cited the disparity between the severe negative economic consequences of the policy for States with hospitals receiving a floor payment, compared to the relatively minor benefits received by nonfloor States. Multiple commenters pointed out that, because numerous other aspects of the Medicare wage index either cross State lines (CBSAs), or are modeled on national budget neutrality (geographic reclassification and outlier payments), they were concerned that a State-specific adjustment establishes a poor precedent and violates the intent of the legislation that established the rural floor.

Response: We disagree that a State level budget neutrality adjustment establishes a poor precedent. Unlike geographic reclassification or outlier payment budget neutrality adjustments, the construction of the rural and imputed floors requires that wage index comparisons be made between labor market areas within a specific State. Analysis in the FY 2009 IPPS final rule demonstrated how, at a State-by-State level, the rural and imputed floors create a benefit for a minority of States that is then funded by a majority of States, including States that are overwhelmingly rural in character. In the FY 2009 IPPS final rule, we also explained that because the imputed and rural floor comparisons occur at the State level, we believed it would be sound policy to make the budget neutrality adjustment specific to the State, redistributing payments among hospitals within the State, rather than adjusting payments to hospitals in other States. In the FY 2009 IPPS final rule, we adopted a 3-year phase-in to address the concerns that such a transition in policy may lead to sudden decreases in payments for certain providers. FY 2010 will mark the second year of this transition, with a 50-percent national, 50-percent within-State budget neutrality adjustment. We believe that this transition period will continue to mitigate any negative impacts on affected hospitals while we proceed towards the planned adoption of 100-percent within-State budget neutrality in FY 2011.

In addition, we do not believe the legislative history demonstrates an intent for a particular type of budget neutrality adjustment. The Conference Report for the rural floor states: ''The Secretary would be required to make any adjustments in the wage index in a budget neutral manner.'' (H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess. at 712) However, the report does not reference a national budget neutrality adjustment, as compared to a statewide budget neutrality adjustment. Both the legislative history and the plain language of the rural floor provision anticipate that the Secretary would have administrative discretion regarding the ''manner'' of the budget neutrality adjustment. Section 4410(b) of the BBA of 1997 (Pub. L. 105–33) requires that the Secretary adjust wage indices ''in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act * * * in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would be made in the year if this section did not apply.'' Thus, Congress provided discretion to the Secretary to determine the manner of ensuring that the rural floor did not increase costs above what they would have been in the absence of the rural floor, and the Secretary has exercised such discretion through the adoption of a statewide adjustment.

Comment: A number of commenters in an all-urban State urged CMS to make the imputed floor a permanent provision. The commenters explained that their State is geographically disadvantaged because it is bordered by two of the five largest cities in the United States, and the hospitals in the State have to compete with those larger cities for labor resources and patients. The commenters noted that, when CMS adopted the imputed floor policy in the FY 2005 IPPS final rule (69 FR 49109), CMS acknowledged a concern by some individuals that hospitals in all-urban States are financially and competitively disadvantaged in the absence of an imputed floor wage index. The commenters stated that CMS has provided no rationale for discontinuing the imputed floor after FY 2011 and has provided no documentation to support that the ''anomalous'' situation, as it was described by CMS in the FY 2005 IPPS final rule, has changed for all-urban States.

Response: We appreciate the commenter's concern about the imputed floor. However, we made no proposals regarding the imputed floor in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. Therefore, we are making no decisions in this final rule regarding any future extension of the imputed floor. We will address the imputed floor policy in the FY 2011 IPPS proposed rule, which will allow for opportunity for public comment.

Comment: One commenter requested clarification as to the discrepancy between rural and imputed floor budget neutrality factors referenced in the proposed rule (1.00016 referenced at 74 FR 24243 (the Addendum to the proposed rule) and 1.000017 referenced at 74 FR 24663 (Appendix A to the proposed rule)).

Response: We have included an updated budget neutrality factor in section I.A.4.c. of the Addendum to this final rule, along with an explanation in section VI.I of Appendix A to this final rule of why the adjustment amounts varied in the proposed rule.

Comment: One commenter requested CMS to explain how the rural floor budget neutrality adjustment is performed so that it can be certified and compared to prior years. The commenter also expressed concerns about how State level budget neutrality may complicate a hospital's geographic reclassification application process, may result in rural hospitals with high wage indices being significantly disadvantaged, and may cause deviations in payments between hospital reclassifications into a labor market from an adjoining State.

Response: We provided ample details of the iterative rural floor budget neutrality calculation process in the FY 2008 IPPS final rule with comment period (72 FR 47325 through 4733). In the FY 2009 IPPS final rule (73 FR 48574), we further explained how the

same calculation process will be used to phase in a State level budget neutrality adjustment.

In response to the commenter's other concerns, the specific scenarios presented may occur regardless of how rural and imputed floor budget neutrality is achieved. The application of the rural floor itself, despite a national or a State level budget neutrality adjustment, may result in situations where hospitals classified or reclassified to the same labor market area may receive differing wage indices. Hospitals always must evaluate multiple scenarios when determining whether to apply for a reclassification or withdraw a geographic reclassification request. We provide the best information available in the IPPS proposed rule to facilitate these decisions and allow hospitals a 45-day period following publication of the proposed rule to evaluate their options.

C. Core-Based Statistical Areas for the Hospital Wage Index

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, beginning with FY 2005, we define hospital labor market areas based on the Core-Based Statistical Areas (CBSAs) established by OMB and announced in December 2003 (69 FR 49027). For a discussion of OMB's revised definitions of CBSAs and our implementation of the CBSA definitions, we refer readers to the preamble of the FY 2005 IPPS final rule (69 FR 49026 through 49032).

As with the FY 2009 final rule, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24139), we proposed to provide that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, for each hospital, we proposed to determine a wage index for FY 2010 employing wage index data from hospital cost reports for cost reporting periods beginning during FY 2006 and using the CBSA labor market definitions. We consider CBSAs that are MSAs to be urban, and CBSAs that are Micropolitan Statistical Areas as well as areas outside of CBSAs to be rural. In addition, it has been our longstanding policy that where an MSA has been divided into Metropolitan Divisions, we consider the Metropolitan Division to comprise the labor market areas for purposes of calculating the wage index (69 FR 49029) (regulations at § 412.64(b)(1)(ii)(A)).

On November 20, 2008, OMB announced three Micropolitan Statistical Areas that now qualify as MSAs (OMB Bulletin No. 09–01). The new urban CBSAs are as follows:

- Cape Girardeau-Jackson, Missouri-Illinois (CBSA 16020). This CBSA is comprised of the principal cities of Cape Girardeau and Jackson, Missouri in Alexander County, Illinois; Bollinger County, Missouri, and Cape Girardeau County, Missouri.
- Manhattan, Kansas (CBSA 31740). This CBSA is comprised of the principal city of Manhattan, Kansas in Geary County, Pottawatomie County, and Riley County.
- Mankato-North Mankato, Minnesota (CBSA 31860). This CBSA is comprised of the principal cities of Mankato and North Mankato, Minnesota in Blue Earth County and Nicollet County.

OMB also changed the principal cities and titles of a number of CBSAs and a Metropolitan Division, as follows:

- Broomfield, Colorado qualifies as a new principal city of the Denver-Aurora, Colorado CBSA. The new title is Denver-Aurora-Broomfield, Colorado CBSA.
- Chapel Hill, North Carolina qualifies as a new principal city of the Durham, North Carolina CBSA. The new title is Durham-Chapel Hill, North Carolina CBSA.
- Chowchilla, California qualifies as a new principal city of the Madera, California CBSA. The new title is Madera-Chowchilla, California CBSA.
- Panama City Beach, Florida qualifies as a new principal city of the Panama City-Lynn Haven, Florida CBSA. The new title is Panama City-Lynn Haven-Panama City Beach, Florida CBSA.
- East Wenatchee, Washington qualifies as a new principal city of the Wenatchee, Washington CBSA. The new title is Wenatchee-East Wenatchee, Washington CBSA.
- Rockville, Maryland replaces Gaithersburg, Maryland as the third most populous city of the Bethesda-Frederick-Gaithersburg, Maryland Metropolitan Division. The new title is Bethesda-Frederick-Rockville, Maryland Metropolitan Division.

The OMB bulletin is available on the OMB Web site at *http://www.whitehouse.gov/OMB*—go to ''Bulletins'' or ''Statistical Programs and Standards.'' CMS will apply these changes to the IPPS beginning October 1, 2009.

We note that several public commenters who responded to the proposed rule expressed their concerns that CAHs in the new MSAs will lose their CAH status and be forced to convert to IPPS hospitals because the areas will be designated as urban instead of rural. The commenters recalled that the same situation occurred in FY 2005 when CMS adopted OMB's CBSA definitions. At that time, CMS allowed CAHs located in rural counties that became urban to maintain their CAH status for 2 years (69 FR 49221). If these CAHs were unable in 2 years to obtain rural status under § 412.103, they were required to convert to IPPS status. A more detailed discussion of the public comments and our response is included in section VII.C. of the preamble of this final rule.

D. Occupational Mix Adjustment to the FY 2010 Wage Index

As stated earlier, section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, for application beginning October 1, 2004 (the FY 2005 wage index). The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

1. Development of Data for the FY 2010 Occupational Mix Adjustment Based on the 2007–2008 Occupational Mix Survey

As provided for under section 1886(d)(3)(E) of the Act, we collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. For the FY 2009 hospital wage index, we used data from the 2006 Medicare Wage Index Occupational Mix Survey (the 2006 survey) to calculate the occupational mix adjustment. In the 2006 survey, we included several modifications to the original occupational mix survey, the 2003 survey, including (1) allowing hospitals to report their own average hourly wage rather than using BLS data; (2) extending the prospective survey period; and (3) reducing the number of occupational categories but refining the subcategories for registered nurses.

The 2006 survey provided for the collection of hospital-specific wages and hours data, a 6-month prospective

reporting period (that is, January 1, 2006, through June 30, 2006), the transfer of each general service category that comprised less than 4 percent of total hospital employees in the 2003 survey to the ''all other occupations'' category (the revised survey focused only on the mix of nursing occupations), additional clarification of the definitions for the occupational categories, an expansion of the registered nurse category to include functional subcategories, and the exclusion of average hourly rate data associated with advance practice nurses. The 2006 survey included only two general occupational categories: Nursing and ''all other occupations.'' The nursing category had four subcategories: Registered nurses, licensed practical nurses, aides, orderlies, attendants, and medical assistants. The registered nurse subcategory included two functional subcategories: Management personnel and staff nurses or clinicians. As indicated above, the 2006 survey provided for a 6-month data collection period, from January 1, 2006 through June 30, 2006. To allow flexibility for the reporting period beginning and ending dates to accommodate some hospitals' biweekly payroll and reporting systems, we modified the 6-month data collection period for the 2006 survey from January 1, 2006, through June 30, 2006, to a 6-month reporting period that began on or after December 25, 2005, and ended before July 9, 2006. OMB approved the revised 2006 occupational mix survey (Form CMS–10079 (2006)) on April 25, 2006. The original timelines for the collection, review, and correction of the 2006 occupational mix data were discussed in detail in the FY 2007 IPPS final rule (71 FR 48008).

As we proposed, for the FY 2010 hospital wage index, we used occupational mix data collected on a revised 2007–2008 Medicare Wage Index Occupational Mix Survey (the 2007–2008 survey) to compute the occupational mix adjustment for FY 2010. In the FY 2008 IPPS final rule with comment period (72 FR 47315), we discussed how we modified the 2006 occupational mix survey. The revised 2007–2008 occupational mix survey provided for the collection of hospital-specific wages and hours data for the 1-year period of July 1, 2007, through June 30, 2008, additional clarifications to the survey instructions, the elimination of the registered nurse subcategories, some refinements to the definitions of the occupational categories, and the inclusion of additional cost centers that typically provide nursing services.

On February 2, 2007, we published in the **Federal Register** a notice soliciting comments on the proposed revisions to the 2006 occupational mix survey (72 FR 5055). The comment period for the notice ended on April 3, 2007. After considering the comments we received, we made a few minor editorial changes and published the final 2007–2008 occupational mix survey on September 14, 2007 (72 FR 52568). OMB approved the survey without change on February 1, 2008 (OMB Control Number 0938–0907). The 2007–2008 Medicare occupational mix survey (Form CMS–10079 (2008)) is available on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage,* and through the fiscal intermediaries/MACs. Hospitals were required to submit their completed surveys to their fiscal intermediaries/MACs by September 2, 2008. The preliminary, unaudited 2007–2008 occupational mix survey data were released in early October 2008, along with the FY 2006 Worksheet S–3 wage data, for the FY 2010 wage index review and correction process.

2. Calculation of the Occupational Mix Adjustment for FY 2010

For FY 2010 (as we did for FY 2009), we are calculating the occupational mix adjustment factor using the following steps:

Step 1—For each hospital, determine the percentage of the total nursing category attributable to a nursing subcategory by dividing the nursing subcategory hours by the total nursing category's hours. Repeat this computation for each of the four nursing subcategories: Registered nurses; licensed practical nurses; nursing aides, orderlies, and attendants; and medical assistants.

Step 2—Determine a national average hourly rate for each nursing subcategory by dividing a subcategory's total salaries for all hospitals in the occupational mix survey database by the subcategory's total hours for all hospitals in the occupational mix survey database.

Step 3—For each hospital, determine an adjusted average hourly rate for each nursing subcategory by multiplying the percentage of the total nursing category (from Step 1) by the national average hourly rate for that nursing subcategory (from Step 2). Repeat this calculation for each of the four nursing subcategories.

Step 4—For each hospital, determine the adjusted average hourly rate for the total nursing category by summing the adjusted average hourly rate (from Step 3) for each of the nursing subcategories.

Step 5—Determine the national average hourly rate for the total nursing category by dividing total nursing category salaries for all hospitals in the occupational mix survey database by total nursing category hours for all hospitals in the occupational mix survey database.

Step 6—For each hospital, compute the occupational mix adjustment factor for the total nursing category by dividing the national average hourly rate for the total nursing category (from Step 5) by the hospital's adjusted average hourly rate for the total nursing category (from Step 4).

If the hospital's adjusted average hourly rate is less than the national average hourly rate (indicating the hospital employs a less costly mix of nursing employees), the occupational mix adjustment factor is greater than 1.0000. If the hospital's adjusted average hourly rate is greater than the national average hourly rate, the occupational mix adjustment factor is less than 1.0000.

Step 7—For each hospital, calculate the occupational mix adjusted salaries and wage-related costs for the total nursing category by multiplying the hospital's total salaries and wage-related costs (from Step 5 of the unadjusted wage index calculation in section III.G. of this preamble) by the percentage of the hospital's total workers attributable to the total nursing category (using the occupational mix survey data, this percentage is determined by dividing the hospital's total nursing category salaries by the hospital's total salaries for ''nursing and all other'') and by the total nursing category's occupational mix adjustment factor (from Step 6 above).

The remaining portion of the hospital's total salaries and wage-related costs that is attributable to all other employees of the hospital is not adjusted by the occupational mix. A hospital's all other portion is determined by subtracting the hospital's nursing category percentage from 100 percent.

Step 8—For each hospital, calculate the total occupational mix adjusted salaries and wage-related costs for a hospital by summing the occupational mix adjusted salaries and wage-related costs for the total nursing category (from Step 7) and the portion of the hospital's salaries and wage-related costs for all other employees (from Step 7).

To compute a hospital's occupational mix adjusted average hourly wage, divide the hospital's total occupational mix adjusted salaries and wage-related costs by the hospital's total hours (from Step 4 of the unadjusted wage index calculation in section III.G. of this preamble).

Step 9—To compute the occupational mix adjusted average hourly wage for an urban or rural area, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the area, then sum the total hours for all hospitals in the area. Next, divide the area's occupational mix adjusted salaries and wage-related costs by the area's hours.

Step 10—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the Nation, then sum the total hours for all hospitals in the Nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours. The FY 2010 occupational mix adjusted national average hourly wage is $33.5268.

Step 11—To compute the occupational mix adjusted wage index, divide each area's occupational mix adjusted average hourly wage (Step 9) by the national occupational mix adjusted average hourly wage (Step 10).

Step 12—To compute the Puerto Rico specific occupational mix adjusted wage index, follow Steps 1 through 11 above. The FY 2010 occupational mix adjusted Puerto Rico-specific average hourly wage is $14.2555.

The table below is an illustrative example of the occupational mix adjustment.

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Example of Occupational Mix Adjustment

Hospital A								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	Provider Occupational Mix Salaries	Provider % by Subcategory	National AHWs by Subcategory	Provider Adjusted AHW	National Adjusted Nurse AHW	Nurse Occupa-tional Mix Adjust-ment Factor	Provider % by Total
Registered Nurses	1,642,129	18,125,763	79.84%	$40.00	$31.94			
Licensed Practical Nurses and Surgical Technologists	67,860	404,822	3.30%	$20.00	$0.66			
Nursing Aides, Orderlies, & Attendants	259,177	1,762,579	12.60%	$13.00	$1.64			
Medical Assistants	87,622	577,045	4.26%	$12.00	$0.51			
Total Nurse Hours and Salaries	2,056,788	20,870,209			$34.75	$27.00	0.7771	52.40%
ALL OTHER	5,000,000	$18,957,010			Step 4			47.60%
TOTAL	7,056,788	$39,827,219						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$83,312,942.55							
Hours (From S-3, Parts II and III)	3,836,299.60							
Hospital A Unadjusted AHW	$21.72							
Nurse Occupational Mix Wages	$33,925,838	Step 7						
All Other Unadjusted Occupational Mix Wages	$39,655,400	Step 7						
Total Occupational Mix Wages	$73,581,237	Step 8						
Hospital A Final Occupational Mix Adjusted AHW	$19.18	Step 8						
Hospital B								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7

	Provider Occupational Mix Hours	Provider Occupational Mix Salaries	Provider % by Subcategory	National AHWs by Subcategory	Provider Adjusted AHW	National Adjusted Nurse AHW	Nurse Occupational Mix Adjustment Factor	Provider % by Total
Registered Nurses	1,142,129	18,125,763	**72.43%**	$30.00	**$21.73**			
Licensed Practical Nurses and Surgical Technologists	67,860	404,822	**4.30%**	$20.00	**$0.86**			
Nursing Aides, Orderlies, & Attendants	279,177	1,762,579	**17.71%**	$13.00	**$2.30**			
Medical Assistants	87,622	577,045	**5.56%**	$12.00	**$0.67**			
Total Nurse Hours and Salaries	**1,576,788**	**20,870,209**			**$25.56**	**$27.00**	**1.0564**	**52.40%**
ALL OTHER	5,000,000	18,957,010			Step 4			**47.60%**
TOTAL	**6,576,788**	**$39,827,219**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$25,979,714							
Hours (From S-3, Parts II and III)	1,097,585							
Hospital B Unadjusted AHW	**$23.67**							
Nurse Occupational Mix Wages	**$14,381,144**	Step 7						
All Other Unadjusted Occupational Mix Wages	**$12,365,857**	Step 7						
Total Occupational Mix Wages	**$26,747,001**	Step 8						
Hospital B Final Occupational Mix Adjusted AHW	**$24.37**	Step 8						

Note: The numbers in this example are hypothetical, including all National AHW amounts.

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Because the occupational mix adjustment is required by statute, all hospitals that are subject to payments under the IPPS, or any hospital that would be subject to the IPPS if not granted a waiver, must complete the occupational mix survey, unless the hospital has no associated cost report wage data that are included in the proposed FY 2010 wage index. For the FY 2007–2008 survey, the response rate was 89 percent.

In computing the FY 2010 wage index, if a hospital did not respond to the occupational mix survey, or if we determined that a hospital's submitted data were too erroneous to include in the wage index, we assigned the hospital the average occupational mix adjustment for the labor market area. We believed this method had the least impact on the wage index for other hospitals in the area. For areas where no hospital submitted data for purposes of calculating the proposed occupational mix adjustment, we applied the national occupational mix factor of 1.0000 in calculating the area's FY 2010 occupational mix adjusted wage index. (We indicated in the FY 2008 and FY 2009 IPPS final rules that we reserve the right to apply a different approach in future years, including potentially penalizing nonresponsive hospitals (72 FR 47314).) In addition, if a hospital submitted a survey, but that survey data cannot be used because we determine it to be aberrant, we also assigned the hospital the average occupational mix adjustment for its labor market area. For example, if a hospital's individual nurse category average hourly wages were out of range (that is, unusually high or low), and the hospital did not provide sufficient documentation to explain the aberrancy, or the hospital did not submit any registered nurse salaries or hours data, we assigned the hospital the average occupational mix adjustment for the labor market area in which it is located.

In calculating the average occupational mix adjustment factor for a labor market area, we replicated Steps 1 through 6 of the calculation for the occupational mix adjustment. However, instead of performing these steps at the hospital level, we aggregated the data at the labor market area level. In following these steps, for example, for CBSAs that contain providers that did not submit occupational mix survey data, the occupational mix adjustment factor ranged from a low of 0.9252 (CBSA 17780, College Station-Bryan, TX), to a high of 1.0933 (CBSA 29700, Laredo, TX). Also, in computing a hospital's occupational mix adjusted salaries and wage-related costs for nursing employees (Step 7 of the calculation), in the absence of occupational mix survey data, we multiplied the hospital's total salaries and wage-related costs by the percentage of the *area's* total workers attributable to the *area's* total nursing category. For FY 2010, there are 7 CBSAs (that include 15 hospitals) for which we did not have occupational mix data for any of its hospitals. The CBSAs are:

- CBSA 21940—Fajardo, PR (one hospital)
- CBSA 22140—Farmington, NM (one hospital)
- CBSA 25020—Guayama, PR (three hospitals)
- CBSA 36140—Ocean City, NJ (one hospital)
- CBSA 38660—Ponce, PR (six hospitals)
- CBSA 41900—San German-Cabo Rojo, PR (two hospitals)
- CBSA 49500—Yauco, PR (one hospital)

Since the FY 2007 IPPS final rule, we have periodically discussed applying a hospital-specific penalty to hospitals that fail to submit occupational mix survey data. (71 FR 48013 through 48014; 72 FR 47314 through 47315; and 73 FR 48580). During the FY 2008 rulemaking cycle, some commenters suggested a penalty equal to a 1- to 2-percent reduction in the hospital's wage index value or a set percentage of the standardized amount. During the FY 2009 rulemaking cycle, several commenters reiterated their view that full participation in the occupational mix survey is critical, and that CMS should develop a methodology that encourages hospitals to report occupational mix survey data but does not unfairly penalize neighboring hospitals. However, to date, we have not adopted a penalty for hospitals that fail to submit occupational mix data.

After review of the data for the proposed FY 2010 wage index, we became concerned about the increasing number of hospitals that fail to submit occupational mix data and the impact it may have on area wage indices. The survey response rate has dropped significantly from 93.8 percent for the 2003 survey to 90.7 percent for the 2006 survey and 90.3 percent for the 2007–2008 survey. In 40 CBSAs, the response rate was under 70 percent. In addition, for 50 areas, including New York-White Plains-Wayne, New York-New Jersey (35644), Oklahoma City, Oklahoma (36420), Rural Georgia (11), Rural Oklahoma (37), Dallas-Plano-Irving, TX (19124), Newark-Union, NJ–PA (35084), and Fort Worth-Arlington, TX (23104), the area response rate decreased 15 percent or more between the 2006 survey and the 2007–2008 survey. In all of Puerto Rico, only 21.6 percent of hospitals submitted 2007–2008 survey data. If we had proposed to apply a penalty for nonresponsive hospitals for the FY 2010 wage index, Puerto Rico hospitals would have been significantly adversely affected in both the proposed national and Puerto Rico-specific wage indices. We indicated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule that, while we were not proposing a penalty at that time, we would consider the public comments we previously received, as well as any public comments on the proposed rule, as we develop the proposed FY 2011 wage index. One approach that we will explore is to assign any nonresponsive hospital the occupational mix factor deriving from the survey that would result in the greatest negative adjustment to the hospital's wage index. We also will consider applying the same penalty to hospitals that submit unusable occupational mix data. Although we would apply this penalty factor in establishing the hospital's payment rate, we would not use this factor in computing the area's wage index. Rather, in computing the area wage index, we would apply the same methodology as described above (that is, assign the nonresponsive hospital the average occupational mix adjustment factor for the labor market area) so that other hospitals in the area are minimally impacted by the hospital's failure to submit occupational mix data. Again, we note that we reserve the right to penalize nonresponsive hospitals in the future. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we welcomed public comments on this matter and indicated that we would address this issue in next year's IPPS proposed rule.

Comment: Several commenters indicated that they share CMS' concerns about the increasing number of hospitals that fail to submit occupational mix data. The commenters contended that accuracy and fairness in the occupational mix adjustment will only be achieved through 100 percent hospital participation and agreed that CMS should consider a penalty for hospitals that do not participate. The commenters suggested that CMS should not simply substitute unfavorable occupational mix data for noncompliant hospitals because it could unfairly penalize other neighboring hospitals that are diligent in reporting their data. Some commenters recommended that CMS apply a percentage adjustment to the standardized rate or to the wage index that would reduce Medicare

payment to nonparticipating hospitals, similar to the slight payment differential for hospitals failing to provide quality data. One commenter added that the penalty should be applied in a budget neutral manner. Another commenter suggested that the penalty should be applied to inpatient and outpatient payments. The commenters also recommended an appeal process that would allow hospitals to rectify the situation when the Medicare contractor or CMS determines that a hospital's data were not submitted, not acceptable, or unusable.

Response: We appreciate all of the comments and suggestions we received regarding a penalty for hospitals that do not participate in the occupational mix survey. We will consider these comments and other methods in developing a proposal for the FY 2011 IPPS proposed rule.

Comment: Several commenters gave suggestions for improving the next update of the occupational mix survey. (The 2007–2008 survey will expire with the FY 2012 wage index.) Suggestions included the following:

- Use calendar year 2010 instead of the 12 months ending June 30, 2011.
- Add unit secretaries because their duties are similar to the administrative functions of nurses and medical assistants.
- Add an ''all other nursing'' category to capture all employees in the specified cost centers who are not in the specific categories (for example, emergency medical technicians and instrument technicians). This will help CMS and others to quantify the percent of nursing cost center employees that are not covered under the survey categories.
- Revise the Medicare cost report to include the occupational mix survey data.

Response: Although we made no proposals in the FY 2010 proposed rule regarding the next update of the occupational mix survey, we appreciate receiving these comments and will consider them as we plan and develop the new survey. As with prior updates to the occupational mix survey, we will publish a notice of proposed data collection with a comment period, through the Paperwork Reduction Act process, in a future **Federal Register**.

E. Worksheet S–3 Wage Data for the FY 2010 Wage Index

The FY 2010 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2006 (the FY 2009 wage index was based on FY 2005 wage data).

1. Included Categories of Costs

The FY 2010 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

- Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty).
- Home office costs and hours.
- Certain contract labor costs and hours (which include direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services, and certain contract indirect patient care services (as discussed in the FY 2008 final rule with comment period (72 FR 47315)).
- Wage-related costs, including pensions and other deferred compensation costs. We note that, on March 28, 2008, CMS published a technical clarification to the cost reporting instructions for pension and deferred compensation costs (sections 2140 through 2142.7 of the Provider Reimbursement Manual, Part I). These instructions are used for developing pension and deferred compensation costs for purposes of the wage index, as discussed in the instructions for Worksheet S–3, Part II, Lines 13 through 20 and in the FY 2006 IPPS final rule (70 FR 47369).

Comment: Several commenters addressed our policy for determining pension costs for the wage index. The commenters acknowledged that they have raised many of their arguments, such as arguments regarding retroactivity, before the Provider Reimbursement Review Board (PRRB).

Response: First, we did not propose to make any changes to, nor request public comments on, reporting pension costs for the wage index. Therefore, we consider the public comments received on this issue outside of the scope of this rulemaking. Further, we already discussed our policies for reporting pension costs in the FY 2006 IPPS final rule (70 FR 47369). We note that the policy for reporting pension costs for the wage index currently can be found in section 3605.2 of the Provider Reimbursement Manual (PRM), Part II, and section 2142 of PRM, Part I. We expect that purely legal arguments, such as arguments on retroactivity, will be addressed through the adjudication process.

2. Excluded Categories of Costs

Consistent with the wage index methodology for FY 2009, the wage index for FY 2010 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The FY 2010 wage index also excludes the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours, and wage-related costs of CAHs are excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

3. Use of Wage Index Data by Providers Other Than Acute Care Hospitals Under the IPPS

Data collected for the IPPS wage index are also currently used to calculate wage indices applicable to other providers, such as SNFs, home health agencies (HHAs), and hospices. In addition, they are used for prospective payments to IRFs, IPFs, and LTCHs, and for hospital outpatient services. We note that, in the IPPS rules, we do not address comments pertaining to the wage indices for non-IPPS providers, other than for LTCHs. (Beginning with this final rule, for the RY 2010, we are including in the same document updates to the LTCH PPS.) Such comments should be made in response to separate proposed rules for those providers.

F. Verification of Worksheet S–3 Wage Data

The wage data for the FY 2010 wage index were obtained from Worksheet S–3, Parts II and III of the FY 2006 Medicare cost reports. Instructions for completing Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual (PRM), Part II, sections 3605.2 and 3605.3. The data file used to construct the wage index includes FY 2006 data submitted to us as of March 2, 2009. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries/MACs to revise or verify data elements that resulted in specific edit failures. For the proposed FY 2010 wage index, we identified and excluded 34 providers with data that were too aberrant to include in the proposed wage index, although we stated that if data elements for some of these providers were corrected, we intended to include some of these providers in the FY 2010 final wage index. We instructed fiscal intermediaries/MACs to complete their

data verification of questionable data elements and to transmit any changes to the wage data no later than April 15, 2009. The data for 2 of the hospitals identified in the proposed rule were resolved; however, the data for 8 additional hospitals were identified as too aberrant to include in the final wage index. Therefore, we determined that the data for 40 hospitals (that is, 34 − 2 + 8 = 40) should not be included in the FY 2010 final wage index.

In constructing the FY 2010 wage index, we included the wage data for facilities that were IPPS hospitals in FY 2006, inclusive of those facilities that have since terminated their participation in the program as hospitals, as long as those data did not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period and to ensure that the current wage index represents the labor market area's current wages as compared to the national average of wages. However, we excluded the wage data for CAHs as discussed in the FY 2004 IPPS final rule (68 FR 45397). For this final rule, we removed 17 hospitals that converted to CAH status between February 18, 2008, the cut-off date for CAH exclusion from the FY 2009 wage index, and February 16, 2009, the cut-off date for CAH exclusion from the FY 2010 wage index. After removing hospitals with aberrant data and hospitals that converted to CAH status, the FY 2010 wage index is calculated based on 3,519 hospitals.

In the FY 2008 final rule with comment period (72 FR 47317) and the FY 2009 IPPS final rule (73 FR 48582), we discussed our policy for allocating a multicampus hospital's wages and hours data, by full-time equivalent (FTE) staff, among the different labor market areas where its campuses are located. During the FY 2010 wage index desk review process, we requested fiscal intermediaries/MACs to contact multicampus hospitals that had campuses in different labor market areas to collect the data for the allocation. As we proposed, the FY 2010 wage index in this final rule includes separate wage data for campuses of three multicampus hospitals.

For FY 2010, we are again allowing hospitals to use FTE or discharge data for the allocation of a multicampus hospital's wage data among the different labor market areas where its campuses are located. The Medicare cost report was updated in May 2008 to provide for the reporting of FTE data by campus for multicampus hospitals. Because the data from cost reporting periods that begin in FY 2008 will not be used in calculating the wage index until FY 2012, a multicampus hospital will still have the option, through the FY 2011 wage index, to use either FTE or discharge data for allocating wage data among its campuses by providing the information from the applicable cost reporting period to CMS through its fiscal intermediary/MAC. Two of the three multicampus hospitals chose to have their wage data allocated by their Medicare discharge data for the FY 2010 wage index. One of the hospitals provided FTE staff data for the allocation. The average hourly wage associated with each geographical location of a multicampus hospital is reflected in Table 2 of the Addendum to this final rule.

G. Method for Computing the FY 2010 Unadjusted Wage Index

The method used to compute the FY 2010 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we are basing the FY 2010 wage index on wage data reported on the FY 2006 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 2005, and before October 1, 2006. In addition, we included data from some hospitals that had cost reporting periods beginning before October 2005 and reported a cost reporting period covering all of FY 2005. These data are included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2005 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2006 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2005, and before October 1, 2006), we included wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. (We note that, beginning with FY 2008 (72 FR 47315), we include Lines 22.01, 26.01, and 27.01 of Worksheet S–3, Part II for overhead services in the wage index. However, we note that the wages and hours on these lines are not incorporated into Line 101, Column 1 of Worksheet A, which, through the electronic cost reporting software, flows directly to Line 1 of Worksheet S–3, Part II. Therefore, the first step in the wage index calculation for FY 2010 is to compute a ''revised'' Line 1, by adding to the Line 1 on Worksheet S–3, Part II (for wages and hours respectively) the amounts on Lines 22.01, 26.01, and 27.01.) In calculating a hospital's average salaries plus wage-related costs, we subtract from Line 1 (total salaries) the GME and CRNA costs reported on Lines 2, 4.01, 6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and exclude salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtract from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we add to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

We note that contract labor and home office salaries for which no corresponding hours are reported are not included. In addition, wage-related costs for nonteaching physician Part A employees (Line 18) are excluded if no corresponding salaries are reported for those employees on Line 4.

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we compute total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocate overhead costs to areas of the hospital excluded from the wage index calculation. First, we determine the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S–3). We then compute the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on

Line 13 of Worksheet S–3, Part III. Next, we compute the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determine the ratio of overhead hours (Part III, Line 13 minus the sum of lines 22.01, 26.01, and 27.01) to revised hours excluding the sum of lines 22.01, 26.01, and 27.01 (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, 8.01, 22.01, 26.01, and 27.01). (We note that for the FY 2008 and subsequent wage index calculations, we are excluding the sum of lines 22.01, 26.01, and 27.01 from the determination of the ratio of overhead hours to revised hours because hospitals typically do not provide fringe benefits (wage-related costs) to contract personnel. Therefore, it is not necessary for the wage index calculation to exclude overhead wage-related costs for contract personnel. Further, if a hospital does contribute to wage-related costs for contracted personnel, the instructions for Lines 22.01, 26.01, and 27.01 require that associated wage-related costs be combined with wages on the respective contract labor lines.); (2) we compute overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, and 18; and (3) we multiply the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtract the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjust the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimate the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 2003, through April 15, 2005, for private industry hospital workers from the BLS' *Compensation and Working Conditions*. We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. We also note that, since April 2006 with the publication of March 2006 data, the BLS' ECI uses a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SICs), which no longer exist. We have consistently used the ECI as the data source for our wages and salaries and other price proxies in the IPPS market basket and, as we proposed, we are not making any changes to the usage for FY 2010. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/2005	11/15/2005	1.04966
11/14/2005	12/15/2005	1.04632
12/14/2005	01/15/2006	1.04296
01/14/2006	02/15/2006	1.03955
02/14/2006	03/15/2006	1.03610
03/14/2006	04/15/2006	1.03269
04/14/2006	05/15/2006	1.02936
05/14/2006	06/15/2006	1.02613
06/14/2006	07/15/2006	1.02298
07/14/2006	08/15/2006	1.01990
08/14/2006	09/15/2006	1.01688
09/14/2006	10/15/2006	1.01391
10/14/2006	11/15/2006	1.01098
11/14/2006	12/15/2006	1.00808
12/14/2006	01/15/2007	1.00526
01/14/2007	02/15/2007	1.00257
02/14/2007	03/15/2007	1.00000
03/14/2007	04/15/2007	0.99745

For example, the midpoint of a cost reporting period beginning January 1, 2006, and ending December 31, 2006, is June 30, 2006. An adjustment factor of 1.02298 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 2006 and covered a period of less than 360 days or more than 370 days, we annualize the data to reflect a 1-year cost report. Dividing the data by the number of days in the cost report and then multiplying the results by 365 accomplishes annualization.

Step 6—Each hospital is assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B), section 1886(d)(8)(E), or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divide the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the Nation and then divide the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage (unadjusted for occupational mix) is $33.5491.

Step 9—For each urban or rural labor market area, we calculate the hospital wage index value, unadjusted for occupational mix, by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we develop a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We add the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divide the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage (unadjusted for occupational mix) of $14.2462 for Puerto Rico. For each labor market area in Puerto Rico, we calculate the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. The areas affected by this provision are identified in Table 4D–2 of the Addendum to this final rule.

In the FY 2005 IPPS final rule (69 FR 49109), we adopted the ''imputed'' floor as a temporary 3-year measure to address a concern by some individuals that hospitals in all-urban States were disadvantaged by the absence of rural hospitals to set a wage index floor in those States. The imputed floor was originally set to expire in FY 2007, but we extended it an additional year in the FY 2008 IPPS final rule with comment period (72 FR 47321). In the FY 2009 IPPS final rule (73 FR 48570 through 48574 and 48584), we extended the imputed floor for an additional 3 years, through FY 2011.

H. Analysis and Implementation of the Occupational Mix Adjustment and the FY 2010 Occupational Mix Adjustment Wage Index

As discussed in section III.D. of this preamble, for FY 2010, we apply the occupational mix adjustment to 100 percent of the FY 2010 wage index. We calculated the occupational mix adjustment using data from the 2007–2008 occupational mix survey data, using the methodology described in section III.D.3. of this preamble.

Using the occupational mix survey data and applying the occupational mix adjustment to 100 percent of the FY 2010 wage index results in a national average hourly wage of $33.5268 and a Puerto Rico-specific average hourly wage of $14.2555. After excluding data of hospitals that either submitted aberrant data that failed critical edits, or that do not have FY 2006 Worksheet S–3 cost report data for use in calculating the FY 2010 wage index, we calculated the FY 2010 wage index using the occupational mix survey data from 3,178 hospitals. Using the Worksheet S–3 cost report data of 3,519 hospitals and occupational mix survey data from 3,178 hospitals represents a 90.3 percent survey response rate. The FY 2010 national average hourly wages for each occupational mix nursing subcategory as calculated in Step 2 of the occupational mix calculation are as follows:

Occupational mix nursing subcategory	Average hourly wage
National RN	$36.071788464
National LPN and Surgical Technician	20.882610908
National Nurse Aide, Orderly, and Attendant	14.619113985
National Medical Assistant	16.486068445
National Nurse Category	30.482374867

The national average hourly wage for the entire nurse category as computed in Step 5 of the occupational mix calculation is $30.482374867. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of greater than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of less than 1.0. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of less than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of greater than 1.0.

Based on the July 2007 through June 2008 occupational mix survey data, we determined (in Step 7 of the occupational mix calculation) that the national percentage of hospital employees in the nurse category is 44.31 percent, and the national percentage of hospital employees in the all other occupations category is 55.69 percent. At the CBSA level, the percentage of hospital employees in the nurse category ranged from a low of 29.08 percent in one CBSA, to a high of 70.76 percent in another CBSA.

We compared the FY 2010 occupational mix adjusted wage indices for each CBSA to the unadjusted wage indices for each CBSA. As a result of applying the occupational mix adjustment to the wage data, the wage index values for 205 (52.4 percent) urban areas and 32 (68.1 percent) rural areas will increase. One hundred and six (27.1 percent) urban areas will increase by 1 percent or more, and 5 (1.3 percent) urban areas will increase by 5 percent or more. Nineteen (40.4 percent) rural areas will increase by 1 percent or more, and no rural areas will increase by 5 percent or more. However, the wage index values for 186 (47.6 percent) urban areas and 14 (29.8 percent) rural areas will decrease. Eighty-eight (22.5 percent) urban areas will decrease by 1 percent or more, and no urban area will decrease by 5 percent or more. Seven (14.9 percent) rural areas will decrease by 1 percent or more, and no rural areas will decrease by 5 percent or more. The largest positive impacts are 7.83 percent for an urban area and 2.97 percent for a rural area. The largest negative impacts are 3.90 percent for an urban area and 2.32 percent for a rural area. One rural area is unaffected. These results indicate that a larger percentage of rural areas (68.1 percent) benefit from the occupational mix adjustment than do urban areas (52.4 percent). While these results are more positive overall for rural areas than under the previous occupational mix adjustment that used survey data from 2006, approximately one-third (29.8 percent) of rural CBSAs will still experience a decrease in their wage indices as a result of the occupational mix adjustment.

We also compared the FY 2010 wage data adjusted for occupational mix from the 2007–2008 survey to the FY 2010 wage data adjusted for occupational mix from the 2006 survey. This analysis illustrates the effect on area wage indices of using the 2007–2008 survey data compared to the 2006 survey data; that is, it shows whether hospitals' wage indices are increasing or decreasing under the current survey data as compared to the prior survey data. Our analysis shows that the FY 2010 wage index values for 185 (47.3 percent) urban areas and 19 (40.4 percent) rural areas will increase. Sixty-two (15.9 percent) urban areas will increase by 1 percent or more, and no urban areas will increase by 5 percent or more. One (2.1 percent) rural area will increase by 1 percent or more, and no rural areas will increase by 5 percent or more. However, the wage index values for 202 (51.7 percent) urban areas and 28 (59.6 percent) rural areas will decrease using the 2007–2008 data. Fifty-five (14.1 percent) urban areas will decrease by 1 percent or more, and one (0.26 percent) urban area will decrease by 5 percent or more. Three (6.4 percent) rural areas will decrease by 1 percent or more, and no rural areas will decrease by 5 percent or more. The largest positive impacts using the 2007–2008 data compared to the 2006 data are 4.32 percent for an urban area and 2.34 percent for a rural area. The largest negative impacts are 6.46 percent for an urban area and 4.40 percent for a rural area. Four urban areas and no rural areas will be unaffected. These results indicate that a larger percentage of urban areas (47.3 percent) will benefit from the 2007–2008 occupational mix survey as compared to the 2006 survey than will rural areas (40.4 percent). Further, the wage indices of more CBSAs overall (52.5 percent) will be decreasing due to application of the 2007–2008 occupational mix survey data as compared to the 2006 survey data to the wage index. However, as noted in the analysis above, a greater percentage of rural areas (68.1 percent) will benefit from the application of the occupational mix adjustment than will urban areas.

The wage index values for FY 2010 (except those for hospitals receiving wage index adjustments under section 1886(d)(13) of the Act) included in Tables 4A, 4B, 4C, and 4F of the

Addendum to this final rule include the occupational mix adjustment.

Tables 3A and 3B in the Addendum to this final rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals based on FYs 2008, 2009, and 2010 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this final rule includes the adjusted average hourly wage for each hospital from the FY 2004 and FY 2005 cost reporting periods, as well as the FY 2006 period used to calculate the FY 2010 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period. The average hourly wages in Tables 2, 3A, and 3B in the Addendum to this final rule include the occupational mix adjustment. The wage index values in Tables 4A, 4B, 4C, and 4D–1 also include the State-specific rural floor and imputed floor budget neutrality adjustments.

I. Revisions to the Wage Index Based on Hospital Redesignations

1. General

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify 13 months prior to the start of the fiscal year for which reclassification is sought (generally by September 1). Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in 42 CFR 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, a MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use average hourly wage data from the 3 most recently published hospital wage surveys in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Public Law 106–554 provides that the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. The implementing regulations for this provision are located at 42 CFR 412.235.

Section 1886(d)(8)(B) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the labor market area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards for designating MSAs and if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of *all* contiguous MSAs. In light of the CBSA definitions and the Census 2000 data that we implemented for FY 2005 (69 FR 49027), we undertook to identify those counties meeting these criteria. Eligible counties are discussed and identified under section III.I.5. of this preamble.

2. Effects of Reclassification/Redesignation

Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. These requirements for determining the wage index values for redesignated hospitals are applicable both to the hospitals deemed urban under section 1886(d)(8)(B) of the Act and hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals increases the wage index value for the urban area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value. Otherwise, the hospitals located in the urban area receive a wage index excluding the wage data of hospitals redesignated into the area.

Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred (otherwise, redesignated rural hospitals are excluded from the calculation of the rural wage index). The wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

CMS also has adopted the following policies:

- The wage data for a reclassified urban hospital is included in both the wage index calculation of the urban area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.
- In cases where hospitals have reclassified to rural areas, such as urban hospitals reclassifying to rural areas under 42 CFR 412.103, the hospital's wage data are: (a) included in the rural wage index calculation, unless doing so would reduce the rural wage index; and (b) included in the urban area where the hospital is physically located. The effect of this policy, in combination with the statutory requirement at section 1886(d)(8)(C)(ii) of the Act, is that rural areas may receive a wage index based upon the highest of: (1) Wage data from hospitals geographically located in the rural area; (2) wage data from hospitals geographically located in the rural area, but excluding all data associated with hospitals reclassifying out of the rural area under section 1886(d)(8)(B) or section 1886(d)(10) of the Act; or (3) wage data associated with hospitals geographically located in the area plus all hospitals reclassified into the rural area.

In addition, in accordance with the statutory language referring to ''hospitals'' in the plural under sections 1886(d)(8)(C)(i) and 1886(d)(8)(C)(ii) of the Act, our longstanding policy is to consider reclassified hospitals as a group when deciding whether to include or exclude them from both urban and rural wage index calculations.

3. FY 2010 MGCRB Reclassifications

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. The specific procedures and rules that apply to the geographic reclassification process are outlined in 42 CFR 412.230 through 412.280.

At the time this final rule was constructed, the MGCRB had completed its review of FY 2010 reclassification requests. Based on such reviews, there were 292 hospitals approved for wage index reclassifications by the MGCRB for FY 2010. Because MGCRB wage index reclassifications are effective for 3 years, for FY 2010, hospitals reclassified during FY 2008 or FY 2009 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications. There were 313 hospitals approved for wage index reclassifications in FY 2008 and 271 hospitals approved for wage index reclassifications in FY 2009. Of all of the hospitals approved for reclassification for FY 2008, FY 2009, and FY 2010, based upon the review at the time of this final rule, 861 hospitals are in a reclassification status for FY 2010.

Under 42 CFR 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of a proposed rule. Generally stated, the request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2010 had to be received by the MGCRB within 45 days of the publication of the FY 2010 IPPS proposed rule. Hospitals may also cancel prior reclassification withdrawals or terminations in certain circumstances. For further information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer the reader to 42 CFR 412.273, as well as the FY 2002 IPPS final rule (66 FR 39887) and the FY 2003 IPPS final rule (67 FR 50065).

Changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process for FY 2010 are incorporated into the wage index values published in this FY 2010 IPPS/RY 2010 LTCH PPS final rule. These changes affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive; that is, whether they receive the wage index that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated may be affected.

Applications for FY 2011 reclassifications are due to the MGCRB by September 1, 2009 (the first working day of September 2009). We note that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under 42 CFR 412.273(d). Applications and other information about MGCRB reclassifications may be obtained, beginning in mid-July 2009, via the CMS Internet Web site at: *http://cms.hhs.gov/MGCRB/02_instructions_and_applications.asp,* or by calling the MGCRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

Comment: Several commenters suggested that CMS lower the employment interchange measure (EIM) from 15 percent to 7.5 percent. EIM is a measure of ties between two adjacent entities, used when defining Combined Statistical Areas (CSAs). The EIM is calculated as the sum of the percentage of employed residents commuting from the smaller area to the larger area and the percentage of employment in the smaller area accounted for by workers residing in the larger area. Hospitals seeking a group reclassification from one urban area to another must be located in the same CSA (or CBSA where relevant) as the urban area to which they seek redesignation, as stated in § 412.234(a)(3)(iv) of the regulations.

Response: We are not adopting the commenters' recommendation. First, we have a longstanding policy of using OMB's statistical area definitions to set our labor market areas, and OMB does not modify the statistical area definitions to meet the requirements of any nonstatistical program. Second, such a change in the EIM could significantly reduce the wage indices of some reclassified hospitals. In analyzing the implications of the EIM change suggested by the commenters, we reviewed 31 of 127 CSAs (these are the 31 areas for which the Office of Personnel Management uses a 7.5 percent EIM in determining locality payment adjustments under the general schedule for Federal employees). The result was that the change would allow a total of at least 57 hospitals in 21 counties to reclassify, and while a national budget neutrality adjustment would affect all hospitals equally, the additional reclassifications could significantly reduce the wage index applied to reclassified hospitals in certain areas—in some cases, by as much as 10 percent as a result of the additional reclassifications. These effects could be even more significant were the EIM changed for all counties nationally.

4. Redesignations of Hospitals Under Section 1886(d)(8)(B) of the Act

Section 1886(d)(8)(B) of the Act requires us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA if certain criteria are met. Effective beginning FY 2005, we use OMB's 2000 CBSA standards and the Census 2000 data to identify counties in which hospitals qualify under section 1886(d)(8)(B) of the Act to receive the wage index of the urban area. Hospitals located in these counties have been known as ''Lugar'' hospitals and the counties themselves are often referred to as ''Lugar'' counties. We provide the FY 2010 chart below with the listing of the rural counties containing the hospitals designated as urban under section 1886(d)(8)(B) of the Act. For discharges occurring on or after October 1, 2009, hospitals located in the rural county in the first column of this chart will be redesignated for purposes of using the wage index of the urban area listed in the second column.

RURAL COUNTIES CONTAINING HOSPITALS REDESIGNATED AS URBAN UNDER SECTION 1886(d)(8)(B) OF THE ACT

[Based on CBSAs and Census 2000 data]

Rural county	CBSA
Cherokee, AL	Rome, GA.

RURAL COUNTIES CONTAINING HOSPITALS REDESIGNATED AS URBAN UNDER SECTION 1886(d)(8)(B) OF THE ACT—Continued

[Based on CBSAs and Census 2000 data]

Rural county	CBSA
Macon, AL	Auburn-Opelika, AL.
Talladega, AL	Anniston-Oxford, AL.
Hot Springs, AR	Hot Springs, AR.
Windham, CT	Hartford-West Hartford-East Hartford, CT.
Bradford, FL	Gainesville, FL.
Hendry, FL	West Palm Beach-Boca Raton-Boynton, FL.
Levy, FL	Gainesville, FL.
Walton, FL	Fort Walton Beach-Crestview-Destin, FL.
Banks, GA	Gainesville, GA.
Chattooga, GA	Chattanooga, TN-GA.
Jackson, GA	Atlanta-Sandy Springs-Marietta, GA.
Lumpkin, GA	Atlanta-Sandy Springs-Marietta, GA.
Morgan, GA	Atlanta-Sandy Springs-Marietta, GA.
Peach, GA	Macon, GA.
Polk, GA	Atlanta-Sandy Springs-Marietta, GA.
Talbot, GA	Columbus, GA-AL.
Bingham, ID	Idaho Falls, ID.
Christian, IL	Springfield, IL.
DeWitt, IL	Bloomington-Normal, IL.
Iroquois, IL	Kankakee-Bradley, IL.
Logan, IL	Springfield, IL.
Mason, IL	Peoria, IL.
Ogle, IL	Rockford, IL.
Clinton, IN	Lafayette, IN.
Henry, IN	Indianapolis-Carmel, IN.
Spencer, IN	Evansville, IN-KY.
Starke, IN	Gary, IN.
Warren, IN	Lafayette, IN.
Boone, IA	Ames, IA.
Buchanan, IA	Waterloo-Cedar Falls, IA.
Cedar, IA	Iowa City, IA.
Allen, KY	Bowling Green, KY.
Assumption Parish, LA	Baton Rouge, LA.
St. James Parish, LA	Baton Rouge, LA.
Allegan, MI	Holland-Grand Haven, MI.
Montcalm, MI	Grand Rapids-Wyoming, MI.
Oceana, MI	Muskegon-Norton Shores, MI.
Shiawassee, MI	Lansing-East Lansing, MI.
Tuscola, MI	Saginaw-Saginaw Township North, MI.
Fillmore, MN	Rochester, MN.
Dade, MO	Springfield, MO.
Pearl River, MS	Gulfport-Biloxi, MS.
Caswell, NC	Burlington, NC.
Davidson, NC	Greensboro-High Point, NC.
Granville, NC	Durham, NC.
Harnett, NC	Raleigh-Cary, NC.
Lincoln, NC	Charlotte-Gastonia-Concord, NC-SC.
Polk, NC	Spartanburg, SC.
Los Alamos, NM	Santa Fe, NM.
Lyon, NV	Carson City, NV.
Cayuga, NY	Syracuse, NY.
Columbia, NY	Albany-Schenectady-Troy, NY.
Genesee, NY	Rochester, NY.
Greene, NY	Albany-Schenectady-Troy, NY.
Schuyler, NY	Ithaca, NY.
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY.
Wyoming, NY	Buffalo-Niagara Falls, NY.
Ashtabula, OH	Cleveland-Elyria-Mentor, OH.
Champaign, OH	Springfield, OH.
Columbiana, OH	Youngstown-Warren-Boardman, OH-PA.
Cotton, OK	Lawton, OK.
Linn, OR	Corvallis, OR.
Adams, PA	York-Hanover, PA.
Clinton, PA	Williamsport, PA.
Greene, PA	Pittsburgh, PA.
Monroe, PA	Allentown-Bethlehem-Easton, PA-NJ.
Schuylkill, PA	Reading, PA.
Susquehanna, PA	Binghamton, NY.
Clarendon, SC	Sumter, SC.

RURAL COUNTIES CONTAINING HOSPITALS REDESIGNATED AS URBAN UNDER SECTION 1886(d)(8)(B) OF THE ACT—Continued

[Based on CBSAs and Census 2000 data]

Rural county	CBSA
Lee, SC	Sumter, SC.
Oconee, SC	Greenville, SC.
Union, SC	Spartanburg, SC.
Meigs, TN	Cleveland, TN.
Bosque, TX	Waco, TX.
Falls, TX	Waco, TX.
Fannin, TX	Dallas-Plano-Irving, TX.
Grimes, TX	College Station-Bryan, TX.
Harrison, TX	Longview, TX.
Henderson, TX	Dallas-Plano-Irving, TX.
Milam, TX	Austin-Round Rock, TX.
Van Zandt, TX	Dallas-Plano-Irving, TX.
Willacy, TX	Brownsville-Harlingen, TX.
Buckingham, VA	Charlottesville, VA.
Floyd, VA	Blacksburg-Christiansburg-Radford, VA.
Middlesex, VA	Virginia Beach-Norfolk-Newport News, VA.
Page, VA	Harrisonburg, VA.
Shenandoah, VA	Winchester, VA-WV.
Island, WA	Seattle-Bellevue-Everett, WA.
Mason, WA	Olympia, WA.
Wahkiakum, WA	Longview, WA.
Jackson, WV	Charleston, WV.
Roane, WV	Charleston, WV.
Green, WI	Madison, WI.
Green Lake, WI	Fond du Lac, WI.
Jefferson, WI	Milwaukee-Waukesha-West Allis, WI.
Walworth, WI	Milwaukee-Waukesha-West Allis, WI.

As in the past, hospitals redesignated under section 1886(d)(8)(B) of the Act are also eligible to be reclassified to a different area by the MGCRB. Affected hospitals were permitted to compare the reclassified wage index for the labor market area in Table 4C in the Addendum to the proposed rule into which they would be reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals could have withdrawn from an MGCRB reclassification within 45 days of the publication of the FY 2010 proposed rule.

Comment: Several commenters suggested that CMS allow Lugar hospitals the ability to waive their Lugar status once and have the waiver be effective until the hospital chooses to withdraw.

Response: Section 1886(d)(8)(B) of the Act required us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA to which the greatest number of workers in the county commute. Hospitals satisfying the criteria under section 1886(d)(8)(B) of the Act are treated as urban hospitals and are also eligible for reclassification through the MGCRB or may waive their Lugar status if eligible to receive the out-migration adjustment. Once a hospital is listed as a Lugar hospital under section 1886(d)(8)(B) of the Act, it is treated as such until the hospital waives its Lugar status. Hospitals can only waive Lugar status if they are in a county that is eligible to receive an out-migration adjustment. A rural hospital that is redesignated as Lugar, or urban, that wishes to stay rural can apply to be reclassified back to rural status under § 412.103 of the regulations. Otherwise, hospitals that are redesignated as Lugar can only waive Lugar status if they are eligible for the out-migration adjustment.

The wage index is updated annually and, as such, hospitals wishing to waive their Lugar redesignation in order to receive the rural area wage index plus the out-migration adjustment must request the waiver annually. Each year, the preamble of the IPPS proposed rule is specific that hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(10) of the Act will be deemed to have chosen to retain their redesignation or reclassification, and that hospitals redesignated under section 1886(d)(8) of the Act will be deemed to have waived the out-migration adjustment, unless they explicitly notify CMS within 45 days from the publication of the proposed rule that they elect to receive the out-migration adjustment instead. For example, we refer readers to the FY 2009 IPPS proposed rule (73 FR 23635). The introductory text of Table 4J in the Addendum to the rule also reminds hospitals of the annual process.

If a hospital chooses to waive its Lugar status within 45 days of the proposed rule, each year it must send a written request to CMS at the following address: Division of Acute Care, Center for Medicare Management, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244, Attn: Brian Slater; and must send a copy to the MGCRB. The mailing address for the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

5. Reclassifications Under Section 1886(d)(8)(B) of the Act

As discussed in the FY 2009 IPPS final rule (73 FR 48588), Lugar hospitals are treated like reclassified hospitals for purposes of determining their applicable wage index and receive the reclassified wage index for the urban area to which they have been redesignated. Because Lugar hospitals are treated like reclassified hospitals, when they are seeking reclassification by the MGCRB, they are subject to the rural reclassification rules set forth at 42 CFR 412.230. The procedural rules set forth at § 412.230 list the criteria that a hospital must meet in order to reclassify as a rural hospital. Lugar hospitals are

subject to the proximity criteria and payment thresholds that apply to rural hospitals. Specifically, the hospital must be no more than 35 miles from the area to which it seeks reclassification (§ 412.230(b)(1)); and the hospital must show that its average hourly wage is at least 106 percent of the average hourly wage of all other hospitals in the area in which the hospital is located (§ 412.230(d)(1)(iii)(C)). In accordance with policy adopted in the FY 2009 IPPS final rule (73 FR 48568 and 48569), beginning with reclassifications for the FY 2010 wage index, a Lugar hospital must also demonstrate that its average hourly wage is equal to at least 84 percent (for FY 2010 reclassifications) and 86 percent (for reclassifications for FY 2011 and subsequent fiscal years) of the average hourly wage of hospitals in the area to which it seeks redesignation (§ 412.230(d)(1)(iv)(C)).

Hospitals not located in a Lugar county seeking reclassification to the urban area where the Lugar hospitals have been redesignated are not permitted to measure to the Lugar county to demonstrate proximity (no more than 15 miles for an urban hospital, and no more than 35 miles for a rural hospital or the closest urban or rural area for RRCs or SCHs) in order to be reclassified to such urban area. These hospitals must measure to the urban area exclusive of the Lugar County to meet the proximity or nearest urban or rural area requirement. We treat New England deemed counties in a manner consistent with how we treat Lugar counties. (We refer readers to FY 2008 IPPS final rule with comment period (72 FR 47337) for a discussion of this policy.)

6. Reclassifications Under Section 508 of Public Law 108–173

Section 508 of Public Law 108–173 allowed certain qualifying hospitals to receive wage index reclassifications and assignments that they otherwise would not have been eligible to receive under the law. Although section 508 originally was scheduled to expire after a 3-year period, Congress extended the provision several times, as well as certain special exceptions that would have otherwise expired. For a discussion of the original section 508 provision and its various extensions, we refer readers to the FY 2009 IPPS final rule (73 FR 48588). The most recent extension of the provision was included in section 124 of Public Law 110–275 (MIPPA). Section 124 extended, through FY 2009, section 508 reclassifications as well as certain special exceptions. Because the latest extension of these provisions expires on September 30, 2009, and will not be applicable in FY 2010, we are not making any changes related to these provisions in this final rule.

J. FY 2010 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

In accordance with the broad discretion under section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, beginning with FY 2005, we established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees (the ''out-migration'' adjustment). The process, outlined in the FY 2005 IPPS final rule (69 FR 49061), provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Such adjustments to the wage index are effective for 3 years, unless a hospital requests to waive the application of the adjustment. A county will not lose its status as a qualifying county due to wage index changes during the 3-year period, and counties will receive the same wage index increase for those 3 years. However, a county that qualifies in any given year may no longer qualify after the 3-year period, or it may qualify but receive a different adjustment to the wage index level. Hospitals that receive this adjustment to their wage index are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Adjustments under this provision are not subject to the budget neutrality requirements under section 1886(d)(3)(E) of the Act.

Hospitals located in counties that qualify for the wage index adjustment are to receive an increase in the wage index that is equal to the average of the differences between the wage indices of the labor market area(s) with higher wage indices and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any labor market area with a higher wage index. Beginning with the FY 2008 wage index, we use post-reclassified wage indices when determining the out-migration adjustment (72 FR 47339).

For the FY 2010 wage index, we calculated the out-migration adjustment using the same formula described in the FY 2005 IPPS final rule (69 FR 49064), with the addition of using the post-reclassified wage indices, to calculate the out-migration adjustment. This adjustment is calculated as follows:

Step 1—Subtract the wage index for the qualifying county from the wage index of each of the higher wage area(s) to which hospital workers commute.

Step 2—Divide the number of hospital employees residing in the qualifying county who are employed in such higher wage index area by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area. For each of the higher wage index areas, multiply this result by the result obtained in Step 1.

Step 3—Sum the products resulting from Step 2 (if the qualifying county has workers commuting to more than one higher wage index area).

Step 4—Multiply the result from Step 3 by the percentage of hospital employees who are residing in the qualifying county and who are employed in any higher wage index area.

These adjustments will be effective for each county for a period of 3 fiscal years. For example, hospitals that received the adjustment for the first time in FY 2009 will be eligible to retain the adjustment for FY 2010. For hospitals in newly qualified counties, adjustments to the wage index are effective for 3 years, beginning with discharges occurring on or after October 1, 2009.

Hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of the Act are not eligible for reclassification under sections 1886(d)(8) or (d)(10) of the Act unless they waive the out-migration adjustment. Consistent with our FY 2005, 2006, 2007, 2008, and 2009 IPPS final rules, we are specifying that hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(d)(10) of the Act will be deemed to have chosen to retain their redesignation or reclassification. Section 1886(d)(10) hospitals that wished to receive the out-migration adjustment, rather than their reclassification adjustment, had to follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of the proposed rule. Otherwise, they were deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8) of the Act were deemed to have waived the out-migration adjustment unless they explicitly notified CMS within 45 days from the publication of the proposed rule that they elected to receive the out-migration adjustment instead.

Table 4J in the Addendum to this final rule lists the out-migration wage index adjustments for FY 2010.

Hospitals that are not otherwise reclassified or redesignated under section 1886(d)(8) or section 1886(d)(10) of the Act will automatically receive the listed adjustment. In accordance with the procedures discussed above, redesignated/reclassified hospitals will be deemed to have waived the out-migration adjustment unless CMS was otherwise notified within the necessary timeframe. In addition, hospitals eligible to receive the out-migration wage index adjustment and that withdrew their application for reclassification will automatically receive the wage index adjustment listed in Table 4J in the Addendum to this final rule.

Comment: One commenter requested that CMS allow hospitals to submit their own commuting data to apply for the out-migration adjustment.

Response: First, we did not propose any changes on commuting data for purposes of calculating the out-migration adjustment. Therefore, we believe this comment is outside the scope of the proposed rule. In addition, as we stated in the FY 2005 IPPS final rule (69 FR 49063), because the adjustment is based on the number of hospital workers in a county who commute to other higher wage areas, we believe it would be extremely problematic for individual hospitals to track and submit the data necessary for determining the out-migration adjustment. A hospital could not simply survey its own employees to obtain these necessary data, but would have to survey all hospital workers who live in the county where the hospital is located and commute to hospitals in other higher wage index areas.

K. Process for Requests for Wage Index Data Corrections

The preliminary, unaudited Worksheet S–3 wage data and occupational mix survey data files for the FY 2010 wage index were made available on October 6, 2008, through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

In the interest of meeting the data needs of the public, beginning with the proposed FY 2009 wage index, we post an additional public use file on our Web site that reflects the actual data that are used in computing the proposed wage index. The release of this new file does not alter the current wage index process or schedule. We notified the hospital community of the availability of these data as we do with the current public use wage data files through our Hospital Open Door forum. We encouraged hospitals to sign up for automatic notifications of information about hospital issues and the scheduling of the Hospital Open Door forums at: *http://www.cms.hhs.gov/OpenDoorForums/*.

In a memorandum dated October 6, 2008, we instructed all fiscal intermediaries/MACs to inform the IPPS hospitals they service of the availability of the wage index data files and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries/MACs to advise hospitals that these data were also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in the October 6, 2008 wage and occupational mix data files, the hospital was to submit corrections along with complete, detailed supporting documentation to its fiscal intermediary/MAC by December 8, 2008. Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage index data files on the Internet, through the October 6, 2008 memorandum referenced above.

In the October 6, 2008 memorandum, we also specified that a hospital requesting revisions to its first and/or second quarter occupational mix survey data was to copy its record(s) from the CY 2007–2008 occupational mix preliminary files posted to our Web site in October, highlight the revised cells on its spreadsheet, and submit its spreadsheet(s) and complete documentation to its fiscal intermediary/MAC no later than December 8, 2008.

The fiscal intermediaries/MACs notified the hospitals by mid-February 2009 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals' early-December revision requests. The fiscal intermediaries/MACs also submitted the revised data to CMS by mid-February 2009. CMS published the proposed wage index public use files that included hospitals' revised wage index data on February 23, 2009. In a memorandum also dated February 23, 2009, we instructed fiscal intermediaries/MACs to notify all hospitals regarding the availability of the proposed wage index public use files and the criteria and process for requesting corrections and revisions to the wage index data. Hospitals had until March 10, 2009, to submit requests to the fiscal intermediaries/MACs for reconsideration of adjustments made by the fiscal intermediaries/MACs as a result of the desk review, and to correct errors due to CMS's or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the wage index data. Hospitals also were required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries/MACs were required to transmit any additional revisions resulting from the hospitals' reconsideration requests by April 15, 2009. The deadline for a hospital to request CMS intervention in cases where the hospital disagrees with the fiscal intermediary's (or, if applicable, the MAC's) policy interpretations was April 22, 2009.

Hospitals were given the opportunity to examine Table 2 in the Addendum to the proposed rule. Table 2 in the Addendum to the proposed rule contained each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2006 data used to construct the proposed FY 2010 wage index. We noted that the hospital average hourly wages shown in Table 2 only reflect changes made to a hospital's data and transmitted to CMS by March 2, 2009.

We released the final wage index data public use files in early May 2009 on the Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*. The May 2009 public use files were made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary/MAC in the entry of the final wage index data that resulted from the correction process described above (revisions submitted to CMS by the fiscal intermediaries/MACs by April 15, 2009). If, after reviewing the May 2009 final files, a hospital believed that its wage or occupational mix data were incorrect due to a fiscal intermediary/MAC or CMS error in the entry or tabulation of the final data, the hospital had to send a letter to both its fiscal intermediary/MAC and CMS that outlined why the hospital believed an error existed and that provided all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries (or, if applicable, the MACs) had to receive these requests no later than June 8, 2009.

Each request also had to be sent to the fiscal intermediary/MAC. The fiscal intermediary/MAC reviewed requests upon receipt and contacted CMS immediately to discuss any findings.

At this point in the process, that is, after the release of the May 2009 wage index data files, changes to the wage and occupational mix data were only made in those very limited situations involving an error by the fiscal intermediary/MAC or CMS that the hospital could not have known about before its review of the final wage index data files. Specifically, neither the fiscal intermediary/MAC nor CMS approved the following types of requests:

- Requests for wage index data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries or the MACs on or before April 15, 2009.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 23, 2009 wage index public use files.
- Requests to revisit factual determinations or policy interpretations made by the fiscal intermediary or the MAC or CMS during the wage index data correction process.

Verified corrections to the wage index data received timely by CMS and the fiscal intermediaries or the MACs (that is, by June 8, 2009) were incorporated into the final wage index in this FY 2010 IPPS/RY 2010 LTCH PPS final rule, which will be effective October 1, 2009.

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2010 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the fiscal intermediary's (or, if applicable the MAC's) decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision. (*See W. A. Foote Memorial Hospital* v. *Shalala*, No. 99–CV–75202–DT (E.D. Mich. 2001) and *Palisades General Hospital* v. *Thompson*, No. 99–1230 (D.D.C. 2003).) We refer readers also to the FY 2000 IPPS final rule (64 FR 41513) for a discussion of the parameters for appealing to the PRRB for wage index data corrections.

Again, we believe the wage index data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage and occupational mix data to the fiscal intermediary's (or, if applicable, the MAC's) attention. Moreover, because hospitals had access to the final wage index data by early May 2009, they had the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or the MAC or CMS before the development and publication of the final FY 2010 wage index by August 2009, and the implementation of the FY 2010 wage index on October 1, 2009. If hospitals availed themselves of the opportunities afforded to provide and make corrections to the wage and occupational mix data, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified by hospitals and brought to our attention after June 8, 2009, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with 42 CFR 412.64(k)(1) of our existing regulations, we make midyear corrections to the wage index for an area only if a hospital can show that: (1) the fiscal intermediary or the MAC or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, ''before the beginning of the fiscal year'' means by the June 8 deadline for making corrections to the wage data for the following fiscal year's wage index. This provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index for the labor market area. As indicated earlier, because CMS makes the wage index data available to hospitals on the CMS Web site prior to publishing both the proposed and final IPPS rules, and the fiscal intermediaries or the MAC notify hospitals directly of any wage index data changes after completing their desk reviews, we do not expect that midyear corrections will be necessary. However, under our current policy, if the correction of a data error changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is made.

In the FY 2006 IPPS final rule (70 FR 47385), we revised 42 CFR 412.64(k)(2) to specify that, effective on October 1, 2005, that is, beginning with the FY 2006 wage index, a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when: (1) The fiscal intermediary (or, if applicable, the MAC) or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the fiscal intermediary (or if applicable the MAC) and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage index data, before the beginning of the fiscal year for the applicable IPPS update (that is, by the June 8, 2009 deadline for the FY 2010 wage index); and (3) CMS agreed that the fiscal intermediary (or if applicable, the MAC) or CMS made an error in tabulating the hospital's wage index data and the wage index should be corrected.

In those circumstances where a hospital requested a correction to its wage index data before CMS calculates the final wage index (that is, by the June 8, 2009 deadline), and CMS acknowledges that the error in the hospital's wage index data was caused by CMS' or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the data, we believe that the hospital should not be penalized by our delay in publishing or implementing the correction. As with our current policy, we indicated that the provision is not available to a hospital seeking to revise another hospital's data. In addition, the provision cannot be used to correct prior years' wage index data; and it can only be used for the current Federal fiscal year. In other situations where our policies would allow midyear corrections, we continue to believe that it is appropriate to make prospective-only corrections to the wage index.

We note that, as with prospective changes to the wage index, the final retroactive correction will be made irrespective of whether the change increases or decreases a hospital's payment rate. In addition, we note that the policy of retroactive adjustment will still apply in those instances where a judicial decision reverses a CMS denial of a hospital's wage index data revision request.

IV. Rebasing and Revision of the Hospital Market Baskets for Acute Care Hospitals

A. Background

Effective for cost reporting periods beginning on or after July 1, 1979, we developed and adopted a hospital input price index (that is, the hospital market basket for operating costs). Although ''market basket'' technically describes the mix of goods and services used in providing hospital care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket. Accordingly, the term ''market basket''

as used in this document refers to the hospital input price index.

The percentage change in the market basket reflects the average change in the price of goods and services hospitals purchase in order to provide inpatient care. We first used the market basket to adjust hospital cost limits by an amount that reflected the average increase in the prices of the goods and services used to provide hospital inpatient care. This approach linked the increase in the cost limits to the efficient utilization of resources.

Since the inception of the IPPS, the projected change in the hospital market basket has been the integral component of the update factor by which the prospective payment rates are updated every year. An explanation of the hospital market basket used to develop the prospective payment rates was published in the **Federal Register** on September 1, 1983 (48 FR 39764). We also refer readers to the FY 2006 IPPS final rule (70 FR 47387) in which we discussed the most recent previous rebasing of the hospital input price index.

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

The index itself is constructed in three steps. First, a base period is selected (in this final rule, the base period is FY 2006) and total base period expenditures are estimated for a set of mutually exclusive and exhaustive spending categories based upon type of expenditure. Then the proportion of total operating costs that each category represents is determined. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price or wage variable, referred to as a price proxy. In nearly every instance, these price proxies are price levels derived from publicly available statistical series that are published on a consistent schedule (preferably at least on a quarterly basis). Finally, the expenditure weight for each cost category is multiplied by the level of its respective price proxy. The sum of these products (that is, the expenditure weights multiplied by their price levels) for all cost categories yields the composite index level of the market basket in a given period. Repeating this step for other periods produces a series of market basket levels over time. Dividing an index level for a given period by an index level for an earlier period produces a rate of growth in the input price index over that timeframe.

The market basket is described as a fixed-weight index because it represents the change in price over time of the same mix (quantity and intensity) of goods and services purchased to provide hospital services in a base period. The effects on total expenditures resulting from changes in the mix of goods and services purchased subsequent to the base period are not measured. For example, shifting a traditionally inpatient type of care to an outpatient setting might affect the volume of inpatient goods and services purchased by the hospital, but would not be factored into the price change measured by a fixed-weight hospital market basket. In this manner, the market basket measures pure price change only. Only when the index is rebased would changes in the quantity and intensity be captured in the cost weights. Therefore, we rebase the market basket periodically so the cost weights reflect recent changes in the mix of goods and services that hospitals purchase (hospital inputs) to furnish inpatient care between base periods. We last rebased the hospital market basket cost weights effective for FY 2006 (70 FR 47387), with FY 2002 data used as the base period for the construction of the market basket cost weights.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24154), we invited public comments on our proposed methodological changes to both the IPPS operating market basket and the capital input price index (CIPI). We note that this section addresses only the rebasing and revision of the IPPS market basket and CIPI for acute care hospitals and for children's and cancer hospitals and RNHCIs, which are excluded from the IPPS. We address the market basket that will be applicable to LTCHs in section VIII.C.2. of the preamble of this final rule. Separate documents will address the market basket for other hospitals that are excluded from the IPPS.

B. Rebasing and Revising the IPPS Market Basket

The terms ''rebasing'' and ''revising,'' while often used interchangeably, actually denote different activities. ''Rebasing'' means moving the base year for the structure of costs of an input price index (for example, in this final rule, we are shifting the base year cost structure for the IPPS hospital index from FY 2002 to FY 2006). ''Revising'' means changing data sources, or price proxies, used in the input price index. As published in the FY 2006 IPPS final rule (70 FR 47387), in accordance with section 404 of Public Law 108–173, CMS determined a new frequency for rebasing the hospital market basket. We established a rebasing frequency of every 4 years and, therefore, for the FY 2010 IPPS update, as we proposed, we are rebasing and revising the IPPS market basket and the CIPI.

1. Development of Cost Categories and Weights

a. Medicare Cost Reports

The major source of expenditure data for developing the rebased and revised hospital market basket cost weights is the FY 2006 Medicare cost reports. As was done in previous rebasings, these cost reports are from IPPS hospitals only (hospitals excluded from the IPPS and CAHs are not included) and are based on IPPS Medicare-allowable operating costs. IPPS Medicare-allowable operating costs are costs that are eligible to be paid for under the IPPS. For example, the IPPS market basket excludes home health agency (HHA) costs as these costs would be paid under the HHA PPS and, therefore, these costs are not IPPS Medicare-allowable costs.

The IPPS cost reports yield seven major expenditure or cost categories—the same as in the FY 2002-based hospital market basket: Wages and salaries, employee benefits, contract labor, pharmaceuticals, professional liability insurance (malpractice), blood and blood products, and a residual ''all other.'' The cost weights that were obtained directly from the Medicare cost reports are reported in Chart 1. These Medicare cost report cost weights are then supplemented with information obtained from other data sources to derive the IPPS market basket cost weights.

CHART 1—MAJOR COST CATEGORIES AND THEIR RESPECTIVE COST WEIGHTS FOUND IN THE MEDICARE COST REPORTS

Major cost categories	FY 2002-based market basket	FY 2006-based market basket
Wages and salaries	45.590	45.156

CHART 1—MAJOR COST CATEGORIES AND THEIR RESPECTIVE COST WEIGHTS FOUND IN THE MEDICARE COST REPORTS—Continued

Major cost categories	FY 2002-based market basket	FY 2006-based market basket
Employee benefits	11.189	11.873
Contract labor	3.214	2.598
Professional Liability Insurance (Malpractice)	1.589	1.661
Pharmaceuticals	5.855	5.380
Blood and blood products	1.082	1.078
All other	31.481	32.254

b. Other Data Sources

In addition to the Medicare cost reports, the other data source we used to develop the IPPS market basket cost weights was the Benchmark Input-Output (I–O) Tables created by the Bureau of Economic Analysis (BEA), U.S. Department of Commerce. The BEA Benchmark I–O data are scheduled for publication every 5 years. The most recent data available are for 2002. BEA also produces Annual I–O estimates; however, the 2002 Benchmark I–O data represent a much more comprehensive and complete set of data that are derived from the 2002 Economic Census. The Annual I–O is simply an update of the Benchmark I–O tables. For the FY 2006 market basket rebasing, we used the 1997 Benchmark I–O data. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24155), we proposed to use the 2002 Benchmark I–O data in the FY 2006-based IPPS market basket, to be effective for FY 2010. Instead of using the less detailed, less accurate Annual I–O data, we aged the 2002 Benchmark I–O data forward to FY 2006. The methodology we used to age the data forward involves applying the annual price changes from the respective price proxies to the appropriate cost categories. We repeat this practice for each year.

The ''all other'' cost category obtained directly from the Medicare cost reports is divided into other hospital expenditure category shares using the 2002 Benchmark I–O data. Therefore, the ''all other'' cost category expenditure shares are proportional to their relationship to ''all other'' totals in the 2002 Benchmark I–O data. For instance, if the cost for telephone services was to represent 10 percent of the sum of the ''all other'' Benchmark I–O (see below) hospital expenditures, then telephone services would represent 10 percent of the IPPS market basket's ''all other'' cost category. Following publication of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, and in an effort to provide greater transparency, we posted on the CMS market basket Web page at: *http://www.cms.hhs.gov/MedicareProgramRatesStats/05_MarketBasketResearch.asp#TopOfPage* an illustrative spreadsheet that shows how the detailed cost weights in the proposed rule (that is, those not calculated using Medicare cost reports) were determined using the 2002 Benchmark I–O data.

2. Final Cost Category Computation

As stated previously, for this rebasing we used the Medicare cost reports to derive seven major cost categories. As we proposed, the FY 2006-based IPPS market basket includes three additional cost categories that were not broken out separately in the FY 2002-based IPPS market basket. The first is lifted directly from the Medicare cost reports: Blood and blood products. The remaining two are derived using the Benchmark I–O data: Administrative and business support services and financial services. As we proposed, we broke out the latter two categories so we can better match their respective expenses with price proxies. A thorough discussion of our rationale for each of these cost categories is provided in section IV.B.3. of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24155) and this final rule. Also, the FY 2006-based IPPS market basket excludes one cost category: Photo supplies. The 2002 Benchmark I–O weight for this category is considerably smaller than the 1997 Benchmark I–O weight, presently accounting for less than one-tenth of one percentage point of the IPPS market basket. Therefore, as we proposed, we include the photo supplies costs in the chemical cost category weight with other similar chemical products (74 FR 24155).

As we proposed, we are not changing our definition of the labor-related share. However, we rename our aggregate cost categories from ''labor-intensive'' and ''non-labor-intensive'' services to ''labor-related'' and ''nonlabor-related'' services (74 FR 24155). As discussed in more detail below and similar to the previous rebasing, we classify a cost category as labor-related and include it in the labor-related share if the cost category is defined as being labor-intensive and its cost varies with the local labor market. In previous regulations, we grouped cost categories that met both of these criteria into labor-intensive services. We believe the new labels more accurately reflect the concepts that they are intended to convey. We are not changing our definition of the labor-related share because we continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

3. Selection of Price Proxies

After computing the FY 2006 cost weights for the rebased hospital market basket, it was necessary to select appropriate wage and price proxies to reflect the rate of price change for each expenditure category. With the exception of the proxy for professional liability, all the proxies are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

- Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in markets other than the retail market. PPIs are preferable price proxies for goods and services that hospitals purchase as inputs because these PPIs better reflect the actual price changes faced by hospitals. For example, we use a special PPI for prescription drugs, rather than the Consumer Price Index (CPI) for prescription drugs, because hospitals generally purchase drugs directly from a wholesaler. The PPIs that we use measure price changes at the final stage of production.
- Consumer Price Indexes—Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by the typical consumer. Because they may not represent the price faced by a producer, we used CPIs only if an appropriate PPI was not available, or if the expenditures were more similar to those faced by retail consumers in general rather than by purchasers of goods at the wholesale level. For example, the CPI for food

purchased away from home is used as a proxy for contracted food services.

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

We evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance. Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Timeliness implies that the proxy is published regularly, preferably at least once a quarter. Availability means that the proxy is publicly available. Finally, relevance means that the proxy is applicable and representative of the cost category weight to which it is applied. The CPIs, PPIs, and ECIs selected meet these criteria.

Comment: Several commenters stated that although the MMA requires CMS to rebase the weights used in the hospital market basket more frequently than every 5 years to reflect the most current data available, it does not require CMS to modify or revise the price proxies used in the market basket calculation. The commenters discouraged CMS from incorporating any new price proxies, particularly the new blended price proxy associated with the Chemicals cost category, and indicated that such a change was not preferred at this time. They pointed out that the methodology and data sources used by CMS to derive the proposed 2006-based IPPS market basket yield a projected 2.1 percent increase in the hospital market basket update, while the historical methodology and data sources used to derive the FY 2002-based IPPS market basket yield a projected update of 2.3 percent. Several commenters pointed to the current status and volatility of the economy as a basis for maintaining the same price proxies going forward. Those comments included the following:

• Maintaining the current proxies will result in a more stable market basket increase and will demonstrate forbearance, given the current economic volatility that has occurred or may be yet to come.

• The country has recently experienced a period of very low inflation. The funds from the ARRA (Pub. L. 111–5) are beginning to work their way into the economy, possibly resulting in a period of higher inflation that could substantially affect the market basket estimate.

• The new price proxies selected by CMS are not responsive to the inflationary effects of the President's FY 2010 Budget and the inflationary stimulus effect of the Troubled Asset Relief Program (TARP), which is demonstrated by the modest market basket increases in FY 2010 and FY 2011.

• The traditional approach taken in developing the annual market basket forecast is inadequate, given the severe downturn in the economy and the potential for inflation to pick up at a pace quicker than we have seen for many years. Following several years of updates between 3 percent and 3.5 percent, a lower forecast may well underestimate hospital input costs, particularly nursing labor, as hospitals will not benefit from swelling labor markets due to the fact that it is unlikely that newly-unemployed workers possess the specialized skills required by hospitals.

As a result of these issues, multiple commenters urged CMS only to rebase the data and weights used in the market basket calculation, and not to revise the price proxies.

Response: We continuously monitor the technical appropriateness of all of CMS' market baskets (including the hospital market basket) whether or not the market basket is being rebased. However, whenever a market basket is rebased, it is a matter of practice for CMS to scrutinize all of its aspects, including the data sources that are used to construct it, the selection of its exhaustive and mutually exclusive cost categories, the weights associated with those categories, and the price proxies that are applied. We are revising the hospital market basket to make technical improvements that we believe results in more accurate payment updates.

We believe that revising four new price proxies for existing cost categories and including three additional price proxies for the new cost categories in the FY 2006-based hospital market basket represents a significant technical improvement to the market basket.

As many of the commenters stated, we proposed (and are adopting as final) a new blended chemical price proxy for the Chemicals cost weight in the FY 2006-based IPPS market basket. The FY 2002-based IPPS market basket used the PPI for industrial chemicals (WPI061) to proxy the chemicals cost category. In evaluating the technical merit of the continuing use of that proxy, we compared the 2002 BEA Benchmark I–O expenditure weights with the composition of the PPI for industrial chemicals. Using a commodity-to-industry crosswalk, we were able to identify the industry expenses classified by North American Industrial Classification System (NAICS) that comprise the commodity-based PPI for industrial chemicals.

We found that the relative PPI weights for each of the NAICS expense categories were not always consistent with the expense weights for the hospital industry, as indicated by the 2002 Benchmark I–O data. For example, hospital spending for NAICS 325120 (Industrial Gas Manufacturing)—the hospital industry's largest chemical expense category (accounting for 29 percent of the hospital industry's total chemical expenses)—is not found in the PPI for industrial chemicals. In addition, hospital spending attributable to NAICS 325190 (Other Basic Organic Chemical Manufacturing) accounts for just 26 percent of the hospital industry's total chemical expenses. However, NAICS 325190 accounts for 41 percent of the PPI for industrial chemicals.

Given these findings, we proposed using a blended chemical price index that reflects the relative weights of the hospital industry's chemical expenses as indicated by the 2002 Benchmark I–O data. This blended index is composed of the PPI for industrial gases (NAICS 325120), the PPI for other basic inorganic chemical manufacturing (NAICS 325180), the PPI for other basic organic chemical manufacturing (NAICS 325190), and the PPI for soap and cleaning compound manufacturing (NAICS 325610). The expenses for these NAICS industries account for approximately 90 percent of the hospital industry's chemical expenses, excluding NAICS 324110—Petroleum Refineries, which we proposed to include with other petroleum-related expenses classified in the fuel, oil, and gas cost category. We believe this new blended proxy represents a more accurate reflection of the price pressures associated with hospital chemical expenses.

With respect to the state of the economy, we are attentive to the recent downturn and the fact that this year's update is lower relative to historical market basket updates. We also recognize the commenters' uncertainty regarding future inflationary pressures, given the activities undertaken in the last several months to aid the economy. However, the most recent forecast of the rebased and revised FY 2006-based IPPS market basket FY 2010 update factor reflects the current expectations regarding the performance of the economy during FY 2010, including the inflation expectations associated with the economic stimulus plans. Moreover,

this forecast also reflects our most recent expectations regarding price pressures associated with the labor market for hospital workers.

Comment: One commenter stated that CMS' proposal to rebase and revise the market basket appears to be directed at reducing the rate of increase in future market basket increases.

Response: When selecting the price proxies for the IPPS market basket, we do not evaluate the resulting market basket update as a criterion in selecting these proxies, but rather choose the most technically appropriate measures of the price pressures faced by the hospital industry. We believe the proxies that were articulated in the FY 2010 proposed rule reflect that approach.

Comment: Several commenters supported CMS' proposed use of the PPI for blood and organ banks for measuring changes in the cost of blood and blood products. The commenters expressed appreciation for CMS' responsiveness to the need for greater accuracy in the calculation of price changes attributable to blood and blood products in the IPPS market basket.

Response: We appreciate the commenters' support for our proposed price proxy for the blood and blood products cost category. We agree with the commenters that the implementation of this price proxy represents a technical improvement to the IPPS market basket.

After consideration of the public comments received, we are adopting as final the price proxies that we proposed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24155–24159).

Chart 2 sets forth the FY 2006-based IPPS market basket, including cost categories, weights, and price proxies. For comparison purposes, the corresponding FY 2002-based IPPS market basket is listed as well. A summary outlining the choice of the various proxies follows the chart.

CHART 2—FY 2006-BASED IPPS HOSPITAL MARKET-BASKET COST CATEGORIES, WEIGHTS, AND PRICE PROXIES WITH FY 2002-BASED IPPS MARKET BASKET INCLUDED FOR COMPARISON

Cost Categories	FY 2002-based hospital market basket cost weights	Rebased FY 2006-based hospital market basket cost weights	Rebased FY 2006-based hospital market basket price proxies
1. Compensation	59.993	59.627	
A. Wages and Salaries [1]	48.171	47.213	ECI for Wages and Salaries, Civilian Hospital Workers.
B. Employee Benefits [1]	11.822	12.414	ECI for Benefits, Civilian Hospital Workers.
2. Utilities	1.251	2.180	
A. Fuel, Oil, and Gasoline	0.206	0.418	PPI for Petroleum Refineries.
B. Electricity	0.669	1.645	PPI for Commercial Electric Power.
C. Water and Sewage	0.376	0.117	CPI–U for Water & Sewerage Maintenance.
3. Professional Liability Insurance	1.589	1.661	CMS Professional Liability Insurance Premium Index.
4. All Other	37.167	36.533	
A. All Other Products	20.336	19.473	
(1.) Pharmaceuticals	5.855	5.380	PPI for Pharmaceutical Preparations (Prescriptions).
(2.) Food: Direct Purchases	1.664	3.982	PPI for Processed Foods & Feeds.
(3.) Food: Contract Services	1.180	0.575	CPI–U for Food Away From Home.
(4.) Chemicals [2]	2.096	1.538	Blend of Chemical PPIs.
(5.) Blood and Blood Products [3]	.....	1.078	PPI for Blood and Organ Banks.
(6.) Medical Instruments	1.932	2.762	PPI for Medical, Surgical, and Personal Aid Devices.
(7.) Photographic Supplies	0.183		
(8.) Rubber and Plastics	2.004	1.659	PPI for Rubber & Plastic Products.
(9.) Paper and Printing Products	1.905	1.492	PPI for Converted Paper & Paperboard Products.
(10.) Apparel	0.394	0.325	PPI for Apparel.
(11.) Machinery and Equipment	0.565	0.163	PPI for Machinery & Equipment.
(12.) Miscellaneous Products [3]	2.558	0.519	PPI for Finished Goods Less Food and Energy.
B. Labor-related Services	9.738	9.175	
(1.) Professional Fees: Labor-related [4]	5.510	5.356	ECI for Compensation for Professional and Related Occupations.
(2.) Administrative and Business Support Services [5].	n/a	0.626	ECI for Compensation for Office and Administrative Services.
(3.) All Other: Labor-Related Services [5]	4.228	3.193	ECI for Compensation for Private Service Occupations.
C. Nonlabor-Related Services	7.093	7.885	
(1.) Professional Fees: Nonlabor-Related [4]	n/a	4.074	ECI for Compensation for Professional and Related Occupations.
(2.) Financial Services [6]	n/a	1.281	ECI for Compensation for Financial Activities.
(3.) Telephone Services	0.458	0.627	CPI–U for Telephone Services.
(4.) Postage	1.300	0.963	CPI–U for Postage.
(5.) All Other: Nonlabor-Related Services [6]	5.335	0.940	CPI–U for All Items Less Food and Energy.
Total	100.000	100.000	

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

[1] Contract labor is distributed to wages and salaries and employee benefits based on the share of total compensation that each category represents.

[2] To proxy the "chemicals" cost category, we used a blended PPI composed of the PPI for industrial gases, the PPI for other basic inorganic chemical manufacturing, the PPI for other basic organic chemical manufacturing, and the PPI for soap and cleaning compound manufacturing. For more detail about this proxy, see section IV.B.3.j. of the preamble of this final rule.

[3] The "blood and blood products" cost category was contained within "miscellaneous products" cost category in the FY 2002-based IPPS market basket.

[4] The "professional fees: Labor-related" and "professional fees: Nonlabor-related" cost categories were included in one cost category called "professional fees" in the FY 2002-based IPPS market basket. For more detail about how these new categories were derived, we refer readers to sections IV.B.3.s. and v. of the preamble of this final rule, on the labor-related share.

[5] The "administrative and business support services" cost category was contained within "all other: Labor-intensive services" cost category in the FY 2002-based IPPS market basket. The "all other: Labor-intensive services" cost category is renamed the "all other: Labor-related services" cost category for the FY 2006-based IPPS market basket.

[6] The "financial services" cost category was contained within the "all other: Non-labor intensive services" cost category in the FY 2002-based IPPS market basket. The "all other: Nonlabor intensive services" cost category is renamed the "all other: Nonlabor-related services" cost category for the FY 2006-based IPPS market basket.

As we proposed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24156 through 24159), for this final rule, we use the following choices with respect to the various proxies:

a. Wages and Salaries

We use the ECI for wages and salaries for hospital workers (all civilian) (series code #CIU1026220000000I) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based IPPS market basket.

b. Employee Benefits

We use the ECI for employee benefits for hospital workers (all civilian) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based IPPS market basket.

c. Fuel, Oil, and Gasoline

For the FY 2002-based market basket, this category only included expenses classified under North American Industry Classification System (NAICS) 21 (Mining). We proxied this category using the PPI for commercial natural gas (series code #WPU0552). For the FY 2006-based market basket, we add costs to this category that had previously been grouped in other categories. The added costs include petroleum-related expenses under NAICS 324110 (previously captured in the miscellaneous category), as well as petrochemical manufacturing classified under NAICS 325110 (previously captured in the chemicals category). These added costs represent 80 percent of the hospital industry's fuel, oil, and gasoline expenses (or 80 percent of this category). Because the majority of the industry's fuel, oil, and gasoline expenses originate from petroleum refineries (NAICS 324110), we use the PPI for petroleum refineries (series code #PCU324110) as the proxy for this cost category.

d. Electricity

We use the PPI for commercial electric power (series code #WPU0542) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based IPPS market basket.

e. Water and Sewage

We use the CPI for water and sewerage maintenance (all urban consumers) (series code #CUUR0000SEHG01) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based IPPS market basket.

f. Professional Liability Insurance

We proxy price changes in hospital professional liability insurance premiums (PLI) using percentage changes as estimated by the CMS Hospital Professional Liability Index. To generate these estimates, we collect commercial insurance premiums for a fixed level of coverage while holding nonprice factors constant (such as a change in the level of coverage). This method also is used to proxy PLI price changes in the Medicare Economic Index (68 FR 63244). This same proxy was used in the FY 2002-based IPPS market basket.

g. Pharmaceuticals

We use the PPI for pharmaceutical preparations (prescription) (series code #PCU32541DRX) to measure the price growth of this cost category. This is a special index produced by BLS and is the same proxy used in the FY 2002-based IPPS market basket.

h. Food: Direct Purchases

We use the PPI for processed foods and feeds (series code #WPU02) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based IPPS market basket.

i. Food: Contract Services

We use the CPI for food away from home (all urban consumers) (series code #CUUR0000SEFV) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based IPPS market basket.

j. Chemicals

We use a blended PPI composed of the PPI for industrial gases (NAICS 325120), the PPI for other basic inorganic chemical manufacturing (NAICS 325180), the PPI for other basic organic chemical manufacturing (NAICS 325190), and the PPI for soap and cleaning compound manufacturing (NAICS 325610). Using the 2002 Benchmark I–O data, we found that these NAICS industries accounted for approximately 90 percent of the hospital industry's chemical expenses. Therefore, we use this blended index because we believe its composition better reflects the composition of the purchasing patterns of hospitals than does the PPI for industrial chemicals (series code #WPU061), the proxy used in the FY 2002-based IPPS market basket. Chart 3 below shows the weights for each of the four PPIs used to create the blended PPI, which we determined using the 2002 Benchmark I–O data.

CHART 3—BLENDED CHEMICAL PPI WEIGHTS

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

k. Blood and Blood Products

In the FY 2002-based IPPS market basket, we classified blood and blood products into the miscellaneous products category and used the PPI for finished goods less food and energy to proxy the price changes associated with these expenses. At the time of the rebasing of the FY 2002-based IPPS market basket, we noticed an apparent divergence between the PPI for blood

and blood derivatives, the price proxy used in the FY 1997-based IPPS market basket, and blood costs faced by hospitals over the recent time period. A thorough discussion of this analysis is found in the FY 2006 IPPS final rule (70 FR 47390).

Since the last rebasing of the market basket, BLS began collecting data and publishing an industry PPI for blood and organ banks (NAICS 621991). For the FY 2006-based IPPS market basket, as we proposed, we incorporate this series (series code #PCU621991) into the market basket and use it to proxy the blood and blood products cost category.

l. Medical Instruments

We use the PPI for medical, surgical, and personal aid devices (series code #WPU156) to measure the price growth of this cost category. In the 1997 Benchmark I–O data, approximately half of the expenses classified in this category were for surgical and medical instruments. Thus, we used the PPI for surgical and medical instruments and equipment (series code #WPU1562) to proxy this category in the FY 2002-based IPPS market basket. The 2002 Benchmark I–O data show that this category now represents only 33 percent of these expenses and the largest expense category is surgical appliance and supplies manufacturing (corresponding to series code #WPU1563). Due to this reallocation of costs over time, we are changing the price proxy for this cost category to the more aggregated PPI for medical, surgical, and personal aid devices.

m. Photographic Supplies

We are eliminating the cost category specific to photographic supplies for the proposed FY 2006-based IPPS market basket. These costs will now be included in the chemicals cost category because the costs are presently reported as all other chemical products. Notably, although we are eliminating the specific cost category, these costs will still be accounted for within the IPPS market basket.

n. Rubber and Plastics

We use the PPI for rubber and plastic products (series code #WPU07) to measure price growth of this cost category. This same proxy was used in the FY 2002-based IPPS market basket.

o. Paper and Printing Products

We use the PPI for converted paper and paperboard products (series code #WPU0915) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based IPPS market basket.

p. Apparel

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

q. Machinery and Equipment

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

r. Miscellaneous Products

We use the PPI for finished goods less food and energy (series code #WPUSOP3500) to measure the price growth of this cost category. Using this index removes the double-counting of food and energy prices, which are already captured elsewhere in the market basket. This same proxy was used in the FY 2002-based IPPS market basket.

s. Professional Fees: Labor-Related

We use the ECI for compensation for professional and related occupations (private industry) (series code #CIS2020000120000I) to measure the price growth of this category. It includes occupations such as legal, accounting, and engineering services. This same proxy was used in the FY 2002-based IPPS market basket.

t. Administrative and Business Support Services

We use the ECI for compensation for office and administrative support services (private industry) (series code #CIU2010000220000I) to measure the price growth of this category. Previously these costs were included in the ''all other: labor-intensive cost'' category (now renamed the ''all other: labor-related cost'' category), and were proxied by the ECI for compensation for service occupations. We believe that this compensation index better reflects the changing price of labor associated with the provision of administrative services and its incorporation represents a technical improvement to the market basket.

u. All Other: Labor-Related Services

We use the ECI for compensation for service occupations (private industry) (series code #CIU2010000300000I) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based IPPS market basket.

v. Professional Fees: Nonlabor-Related

We use the ECI for compensation for professional and related occupations (private industry) (series code #CIS2020000120000I) to measure the price growth of this category. This is the same price proxy that we use for the professional fees: labor-related cost category.

w. Financial Services

We use the ECI for compensation for financial activities (private industry) (series code #CIU201520A000000I) to measure the price growth of this cost category. Previously these costs were included in the ''all other: nonlabor-intensive cost'' category (now renamed the ''all other: nonlabor-related cost'' category), and were proxied by the CPI for all items. We believe that this compensation index better reflects the changing price of labor associated with the provision of financial services and its incorporation represents a technical improvement to the market basket.

x. Telephone Services

We use the CPI for telephone services (series code #CUUR0000SEED) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based IPPS market basket.

y. Postage

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

z. All Other: Nonlabor-Related Services

We use the CPI for all items less food and energy (series code #CUUR0000SA0L1E) to measure the price growth of this cost category. Previously these costs were proxied by the CPI for all items in the FY 2002-based IPPS market basket. We believe that using the CPI for all items less food and energy will remove any double-counting of food and energy prices, which are already captured elsewhere in the market basket. Consequently, we believe that the incorporation of this proxy represents a technical improvement to the market basket.

Chart 4 compares both the historical and forecasted percent changes in the FY 2002-based IPPS market basket and the FY 2006-based IPPS market basket.

CHART 4—FY 2002–BASED AND FY 2006–BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING INDEX PERCENT CHANGE, FY 2004 THROUGH FY 2012

Fiscal year (FY)	FY 2002-based IPPS market basket operating index percent change	FY 2006–based IPPS market basket operating index percent change
Historical data:		
FY 2004	4.0	4.0
FY 2005	4.3	3.9
FY 2006	4.3	4.0
FY 2007	3.4	3.6
FY 2008	4.3	4.0
Average FYs 2004–2008	4.1	3.9
Forecast:		
FY 2009	2.1	2.6
FY 2010	2.3	2.1
FY 2011	2.8	2.7
FY 2012	3.0	2.9
Average FYs 2009–2012	2.6	2.6

Source: IHS Global Insight, Inc., 2nd Quarter 2009, *USMACRO/CONTROL0609@CISSIM/TL0509.SIM.*

The differences between the FY 2002-based and the FY 2006-based IPPS market basket increases are mostly stemming from the revision the proxy used for the chemicals cost category. As stated earlier, we are adopting a blended chemical index that is comprised of four industry-based chemical price proxies that represent approximately 90 percent of the hospital industry's chemical expenses. The FY 2002-based IPPS market basket used the PPI for industrial chemicals. The PPI for industrial chemicals attributes more weight to direct petroleum expenses, which is not consistent with a hospital's most recent purchasing pattern according to the 2002 Benchmark I–O data. The lower weight for direct petroleum expenses in the blended chemical index results in less volatile price movements. We believe the blended index represents a technical improvement because it better reflects the purchasing patterns of hospitals.

Also contributing to the differences between the FY 2002-based and the FY 2006-based IPPS market basket increases is the larger weight associated with the professional fees category. In both market baskets, these expenditures are proxied by the ECI for compensation for professional and related services. The weight for professional fees in the FY 2002-based IPPS market basket is 5.5 percent compared to 9.4 percent in the FY 2006-based IPPS market basket.

4. Labor-Related Share

Under section 1886(d)(3)(E) of the Act, the Secretary estimates from time to time the proportion of payments that are labor-related. ''The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *.'' We refer to the proportion of hospitals' costs that are attributable to wages and wage-related costs as the ''labor-related share.''

The labor-related share is used to determine the proportion of the national PPS base payment rate to which the area wage index is applied. We include a cost category in the labor-related share if the costs are *labor intensive* and *vary with the local labor market.* Given this, as we proposed, we are including in the labor-related share the national average proportion of operating costs that are attributable to wages and salaries, employee benefits, contract labor, the labor-related portion of professional fees, administrative and business support services, and all other: labor-related services (previously referred to in the FY 2002-based IPPS market basket as labor-intensive) (74 FR 24159). Consistent with previous rebasings, the ''all other: labor-related services'' cost category is mostly comprised of building maintenance and security services (including, but not limited to, commercial and industrial machinery and equipment repair, nonresidential maintenance and repair, and investigation and security services). Because these services tend to be labor-intensive and are mostly performed at the hospital facility (and, therefore, unlikely to be purchased in the national market), we believe that they meet our definition of labor-related services.

For the rebasing of the FY 2002-based IPPS market basket in the FY 2006 IPPS final rule, we included in the labor-related share the national average proportion of operating costs that are attributable to wages and salaries, employee benefits, contract labor, professional fees, and labor-intensive services (70 FR 47393). For the FY 2006-based IPPS market basket rebasing, the inclusion of the administrative and business support services cost category into the labor-related share remains consistent with the current labor-related share because this cost category was previously included in the labor-intensive cost category. As previously stated, we are establishing a separate administrative and business support service cost category so that we can use the ECI for compensation for office and administrative support services to more precisely proxy these specific expenses.

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

We continue to look for ways to refine our market basket approach to more accurately account for the proportion of costs influenced by the local labor market. To that end, we conducted a survey of hospitals to empirically determine the proportion of contracted

professional services purchased by the industry that are attributable to local firms and the proportion that are purchased from national firms. We notified the public of our intent to conduct this survey on December 9, 2005 (70 FR 73250) and received no comments (71 FR 8588).

With approval from the OMB, we contacted the industry and received responses to our survey from 108 hospitals. Using data on FTEs to allocate responding hospitals across strata (region of the country and urban/rural status), we calculated poststratification weights. Based on these weighted results, we determined that hospitals purchase, on average, the following portions of contracted professional services outside of their local labor market:

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

We applied each of these percentages to its respective Benchmark I–O cost category underlying the professional fees cost category. This is the methodology that we used to separate the FY 2006-based IPPS market basket professional fees category into professional fees: Labor-related and professional fees: Nonlabor-related cost categories. In addition to the professional services listed above, we also classified expenses under NAICS 55, Management of Companies and Enterprises, into the professional fees cost category as was done in previous rebasings. The NAICS 55 data are mostly comprised of corporate, subsidiary, and regional managing offices, or otherwise referred to as home offices. Formerly, all of the expenses within this category were considered to vary with, or be influenced by, the local labor market and were thus included in the labor-related share. Because many hospitals are not located in the same geographic area as their home office, we analyzed data from a variety of sources in order to determine what proportion of these costs should be appropriately included in the labor-related share.

Comment: Several commenters disagreed with the proposed methodology to apportion home offices costs into the labor-related share.

Response: Our proposed methodology was primarily based on data from the Medicare cost reports, as well as a CMS database of Home Office Medicare Records (HOMER) (a database that provides city and state information (addresses) for home offices). The Medicare cost report requires hospitals to report their home office provider numbers. Using the HOMER database to determine the home office location for each home office provider number, we compared the location of the hospital with the location of the hospital's home office. We then proposed to determine the proportion of costs that should be allocated to the labor-related share based on the percent of hospitals that had home offices located in their respective local labor markets—defined as being in the same MSA. Using this proposed methodology, we had determined that 27 percent of hospitals that had home offices had those home offices located in their respective local labor markets, and therefore, we proposed to allocate 27 percent of NAICS 55 expenses to the labor-related share.

In response to the public comments submitted, we have revisited the home office cost allocation method and determined that a revision of the approach is appropriate. As an alternative to using provider counts (where each provider counts evenly) as the means by which home office costs are apportioned to the labor-related share, or deemed nonlabor-related, for this final rule, we are weighting the providers by home office compensation costs as reported in Worksheet S–3, part II, line 11 of the hospital MCR. (The Medicare cost report includes, but does not explicitly itemize, all home office costs. However, it does contain a line item for home office compensation costs.) We believe that this revised methodology of weighting the providers based on home office compensation costs provides a more technically appropriate estimate of the proportion of NAICS 55 expenses that should be allocated to the labor-related share.

As proposed, we are still continuing to use the same data sources and methodology to determine whether a hospital's home office is located in their respective MSA. Once we determined whether the hospital's home office is located in their respective MSA, we used additional data on home office compensation costs from the Medicare cost report to assign weights to the providers. Using this revised methodology, we determined that 57 percent of hospitals' home office costs are paid into their respective local labor markets—defined as being in the same MSA.

As was published in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24159 through 24161), below is a more detailed explanation on our methodology used to determine whether a hospital's home office was located in their respective MSA. In addition to the number of providers that appeared in the proposed rule, we have also included our weighted results.

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

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

We found that 59 percent of the hospitals with home offices (34 percent of total home office compensation costs for hospitals with home offices) were classified into Group 1 (that is, different State) and, thus, these hospitals were determined to not be located in the same local labor market as their home office.

We found that 12 percent of all hospitals with home offices (35 percent of total home office compensation costs for hospitals with home offices) were classified into Group 2 (that is, same State and same city and, therefore, the same MSA). Consequently, these hospitals were determined to be located in the same local labor market as their home offices.

We found that 29 percent of all hospitals with home offices (30 percent of total home office compensation costs for hospitals with home offices) were classified into Group 3 (that is, same State and different city). Using data from the Census Bureau to determine the specific MSA for both the hospital and its home office, we found that 16 percent of all hospitals with home offices (22 percent of total home office compensation costs for hospitals with home offices) were identified as being in the same State, a different city, but the same MSA.

Pooling these results, we were able to determine that approximately 28 percent of hospitals with home offices (57 percent of total home office compensation costs for hospitals with home offices) had home offices located within their local labor market (that is, 12 percent of hospitals with home offices (35 percent of total home office compensation costs for hospitals with home offices) had their home offices in the same State and city (and, thus, the same MSA), and 16 percent of hospitals with home offices (22 percent of total

home office compensation costs for hospitals with home offices) had their home offices in the same State, a different city, but the same MSA). We note that due to data anomalies associated with home office compensation cost data on the Medicare cost report, we trimmed the data and, thus, the number of providers classified in each of the groups is slightly different than we had published in the proposed regulation. The aforementioned trim resulted in excluding hospitals whose home office costs as a percent of total hospital costs were in the top and bottom five percent of that ratio. In the proposed rule, we had determined that 27 percent of providers had a home office located in their respective MSA. Applying our trimming method resulted in 28 percent of providers having a home office located in their respective MSA. Therefore, using the results of our weighting methodology, we are classifying 57 percent of the NAICS 55 costs into the professional fees: labor-related cost category and the remaining 43 percent into the professional fees: nonlabor-related cost category.

Comment: Several commenters suggested that CMS maintain the labor-related share from the FY 2002-based market basket (69.7 percent) for hospitals with an area wage index greater than 1.0 until a statistically valid approach for changing the labor-related share can be implemented. In addition, some commenters stated that, although CMS is required to rebase the hospital market basket, the proposal to revise the labor-related share is not required by statute and, thus, represents a discretionary decision by CMS.

Response: As a matter of practice, CMS typically rebases and revises the market basket and the labor-related share simultaneously. We believe that doing so results in a more technically accurate market basket that has the effect of more precisely updating payments to Medicare's providers. We believe that revising the labor-related share is based on empirical research and relies on more recent data, representing a technical improvement to the construction of the market basket. The methodology relies, in part, on the results of a survey of professional fees that was nationally representative and inclusive of large, urban-based hospitals and whose results were estimated using widely accepted survey estimation techniques. It also is dependent on data from the Medicare cost reports and the HOMER database that showed 43 percent of total home office compensation costs for hospitals with home offices had home offices located in different MSAs. Therefore, we disagree with the commenter's suggestion to continue to use a labor-related share of 69.7 percent.

Comment: Several commenters disagreed with the proposal to only allocate a portion of home office costs to the labor-related share based on whether these costs were incurred in the local labor market. One commenter stated that it is generally understood that there is a significant degree of correlation between the location of a multihospital system and the geographic locations of its member hospitals. All systems except the limited number of truly national hospital chains tend to be clustered in subareas of the country. Therefore, the commenters claimed that an assumption that 73 percent of home office labor costs more closely resemble national versus regional wage patterns is not necessarily supported by the methodology CMS proposed. Second, the commenter stated that it is generally the case that home office operations of multihospital systems and chains tend to be located in urban areas, even if the hospitals in the system or chain are nonurban or rural. The commenter further stated that this implies that average wage costs in these system headquarters may be systematically higher than the national average wage cost, making a national pricing proxy suspect in this case, as well.

Response: In rebasing the labor-related share, we have identified new methodologies and newly available empirical evidence to estimate the portion of the standardized payment amount that is subject to the hospital area wage index. In determining what proportion of that amount should be apportioned to the labor-related share and what proportion should be deemed nonlabor-related, we referenced the following:

Section 1886(d)(3)(E)(i) of the Act states that ''in general.—Except as provided in clause (ii), the Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.''

Because the labor-related share determined through the market basket is linked to the hospital area wage index, for this rebasing, we have identified new methodologies and newly available empirical evidence to determine a labor-related share that more precisely reflects the wage and wage-related proportion of activities purchased where the individual hospital is located. Services purchased beyond the boundaries of the local labor market of the individual hospital are thereby excluded from the labor-related share.

In order to distribute the appropriate proportion of home office costs to the labor-related share, we constructed a methodology that is similar to that undertaken to determine the area wage index. That is, we analyzed the locations of the individual hospitals and their respective home offices (at the MSA-level) as well as the home office compensation costs of the individual hospitals. The proportion of home office costs that we do not include in the labor-related share was not based on assumption, but rather it was based on Medicare cost report data and the HOMER database. Those data showed 43 percent of home office compensation costs were purchased from a different MSA than where the individual hospital is located and, thus, that proportion of home office costs are excluded from the labor-related share. The remaining 57 percent of home office compensation costs were purchased in the same MSA as the hospital; therefore, that proportion of home office costs is included in the labor-related share.

Based on data published by the BEA, we determined that the share of total hospital costs attributable to home office costs in 2006 was 5.8 percent. Applying the aforementioned shares to the 5.8 percent figure, we determined that 2.494 percentage points of total costs represent home office costs that are not incurred in the same local labor market as the hospital itself and, thus, are removed from the labor-related share. The remaining 3.306 percentage points remain in the labor-related share.

Comment: Several commenters addressed the survey CMS conducted regarding certain professional fees purchased by hospitals, stating that CMS used this survey to impute a 2.631 percentage point reduction in the labor-related share. These commenters stated that CMS failed to share data on the characteristics of the hospitals that responded, possible selection bias, or survey methodology. They also cited that the survey only received 108 respondents, which could lead to a high margin of error. The commenters stated that CMS provides no indication that it assessed for response bias in its survey nor did it explain how (or whether) it assured that the survey respondents were representative of all hospitals or of hospitals in wage areas greater than 1.0. Another commenter stated that the CMS survey assumed that such professional

services should be available in the local labor market and ignored some hospital's unavoidable need to incur those costs in order to comply with Federal and State requirements. The commenters requested CMS not remove a portion of professional fees from the labor-related share based on the results of this survey.

Response: We disagree with the commenters' suggestion that we ignore the survey results and continue to assign 100 percent of nonmedical professional fees to the labor-related share, as has been done historically. We believe a method that distributes these fees based on empirical research and data represents a technical improvement to the construction of the market basket. Our intent to survey for this purpose was announced in the **Federal Register** on December 9, 2005 (70 FR 73250). We received no public comment at that time.

Although several commenters indicated that the professional fees survey was used to decrease the labor-related share by 2.631 percentage points, that indication is not correct. In the FY 2006-based IPPS market basket, nonmedical professional fees that were subject to allocation based on the survey results represent 2.114 percent of total costs (and are limited to those fees related to Accounting & Auditing, Legal, Engineering, and Management Consulting services). Based on our survey results, we are apportioning 1.335 percentage points of the 2.114 percentage point figure into the labor-related share and designating the remaining 0.779 percentage point as nonlabor-related.

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

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

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

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

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

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

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

We do not assume that access to professional services such as those included in this survey should be available to all hospitals within their respective local labor market and we understand that, in some cases, hospitals may have to obtain these services from vendors beyond those boundaries. However, for purposes of estimating the labor-related share of the market basket, in accordance with the

aforementioned section 1886(d)(3)(E)(i) of the Act, we have used the newly available empirical evidence to determine the wage and wage-related costs in the labor-related share that are incurred within the geographic location of the hospital itself.

Comment: Several commenters questioned why CMS chose to conduct a survey to determine which proportion of professional fees is purchased in the local labor market when they could have conducted a study of Medicare cost reports for hospitals which, on line 22.01 of Worksheet S–3, part II, contains hospitals' average annual wage for professional services. In addition, one commenter suggested that instead of a survey, CMS should have proposed a change to the cost report in order to collect accurate data for all facilities.

Response: The Medicare cost report data do provide an average hourly wage for administrative and general (A&G) services (including those professional services included in the CMS survey) under contract. However, the data do not distinguish whether these services were purchased in the local labor market. In addition, a comparison of the average hourly wage for A&G services performed by hospital staff (as reported in line 22 of Worksheet S–3, part II) and the average hourly wage for A&G services under contract (as reported on line 22.01 of Worksheet S–3, part II) would not be sufficient to determine whether the contracted services were purchased in the local or national labor market. The reason for this is that the average A&G wages reported for hospital staff could represent a different occupational mix than the average A&G wages under contract. For example, a hospital could choose to employ staff to perform their bookkeeping and tax preparation services, but contract out their legal services. The higher average annual wage rate for the contracted A&G services compared to the in-house A&G services would not necessarily be a result of purchasing services in differing geographic areas, but rather a reflection of the different skill-mix represented in each group.

At the time this survey was initiated, it was not a viable option to alter the Medicare cost report in such a way as to collect this information due to the long periods of time between when the Medicare cost report questions are updated.

Comment: One commenter stated that it is inappropriate to restrict the wage index adjustment to labor-related costs that vary with the local labor market without recognizing that there are significant nonlabor costs that vary with the local market, of which professional liability insurance is but one obvious example. The commenter cited a regression analysis which showed that 85 percent of the variation in the estimated total unit costs of Medicare fee-for-service cases was explained by local input prices.

Response: For purposes of estimating the labor-related share of the market basket, in accordance with the aforementioned section 1886(d)(3)(E)(i) of the Act, we include only wage and wage-related costs in that proportion. The law does not call for the inclusion of nonlabor-related costs to be included in the labor-related share.

As described in the FY 2006 IPPS final rule (70 FR 47394), we previously performed regression analyses to reevaluate the assumptions used in determining the labor-related share. Using several regression specifications, we attempted to determine the proportion of costs that are influenced by the area wage index. We note that the results obtained for the relevant coefficients (roughly equivalent to the labor share) using the various specifications were less than 85 percent.

Comment: Many commenters disagreed with CMS removing any portion of professional fees from the labor-related share. The commenters stated that CMS did not appear to take into account the prevailing wages of areas from which hospitals typically purchase professional fees. They believe that it is uncommon for hospitals to purchase professional services from firms located in areas with lower prevailing wages than their own wage area. Therefore, they claimed that CMS failed to recognize the premium that hospitals must pay professionals from similar or higher prevailing wage areas.

Several commenters also believed that CMS' assertion that a portion of professional fees is nonlabor-related is invalid because professional fees do, in fact, vary across regions and localities. The commenters indicated that even if a professional services firm is not based in the local area, professional fees are modified in response to local market factors. They added that rates and fees are set in a competitive market and must reflect the conditions of that market. In addition, several commenters stated that professional services are highly labor-intensive and constitute a necessary business expense. Finally, one commenter indicated that even though these services may be purchased from another entity, they represent substitutes for hospital-employed staff and, thus, should be regarded by CMS as labor-related.

Response: We disagree with the commenters' assertion that CMS should include all professional fees in the labor-related share. We recognize that hospitals may often purchase professional services from geographic areas with higher prevailing wages than their own. We further recognize that the prices for these services vary across regions and localities and that the services themselves are labor-intensive. However, because we now have empirical evidence we can use to establish what portion of these professional fees are actually incurred in the local labor market, in accordance with section 1886(d)(3)(E)(i) of the Act, we are including only such wage and wage-related costs in the labor-related share. To the extent the evidence shows that the fees paid do not vary with, or are not influenced by, the local labor market, we are not including them in the labor-related share and are not subjecting them to the wage index adjustment.

Comment: Several commenters stated that the proposed change to the labor-related share will only affect hospitals in areas with a wage index over 1.0. However, the commenters claimed that these higher-wage hospitals are much more likely to hire professional firms that are actually located in their local labor market and, thus, are paying higher wages. The commenters stated that most urban areas have an excellent supply of professional services firms, thereby enabling urban hospitals to purchase such services from a local or regional market rather than a national market. In addition, some commenters claimed that this proposal will have an adverse effect on urban hospitals in general. One commenter stated that the proposed labor-related share reduction would most seriously affect large urban teaching hospitals.

One commenter stated that CMS' proposed change to the labor-related share is counter-intuitive to CMS's policy goal and would actually dampen the sensitivity of the IPPS payment methodology to area wage variations. The commenter cited that academic medical centers located in large urban markets are the most likely hospitals to be in markets with substantial local competition for professional services—markets in which professional services fees are most likely to be influenced by local labor market conditions. The commenter stated that the proposed methodology premised on the assumption that 73 percent of home office costs reflect national average wage patterns produces a substantial downward payment bias for teaching hospitals. Thus, the commenter urged CMS to only use more recent data and hold all other aspects constant, which

would result in a labor-related share of 72.1 percent. The commenter stated that, at a minimum, the current labor-related share of 69.7 percent should be retained, pending further study and analysis.

Response: We recognize that many hospitals could be affected differently by a change in the labor-related share. However, we believe the law calls for this proportion to be based on a national average and does not distinguish between types of hospitals for purposes of estimating or applying the labor-related share.

We disagree with the suggestions that the FY 2006-based market basket's labor-related share should be set to 72.1 percent (as a result of holding all other aspects constant from the FY 2002-based market basket) or that it should be held to its current 69.7 percent level. We believe that incorporating more recent data, as well as the results of our research, represents a technical improvement to the accuracy of the market basket.

Comment: One commenter stated that in order for hospitals to become more efficient and cost effective, they often use contract employees. The commenter further stated that in order to obtain the best price and service, these employees are located outside the local labor market. The commenter claimed that disallowing these services to be included in the wage index survey would reduce their labor-related payment rate and not adequately reimburse for care of Medicare patients.

Response: We do include direct patient contract labor expenses in the labor-related share of the IPPS market basket. These costs are included in the Wages & Salaries and Benefits cost weights. We only exclude from the labor-related share those contract labor costs associated with professional fees and home office costs that were purchased outside of the local labor market. As stated previously, the purpose of the labor-related share is to determine which portion of the standardized payment amount that is subject to the hospital wage index. Therefore, we define the labor-related share as those expenses that are labor-intensive and vary with, or are influenced by, the local labor market.

Comment: One commenter stated that without survey detail, they were unsure of CMS' treatment of professional fees paid for by a home office. The commenter stated that currently CMS excludes this expense for wage index purposes as the ''home office cost center is not included in the current definition of contract services for the wage index.'' The commenter believed that this created an inconsistency among the independent hospitals, which can include the professional fee costs/hours while health systems cannot. The commenter asked CMS to comment on its treatment of professional fees paid for by a home office and its use of such data in its survey.

Response: The CMS survey asked the responding hospitals to share what proportion of their professional services were purchased from vendors located beyond their local labor market. We expected that, irrespective of the mechanism of the purchase (that is, purchased directly by the hospital or purchased by the hospital's home office on the hospital's behalf), the approach to answering the questions remains the same. Therefore, we believe independent hospitals, as well as hospital groups, were captured appropriately.

Comment: One commenter questioned the conclusion from CMS' methodology, which implicitly assumes that the labor costs associated with ''non-local'' services, or those that are not adjusted at all for area wage variations, more closely reflects the national average than labor market conditions in the local area of the hospital receiving the services. The commenter described the market for professional services provided to hospitals as those that can be divided into the following categories: (1) Truly local firms whose clientele is comprised of the hospitals in a specific geographic area; (2) local offices of regional or national firms that will staff local assignments with some mix of local and non-local professionals; (3) firms that are ''regional'' in the sense of serving multiple geographic markets from a centralized location; and (4) truly national firms that operate nationwide from a single headquarters office and that serve local hospitals without assistance from locally based practitioners. The commenter claimed that CMS implicitly assumed that any firm that does not fall into the first category would experience labor costs indistinguishable from those that fall in the last category. However, the commenter stated that, in reality all such firms compete against each other in each local market. Therefore, the commenter added, local labor market conditions drive the prices local hospitals will pay for professional services even if those services wind up being rendered by professionals from out of town. The commenter stated that there is substantial regional variation in salaries paid to entry-level and early-career professionals who represent the lion's share of the cost that will be billed to hospitals. The commenter concluded that a payment methodology premised on the notion of a national professional services market with uniform prices fails to reflect the reality of what hospitals pay for professional services. The commenter also states that CMS did not disclose how professional services firms were identified as being ''national'' firms in its survey. The commenter believed that determining the location of a contract based on the mailing address of the contractor could materially understate the volume of services rendered by national or regional firms with a local presence, which would be fully subject to local labor market conditions. Thus, the commenter concluded the effect of reducing the labor-related share would be to dampen the sensitivity of the IPPS payment methodology to area wage variations.

Response: We recognize that fees paid for professional services provided by firms not located in the same local labor market as the hospital may be purchased in local labor markets and not always in a national market. However, given that we now have empirical evidence that can be used to estimate the portion of costs that varies based on the local labor market, we believe it is in keeping with section 1886(d)(3)(E)(i) of the Act to only assign that portion that does vary to the labor-related share. Section 1886(d)(3)(E)(i) of the Act states that ''in general.—Except as provided in clause (ii), the Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.''

Comment: One commenter stated that the treatment of contract labor has a direct influence on the labor-related share, which in turn affects the area wage index adjusted portion of the payments. Conversely, the commenter stated, because the labor-related share now includes accounting and auditing services, it is not clear whether the data currently used to develop the area wage index are inclusive of the costs for accounting and auditing because consideration of these costs for area wage index purposes is only a current CMS wage data policy convention. Therefore, the commenter added, there could be a mismatch between the data CMS is using for the labor-related share

determination and the data CMS utilizes for developing the area wage index.

Response: We are not changing our methodology on how contract labor costs are included in the IPPS market basket. As has been done historically, the market basket includes all contract labor services purchased by the hospital. Direct patient contract labor costs are included in the Wage & Salaries and Benefits cost weights, whereas other nondirect patient contract labor costs are represented in the other cost weights.

Also, we interpret the commenter's statement to imply that accounting and auditing services were previously excluded from the labor-related share. Historically, 100 percent of the accounting and auditing services expenses were included in the labor-related share. We proposed to only include 66 percent of the accounting and auditing costs in the labor-related share because the remaining 34 percent of these costs were determined to have been purchased outside of the local labor market.

With respect to a possible mismatch between the labor-related share and the area wage index, data from Worksheet S–3, part II, of the Medicare cost report are used to estimate both. Those data provide information on wage and wage-related costs incurred by the hospital but are not detailed enough to distinguish between costs incurred via purchase and costs incurred via direct hire. In estimating the labor-related share, we incorporate data from other data sources to supplement the Medicare cost report data to more accurately capture and apportion wage and wage-related costs that are purchased.

Comment: One commenter questioned whether the proposed revision of the labor-related share of the operating IPPS rates would affect the capital IPPS geographic adjustment factor (GAF), which is derived from the hospital wage index. The commenter requested that CMS review whether the formula used to determine the capital GAF should be revised based on the update of the operating IPPS labor-related share.

Response: In determining payments under the capital IPPS, the capital rate is adjusted for differences in local cost variations by a factor (the GAF) that is equal to the hospital's applicable wage index raised to the 0.6848 power (§ 412.316(a) of our regulations). The formula for the GAF was developed using a regression analysis and the exponential form of this factor is used in order to apply a single factor to the entire capital rate rather than splitting the capital rate into labor-related share and nonlabor-related share (56 FR 43375). The formula for the GAF is independent of the operating IPPS labor-related share and, therefore, requires no adjustment based on the revision of the operating IPPS labor-relate share. The GAF will continue to be computed as the hospital's applicable wage index raised to the 0.6848 power.

After consideration of the public comments received, in this final rule, we are revising our labor-related share that we proposed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24159–24161) to incorporate a revision to our methodology for allocating NAICS 55 expenses to the labor-related share.

Below is a chart comparing the FY 2006-based labor-related share and the FY 2002-based labor-related share.

CHART 5—COMPARISON OF THE FY 2006-BASED LABOR-RELATED SHARE AND THE FY 2002-BASED LABOR-RELATED SHARE

	FY 2002-based market basket cost weights	FY 2006-based market basket cost weights
Wages and Salaries	48.171	47.213
Employee Benefits	11.822	12.414
Professional Fees: Labor-Related	5.510	5.356
Administrative and Business Support Services	.....	0.626
All Other: Labor-Related Services	4.228	3.193
Total Labor-Related Share	69.731	68.802

Using the cost category weights from the FY 2006-based IPPS market basket, we calculated a labor-related share of 68.802 percent, approximately 0.9 percentage points lower than the current labor-related share of 69.731.

We continue to believe, as we have stated in the past, that these operating cost categories are related to, influenced by, or vary with the local markets. Therefore, our definition of the labor-related share continues to be consistent with section 1886(d)(3) of the Act.

Using the cost category weights that we determined in section IV.B.1. of this preamble, we calculated a labor-related share of 68.802 percent, using the FY 2006-based IPPS market basket. Accordingly, we are implementing a labor-related share of 68.8 percent for discharges occurring on or after October 1, 2009. We note that section 403 of Public Law 108–173 amended sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this employment ''would result in lower payments than would otherwise be made.''

As we proposed, we also are updating the labor-related share for Puerto Rico. Consistent with our methodology for determining the national labor-related share, we add the Puerto Rico-specific relative weights for wages and salaries, employee benefits, and contract labor. Because there are no Puerto Rico-specific relative weights for professional fees and labor intensive services, we use the national weights.

Below is a chart comparing the FY 2006-based Puerto Rico-specific labor-related share and the FY 2002-based Puerto Rico-specific labor-related share.

CHART 6—COMPARISON OF THE FY 2006-BASED PUERTO RICO-SPECIFIC LABOR-RELATED SHARE AND FY 2002-BASED PUERTO RICO-SPECIFIC LABOR-RELATED SHARE

	FY 2002-based market basket cost weights	FY 2006-based market basket cost weights
Wages and Salaries	40.201	44.221
Benefits	8.782	8.691
Professional Fees: Labor-Related	5.510	5.356
Administrative and Business Support Services		0.626
All Other: Labor-Related Services	4.228	3.193
Total Labor-Related Share	58.721	62.087

Using the FY 2006-based Puerto Rico cost category weights, we calculated a labor-related share of 62.087 percent, approximately 3.4 percentage points higher than the current Puerto-Rico specific labor-related share of 58.721. Accordingly, we are adopting an updated Puerto Rico labor-related share of 62.1 percent.

C. Separate Market Basket for Certain Hospitals Presently Excluded from the IPPS

In the FY 2006 IPPS final rule (70 FR 47396), we adopted the use of the FY 2002-based IPPS operating market basket to update the target amounts for children's and cancer hospitals and religious nonmedical health care institutions (RNHCIs). Children's and cancer hospitals and RNHCIs are still reimbursed solely under the reasonable cost-based system, subject to the rate-of-increase limits. Under these limits, an annual target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages.

As we proposed (74 FR 24161), under the broad authority in sections 1886(b)(3)(A) and (B), 1886(b)(3)(E), and 1871 of the Act and section 4454 of the BBA, consistent with our use of the IPPS operating market basket percentage increase to update target amounts, we are using the FY 2006-based IPPS operating market basket percentage increase to update the target amounts for children's and cancer hospitals and RNHCIs.

Due to the small number of children's and cancer hospitals and RNHCIs that receive, in total, less than 1 percent of all Medicare payments to hospitals and because these hospitals provide limited Medicare cost report data, we are unable to create a separate market basket specifically for these hospitals. Based on the limited data available, we believe that the FY 2006-based IPPS operating market basket most closely represents the cost structure of children's and cancer hospitals and RNHCIs. Therefore, we believe that the percentage change in the FY 2006-based IPPS operating market basket is the best available measure of the average increase in the prices of the goods and services purchased by cancer and children's hospitals and RNHCIs in order to provide care.

We did not receive any public comments on the provisions of this section.

D. Rebasing and Revising the Capital Input Price Index (CIPI)

The CIPI was originally described in the FY 1993 IPPS final rule (57 FR 40016). There have been subsequent discussions of the CIPI presented in the IPPS proposed and final payment rules. The FY 2006 IPPS final rule (70 FR 47387) discussed the most recent rebasing and revision of the CIPI to a FY 2002 base year, which reflected the capital cost structure of the hospital industry in that year.

As we proposed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24161), we are rebasing and revising the CIPI to a FY 2006 base year to reflect the more current structure of capital costs in hospitals. As with the FY 2002-based index, we developed two sets of weights in order to calculate the FY 2006-based CIPI. The first set of weights identifies the proportion of hospital capital expenditures attributable to each expenditure category, while the second set of weights is a set of relative vintage weights for depreciation and interest. The set of vintage weights is used to identify the proportion of capital expenditures within a cost category that is attributable to each year over the useful life of the capital assets in that category. A more thorough discussion of vintage weights is provided later in this section.

Both sets of weights are developed using the best data sources available. In reviewing source data, we determined that the Medicare cost reports provided accurate data for all capital expenditure cost categories. We used the FY 2006 Medicare cost reports for IPPS hospitals to determine weights for all three cost categories: depreciation, interest, and other capital expenses.

Lease expenses are unique in that they are not broken out as a separate cost category in the CIPI, but rather are proportionally distributed among the cost categories of depreciation, interest, and other, reflecting the assumption that the underlying cost structure of leases is similar to that of capital costs in general. As was done in previous rebasings of the CIPI, we first assumed 10 percent of lease expenses represents overhead and assigned them to the other capital expenses cost category accordingly. The remaining lease expenses were distributed across the three cost categories based on the respective weights of depreciation, interest, and other capital not including lease expenses.

Depreciation contains two subcategories: (1) Building and fixed equipment; and (2) movable equipment. The apportionment between building and fixed equipment and movable equipment was determined using the Medicare cost reports. This methodology was also used to compute the apportionment used in the FY 2002-based index.

The total interest expense cost category is split between government/nonprofit interest and for-profit interest. The FY 2002-based CIPI allocated 75 percent of the total interest cost weight to government/nonprofit interest and proxied that category by the average yield on domestic municipal bonds. The remaining 25 percent of the interest cost weight was allocated to for-profit interest and was proxied by the average yield on Moody's Aaa bonds (70 FR 47387).

For this rebasing, we derived the split using the relative FY 2006 Medicare cost report data on interest expenses for government/nonprofit and for-profit hospitals. Based on these data, we calculated an 85/15 split between

government/nonprofit and for-profit interest. We believe it is important that this split reflects the latest relative cost structure of interest expenses.

Chart 7 presents a comparison of the FY 2006-based CIPI cost weights and the FY 2002-based CIPI cost weights.

CHART 7—FY 2006-BASED CIPI COST CATEGORIES, WEIGHTS, AND PRICE PROXIES WITH FY 2002-BASED CIPI INCLUDED FOR COMPARISON

Cost categories	FY 2002 weights	FY 2006 weights	Price proxy
Total	100.00	100.00	
Total depreciation	74.583	75.154	
Building and fixed equipment depreciation.	36.234	35.789	BEA chained price index for nonresidential construction for hospitals and special care facilities—vintage weighted (25 years).
Movable equipment depreciation	38.349	39.365	PPI for machinery and equipment—vintage weighted (12 years).
Total interest	19.863	17.651	
Government/nonprofit interest	14.896	15.076	Average yield on domestic municipal bonds (Bond Buyer 20 bonds)—vintage-weighted (25 years).
For-profit interest	4.967	2.575	Average yield on Moody's Aaa bonds—vintage-weighted (12 years).
Other	5.554	7.195	CPI–U for residential rent.

Because capital is acquired and paid for over time, capital expenses in any given year are determined by both past and present purchases of physical and financial capital. The vintage-weighted CIPI is intended to capture the long-term consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the proportion of capital purchases attributable to each year of the expected life of building and fixed equipment, movable equipment, and interest. We used the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense. Following publication of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, and in order to provide greater transparency, we posted on the CMS market basket Web page at: *http://www.cms.hhs.gov/MedicareProgramRatesStats/05_MarketBasketResearch.asp#TopOfPage* an illustrative spreadsheet that contains an example of how the vintage-weighted price indexes are calculated.

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

To calculate the vintage weights for depreciation and interest expenses, we needed a time series of capital purchases for building and fixed equipment and movable equipment. We found no single source that provides a uniquely best time series of capital purchases by hospitals for all of the above components of capital purchases. The early Medicare cost reports did not have sufficient capital data to meet this need. Data we obtained from the American Hospital Association (AHA) do not include annual capital purchases. However, AHA does provide a consistent database back to 1963. We used data from the AHA Panel Survey and the AHA Annual Survey to obtain a time series of total expenses for hospitals. We then used data from the AHA Panel Survey supplemented with the ratio of depreciation to total hospital expenses obtained from the Medicare cost reports to derive a trend of annual depreciation expenses for 1963 through 2006.

In order to estimate capital purchases using data on depreciation expenses, the expected life for each cost category (building and fixed equipment, movable equipment, and interest) is needed to calculate vintage weights. We used FY 2006 Medicare cost reports to determine the expected life of building and fixed equipment and of movable equipment. The expected life of any piece of equipment can be determined by dividing the value of the asset (excluding fully depreciated assets) by its current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation were to continue at current year levels, assuming straight-line depreciation. From the FY 2006 Medicare cost reports, the expected life of building and fixed equipment was determined to be 25 years, and the expected life of movable equipment was determined to be 12 years. The FY 2002-based CIPI was based on an expected life of building and fixed equipment of 23 years. It used 11 years as the expected life for movable equipment.

As we proposed, we used the building and fixed equipment and movable equipment weights derived from FY 2006 Medicare cost reports to separate the depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation (74 FR 24162). Year-end asset costs for building and fixed equipment and movable equipment were determined by multiplying the annual depreciation amounts by the expected life calculations from the FY 2006 Medicare cost reports. We then calculated a time series back to 1963 of annual capital purchases by subtracting the previous year asset costs from the current year asset costs. From this capital purchase time series, we were able to calculate the vintage weights for building and fixed equipment and for movable equipment. Each of these sets of vintage weights is explained in more detail below.

For building and fixed equipment vintage weights, we used the real annual capital purchase amounts for building and fixed equipment to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual purchase amount for building and fixed equipment was produced by deflating the nominal annual purchase amount by

the building and fixed equipment price proxy, BEA's chained price index for nonresidential construction for hospitals and special care facilities. Because building and fixed equipment have an expected life of 25 years, the vintage weights for building and fixed equipment are deemed to represent the average purchase pattern of building and fixed equipment over 25-year periods. With real building and fixed equipment purchase estimates available back to 1963, we averaged nineteen 25-year periods to determine the average vintage weights for building and fixed equipment that are representative of average building and fixed equipment purchase patterns over time. Vintage weights for each 25-year period are calculated by dividing the real building and fixed capital purchase amount in any given year by the total amount of purchases in the 25-year period. This calculation is done for each year in the 25-year period, and for each of the nineteen 25-year periods. We used the average of each year across the nineteen 25-year periods to determine the average building and fixed equipment vintage weights for the FY 2006-based CIPI.

For movable equipment vintage weights, the real annual capital purchase amounts for movable equipment were used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment was calculated by deflating the nominal annual purchase amounts by the movable equipment price proxy, the PPI for machinery and equipment. Based on our determination that movable equipment has an expected life of 12 years, the vintage weights for movable equipment represent the average expenditure for movable equipment over a 12-year period. With real movable equipment purchase estimates available back to 1963, thirty-two 12-year periods were averaged to determine the average vintage weights for movable equipment that are representative of average movable equipment purchase patterns over time. Vintage weights for each 12-year period are calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 12-year period. This calculation was done for each year in the 12-year period and for each of the thirty-two 12-year periods. We used the average of each year across the thirty-two 12-year periods to determine the average movable equipment vintage weights for the FY 2006-based CIPI.

For interest vintage weights, the nominal annual capital purchase amounts for total equipment (building and fixed, and movable) were used to capture the value of the debt instrument. Because we have determined that hospital debt instruments have an expected life of 25 years, the vintage weights for interest are deemed to represent the average purchase pattern of total equipment over 25-year periods. With nominal total equipment purchase estimates available back to 1963, nineteen 25-year periods were averaged to determine the average vintage weights for interest that are representative of average capital purchase patterns over time. Vintage weights for each 25-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 25-year period. This calculation is done for each year in the 25-year period and for each of the nineteen 25-year periods. We used the average of each year across the nineteen 25-year periods to determine the average interest vintage weights for the FY 2006-based CIPI.

The vintage weights for the FY 2002-based CIPI and the FY 2006-based CIPI are presented in Chart 8.

CHART 8—FY 2002 VINTAGE WEIGHTS AND FY 2006 VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Year	Building and fixed equipment		Movable equipment		Interest	
	FY 2002 23 years	FY 2006 25 years	FY 2002 11 years	FY 2006 12 years	FY 2002 23 years	FY 2006 25 years
1	0.021	0.021	0.065	0.063	0.010	0.010
2	0.022	0.023	0.071	0.067	0.012	0.012
3	0.025	0.025	0.077	0.071	0.014	0.014
4	0.027	0.027	0.082	0.075	0.016	0.016
5	0.029	0.029	0.086	0.079	0.019	0.018
6	0.031	0.031	0.091	0.082	0.023	0.020
7	0.033	0.032	0.095	0.085	0.026	0.023
8	0.035	0.033	0.100	0.086	0.029	0.025
9	0.038	0.036	0.106	0.090	0.033	0.028
10	0.040	0.038	0.112	0.093	0.036	0.031
11	0.042	0.040	0.117	0.102	0.039	0.034
12	0.045	0.042	.....	0.106	0.043	0.038
13	0.047	0.044	.....	.....	0.048	0.041
14	0.049	0.045	.....	.....	0.053	0.044
15	0.051	0.046	.....	.....	0.056	0.047
16	0.053	0.047	.....	.....	0.059	0.050
17	0.056	0.048	.....	.....	0.062	0.053
18	0.057	0.050	.....	.....	0.064	0.057
19	0.058	0.050	.....	.....	0.066	0.059
20	0.060	0.050	.....	.....	0.070	0.060
21	0.060	0.048	.....	.....	0.071	0.060
22	0.061	0.048	.....	.....	0.074	0.062
23	0.061	0.047	.....	.....	0.076	0.063
24	.....	0.049	.....	.....	.....	0.068
25	.....	0.048	.....	.....	.....	0.069
Total	1.000	1.000	1.000	1.000	1.000	1.000

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

After the capital cost category weights were computed, it was necessary to select appropriate price proxies to reflect the rate-of-increase for each expenditure category. As we proposed, in this final rule, we used the same price proxies for the FY 2006-based CIPI that were used in the FY 2002-based CIPI, with the exception of the Boeckh Construction Index (74 FR 24164). We replaced the Boeckh Construction Index with BEA's chained price index for nonresidential construction for hospitals and special care facilities. The BEA index represents construction of facilities such as hospitals, nursing homes, hospices, and rehabilitation centers. Although these price indices move similarly over time, we believe that it is more technically appropriate to use an index that is more specific to the hospital industry. We believe these are the most appropriate proxies for hospital capital costs that meet our selection criteria of relevance, timeliness, availability, and reliability. The rationale for selecting the price proxies, excluding the building and fixed equipment price proxy, was explained more fully in the FY 1997 IPPS final rule (61 FR 46196).

The price proxies are presented in Chart 7.

Chart 9 below compares both the historical and forecasted percent changes in the FY 2002-based CIPI and the FY 2006-based CIPI.

CHART 9—COMPARISON OF FY 2002-BASED AND FY 2006-BASED CAPITAL INPUT PRICE INDEX, PERCENT CHANGE, FY 2004 THROUGH FY 2012

Fiscal year	CIPI, FY 2002-based	CIPI, FY 2006-based
FY 2004	0.5	0.8
FY 2005	0.6	0.9
FY 2006	0.9	1.1
FY 2007	1.2	1.3
FY 2008	1.4	1.4
Forecast:		
FY 2009	1.7	1.5
FY 2010	1.5	1.2

CHART 9—COMPARISON OF FY 2002-BASED AND FY 2006-BASED CAPITAL INPUT PRICE INDEX, PERCENT CHANGE, FY 2004 THROUGH FY 2012—Continued

Fiscal year	CIPI, FY 2002-based	CIPI, FY 2006-based
FY 2011	1.4	1.3
FY 2012	1.6	1.4
Average:		
FYs 2004–2008	0.9	1.1
FYs 2009–2012	1.6	1.4

Source: IHS Global Insight, Inc, 2nd Quarter 2009; *USMACRO/CONTROL0609@CISSIM/TL0509.SIM.*

IHS Global Insight, Inc. forecasts a 1.2 percent increase in the FY 2006-based CIPI for FY 2010, as shown in Chart 9. The underlying vintage-weighted price increases for depreciation (including building and fixed equipment and movable equipment) and interest (including government/nonprofit and for-profit) are included in Chart 10.

CHART 10—CMS CAPITAL INPUT PRICE INDEX PERCENT CHANGES, TOTAL AND DEPRECIATION AND INTEREST COMPONENTS, FYS 2004 THROUGH 2012

Fiscal year	Total	Depreciation	Interest
FY 2004	0.8	1.5	−2.6
FY 2005	0.9	1.7	−3.1
FY 2006	1.1	2.0	−3.2
FY 2007	1.3	2.1	−3.4
FY 2008	1.4	2.1	−2.6
Forecast:			
FY 2009	1.5	2.1	−2.0
FY 2010	1.2	1.8	−2.1
FY 2011	1.3	1.7	−1.4
FY 2012	1.4	1.7	−0.7

Source: IHS Global Insight, Inc, 2nd Quarter 2009; *USMACRO/CONTROL0609@CISSIM/TL0509.SIM.*

Rebasing the CIPI from FY 2002 to FY 2006 decreased the percent change in the FY 2010 forecast by 0.3 percentage point, from 1.5 to 1.2, as shown in Chart 9. The difference in the forecast of the FY 2010 market basket increase is primarily due to the proposed change in the price proxy for building and fixed equipment as well as the proposed change in the vintage weights applied to the price proxy for interest. As mentioned above, we are changing the price proxy used for building and fixed equipment to BEA's chained price index for nonresidential construction for hospitals and special care facilities. We believe this change represents a technical improvement as the BEA price index is an index that is more representative of the hospital industry. For the FY 2010 update, the result of this change is a forecasted price change in total depreciation of 1.8 percent in the FY 2006-based CIPI compared to 2.0 percent in the FY 2002-based CIPI. The other primary factor contributing to the difference is the change in the vintage weights used to calculate the vintage-weighted price proxy for interest. The forecasted price change in total interest is −2.1 percent in the FY 2006-based CIPI compared to −1.5 percent in the FY 2002-based CIPI. This is a result of changing the expected life of hospital debt instruments from 23 years to 25 years. We did not receive any public comments on our proposed methodological changes to the capital input price index published in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24154). Therefore, we are adopting as final, without modification, the proposed FY 2006-based CIPI for FY 2010 in this final rule.

V. Other Decisions and Changes to the IPPS for Operating Costs and GME Costs

A. Reporting of Hospital Quality Data for Annual Hospital Payment Update

1. Background

a. Overview

CMS is seeking to promote higher quality and more efficient health care for Medicare beneficiaries. This effort is supported by the adoption of an increasing number of widely-agreed upon quality measures. CMS has worked with relevant stakeholders to define measures of quality in almost every setting and currently measures some aspect of care for almost all Medicare beneficiaries. These measures assess structural aspects of care, clinical processes, patient experiences with care, and, increasingly, outcomes.

CMS has implemented quality measure reporting programs for multiple settings of care. The Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program implements a quality reporting program for hospital inpatient services. In addition, CMS has implemented quality reporting programs for hospital outpatient services, the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), and for physicians and other eligible professionals, the Physician Quality Reporting Initiative (PQRI). CMS has also implemented quality reporting programs for home health agencies and skilled nursing facilities that are based on conditions of participation, and an end-stage renal disease quality reporting program that is based on conditions for coverage.

b. Hospital Quality Data Reporting Under Section 501(b) of Public Law 108–173

Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, added section 1886(b)(3)(B)(vii) to the Act. This section established the authority for the RHQDAPU program and revised the mechanism used to update the standardized payment amount for inpatient hospital operating costs. Specifically, section 1886(b)(3)(B)(vii)(I) of the Act, before it was amended by section 5001(a) of Public Law 109–171, provided for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for FY 2005 through FY 2007 for any subsection (d) hospital that did not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. It also provides that any reduction would apply only to the fiscal year involved, and would not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. The statute thereby established an incentive for IPPS hospitals to submit data on the quality measures established by the Secretary, and also built upon the previously established Voluntary Hospital Quality Data Reporting Program that we described in the FY 2009 IPPS final rule (73 FR 48598).

We implemented section 1886(b)(3)(B)(vii) of the Act in the FY 2005 IPPS final rule (69 FR 49078) and codified the applicable percentage change in § 412.64(d) of our regulations. We adopted additional requirements under the RHQDAPU program in the FY 2006 IPPS final rule (70 FR 47420).

c. Hospital Quality Data Reporting under Section 5001(a) of Public Law 109–171

Section 5001(a) of the Deficit Reduction Act of 2005 (DRA), Public Law 109–171, further amended section 1886(b)(3)(B) of the Act to revise the mechanism used to update the standardized payment amount for hospital inpatient operating costs, in particular, by adding new section 1886(b)(3)(B)(viii) to the Act. Specifically, sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year be reduced by 2.0 percentage points for any subsection (d) hospital that does not submit quality data in a form and manner, and at a time, specified by the Secretary. Section 1886(b)(3)(B)(viii)(I) of the Act also provides that any reduction in a hospital's payment update will apply only with respect to the fiscal year involved, and will not be taken into account for computing the applicable percentage increase for a subsequent fiscal year. In the FY 2007 IPPS final rule (71 FR 48045), we amended our regulations at § 412.64(d)(2) to reflect the 2.0 percentage point reduction in the payment update for FY 2007 and subsequent fiscal years for subsection (d) hospitals that do not comply with requirements for reporting quality data, as provided for under section 1886(b)(3)(B)(viii) of the Act.

(1) Quality Measures

Section 1886(b)(3)(B)(viii)(III) of the Act requires that the Secretary expand the ''starter set'' of 10 quality measures that was established by the Secretary as of November 1, 2003, as the Secretary determines to be appropriate for the measurement of the quality of care furnished by a hospital in inpatient settings. In expanding this set of measures, section 1886(b)(3)(B)(viii)(IV) of the Act requires that, effective for payments beginning with FY 2007, the Secretary begin to adopt the baseline set of performance measures as set forth in a report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of Public Law 108–173.[8]

The IOM measures include: 21 Hospital Quality Alliance (HQA) quality measures (including the ''starter set'' of 10 quality measures); the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) patient experience of care survey; and 3 structural measures.[9] The structural measures are: (1) Adoption of computerized provider order entry for prescriptions; (2) staffing of intensive care units with intensivists; and (3) evidence-based hospital referrals. These structural measures constitute the Leapfrog Group's original ''three leaps,'' and are part of the National Quality Forum's (NQF's) 30 Safe Practices for Better Healthcare. The HCAHPS survey is part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program, which develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. CAHPS originally stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the name has evolved as well to capture the full range of survey products and tools.

Section 1886(b)(3)(B)(viii)(V) of the Act requires that, effective for payments beginning with FY 2008, the Secretary add other quality measures that reflect consensus among affected parties, and to the extent feasible and practicable, have been set forth by one or more national consensus building entities. The NQF is a voluntary consensus standard-setting organization with a diverse representation of consumer, purchaser, provider, academic, clinical, and other health care stakeholder organizations. The NQF was established to standardize health care quality measurement and reporting through its consensus development process. We have generally adopted NQF-endorsed measures. However, we believe that consensus among affected parties also can be reflected by other means, including consensus achieved during the measure development process, consensus shown through broad acceptance and use of measures, and consensus through public comment.

Section 1886(b)(3)(B)(viii)(VI) of the Act authorizes the Secretary to replace any quality measures or indicators in

[8] Institute of Medicine, ''Performance Measurement: Accelerating Improvement,'' December 1, 2005, available at: *http://www.iom.edu/CMS/3809/19805/31310.aspx.* IOM set forth these baseline measures in a November 2005 report. However, the IOM report was not released until December 1, 2005 on the IOM Web site.

[9] Structural measures assess characteristics linked to the capacity of the provider to deliver quality healthcare. Institute of Medicine: Division of Health Care Services. Measuring the Quality of Health Care: A Statement by the National Roundtable on Healthcare Quality. National Academy Press; Washington, DC 1999.

appropriate cases, such as where all hospitals are effectively in compliance with a measure, or the measures or indicators have been subsequently shown to not represent the best clinical practice. Thus, the Secretary is granted broad discretion to replace measures that are no longer appropriate for the RHQDAPU program.

In the FY 2007 IPPS final rule, we began to expand the RHQDAPU program measures by adding 11 quality measures to the 10-measure starter set to establish an expanded set of 21 quality measures for the FY 2007 payment determination (71 FR 48033 through 48037, 48045).

In the CY 2007 OPPS/ASC final rule (71 FR 68201), we adopted six additional quality measures for the FY 2008 payment determination, for a total of 27 measures. Two of these measures (30–Day Risk Standardized Mortality Rates for Heart Failure and 30–Day Risk Standardized Mortality Rates for AMI) were calculated using existing administrative Medicare claims data; thus, no additional data submission by hospitals was required for these two measures. The measures used for the FY 2008 payment determination included, for the first time, the HCAHPS patient experience of care survey.

In the FY 2008 IPPS final rule (72 FR 47348 through 47358) and the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875 through 66877), we added three additional process measures to the RHQDAPU program measure set. (These three measures are SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose, SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal, and Pneumonia 30-day mortality (Medicare patients).) The addition of these 3 measures brought the total number of RHQDAPU program measures to be used for the FY 2009 payment determination to 30 (72 FR 66876). The 30 measures used for the FY 2009 annual payment determination are listed in the FY 2009 IPPS final rule (73 FR 48600 through 48601).

For the FY 2010 payment determination, we added 15 new measures to the RHQDAPU program measure set and retired one. Of the new measures, 13 were adopted in the FY 2009 IPPS final rule (73 FR 48602 through 48611) and two additional measures were finalized in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68780 through 68781). This resulted in an expansion of the RHQDAPU program measures from 30 measures for the FY 2009 payment determination to 44 measures for the FY 2010 payment determination. The RHQDAPU program measures for the FY 2010 payment determination consist of: 26 chart-abstracted process measures, which measure care provided for Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), or Surgical Care Improvement (SCIP); 6 claims-based measures, which evaluate 30-day mortality or 30-day readmission rates for AMI, HF, or PN; 9 AHRQ claims-based patient safety/inpatient quality indicator measures; 1 claims-based nursing sensitive measure; 1 structural measure that assesses participation in a systematic database for cardiac surgery; and the HCAHPS patient experience of care survey. The measures are listed below.

Topic	RHQDAPU program quality measures for the FY 2010 payment determination
Acute Myocardial Infarction (AMI)	• AMI–1 Aspirin at arrival. • AMI–2 Aspirin prescribed at discharge. • AMI–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction. • AMI–4 Adult smoking cessation advice/counseling. • AMI–5 Beta blocker prescribed at discharge. • AMI–6 Beta blocker at arrival. • AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival. • AMI–8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI).
Heart Failure (HF)	• HF–1 Discharge instructions. • HF–2 Left ventricular function assessment. • HF–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction. • HF–4 Adult smoking cessation advice/counseling.
Pneumonia (PN)	• PN–2 Pneumococcal vaccination status. • PN–3b Blood culture performed before first antibiotic received in hospital. • PN–4 Adult smoking cessation advice/counseling. • PN–5c Timing of receipt of initial antibiotic following hospital arrival. • PN–6 Appropriate initial antibiotic selection. • PN–7 Influenza vaccination status.
Surgical Care Improvement Project (SCIP)	• SCIP–1 Prophylactic antibiotic received within 1 hour prior to surgical incision. • SCIP–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time. • SCIP–VTE–1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients. • SCIP–VTE–2: VTE prophylaxis within 24 hours pre/post surgery. • SCIP–Infection-2: Prophylactic antibiotic selection for surgical patients. • SCIP–Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose. • SCIP–Infection-6: Surgery Patients with Appropriate Hair Removal.

Topic	RHQDAPU program quality measures for the FY 2010 payment determination
Mortality Measures (Medicare Patients)	• SCIP–Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period. • MORT–30–AMI: Acute Myocardial Infarction 30-day mortality–Medicare patients. • MORT–30–HF: Heart Failure 30-day mortality—Medicare patients. • MORT–30–PN: Pneumonia 30-day mortality —Medicare patients.
Patients' Experience of Care	• HCAHPS survey.
Readmission Measures (Medicare Patients)	• READ–30–HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients). • READ–30–AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients). • READ–30–PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients).
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures.	• PSI 04: Death among surgical patients with treatable serious complications. • PSI 06: Iatrogenic pneumothorax, adult. • PSI 14: Postoperative wound dehiscence. • PSI 15: Accidental puncture or laceration. • IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume). • IQI 19: Hip fracture mortality rate. • Mortality for selected surgical procedures (composite). • Complication/patient safety for selected indicators (composite). • Mortality for selected medical conditions (composite).
Nursing Sensitive	• Failure to Rescue (Medicare claims only).
Cardiac Surgery	• Participation in a Systematic Database for Cardiac Surgery.

On December 31, 2008, CMS advised hospitals that they would no longer be required to submit data for the RHQDAPU program measure AMI–6–Beta blocker at arrival, beginning with discharges occurring on April 1, 2009. This change was based on the evolving evidence regarding AMI patient care, as well as changes in the American College of Cardiology/American Heart Association (ACC/AHA) practice guidelines for ST-segment elevation myocardial infarction and non-ST segment elevation myocardial infarction, upon which AMI–6 is based. The new guideline recommends that early intravenous beta-blockers specifically should be avoided in certain patient populations due to increased mortality risk. These patients are identified by a complex set of contraindications that we believe would make revision of the measure impractical and might result in unintended consequences, including harm to patients based on misinterpretation of an overly complex measure in the clinical setting. Based on the new studies, the ACC/AHA Task Force on Performance Measures removed this measure from the set of AMI performance measures as of November 10, 2008, and did not replace the measure. CMS took action to remove the measure from reporting initiatives based on the lack of support by the measure developer and the considerations identified above.

We discussed considerations relating to retiring or replacing measures in the FY 2008 IPPS final rule with comment period and the FY 2009 IPPS final rule, including the ''topping out'' of hospitals' performance under a measure (72 FR 47358 through 47359 and 73 FR 48603 through 48604, respectively). However, in this instance, the measure no longer ''represent[s] the best clinical practice,'' an additional basis under section 1886(b)(3)(B)(viii)(VI) of the Act for retiring a measure. For the FY 2010 payment determination and subsequent payment determinations, we have formally retired the AMI–6 measure from the RHQDAPU program. Therefore, hospitals participating in the RHQDAPU program are not required to submit data on the AMI–6 measure beginning with discharges occurring on April 1, 2009. However, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24167), we sought public comment on the retirement of the AMI–6 measure.

Comment: Many commenters supported immediate retirement of quality measures, including AMI–6, for which evolving clinical evidence suggests potential patient safety concerns. Other commenters suggested that CMS seek public input when it is considering immediate retirement of a measure. These commenters also indicated that measure retirement for other reasons should be conducted through the rulemaking process. One commenter indicated that formal retirement through rulemaking following immediate retirement is confusing.

Response: We believe that immediate retirement of quality measures should occur when the clinical evidence suggests that continued collection of the data may result in harm to patients. Under such circumstances, we may not be able to wait until the annual rulemaking cycle or until we have had the opportunity to obtain input from the public to retire the measure because of the necessity to discourage potentially harmful practices which may result from continued collection of the measure. We agree with the commenters that retirement of measures for reasons other than potential patient safety concerns should occur through the rulemaking process allowing for public comment. Because we generally adopt and retire RHQDAPU program quality measures through the rulemaking process (except for the immediate retirement exception we are adopting in this final rule), we believe that it is appropriate to use the rulemaking process to confirm the retirement of measures that were the subject of recent immediate retirement activity.

(2) Maintenance of Technical Specifications for Quality Measures

The technical specifications for each RHQDAPU program measure are listed in the CMS/The Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures (Specifications Manual). This

Specifications Manual is posted on the CMS QualityNet Web site at *https://www.QualityNet.org/.* We maintain the technical specifications by updating this Specifications Manual semiannually, or more frequently in unusual cases, and include detailed instructions and calculation algorithms for hospitals to use when collecting and submitting data on required measures. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24167), we invited public comment on our process of notifying the public about the technical specifications for RHQDAPU program quality measures and whether it can be improved to enable more meaningful public comment on our proposed measures. We also invited public comment on whether the information posted on the *https://www.QualityNet.org* Web site, including the frequency with which this information is updated, provides hospitals enough information and time to implement the collection of data necessary for these required quality measures.

Comment: Commenters agreed that timely updates to quality measures are necessary for maintaining comparable and credible measurement results and supported our process for posting changes to the Specifications Manual on the QualityNet Web site, and issuing notifications regarding updates issued. Some commenters suggested adding other methods to notify stakeholders as to technical specifications updates. These suggestions included utilizing a Real Simple Syndication (RSS) to send e-mail alerts to stakeholders, providing links to specifications not on the QualityNet Web site, listserv notifications, sharing the draft technical specifications with hospitals and data vendors 30 days prior to their release so that errors and omissions can be identified and corrected before the final version of the specifications is released, and not releasing the Specifications Manual until all revisions and updates are complete, thereby reducing the number of addenda. One commenter requested that the Specifications Manual be released with all relevant changes once a year.

Response: We will consider these suggestions for other methods to notify stakeholders as to technical specifications updates. The Specifications Manual is updated in two scheduled releases a year occurring at 6 month intervals in order to incorporate updates to the code sets used in the measure specifications, add or remove measures, and to provide vendors with adequate notice of changes. The Specifications Manual contains specifications for measures that have been adopted into the RHQDAPU program. However, we may include specifications for some of the proposed measures or measures under consideration for preview purposes only. Specifications for measures that are under development are not included in the Specifications Manual.

(3) Public Display of Quality Measures

Section 1886(b)(3)(B)(viii)(VII) of the Act requires that the Secretary establish procedures for making quality data available to the public after ensuring that a hospital has the opportunity to review its data before these data are made public. Data from the RHQDAPU program are included on the *Hospital Compare* Web site, *https://www.hospitalcompare.hhs.gov.* The RHQDAPU program currently includes process of care measures, risk adjusted outcome measures, the HCAHPS patient experience of care survey, and a structural measure regarding cardiac surgery registry participation. This Web site assists beneficiaries and the general public by providing information on hospital quality of care to consumers who need to select a hospital. It further serves to encourage consumers to work with their doctors and hospitals to discuss the quality of care hospitals provide to patients, thereby providing an additional incentive to hospitals to improve the quality of care that they furnish.

Comment: Several commenters submitted suggestions for improving public reporting of RHQDAPU program measures on the *Hospital Compare* Web site. A number of commenters stated that the *Hospital Compare* Web site is cumbersome to navigate and that data are displayed in a rigid fashion. The commenters suggested that CMS give end users the flexibility to create customized reports or tailor the data display to the end user's needs. Some commenters also suggested that hospitals would benefit from examining how well they are performing if they had access to reports that show performance on the care processes that take place during discharge. Other commenters stated that the display of data on the *Hospital Compare* Web site for the public may be interpreted as encouraging performance at 100 percent on the measures even though lower levels of performance on measures may be appropriate, and requested that CMS remove the current wording under the ''*Learn how to use the information from this site*'' link on the *Hospital Compare* Web site because it misrepresents to the public what the appropriate quality benchmarks are for certain measures. Several commenters supported the adoption of a more consumer-friendly star rating system for hospitals that would allow consumers to make decisions about where to receive care based on a composite ''score'' for the facility, rather than minor performance differences on individual measures. Another commenter disagreed with posting results on the *Hospital Compare* Web site when a hospital has fewer than 25 eligible cases in a reporting period for a measure, stating that the results may not be statistically valid or understood by most health care consumers. Another commenter stated that all reporting formats should be tested with consumers before being publicly displayed.

Response: Section 1886(b)(3)(B)(viii)(VII) of the Act requires that the Secretary establish procedures for making the data reported under the RHQDAPU program available to the public. We appreciate these suggestions regarding potential improvements to the *Hospital Compare* Web site. We continue to conduct consumer focus groups and work to identify areas for improvement, and will make changes that we believe are beneficial. In terms of a report that focuses upon care provided at discharge, hospitals can use their quarterly *Hospital Compare* preview reports, the downloadable *Hospital Compare* data sets, and other QualityNet reports to examine their performance on measures that relate to care provided at discharge. Although we do not believe that the current wording in the ''*Learn how to use the information from this site''* is misleading, we will re-examine the language and determine whether it would be appropriate to make changes. We are also working on condition-specific (AMI, HF, PN, SCIP and HCAHPS) composites for the *Hospital Compare* Web site in the future to make it more consumer-friendly.

On the *Hospital Compare* Web site, we employ a footnote for rates based upon fewer than 25 cases: ''The number of cases is too small (<25) to reliably tell how well a hospital is performing,'' but display the rate so that consumers can decide whether and how to consider the information.

2. Retirement of RHQDAPU Program Measures

As stated above, we retired the AMI–6 measure from the RHQDAPU program measure set beginning with discharges occurring on April 1, 2009, because we believed, based on new evidence, that the continued use of the measure raised specific patient safety concerns. In situations such as this, we do not

believe that it is appropriate to wait for the annual rulemaking cycle. Rather, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24168), we proposed to promptly retire the measure and notify hospitals and the public of the retirement of the measure and the reasons for its retirement through the usual hospital and QIO communication channels used for the RHQDAPU program, which include e-mail blasts to hospitals and the dissemination of Standard Data Processing System (SDPS) memoranda to QIOs, as well as posting the information on the QualityNet Web site. We proposed to confirm the retirement of the measure in the next IPPS rulemaking. In other circumstances where we do not believe that continued use of a measure raises specific patient safety concerns, we intend to use the regular rulemaking process to retire a measure.

We invited public comment on whether any other RHQDAPU program measures should be retired from the RHQDAPU program, as well as on the criteria that should be used in retiring measures. To the extent that performance has improved because of the collection and public display of quality measures, we also invited public comment on how performance could be maintained on the ''topped out'' measures once they are retired. We note that many of the measures in the existing program have experienced improved performance rates over the years. On our Web site, *https://www.cms.hhs.gov/HospitalQualityInits/,* we have posted the performance rates for the existing measures over the years that they have been collected through the RHQDAPU program. However, thus far, only one measure, the pneumonia oxygenation assessment measure, has reached such a high level of compliance (nearly 100 percent for the vast majority of hospitals) that we retired the measure.

Comment: Some commenters recommended 11 measures for retirement for varying reasons. Seven of these measures were recommended for retirement based on their performance being uniformly high nationwide, with little variability among hospitals. These seven measures are:

- AMI–1 Aspirin at arrival
- AMI–3 ACEI/ARB for left ventricular systolic dysfunction
- AMI–4 Adult smoking cessation advice/counseling
- AMI–5 Beta-blocker prescribed at discharge
- HF–4 Adult smoking cessation advice/counseling
- PN–4 Adult smoking cessation advice/counseling
- SCIP–Infection-6: Surgery patients with appropriate hair removal

Commenters also recommended that CMS implement an ongoing surveillance mechanism for measures that are retired due to unvarying high performance rates nationwide in order to prevent deterioration of performance.

Four of the 11 measures recommended for retirement from the RHQDAPU program were recommended for reasons other than high unvarying performance. These four measures are:

- HF–1 Discharge instructions
- PN–3b Blood culture performed before first antibiotic received in hospital
- SCIP–Infection-2: Prophylactic antibiotic selection for surgical patients
- SCIP–Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

With regard to the HF–1 Discharge instructions measure, a commenter stated that while high quality discharge instructions are important for better outcomes, this measure neither measures nor affects the quality of the discharge instruction. Another commenter stated that the complexity of the data collection guidelines for this measure outweighs its value.

Several commenters recommended retirement of measure PN–3b, Blood culture performed before first antibiotic received in hospital, because they believe that it does not align with current clinical guidelines.

Some commenters also suggested retirement of the SCIP–Infection-2: Prophylactic antibiotic selection for surgical patients measure because the measure is overly complicated and confusing, and the SCIP–Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose measure because of a perceived risk of complications due to extended insulin drips. Several commenters suggested that CMS develop a process for determining when process measures should be retired to accommodate the inclusion of broad outcome measures on a topic, and that CMS retire measures when negative unintended consequences result.

Response: We will consider these suggestions for measures to retire in a future rulemaking. We note that we will continue to retire measures based on reasons other than potential harm to patients by using the rulemaking process, and we believe it is important to weigh all relevant factors and consequences related to retirement of a measure with affected parties before proposing retirement. We agree that high levels of unvarying performance across hospitals should be among the factors considered in measure retirement. Such measures do not afford opportunities for improvements in care, nor do they allow consumers to discern meaningful differences in performance among hospitals.

We currently do not have mechanisms available to conduct continued surveillance of retired measures, but will explore options for monitoring whether the performance on retired measures deteriorates following their retirement. We also agree that quality measures should relate to high quality care processes, should be related to better patient outcomes, should align with current clinical guidelines when possible, and should not be overly burdensome to collect. We will consider these factors when evaluating current RHQDAPU program measures for retirement. We agree that outcome measures are useful indicators of quality, and in recent years have added outcome measures for mortality, readmission, and patient safety indicators to the RHQDAPU program. However, we do not believe that outcome measures necessarily render process measures incompatible or redundant.

Also, we agree that measures should be evaluated for negative unintended consequences, and that this should be a consideration for measure retirement. We strive to stay informed about measure support in current scientific literature, the continuing ability of measures to assess quality of care, and evolving unintended consequences. Some negative unintended consequences (such as patient harm) may warrant immediate action while other consequences (such as increased burden on the hospital) may need to be weighed against the utility of continuing to collect and publicly post the measure.

Comment: One commenter indicated that there are no further measures that needed to be retired because there are no other ''topped out'' measures.

Response: We have observed and other commenters have pointed out that there may be a number of RHQDAPU program measures that have high levels of unvarying performance. However, as we stated in the response to a previous comment, we also believe that there are other criteria that we must additionally consider before we propose to retire a measure from the RHQDAPU program.

3. Quality Measures for the FY 2011 Payment Determination and Subsequent Years

a. Considerations in Expanding and Updating Quality Measures Under the RHQDAPU Program

In the FY 2009 IPPS proposed rule, we solicited public comment on several considerations related to expanding and updating quality measures, including how to reduce the burden on the hospitals participating in the RHQDAPU program and which approaches to measurement and collection would be most useful while minimizing burden (73 FR 23653 through 23654).

In the FY 2009 IPPS final rule, we responded to the public comments we received on these issues (73 FR 48613 through 48616). We also stated that in future expansions and updates to the RHQDAPU program measure set, we would be taking into consideration several important goals. These goals include: (a) Expanding the types of measures beyond process of care measures to include an increased number of outcome measures, efficiency measures, and patients' experience-of-care measures; (b) expanding the scope of hospital services to which the measures apply; (c) considering the burden on hospitals in collecting chart-abstracted data; (d) harmonizing the measures used in the RHQDAPU program with other CMS quality programs to align incentives and promote coordinated efforts to improve quality; (e) seeking to use measures based on alternative sources of data that do not require chart abstraction or that utilize data already being reported by many hospitals, such as data that hospitals report to clinical data registries, or all-payer claims data bases; and (f) weighing the relevance and utility of the measures compared to the burden on hospitals in submitting data under the RHQDAPU program. Specifically, we give priority to quality measures that assess performance on: (a) Conditions that result in the greatest mortality and morbidity in the Medicare population; (b) conditions that are high volume and high cost for the Medicare program; and (c) conditions for which wide cost and treatment variations have been reported, despite established clinical guidelines. We have used and continue to use these criteria to guide our decisions regarding what measures to add to the RHQDAPU program measure set.

Although RHQDAPU program payment decisions were initially based solely on a hospital's submission of chart-abstracted quality measure data, in recent years we have adopted measures, including structural and claims-based quality measures that do not require a hospital to submit chart-abstracted clinical data. This supports our stated goal to expand the measures for the RHQDAPU program while minimizing the burden on hospitals and, in particular, without significantly increasing the chart abstraction burden.

In addition to claims-based measures, we are considering registries [10] and electronic health records (EHRs) as alternative ways to collect data from hospitals. Many hospitals submit data to and participate in existing registries. In addition, registries often capture outcome information and provide ongoing quality improvement feedback to registry participants. Instead of requiring hospitals to submit the same data to CMS that they are already submitting to registries, we believe that we could collect the data directly from the registries, thereby enabling us to expand the RHQDAPU program measure set without increasing the burden of data collection for those hospitals participating in the registries. Examples of registries actively used by hospitals include the Society of Thoracic Surgeons (STS) Cardiac Surgery Registry (with approximately 90 percent participation by cardiac surgery programs), the AHA Stroke Registry (with approximately 1200 hospitals participating), and the American Nursing Association (ANA) Nursing Sensitive Measures Registry (with approximately 1400 hospitals participating). In the FY 2009 IPPS final rule (73 FR 48608 through 48609), we adopted the first RHQDAPU program measure related to registries: Participation in a Systematic Database for Cardiac Surgery. We continue to evaluate whether it is feasible to adopt measures that rely on one or more registries as a source for data collection.

We also stated our intention to explore mechanisms for data submission using EHRs (73 FR 48614). Establishing such a system will require interoperability between EHRs and CMS data collection systems, additional infrastructure development on the part of hospitals and CMS, and the adoption of standards for the capturing, formatting, and transmission of data elements that make up the measures. However, once these activities are accomplished, the adoption of measures that rely on data obtained directly from EHRs will enable us to expand the RHQDAPU program measure set with less cost and burden to hospitals.

[10] A registry is a collection of clinical data for purposes of assessing clinical performance, quality of care, and opportunities for quality improvement.

In the FY 2009 IPPS final rule, we adopted nine AHRQ measures for the RHQDAPU program. Although we stated that we would initially calculate the measures using Medicare claims data (73 FR 48608), we also stated that we remained interested in using all-payer claims data to calculate them and that we might propose to collect such data in the future. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24169), we invited input and suggestions on how all-payer claims data can be collected and used by CMS to calculate these measures, as well as on additional AHRQ measures that we should consider adopting for future RHQDAPU program payment determinations.

We noted that we continue to use these criteria to guide our decisions on what measures to propose for the RHQDAPU program measure set. Therefore, we invited comments on the new quality measures we have proposed to include in future payment years and on the criteria we should use to retire measures.

Comment: Several commenters supported the concept of EHR-based data collection. One commenter expressed concern that the process to implement electronic data collection may delay the adoption of measures, in particular the stroke measures, for the RHQDAPU program. Another commenter applauded CMS for considering EHRs as an alternative way to collect data, but suggested that no new quality measures be introduced for 2 years while the industry implements EHRs, and that some consideration be given to small rural hospitals that may not be able to adopt EHRs as soon as larger urban hospitals. One commenter believed that infrastructure development for establishing interoperability will be challenging and asked that CMS consider a phase-in period of 5 years, with reasonable benchmarks for every 6 months to 1 year.

Response: We appreciate these supportive comments regarding EHR-based data collection as an alternative data source for quality measures. We encourage adoption of EHRs, and we also acknowledge the challenges that must be met both by hospitals and CMS to establish the infrastructure and interoperability necessary to collect data on quality measures via EHRs. In determining whether to adopt new quality measures for the RHQDAPU program, we weigh the potential benefit of improvement that would result from reporting a given measure against the potential resource burden associated with reporting a measure. For purposes

of the RHQDAPU program, EHR-based data submission may provide an alternative means of submitting quality data that would benefit hospitals by reducing their chart abstraction burden. However, because of the challenges noted above, we do not plan to make EHR-based data submission the only means by which hospitals can submit quality data for the RHQDAPU program in the near future.

Comment: Several commenters opposed the direct collection of data from EHRs for quality measures, stating that quality data produced in this manner is unlikely to be useful or valid either for quality measurement or for research, and that programming software is incapable of interpreting and deciding between discrepant documentation in a single medical record.

Response: We disagree with the comment that quality data produced from EHRs is not likely to be useful for quality measurement and research. The data collected from the EHR would essentially be the same data that hospitals would otherwise have to manually abstract from a medical chart. These data are what we currently use for quality measure reporting and for research. We acknowledge that additional programming work may need to be completed to enable current EHR systems to collect and submit quality measure data. We are currently working with the Healthcare Information Technology Standards Panel (HITSP), a public-private partnership working to establish Health IT interoperability standards under contract to the DHHS Office of the National Coordinator on Health IT, to standardize the specifications of data elements used in stroke, VTE, and emergency department measures so that they may be collected and reported via EHRs. Standardization of the specifications allows software to convert clinical data of different types into a form that can be analyzed for quality measurement. We encourage collaboration between standards setting organizations and measure developers on the creation of standards for electronic collection of data elements for other quality measures as well, particularly those used in our quality data reporting programs.

Comment: A number of commenters supported the use of registries as an alternative source of hospital-specific data on quality measures and as a means to reduce hospital burden. Several commenters indicated that the use of registries to collect hospital-level data would reduce administrative burden and ensure appropriate risk-adjustment for quality improvement and public reporting purposes, as well as other benefits, including the identification of opportunities for quality improvement, improvements in patient safety practices and coordination of care, and improved patient outcomes.

However, several commenters expressed concern regarding the possibility that they may be required to participate in proprietary registries in the future, and requested clarity regarding alternatives for data submission should some hospitals (for example, small hospitals, rural hospitals) not have the resources to participate in registry-based data collection initiatives. These commenters saw registry-based data collection as costly and labor intensive because many registries require chart abstraction. Other commenters saw registries as useful for monitoring quality, but indicated that many data fields collected by registries are not related to quality measures, and preferred that if such a mechanism were to be used for data collection, CMS only receive data relevant to the quality measures of interest, and that the data be limited to the Medicare population only.

Response: We are interested in reducing the burden associated with quality measurement. If hospitals are participating in registries and submit the same data to those registries that they would otherwise have to submit for measures that are part of the RHQDAPU program, we believe that the registry data would be an efficient alternative source from which to collect the data, and that this would prevent the hospital from having to report the same data twice. Many hospitals are currently participating in a number of registries that collect data on quality measures that are topics of interest to us. However, we acknowledge the commenters' concern regarding the cost associated with participation in certain registries which may make this alternative mechanism for data submission less feasible for some hospitals. We anticipate that registry-based data collection may be one means, but not an exclusive means, of submitting data for quality measures. We will take these considerations into account when selecting measures and potential data submission mechanisms for those measures for the RHQDAPU program in the future.

Comment: A number of commenters indicated that it would not be feasible for hospitals to implement all-payer claims reporting for the AHRQ measures while trying to adopt a standardized EHR at the same time. Another commenter indicated that, for all-payer data to be transmitted to the QIO Clinical Warehouse, data vendors that currently collect and submit most of the clinical data for the RHQDAPU program would need to develop the capability to process and submit all-payer administrative data to the QIO Clinical Warehouse, and that the current CMS Abstraction & Reporting Tool (CART) would need to be modified to collect these additional data. One commenter urged CMS to develop a national all-payer claims database.

Response: We thank the commenters for these comments. While we are interested in collecting all-payer claims data from hospitals in the future, we currently do not have a data collection mechanism in place to receive these claims. We will continue to explore the feasibility of collecting all-payer claims data in the future.

Comment: Several commenters encouraged CMS to look to the National Priorities Partnership goals as a framework for the types of measures that should be included in the RHQDAPU program. Some commenters believe that some of the measures proposed are not NQF-endorsed. Some commenters suggested that CMS consider adopting the criteria for measure selection developed by The Joint Commission.

Response: The National Priorities Partnership is a 28 member organization convened by the NQF for the purpose of identifying improvement goals and action steps for the U.S. healthcare system. We are a member of the National Priorities Partnership and participate in its framework-setting activity. Our measure selection activity for the RHQDAPU program is informed by this framework. The SCIP—Infection-9 and -10 measures and the two measures of registry participation included in the proposed rule address the National Priorities Partnership goals of increasing patient safety and population health. The proposed SCIP—Infection-9 and -10 measures are NQF-endorsed, and the two structural measures regarding registry participation are inpatient applications of an NQF-endorsed measure of registry participation (NQF #0493). We regularly communicate with The Joint Commission regarding the aligned measures and participate in measure maintenance workgroups with The Joint Commission.

Comment: Several commenters stated that measures selected for the RHQDAPU program should be both endorsed by the NQF and adopted by the HQA. Some commenters suggested that these steps were required by the DRA. One commenter stated that the standard for consensus for selection of

quality measures should be consistent with the National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113) (NTTAA) standards.

Response: Section 1886(b)(3)(B)(viii)(V) of the Act requires, effective for payments beginning with FY 2008, that the Secretary add quality measures that reflect consensus among affected parties and, to the extent feasible and practicable, have been set forth by one or more national consensus building entities. This provision does not require that the measures we adopt for the RHQDAPU program be endorsed by any particular entity, and we believe that consensus among affected parties can be reflected by means other than endorsement by a voluntary consensus organization, including consensus achieved during the measure development process, consensus shown through broad acceptance and use of measures, and consensus through public comment (74 FR 24165 through 24166). Nevertheless, we have stated on numerous occasions that we prefer to adopt quality measures that have been endorsed by the NQF. The NQF uses a formal consensus development process. As the NQF notes on its Web site at: *http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx*, it has been recognized as a voluntary consensus standards-setting organization as defined by the NTTAA and Office of Management and Budget Circular A–119.

In contrast, the HQA has a limited membership and its current policy is to limit measures that it selects for adoption to a subset of NQF-endorsed measures. In selecting measures for the RHQDAPU program we consider a variety of factors that we have discussed both in this final rule and in previous final rules and take into consideration input received from the public including but not limited to members of the HQA.

Comment: One commenter supported the measure selection criteria that CMS stated in the proposed rule and suggested that emphasis in measure selection be placed upon the following: results of cost-benefit analyses; opportunities to leverage data reported to State health agencies and State hospital associations; alignment of measures and incentives across providers and settings through the application of care coordination measures and measures of quality across episodes of care that increase providers' clinical and financial accountability; and measurement of ambulatory care sensitive and preventable hospital admissions and readmissions for beneficiaries with chronic conditions. The commenter also suggested that CMS avoid selecting measures that allow hospitals to be rewarded for providing marginally effective care or care that is already routinely furnished.

Response: We thank the commenter for these suggestions. In general, we agree with these suggested considerations for measure selection. We adopt measures of high relevance to the Medicare population for which the benefit of public reporting and improvement justifies the collection burden, and intend to reduce the collection burden by utilizing data sources such as administrative data, registries, and EHRs. We strive to align measures across settings whenever possible and will continue to do so. The current and proposed RHQDAPU program measure set contains measures of readmission for beneficiaries with certain acute and chronic conditions, and we intend to expand measurement in this area. We also intend to adopt measures of care coordination suitable for inclusion in the RHQDAPU program when such measures are developed. We also agree with the commenter that quality measures should emphasize effective care for which there is evidence of wide variability despite the presence of established guidelines. With regard to measurement of quality across episodes of care, the current RHQDAPU program process measures focus on topics of acute care quality. However, we believe that the 30-day mortality and 30-day readmission measures adopted for the RHQDAPU program also touch on the issue of quality across the continuum of care because other providers in the larger community share responsibility with the hospital for mortality and readmission during the 30-day period measured, as the quality of ambulatory follow up care or postacute care after discharge affects the likelihood of these events occurring.

Comment: Two commenters supported the RHQDAPU program in general. One of these commenters attributed great improvements in performance and benefits to patients to the reporting of quality data and indicated that the reporting program allows hospitals to see comparative information that they otherwise might not see.

Response: We agree with and appreciate these supportive comments.

Comment: One commenter opposed quality data reporting and stated that decreasing payments via incentive programs leads to decreases in quality and safety of care for patients.

Response: We disagree with this statement. The IOM, in its 2005 volume titled *Performance Measurement: Accelerating Improvement* (part of the IOM series on ''Pathways to Quality Health Care'') credits performance measurement as the cornerstone of quality improvement in healthcare. Analyses of *Hospital Compare* data over time indicates improvement trends in most of the measures since reporting began in 2004.

In summary, we will continue to pursue goals regarding the expansion and updating of quality measures under the RHQDAPU program while minimizing burden. We will take into account the public comments we received on the possible uses of EHRs, registries, and all-payer claims data in the RHQDAPU program. We also will consider the measure selection criteria suggested by various commenters in prioritizing and selecting quality measures for the future.

b. RHQDAPU Program Quality Measures for the FY 2011 Payment Determination

(1) Retention of Existing RHQDAPU Program Quality Measures

For the FY 2011 payment determination, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24169), we proposed to retain 41 RHQDAPU program quality measures that we are using for the FY 2010 payment determination. We refer readers to the table in the proposed rule (74 FR 24169 through 24170) for a complete list of the measures we proposed to retain.

As we discussed in section V.A.1.c.(1) of this final rule, we retired the AMI–6 Beta blocker at arrival measure from the RHQDAPU program measure set for the FY 2010 payment determination and subsequent years.

We discussed above the public comments we received regarding the retirement of measures that are proposed for the FY 2011 payment determination. We did not receive any other public comments regarding our proposal to retain for the FY 2011 payment determination the 41 measures that we are using for the FY 2010 payment determination. Therefore, we are adopting as final, without change, our proposal to retain the 41 quality measures used for the FY 2010 payment update.

(2) NQF Harmonization of Two Existing RHQDAPU Program Measures

In May 2008, the NQF reviewed the specifications for two of the RHQDAPU program measures that we adopted for the FY 2010 payment determination: PSI 04—Death among surgical patients with treatable serious complications;

and Nursing Sensitive—Failure to rescue (Medicare claims only). This was part of an NQF project titled ''National Voluntary Consensus Standards for Hospital Care 2007: Performance Measures.'' As a result of this project by the NQF, these two measures now have the same name: ''Death among surgical inpatients with serious, treatable complications'' and share a single set of measure specifications.

In order to maintain consistency with national voluntary consensus standards with respect to referencing the measure, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24170), we proposed to combine PSI 04—Death among surgical patients with treatable serious complications; and Nursing Sensitive—Failure to rescue (Medicare claims only) into a single measure, Death among surgical inpatients with serious, treatable complications, and to list the measure under proposed topic name—AHRQ PSI and Nursing Sensitive Care. This measure, as well as its specifications, would replace, for purposes of hospital reporting, the two RHQDAPU program measures that we adopted for the FY 2010 payment determination: PSI 04: Death among surgical patients with treatable serious complications; and Nursing Sensitive—Failure to rescue (Medicare claims only). However, we indicated that we may continue to publicly report the measure in two different topics areas on the *Hospital Compare* Web site—Nursing Sensitive Care and AHRQ PSIs, IQIs and Composite Measures. We invited public comment on this proposal.

Comment: Several commenters supported harmonization of the Failure to Rescue measure and PSI 04: Death among surgical inpatients with serious, treatable complication in accordance with consensus standards. However, a number of commenters questioned the possible display of the harmonized measure in more than one topic area on the *Hospital Compare* Web site, stating this may be unnecessary, redundant, and result in confusion. One commenter indicated that continuing to report the measure under the two separate topic areas is beneficial.

Response: We thank the commenters for their support of our use of the single harmonized measure and measure specification for the RHQDAPU program. The harmonized measure addresses two areas of topical significance, patient safety and nursing sensitive care. Therefore, we believe that publicly displaying the measure results in more than one topic area on the *Hospital Compare* Web site will give end-users a richer picture of a hospital's performance in both of these topic areas. We will conduct consumer testing to ensure that display of the measure on the *Hospital Compare* Web site does not appear redundant or confusing to consumers.

After consideration of the public comments we received, we have decided to adopt as final our proposal to harmonize these two measures for the FY 2011 payment determination.

(3) New Chart-Abstracted Measures

For the FY 2011 payment determination, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24170), we proposed to add two new chart-abstracted measures. These proposed new measures, SCIP–Infection-9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2 and SCIP–Infection-10: Perioperative Temperature Management, are additions to the existing SCIP measure set. The SCIP Infection measures are designed to assess practices that reduce the risk of infections that surgical patients could acquire in the hospital. They have high relevance to the Medicare population, and address the growing concern regarding hospital-acquired infections.[11]

Although these two measures require that hospitals abstract data from medical records, they add to the scope of the existing SCIP measure set. Hospitals currently collect and report data elements for eight SCIP measures. Additional data elements required for these two proposed new SCIP measures are minimal, and would be abstracted from the same records hospitals use to abstract data for the other SCIP measures. Therefore, we expect the additional burden on hospitals to be minimal. The two measures are NQF-endorsed. We invited public comment on our proposal to include SCIP–Infection-9 and SCIP–Infection-10 as RHQDAPU program measures to be used for the FY 2011 payment determination.

Comment: Several commenters supported CMS' recognition of the burden associated with collection of chart-abstracted measures and limiting the number of chart-abstracted measures proposed this year.

Response: We appreciate these comments and will continue to carefully consider the potential burden associated with the collection of chart-abstracted measures for the RHQDAPU program relative to potential benefit of public reporting and quality improvement.

Comment: Several commenters supported the two proposed new chart-abstracted measures. The commenters indicated that these measures have the potential to reduce hospital-acquired infections while minimizing burden, as the data elements would come from the same records hospitals are using to abstract data for the other SCIP measures.

Response: We appreciate these supportive comments. We believe that these measures address areas of topical importance to the Medicare program because they measure quality of surgical care and practices associated with reduction of hospital-acquired infections, and thus, ensure better patient outcomes.

Comment: A few commenters opposed the inclusion of both SCIP–Infection-9 and SCIP–Infection-10 in the RHQDAPU program solely because they are not HQA adopted.

Response: As we discussed more fully in our response to a prior comment, we do not believe that HQA endorsement is a required prerequisite for quality measure selection under the RHQDAPU program.

Comment: One commenter expected a moderate increase in the administrative burden related to abstraction. Another commenter asked CMS to consider whether it should adopt SCIP–Infection-9 if it is considering implementing the Nursing Sensitive/HAI measure, Catheter Associated Urinary Tract Infection (CA UTI), in FY 2012. The commenter stated that the two measures work toward the same goal of reduced UTIs, and ultimately, a broader outcome measure should supplant the related process measure that is more likely to become outdated as science evolves.

Response: Both SCIP–Infection-9 and SCIP–Infection-10 impose minimal additional abstraction burden as they build upon an existing measurement set for a population for which charts are already being pulled for abstraction. We acknowledge that the process measured by SCIP–Infection-9 is related to the outcome measured by the CA UTI measure being considered among measures for future adoption in FY 2012 and beyond. Though CA UTI is being considered for the future, SCIP–Infection-9 was proposed for the FY 2011 payment determination because there is widespread variation in practice for the processes measured, and the practices associated with the measure improve patient outcomes. The processes measured in SCIP–Infection-9 may be related to the CA UTI measure, but the process measure is not

[11] U.S. Government Accountability Office. Health-Care Associated Infections in Hospitals: An Overview of State Reporting Programs and Individual Hospital Initiatives to Reduce Certain Infections. September 2008.

supplanted by the outcome measure. The processes SCIP–Infection-9 is intended to measure are of clinical relevance to the Medicare population and have the potential to improve patient care outcomes.

After consideration of the public comments we received, we have decided to finalize our proposal, without change, to adopt SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2 and SCIP–Infection-10: Perioperative Temperature Management as quality measures under the RHQDAPU program for the FY 2011 payment determination. As we stated in the proposed rule, the collection of the new chart-abstracted measures for the FY 2011 payment determination will begin with 1st calendar quarter 2010 discharges, for which the submission deadline will be August 15, 2010.

(4) New Structural Measures

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24170), we also proposed to adopt two additional structural measures for the FY 2011 payment determination. Structural measures assess the characteristics and capacity of the provider to deliver quality health care. We proposed to add two additional registry participation measures. The two structural measures are: (1) Participation in a Systematic Clinical Database Registry for Stroke Care; and (2) Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care. These measures are specific applications for the inpatient setting of a structural measure entitled ''Participation by a physician or other clinician in a systematic clinical database registry that includes consensus endorsed measures,'' which received NQF endorsement under a project titled ''National Voluntary Consensus Standards for Health IT: Structural Measures 2008.'' The proposed measures are appropriate applications of the NQF-endorsed measure because the NQF has endorsed measures for Stroke Care and Nursing Sensitive Care which are currently being collected by widely used stroke and nursing sensitive care registries. Therefore, we believe that the proposed Stroke Registry Participation structural measure and Nursing Sensitive Care Registry Participation structural measure meet the consensus requirement in section 1886(b)(3)(B)(viii)(V) of the Act.

As we have previously stated, we also believe that participation in registries reflects a commitment to assessing the quality of care provided and identifying opportunities for improvement. Many registries also collect outcome data and provide feedback to hospitals about their performance. Moreover, registries offer a potential future data source from which we can collect quality data.

The Participation in a Systematic Clinical Database Registry for Stroke structural measure would require each hospital that participates in the RHQDAPU program to indicate whether it is participating in a systematic qualified clinical database registry for inpatient stroke care and, if so, to identify the registry.

The Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care structural measure would similarly require each hospital participating in the RHQDAPU program to indicate whether it is participating in a systematic qualified clinical database registry measuring nursing sensitive care quality for inpatient care and, if so, to identify the registry.

We solicited public comment on these registry structural measures. Specifically, we invited public comment on whether ''systematic qualified clinical database registry'' is adequately defined and, if not, how it should be defined. In defining ''systematic qualified clinical database registry,'' should registries that do not collect outcome measures and/or do not provide feedback to hospitals about their performance be excluded? Are there other registries that we should consider in future rulemakings, beyond stroke and nursing sensitive registries, particularly for conditions where there is high mortality/morbidity in the Medicare population, high cost to the health care system, and widespread treatment variations despite established clinical guidelines? Finally, we welcomed more precise data on what percentage of hospitals already participate in a stroke registry or a nursing sensitive registry.[12] Because we also retire measures when performance has reached a sufficiently high level, we invited public comment on whether reporting on stroke registry and nursing sensitive care registry structural measures has sufficient relevance and utility to justify the reporting burden, if a substantial proportion of hospitals already participate in these registries.

Both proposed structural measures can be submitted using a Web-based collection tool that we will make available on the QualityNet Web site. We invited public comment on our proposal to adopt these two structural measures for the FY 2011 payment determination.

Comment: Several commenters indicated that the two structural measures of clinical registry participation should not be included in the RHQDAPU program. They indicated that the measures had not been endorsed by the NQF or adopted by the HQA and there appears to be no established connection between whether a hospital answers ''yes'' or ''no'' to the registry participation measures and the quality of the care that hospital provides. Some commenters expressed concern that these measures contain an implicit encouragement by the Medicare program for hospitals to participate in clinical data registries designed and operated by external organizations, which can be costly. Others commenters applauded the use of registries to promote quality improvement.

Response: The proposed structural measures are specific applications for the inpatient setting of NQF-endorsed measure ''participation by a physician or other clinician in a systematic clinical database registry that includes consensus endorsed measures.'' Therefore, we believe that they meet the requirement for consensus in section 1886(b)(3)(B)(viii)(V) of the Act. The measure as endorsed by the NQF is an indicator of quality, because it measures adoption of technology that has the capacity to improve quality of care. We believe that registries can play an important role in providing hospitals with information and services for internal quality improvement by providing performance benchmarking information, continuous feedback, and opportunities to learn best practices. Our intent with these structural measures is to assess the degree of current participation in registries collecting NQF-endorsed measures on the topics of stroke and nursing sensitive quality measures among hospitals participating in the RHQDAPU program. We note that hospitals are not required to actually participate in the registries in order to meet the RHQDAPU program requirements. We also note that in the public comments we received, many hospitals indicated that registry participation afforded them with valuable insights for improving quality and patient outcomes.

Comment: Several commenters supported the structural measure ''Participation in a systematic clinical database registry for stroke.'' The

[12] Examples of registries that we are aware of that are being actively used by hospitals include the Society of Thoracic Surgeons (STS) Cardiac Surgery Registry (with approximately 90 percent participation by cardiac surgery programs), the AHA Stroke Registry (with approximately 1200 hospitals participating), and the American Nursing Association (ANA) Nursing Sensitive Measures Registry (with approximately 1400 hospitals participating).

commenters agreed that stroke measurement should be a priority for the RHQDAPU program because strokes cause significant mortality and morbidity in the Medicare population, and are treated with wide variation despite established guidelines. The commenters also stated that participation in such registries has resulted in improvements in the quality of care delivered to stroke patients. Commenters recommended that the Massachusetts Department of Public Health's acute stroke registry, the American Stroke Association (ASA) Get With the Guidelines-Stroke registry, and the CDC Paul Coverdell stroke registry should be recognized as qualifying registries for the Systematic Clinical Database Registry for Stroke measures. A few commenters indicated that quarterly submission of registry participation, while not overly burdensome, is unnecessary because hospitals tend to participate for an entire year, and not on an intermittent basis.

Response: We agree that strokes cause high morbidity and mortality in the Medicare population, and we believe that stroke registries can play an important role in providing hospitals with information and services for internal quality improvement by providing performance benchmarking information, continuous feedback, and opportunities to learn best practices. We understand that hospitals that participate in registries tend to participate continuously for an entire year, rather than intermittently. Based on the feedback, we are modifying our proposal to require that hospitals only report whether they participate in a stroke and/or nursing sensitive care registry once annually. We also are modifying our submission requirement with respect to the cardiac surgery registry participaton measure to be consistent with the annual submisssion requirement for the stroke and nursing sensitive care registry participation measures.

Comment: A number of commenters indicated that participation in stroke registries should not be mandated due to perceived burden, and that hospitals should be allowed to report the measures to CMS without a vendor. One commenter asked whether and how CMS would determine volume thresholds for participation in a stroke registry, and specifically whether there would be an expectation that hospitals having a low volume of stroke cases participate in a registry.

Response: We acknowledge that registry participation may be burdensome for some hospitals, and we note that the proposed structural measures do not mandate that hospitals actually participate in either a stroke or nursing sensitive care registry. We also note that there is no requirement under the RHQDAPU program that hospitals use a vendor to report measures to the QIO Clinical Warehouse, the structural measures can be reported directly by hospitals using a Web-based tool.

Comment: Commenters suggested criteria for a qualified systematic clinical database registry for stroke care. One commenter suggested a data collection system that supports real-time data collection concurrent with patient care, that collects at a minimum all data required to support the NQF-endorsed stroke measures, and that uses the data to guide improvement in stroke care within an organized program of quality improvement. Another commenter suggested that registries should be required to include the following services and information: (1) A feedback component; (2) the intended use (that is, plan of action/care) of the information; (3) potential intervention actions; (4) evaluation; and (5) the outcome measure intended to impact (this could be either a process-outcome link supported by literature, intermediate outcome, or long-term outcome). Commenters also suggested that the risk adjustment methodologies employed must be explained if a hospital is collecting outcome data, and the feedback provided should be ''systematic,'' which requires coordination of the feedback and dissemination of that feedback to the defined stroke team (not just the statement feedback to hospital).

Response: We appreciate these suggestions and will consider these for future measure refinement. We note that the current NQF-endorsed measure #0493, upon which the stroke and nursing sensitive registry participation structural measures are based, contains the following definition for systematic clinical database registry:

''c. Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry's clinical topic(s) and report on all patients eligible for the selected measures.

''d. Registry provides calculated measures results, benchmarking, and quality improvement information to individual physicians and clinicians.

''e. Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group's practice. Participation in a national or state-wide registry is encouraged for this measure.

''f. Registry may provide feedback directly to the provider's local registry if one exists.''

This definition of systematic clinical database registry is part of the specification for measure #0493 shown in NQF's 2008 Consensus Report regarding National Voluntary Consensus Standards for Health Information Technology. We will modify this definition to apply to inpatient hospitals, and to the specific topics of stroke and nursing sensitive care registries.

Comment: Some commenters supported the structural measure for ''Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care.'' One commenter suggested that the Patients First nursing sensitive measure project be recognized as a qualifying registry under the measure. Another commenter suggested that the National Database of Nursing Quality Indicators (NDNQI) be considered a qualifying registry.

Response: We appreciate these supportive comments. Participation in a particular registry is not required in order for a hospital to properly report the Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care measure, or any of the other structural measures we have, to date, adopted for the RHQDAPU program. A hospital can successfully report this structural measure simply by indicating whether they participate in a systematic clinical database registry for nursing sensitive care and, if so, which registry.

Comment: A number of commenters indicated that participation in a nursing sensitive care registry, though currently widespread, may not be feasible for smaller hospitals due to the cost and the need for additional staff for data abstraction and reporting.

Response: We understand the cost implications of participating in such registries. However, as we have stated above, actual participation in a nursing sensitive care registry is not required under the RHQDAPU program.

Comment: Commenters suggested that CMS consider three additional registry topics for measuring hospital participation:

- Sepsis Survival
- Surgical Quality Improvement
- Healthcare Safety and Healthcare Acquired Infections

Response: We thank the commenters for these suggestions and will consider these registry topics in the future.

After consideration of the public comments we received, we are adopting as final the two proposed structural measures: Participation in a Systematic

Clinical Database Registry for Stroke Care; and Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care under the RHQDAPU program for the FY 2011 payment determination. Based on public comments, we will collect these structural measures once annually rather than quarterly as originally proposed. Annual data submission for these structural measures via a Web-based collection tool will begin in July 2010 with respect to the time period January 1, 2010, through June 30, 2010.

In summary, after consideration of the public comments we received, for the FY 2011 payment determination, we are adopting as final our proposals to retain 41 of the measures we adopted for the FY 2010 payment determination. In addition, we are adopting as final our proposal to harmonize an AHRQ measure and a Nursing Sensitive measure by combining these measures into a single measure entitled Death among surgical inpatients with serious, treatable complications for the RHQDAPU program measure set for FY 2011 payment determination. Finally, we are adopting as final our proposal to add an additional four measures to the RHQDAPU program measure set for the FY 2011 payment determination: SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2; SCIP–Infection-10: Perioperative Temperature Management; Participation in a Systematic Clinical Database Registry for Stroke Care; and Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care.

Set out below are the 46 RHQDAPU program quality measures we are adopting for the FY 2011 payment determination:

Topic	RHQDAPU Program quality measures for the FY 2011 payment determination
Acute Myocardial Infarction (AMI)	• AMI–1 Aspirin at arrival. • AMI–2 Aspirin prescribed at discharge. • AMI–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction. • AMI–4 Adult smoking cessation advice/counseling. • AMI–5 Beta blocker prescribed at discharge. • AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival. • AMI–8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI).
Heart Failure (HF)	• HF–1 Discharge instructions. • HF–2 Left ventricular function assessment. • HF–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction. • HF–4 Adult smoking cessation advice/counseling.
Pneumonia (PN)	• PN–2 Pneumococcal vaccination status. • PN–3b Blood culture performed before first antibiotic received in hospital. • PN–4 Adult smoking cessation advice/counseling. • PN–5c Timing of receipt of initial antibiotic following hospital arrival. • PN–6 Appropriate initial antibiotic selection. • PN–7 Influenza vaccination status.
Surgical Care Improvement Project (SCIP)	• SCIP–1 Prophylactic antibiotic received within 1 hour prior to surgical incision. • SCIP–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time. • SCIP–VTE–1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients. • SCIP–VTE–2: VTE prophylaxis within 24 hours pre/post surgery. • SCIP–Infection-2: Prophylactic antibiotic selection for surgical patients. • SCIP–Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose. • SCIP–Infection-6: Surgery Patients with Appropriate Hair Removal. • SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2*. • SCIP–Infection-10: Perioperative Temperature Management*. • SCIP–Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period.
Mortality Measures (Medicare Patients)	• MORT–30–AMI: Acute Myocardial Infarction 30-day mortality –Medicare patients. • MORT–30–HF: Heart Failure 30-day mortality Medicare patients. • MORT–30–PN: Pneumonia 30-day mortality –Medicare patients.
Patients' Experience of Care	• HCAHPS survey.
Readmission Measure (Medicare Patients)	• READ–30–HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients). • READ–30–AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients). • READ–30–PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients).
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures.	• PSI 06: Iatrogenic pneumothorax, adult.

Topic	RHQDAPU Program quality measures for the FY 2011 payment determination
AHRQ PSI and Nursing Sensitive Care**	• PSI 14: Postoperative wound dehiscence. • PSI 15: Accidental puncture or laceration. • IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume). • IQI 19: Hip fracture mortality rate. • Mortality for selected surgical procedures (composite). • Complication/patient safety for selected indicators (composite). • Mortality for selected medical conditions (composite). • Death among surgical inpatients with serious, treatable complications.
Cardiac Surgery	• Participation in a Systematic Database for Cardiac Surgery.
Stroke Care	• Participation in a Systematic Clinical Database Registry for Stroke Care*.
Nursing Sensitive Care	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care*.

* New measure for FY 2011 payment determination.
** Harmonized measure. This measure may be publicly reported under two topics—the AHRQ PSIs and the Nursing Sensitive Care topic.

4. Possible New Quality Measures for the FY 2012 Payment Determination and Subsequent Years

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24172), we invited public comment on the following quality measures and topics that we might consider adopting beginning with the FY 2012 payment determination. We also sought suggestions and rationales to support the adoption of measures and topics for the RHQDAPU program that are not included in this list.

Measure topic	Measure description
AMI	Statin at discharge.
ED—Throughput	Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.
ED—Throughput	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.
Complications	Lower Extremity Bypass Complications.
Complications	Comorbidity Adjusted Complication Index.
PCI	PCI mortality rate for patients without ST segment elevation myocardial infarction (STEMI) and without cardiogenic shock.
Stroke	Patients with an ischemic stroke or a hemorrhagic stroke and who are non-ambulatory should start receiving DVT prophylaxis by end of hospital day two.
Stroke	Patients with an ischemic stroke prescribed antithrombotic therapy at discharge.
Stroke	Patients with an ischemic stroke with atrial fibrillation discharged on anticoagulation therapy.
Stroke	Acute ischemic stroke patients who arrive at the hospital within 120 minutes (2 hours) of time last known well and for whom IV t-PA was initiated at this hospital within 180 minutes (3 hours) of time last known well.
Stroke	Patients with ischemic stroke who receive antithrombotic therapy by the end of hospital day two.
Stroke	Ischemic stroke patients with LDL >/= 100 mg/dL, or LDL not measured, or, who were on cholesterol reducing therapy prior to hospitalization are discharged on a statin medication.
Stroke	Patients with ischemic or hemorrhagic stroke or their caregivers who were given education or educational materials during the hospital stay addressing all of the following: personal risk factors for stroke, warning signs for stroke, activation of emergency.
Stroke	Patients with an ischemic stroke or hemorrhagic stroke who were assessed for rehabilitation services.
VTE	This measure assesses the number of patients that receive VTE prophylaxis or have documentation why no VTE prophylaxis was given within 24 hours after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end time.
VTE	Patients who received parenteral and warfarin therapy (overlap therapy): (1) For at least 5 days, with an INR greater than or equal to 2 prior to discontinuation of parenteral therapy OR (2) For more than 5 days, with an INR less than 2, but were discharged on overlap therapy OR (3) Who were discharged in less than five days on overlap therapy.

Measure topic	Measure description
VTE	This measure assesses the number of patients receiving intravenous (IV) UFH therapy with documentation that the dosages and platelet counts are monitored by protocol (or nomogram).
VTE	This measure assesses the number of VTE patients that are discharged home, home care, or home hospice on warfarin with written discharge instructions that addresses all four criteria: Follow-up Monitoring; Compliance Issues; Dietary Restrictions; and, Potential for Adverse Drug Reactions/Interactions.
VTE	This measure assesses the number of patients that were diagnosed with VTE during hospitalization (not present at admission) that did not receive VTE prophylaxis.
Cardiac Surgery	Post-operative Renal Failure.
Cardiac Surgery	Surgical Re-exploration.
Cardiac Surgery	Anti-Platelet Medication at Discharge.
Cardiac Surgery	Beta Blockade at Discharge.
Cardiac Surgery	Anti-Lipid Treatment Discharge.
Cardiac Surgery	Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft CABG.
Cardiac Surgery	Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR).
Cardiac Surgery	Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair (MVR).
Cardiac Surgery	Risk-Adjusted Operative Mortality MVR+CABG Surgery.
Cardiac Surgery	Risk-Adjusted Operative Mortality for AVR+CABG.
Cardiac Surgery	Pre-Operative Beta Blockade.
Cardiac Surgery	Duration of Prophylaxis for Cardiac Surgery Patients.
Cardiac Surgery	Prolonged Intubation (ventilation).
Cardiac Surgery	Deep Sternal Wound Infection Rate.
Cardiac Surgery	Stroke/Cerebrovascular Accident.
Nursing Sensitive	Patient Falls: All documented falls with or without injury, experienced by patients on an eligible unit in a calendar month.
Nursing Sensitive	Falls with Injury: All documented patient falls with an injury level of minor or greater.
Nursing Sensitive/HAI	Catheter Associated Urinary Tract Infection.
Nursing Sensitive/HAI	Central Line Associated Blood Stream Infection in the ICU and high risk neonatal intensive care unit.
Nursing Sensitive/HAI	Ventilator Associated Pneumonia in the ICU.
Nursing Sensitive	Pressure Ulcer Prevalence.
Nursing Sensitive	Restraint Prevalence (vest and limb).
Nursing Sensitive	Skill Mix: Percentage of hours worked by: RN, LPN/LVN, UAP, Contract/Agency.
Nursing Sensitive	Hours per patient day worked by RN, LPN, and UAP.
Nursing Sensitive	Practice Environment Scale-Nursing Work Index.
Nursing Sensitive	Voluntary turnover for RN, APN, LPN, UAP.
Outcomes	PSI 03: Decubitus Ulcer.
Outcomes	PSI 07: Infection Due to Medical Care.
Outcomes	PSI 08: Post Operative Hip Fracture.
Outcomes	PSI 09: Post Operative Hemorrhage or Hematoma*.
Outcomes	PSI 10: Post Operative Physiologic Metabolic Derangement*.
Outcomes	PSI 11: Post Operative Respiratory Failure.
Outcomes	PSI 12: Post Operative PE or DVT.
Outcomes	PSI 13: Post Operative Sepsis.
Outcomes	IQI 08: In-hospital Mortality for Esophageal Resection.
Outcomes	IQI 09: In-hospital Mortality for Pancreatic Resection.
Outcomes	IQI 12: In-hospital Mortality for Coronary Artery Bypass Graft CABG.
Outcomes	IQI 13: In-hospital Mortality for Craniotomy*.
Outcomes	IQI 14: In-hospital Mortality for Hip Replacement.
Outcomes	IQI 15: In-hospital Mortality for AMI.
Outcomes	IQI 16: In-hospital Mortality for CHF.
Outcomes	IQI 17: In-hospital Mortality for Stroke.
Outcomes	IQI 18: In-hospital Mortality for GI Hemorrhage*.
Outcomes	IQI 20: In-hospital Mortality for Pneumonia.
SCIP	Short Half-Life prophylactic administered preoperatively redosed within 4 hours after preoperative dose.
PCI Readmission	Hospital-specific 30-day risk-standardized readmission rate following Percutaneous Coronary Intervention (PCI) among patients aged 18 years or older.
PCI Mortality	PCI Mortality for STEMI/shock patients: Hospital-specific 30-day all-cause risk-standardized mortality rate following Percutaneous Coronary Intervention (PCI) among patients aged 18 years or older with ST segment elevation myocardial infarction (STEMI) or cardiogenic shock at the time of procedure.

Measure topic	Measure description
	PCI Mortality for non-STEMI/non-shock patients: Hospital-specific 30-day all-cause risk-standardized mortality rate following Percutaneous Coronary Intervention (PCI) among patients aged 18 years or older without ST segment elevation myocardial infarction (STEMI) and without cardiogenic shock at the time of procedure.
ICD Complications	Hospital-specific risk-standardized complication rate following implantable cardioverter defibrillator (ICD) implantation among patients aged 18 years or older.
Hospital Acquired Infections	Methicillin-Resistant *Staphylococcus Aureus* (MRSA).
Hospital Acquired Infections	Clostridium Difficile Associated Diseases (CDAD).

* AHRQ is currently working with to improve and refine these measures, after which they will be updated to reflect the most current evidence learned as a result of validation efforts and empirical analyses.

We invited public comment on these measures for potential future use in the RHQDAPU program, as well as suggestions and supporting rationales for additional measures to consider using in the program at a future time.

• General Comments

Comment: Several commenters expressed concern over the number of measures listed as being under consideration for FY 2012 and subsequent years in the proposed rule. Commenters believed that a large increase in measures in future years would compete with other critical initiatives that would be occurring (such as HIT adoption for incentive payments and transitioning to ICD–10–CM and ICD–10–PCS implementation). The commenters recommended that CMS give consideration to the number and burden associated with the measures particularly as many are not EHR-based or registry-based measures. The commenters also suggested that CMS prioritize the measures, avoid redundancy by adopting measures that add information not captured in other measures, and consider measures that are closest in relation to desired outcomes for patients. One commenter also suggested that CMS assess the feasibility of constructing measures from data contained in the typical hospital electronic health record.

Response: We listed an array of measures that we are considering for the future. We will carefully weigh the burden associated with the adoption of measures against the benefit of publicly reporting that data. We anticipate limited adoption of chart-abstracted measures in the future because we wish to minimize the burden associated with quality measurement during a time when hospitals will be implementing new technologies and systems. We also will continue to assess the feasibility of alternative data sources for measures, such as registries and EHRs.

Comment: Commenters recommended that CMS provide clarity on the status of the proposed measures regarding NQF endorsement, information about the data abstraction burden, and a central location for specifications for measures under consideration. Another commenter also suggested that for measures under consideration, CMS provide information on benchmarking, potential use, affect on patient care, and development.

Response: We understand the commenters' desire to have more information about the measures being considered for the future. We provide some additional information in our responses to comments below, and we will endeavor to provide more detailed information about measures under consideration in the future.

• Comment on Measure Topic: AMI

Comment: One commenter indicated that the Statin at Discharge measure for AMI would be better suited as a physician measure rather than a hospital measure.

Response: We will take this into consideration in determining whether to adopt this measure for the RHQDAPU program in the future. However discharge medications, such as aspirin at discharge, form the basis for other measures which we have implemented in the RHQDAPU program.

• Comments on Measure Topic: ED–Throughput

Comment: Several commenters supported the concept of the ED–Throughput measures. Some commenters made suggestions for refinements to the specifications for ''Median time from admit decision time to time of departure from the emergency room for patients admitted to the facility from the ED'' measure. They suggested using the time when an admit order is written, and the time of departure from the emergency department to calculate the median times for this measure. Other commenters suggested stratification by population type.

Response: We appreciate the supportive comments. These suggestions are in keeping with the current measure specifications as endorsed by NQF. These ED–Throughput measure specifications are available in the Specifications Manual on *http://www.QualityNet.org*.

Comment: One commenter opposed the ED–Throughput measures because the commenter believed that they measured utilization.

Response: The ED–Throughput measures are NQF-endorsed quality measures. The ED–Throughput measures reflect not only the processes of care that occur while the patient is in the emergency department, but also reflect the coordination of care, communication, and efficiency of service provision beyond the walls of the emergency department. They address ED overcrowding, which has been identified as a major quality issue by the IOM.

• Comment on Measure Topic: Complications

Comment: One commenter stated that global measures such the Comorbidity Adjusted Complication Index are useful to hospitals in quality improvement efforts.

Response: We agree that global measures can provide useful quality improvement information to hospitals. We also believe that the topic of complications is an important one for consumers. This measure is currently undergoing evaluation as part of the NQF consensus development project entitled Hospital Care: Outcomes and Efficiency Measures Phase II. We will take this comment into consideration in determining whether to adopt such measures in the future.

• Comments on Measure Topic: Stroke

Comment: Numerous commenters encouraged CMS to adopt the stroke measures, which they see as evidence-based measures that accurately measure evidence-based care of the stroke patient to minimize secondary strokes and other complications, have been thoroughly researched, and are widely recognized. Several commenters cited firsthand

experience with dramatic quality improvements resulting from the collection and reporting of these measures to a registry.

Response: We appreciate and agree with these supportive statements. Stroke is a topic of great relevance to the Medicare population due to its impact on morbidity and mortality, and an area of great potential improvement for hospitals.

Comment: Two commenters supported the stroke measures under consideration but recommended limiting the measures in scope to ''Certified Stroke Centers'' in order to minimize the possibility that patients will suffer from unintended consequences due to a provider's lack of expertise with stroke. One commenter supported all but the STK–10 Assessed for Rehabilitation stroke measure and recommended that CMS establish eligibility criteria for the Assessment of Rehabilitation measure instead of including the entire stroke population as currently defined in the Specifications Manual.

Response: We will consider these comments in deciding whether to adopt these measures in the future. We note that we adopt measures for the RHQDAPU program that are broadly applicable to all participating hospitals, and that acute care for stroke is not given only by hospitals that have attained specific certifications. Regarding the measure on stroke assessment, the scope of the NQF-endorsed measure includes the entire stoke population. However, the measure allows for variation in the extent/degree of the assessment based on clinical indications. Specifications for the stroke measures are available in the Specifications Manual at *https://www.QualityNet.org*.

Comment: Several commenters generally opposed the future adoption of one or more of the stroke measures into the RHQDAPU program. One commenter stated that the abstraction rules for stroke are in need of greater refinement as they currently allow too much room for subjective interpretation. One commenter had concerns regarding inclusion of the anticoagulation measure because falls in the elderly population can be a significant problem with the risk of intracranial bleeding surpassing the benefit of anticoagulation therapy for atrial fibrillation. A few commenters opposed ''Thrombolysis therapy'' for stroke, stating that this therapy is not yet the standard of care for community or rural hospitals and that administering thrombolytic therapy to stroke patients has a high risk of complications.

Response: We appreciate these comments and will take them into consideration. Most of the comments we received overwhelmingly supported the adoption of these measures for the RHQDAPU program in the future. We believe that the stroke topic is of great clinical relevance to the Medicare population because of its impact on morbidity and mortality, as well a stroke's debilitating effect on the quality of life among Medicare beneficiaries. All of the measures in the stroke set under consideration are important to the overall outcome of the patient. The stroke measures are based on current AHA and ASA guidelines. We believe that current guidelines for stroke care apply across hospital types. The measure ''Patients with an ischemic stroke with atrial fibrillation discharged on anticoagulation therapy'' currently excludes patients for whom risks associated with treatment with an anticoagulant would outweigh potential benefits. Providing timely thrombolytic therapy has shown to greatly reduce complications, mortality and morbidity related to stroke. The measures are intended for public reporting, and are not intended to encourage a particular treatment when it is not warranted.

- Comments on Measure Topic: VTE

Comment: Two commenters supported CMS adding measures VTE–1, –2 and –3 as shown in the inpatient measure specification manual in FY 2012, but did not support measures VTE–4, –5, and –6. The commenters stated that the measures shown in the table do not seem to align with the VTE measures included in the Specifications Manual effective with October 1, 2009 discharges. The commenters also recommended that the measure ''VTE–1: prophylaxis in medical and non-SCIP–VTE surgical patients'', which we proposed in the FY 2009 IPPS proposed rule (73 FR 23648) but did not adopt, be considered for future adoption into the RHQDAPU program.

Response: The VTE measures we listed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule are the same as the VTE measures in the aligned Specifications Manual. VTE–1 appears in the aligned Specifications Manual, and we will include VTE–1 on the list of measures to be considered for FY 2012 and beyond.

Comment: One commenter supported all but VTE–3 and –4 as shown in the inpatient measure specification manual, and suggested that the measure descriptions be clarified.

Response: The formal specifications can be found in the aligned Specifications Manual on the QualityNet Web site: *https://www.QualityNet.org*.

- Comments on Measure Topic: Cardiac Surgery

Comment: One commenter supported adopting the Cardiac Surgery measures for the RHQDAPU program because these measures are appropriate and useful for quality improvement and public reporting purposes. Another commenter indicated that the data element specifications for the Cardiac Surgery topic need more rigor and standardization.

Response: Cardiac surgery is a topic of high relevance to the Medicare program because of its high volume among Medicare beneficiaries. We note that the cardiac surgery measures that are under consideration for adoption in future years, as well as their specifications, are NQF-endorsed and are available at *http://www.qualityforum.org/*.

- Comments on Measure Topics: Nursing Sensitive and Nursing Sensitive/HAI

Comment: Several commenters supported the Central Line [catheter] Associated Blood Stream Infection in the ICU and high risk neonatal intensive care unit measure, and the CA UTI infection measure. Several commenters urged CMS to consider adopting a Center for Disease Control measure of Surgical Site Infection that is not listed in the table of measures under consideration for future years (Table—above) but which was listed in the future measure table in the 2009 IPPS rule at 73 FR 48611. The commenters stated that the Central Line Associated Blood Stream Infection, Catheter Associated Urinary Tract Infection, and Surgical Site Infection measures are thoroughly specified, are currently used in other reporting initiatives, are relevant to consumers, and reveal important information that hospitals can use for their quality improvement programs. One commenter supported adoption of these measures if hospitals do not have to join a registry to report the information.

Response: We thank the commenters for these suggestions and will add Surgical Site Infection to the list of measures being considered for FY 2012 and beyond because it addresses the high priority topical area of hospital-acquired infections. The Central Line [catheter] Associated Blood Stream Infection in the ICU and high risk neonatal intensive care unit measure and the Catheter Associated UTI measure are currently being collected by the CDC's National Healthcare Safety Network (NHSN) database as

surveillance measures. We are supportive of these measures as they address hospital-acquired infections. We are exploring the possibility of receiving data, with permission from participating hospitals, from the CDC to avoid duplicative reporting of information by hospitals that participate in NHSN. Furthermore, we are exploring the development of electronic specifications for the collection of these measures from EHRs.

Comment: Several commenters indicated that more specificity, information, and clear expectations are needed for the following Nursing Sensitive measures: Patient Falls: All documented falls with or without injury, experienced by patients on an eligible unit in a calendar month; Falls with Injury: All documented patient falls with an injury level of minor or greater; CA UTI; Pressure Ulcer Prevalence; and Restraint Prevalence (vest and limb). In particular, the commenters believe that definitions for falls and CA UTI are needed. Two commenters indicated that the Pressure Ulcer Prevalence measure needs more specificity regarding the stage of the ulcer and whether the pressure ulcer was present on admission or hospital-acquired. One commenter indicated that, at times, pressure ulcers may not be preventable (for example, cases where patients experience multisystem organ failure, malnutrition, when vasopressors or fluid resuscitation have been employed, or when the patient cannot be turned due to traumas requiring surgery to be performed).

Response: The Nursing Sensitive measures are currently the subject of an NQF reevaluation project. We anticipate that considerations such as these will be brought forth and addressed as necessary during the reevaluation process prior to the time we would propose to adopt the measures.

Comment: A few commenters indicated that they would not be able to calculate the voluntary turnover measure unless this was manually tracked, making the collection of data necessary for this measure resource intensive. Another commenter indicated that the measures in the Nursing Sensitive measure set that rely on administrative data (such as voluntary turnover and skill mix) are of questionable validity for quality improvement.

Response: We appreciate these comments and will take them into consideration in deciding whether to adopt these measures in the future. Our understanding is that most hospitals are currently collecting the data elements for the voluntary turnover and skill mix measures. Registries of Nursing Sensitive Care quality measures currently feature these administrative-based measures in hospital feedback reports for quality improvement purposes.

Comment: Two commenters criticized the Ventilator Associated Pneumonia [VAP] in the ICU measure. One commenter noted that a recent HHS National Action Plan to Prevent Healthcare-Associated Infections indicated that ''no valid outcome or process metric had been identified for VAP.'' Another commenter indicated that, while VAP in the ICU is frequently tracked for State reporting purposes, it is a poor measure for quality improvement or for external comparison because of the challenges with diagnosis and definitions.

Response: Healthcare-associated infections are a high priority area for us because they increase complications and treatment costs, and we are looking to this as an area for future measurement. We agree that the definition of VAP should undergo further standardization. Therefore, we will not consider adopting this measure for the RHQDAPU program until such a definition has been determined.

• Comments on Measure Topic: Outcomes

Comment: Several commenters supported adoption of the AHRQ patient safety indicators and inpatient quality indicators, but many commenters suggested limiting adoption to two or three AHRQ measures annually because collection of more than three may present a burden to hospitals. A few commenters suggested reporting one or more of the AHRQ indicators separately from the composite measures.

Response: We agree that these are important patient safety and outcome measures for the inpatient setting. These would be claims-based measures. Therefore, because we currently calculate claims-based measures using only Medicare claims, there would be no additional reporting burden associated with these measures. To the extent that the measures focus on quality of care issues, we believe that hospitals will benefit from the information these measures reveal. We will consider the suggestion for separate public reporting of selected indicators. However, if any of these individual measures are adopted, we will engage in consumer testing regarding how best to display the measures on the *Hospital Compare* Web site. The measure specifications for the AHRQ inpatient quality indicators and patient safety indicators are available at *http://www.qualityindicators.ahrq.gov/.*

Comment: One commenter stated that, while AHRQ patient safety measures may have value to hospitals for internal quality improvement purposes, they currently lack the sensitivity and specificity required for use as comparative, publicly reported measures, especially the research-oriented PSI measures. Because they are derived from administrative data, one commenter suggested that they are less sensitive than measures derived from clinical chart abstraction at identifying relevant patients and excluding other patients. One commenter indicated that some of the AHRQ indicators have very high false positive rates and that extensive field testing and respecification would be needed. One commenter suggested that the risk adjustment seems unfairly advantageous to larger volume hospitals.

Response: We appreciate these comments and will take them into consideration in determining which measures to adopt for the RHQDAPU program in the future. We are aware of and encourage current validation projects involving positive predictive value and sensitivity being performed on these measures as they will lead to improvements in the measure specifications.

Comment: One commenter expressed concern that traditional risk adjustment would not be appropriate for IQI 17: In-hospital Mortality for Stroke. The commenter suggested that a proper risk adjustment model for in-hospital stroke mortality should account for stroke severity on presentation and stroke type (hemorrhagic versus ischemic stroke). The commenter suggested stratification of stroke mortality by type and suggested use of a well-established stroke severity scale in risk adjustment models for stroke mortality.

Response: We appreciate this suggestion. However, we note that the current risk adjustment model for the in-hospital stroke mortality measure has been endorsed by the NQF as appropriate for this measure, and we also believe the model is appropriate because it underwent a rigorous consensus development process.

• Comments on Measure Topics: PCI Readmission and PCI Mortality

Comment: Two commenters supported the PCI 30-day mortality and 30-day readmission rates and requested that CMS consider adopting the PCI measure set for FY 2011 payment determination. One commenter also stated that it is imperative that the outcome findings are drilled down far

enough that hospital-specific results can be obtained and patients can view hospital results based upon the condition or procedure they are undergoing. One commenter recommended that that the PCI Readmission and PCI Mortality measure related to STEMI/Shock be defined to include the base population as defined in the AMI Core Measure in order to reduce additional abstraction burden in identifying and defining shock.

Response: We thank the commenters for their support for the PCI mortality and readmission measures and will consider adopting these measures for the RHQDAPU program. Before we add them to the RHQDAPU program measure set, however, we will propose to adopt them as part of the rulemaking process. The current outcomes and readmissions measures are all calculated at the hospital level for various conditions, allowing patients to view hospital level results. Future outcomes and readmission measures, including the PCI 30-day mortality and 30-day readmission rates, if adopted for the RHQDAPU program, would be calculated in this manner as well. These measures are specified as claims-based measures for which there is no chart abstraction. These measures are currently undergoing evaluation as part of an NQF consensus development project entitled Hospital Care: Outcomes and Efficiency Measures Phase II.

• Comment on Measure Topic: ICD Complications

Comment: One commenter recommended that CMS follow definitions established by the ICD Registry to assure standardization of the ICD Complications measure.

Response: We intend to use standardized measure specifications for measures that are adopted into the RHQDAPU program and seek to adopt measures that have been endorsed by the NQF. Therefore, when available, we adopt NQF-endorsed measures for a particular topic and utilize the measure specifications that were endorsed by the NQF.

• Comment on Measure Topic: Hospital-Acquired Infections

Comment: One commenter indicated that, because of increased screening, there is a need to distinguish between healthcare-acquired MRSA infections and community-associated infections, and that all multi-drug resistant infections should be reported in order to focus efforts on reducing these infections, rather than one in particular.

Response: We agree that the distinction between the sources of MRSA infections is important. The MRSA measure under consideration for the RHQDAPU program focuses only on hospital-acquired infections. As for the reporting of other multi-drug resistant infections, we will take this comment into account as we develop future measures.

• Comments on Measure Topic: Topics and Measures Suggested by Commenters

Comment: Commenters suggested seven additional topics and measures to consider for future adoption into the RHQDAPU program:

- Surgical site infection rate
- Dysphagia screening for stroke
- Pediatric Quality Indicators
- Chronic Obstructive Pulmonary Disease (COPD)
- Inpatient Resource Use and Efficiency
- Global smoking cessation measure
- Inpatient Psychiatric Measures

Commenters noted that two of these topics (Surgical Site Infection and Chronic Obstructive Pulmonary Disease (COPD) were discussed in the future measure section of the FY 2009 IPPS proposed rule but not in the current proposed rule for FY 2010.

Response: We will consider these suggestions when selecting measures for the RHQDAPU program in the future. We agree that surgical site infection, dysphagia screening for stroke, and COPD are appropriate areas for the RHQDAPU program because they address conditions that are of high prevalence and cost to the Medicare program.

CMS currently includes several indicators of Pediatric Quality on the *Hospital Compare* Web site based on the submission of the data as part of other voluntary quality reporting initiatives. While we publicly report these measures, we are not currently considering requiring these indicators or other Pediatric Quality indicators for the RHQDAPU program because pediatric conditions affect a very small number of Medicare beneficiaries.

In summary, we appreciate the public comments we received and will consider them as we develop proposals for new quality measures for the FY 2012 payment determination and subsequent years.

5. Form, Manner, and Timing of Quality Data Submission

Section 1886(b)(3)(B)(viii)(I) of the Act requires that subsection (d) hospitals submit data on measures selected under that clause with respect to the applicable fiscal year. In addition, section 1886(b)(3)(B)(viii)(II) of the Act requires that each subsection (d) hospital submit data on measures selected under that clause to the Secretary in a form and manner, and at a time, specified by the Secretary. The data submission requirements, Specifications Manual, and submission deadlines are posted on the QualityNet Web site at: *https://www.QualityNet.org.* CMS requires that hospitals submit data in accordance with the specifications for the appropriate discharge periods.

Hospitals submit quality data through the secure portion of the QualityNet Web site (formerly known as QualityNet Exchange) (*https://www.QualityNet.org*). This Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements for security of protected health information.

a. RHQDAPU Program Procedures for the FY 2011 Payment Determination

For the FY 2011 payment determination, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24174), we proposed that the following procedures would apply to hospitals participating in the RHQDAPU program. These procedures are, for the most part, the same as the procedures that apply to the FY 2010 payment determination. We identify below where we proposed to modify a procedure.

- Register with QualityNet, before participating hospitals initially begin reporting data, regardless of the method used for submitting data.
- Identify a QualityNet Administrator who follows the registration process located on the QualityNet Web site (*https://www.QualityNet.org*).
- Notice of Participation. New subsection (d) hospitals and existing hospitals that wish to participate in the RHQDAPU program for the first time must complete a revised ''Reporting Hospital Quality Data for Annual Payment Update Notice of Participation'' form (Notice of Participation form) that includes the name and address of each hospital campus that shares the same CMS Certification Number (CCN).

We proposed that any hospital that receives a new CCN on or after October 15, 2009 (including new subsection (d) hospitals and hospitals that have merged) that wishes to participate in the RHQDAPU program and has not otherwise submitted a Notice of Participation form using that CCN must submit a completed Notice of Participation form no later than 180 days from the date identified as the open date (that is, the Medicare acceptance date) on the approved CMS Online System Certification and Reporting (OSCAR) system. We believe that this deadline will give these

hospitals a sufficient amount of time to get their operations up and running while simultaneously providing CMS with clarity regarding whether they intend to participate in the RHQDAPU program for FY 2011.

We also proposed that hospitals having an open date (or Medicare acceptance date) (as noted on the approved CMS OSCAR system) before October 15, 2009, that did not participate in the RHQDAPU program in FY 2010 but that wish to participate in the RHQDAPU program for the FY 2011 payment determination must submit completed Notice of Participation forms to CMS on or before December 31, 2009. These hospitals, unlike hospitals that receive a new CCN, do not need to get their operations up and running. Therefore, we believe this is a reasonable deadline that will enable these hospitals to decide whether they want to participate in the RHQDAPU program while also enabling CMS to collect enough data from them to make an accurate FY 2011 payment determination.

We note that under our current requirements, hospitals must begin submitting RHQDAPU program data starting with the first day of the quarter following the date when the hospital registers to participate in the program. For purposes of meeting this requirement, we interpret the registration date to be the date that the hospital submits a completed Notice of Participation form. As proposed previously in this section, hospitals must also register with QualityNet and identify a QualityNet Administrator who follows the QualityNet registration process before submitting RHQDAPU program data.

- Collect and report data for each of the quality measures under the topic areas that require chart abstraction. For the FY 2011 payment determination, these topic areas are AMI, HF, PN, and SCIP. Hospitals must report these data by each quarterly deadline. Hospitals must submit the data to the QIO Clinical Warehouse using the CART, The Joint Commission ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that meets the measurement specification requirements for data transmission to QualityNet. All submissions will be executed through My QualityNet, the secure part of the QualityNet Web site. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR part 480. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals.
- Submit complete data for each quality measure that requires chart abstraction in accordance with the joint CMS/The Joint Commission sampling requirements located on the QualityNet Web site. These requirements specify that hospitals must submit a random sample or complete population of cases for each of the topics covered by the quality measures. Hospitals must meet the sampling requirements for these quality measures for discharges in each quarter.
- Submit to CMS on a quarterly basis aggregate population and sample size counts for Medicare and non-Medicare discharges for the topic areas for which chart-abstracted data must be submitted (currently AMI, HF, PN, and SCIP). However, in order to reduce the burden on hospitals that treat a low number of patients in a RHQDAPU program topic area, a hospital that has five or fewer discharges (Medicare and non-Medicare combined) in a topic area during a quarter in which data must be submitted is not required to submit patient-level data for that topic area for the quarter. The hospital must still submit its aggregate population and sample size counts for Medicare and non-Medicare discharges for the four topic areas each quarter. We also note that hospitals meeting the five or fewer patient discharge exception may voluntarily submit these data.
- Continuously collect and submit HCAHPS data in accordance with the HCAHPS *Quality Assurance Guidelines, V4.0* (the most current version of the guidelines), located at the Web site *http://www.hcahpsonline.org.* The QIO Clinical Warehouse will accept zero HCAHPS-eligible discharges. However, in order to reduce the burden on hospitals that treat a low number of patients that would be otherwise covered by the HCAHPS submission requirements, a hospital that has five or fewer HCAHPS-eligible discharges during a month is not required to submit HCAHPS surveys for that month. However, hospitals that meet this exception may voluntarily submit this data. The hospital must still submit its total number of HCAHPS-eligible cases for that month as part of its quarterly HCAHPS data submission.
- The quarterly data submission deadline for hospitals to submit patient level data for the proposed measures that require chart abstraction is 4 months following the last discharge date in the calendar quarter. CMS will post the quarterly submission deadline schedule on the QualityNet Web site (*https://www.QualityNet.org*). The collection of new chart-abstracted measures for the FY 2011 payment determination would begin with 1st calendar quarter 2010 discharges, for which the submission deadline would be August 15, 2010.
- The data submission deadline for hospitals to submit aggregate population and sample size count data for the measures requiring chart abstraction is four months following the last discharge date in the calendar quarter. This requirement allows CMS to advise hospitals regarding their submission status in enough time for them to make appropriate revisions before the data submission deadline. We will post the aggregate population and sample size count data submission deadlines on the QualityNet Web site (*https://www.QualityNet.org*).
- CMS strongly recommends that hospitals review the QIO Clinical Warehouse Feedback Reports and the RHQDAPU Program Provider Participation Reports that are available after patient level data are submitted to the QIO Clinical Warehouse. CMS generally updates these reports on a daily basis to provide accurate information to hospitals about their submissions. These reports enable hospitals to ensure that their data were submitted on time and accepted into the QIO Clinical Warehouse.

Hospitals are encouraged to regularly check the QualityNet Web site, *https://www.QualityNet.org,* for program updates and information.

- We also proposed that the following RHQDAPU program claims-based measures would be calculated using Medicare claims:

Topic	FY 2011 payment determination: proposed claims-based quality measures (no hospital data submission required)
Mortality Measures (Medicare Patients)	
	• MORT–30–AMI Acute Myocardial Infarction 30-day mortality—Medicare patients. • MORT–30–HF Heart Failure 30-day mortality—Medicare patients.

Topic	FY 2011 payment determination: proposed claims-based quality measures (no hospital data submission required)
	• MORT–30–PN Pneumonia 30-day mortality—Medicare patients.
Readmission Measures (Medicare Patients)	
	• READ–30–HF Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients). • READ–30–AMI Acute Myocardial Infarction (AMI) 30-Day Risk Standardized Readmission Measure (Medicare patients). • READ–30–PN Pneumonia (PN) 30-Day Risk Standardized Readmission Measure (Medicare patients).
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures	
	• PSI 06: Iatrogenic pneumothorax, adult. • PSI 14: Postoperative wound dehiscence. • PSI 15: Accidental puncture or laceration. • IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume). • IQI 19: Hip fracture mortality rate. • Mortality for selected surgical procedures (composite). • Complication/patient safety for selected indicators (composite). • Mortality for selected medical conditions (composite).
AHRQ Patient Safety Indicator (PSI) and Nursing Sensitive Care	
	• Death among surgical inpatients with serious, treatable complications.

For the claims-based RHQDAPU program measures listed in the table above, hospitals are not required to submit the data to the QIO Clinical Warehouse. CMS uses the existing Medicare fee-for-service claims to calculate the measures. For the FY 2011 payment determination, CMS will use 3 years of discharges from July 1, 2006, through June 30, 2009, for the 30-day mortality and 30-day readmission measures. For the AHRQ PSI, IQI and Composite measures (including the AHRQ PSI and Nursing Sensitive Care measure, Death among surgical inpatients with serious, treatable complications), we will use 1 year of claims from July 1, 2008, through June 30, 2009, to calculate these measures.

• We proposed that hospitals report the information needed to calculate the three proposed structural measures directly onto the QualityNet Web site on a quarterly basis starting with 1st calendar quarter 2010. The quarterly submission deadline for reporting these measures will be 4½ months following the last date in the quarter covered by the data report. For example, the reporting deadline for these structural measures covering 1st calendar quarter 2010 is August 15, 2010. The 4½ month lag between the end of the quarter and the reporting deadline is intended to provide hospitals with sufficient time to collect the information needed to accurately report the proposed structural measures, and aligns with the quarterly submission deadlines for the measures for which chart-abstraction is required. As noted above in section V.A.3.b.(4). of this final rule, after consideration and review of public comments, we are modifying our proposal that the two new structural measures be reported quarterly and instead, we are finalizing a requirement that hospitals report these data annually. We also are requiring annual reporting for the existing cardiac surgery structural requirement for the FY 2011 payment determination. Annual data submission for the structural measures via a Web-based collection tool will begin in July 2010 with respect to the time period of January 1, 2010 through June 30, 2010.

Below is the list of three structural measures we are adopting for the FY 2011 payment determination:

Topic	FY 2011 payment determination: structural measures
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery.
Stroke Care	
	• Participation in a Systematic Clinical Database Registry for Stroke Care.
Nursing Sensitive Care	
	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care.

We indicated that we would add a link on the QualityNet Web site to the Web page(s) that hospitals can use to report the structural measures after we issued this final rule.

Comment: Several commenters supported our proposal to allow hospitals with five or fewer heart failure, pneumonia, or surgical care patients in a calendar quarter to not submit quality measure data for that quarter. However, the commenters suggested that should a hospital wish to voluntarily report such data, it should be permitted to do so. This will reduce the burden on small hospitals with a very small number of cases.

Response: We currently allow hospitals treating five or fewer patients in a calendar quarter in a topic area that do not otherwise have to submit data for that topic area to voluntarily report data for that topic. We believe that this

allowance is consistent with the intent of the RHQDAPU program to promote public reporting and hospital quality improvement through measuring quality of care. Currently, many hospitals to which the RHQDAPU program does not apply (including CAHs and hospitals located in Maryland and Puerto Rico) report these data on a voluntary basis as part of their quality improvement efforts.

We note that we will publicly report the measure rates for all data submitted by RHQDAPU program participating hospitals, including data voluntarily reported by RHQDAPU program participating hospitals treating five or fewer cases in a topic in a calendar quarter, because we expect that a portion of these hospitals will have variable quarterly caseloads and will submit data on a sufficient number of cases (that is, more than 25) across all four posted quarters to make their overall measure rates generally reliable. However, we also will continue to include a footnote on the *Hospital Compare* Web site in the event that some of these hospitals do not have data for at least 25 cases combined over the four quarters. That footnote states that ''The number of cases is too small (<25) to reliably tell how well a hospital is performing.'' We believe that this footnote adequately addresses hospital concerns about data reliability.

Comment: One commenter stated that the proposed rule does not address the issue of data resubmission when a hospital or its vendor becomes aware of an error in the data that was sent for posting on the *Hospital Compare* Web site. The commenter urged immediate adoption of an effective mechanism that allows hospitals and their vendors to resubmit quality measure data if they discover an error. The commenter stated that the point of public reporting is to put accurate and useful information into the hands of the public, and this is facilitated by allowing known mistakes to be corrected.

Response: Although we understand the commenter's concern, the quarterly validation sample selection is reliant on a locked final data file of hospital submitted cases. Allowing resubmission after the quarterly deadline would delay the final lockdown date of the quarterly data file, and CMS would have to delay the validation process or simply not validate resubmitted data. We believe that both of these options would adversely impact data quality.

We remind the commenter that hospitals can correct information and resubmit cases until the quarterly submission deadline, which generally occurs 4½; months following the last discharge date in a calendar quarter. We also encourage hospitals to submit data early in the submission schedule, so that they can identify errors and resubmit data before the quarterly submission deadline. Generally, hospitals can submit cases from the first discharge date in a quarter until the quarterly submission deadline.

After consideration of the public comments we received, we are adopting as final our proposals regarding RHQDAPU program procedures for the FY 2011 payment determination.

b. RHQDAPU Program Disaster Extensions and Waivers

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24176), we solicited public comment about rules we could adopt that would enable hospitals to request either an extension or a waiver of various RHQDAPU program requirements in the event of a disaster (such as a hurricane that damages or destroys the hospital).

Specifically, we welcomed public comment on the following issues:

- Recommendations for rules that we could follow when considering whether to grant an extension or waiver of RHQDAPU program requirements in the event of a disaster, including suggested criteria that we should take into account (for example, specific hospital infrastructure damage, hospital closure time period, degree of destruction of medical records, impact on data vendors, and long-term evacuation of discharged patients impacting HCAHPS survey participation).
- The role that QIOs and QIO support contractors should play in the event of a disaster, including communicating with affected hospitals, communicating with State hospital associations, and collecting information directly from hospitals.
- How CMS extension or waiver decisions should be communicated to affected hospitals.
- Any other issues commenters deem relevant to a hospital's request for an extension or waiver of RHQDAPU program requirements in the event of a disaster.

Comment: One commenter appreciated CMS recognizing that hospitals facing certain disasters, such as a hurricane, should be granted an extension or waiver of the RHQDAPU program requirements. Commenters suggested that, although the decision to grant an extension or waiver is best made on a case-by-case basis depending on each hospital's unique situation, CMS develop some general criteria for when such extensions or waivers would be granted. Commenters reminded CMS that when a hospital is damaged or destroyed, CMS' usual means of communicating to the hospital, such as by QualityNet or the mail, may be impossible. Commenters urged CMS to develop a creative and flexible approach to communicating with hospitals in these situations to ensure that such hospitals are aware that they may receive waivers during difficult times.

Response: We will consider these comments as we develop program procedures for disaster extensions or waivers. We are mindful that many hospitals operating in these adverse situations cannot access the Internet or mail service. We note that we currently use a variety of means to communicate with hospitals in these circumstances, including utilizing our State QIOs and national/state hospital associations, and we will continue to do so.

Comment: One commenter supported CMS and QIOs contacting both hospitals in affected areas and their data vendors in the event of disaster. The commenter also supported using e-mail first to communicate this information, followed by a phone call (if phone service is available) from a QIO, then a follow-up letter to the hospital administrator and hospital QualityNet Administrator. The commenter believed that the reasons for providing a waiver as outlined in the proposed rule were fair, but suggested that when a hospital response is requested by State or local government for any reason, then a waiver or extension should also be considered. The commenter recommended that, if a vendor is impacted, that should be should also be grounds for a hospital extension or waiver.

Response: We will consider these recommendations when considering disaster extension/waiver communications and reasons for granting extensions or waivers. We interpret the comment about ''when a hospital response is requested by a State or local government'' to mean that the governmental entity has asked the hospital to continue or cease certain operations. Since hospital resources might be redirected from activities related to hospital quality data reporting to providing critical services in disaster situations, we will also consider State and local government requirements for hospitals providing critical services to the public while continuing to operate in disaster situations. We believe that if a hospital is required to provide critical public health services during a disaster or pandemic, this should be a factor that we consider when deciding whether to grant a waiver or extension. We will also consider the impact a disaster

might have had on a vendor when developing our policy on this issue.

Comment: One commenter supported granting extensions and waivers of RHQDAPU program requirements in the event of a disaster and agreed with some of the criteria we requested comment on in the proposed rule. The commenter also supported CMS' interest in the role that QIOs would play in the event of a disaster and believes that they should be as proactive as possible in providing support to hospitals.

Response: We thank the commenter for the feedback as we further develop our policy for disaster extensions/waivers. We also acknowledge the important service that QIOs provide to hospitals in their support of inpatient quality data reporting and will incorporate this comment into our future plans for operating the RHQDAPU program.

c. HCAHPS Requirements for the FY 2011 Payment Determination

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24176), we proposed that, for the FY 2011 payment determination, the RHQDAPU program HCAHPS requirements we adopted for FY 2010 would continue to apply. Under these requirements, a hospital must continuously collect and submit HCAHPS data in accordance with the current HCAHPS *Quality Assurance Guidelines* and the quarterly data submission deadlines, both of which are posted at *http://www.hcahpsonline.org.* In order for a hospital to participate in the collection of HCAHPS data, a hospital must either: (1) Contract with an approved HCAHPS survey vendor that will conduct the survey and submit data on the hospital's behalf to the QIO Clinical Warehouse; or (2) self-administer the survey without using a survey vendor provided that the hospital attends HCAHPS training and meets Minimum Survey Requirements as specified on the Web site at: *https://www.hcahpsonline.org.* A current list of approved HCAHPS survey vendors can be found on the HCAHPS Web site at: *https://www.hcahpsonline.org.*

Every hospital choosing to contract with a survey vendor should provide the sample frame of HCAHPS-eligible discharges to its survey vendor with sufficient time to allow the survey vendor to begin contacting each sampled patient within 6 weeks of discharge from the hospital. (We refer readers to the *Quality Assurance Guidelines* located at *https://www.hcahpsonline.org* for details about HCAHPS eligibility and sample frame creation.) In addition, the hospital must authorize the survey vendor to submit data via My QualityNet, the secure part of the QualityNet Web site, on the hospital's behalf.

After the survey vendor submits the data to the QIO Clinical Warehouse, we strongly recommend that hospitals employing a survey vendor promptly review the two HCAHPS Feedback Reports (the Provider Survey Status Summary Report and the Data Submission Detail Report) that are available. These reports enable a hospital to ensure that its survey vendor has submitted the data on time and the data has been accepted into the QIO Clinical Warehouse.

As we stated above, any hospital that has five or fewer HCAHPS-eligible discharges in any month is no longer required to submit HCAHPS surveys for that month, although the hospital may voluntarily choose to submit these data. However, the hospital must still submit its total number of HCAHPS-eligible cases for that month as part of its quarterly HCAHPS data submission.

In order to ensure compliance with HCAHPS survey and administration protocols, hospitals and survey vendors must participate in all oversight activities. As part of the oversight process, during the onsite visits or conference calls, the HCAHPS Project Team will review the hospital's or survey vendor's survey systems and assess protocols based upon the most recent HCAHPS *Quality Assurance Guidelines.* All materials relevant to survey administration will be subject to review. The systems and program review includes, but is not limited to: (a) Survey management and data systems; (b) printing and mailing materials and facilities; (c) telephone and IVR materials and facilities; (d) data receipt, entry and storage facilities; and (e) written documentation of survey processes. Organizations will be given a defined time period in which to correct any problems and provide follow-up documentation of corrections for review. As needed, hospitals and survey vendors will be subject to follow-up site visits or conference calls. If CMS determines that a hospital is not compliant with HCAHPS program requirements, CMS may determine that the hospital is not submitting HCAHPS data that meet the requirements of the RHQDAPU program.

We continue to strongly recommend that each new hospital participate in an HCAHPS dry run, if feasible, prior to beginning to collect HCAHPS data on an ongoing basis to meet RHQDAPU program requirements. New hospitals can conduct a dry run in the last month of a calendar quarter. We refer readers to the Web site at *https://www.hcahpsonline.org* for a schedule of upcoming dry runs. The dry run will give newly participating hospitals the opportunity to gain first-hand experience collecting and transmitting HCAHPS data without the public reporting of results. Using the official survey instrument and the approved modes of administration and data collection protocols, hospitals/survey vendors will collect HCAHPS data and submit the data to My QualityNet, the secure portion of QualityNet.

For FY 2011, we are again encouraging hospitals to regularly check the HCAHPS Web site at *https://www.hcahpsonline.org* for program updates and information.

We did not receive any public comments regarding our HCAHPS proposals. Therefore, we are adopting as final our proposals regarding HCAHPS requirements for the FY 2011 payment determination.

6. Chart Validation Requirements

a. Chart Validation Requirements and Methods for the FY 2011 Payment Determination

For the FY 2011 payment determination, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24177), we proposed to generally continue using the following existing requirements implemented in previous years. We note below where we proposed to modify a requirement. These requirements, as well as additional information on these requirements, will be posted on the QualityNet Web site after we issue this FY 2010 IPPS final rule.

- The Clinical Data Abstraction Center (CDAC) contractor will, each quarter, ask every participating hospital to submit five randomly selected medical charts from which the hospital previously abstracted and submitted data to the QIO Clinical Warehouse.

We proposed the following timeline with respect to CDAC contractor requests for paper medical records for the purpose of validating RHQDAPU program data. Beginning with CDAC contractor requests for second calendar quarter 2009 paper medical records, the CDAC contractor will request paper copies of the randomly selected medical charts from each hospital via certified mail, and the hospital will have 45 days from the date of the request (as documented on the request letter) to submit the requested records to the CDAC contractor. If the hospital does not comply within 30 days, the CDAC contractor will send a second certified letter to the hospital, reminding the hospital that it must return paper copies

of the requested medical records within 45 calendar days following the date of the initial CDAC contractor medical record request. If the hospital still does not comply, then the CDAC contractor will assign a ''zero'' score to each data element in each missing record.

We proposed this timeline to provide hospitals with transparent and documented correspondence about RHQDAPU program validation paper medical record requests. Hospitals have submitted numerous questions to CMS about this process, and we believe this timeline will provide hospitals with adequate notice and time to submit paper copies of requested medical records to the CDAC contractor. We also believe that this timeline does not unduly burden hospitals. We remind hospitals that CMS reimburses up to 12 cents per copied page to copy the requested medical records, and CMS also pays United States Postal Service fees for hospitals to mail back a paper copy of the requested medical records.

• Once the CDAC contractor receives the charts, it will re-abstract the same data submitted by the hospitals and calculate the percentage of matching RHQDAPU program data element values for all of that data.

• The hospital must pass our validation requirement of a minimum of 80 percent reliability. We use appropriate confidence intervals to determine if a hospital has achieved 80 percent reliability. The use of confidence intervals allows us to establish an appropriate range below the 80 percent reliability threshold that demonstrates a sufficient level of reliability to allow the data to still be considered validated. We estimate the percent reliability based upon a review of the sampled charts, and then calculate the upper 95 percent confidence limit for that estimate. If this upper limit is above the required 80 percent reliability, the hospital data are considered validated.

• We will pool the quarterly validation estimates for the four most recently validated quarters (except for the SCIP–Cardiovascular-2 measure discussed below). For the FY 2011 payment update, we proposed to validate 4th quarter CY 2008 through 3rd quarter 2009 discharge data for the following measures:

Topic	Quality measures validated using data from 4th quarter CY 2008 through 3rd quarter CY 2009 discharges	Measure ID No.
AMI (Acute Myocardial Infarction)	Aspirin at Arrival	AMI–1.
	Aspirin Prescribed at Discharge	AMI–2.
	ACEI or ARB for LVSD	AMI–3.
	Adult Smoking Cessation Advice/Counseling	AMI–4.
	Beta-Blocker Prescribed at Discharge	AMI–5.
	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	AMI–7a.
	Primary PCI Received Within 90 Minutes of Hospital Arrival	AMI–8a.
HF (Heart Failure)	Discharge Instructions	HF–1.
	Evaluation of LVS Function	HF–2.
	ACEI or ARB for LVSD	HF–3.
	Adult Smoking Cessation Advice/Counseling	HF–4.
PN (Pneumonia)	Pneumococcal Vaccination	PN–2.
	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital.	PN–3b.
	Adult Smoking Cessation Advice/Counseling	PN–4.
	Initial Antibiotic Received Within 6 Hours of Hospital Arrival	PN–5c.
	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients.	PN–6.
	Influenza Vaccination	PN–7.
SCIP (Surgical Care Improvement Project)—named SIP for discharges prior to July 2006 (3Q06).	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	SCIP–Inf-1.
	Prophylactic Antibiotic Selection for Surgical Patients	SCIP–Inf-2.
	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	SCIP–Inf-3.
	Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose	SCIP–Inf-4.
	Surgery Patients with Appropriate Hair Removal	SCIP–Inf-6.
	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered.	SCIP–VTE–1.
	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery.	SCIP–VTE–2.

• SCIP–Cardiovascular-2 will be validated using data from 2nd and 3rd calendar quarter 2009 discharges. CMS adopted this measure in the FY 2009 IPPS final rule and hospitals began submitting data for this measure starting with 1st calendar quarter 2009 discharges (73 FR 48605). However, because we generally strive to provide hospitals with ample notice before we add a new measure to the list of measures for which we will validate data, we believe that 2nd quarter discharge data is an appropriate validation starting point for this measure (these data are not due to the QIO Clinical Warehouse until November 15, 2009).

• We will continue using the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a stratified single stage cluster sample, with unequal cluster sizes. (For reference, *see* Cochran, William G.: Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12 (1977); and Kish, Leslie: Survey Sampling, John Wiley & Sons, New York, chapter 3, section 3.3 (1964).) Each quarter is treated as a stratum for variance estimation purposes.

Comment: Several commenters supported CMS' proposal to document the validation contact process. Specifically, the commenters supported CMS' plans to send two certified letter requests for medical records for data validation in case the hospital does not receive the first letter. The commenters suggested that CMS contractors also place phone calls to any hospital that does not respond to the first letter to ensure that every effort is made to

communicate the request to the appropriate staff in the hospital.

Response: We thank the commenters and agree that certified letters provide hospitals with multiple written documented notification and reminder attempts. We did not propose supplementing this notification with telephone calls because the CDAC contractor already attempts to call hospitals as current practice at least three times about 30 calendar days after it sends the initial medical record request. As a practice, we intend to continue attempting to call hospitals at least three times around the 30th calendar day following the initial request, in addition to sending written certified letters. We believe that these attempted calls at different time periods around the 30th calendar day following the initial request demonstrate our commitment to notify hospitals using multiple communication modes.

Comment: Two commenters indicated that under the current process, the validation does not incorporate skip logic, despite The Joint Commission and CMS measure specifications and algorithms that clearly call for skip logic. The commenters stated that as a result, charts that are appropriately abstracted do not pass validation with the contractor. The commenters noted that this can be a challenge for some hospitals because the CDAC contractor's decision could affect the cumulative annual results and cause a hospital to fail the validation requirement for the year.

Response: The Specifications Manual contains instructions regarding the use of skip logic by hospitals. Starting with discharges on or after April 1, 2008, and continuing to the most current update of the Specifications Manual, CMS and The Joint Commission have included the following text in the Missing and Invalid Data appendix of the Specifications Manual (currently under the heading ''Abstraction Software Skip Logic and Missing Data''):

''Skip logic allows hospitals and vendors to minimize abstraction burden by using vendor software edit logic to bypass abstraction of data elements not utilized in the measure algorithm. However, these bypassed elements also negatively impact data quality and the hospital's CMS chart audit validation results when elements are incorrectly abstracted and subsequent data elements are bypassed and left blank.''

''The use of skip logic by hospitals and ORYX vendors is optional and not required by CMS and The Joint Commission. Hospitals should be aware of the potential impact of skip logic on data quality, abstraction burden, and CMS chart audit validation scores. Vendors and hospitals utilizing skip logic should closely monitor the accuracy rate of abstracted data elements, particularly data elements placed higher in the algorithm flow (for example, Comfort Measures data element).''

''Historically, CMS chart audit validation results have been used in previous payment years as one of many requirements in the Reporting Hospital Quality for Annual Payment Update (RHQDAPU) program. We refer readers to the **Federal Register** and the QualityNet Web site for the current payment year's proposed and final requirements for acute care IPPS hospitals.''

The CDAC contractor abstracts all data elements necessary to calculate a sampled case's measure status. The CDAC contractor uses skip logic only when it abstracts a data element value resulting in no additional data necessary to calculate a measure status. When it re-abstracts the data elements, the CDAC contractor also uses the CART tool provided by CMS free of charge to hospitals. Under the current validation process, hospitals are at risk when utilizing skip logic, if they incorrectly abstract data elements and do not abstract subsequent data elements for the measure.

We do recognize that the use of skip logic has been an issue for some hospitals, and we believe that our proposal for FY 2012 to change the methodology for calculating the validation score from data element counts to a measure match basis will reduce the likelihood that the use of skip logic will create validation problems for hospitals.

After consideration of the public comments we received, we have decided to adopt as final, without change, our proposals regarding chart validation requirements and methods for the FY 2011 payment determination.

b. Chart Validation Requirements and Methods for the FY 2012 Payment Determination and Subsequent Years

RHQDAPU program data are currently validated by re-abstracting on a quarterly basis a random sample of five medical records for each hospital. This quarterly sample generally results in an annual combined sample of 20 patient records across four calendar quarters per hospital, but because each sample is random, it might not include medical records from each of the measure topics (for example, AMI, SCIP, etc.). As a result, data submitted by a hospital for one or more measure topics might not be validated for a given quarter or, in some cases, for an entire year or longer.

In the FY 2009 IPPS proposed rule (73 FR 23658), we solicited public comments on the impact of adding measures to the validation process, as well as on modifications to the current validation process that could improve the reliability and validity of the methodology. We specifically requested input concerning the following:

- Which of the measures or measure sets should be included in the chart validation process for subsequent years?
- What validation challenges are posed by the RHQDAPU program measures and measure sets? What improvements could be made to validation or reporting that might offset or otherwise address those challenges?
- Should CMS switch from its current quarterly validation sample of five charts per hospital to randomly selecting a sample of hospitals, and selecting more charts on an annual basis to improve the reliability of hospital level validation estimates?
- Should CMS select the validation sample by clinical topic to ensure that all publicly reported measures are covered by the validation sample?

In the FY 2009 IPPS final rule, we summarized and responded to commenters' views on these issues and stated that we will consider the issues raised by these commenters if we decide to make changes to the RHQDAPU program chart validation methodology.

Our objective is to validate the accuracy of RHQDAPU program data collected by hospitals using medical record abstraction. Accurate data provide consumers with objective publicly reported information about hospital quality for more informed decision making. Consistent with the public comments we received in response to the FY 2009 IPPS proposed rule (73 FR 23658–9) and discussed in the FY 2009 IPPS final rule (73 FR 48623), we believe that the methodology recommended in the CMS Hospital Value-Based Purchasing Report to Congress is a promising approach worth consideration in the RHQDAPU program. This approach is designed to validate the accuracy of hospital reported quality measure data, and is also directly applicable to validating RHQDAPU program chart-abstracted quality data.

We recognize that hospitals need ample notification regarding proposed changes to the current RHQDAPU program validation process. We believe that the FY 2012 RHQDAPU program annual payment determination is the earliest opportunity to make significant modifications to our validation process.

Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR

24178), we proposed modifications to the RHQDAPU program validation methodology beginning with the FY 2012 payment determination. Specifically, we proposed to do the following:

• Randomly select on an annual basis 800 participating hospitals that submitted chart-abstracted data for at least 100 discharges combined in the measure topics to be validated. To determine whether a hospital meets this ''100-case threshold,'' we will look to the discharge data submitted by the hospital during the *calendar* year three years prior to the *fiscal* year of the relevant payment determination. For example, if the 100-case threshold applied for the FY 2011 payment determination (which it will not), the applicable measure topics would be AMI, HF, PN, and SCIP, and we would choose 800 hospitals that submitted discharge data for at least 100 cases combined in these topics during calendar year 2008. If a hospital did not submit discharge data for at least 100 cases in these topics during CY 2008, we would not select the hospital for validation. We will announce the topic areas that apply for the FY 2012 payment determination at a later date, and we plan to select the first 800 hospitals in July 2010. We will select hospitals for the FY 2012 validation if they meet the 100-case threshold during CY 2009. We have proposed this 100-case threshold because we believe that it strikes the appropriate balance between ensuring that the selected hospitals have a large enough patient population to be able to submit sufficient data to allow us to complete an accurate validation, while not requiring validation for hospitals with a low number of submitted quarterly cases and relatively unreliable measure estimates. Based on previously submitted data, we estimate that 98 percent of participating RHQDAPU program hospitals will meet this threshold and, thus, be eligible for validation. As noted below, we solicited comments and suggestions on how we might be able to target the remaining 2 percent of hospitals for validation.

• We validate for each of the 800 hospitals a randomly selected stratified sample for each quarter of the validation period. Each quarterly sample will include 12 cases, with at least one but no more than three cases per topic for which chart-abstracted data was submitted by the hospital. However, we recognize that some selected hospitals might not have enough cases in all of the applicable topics to submit data (for example, if they have 5 or fewer discharges in a topic area in a quarter). For those hospitals, we would validate measures in only those topic areas for which they have submitted data. For the FY 2012 payment determination, we will validate 1st calendar quarter 2010 through 3rd calendar quarter 2010 discharge data. We proposed to validate 3 quarters of data for FY 2012 in order to provide hospitals with enough time to assess their medical record documentation and abstraction practices, and to take necessary corrective actions to improve these practices, before documenting their 1st calendar quarter 2010 discharges into medical records that may be sampled as part of this proposed validation process.

Beginning with the FY 2013 payment determination, we proposed to validate data submitted by hospitals during the four quarters that make up the fiscal year that occurs two years prior to the year that applies to the payment determination. For example, for FY 2013, we would validate 4th calendar quarter 2010 through 3rd quarter 2011 discharge data. This lag between the time a hospital submits data and the time we can validate that data is necessary because data is not due to the QIO Clinical Warehouse until 4½ months after the end of each quarter, and we need additional time to select hospitals and complete the validation process.

• We proposed that the CDAC contractor will, each quarter that applies to the validation, ask each of the 800 selected hospitals to submit 12 randomly selected medical charts from which data was abstracted and submitted by the hospital to the QIO Clinical Warehouse. We note that, under our current requirements, hospitals must begin submitting RHQDAPU program data starting with the first day of the quarter following the date when the hospital registers to participate in the program. For purposes of meeting this requirement, we interpret the registration date to be the date that the hospital submits a completed Notice of Participation form. As proposed previously in this section, hospitals must also register with QualityNet and identify a QualityNet Administrator who follows the QualityNet registration process before submitting RHQDAPU program data.

In addition, we proposed to continue the following timeline with respect to CDAC contractor requests for paper medical records for the purpose of validating RHQDAPU program data. Beginning with CDAC contractor requests for second calendar quarter 2009 paper medical records, the CDAC contractor will request paper copies of the randomly selected medical charts from each hospital via certified mail, and the hospital will have 45 days from the date of the request (as documented on the request letter) to submit the requested records to the CDAC contractor. If the hospital does not comply within 30 days, the CDAC contractor will send a second certified letter to the hospital, reminding the hospital that it must return paper copies of the requested medical records within 45 calendar days following the date of the initial CDAC contractor medical record request. If the hospital still does not comply, then the CDAC contractor will assign a ''zero'' score to each measure in each missing record.

• Once the CDAC contractor receives the charts, it will re-abstract the same data submitted by the hospitals and calculate the percentage of matching RHQDAPU program measure numerators and denominators for each measure within each chart submitted by the hospital. Specifically, we will estimate the accuracy by calculating a match rate percent agreement for all of the variables submitted in all of the charts. For any selected record, a measure's numerator and denominator can have two possible states, included or excluded, depending on whether the hospital accurately included the cases in the measure numerator(s) and denominator(s). We will count each measure in a selected record as a match if the hospital-submitted measure numerator and denominator sets match the measure numerator and denominator states independently abstracted by our contractor. For example, one heart failure case from which data has been abstracted for four RHQDAPU program chart-abstracted measures (that is, HF–1, HF–2, HF–3, and HF–4) would receive a 75 percent match if three out of four of the hospital-reported heart failure measure numerator and denominator states matched the re-abstracted numerator and denominator states. This proposed scoring approach is the same as recommended in the CMS Hospital Value-Based Purchasing Report to Congress, and is illustrated in further detail using an example in pages 83–84 of the report which can be found on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf.* We believe that this approach is appropriate, and was supported by many commenters when we requested comment in the FY 2009 IPPS final rule for input about the RHQDAPU program validation process (73 FR 48622 and 48623).

• Use, as we currently do, each selected case as a cluster comprising

one or multiple measures utilized in a validation score estimate. Each selected case will have multiple measures included in the validation score (for example, for the FY 2011 payment determination, a heart failure record will include 4 heart failure measures). Specifically, we propose to continue using the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a stratified single-stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G.: Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12 (1977); and Kish, Leslie: Survey Sampling, John Wiley & Sons, New York, chapter 3, section 3.3 (1964).) Each quarter and clinical topic is treated as a stratum for variance estimation purposes.

In the proposed rule, we indicated that we believe that the proposed clustering approach is a statistically appropriate technique for calculating the annual validation confidence interval. Because CMS will not be validating all hospital records, we need to calculate a confidence interval that incorporates a potential sampling error. Our clustering approach incorporates the degree of correlation at the individual data record level, because our previous validation experience indicates that hospital data mismatch errors tend to be clustered in individual data records. We have used this clustering since the inception of the RHQDAPU program validation requirement to calculate variability estimates needed for calculating confidence intervals (70 FR 47423).

- Use the upper bound of a one-tailed 95 percent confidence interval to estimate the validation score; and
- Require all RHQDAPU program participating hospitals selected for validation to attain at least a 75 percent validation score per quarter to pass the validation requirement.

We believe that this proposal incorporates many of the principles supported by the vast majority of commenters in response to our solicitation for public comments in the FY 2009 IPPS proposed rule (73 FR 23658 through 23659). Specifically, we believe that the increased annual sample size per hospital will provide more reliable estimates of validation accuracy. The proposed sample size of 12 records per quarter would provide a total of 36 records across the three sampled quarters for the FY 2012 payment determination, and 48 records in subsequent years. This estimate would improve the reliability of our validation estimate, as compared to the current RHQDAPU program annual validation sample of 20 cases per year. We also believe that modifying the validation score to reflect measure numerator and denominator accuracy will ensure that accurate data are posted on the *Hospital Compare* Web site.

In addition, we believe that stratified quarterly samples by topic will improve the feedback provided to hospitals. CMS would provide validation feedback to hospitals about all sampled topics submitted by the hospitals each quarter. Because all relevant data elements submitted by the hospital must match the independently re-abstracted data elements to count as a match, we have proposed to reduce the passing threshold from 80 percent to 75 percent. We proposed to use an one-tail confidence interval to calculate the validation score because we strongly believe that a one-tail test most appropriately reflects the pass or fail dichotomous nature of the statistical test regarding whether the confidence interval includes or is completely above the 75 percent passing validation score.

We also proposed to continue to allow hospitals that fail to meet the passing threshold for the quarterly validation an opportunity to appeal the validation results to their State QIO. QIOs are currently tasked by CMS to provide education and technical assistance about RHQDAPU program data abstraction and measures to hospitals, and the quarterly validation appeals process will provide hospitals with an opportunity to both appeal their quarterly results and receive education free of charge from their State QIO. This State QIO quarterly validation appeals process is independent of the proposed RHQDAPU program reconsideration procedures for hospital reconsideration requests involving validation for the FY 2010 payment update proposed below in section V.A.9. of this final rule.

Comment: Several commenters supported setting a slightly lower validation threshold for the beginning years of the new validation process as hospitals and CMS gain experience with the new system. These commenters were generally pleased with CMS' proposal for the changes to the data validation process and urged CMS to continue to refine the plan put forward in the proposed rule.

Response: We agree with the commenters that the proposed 75 percent threshold provides a reasonable passing threshold for the proposed validation process. We will evaluate the new validation process after initial implementation through data analysis of validation results. Based on the results of this data analysis, we may consider proposing modifications in future years to further refine the validation process.

Comment: Several commenters stated that the burden to hospitals will be reduced if they do not have to submit records for validation every year. However, because hospitals will be selected at random each year and there is no guarantee that a hospital selected in one year will not be selected in the following year as well, some commenters urged CMS to refine the validation selection process so that hospitals selected for validation in one year are not eligible for selection again until 2 years later. Alternatively, the commenters suggested that CMS could ensure that no hospital is selected more than two times within a 5-year period, arguing that this would help guarantee that a particular hospital is not disproportionately burdened by the selection process. In addition, the commenters suggested that CMS should consider allowing hospitals that pass validation with a very high score to receive a ''pass'' from the validation process for several years. The commenters believed that such a policy would encourage hospitals to ensure their data are as accurate as possible and reward those hospitals with high accuracy rates.

Response: We appreciate these comments and understand the concern about being selected multiple times during a short timeframe. We also appreciate the recommendation that hospitals receiving a high validation score be exempt from validation for two years. We must weigh this burden relative to the policy objective to ensure that we receive accurate data, and believe that using a truly random selection process strikes the appropriate balance. We considered options such as providing hospitals achieving high validation scores with a ''free pass'' for a certain period, and using a 4 to 5 year rotating panel of hospitals to lessen burden. However, we believe that using a truly random sample on an annual basis is fair to all hospitals included in the sample and will encourage all hospitals to take steps to ensure that their data are consistently accurate. We believe that providing hospitals with automatic exemptions from our validation requirement could detract from this policy objective, because hospitals receiving these exemptions would know in advance of data abstraction that CMS would not be validating their data.

Comment: Commenters agreed that it is appropriate to focus on the hospital's measure rate, as opposed to individual data elements, because the measure rate captures the information that is

important to patient care. Commenters noted that for data validation in the current program, there have been several instances in which a mismatch between single data elements unrelated to the quality of care provided by a hospital, such as the patient's birth date, has caused hospitals to fail validation. Comments believe that validating the hospital's measure rate should eliminate these unfortunate incidents.

Response: The proposed validation process focuses on validating whether hospital abstracted data results in accurate measure rates and denominator inclusion. We wish to clarify that the proposed validation process would measure the accuracy of each measure rate and measure denominator count posted on the *Hospital Compare* Web site. We will continue to use the data elements used in the current validation process to calculate the validation scores. We also note that all data used as part of the validation process (both the current process and the process proposed for FY 2012 and beyond) is protected under the Business Associate provisions of HIPAA and the QIO regulations.

Comment: Commenters stated that CMS' proposed process for validating hospitals' quality data beginning in FY 2012 holds promise as a reasonable approach to ensure the accuracy of the quality data and improve upon the deficiencies in the current validation process.

Response: We agree with the commenters that the proposed new validation process is an improved approach for the validation process. We will evaluate the new validation process after initial implementation and may consider proposing modifications in future years to further refine it.

Comment: Several commenters stated that the current CMS validation sample of five charts per quarter does not provide a reliable estimate and advocated increasing the sample size.

Response: We agree that the proposed requirement to increase the quarterly sample size from 5 records to 12 records will provide a more reliable annual validation estimate.

Comment: One commenter objected to the proposal to randomly sample hospitals in the proposed validation process, as all hospitals would not be held equally accountable via a valid sample across all measures.

Response: We believe that the proposed approach is equitable because all hospitals meeting the 100-case threshold will have an equal probability of being selected in the random sample. As we stated in the proposed rule (74 FR 24180), we are considering ways to include hospitals that do not meet the 100 case threshold in the validation process, such as by developing targeting criteria that would focus on these hospitals.

Comment: One commenter asked for clarity on how CMS plans to address validation for hospitals with low numbers. While the commenter agreed that it is appropriate to ease the burden on hospitals with a very small number of cases, the commenter also believed that hospitals should always be able to voluntarily report on quality measures if they wish and should be held equally accountable for their participation and reported data.

Response: As we stated in the proposed rule (74 FR 24180), we are considering ways to include hospitals that do not meet the 100-case threshold in the validation process, such as by developing targeting criteria that would focus on these hospitals. One possible approach would be to randomly sample these hospitals as part of the targeted sample, thereby ensuring that data from some of these hospitals also would be validated.

Comment: One commenter urged that State QIOs be supportive not only during the validation appeals process but also proactively during data collection and reporting.

Response: We agree with the commenter. CMS currently requires QIOs under their contract to improve or maintain consistently high levels of RHQDAPU program participation to meet all RHQDAPU program requirements, not solely validation appeals.

Comment: Several commenters asked CMS to consider sending formal notification to hospitals not selected as part of the random sample. The commenters believe that this notification will aid hospitals with recordkeeping and internal operating procedures. The commenters were concerned that the lack of a consistent validation could cause internal processes within the hospitals to break down in the event that a hospital is not selected as part of the data validation sample for multiple years.

Response: We will consider this comment and will consider using our QIOs to provide outreach to both selected and non-selected hospitals. We understand that hospitals must receive ample and clear communication about the requirements, and we recognize that the absence of quarterly medical record requests for all hospitals under the proposed validation process could affect the hospital's knowledge and ability to efficiently comply with the validation requirement.

Comment: One commenter supported keeping validation standardized to a quarterly process that includes all hospitals. The commenter objected to excluding hospitals submitting fewer than 100 records.

Response: We appreciate the comment but believe that the improved reliability of the validation estimate under the proposed new validation process will outweigh the benefit of validating a smaller number of records for all hospitals. As hospitals have improved their abstraction methods over time, we believe that the benefit of every hospital receiving quarterly feedback on their hospital's data has lessened over time. Regardless of whether a hospital was included in our annual validation sample, we plan to continue providing validation feedback on highly mismatching data elements and measures to all hospitals by providing aggregate validation information to all hospitals that submit quality data.

Comment: Commenters stated that the lack of timely quarterly validation feedback is a huge problem. Some commenters did not believe that the 2,500 hospitals not selected for annual validation under the proposed new validation process would incorporate feedback provided to other selected hospitals, and data errors would increase over time due to the lack of hospital-specific feedback.

Response: We interpret the comment to mean that hospitals that are not selected under the proposed, new validation process would not incorporate aggregate feedback information because they would not believe that the aggregate information would be relevant to them; and that their failure to incorporate supplied feedback would cause these hospitals' data errors to increase over time. However, we believe that the improved reliability of the validation estimate under the proposed new validation process will outweigh the benefit of validating a smaller number of records for all hospitals. As hospitals have improved their abstraction over time, we believe that the benefit of every hospital receiving quarterly feedback has lessened over time. As we noted in an earlier response, we plan to continue providing aggregate validation feedback at a State and national level on highly mismatching data elements and measures to all hospitals regardless of whether they were included in the annual validation sample.

Comment: One commenter requested that CMS clarify that, under the proposed validation process, only those hospitals that are selected for validation

would have their payment at risk, and that the remaining hospitals would not be affected in any way by the validation results of the selected hospitals for that given year.

Response: Only hospitals randomly selected for the proposed new annual validation process would have to meet the validation requirement for the applicable payment year. We note, however, that hospitals that are not selected for validation in a given year may nonetheless not receive the full annual payment update if they fail to meet other RHQDAPU program requirements, or if they withdraw from the program.

Comment: One commenter supported a randomized selection of 200 hospitals per quarter for validation with a minimum number of 20 charts reviewed. The commenter believes that hospitals should not be selected for validation any more frequently than one time per year. The commenter expressed concern that if validation occurred more than one time per year, hospitals may become complacent in their validation processes and this may lead to issues with data integrity. The commenter urged CMS to reduce the current administrative burden of quarterly validation and supported random selection of hospitals one per quarter per year with more charts reviewed.

Response: We appreciate the commenter's concern and the suggestion to reduce the burden on the hospitals through validating one quarter of data per year. However, we believe that our proposed approach will enable hospitals to incorporate feedback learned earlier in the year and make improvements if necessary. The increased annual sample size from the current 20 records per year to 48 records per year also provides a more reliable validation estimate for sampled hospitals.

Comment: One commenter urged continued attention to the data element level in order to increase the denominator and minimize the impact of a small number of errors.

Response: We understand this comment and remind hospitals that they must continue to monitor their data element level validation processes because we use individual data elements as a combined set to calculate quality measures. The proposed validation score serves as a composite score of all data elements used to calculate quality measures, so it is critical that hospitals continue to ensure that data elements are abstracted accurately because inaccurately abstracted data elements can result in inaccurate measure rates and denominators.

Comment: One commenter urged CMS to extend the turnaround time for chart selection to 60 days. The commenter suggested that CMS give hospitals the option to submit validation cases electronically rather than by mailing printed copies because such submissions would avoid shipping delays and allow faster turn around time.

Response: We understand the commenter's concern about the deadline for hospitals to return requested medical records but note that under the current quarterly validation process, it takes 5 to 6 months from the initial medical record request until the CDAC contractor completes the validation process each quarter and the QIO completes its review of an appeal (if so requested by the hospital). We are concerned that adding time to this process would adversely impact hospitals' ability to incorporate validation feedback into future abstraction work.

We will consider accepting electronic submission of validation cases using compact disc and electronic health record submission in future years. We must consider both the cost to accept and review these submissions, and the added benefit to the hospitals using electronic methods to store medical record information.

Comment: Several commenters recommended that any changes to the validation process be tested before CMS imposes a payment penalty against the hospitals. These commenters also recommended that no hospital be penalized in terms of its annual payment update if it fails the validation requirement for only a single quarter.

Response: We believe that the proposed changes represent a small relative change to the overall validation process. We have assessed the impact by calculating revised scores using the proposed new validation method. Preliminary results indicate that our proposal would not adversely impact the number of hospitals failing to meet our annual validation requirement. We will continue to assess the impact of this change in the near future, and consider changes in future years.

Comment: One commenter recommended allowing all hospitals passing quarterly validation to appeal individual mismatches and adjust the score on a quarterly basis based upon a successful appeal.

Response: Our proposal, which we discuss below, to require all hospitals failing our annual validation requirement to submit all mismatched data elements partially addresses this concern because hospitals failing our annual validation requirement would be able to appeal all data elements classified as mismatches by the CDAC contractor. We understand the desire of the commenter to correct mismatches on a quarterly basis; however, we do not currently have a mechanism in place to accommodate this need. We will investigate a possible solution to addrress mismatches on a quarterly basis for the future.

Comment: One commenter suggested that CMS and CMS contractors return case detail reports in Excel file format rather than using portable document format (pdf).

Response: We believe that this is an excellent suggestion, and we will consider the feasibility of implementing this suggestion for future years.

Comment: One commenter asked whether hospitals would be selected from each State.

Response: In order to maximize the overall sampling efficiency, the random sample would not be stratified by State. The intent of the random sample is to provide all participating hospitals that meet the 100-case threshold with an equal probability of selection.

Comment: Commenters asked whether hospitals not selected for validation would be considered for VBP. Commenters stated that hospitals use the validation process to learn and educate their staff about abstraction and documentation in the medical record.

Response: We interpret the comment ''considered for VBP'' to mean eligible to receive payment under a proposed VBP methodology, as outlined in the 2007 CMS Hospital Value-Based Purchasing Report to Congress. As of the date of this final rule, value-based purchasing for hospitals has not been legislatively authorized. The proposed validation requirements would apply only for purposes of the RHQDAPU program.

Comment: Commenters asked what would be the incentive for hospitals submitting fewer than 100 cases to continue abstracting and reporting data.

Response: We remind the commenter that all RHQDAPU program participating hospitals must continue to meet the data submission and other requirements. We also note that we are considering developing targeting criteria that would enable us to also validate data submitted by hospitals that do not meet the 100-case threshold.

Comment: Commenters noted that both hospitals and QIOs will have difficulty allocating resources for staffing when they do not know, from year to year, what hospitals will be selected for validation.

Response: We understand that hospitals selected for validation will

need to allocate staffing for this effort and that hospitals that are not selected will not need to do so. However, the additional, minimal burden would be to submit the documentation for the requested medical records; a maximum of 12 records 4 times spaced over a year. Therefore, we do not believe that there will be a need for a large allocation of resources to meet this validation requirement.

Comment: One commenter asked how CMS can compare all hospitals when different measure evaluations are being used, if some hospitals are using the new validation process and their measure score is based on this process.

Response: We interpret the comment to be asking how we would validate all publicly reported data through a random sample of hospitals. We believe that a random sample of 800 hospitals provides a reliable estimate of accuracy for both sampled hospitals and national measure rates, since the sample is random and of sufficient size. We proposed stratifying the validation sample to ensure that all hospital-submitted data are validated for selected hospitals. The validation sample for all sampled hospitals would be similar in sample size by clinical topic to ensure that the sample is representative of each hospital's population of submitted cases.

After consideration of the public comments we received, we have decided to adopt as final our proposal regarding chart validation requirements and methods for the FY 2012 payment determination and subsequent years.

c. Possible Supplements to the Chart Validation Process for the FY 2013 Payment Determination and Subsequent Years

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24180), we also solicited public comment about criteria we could use to target hospitals for validation in the future. These targeting criteria could include abnormal data patterns identified by analyzing hospital-submitted measure rates and counts for RHQDAPU program measures. For example:

- A high number of years a hospital was not randomly selected for annual validation (for example, at least 5 years);
- Consistently high measure denominator exclusion rates resulting in unexpectedly low denominator counts;
- Consistently high measure rates, relative to national averages;
- Small annual submission in the number of cases in previous years resulting in hospital exclusion from RHQDAPU program validation sample.

Comment: One commenter recommended that CMS not implement targeting criteria for the FY 2013 validation. The commenter indicated that it does not appear to be random, and CMS would not provide all hospitals with feedback on their abstraction accuracy. The commenter believed that because hospitals widely vary in their abstraction accuracy, feedback to all hospitals is more important than lessening burden through targeted validation.

Response: We recognize that providing feedback to hospitals is an important part of the validation process. We will continue to work with State QIOs to provide data element and measure-specific feedback to all participating hospitals, regardless of inclusion in the random sample. Additionally, our targeting criteria would not be random; they would be designed to select hospitals based on specific criteria. The increased annual sample size and stratification is designed to provide hospitals selected for validation with reliable information about all of their abstracted data.

Comment: With regard to the reconsideration process, several commenters supported CMS' proposal to require hospitals to submit their paper medical records for re-abstraction when they submit a request for reconsideration involving data validation. The commenters believe that this process will give hospitals that believe the results of their data validation testing were inaccurate an opportunity to have their data re-abstracted.

Response: We agree with the commenters that hospitals should be able to seek reconsideration of all validation mismatched data elements and measures throughout the year if the hospital fails to meet the annual validation requirement.

Comment: Some commenters recommended continuing with the process of random selection of five charts per quarter for hospitals having fewer than 100 discharges.

Response: We appreciate the recommendation that we continue validating hospital data for hospitals having fewer than 100 discharges. As we discussed above, we are considering developing targeting criteria that would focus on these hospitals.

We appreciate the public comments we received and will take them into consideration as we consider possible supplements to the chart validation process for the FY 2013 payment determination and subsequent years. Specifically, CMS plans to propose the following targeting criteria for FY 2013:

- Validating hospital data when the hospital failed the previous year's RHQDAPU program validation;
- Validating a sample of hospitals not included in the previous year's RHQDAPU program validation random sample for submitting fewer than 100 cases; and
- Validating hospital data when the hospital was not selected in 3 previous years' RHQDAPU program random validation samples.

We will also consider other targeting criteria for FY 2013 and future years.

7. Data Accuracy and Completeness Acknowledgement Requirements for the FY 2011 Payment Determination and Subsequent Years

For the FY 2011 payment determination and subsequent years, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24180), we proposed to require hospitals to electronically acknowledge on an annual basis the completeness and accuracy of the data submitted for the RHQDAPU program payment determination. Hospitals will be able to submit this acknowledgement on the same Web page that they use to submit data necessary to calculate the structural measures, and we believe that this Web page will provide a secure vehicle for hospitals to directly acknowledge that their information is complete and accurate to the best of their knowledge. A single annual electronic acknowledgement will provide us with explicit documentation acknowledging that the hospital's data is accurate and complete, but will not unduly burden hospitals. We noted that commenters generally supported the idea of electronic attestation in the FY 2009 IPPS final rule (73 FR 48625) at the point of data submission to the QIO Clinical Warehouse.

In addition, the Government Accountability Office (GAO) recommended in a 2006 report (GAO–06–54) that hospitals self-report that their data are complete and accurate. Therefore, for the FY 2011 payment determination, we proposed to require hospitals to electronically acknowledge their data accuracy and completeness once between January 1, 2010, and August 15, 2010. Hospitals will acknowledge that all information that is, or will be, submitted as required by the RHQDAPU program for the FY 2011 payment determination is complete and accurate to the best of their knowledge.

Comment: Several commenters commended CMS for proposing to collect data accuracy and completeness acknowledgements using an electronic method.

Response: We thank the commenters, and believe that this proposed requirement imposes a minimal burden for hospitals.

Comment: A number of commenters questioned the benefit of the proposed electronic data accuracy and completeness acknowledgement, and believed that data quality would not be improved. The commenters believed that requiring hospitals to attest to the accuracy of their data will not increase the reliability of the data collected for the RHQDAPU program and noted that historically, almost all hospitals have passed the data validation requirements, meaning that their data are found to be accurate and complete.

Response: We believe that this proposed requirement will ensure that hospitals continue implementing procedures for ensuring data completeness and accuracy. This proposed requirement is intended to supplement our existing submission and validation requirements.

After consideration of the public comments we received, we are adopting as final, without modification, our proposal to require hospitals to electronically acknowledge on an annual basis the completeness and accuracy of the data submitted for the RHQDAPU program payment determination.

8. Public Display Requirements for the FY 2011 Payment Determination and Subsequent Years

For the FY 2011 payment determination, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24180), we proposed to generally continue using the following existing requirements implemented in previous years. Our continued goal for the chart validation requirements is to validate the reliability of RHQDAPU program chart-abstracted data. Accurate data are needed to calculate accurate publicly reported quality measures that are posted on the *Hospital Compare* Web site. We added the validation requirement in the FY 2006 IPPS final rule (70 FR 47421 through 47422) to ensure that hospitals submit reliable data for RHQDAPU program chart-abstracted measures, based on our experience in FY 2005 that hospitals vastly differed in their data reliability. We modified the validation requirements in the FY 2008 IPPS final rule with comment period (72 FR 47366 and 47367) to update the RHQDAPU program list of validated measures for FY 2008, and pooled multiple quarterly validation estimates into a single annual estimate to improve reliability. We modified these requirements to reflect the changing RHQDAPU program list of chart-abstracted measures and validate all available RHQDAPU program data.

We proposed to update the list of validated RHQDAPU program measures for the FY 2011 payment determination to incorporate changes to our list of required chart-abstracted RHQDAPU program measures for CY 2009 discharges. These requirements, as well as additional information on these requirements, will be posted on the QualityNet Web site after we issue this final rule.

Section 1886(b)(3)(B)(viii)(VII) of the Act provides that the Secretary shall establish procedures for making data submitted under the RHQDAPU program available to the public. The RHQDAPU program quality measures are posted on the *Hospital Compare* Web site (*https://www.hospitalcompare.hhs.gov*). We require that hospitals sign a Notice of Participation form when they first register to participate in the RHQDAPU program. Once a hospital has submitted a form, the hospital is considered to be an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS (72 FR 47360). Hospitals signing this form agree that they will allow CMS to publicly report the quality measures included in the RHQDAPU program.

We will continue to display quality information for public viewing as required by section 1886(b)(3)(B)(viii)(VII) of the Act. Before we display this information, hospitals will be permitted to review their information as recorded in the QIO Clinical Warehouse.

Currently, hospital campuses that share the same CCN must combine data collection and submission across their multiple campuses (for both clinical measures and HCAHPS). These measures are then publicly reported on the *Hospital Compare* Web site as if they apply to a single hospital. We estimate that approximately 5 to 10 percent of the hospitals reported on the *Hospital Compare* Web site share CCNs. To increase transparency in public reporting and improve the usefulness of the *Hospital Compare* Web site, we plan to note on the Web site instances where publicly reported measures combine results from two or more hospitals.

We did not receive any public comments on our proposals and are adopting them as final in this final rule.

9. Reconsideration and Appeal Procedures for the FY 2010 Payment Determination

The general deadline for submitting a request for reconsideration in connection with the FY 2010 payment determination is November 1, 2009. As discussed more fully below, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24181), we proposed that all hospitals submit a request for reconsideration and receive a decision on that request before they can file an appeal with the Provider Reimbursement Review Board (PRRB).

For the FY 2010 payment determination, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24181), we proposed to continue utilizing most of the same procedures that we utilized in FY 2009. Under these proposed procedures, the hospital must—

- Submit to CMS, via QualityNet, a Reconsideration Request form (available on the *QualityNet* Web site) containing the following information:

—Hospital CMS Certification number (CCN).

—Hospital Name.

—CMS-identified reason for failure (as provided in the CMS notification of failure letter to the hospital).

—Hospital basis for requesting reconsideration. This must identify the hospital's specific reason(s) for believing it met the RHQDAPU program requirements and should receive the full FY 2010 IPPS annual payment update.

—CEO contact information, including name, e-mail address, telephone number, and mailing address (must include the physical address, not just the post office box). We proposed to no longer require that the hospital's CEO sign the RHQDAPU program reconsideration request. We have found that this requirement increases the burden for hospitals because it prevents them from electronically submitting the RHQDAPU program reconsideration request forms. In addition, to the extent that a hospital can submit a request for reconsideration on-line, the burden on our staff is reduced and, as a result, we can more quickly review the request.

—QualityNet System Administrator contact information, including name, e-mail address, telephone number, and mailing address (must include the physical address, not just the post office box).

—Paper medical record requirement for reconsideration requests involving validation. We proposed that if a hospital asks us to reconsider an adverse RHQDAPU program payment decision made because the hospital failed the validation requirement, the hospital must submit paper copies of all the medical records that it

submitted to the CDAC contractor each quarter for purposes of the validation. Hospitals must submit this documentation to a CMS contractor, which will redact all patient identifying information and forward the redacted copies to CMS. The contractor will be a QIO support contractor, which has authority to review patient level information under 42 CFR part 480. We will post the address where hospitals can ship the paper charts on the QualityNet Web site after we issue the FY 2010 IPPS/RY 2010 LTCH PPS final rule. Hospitals submitting a RHQDAPU program validation reconsideration request will have all mismatched data reviewed by CMS, and not their State QIO. (As discussed in section V.A.6.b. of this final rule, the State QIO is available to conduct a quarterly validation appeal if so requested by a hospital.)

For the FY 2010 payment determination, the RHQDAPU program data that will be validated is 4th calendar quarter 2007 through 3rd quarter calendar year 2008 discharge data, except for SCIP-Infection-4 and Infection-6, which will be validated using 2nd and 3rd calendar quarter 2008 discharges (73 FR 48621 through 48622). Hospitals must provide a written justification for each appealed data element classified during the validation process as a mismatch. We will review the data elements that were labeled as mismatched, as well as the written justifications provided by the hospitals, and make a decision on the reconsideration request. As we mentioned above, we proposed that all hospitals submit a reconsideration request to CMS and receive a decision on that request prior to submitting a PRRB appeal. We believe that the reconsideration process is less costly for both CMS and hospitals, and that this requirement will decrease the number of PRRB appeals by resolving issues earlier in the appeals process.

Following receipt of a request for reconsideration, we will—

- Provide an e-mail acknowledgement, using the contact information provided in the reconsideration request, to the CEO and the QualityNet Administrator that the request has been received.
- Provide written notification to the hospital CEO, using the contact information provided in the reconsideration request, regarding our decision. We expect the process to take approximately 60 to 90 days from the reconsideration request due date of November 1, 2009.

If a hospital is dissatisfied with the result of a RHQDAPU program reconsideration decision, the hospital may file a claim under 42 CFR part 405, Subpart R (a PRRB appeal). We solicited public comments on the extent to which these proposed procedures will be less costly for hospitals, and whether they will lead to fewer PRRB appeals.

Comment: One commenter agreed that CMS should no longer require the CEO to sign the RHQDAPU program reconsideration request so that the request does not get held up for a signature, and can be submitted electronically. The commenter believed that use of the PRRB is less cost efficient, and should be the last resort. The commenter requested that the reconsideration process provide both written notification to the hospital CEO and QualityNet notification to the QualityNet Administrator working at the hospital.

Response: We appreciate the comment and recognize the additional burden to hospitals associated with the requirement of a CEO signature.

Comment: Several commenters supported CMS' proposal to require hospitals to submit their paper medical records for re-abstraction when they submit an appeal involving data validation. The commenters indicated that this process will give hospitals that believe the results of the data validation were inaccurate an opportunity to have their data re-abstracted again as part of the reconsideration process.

Response: In the proposed rule, we proposed that hospitals must provide a written justification for each appealed data element classified during the validation process as a mismatch. We stated that we would review the data elements that were labeled as mismatched, as well as the written justifications provided by the hospitals, and make a decision on the reconsideration request. However, we wish to clarify that this would not be a re-abstraction, but a review of the hospital's justification and the medical record for each appealed mismatching data element. The intent of this proposal is for us to have all of the information necessary to review a request for reconsideration based on the hospital's validation results.

Comment: One commenter asked for clarification about two possible situations that could arise under CMS' proposal to review paper medical records as part of the reconsideration process (when the issue is validation):

1. *Hospital fails to return one or more medical records to the CDAC contractor for the quarterly validation request within the 45 calendar day timeframe.* There are no CDAC contractor-abstracted data elements for the reconsideration contractor to review, except for medical records returned after the 45 calendar day deadline. Would the hospital be allowed to submit medical records during reconsideration to receive credit for information submitted to the CDAC contractor after the quarterly validation 45 day deadline? If not, would the reconsideration contractor's review be limited in scope to the CDAC contractor's original documentation that verifies contact with the hospital as outlined in this regulation, and documents that the CDAC contractor did not receive the requested medical records in the required timeframe (for example, reconsideration limited to data and hospital receipt of CDAC contractor's request for medical records, written reminder notes, and CDAC contractor's non-receipt of medical records).

2. *Hospital receives one or more ''invalid record selection'' zero scores for failing to provide the correct medical record for the requested episode of care.* Invalid record selections occur when the hospital submits medical record(s) that do not match the requested patient episode of care's admission date, discharge date, name or other hospital submitted identification information, and/or birthdate/birth year. Would the reconsideration contractor abstract medical records for these ''invalid records,'' or would the reconsideration contractor and CMS simply review the electronic submitted data, relative to the hospital submitted data to the CDAC contractor in response to the original medical record request?

In both scenarios, the commenter argued that hospitals would attempt to circumvent the CDAC contractor validation process and submit medical records to the reconsideration process. The commenter recommended that CMS limit the scope of RHQDAPU program reconsideration review for validation to verification of CDAC contractor processing, and not circumventing the validation process to allow reconsideration contractor abstraction of these nonreturned and ''invalid record selection'' cases that receive zero validation scores. The commenter indicated that CMS should spend its dollars wisely and create processes that do not allow hospitals to bypass existing and expensive quarterly validation processes.

Response: We appreciate the comment. Our intent is to provide hospitals a process to request our reconsideration review of mismatched data elements abstracted by the CDAC

contractor affecting the hospitals' validation scores. Hospitals must submit a copy of the entire requested medical record to the CDAC contractor during the quarterly validation process for the requested case to be eligible for reconsideration of mismatched data elements. Our review of medical records that we classify as not matching what was requested by the CDAC contractor (called ''invalid record selections'') will initially be limited to ascertaining whether the copy of the record submitted to the CDAC contractor was actually an entire copy of the requested medical record. If we determine during reconsideration that the hospital did submit the entire copy of the requested medical record to the CDAC contractor, then we would abstract data elements from the medical record submitted by the hospital along with its reconsideration request.

We would also review the hospital's justification for medical records not returned in a timely manner to ascertain whether the CDAC contractor received the requested record within 45 calendar days, and whether the hospital received the initial medical record request and reminder notice as specified in this regulation. If we determine during reconsideration that the CDAC contractor did receive a paper copy of the requested medical record within 45 calendar days, then we would abstract data elements from the medical record submitted by the hospital along with its reconsideration request.

After reviewing the public comments we received, we are adopting as final the proposed RHQDAPU program reconsideration requirements for FY 2010. However, we wish to clarify the following regarding the scope of our review when a hospital requests reconsideration because it failed our validation requirements:

1. *Hospital requests reconsideration for CDAC contractor-abstracted data elements classified as mismatches affecting validation scores.* Hospitals must timely submit a copy of the entire requested medical record to the CDAC contractor during the quarterly validation process for the requested case to be eligible to request reconsideration of mismatched data elements.

2. *Hospital requests reconsideration for medical record copies submitted during the quarterly validation process and classified as invalid record selections.* Invalid record selections are defined as medical records submitted by hospitals during the quarterly validation process that do not match the patient's episode of care information as determined by the CDAC contractor (in other words, the contractor determines that the hospital returned a medical record that is different from that which was requested). If the CDAC contractor determines that the hospital has submitted an invalid record selection case, it awards a zero validation score for the case because the hospital did not submit the entire copy of the medical record for that requested case. During the reconsideration process, our review of invalid record selections will initially be limited to determining whether the record submitted to the CDAC contractor was actually an entire copy of the requested medical record. If we determine during reconsideration that the hospital did submit the entire copy of the requested medical record, then we would abstract data elements from the medical record submitted by the hospital along with its reconsideration request.

3. *Hospital requests reconsideration for medical records not submitted to the CDAC contractor within the 45 calendar day deadline.* Our review will initially be limited to determining whether the CDAC contractor received the requested record within 45 calendar days, and whether the hospital received the initial medical record request and reminder notice as specified in this regulation. If we determine during reconsideration that the CDAC contractor did receive a paper copy of the requested medical record within 45 calendar days, then we would abstract data elements from the medical record submitted by the hospital along with its reconsideration request.

In sum, we are initially limiting the scope of our reconsideration reviews involving validation to information already submitted by the hospital during the quarterly validation process, and we will not abstract medical records that were not submitted to the CDAC contractor during the quarterly validation process. We will expand the scope of our review only if we find during the initial review that the hospital correctly and timely submitted the requested medical records. In that case, then we would abstract data elements from the medical record submitted by the hospital along with its reconsideration request.

After consideration of the public comments we received, we are adopting as final, with the clarifications outlined in this final rule, our proposals regarding reconsideration and appeals procedures for the FY 2010 payment determination.

10. RHQDAPU Program Withdrawal Deadlines

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24181), we proposed to accept RHQDAPU program withdrawal forms for the FY 2011 payment determination from hospitals until August 15, 2010. We proposed this deadline so that we would have sufficient time to update the FY 2011 payment to hospitals starting on October 1, 2010. If a hospital withdraws from the program for the FY 2011 payment determination, it will receive a 2.0 percentage point reduction in its FY 2011 annual payment update. We noted that once a hospital has submitted a Notice of Participation form, it is considered to be an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS.

We did not receive any public comments about our proposal. Therefore, we are adopting as final our proposal to accept RHQDAPU program withdrawal forms for the FY 2011 payment determination from hospitals until August 15, 2010.

11. Electronic Health Records

a. Background

Starting with the FY 2006 IPPS final rule, we have encouraged hospitals to take steps toward the adoption of EHRs (also referred to in previous rulemaking documents as electronic medical records) that will allow for reporting of clinical quality data from the EHRs directly to a CMS data repository (70 FR 47420 through 47421). We encouraged hospitals that are implementing, upgrading, or developing EHR systems to ensure that the technology obtained, upgraded, or developed conforms to standards adopted by HHS. We suggested that hospitals also take due care and diligence to ensure that the EHR systems accurately capture quality data and that, ideally, such systems provide point-of-care decision support that promotes optimal levels of clinical performance.

In the FY 2008 IPPS final rule with comment period (72 FR 47366), we responded to comments we received on EHRs and noted that CMS planned to continue participating in the American Health Information Community (which has now sunset and is replaced by the National eHealth Collaborative) and other entities to explore processes through which an EHR could speed the collection of data and minimize the resources necessary for quality reporting.

Recently, we initiated work directed toward enabling EHR submission of quality measures through EHR standards development and adoption. We are working under an inter-agency agreement between CMS and the Office

of the National Coordinator for Healthcare Information Technology (ONC) to identify and harmonize standards for the EHR-based submission of Emergency Department Throughput measures, Stroke measures, and Venous Thromboembolism measures. These measures have received NQF endorsement and are potential measures for future inclusion in the RHQDAPU program. Pursuant to this agreement, the Healthcare Information Technology Standards Panel (HITSP) has been tasked with harmonizing the EHR data element standards for the measure sets. The work for these three measure sets began in September 2008 and is due to be completed in a little more than 1 year. It is expected that interoperable standards will be developed and fully vetted by October 2009. When HITSP posts the standards, we anticipate that EHR vendors will be able to code their EHR systems with the new specifications and begin collecting this data electronically. We expect that these standards will be provided to its Certification Commission for Healthcare Information Technology (CCHIT) for inclusion in the criteria for certification of inpatient EHRs.

b. EHR Testing of Quality Measures Submission

As we have previously stated, we are interested in the reporting of quality measures using EHRs, and we continue to encourage hospitals to adopt and use EHRs that conform to industry standards. We believe that the testing of EHR submission is an important and necessary step to establish the ability of EHRs to report clinical quality measures and the capacity of CMS to receive such data.

Through CMS' interagency agreement with ONC previously described, the interoperable standards for EHR-based submission of the Emergency Department (ED) Throughput, Stroke, and Venous Thromboembolism (VTE) measures are scheduled to be finalized in late 2009 and will be available for review and testing. We anticipate testing the components required for the submission of clinical quality data extracted from EHRs for these measures, and are exploring different mechanisms and formats that will aid the submission process, as well as ensure that the summary measure results extracted from the EHRs are reliable. When the interoperable EHR-based submission standards become available, EHR vendors will be able to employ them in EHR systems and begin testing how they facilitate the electronic collection of these data. We intend to follow similar processes and procedures to those we are using for the PQRI EHR testing being conducted as described in the CY 2009 Medicare Physician Fee Schedule final rule with comment period (73 FR 69828 through 69830).

We anticipate moving forward with testing CMS' technical ability to accept data from EHRs for the ED, Stroke, and VTE measures as early as July 1, 2010. Pursuant to the Paperwork Reduction Act, prior to the beginning of testing EHR-based data submission, we will publish a **Federal Register** notice seeking public comments on the process we intend to follow to select EHR vendors/hospitals and the methodology we plan to use for testing EHR-based data submissions.

The test measures described above are not currently required under the RHQDAPU program. As long as that remains the case, EHR test data that is received for these measures will not be used to make RHQDAPU program payment decisions. In addition, the posting of the electronic specifications for any particular measure should not be interpreted as a signal that we intend to select the measure for inclusion in the RHQDAPU program measure set.

We intend to select several EHR vendors/hospitals to develop and test EHR clinical quality data submission. EHR vendors/hospitals that wish to participate in the development and testing process will be able to self-nominate by sending a letter of interest to: ''RHQDAPU Program IT Testing Nomination'', Centers for Medicare and Medicaid Services, Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group, 7500 Security Boulevard, Mail Stop S3–02–01, Baltimore, MD 21244–8532. The letter must be received by CMS by 6 p.m., E.S.T. on December 31, 2009. Vendors/hospitals will be selected based on the following criteria: (1) They are able to submit clinical EHR data using interoperability standards such as Cross Document Sharing (XDS), Cross Community Access (XCA), Clinical Data Architecture (CDA), and Health Level 7 Version 3 to a CMS-designated clinical data repository; and (2) they have established or have applied for a QualityNet account. More information regarding these capabilities will be made available on the Hospital Quality Initiative section of the CMS Web site at: *https://www.cms.hhs.gov/HospitalQualityInits/.* Preference may be given to EHR vendors/hospitals that utilize EHRs that are currently certified by the CCHIT, use the National Health Information Network (NHIN), and/or utilize Health Information Technology Standards Panel (HITSP)/Integrating the Healthcare Environment (IHE) standards.

EHR vendors/hospitals that would like to test the submission of inpatient EHR data to the CMS-designated clinical data repository should update their EHR products or otherwise ensure that those products can capture and submit the necessary data elements identified for an EHR-based submission once the standardized format has been determined. We suggest that these entities begin submitting EHR data promptly after CMS announces that the clinical data repository is ready to accept such data so that problems that may complicate or preclude a successful quality measure data submission can be corrected.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24182), we welcomed comments on this discussion of EHR-based data submission testing.

Comment: A number of commenters supported voluntary EHR testing, the creation of uniform data content standards, and the concept of reducing the burden to hospitals through automated data transmission via EHR products. The commenters applauded CMS for EHR testing and for working to expand quality data submission to include electronic formats. The commenters also commended CMS for working with ONC to establish electronic standards for ED, Stroke and VTE quality measures. The commenters urged CMS to ensure the scientific integrity of the electronic standards and resulting measures, and encouraged CMS to work closely with NQF's Health IT Expert Panel (HITEP) and to incorporate HITSP standards for measures. Some commenters urged CMS to conduct EHR testing for measures that have already been adopted into the RHQDAPU program as well. However, one commenter stated that the timelines suggested in the proposed rule do not take into account the realities faced by hospitals.

Response: We appreciate these supportive comments regarding voluntary EHR testing, and acknowledge the challenges faced by many hospitals in adopting EHRs at this time. We will continue to work with standard setting organizations toward standardization of data elements for quality measures in EHRs. A voluntary EHR-based data submission testing process would be initiated at such time as CMS systems are able to support it. Hospitals would not be required to participate in this testing process, but would do so voluntarily. We decided to begin EHR testing with non-implemented measures. However, we plan to create electronic formats for measures already

adopted for the RHQDAPU program as well.

We thank the commenters for their suggestions and will take these comments into consideration as we move forward with voluntary EHR testing. We will announce further details regarding this voluntary testing program in a separate **Federal Register** notice.

c. HITECH Act EHR Provisions

On February 17, 2009, the President signed into law the ARRA, Public Law 111–5. The HITECH Act (Title IV of Division B of the ARRA, together with Title XIII of Division A of the ARRA) authorizes payment incentives under Medicare for the adoption and use of certified EHR technology beginning in FY 2011. Hospitals are eligible for these payment incentives if they meet the following three requirements: Meaningful use of certified EHR technology; electronic exchange of health information; and reporting on measures using certified EHR technology (provided the Secretary has the capacity to receive such information electronically). With respect to this requirement, under section 1886(n)(3)(A)(ii) of the Act, as added by section 4102 of the HITECH Act, the Secretary shall select measures, including clinical quality measures, that hospitals must provide to CMS in order to be eligible for the EHR incentive payments. With respect to the clinical quality measures, section 1886(n)(3)(B)(i) of the Act requires the Secretary to give preference to those clinical quality measures that have been selected for the RHQDAPU program under section 1886(b)(3)(B)(viii) of the Act or that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act. Any measures must be proposed for public comment prior to their selection, except in the case of measures previously selected for the RHQDAPU program under section 1886(b)(3)(B)(viii) of the Act.

Thus, the RHQDAPU program and the HITECH Act have important areas of overlap and synergy with respect to the reporting of quality measures using EHRs. We believe the financial incentives under the HITECH Act for the adoption and meaningful use of certified EHR technology by hospitals will encourage the adoption and use of certified EHRs for the reporting of clinical quality measures under the RHQDAPU program. Further, these efforts to test the submission of quality data through EHRs may provide a foundation for establishing the capacity of hospitals to send, and for CMS to receive, quality measures via hospital EHRs for future RHQDAPU program measures. We again note that the provisions in this final rule do not implicate or implement any HITECH statutory provisions. Those provisions will be implemented in a future rulemaking.

B. Medicare-Dependent, Small Rural Hospitals (MDHs): Budget Neutrality Adjustment Factors for FY 2002-Based Hospital-Specific Rate (§ 412.79(i))

1. Background

Under the IPPS, special payment protections are provided to a sole community hospital (SCH). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary) is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that a hospital must meet to be classified as an SCH are located at 42 CFR 412.92. Section 1886(d)(5)(D)(iii)(III) of the Act and the regulations at § 412.109 also provide that certain essential access community hospitals (EACHs) will be treated as an SCH for payment purposes under the IPPS.

Under the IPPS, separate special payment protections also are provided to a Medicare-dependent, small rural hospital (MDH). Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area, has not more than 100 beds, is not an SCH, and has a high percentage of Medicare discharges (not less than 60 percent of its inpatient days or discharges in its 1987 cost reporting year or in two of its most recent three settled Medicare cost reporting years). The regulations that set forth the criteria that a hospital must meet to be classified as an MDH are located at 42 CFR 412.108.

Although SCHs and MDHs are paid under special payment methodologies, they are still paid under section 1886(d) of the Act. Like all IPPS hospitals paid under section 1886(d) of the Act, SCHs and MDHs are paid for their discharges based on the DRG weights calculated under section 1886(d)(4) of the Act.

For SCHs, effective with hospital cost reporting periods beginning prior to January 1, 2009, section 1886(d)(5)(D)(i) of the Act (as amended by section 6003(e) of Public Law 101–239 (OBRA 1989)) and section 1886(b)(3)(I) of the Act (as added by section 405 of Public Law 106–113 (BBRA 1999) and further amended by section 213 of Public Law 106–554 (BIPA 2000) provide that SCHs are paid based on whichever of four statutorily specified rates (listed below) yields the greatest aggregate payment to the hospital for the cost reporting period. For cost reporting periods beginning on or after January 1, 2009, section 122 of Public Law 110–275 (MIPPA 2008) further amended the Act to specify that SCHs will be paid based on a FY 2006 hospital-specific rate (that is, based on their updated costs per discharge from their 12-month cost reporting period beginning during Federal fiscal year 2006), if this results in the greatest payment to the SCH. Therefore, currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period:

- The Federal rate applicable to the hospital;
- The updated hospital-specific rate based on FY 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge;
- The updated hospital-specific rate based on FY 1996 costs per discharge; or
- The updated hospital-specific rate based on FY 2006 costs per discharge.

For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 were based on a blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987 hospital-specific rate. For discharges during FY 2004 and subsequent fiscal years, payments based on the FY 1996 hospital-specific rate are based on 100 percent of the updated FY 1996 hospital-specific rate.

Through and including FY 2006, under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal rate or, if higher, the Federal rate plus 50 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rates based on FY 1982 or FY 1987 costs per discharge, whichever of these hospital-specific rates is higher. Section 5003(b) of Public Law 109–171 (DRA 2005) amended section 1886(d)(5)(G) of the Act to provide that, for discharges occurring on or after October 1, 2006, MDHs are paid based on the Federal rate or, if higher, the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rate based on FY 1982, FY 1987, or FY 2002 costs per discharge, whichever of these hospital-specific rates is the highest. Unlike SCHs, MDHs

do not have the option to use their FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary or MAC determines which of the payment options will yield the highest aggregate payment. Interim payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary or MAC makes the determination. However, it may not be possible for the fiscal intermediary or MAC to determine in advance precisely which of the rates will yield the highest aggregate payment by year's end. In many instances, it is not possible to forecast the outlier payments, or the amount of the DSH adjustment or the IME adjustment, all of which are applicable only to payments based on the Federal rate and not to payments based on the hospital-specific rate. The fiscal intermediary or MAC makes a final adjustment at the close of the cost reporting period after it determines precisely which of the payment rates would yield the highest aggregate payment to the hospital.

If a hospital disagrees with the fiscal intermediary's or the MAC's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the fiscal intermediary's or the MAC's decision in accordance with the procedures set forth in 42 CFR part 405, Subpart R, which govern provider payment determinations and appeals.

2. FY 2002-Based Hospital-Specific Rate

Acute care hospitals, including MDHs and SCHs, are subsection (d) hospitals paid under the IPPS. As mentioned earlier, under the special payment methodologies for MDHs and SCHs, Medicare payments per discharge are made based on DRG weights, as with all other acute care hospitals paid under the IPPS. (We note that effective beginning in FY 2008, the MS–DRGs are used under the IPPS.) As discussed above, although the specific payment formulas for MDHs and SCHs differ, it is common to both types of hospitals that they may be paid based on an updated hospital-specific rate determined from their costs per discharge in a specified base year.

Section 1886(d)(4)(C)(iii) of the Act requires that aggregate IPPS payments be projected to neither increase nor decrease as a result of the annual changes to the DRG classifications and weighting factors. Beginning in FY 1994, in applying the current year's budget neutrality adjustment factor to both the standard Federal rate and hospital-specific rates, we do not remove the prior years' budget neutrality adjustment factors when applying the current year budget neutrality adjustment factor to assure that estimated aggregate payments after the DRG changes are equal to estimated aggregate payments prior to the changes (48 FR 46345). If we were to remove the prior year adjustment(s), we would not satisfy this requirement. As we have previously explained (for example, in the FY 2006 IPPS final rule (70 FR 47429)), all section 1886(d) hospitals, including hospitals that are paid based on a hospital-specific rate, are subject to a DRG budget neutrality adjustment factor. As is the case for all other IPPS hospitals, these hospitals are paid based on DRG classifications and weighting factors that must be considered when we determine whether aggregate IPPS payments are projected to increase or decrease as a result of the annual changes to the DRG classifications and weighting factors.

In order to comply with the statutory requirement that the DRG changes be budget neutral, we compute a budget neutrality adjustment factor based on a comparison of estimated aggregate payments using the current year's relative weights and factors to aggregate payments using the prior year's relative weights and factors. This budget neutrality adjustment factor is then applied to the standardized per discharge payment amounts (that is, the Federal rates and the hospital-specific rates). Cumulative budget neutrality factors, beginning with the adjustment factor for FY 1993, apply to all hospital-specific rates including rebased hospital-specific rate amounts derived from base years later than FY 1993. As discussed in the FY 2001 IPPS proposed rule (55 FR 19466), in setting updated DRG weights, each year we normalize DRG weights by an adjustment factor in order to first ensure that the average case weight after recalibration is equal to the average case weight prior to recalibration. While this adjustment is intended to ensure that recalibration does not affect total payments to hospitals under section 1886(d) of the Act, our analysis has indicated that the normalization adjustment does not usually achieve budget neutrality with respect to aggregate payments to hospitals under section 1886(d) of the Act. Thus, in order to comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that the annual DRG reclassification changes and recalibration of the relative weights be budget neutral, we also compute a budget neutrality adjustment factor that is applied to both the standardized amounts and the hospital-specific rates. This budget neutrality adjustment ensures that the recalibration process neither increases nor decreases total payments to hospitals. If we were to remove this budget neutrality adjustment factor for years prior to the base year, the normalized DRG weights applied to the hospital-specific amounts would result in higher aggregate payments than permitted under the statute.

Section 1886(b)(3)(I) of the Act (as added by section 405 of Public Law 106–113 (BBRA 1999) and further amended by section 213 of Public Law 106–554 (BIPA 2000)) contains a provision for SCHs to rebase their hospital-specific rate using the hospital's FY 1996 cost per discharge data. Specifically, beginning in FY 2001, SCHs can also use their reasonable and allowable FY 1996 operating costs for inpatient hospital services as the basis for their hospital-specific rate rather than only their FY 1982 or FY 1987 costs, if using FY 1996 costs would result in higher payments. Effective for cost reporting periods beginning on or after January 1, 2009, SCHs will be paid based on their hospital-specific rate using FY 2006 costs, if this rate yields higher payments (as provided for under section 122 of Public Law 110–275 (MIPPA 2008)). For the reasons explained above, the instructions for implementing both the FY 1996 and FY 2006 SCH rebasing provisions direct the fiscal intermediary or MAC to apply cumulative budget neutrality adjustment factors to account for DRG changes *since FY 1993* in determining an SCH's hospital-specific rate based on either FY 1996 or FY 2006 cost data. (The FY 1996 SCH rebasing provision was implemented in Transmittal A–00–66 (Change Request 1331) dated September 18, 2000, and the FY 2006 SCH rebasing provision was implemented in a Joint Signature Memorandum (JSM/TDL–09052), dated November 17, 2008.)

As stated previously, section 5003(b) of Public Law 109–171 (DRA 2005) allows MDHs to use the hospital's FY 2002 costs per discharge (that is, the FY 2002 updated hospital-specific rate) for discharges occurring on or after October 1, 2006, if that results in a higher payment. As we discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24183 through 24185), to implement this provision, CMS issued Transmittal 1067 (Change Request 5276 dated September 25, 2006) with instructions to fiscal intermediaries to determine and update the FY 2002 hospital-specific rate for qualifying MDHs. To calculate an MDH's FY 2002 hospital-specific rate and update it to FY 2007, the instructions directed fiscal

intermediaries to apply cumulative budget adjustment factors for FYs 2003 through 2007. However, the instructions did not include the cumulative budget neutrality adjustment factor to account for changes in the DRGs from FYs 1993 through 2002. As a result, effective beginning in FY 2007, any MDH that was paid based on its FY 2002 hospital-specific rate (calculated in accordance with the instructions provided in Transmittal 1067) has been paid based on a hospital-specific rate that failed to include a cumulative budget neutrality adjustment factor to account for DRG changes from FYs 1993 through 2002 (a cumulative budget neutrality adjustment factor of 0.982557 (or about -1.74 percent)), in addition to the cumulative budget neutrality adjustment factors applied for FYs 2003 through 2007 that have already been applied as specified in the implementing instructions. As we discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, in order to conduct a meaningful comparison between payments under the Federal rate, which is adjusted by the cumulative budget neutrality factor, and payments based on the hospital-specific rate, consistent with our established policy of applying a cumulative budget neutrality adjustment factor to account for DRG changes since FY 1993, for discharges beginning on or after October 1, 2009, we stated our intention to include the cumulative budget neutrality adjustment factors for the DRG changes from FYs 1993 through 2002, in addition to the cumulative budget neutrality adjustment factors for FYs 2003 forward. The cumulative budget neutrality adjustment factor of 0.982557 is calculated as the product of the following budget neutrality adjustment factors to account for DRG changes from FYs 1993 through 2002: 0.999851 for FY 1993; 0.999003 for FY 1994; 0.998050 for FY 1995; 0.999306 for FY 1996; 0.998703 for FY 1997; 0.997731 for FY 1998; 0.998978 for FY 1999; 0.997808 for FY 2000; 0.997174 for FY 2001; and 0.995821 for FY 2002.

We considered applying a factor of 0.982557 to any MDH's FY 2002 hospital-specific rate to account for the cumulative budget neutrality adjustment for DRG changes from FYs 1993 through 2002, either effective for discharges occurring on or after October 1, 2006 (the initial effective date of the FY 2002 rebasing) or, alternatively, effective upon the issuance of the correction. However, consistent with the prospective nature of the rates under the IPPS, we are applying the adjustment on a prospective basis only, effective for discharges occurring on or after October 1, 2009 (FY 2010). This effective date would give affected MDHs sufficient notice of the change to their hospital-specific rate. We estimate that approximately 50 MDHs will be affected by the application of the cumulative budget neutrality adjustment for DRG changes from FYs 1993 through 2002. Based on the current cumulative budget neutrality adjustment factor of 0.982557 to account for DRG changes from FYs 1993 through 2002, we estimate that, in some instances, application of the cumulative budget neutrality adjustment factor will lower the hospital-specific rate to the point that the Federal rate would result in higher payments.

Comment: Some commenters asserted that the application of a cumulative budget neutrality adjustment factor for the DRG changes from FYs 1993 through 2002 doubles the impact of this adjustment on the hospital-specific rates. The commenters believed that the average case weight from FYs 1993 through 2002 increased and that the cumulative budget neutrality adjustment built into the Federal rates and hospital-specific rates for this time period offsets this average case weight increase. The commenters believed, therefore, that this budget neutrality adjustment is already being accounted for when the fiscal intermediary divides the MDH's FY 2002 average cost per discharge by the hospital's case mix index for FY 2002, because the case-mix index reflects the higher average case weight increase.

Response: As described in section II.H. of the preamble of this final rule, the recalibrated DRG weights are normalized each year by an adjustment factor so that the national average case weight after DRG recalibration is equal to the national average case weight before recalibration. The normalization process is designed to offset any increase or decrease in the national average case weight due to recalibration. Because the weights are normalized, they do not reflect national average case weight change due to recalibration. Therefore, the hospital's case-mix index for FY 2002, which is calculated using DRG weights after normalization, do not reflect national average case weight change. We disagree with commenter's assertions that the average case weight from FYs 1993 through 2002 increased due to recalibration and that the cumulative budget neutrality adjustment built into the Federal rates and hospital specific rates for this time period offsets an average case weight increase due to recalibration. The cumulative budget neutrality adjustment is not already being accounted for when the fiscal intermediary divides the FY 2002 average cost per discharge for a hospital by the hospital's case-mix index for FY 2002.

Comment: One commenter stated that even if a cumulative budget neutrality factor should be applied, it is wrongly calculated, pointing to a change made by CMS, effective FY 2006 and forward, to no longer apply the wage index budget neutrality adjustment factor to the hospital-specific rate of SCHs and MDHs, but rather only a DRG recalibration budget neutrality adjustment factor (70 FR 47430). The budget neutrality adjustment factor applied to the hospital-specific rate prior to FY 2006 was a composite of both the budget neutrality adjustment to account for redistribution of cases among DRGs and the budget neutrality adjustment to account for changes to the wage index. The commenter took issue that the cumulative budget neutrality adjustment factor continues to include factors that adjust for wage index changes prior to FY 2006, and stated that the adjustment factors prior to FY 2006 that are included in the cumulative budget neutrality factor should be only the DRG recalibration budget neutrality adjustment factors, consistent with the change made for FY 2006 forward.

Response: Regarding the application of combined wage index and DRG recalibration budget neutrality adjustment factors for FYs 1993 through 2005, in the FY 2006 IPPS final rule (70 FR 47430), we stated that we believe that our former policy of applying both a combined wage and DRG budget neutrality adjustment factor is still valid. Therefore, we do not believe it is necessary or appropriate to change the applicable budget neutrality adjustment factors to only DRG recalibration budget neutrality adjustment factors for that period. We also note that those factors, the cumulative budget neutrality adjustment factors for the hospital-specific rates, which included both the wage index and DRG recalibration budget neutrality adjustment factors for FYs 1993 through 2005, were established as a result of a notice-and-comment rulemaking process, and we would not retroactively recalculate these factors.

Comment: One commenter stated that the cumulative budget neutrality adjustment factor for FYs 1993 through 2005 is incorrect because two factors within it, the FY 1999 and the FY 2003 budget neutrality adjustment factors, are incorrect; that is, they are not those

presented in the applicable **Federal Register** notice.

Response: Although the FY 1999 budget neutrality adjustment factor was initially published in the FY 1999 IPPS final rule, in the February 25, 1999 final notice (64 FR 9381), the budget neutrality adjustment factor for FY 1999 was subsequently revised to 0.998978, in conjunction with subsequent revisions to the wage index, effective March 1, 1999 through September 30, 1999. Consistent with our policy of applying DRG budget neutrality in a cumulative manner, the revised factor is carried permanently in both the standardized rate and the hospital-specific rates.

Similarly, for FY 2003, the original budget neutrality adjustment factor initially published in the FY 2003 IPPS final rule was subsequently revised. In conjunction with the implementation of the temporary equalization of the IPPS standardized amounts required by section 402(b) of Public Law 108–7, the budget neutrality adjustment factor was again revised based on wage index corrections.

We note that we received a number of public comments of issues that were outside of the scope of the provisions of the proposed rule, and therefore, we are not responding to them in this final rule. These public comments related to the SCH FY 2006 hospital-specific rate, the SCH volume decrease adjustment, and the application of DSH payments to the hospital-specific rate.

After considering the public comments we received and our findings regarding those comments, we are finalizing the policy discussed in the proposed rule to apply a cumulative budget neutrality adjustment factor to MDHs' FY 2002 hospital-specific rates to adjust for each fiscal year from 1993 forward, as is done for the Federal rate.

C. Rural Referral Centers (RRCs) (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as an RRC. For discharges that occurred before October 1, 1994, RRCs received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount (as discussed in the FY 1993 IPPS final rule (59 FR 45404 through 45409). Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, RRCs continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Public Law 108–173 raised the DSH adjustment for RRCs such that they are not subject to the 12-percent cap on DSH payments applicable to other rural hospitals. RRCs are also not subject to the proximity criteria when applying for geographic reclassification. In addition, they do not have to meet the requirement that a hospital's average hourly wage must exceed, by a certain percentage, the average hourly wage of the labor market area where the hospital is located.

Section 4202(b) of Public Law 105–33 states, in part, ''[a]ny hospital classified as an RRC by the Secretary * * * for fiscal year 1991 shall be classified as such an RRC for fiscal year 1998 and each subsequent year.'' In the August 29, 1997 IPPS final rule with comment period (62 FR 45999), CMS reinstated RRC status for all hospitals that lost the status due to triennial review or MGCRB reclassification. However, CMS did not reinstate the status of hospitals that lost RRC status because they were now urban for all purposes because of the OMB designation of their geographic area as urban. Subsequently, in the August 1, 2000 IPPS final rule (65 FR 47089), we indicated that we were revisiting that decision. Specifically, we stated that we would permit hospitals that previously qualified as an RRC and lost their status due to OMB redesignation of the county in which they are located from rural to urban, to be reinstated as an RRC. Otherwise, a hospital seeking RRC status must satisfy all of the other applicable criteria. We use the definitions of ''urban'' and ''rural'' specified in Subpart D of 42 CFR part 412. One of the criteria under which a hospital may qualify as an RRC is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as an RRC if the hospital meets two mandatory prerequisites (a minimum CMI and a minimum number of discharges), and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). (We refer readers to § 412.96(c)(1) through (c)(5) and the September 30, 1988 **Federal Register** (53 FR 38513).) With respect to the two mandatory prerequisites, a hospital may be classified as an RRC if—

- The hospital's CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index (CMI)

Section 412.96(c)(1) provides that CMS establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining RRC status. The methodology we used to determine the national and regional CMI values is set forth in the regulations at § 412.96(c)(1)(ii). The national median CMI value for FY 2010 includes data from all urban hospitals nationwide, and the regional values for FY 2010 are the median CMI values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals that train residents in an approved GME program as provided in § 413.75). These values are based on discharges occurring during FY 2008 (October 1, 2007 through September 30, 2008), and include bills posted to CMS' records through March 2009.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24185), we proposed that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2009, they must have a CMI value for FY 2008 that is at least—

- 1.4667; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

Based on the latest available data (FY 2008 bills received through March 2009), in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2009, they must have a CMI value for FY 2008 that is at least—

- 1.4669; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The final median CMI values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2612
2. Middle Atlantic (PA, NJ, NY)	1.3011
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.4212
4. East North Central (IL, IN, MI, OH, WI)	1.3994
5. East South Central (AL, KY, MS, TN)	1.3311
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.4045
7. West South Central (AR, LA, OK, TX)	1.4692
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.5217
9. Pacific (AK, CA, HI, OR, WA)	1.4298

A hospital seeking to qualify as an RRC should obtain its hospital-specific CMI value (not transfer-adjusted) from its fiscal intermediary or MAC. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, the CMI values are computed based on all Medicare patient discharges subject to the IPPS MS–DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24186) we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2007 (that is, October 1, 2006 through September 30, 2007), which were the latest cost report data available at the time the proposed rule was developed.

Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2009, must have as the number of discharges for its cost reporting period that began during FY 2007 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (We refer readers to the table set forth in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule at 74 FR 24186.)

Based on the latest discharge data available at this time, that is, for cost reporting periods that began during FY 2007, the final median number of discharges for urban hospitals by census region are set forth in the following table.

Region	Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT)	8,347
2. Middle Atlantic (PA, NJ, NY)	10,729
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,725
4. East North Central (IL, IN, MI, OH, WI)	9,282
5. East South Central (AL, KY, MS, TN)	7,281
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	8,636
7. West South Central (AR, LA, OK, TX)	7,254
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,823
9. Pacific (AK, CA, HI, OR, WA)	8,715

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that, if an osteopathic hospital is to qualify for RRC status for cost reporting periods beginning on or after October 1, 2009, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2007.

D. Indirect Medical Education (IME) Adjustment (§ 412.105)

1. Background

Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the IPPS for hospitals that have residents in an approved graduate medical education (GME) program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

Public Law 105–33 (BBA 1987) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its full-time equivalent (FTE) resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997.

2. IME Adjustment Factor for FY 2010

The IME adjustment to the MS–DRG payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated by using a hospital's ratio of residents to beds, which is represented as *r,* and a formula multiplier, which is represented as *c,* in the following equation: $c \times [\{1 + r\}^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 502(a) of Public Law 108–173 modified the formula multiplier *(c)* to be used in the calculation of the IME adjustment. Prior to the enactment of Public Law 108–173, the formula multiplier was fixed at 1.35 for discharges occurring during FY 2003 and thereafter. In the FY 2005 IPPS final rule, we announced the schedule of formula multipliers to be used in the calculation of the IME adjustment and incorporated the schedule in our regulations at § 412.105(d)(3)(viii) through (d)(3)(xii). Section 502(a) modified the formula multiplier beginning midway through FY 2004 and provided for a new schedule of formula multipliers for FYs 2005 and thereafter as follows:

- For discharges occurring on or after April 1, 2004, and before October 1, 2004, the formula multiplier is 1.47.
- For discharges occurring during FY 2005, the formula multiplier is 1.42.
- For discharges occurring during FY 2006, the formula multiplier is 1.37.
- For discharges occurring during FY 2007, the formula multiplier is 1.32.
- For discharges occurring during FY 2008 and fiscal years thereafter, the formula multiplier is 1.35.

Accordingly, for discharges occurring during FY 2010, the formula multiplier is 1.35. We estimate that application of this formula multiplier for the FY 2010 IME adjustment will result in an increase in IPPS payment of 5.5 percent for every approximately 10-percent increase in the hospital's resident-to-bed ratio.

We did not receive any public comments specifically on the IME adjustment factor.

3. IME-Related Changes in Other Sections of This Final Rule

We refer readers to section V.E.2. and 4. of the preamble of this final rule for a discussion of changes to the policies for counting beds and patient days in relation to the calculations for the IME adjustment at § 412.105(b) and the DSH payment adjustment at § 412.106(a)(1)(ii). We also address the public comments we received in section V.E.2. and 4. of this preamble. The regulations relating to the DSH payment adjustment at § 412.106(a)(1)(i) cross-reference the IME regulation at § 412.105(b), which specifies how the number of beds in a hospital is determined for purposes of calculating a teaching hospital's IME adjustment. Specifically, as we proposed, we are changing our policies with respect to counting bed days for patients receiving observation services.

We also refer readers to section V.G.2. of the preamble of this final rule for a discussion of our clarification of the definition of a new medical residency training program for purposes of Medicare direct GME payment and the public comments that we received on our proposed clarification and our responses. This clarification also will apply for purposes of IME payment and could affect IME FTE resident cap adjustments for new medical residency training programs. We also address any public comments that we received on this clarification in section V.G.2. of this preamble.

E. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) (§ 412.106)

1. Background

Section 1886(d)(5)(F) of the Act provides for additional Medicare payments to subsection (d) hospitals that serve a significant disproportionate number of low-income patients. The Act specifies two methods by which a hospital may qualify for the Medicare disproportionate share hospital (DSH) adjustment. Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a Medicare DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to needy patients with low incomes. This method is commonly referred to as the ''Pickle method.'' The second method for qualifying for the DSH adjustment, which is the most common, is based on a complex statutory formula under which the DSH payment adjustment is based on the hospital's geographic designation, the number of beds in the hospital, and the level of the hospital's disproportionate patient percentage (DPP). A hospital's DPP is the sum of two fractions: The ''Medicare fraction'' and the ''Medicaid fraction.'' The Medicare fraction is computed by dividing the number of the hospital's inpatient days that are furnished to patients who were entitled to both Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan) and Supplemental Security Income (SSI) benefits by the hospital's total number of patient days furnished to patients entitled to benefits under Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan). The Medicaid fraction is computed by dividing the hospital's number of inpatient days furnished to patients who, for such days, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A, by the hospital's total number of inpatient days in the same period.

Because the DSH payment adjustment is part of the IPPS, the DSH statutory references (under section 1886(d)(5)(F) of the Act) to ''days'' apply only to inpatient days. Regulations located at 42 CFR 412.106 govern the Medicare DSH payment adjustment and specify how the DPP is calculated as well as how beds and patient days are counted in determining the Medicare DSH payment adjustment. Under § 412.106(a)(1)(i), the number of beds for the Medicare DSH payment adjustment is determined in accordance with bed counting rules for the IME adjustment under § 412.105(b).

In section V.E.4. of this preamble, we are combining our discussion of changes to the policies for counting beds in relation to the calculations for the IME adjustment at § 412.105(b) and the DSH payment adjustment at § 412.106(a)(1) because the underlying concepts are similar and we believe they should generally be interpreted in a consistent manner for both purposes. Specifically, as we proposed, we are changing our Medicare DSH policies with respect to counting patient days and bed days, as well as IME bed counting policy, for patients receiving observation services.

2. Policy Change Relating to the Inclusion of Labor and Delivery Patient Days in the Medicare DSH Calculation

a. Background

As discussed in the FY 2004 IPPS final rule (68 FR 45419 through 45420), prior to December 1991, Medicare's policy on counting days for purposes of allocating costs on the cost report and for purposes of the DSH payment adjustment for maternity patients was to count an inpatient day for an admitted maternity patient in a labor and delivery room at the census-taking hour. This pre-December 1991 policy is consistent with current Medicare policy for counting days for admitted patients in any other ancillary department at the census-taking hour. However, based on decisions in a number of Federal Courts of Appeal, including the United States Court of Appeals for the District of Columbia Circuit, relating to Medicare's policy for allocating costs, the policy regarding the counting of inpatient days for maternity patients was revised to reflect our existing policy for purposes of both cost allocation and the DSH calculation.

Under the existing regulations at § 412.106(a)(1)(ii)(B), patient days associated with beds used for ancillary labor and delivery are excluded from the Medicare DSH calculation. This policy, in part, is based on cost allocation rules (that is, rules for counting days for admitted patients in ancillary and routine cost centers for purposes of allocating costs on the Medicare cost report). In particular, section 2205.2 of the Provider Reimbursement Manual (PRM) provides the following: ''A maternity patient in the labor/delivery room ancillary area at midnight is included in the census of the inpatient routine (general or intensive) care area only if the patient has occupied an inpatient routine bed at some time since admission. No days of inpatient routine care are counted for a maternity inpatient who is discharged (or dies) without ever occupying an inpatient routine bed. However, once a maternity patient has occupied an inpatient routine bed, at each subsequent census the patient is included in the census of the inpatient routine care area to which assigned even if the patient is located in an ancillary area (labor/delivery room or another ancillary area) at midnight. In some cases, a maternity patient may occupy an inpatient bed only on the day of discharge, where the day of discharge differs from the day of admission. For purposes of apportioning the cost of inpatient routine care, this single day of routine care is counted as the day of admission (to routine care) and discharge and, therefore, is counted as one day of inpatient routine care.''

In applying the rules discussed above, if, for example, a Medicaid patient is in the labor room at the census-taking hour and has not yet occupied a routine inpatient bed, the day would not be counted as an inpatient day in the

numerator or the denominator of the Medicaid fraction of the Medicare DPP. If, instead, the same patient were in the labor room at the census-taking hour, but had first occupied a routine inpatient bed, the day would be counted as an inpatient patient day in both the numerator and the denominator of the Medicaid fraction of the Medicare DPP for purposes of the DSH payment adjustment (and for apportioning the cost of routine care on the Medicare cost report).

We further clarified this policy in the FY 2004 IPPS final rule (68 FR 45419 through 45420), given that hospitals had increasingly begun redesigning their maternity areas from separate labor and delivery rooms and postpartum rooms to single multipurpose labor, delivery, and postpartum (LDP) rooms. In order to appropriately track the days and costs associated with LDP rooms under our existing Medicare DSH policy, we stated that it was necessary to apportion them between the labor and delivery cost center, which is an ancillary cost center, and the routine adults and pediatrics cost center (68 FR 45420). This is done by determining the proportion of a patient's stay in the LDP room that is associated with the patient receiving ancillary services (labor and delivery), as opposed to routine adult and pediatric services (postpartum).

Therefore, under the current policy, days associated with labor and delivery services furnished to patients who did not occupy a routine bed prior to occupying an ancillary labor and delivery bed before the census-taking hour are not included as inpatient days for purposes of the DSH calculation. This policy is applicable whether the hospital maintains separate labor and delivery rooms and postpartum rooms, or whether it maintains ''maternity suites'' in which labor, delivery, and postpartum services all occur in the same bed. However, in the latter case, patient days are counted proportionally based on the proportion of (routine/ancillary) services furnished. (We refer readers to the example provided in the FY 2004 IPPS final rule (68 FR 45420) that describes how routine and ancillary days are allocated under this policy.)

b. Proposed and Final Policy Change

As we indicated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24188), upon further examination of our existing policy on counting patient days, we no longer believe that it is appropriate to apply the cost allocation rules for purposes of counting labor and delivery patient days in the Medicare DSH calculation. That is, we believe that even if a particular labor and delivery patient day is not included in the inpatient routine care census-taking for purposes of apportioning routine costs, it may still reasonably be considered to be an inpatient day for purposes of determining the DPP, provided that the unit or ward in which the labor and delivery bed is located is generally providing services that are payable under the IPPS. In general, we believe the costs associated with labor and delivery patient days (regardless of whether they are associated with patients who occupied a routine bed prior to occupying an ancillary labor and delivery bed) are generally payable under the IPPS. Therefore, we believe that such patient days should be included in the DPP as inpatient days once the patient has been admitted to the hospital an as inpatient. Accordingly, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, for cost reporting periods beginning on or after October 1, 2009, we proposed to change our existing policy regarding patient days to include, in the DPP calculation, patient days associated with maternity patients who were admitted as inpatients and were receiving ancillary labor and delivery services at the time the inpatient routine census is taken, regardless of whether the patient occupied a routine bed prior to occupying a bed in a distinct ancillary labor and delivery room and regardless of whether the patient occupied a routine bed prior to occupying an ancillary labor and delivery bed and regardless of whether the patient occupies a ''maternity suite'' in which labor, delivery, recovery, and postpartum care all take place in the same room. We believed that this proposed policy would be consistent with our existing policy under section 2205 of the PRM–I regarding counting patient days associated with other ancillary areas (such as surgery and postanesthesia).

We note that we did not propose to change our policy on patient days for labor and delivery patients who are *not* admitted to the hospital as inpatients. For example, if a woman presents at a hospital for labor and delivery services, but is determined by medical staff to be in false labor and is sent home without ever being admitted to the hospital as an inpatient, any days associated with such services furnished by the hospital would not be included in the DPP for purposes of the Medicare DSH calculation. That is, because the patient would be considered an outpatient, the day (or days) associated with the hospital visit would not be counted for purposes of the Medicare DSH calculation because such days would not be considered inpatient days. In addition, we indicated that the proposed policy would not affect existing policies relating to the allocation of costs for Medicare cost reporting purposes or for determining the number of available beds under § 412.105(b)(4) or § 412.106(a)(1)(i). In other words, our hospital instructions in the PRM–I for those purposes remain unchanged and unaffected by the proposed policy.

Comment: Several commenters supported the proposal. Specifically, the commenters asserted that they agreed with CMS' statement that, because inpatient labor and delivery days are generally payable under the IPPS, they should be included in the DSH calculation. Some commenters commended CMS for revisiting its policy.

Response: We thank the commenters for their support.

Comment: One commenter opposed the proposal. The commenter stated that CMS should continue to exclude labor and delivery patient days associated with patients who did not occupy a routine bed prior to occupying a labor and delivery bed. The commenter asserted that ''historical litigation has already resulted in a conclusion that labor and delivery days should be excluded from the cost allocation rules [and that] this recognition of the different nature of labor and delivery days is inconsistent with CMS' proposal to now treat those days exactly the same as routine days for all patients who are admitted.''

Response: As we stated in the proposed rule (74 FR 24188), upon further examination of our existing policy on counting patient days, we no longer believe that it is appropriate to apply the cost allocation rules for purposes of counting labor and delivery patient days in the Medicare DSH calculation. That is, we believe that even if a particular labor and delivery patient day is not included in the inpatient routine care census-taking for purposes of apportioning routine costs, it may still reasonably be considered to be an inpatient day for purposes of determining the DPP, provided that the unit or ward in which the labor and delivery bed is located is generally providing services that are payable under the IPPS. We disagree that the rules for patient days included for purposes of cost allocation must mirror those included for purposes of Medicare DSH. We note that we did not propose to change the cost allocation rules and that to the extent that labor and delivery patient days are excluded for cost

allocation purposes, that policy is unaffected by our proposed policy for Medicare DSH purposes.

Comment: One commenter requested clarification that labor and delivery patient days will be counted only for DSH purposes and not for other patient day allocation purposes. The commenter asked that CMS confirm that a separate line would be added to Worksheet S–3 of the Medicare cost report to accommodate the reporting.

Response: As we indicated in the proposed rule, the proposed policy would not change existing underlying policies relating to the allocation of costs for Medicare cost reporting purposes. We will provide cost reporting instructions (at a later time) to reflect the revised policy.

Comment: Several commenters requested additional clarification of how the proposed policy would be applied. Specifically, the commenters asked how cost reports that had appealed the exclusion of labor and delivery days and cost reports that were either still open or ''reopenable'' would be treated. Some commenters referenced a recent Administrator's decision (''QRS CHW DSH Labor Room Days Groups vs. Blue Cross Blue Shield Association/ United Government Services LLC–CA'' signed April 13, 2009) that allowed the inclusion of patient days associated with labor, delivery, and postpartum beds for a group of hospitals located in the Ninth Circuit Court of Appeals for fiscal years prior to FY 2004. One commenter asked whether hospitals located in the Ninth Circuit would be treated differently with respect to the inclusion of labor and delivery days for periods prior to October 1, 2009. Other commenters noted that there were several appeals pending on the issue of the exclusion of labor and delivery days currently pending at the Provider Review and Reimbursement Board (PRRB) and stated that it would be equitable to allow all hospitals with open cost reports and or appeals on this issue to count all labor and delivery inpatient days because it would be CMS' policy to include the days going forward. One commenter noted that, in the FY 2004 IPPS final rule, when CMS provided guidance for apportioning day in labor-delivery-postpartum rooms, the policy was applied to all currently open and future cost reports and suggested that the FY 2010 proposed policy also be applied to all open cost reports.

Response: In response to the commenters who asked how the proposed policy would affect previous cost reporting periods, our proposal to include labor and delivery days in the DSH calculation for cost reporting periods beginning on or after October 1, 2009, is a change in policy that stemmed from a reevaluation of the existing policy. We believe that both the existing policy and the proposed new policy, although different, are permissible and reasonable interpretations of the law. Accordingly, we are applying the new policy prospectively to future cost reporting periods. Prior cost reporting periods would be covered under the policies that existed in those corresponding periods. With regard to the above-referenced Administrator's decision, we believe it is beyond the scope of this rule, as the decision was not based on the underlying labor and delivery policy but turned instead upon the 9th Circuit's interpretation of the regulation governing the counting of patient days prior to 2004. Consequently, that decision addresses only cost reporting years prior to 2004 for hospitals located in the 9th Circuit. Therefore, the Administrator's decision does not affect the proposed policy that we are adopting in this final rule. In response to the comment regarding hospitals that filed appeals on the exclusion of labor and delivery patient days, we note that such cases will continue to be handled through the administrative appeals process.

In response to the commenters who suggested that the proposed policy apply to all open cost reports, similar to the FY 2004 final IPPS policy relating to labor-delivery-postpartum rooms (68 FR 45420), we remind the commenter that the FY 2004 policy was a clarification of existing policy; whereas this year's proposed policy is a new policy. Accordingly, we cannot apply a new policy to prior cost reporting periods.

Comment: One commenter noted that the proposed policy would continue to apply only to individuals who were admitted as inpatients. The commenter asked whether a patient who was not admitted as an inpatient at the time she began receiving labor and delivery ancillary services, but was later admitted as an inpatient, would have all days counted for purposes of the Medicare DSH adjustment or only the days subsequent to the admission as an inpatient. The commenter also noted that some hospitals use the term ''admitted'' loosely and sometimes consider any patient that presents to the hospital to be admitted either as an inpatient or an outpatient; the commenter asked whether CMS could develop a specific definition of when a patient is admitted.

Response: Because the Medicare DSH adjustment is an add-on payment to the IPPS payment rate, only the days for individuals who are admitted as inpatients may be included in the DSH calculation. Days prior to admission as an inpatient may not be included. We note that standards for inpatient admission already exist, but that the determination to admit a patient is made by the physician who signs the admitting orders. We do not believe it is necessary to create a new standard for inpatient admissions.

Comment: One commenter stated that CMS posited a link between available days for determining the IME payment adjustment and days that are used for calculation the disproportionate patient percentage for DSH. The commenter stated that available days used to calculate IME payment adjustments are unrelated to the Medicare statute that discusses days for DSH purposes and asked that CMS clarify how days for the IME and DSH calculations are related.

Response: We note that the Medicare DSH proposal relating to patient days associated with labor and delivery services specifically referenced *patient* days and that the IME adjustment was not mentioned in the context of this proposal. The IME adjustment was addressed, however, in the Medicare DSH proposal related to available bed days (and patient days) associated with observation services. As we have noted, under § 412,106(a)(1)(i), the number of beds for the Medicare DSH payment adjustment is determined in accordance with bed counting rules for the IME adjustment under § 412.105(b). Accordingly, we combined our discussion of proposed changes to the policies for counting beds with regard to observation services for both the IME and DSH payment adjustments. Both IME and DSH adjustments are additional payments under the IPPS system. Therefore, to the extent that both adjustments include available bed day counts, we believe that the available bed day count generally should be consistent for both adjustments.

After consideration of the public comments received, we are finalizing our proposed policy, without modification, to include patient days associated with patients occupying labor and delivery beds in the disproportionate patient percentage of the Medicare DSH adjustment for cost reporting periods beginning on or after October 1, 2009, under § 412.106(a)(1)(ii).

3. Policy Change Relating to Calculation of Inpatient Days in the Medicaid Fraction in the Medicare DSH Calculation

a. Background

As stated under section V.E.1. of this preamble, a hospital can qualify for the Medicare DSH payment adjustment based on its Medicare DPP, which is equal to the sum of the percentage of total Medicare inpatient days attributable to patients entitled to both Medicare Part A (including patients enrolled in Medicare Advantage (Part C)) and SSI and the percentage of total inpatient days attributable to patients eligible for Medicaid, but not entitled for Medicare Part A.

$$\text{Disproportionate Patient Percentage (DPP)} = \frac{\text{Medicare, SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$$

Our existing policy of aggregating days for the Medicare fraction of the DSH calculation is to count days by the date of discharge. This policy, which is specified in the regulations at § 412.106(b)(2)(i)(A), applies to how days are counted in both the numerator and denominator of the Medicare fraction.

Under the existing Medicare DSH payment adjustment policy, a hospital is required to report its Medicaid inpatient days (that is, the ''numerator'' of the Medicaid fraction) in the cost reporting period in which the patient was discharged. However, despite our existing policy to count the days in the numerator of the Medicaid fraction based on the date of discharge, we believe that there may have been confusion about the existing policy that may have led hospitals to vary in the methodology they use to aggregate days in the numerator of the Medicaid fraction for patients who were eligible for Medicaid. In many cases, we have found that hospitals are reporting these days to their fiscal intermediary or MAC based on the method by which their respective State Medicaid agencies have chosen to collect and report Medicaid-eligible days to the hospital. We understand that State Medicaid agencies differ in how they collect and report Medicaid-eligible days. As a result, hospitals may be counting Medicaid-eligible days in the numerator of the Medicaid fraction of the DPP based on one of several possible methodologies, rather than consistently counting days based on the date of discharge, as required under the existing policy. The various methodologies being used by State Medicaid agencies include date of discharge, date of admission, date of Medicaid payment, and dates of service. As we indicated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24188 through 24189), with the exception of the methodology that accumulates days in the numerator of the Medicaid fraction by the date of Medicaid payment, we believe that any of these methodologies could appropriately capture all inpatient days in which an individual was Medicaid-eligible for a hospital for the purpose of counting days in the numerator of the Medicaid fraction used in the DPP. We do not believe that the date of Medicaid payment is appropriate because our policy is to include inpatient days for which the patient was eligible for Medicaid, regardless of whether Medicaid paid for the days. Therefore, we believe that the date of Medicaid payment methodology may not capture all of the days that a hospital would be allowed to include in the numerator of its Medicaid fraction. With respect to the other possible alternatives to counting days in the numerator of the Medicaid fraction, we believe that it becomes problematic when hospitals change the methodology they use to count days in the numerator of the Medicaid fraction from one cost reporting period to the next. Such changes in the methodology of counting days may result in ''double counting'' of the same patient days in more than one cost reporting period for a hospital.

b. Proposed and Final Policy Change

To address the issue of hospitals reporting days in the numerator for the Medicaid fraction of the DPP in the Medicare DSH calculation based on data they receive from their respective State Medicaid agency and the fact that the State Medicaid agency may report such days based on one of several different methodologies, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24188 through 24189), we proposed to revise our existing policy by adding a new paragraph (iv) to § 412.106(b)(4) to allow hospitals to report days in the numerator of the Medicaid fraction of the DPP based on one of three methodologies. Specifically, we proposed that, effective for cost reporting periods beginning on or after October 1, 2009, a hospital may report Medicaid-eligible days in the numerator of the Medicaid fraction of the DPP of a cost reporting period based on date of admission, date of discharge, or dates of service. However, we indicated that under the proposed revised policy, a hospital would be required to notify CMS (through the fiscal intermediary or MAC) in writing if the hospital chooses to change its methodology of counting days in the numerator of the Medicaid fraction of the DPP. We proposed to require that the written notification be submitted at least 30 days prior to the beginning of the cost reporting period to which the requested change would apply. The written notification must specify the changed methodology the hospital wishes to use and the cost reporting period to which the requested change would apply. We proposed that a hospital would only be able to make such a change effective on the first day of the beginning of a cost reporting period and the change would have to be effective for the entire cost reporting period; that is, a hospital would not be permitted to change its methodology in the middle of a cost reporting period. This change would also be effective for all subsequent cost reporting periods unless the hospital submits a subsequent notification to change its methodology for a future cost reporting period. We noted that we would expect that a hospital would rarely decide to change the methodology it uses to count days in the numerator of the Medicaid fraction of the DPP and that such a change would be prompted out of necessity (for example, the State Medicaid agency changes the methodology it uses to provide patient Medicaid eligibility information to hospitals). In addition, we proposed that if a hospital changes its methodology for counting days in the numerator of the Medicaid fraction, CMS, or the fiscal intermediary or MAC, would have the authority to adjust the inpatient days reported by the hospital in a cost reporting period to prevent ''double counting'' of days in the numerator of the Medicaid fraction of the DPP of the Medicare DSH calculation reported in another cost reporting period.

Comment: Several commenters supported the proposed change to allow

hospitals to choose one of three methodologies to report Medicaid-eligible days in the numerator of the Medicaid fraction of the DPP. The commenters stated that they supported the flexibility that the proposed change afforded to hospitals. They noted that a rigid methodology of aggregating inpatient days is an administrative burden for hospitals if the methodology differs from that used by the hospital's State Medicaid agency to verify Medicaid eligibility. The commenters stated that the proposal could alleviate the administrative burden on hospitals.

Response: We thank the commenters for their support.

Comment: Several commenters requested that CMS confirm that the choice of methodology as addressed by the proposed change to § 412.106(b)(4)(iv) is determined by the hospitals and not the fiscal Intermediary and/or MAC. One commenter asked that CMS modify the proposed regulatory text to say that the choice of methodology for accumulating inpatient days be ''at the hospital's discretion.'' Another commenter stated that, under the existing policy, ''there have been instances in which the hospital has reported Medicaid inpatient days based on discharge but the FI/MAC changed that method to reflect days on and admission basis upon audit'' and asked that CMS clarify that date of discharge be used for prior periods, consistent with existing Medicare policy. The commenter also stated that the choice of methodology is ''not a change that can be made by the FI/MAC upon settlement.''

Response: We reiterate and confirm that the proposed policy would allow hospitals to report Medicaid-eligible days in the numerator of the Medicaid fraction of the DPP of a cost reporting period based on date of admission, date of discharge, or dates of service, effective for cost reporting periods beginning on or after October 1, 2009. We disagree that additional regulatory language is needed to clarify this provision.

The proposed policy also provides CMS and the fiscal intermediary or MAC the authority to adjust the inpatient days reported by the hospital in a cost reporting period to prevent ''double counting'' of days in the numerator of the Medicaid fraction of the DPP of the Medicare DSH calculation reported in another cost reporting period if a hospital changes its methodology. In response to the request for clarification that the choice of methodology is to be made by the hospital, not the fiscal intermediary or MAC, we reiterate that under the proposed policy, the provider may choose one of the three methodologies proposed. The fiscal intermediary or MAC would not choose a methodology for the hospital, but would have the authority to make an adjustment to ensure that no inpatient days are counted more than once in any cost reporting period. This adjustment would not affect the methodology chosen by the hospital for that or any subsequent cost reporting periods.

In response to the commenters question about existing Medicare policy with respect to aggregating inpatient days for the numerator of the Medicaid fraction of the DPP, we agree with the commenters' statement that the fiscal intermediary or MAC should not revise cost reports to reflect any methodology other than date of discharge under the existing policy.

Comment: Several commenters expressed concern that ''hospitals would be allowed to manipulate calculations from year to year'' and that there was a need to ''avoid hospitals 'gaming' the system.'' These commenters stressed the importance of consistency in the calculations over time. One commenter suggested that CMS should not allow hospitals to change methodologies, but insist that hospitals make a one-time election of methodology. Another commenter recommended that, instead of allowing hospitals to choose a methodology, CMS should select the methodology that hospitals should use to accumulate inpatient days in the numerator of the Medicaid fraction of the DPP of the Medicare DSH calculation. Another comment recommended that CMS should require hospitals to follow its State Medicaid agency's methodology. The commenter stated that this would be ''easier in terms of administration and verification of days,'' particularly for hospitals that serve Medicaid patient populations from multiple States. Another commenter suggested that CMS ask hospitals to submit their choice of methodology each year with the rationale for their choice to ensure that the decision to change their methodology is based on necessity. In addition, they asserted that the onus should rest on the hospitals to ensure that they are not ''double counting'' or claiming days to which they are not entitled.

Response: We agree that consistency in the calculations so that no ''double counting'' of days occurs from one cost reporting period to the next is important. In light of public comments supporting our proposal, we disagree that CMS should select the methodology for counting days in the numerator of the Medicaid fraction of the DPP, or require a hospital to follow its State Medicaid agency's methodology, or only allow hospitals to make a one-time election. We continue to believe in the appropriateness of providing hospitals with the flexibility to report Medicaid-eligible days in the numerator of the Medicaid fraction of the DPP of a cost reporting period based on date of admission, date of discharge, or dates of service, effective for cost reporting periods beginning on or after October 1, 2009. For example, if CMS were to select a methodology that differed from a hospital's current methodology and there was no ''double counting'' by the hospital because it had been using one methodology consistently, this would not improve the accuracy of the patient days reported in the numerator of the Medicaid fraction of the DPP but could potentially introduce an administrative burden on the hospital. Another example relates to if a State Medicaid agency were to change the method of verification they currently use. If CMS were to require a hospital to make a one-time election, and the hospital made an election that was identical to the State Medicaid agency's methodology, and the State Medicaid agency changed its methodology, the hospital would no longer have the flexibility to accumulate these days based on the State Medicaid agency's methodology to ensure the accuracy of the Medicaid fraction of the DPP calculation. We reaffirm that, under the proposed policy, hospitals would be permitted to change the methodology they employ from one cost reporting period to the next, to be effective on the first day of their cost reporting period for the entire period, so long as they notify the fiscal intermediary or MAC in writing at least 30 days before the beginning of their cost reporting period for which the change would take effect.

We note that other commenters supported the proposed policy in that it would provide hospitals with the flexibility to choose one of three methodologies to report Medicaid-eligible days. Allowing hospitals the flexibility to use date of discharge, date of admission, or dates of service but precluding ''double counting'' of days from year to year should a hospital choose to change methodologies will assure accuracy in the calculation. This would allow hospitals the ability to accommodate a State Medicaid agency's methodology but not necessarily require them to change their current methodology. The burden to report the correct number of patient days on its cost report remains with the hospital. In addition, under § 412.106(b)(4)(iii) of

the regulations, we specify that, with respect to the Medicaid fraction, ''the hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.'' This responsibility for verification exists without regard to how a State Medicaid agency may accumulate information. In other words, if a hospital were to accept its State Medicaid agency's methodology, it would still be required to verify with the State the patient's eligibility during each claimed patient day. Finally, while we agree that there could be merit to collecting information from hospitals regarding their choice of methodology and rationale for such choice, we seek to be reasonable about the administrative burden placed on both hospitals and the fiscal intermediaries or MACs.

As we indicated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24188 through 24189), we believe that date of discharge, date of admission, or date of service will appropriately capture all inpatient days in which an individual was Medicaid-eligible for a hospital for the purpose of counting days in the numerator of the Medicaid fraction used in the DPP. Because we believe all three methodologies could appropriately capture all relevant days, and our focus is generally only when ''double-counting'' occurs because hospitals change the methodology they use to count days in the numerator of the Medicaid fraction from one cost reporting period to the next, we do not believe that it is necessary for hospitals to submit to CMS the rationale for their change should they change methodologies.

We also agree that the burden remains on the hospital to ensure that the hospital is not ''double counting'' days and reporting the correct number of patient days on their cost report. We believe that ensuring that hospitals are not double counting days should they choose to change methodologies is supported by existing DSH regulations as well as cost reporting requirements which state that hospitals must attest to the accuracy of the data that they submit on the cost report. However, we reiterate that the fiscal intermediary or MAC still has the authority to make any necessary adjustments to the number of days that the hospitals submitted on its cost report, to the extent that such days were already counted in another cost reporting period. Because existing policy with respect to accumulating days in the numerator of the Medicaid fraction of the DPP requires that the days be accumulated based on the date of discharge, if a hospital does not send the fiscal intermediary or MAC a written notice at least 30 days prior to the start of its next cost reporting period, CMS and the fiscal intermediary or MAC may presume that the hospital will accumulate inpatient days in the numerator of the Medicaid proxy of the Medicare DPP using the date of discharge.

Comment: Several commenters asked for clarification about when a hospital must notify CMS and what the hospital must provide in that notification. In particular, one commenter noted that, in a May 6, 2009 Hospital Open Door Forum, it was stated that hospitals should provide notification to CMS if they used a methodology other than date of discharge.

Response: We reiterate that our proposed policy would require hospitals to submit the written notification to the fiscal intermediary or MAC at least 30 days prior to the beginning of the cost reporting period in which the requested change would apply. If a hospital is not changing the methodology that it uses, it is not required to notify the fiscal intermediary or MAC. Should a hospital choose to change its methodology, we require the hospital to provide written notification that specifies the new methodology the hospital wishes to use and the cost reporting period to which the requested change would apply. Because our current policy is that hospitals must report these days in the numerator of the Medicaid fraction by date of discharge, in the absence of such written notification, the fiscal intermediary or MAC may determine that the hospital is reporting these days using date of discharge and act accordingly to ensure that Medicaid patient days are not ''double counted'' in the numerator of the Medicaid fraction of the DPP for cost reporting periods beginning on or after October 1, 2009.

Comment: Some commenters asked that CMS further clarify the methodology for determining total patient days in the denominator of the Medicaid proxy for the Medicare DSH calculation.

Response: Our proposal made no changes to the way in which CMS requires hospitals to accumulate total patient days for the denominator of the Medicaid fraction of the DPP for the Medicare DSH calculation.

After consideration of the public comments we received, we are finalizing, without modification, our proposal to revise our existing policy by adding a new paragraph (iv) to § 412.106(b)(4) to allow hospitals to report days in the numerator of the Medicaid fraction of the DPP of the Medicare DSH calculation based on one of three methodologies. Specifically, we are finalizing our proposal that a hospital may report Medicaid-eligible days in the numerator of the Medicaid fraction of the DPP of a cost reporting period based on date of admission, date of discharge, or dates of service. The policy change is effective for cost reporting periods beginning on or after October 1, 2009. A hospital is required to notify CMS (through the fiscal intermediary or MAC) in writing if the hospital chooses to change its methodology of counting days in the numerator of the Medicaid fraction of the DPP of the Medicare DSH calculation and must submit its written notification at least 30 days prior to the beginning of the cost reporting period to which the requested change would apply. The written notification must specify the changed methodology the hospital wishes to use and the cost reporting period to which the requested change would apply. As of the effective date of this policy, in the absence of such written notification, we clarify that CMS, the fiscal intermediary, or the MAC will determine a hospital to be using date of discharge and act accordingly to ensure that Medicaid patient days are not 'double counted' in the numerator of the Medicaid fraction of the DPP for cost reporting periods beginning on or after October 1, 2009. In addition, we proposed that if a hospital changes its methodology for counting days in the numerator of the Medicaid fraction, CMS, or the fiscal intermediary or MAC, would have the authority to adjust the inpatient days reported by the hospital in a cost reporting period to prevent ''double counting'' of days in the numerator of the Medicaid fraction of the DPP of the Medicare DSH calculation reported in another cost reporting period. Further, we are finalizing our proposed policy that a hospital would only be permitted to make such a change effective on the first day of the beginning of a cost reporting period and the change would be effective for the entire cost reporting period; that is, a hospital would not be permitted to change its methodology in the middle of a cost reporting period. This change would also be effective for all subsequent cost reporting periods unless the hospital submits a subsequent notification to change its methodology for a future cost reporting period following the procedures discussed above.

4. Policy Change Relating to the Exclusion of Observation Beds and Patient Days From the Medicare DSH Calculation

a. Background

Observation services are defined in the Medicare Benefit Policy Manual (Publication No. 100–02, Chapter 6, section 20.6A) as a ''well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment.'' Observation services are furnished by a hospital and include the use of a bed and periodic monitoring by a hospital's nursing or other staff in order to evaluate an outpatient's condition and/or to determine the need for a possible admission to the hospital as an inpatient. As discussed in section 20.6A of the Medicare Benefit Policy Manual, when a physician orders that a patient be placed under observation care but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient. Consequently, the costs incurred for patients receiving observation services are not generally recognized under the IPPS as part of the inpatient operating costs of the hospital. In some circumstances, observation services, although furnished to outpatients, are paid as part of an MS–DRG under the IPPS. In particular, section 1886(d) of the Act sets forth the payment system, based on prospectively determined rates, for the operating costs of inpatient hospital services, which are defined under section 1886(a)(4) of the Act to include ''the costs of all services for which payment may be made under this title that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary).'' As further explained in section 40.3 of Chapter 3 of the Medicare Claims Processing Manual (Publication 100–04), if a hospital outpatient receives diagnostic preadmission services that are related to a patient's hospital admission such that there is an exact match between the principal diagnosis for both the hospital outpatient claim and the inpatient stay, there is no payment for the diagnostic preadmission services under the hospital OPPS. Rather, these preadmission outpatient services are rolled into the particular MS–DRG and paid under the IPPS.

Our policy prior to October 1, 2003, as discussed in the FY 2004 IPPS final rule (68 FR 45418), had been to exclude all observation days from the available bed and the patient day counts. CMS clarified that if a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the days that those beds are used for observation services are to be excluded from the bed day count (even if the patient is ultimately admitted as an acute inpatient).

In the FY 2004 IPPS proposed rule (68 FR 27205 through 27206), we also proposed to amend our policy with respect to observation days for patients who are ultimately admitted for inpatient acute care. Specifically, we proposed that if a patient is admitted as an acute inpatient subsequent to receiving outpatient observation services, the days associated with the observation services would be included in the available bed and patient day counts. We did not finalize this policy until the FY 2005 IPPS final rule (69 FR 49096 through 49098) when we revised our regulations at § 412.105(b)(4) and § 412.106(a)(1)(ii) to specify that observation days are to be excluded from the counts of both available beds and patient days, unless a patient who receives outpatient observation services is ultimately admitted for acute inpatient care, in which case the bed days and patient days would be included in those counts. In implementing this policy, we revised Worksheet S–3, Part I of the Medicare hospital cost report by subscripting columns 5 and 6 to create columns 5.01 and 5.02, and 6.01 and 6.02, to allow for separate reporting of observation days for patients who are subsequently admitted as inpatients and a separate line for observation days for patients not admitted. This policy change applied to all cost reporting periods beginning on or after October 1, 2004.

b. Proposed and Final Policy Change

As we previously indicated, a patient who is receiving observation services is a hospital outpatient, and the costs associated with those services are paid under the OPPS in most circumstances. If, however, a patient receives observation services from a hospital and the outpatient observation care that he or she receives is related to the admission such that there is an exact match between the principal diagnosis for both the hospital outpatient claim and the inpatient stay, a payment is not made to the hospital under the OPPS, as explained in section 40.3–C of Chapter 3 of the Medicare Claims Processing Manual. According to section 40.3–C of the Medicare Claims Processing Manual, these preadmission outpatient diagnostic and nondiagnostic services are ''deemed to be inpatient services, and included in the inpatient payment, unless there is no Part A coverage.'' By this, we mean that such preadmission services are considered operating costs of hospital inpatient services for payment purposes only, as described in section 1886(a)(4) of the Act. That is to say, payment for these preadmission services, which can include services furnished while a hospital outpatient is under observation who is later admitted as an inpatient, is included within the per case inpatient payment if the services meet the statutory criteria described in section 1886(a)(4) of the Act. However, these services are still services furnished to patients who are outpatients of the hospital at the time those services are furnished. We note that although these preadmission services may be considered operating costs for hospital inpatient services for payment purposes, such services are not furnished to an inpatient because these services are furnished prior to the patient being formally admitted and, therefore, the associated day is not considered to be an inpatient day. Thus, even if payment for these preadmission services is included in the inpatient payment, the admission date for the inpatient stay begins when the patient is formally admitted. Because observation services are services furnished to outpatients of the hospital, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24189 through 24191), we proposed that the patient days during which observation services are furnished are not included in the DSH calculation, regardless of whether the patients under observation are later admitted. We believe that patient days during which observation services are furnished, like the days during which preadmission diagnostic and nondiagnostic services are furnished, are not inpatient days and, therefore, we proposed to exclude such patient days from the DPP of the Medicare DSH calculation.

In accordance with section 1812(a) of the Act, for a patient day to be considered part of a beneficiary's spell of illness, the patient must have had ''inpatient hospital services furnished to him during such spell.'' In addition, section 1861(a) of the Act defines a ''spell of illness'' as beginning on the first day on which such ''individual is furnished inpatient hospital services.'' Section 1861(b) of the Act defines

''inpatient hospital services'' as ''services furnished to an inpatient of the hospital.'' Thus, with respect to a spell of illness, even if observation services are eventually bundled into the inpatient payment, the patient is not admitted as an inpatient while he or she remains under observation and the days under observation are not considered to be inpatient days that count toward a beneficiary's spell of illness. In addition, with respect to the 3-day inpatient stay requirement for patients to secure Medicare coverage of SNF benefits, section 20.1 of Chapter 8 of the Medicare Benefit Policy Manual (Publication No. 100–02) states: ''Time spent in observation status or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay, as a person who appears at a hospital's emergency room seeking examination or treatment or is placed on observation has not been admitted to the hospital as an inpatient; instead, the person receives outpatient services. For purposes of the SNF benefit's qualifying hospital stay requirement, inpatient status commences with the calendar day of hospital admission.'' Other Medicare policies do not consider observation days to be inpatient days because observation services are outpatient services furnished to outpatients of the hospital. While other Medicare policies do not necessarily dictate how we treat patient days for DSH payment purposes, we believe it is important that patient days be treated consistently among the various Medicare policies. As we stated in the proposed rule, we believe that because observation days are not considered inpatient days for a beneficiary's spell of illness or for qualifying for SNF benefits, this policy provides additional support for our proposal to no longer include any observation day as an inpatient day in the calculation of the DPP of the Medicare DSH calculation, nor should the associated observation bed days be included in determining the number of available inpatient beds used for purposes of determining a hospital's IME and DSH payment adjustments.

As we indicated above, the DSH regulations at § 412.106 explain how the DPP is calculated. Specifically, the DPP is based on the hospital's patient days where patient days apply only to inpatient days. Because a patient under observation in the hospital is considered to be an outpatient of the hospital and receives services prior to being admitted as an inpatient, we believe that observation days, even for a patient who is subsequently admitted, should not be considered inpatient days. Accordingly, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24190), we proposed to revise the regulations at § 412.106(a)(1)(ii) to exclude patient days associated with beds used for outpatient observation services, even if the patient is later admitted as an inpatient. We proposed to exclude all observation patient days from the DPP of the Medicare DSH calculation. We proposed that this proposed provision would be effective for cost reporting periods beginning on or after October 1, 2009.

For the same reasons, we also proposed to eliminate counting observation bed days for patients who are subsequently admitted as inpatients for purposes of both the DSH payment adjustment and the IME payment adjustment. The rules for counting hospital beds for the purposes of the IME payment adjustment are codified in the IME regulations at § 412.105(b), which is cross-referenced in § 412.106(a)(1)(i) for purposes of the DSH payment adjustment. We believe it is important to apply a consistent definition for counting bed days for both the IME and DSH payment adjustments. Therefore, we proposed to revise § 412.105(b)(4) to state that observation days are excluded from the counts of available beds, regardless of whether or not the patient under observation is ultimately admitted for acute inpatient care.

As we stated earlier, when we implemented the policy to include observation days for admitted patients for DSH payment adjustment purposes for FY 2005, we revised the Medicare hospital cost report to include columns for hospitals to report their observation days for patients admitted as inpatients and observation days for patients not admitted. Under the proposal in the proposed rule, hospitals would no longer be required to distinguish on the cost report between observation bed days and patient days for patients who are ultimately admitted and observation bed days and patient days for patients who are not admitted because none of these bed days and patient days would be included in the DSH payment adjustment. We proposed that, effective for cost reporting periods beginning on or after October 1, 2009, hospitals would be required to report their total observation bed days so that the total observation bed days can be deducted from the total bed day count for IME and DSH payment adjustment purposes.

In summary, we proposed to exclude observation patient days for admitted patients from the patient day count in § 412.106(a)(1)(ii) (for DSH) and the bed day count at § 412.105(b) (for IME), as a cross-reference at § 412.106(a)(1)(i) (for DSH), because observation services are defined as outpatient services furnished to outpatients of the hospital, regardless of whether or not the patient under observation is subsequently admitted.

Comment: Several commenters opposed the proposal to exclude observation patient days for admitted patients from the DSH adjustment and observation bed days for admitted patients from the DSH and IME adjustment. Some commenters argued that because observation services for admitted patients are payable as part of the IPPS bundle, these observation patient days are part of the IPPS payment system and should be counted in the DSH adjustment. Some commenters contended that ''inpatient observation days are currently payable as part of the IPPS bundle, irrespective of whether the observation stay was immediately preceding the non-observation patient stay.'' Some commenters also believed that all observation days, regardless of whether the observation stay precedes an inpatient admission, should be included in the DSH adjustment. In addition, some commenters disagreed with CMS' reliance on other Medicare policies (for example, SNF 3-day stay, spell of illness) to justify excluding observation days from the DSH adjustment. Rather, they asserted that CMS should rely on the inpatient payment rules to determine whether days associated with observation services should be included in the DSH adjustment.

Another commenter disagreed with the proposal to exclude observation days and beds for admitted patient from the DSH adjustment, citing that it goes against Congressional intent. The commenter asserted that when Congress developed the Medicaid ratio for DSH, there was no distinction of observation days. Rather, according to the commenter, all days were considered inpatient days although the services the patient received were what we now consider to be observation services. The commenter believed that the proposal to exclude observation days for admitted patients from the DSH adjustment will discourage the use of observation services, which the commenter believed is an effective and efficient way to deliver health care.

One commenter believed that the proposal to exclude observation days from the DSH adjustment was contradictory. The commenter contended that it is a contradiction that observation services furnished prior to admission can be considered as

inpatient operating costs for payment purposes, but the observation days and beds are not considered an inpatient day or available inpatient bed for the purposes of IME or DSH payment adjustment.

Response: We disagree with the commenters that patient days and beds associated with observation services should continue to be included in the Medicare DSH adjustment. According to the DSH regulations at § 412.106, the DPP is based on the hospital's inpatient days. Observation services, as described above, are, by definition, outpatient services. Because a patient under observation in the hospital is considered to be an outpatient of the hospital and can receive services prior to being admitted as an inpatient, we believe that observation days, even for a patient who is subsequently admitted, should not be considered inpatient days and should not be included in the DPP.

Our policy to exclude observation patient days and observation bed days from the DSH adjustment is not intended to discourage the use of observation services. Rather, it is to ensure that our DSH adjustments are appropriately including only inpatient days and inpatient beds. Because DSH and IME policies use the same methodologies and reference the same regulation to count beds (§ 412.105(b)), and because we are excluding all observation beds from the DSH adjustment, they would be excluded from the IME adjustment. We do not believe that excluding observation bed days and observation patient days from the DSH adjustment (and, because of the cross-referencing of § 412.105(b) under § 412.106(a)(1)(i), excluding observation bed days from the IME payment adjustment) goes against Congressional intent. Because the DSH payment adjustment is part of the IPPS, it is our interpretation that under section 1886(d)(5)(F) of the Act, DSH statutory references of ''days'' apply only to inpatient days. Thus, we do not believe that patient days associated with observation services, defined as outpatient services, should be counted as an inpatient day and included in the DPP of the Medicare DSH calculation. Furthermore, we generally treat inpatient bed days in the DSH adjustment and the IME adjustment consistently; therefore, because we are excluding observation bed days from the DSH adjustment, we are excluding observation bed days from the IME adjustment.

We also disagree with the commenters' assertion that the proposal to exclude observation patient days and bed days from the DSH adjustment has solely been based on the treatment of observation days under other Medicare payment policies. In our discussion in the proposed rule that we believed patient days associated with observation services were not inpatient days for purposes of the Medicare DSH adjustment, we found that other Medicare policies also did not treat days associated with observation services as inpatient days. Specifically, we found that a Medicare beneficiary's ''spell of illness'' is defined under section 1812(a) of the Act as beginning on the first day on which such ''individual is furnished inpatient hospital services'' and days under observation do not count towards a beneficiary's spell of illness. In addition, days associated with patients who are under observation do not count toward the 3-day inpatient stay requirement for patients to secure Medicare coverage of SNF benefits as described in this preamble. We did not solely rely on these other Medicare policies to determine that observation days are not inpatient days, but we believe that patient days should generally be treated consistently across Medicare payment policies when possible and appropriate.

Finally, we do not believe it is contradictory that observation services can be bundled in the IPPS payment while the patient days associated with observation services are not considered inpatient days. As described above, the patient receiving the observation services (which are not unlike any other preadmission service) is receiving an outpatient service and, therefore, the patient is considered an outpatient of the hospital. Accordingly, given that the patient days associated with such observation services (or any preadmission service) are not considered inpatient days, we now believe that such days should not be included in the Medicare DSH adjustment.

Comment: Several commenters supported the proposal to exclude observation patient days and bed days from the DSH adjustment and observation bed days from the IME payment adjustment. One commenter supported the proposal because the commenter believed that patients who receive observation services are hospital outpatients, and therefore their patient days should not be included in the DSH payment adjustment. Other commenters expressed support of the proposal because it would simplify reporting for hospitals.

Response: We thank the commenters for their support of our proposal. We agree that patients receiving observation services, which occur prior to the patient being admitted as an inpatient to the hospital, are outpatients of the hospital, and therefore, we now believe that these patient days should not be considered inpatient days and included in the DSH payment adjustment. We are finalizing our policy to exclude all observation patient days and bed days from the DSH adjustment and observation bed days from the IME adjustment as proposed, without modification.

Comment: One commenter supported the proposal to exclude observation beds and patient days for admitted patients from the Medicare DSH calculation because reporting the data was burdensome on hospitals. The commenter recommended that CMS apply this policy change to prior years.

Response: We thank the commenter for its support of our proposal to no longer include observation patient days and bed days for admitted patients from the DSH payment adjustment calculation. We cannot apply this policy change to prior years because we do not apply policy changes retroactively. The effective date of the policy change is for cost reporting periods beginning on or after October 1, 2009.

Comment: One commenter questioned how the observation beds and patient days would be excluded from the IME and DSH payment adjustment calculations. The commenter cited the proposed rule in which we stated: ''We are proposing that, effective for cost reporting periods beginning on or after October 1, 2009, hospitals would be required to report their observation bed days so that total observation days can be deducted from the bed day count for IME and DSH payment adjustment purposes''. The commenter requested clarification on this statement because patient days reported on the cost report on Worksheet S–3, Lines 1–12, Columns 4, 5, and 6 do not include observation days and that Medicaid patient days and total patient days used in the Medicaid DPP of the Medicare DSH calculation exclude observation bed days. In addition, the commenter stated that observation bed days reported on Worksheet S–3, Line 26 should not be included in the DSH calculation and that it would be incorrect to deduct total observation days from Medicaid patient days or total patient days.

Response: Currently, we include observation patient days for admitted patients in the Medicare DSH DPP. Hospitals currently report total hospital observation bed patient days, observation patient days for patients who are admitted, and observation patient days for patients who are not admitted on the Medicare hospital cost

report. In addition, hospitals report on the Medicare hospital cost report total Medicaid observation patient days, Medicaid observation patient days for patients who are admitted, and Medicaid observation patient days for patients who are not admitted. This information is reported on Worksheet S–3, Part I, Line 26, Columns 5, 5.01, 5.02, 6, 6.01 and 6.02. Currently, we add Medicaid observation patient days for admitted patients to the numerator of the Medicaid fraction of the DPP, and we add total observation patient days for admitted patients to the denominator of the Medicaid fraction of the DPP. The commenter is correct that observation patient days for admitted patients would not be deducted from the numerator or denominator of the Medicaid fraction; rather, we would no longer include observation patient days for admitted patients in the patient day counts in the DPP of the Medicare DSH calculation for cost reporting periods beginning on or after October 1, 2009.

However, to determine available bed days for DSH and IME purposes, observation bed days would need to be deducted from total available bed days. Currently, total bed days available (reported on Worksheet S–3, Part I, Line 12, Column 2) include all observation bed days (for both admitted and nonadmitted patients). Under the current policy where we include observation bed days for admitted patients, we deduct observation bed days for patients not admitted from the total available bed day count. However, effective for cost reporting periods beginning on or after October 1, 2009, to ensure that we no longer include any observation bed days in the bed day count for IME and DSH purposes, we would deduct all observation bed days (reported on Worksheet S–3, Part I, Line 26, Column 6) from the total bed days available (reported on Worksheet S–3, Part I, Line 12, Column 2).

Finally, the cost report will be changed to accommodate this policy change once this final rule is published.

After consideration of the public comments we received, we are finalizing our proposal, without modification, to exclude observation patient days for admitted patients from the patient day count at § 412.106(a)(1)(ii) (for DSH) and the bed day count at § 412.105(b) (for IME), as cross-referenced at § 412.106(a)(1)(i) (for DSH). The policy change is effective for cost reporting periods beginning on or after October 1, 2009.

5. Public Comments That Are Out of the Scope of the Proposed Rule

We received a number of public comments on DSH-related issues regarding appeals or pending litigation on the Medicare fraction and the inclusion of Medicare managed care patient days in the Medicare DSH calculation, for which we did not include any proposed changes in the proposed rule. We are not summarizing these comments in detail nor providing responses to the comments because we consider them to be out of the scope of the provisions of the proposed rule.

F. Technical Correction to Regulations on Payments for Anesthesia Services Furnished by Hospital or CAH Employed Nonphysician Anesthetists or Obtained Under Arrangements (§ 412.113)

Section 412.113(c) of the regulations contains our rules governing payments for anesthesia services furnished by a hospital or CAH by qualified nonphysician anesthetists employed by the hospital or CAH or obtained under arrangements. We have discovered that, under paragraph (c)(2)(i)(B) of § 412.113, there is an incorrect cross-reference to ''§ 410.66'' for the definition of a qualified nonphysician anesthetist. The correct cross-reference for the definition of a qualified nonphysician anesthetist is ''§ 410.69''. As we proposed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24191), we are correcting the cross-reference in § 412.113(c)(2)(i)(B) to refer to ''§ 410.69''. We did not receive any public comments on this proposal.

G. Payments for Direct Graduate Medical Education (GME) (§§ 413.75 and 413.79)

1. Background

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of hospital inpatient services. Section 1886(h) of the Act, as implemented in regulations at § 413.75 through § 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved GME programs. Section 1886(h)(2) of the Act sets forth a methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable direct costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983, through September 30, 1984). Medicare direct GME payments are calculated by multiplying the PRA times the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days. The base year PRA is updated annually for inflation.

Section 1886(h)(4)(F) of the Act established a limit on the number of allopathic and osteopathic FTE residents that a hospital may include in its FTE resident count for purposes of calculating direct GME payments. For most hospitals, the limit, or cap, is the unweighted number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996.

2. Clarification of Definition of New Medical Residency Training Program

For purposes of determining direct GME and IME payments, the Medicare statute establishes a cap on the number of allopathic and osteopathic FTE residents a hospital may count, which, for most hospitals, is based on the number of allopathic and osteopathic FTE residents the hospital was training in its most recent cost reporting period ending on or before December 31, 1996. Section 1886(h)(4)(H)(i) of the Act requires the Secretary to prescribe rules for the application of the FTE resident cap in the case of medical residency programs that are established on or after January 1, 1995. This provision is applicable for purposes of the IME adjustment under the IPPS through section 1886(d)(5)(B)(viii) of the Act. The provision specifies that such rules must be consistent with the principles of the statutory provisions regarding the establishment of the FTE resident caps and regarding application of a 3-year rolling average count of FTE residents. The statute also requires the Secretary to give special consideration in such rules to facilities that meet the needs of underserved rural areas. Accordingly, we issued regulations to permit adjustments to the FTE resident caps, under certain circumstances, for hospitals that establish new medical residency training programs on or after January 1, 1995. Section 413.79(e)(1) of the regulations state that if a hospital had no allopathic or osteopathic residents in the base year, the hospital may receive an adjustment to its FTE resident cap (which otherwise would be zero) if it establishes one or more new medical residency training programs, but only for new programs established within 3 academic years after residents begin training in the first new program.

(Rural hospitals may receive FTE cap adjustments for newly established programs at any time under the regulations at § 413.79(e)(1)(iii)). Under § 413.79(e)(2), hospitals that had allopathic or osteopathic residents in the base year were permitted to receive an adjustment for new programs, but only if the new programs were established on or after January 1, 1995, and before August 5, 1997. Section 413.79(l) defines a new medical residency training program as ''a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.'' These regulations concerning cap adjustments for newly established medical residency training programs also apply for IME purposes as stated at § 412.105(f)(1)(vii).

As we discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24191), it has come to our attention that there has been some misinterpretation or misunderstanding of these regulations among some hospitals and Medicare contractors despite previous discussions of the topic in the **Federal Register**. Specifically, some hospitals or contractors took the regulations to mean that, as long as the relevant accrediting body (either the Accreditation Council on Graduate Medical Education (ACGME) for allopathic programs or the American Osteopathic Association (AOA) for osteopathic programs) grants an ''initial'' accreditation or reaccredits a program as ''new,'' the hospital may receive an FTE cap adjustment for that program, regardless of whether that program may have been accredited previously at another hospital. In other words, some hospitals and contractors appear to have read our regulations to mean that the Secretary would defer, in all circumstances, to the relevant accrediting body's identification of a particular accreditation as a ''new'' or ''initial'' accreditation of a medical residency training program.

In the FY 1998 IPPS final rule that established § 413.79(1) of the regulations, we discussed both the meaning of this regulation and the rationale for establishing it:

''For purposes of this provision, a 'program' will be considered newly established if it is accredited for the first time, including provisional accreditation on or after January 1, 1995, by the accrediting body. Although the Secretary of the Department of Health and Human Services has broad authority to prescribe rules for counting residents in new programs, the Conference Report for Public Law 105–33 [House Conference Report No. 105–217, pp. 821–822] indicates concern that the aggregate number of FTE residents should not increase over current levels.'' (62 FR 46006)

Similarly, in the FY 2000 IPPS final rule (64 FR 41519), we responded to a public comment suggesting that CMS include within the definition of ''new residency program'' a residency program that may have been in existence at other clinical sites in the past. We replied that ''the language 'begins training residents on or after January 1, 1995' [in the regulation at § 413.79(1)] means that the program may have been accredited by the appropriate accrediting body prior to January 1, 1995, but did not begin training in the program until on or after January 1, 1995. The language does *not* mean that it is the first time a particular hospital began training residents in a program on or after January 1, 1995, *but that program was in existence at another hospital prior to January 1, 1995, as the commenter suggests.''* (Emphasis added.)

Accordingly, as we have suggested in discussions in our previous rules, rather than relying solely on the accrediting body's characterization of whether a program is new, we continue to believe it is appropriate that CMS require a hospital to evaluate whether a particular program is a newly established one for Medicare GME purposes by considering whether a program was initially accredited ''for the first time,'' and is not a program that existed previously at another hospital. In evaluating whether a program is truly new, as opposed to an existing program that is relocated to a new site, it is important to consider not only the characterization by the accrediting body, but also supporting factors such as (but not limited to) whether there are new program directors, new teaching staff, and whether there are only new residents training in the program(s) at the different site. In determining whether a particular program is a newly established one, it may also be necessary to consider factors such as the relationship between hospitals (for example, common ownership or a shared medical school or teaching relationship) and the degree to which the hospital with the original program continues to operate its own program in the same specialty. (Although this discussion of new programs is framed in the context of a hospital operating a program, we note that many programs are operated or sponsored by schools of medicine or other nonhospital entities. This section is intended to address all GME programs that were previously accredited at one operating entity, and that entity ceases to operate the program, but the program is then opened and operated at another entity, even if it is accredited as a new program at the second entity. Such a program may not be treated as new at the second entity.) In any case, we believe it is appropriate to be deliberate in the determinations regarding FTE resident cap adjustments relating to residents in new programs. The statute clearly requires that our rules regarding adjustments to hospitals' FTE resident caps for newly established programs must adhere to the principles of the statutory provision limiting the count of FTE residents for direct GME and IME payments to the count for the most recent cost reporting period ending on or before December 31, 1996. In addition, as we indicated in our final rule establishing FTE cap adjustments for ''new programs,'' the Conference Report for the BBA explicitly indicates that the aggregate number of FTE residents should be held to the ''current'' levels at the time the BBA was enacted (House Conference Report No. 105–217, pp. 821–822).

If we were to find that a program at one hospital is a newly established program merely because it was relocated from another hospital, the result would be that an FTE resident cap adjustment would be granted based on the same program at two different hospitals. Furthermore, if both hospitals continue to operate, the FTE resident cap slots that were vacated from the program at the first hospital could potentially be filled with residents from that hospital's other residency training programs. We do not believe such an increase in the aggregate number of FTE residents and the potential duplication of the FTE resident cap adjustment would be consistent with the statutory mandate to adhere to the principles of the base-year FTE resident caps when devising rules to account for newly established medical residency training programs. Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24192), we proposed to clarify our policy that a new medical residency program is one that receives initial accreditation for the first time, as opposed to reaccreditation of a program that existed previously at the same or another hospital. Furthermore, we indicated that we believe it is appropriate and necessary that CMS expect a hospital that wishes to claim an adjustment to its direct GME and IME FTE caps based on residents training in a medical residency program to first evaluate whether the program is ''new'' for Medicare purposes, rather

than to rely exclusively on the characterization of a particular program by the relevant accrediting body.

Comment: Several commenters were hospitals that have been notified by CMS, through their fiscal intermediaries, that their residency training programs were not new and, therefore, the hospitals' FTE resident caps should not have been adjusted under § 413.79(e)(1). These programs were continuations of residency programs that existed at other hospitals. One commenter maintained that its program is separate and distinct from the program that existed and closed at the other hospital. The commenter had provided CMS with evidence to support its belief. Another commenter had already taken steps to address the problem posed by its continuation of existing programs by creating a consortium model for new residency programs that differs greatly from the original models. The commenters also stated that funding from Medicare is vital to the success of the programs and is necessary for combating the shortage of primary care physicians. They urged CMS to reverse its initial position and retroactively restore the hospital's direct GME and IME payments.

Response: If the hospitals disagree with our decision, they may appeal these determinations through the administrative appeals process. Rather than discuss the specifics of these determinations in this response, we will address the commenters' concerns in general, in the context of the policy clarification. In determining whether a particular residency training program is new, the relevant fiscal intermediary/MAC and CMS review the characteristics of the residency program in question, considering all of the relevant criteria discussed earlier to determine whether there has been a transfer of a previously existing program to another hospital. Where we find that the facts point to the conclusion that a program is not a new program, we determine that the hospital does not qualify for the FTE cap increase for new medical residency programs. We understand that in some cases external factors unrelated to the medical school or hospital may contribute to this transfer of a program to another hospital, and we are also very aware of the fact that hospitals rely on Medicare funding for residency programs. However, as discussed above, we wish to ensure that FTE cap increases for new programs are only awarded to programs that are truly new.

Comment: Some commenters asked about the proper course of action for a provider to follow if it has received payment relating to residents in a ''new program,'' even though those residents would not be considered to be training in new programs based on factors detailed in the proposed rule, and the cost reports are within the 3-year reopening period, the issue is under appeal, or the cost report is currently being reopened.

Response: If a fiscal intermediary or MAC identifies a teaching hospital that has received IME and direct GME payments relating to residents in a program that is treated as new, but the program is, in fact, a transfer of an existing program in accordance with the factors outlined in this final rule, the fiscal intermediary or MAC may reopen cost reports that are still within the 3-year reopening period and recover overpayments accordingly. If the issue is already under appeal, the appeal may proceed according to normal procedures.

Comment: Several commenters stated that CMS' proposed clarification of the definition of a new residency program is, in fact, not a clarification, but a ''major change to longstanding agency policy.'' The commenters expressed concern that CMS is retroactively imposing its new interpretation of ''supporting factors,'' which was never previously published in agency guidance, to deny hospitals an adjustment to their FTE resident caps for new programs when they followed the existing regulations in good faith. The commenters asserted that residency programs will no longer be able to qualify as new based on what the commenters argued is the literal, simple meaning of the regulatory phrase (that is, ''initial accreditation by the appropriate accrediting body'') but, instead, they will have to meet ''new and ambiguous criteria in the form of 'supporting factors.' '' The commenters argued that the new policy will result in more confusion because the ''supporting factors'' will lead to subjective determinations, particularly if a hospital's program meets some, but not all, of the factors. Several commenters urged CMS to withdraw the ''confusing, arbitrary, retrospective 'clarification' '' regarding what constitutes a new residency program, and instead establish a prospective, definitive process that is consistent with the prospective payment system under which hospitals should know up front what qualifies as a ''new'' program for purposes of direct GME and IME payments.

Commenters also remarked that there is no legal authority for the proposal in relevant statutes and legislative history, and that no change in law or regulation has prompted these clarifications. The commenters stated that the proposal is inconsistent with regulations at § 413.79(e) and (l), and that the changes are self-serving and ''intended to support CMS's position in currently pending litigation.'' Another commenter expressed concern that CMS is shifting the responsibility for determining what constitutes a new program to a hospital without giving the hospital a way to receive formal approval *before* the hospital begins to operate the program and potentially is subject to disallowances or overpayments. The commenter believed the current practice of allowing the accrediting body to make a formal determination beforehand is appropriate, but if CMS chooses to finalize this ''new'' policy, the commenter recommended that CMS establish a more definitive process that allows prior approvals to minimize uncertainty among hospitals.

Response: We disagree with the commenters that the policy discussed in the proposed rule is not a clarification but instead is a ''major'' policy change. A significant principle that we must consider in implementing a policy on what constitutes a new medical residency program for purposes of establishing new FTE resident caps is that the aggregate number of FTE residents should not increase unnecessarily over the numbers of residents being trained at the time the BBA was passed. To that end, it is important to ensure that FTE cap adjustments are not made for programs that are not actually new, that is, programs that have existed previously at another hospital. As discussed above, we articulated this point in the **Federal Register** at least as early as the FY 2000 IPPS final rule (64 FR 41519).

Further, while we acknowledge that it would be simple to rely solely on the accrediting body's determination as to whether a program is ''new,'' as we have explained above, we also recognize that the accrediting body may have very different reasons from CMS for designating a program as ''new.'' We continue to believe it is appropriate to look at factors in addition to the accrediting body's characterization of its accreditation to determine whether a particular program constitutes a new program. Certainly, a program that maintains the same program director, teaching staff, and residents but has only been moved to a different participating institution would not be considered a new program for Medicare purposes. We also do not believe that there is anything subjective about making determinations based on several ''supporting factors,'' as the commenter

suggests. On the contrary, we believe that taking a more thorough look at the characteristics of a program using an approach that considers multiple factors is more objective and ensures that FTE cap adjustments, which could increase the number of Medicare-funded training slots in the aggregate, will only be granted to qualifying teaching hospitals when warranted. The academic medical community will be able to consider these factors before making decisions related to opening, closing, or expanding programs. Through proper planning and consideration of these factors, teaching hospitals should be able to determine whether programs that have commonalities with previously existing programs may or may not qualify for FTE cap increases and associated Medicare IME and direct GME funding.

We also disagree with the commenter's suggestion that we lack the legal authority to implement this policy. The BBA and our regulations provide that hospitals are permitted to receive an FTE cap increase in order to start new programs, and CMS is the agency charged with administering these provisions. As such, it is our responsibility to provide guidance when we believe clarification is needed. Because it appears there has been some recent confusion surrounding this policy, we proposed to clarify our definition of a new program in the FY 2010 IPPS proposed rule. We believe the fact that there are pending reopenings, disallowances, and litigation relating to the definition of a new program only supports the need to clarify the policy at this time.

Comment: One commenter argued that because the phrase ''initial accreditation'' is a term of art used by the ACGME, it has a ''well understood meaning'' in the academic medical community, and the ''law is clear that the term as used in the regulation has the same meaning as is generally understood in the regulated community.'' The commenter believed that CMS likely was aware of the use of this term by the ACGME when CMS first promulgated the definition of a new medical residency program in the regulations, and CMS cannot decide after the fact that it was ''unwise to have adopted an industry term'' without complying with the APA's [Administrative Procedure Act's] directive for notice and comment rulemaking.

Response: We understand that ''initial accreditation'' is a term that is used by the ACGME and that the term was used by the ACGME before the time that the BBA was passed. Specifically, the ACGME describes ''initial accreditation'' as follows:

''Accreditation is conferred initially when a Review Committee determines that a proposal for a new program or sponsoring institution substantially complies with the requirements.

''(a) This initial cycle is considered a developmental stage during which the proposal for the new program or sponsoring institution will be fully developed and implemented * * *.

''(b) Initial accreditation may be granted to a new program or sponsoring institution or a previously-accredited program or sponsoring institution, which had had its accreditation withheld or withdrawn or has voluntarily withdrawn and has subsequently applied for re-accreditation * * *.''

We first provided a definition in the regulations for ''new medical residency training program'' in the final rule with comment period published in the **Federal Register** published on August 29, 1997, shortly following the passage of the BBA on August 5, 1997. We stated that a '' 'program' will be considered newly established if it is accredited *for the first time*, including provisional accreditation on or after January 1, 1995'' (emphasis added, 62 FR 46006). In the regulatory text, we defined ''new medical residency training program'' as ''a medical residency training program that receives *initial accreditation* by the appropriate accrediting body on or after July [sic] 1, 1995'' (emphasis added, 62 FR 46035). Because we used the phrase ''for the first time'' in the preamble, and the term ''initial accreditation'' in the regulations text, we believed it would be obvious that CMS did not rely on the definition of initial program as used by the ACGME. As defined by the ACGME, initial accreditation can be given to a program that was accredited previously. We did not give any indication that we were using the term ''initial accreditation'' as a term of art as used by the ACGME.

We next discussed new medical residency training programs in the May 12, 1998 final rule responding to public comments on the August 29, 1997 final rule with comment period (63 FR 263359). In response to public comments, we revised the definition of a ''new medical residency training program'' to mean ''a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.'' The purpose of the revision was not to revise the definition of the word ''initial'' but, rather, to include the situation of residency training that begins on or after January 1, 1995, because we recognized that hospitals usually do not begin training residents immediately upon receiving an accreditation letter. The definition has not been revised since then. Thus, this is the definition that is currently in the regulations at § 413.79(l).

Furthermore, it would not be appropriate for CMS to use a term of art if that term is unique to only one of the organizations that accredit GME programs. The graduate medical education community consists not just of the ACGME, but also includes the AOA (and the Commission on Dental Accreditation and the Council on Podiatric Medical Education). We believe that if, in fact, the term ''initial accreditation'' is an industry standard whose meaning is clearly understood by the academic medical community, we would expect it to be used by the AOA as well. However, we understand that the AOA does not use ''initial accreditation'' as a formal term with respect to identifying programs as new. In fact, we understand the AOA only uses the term ''accreditation'' with respect to approvals of sponsoring institutions (such as Osteopathic Postdoctoral Training Institutions (OPTIs)), while the term ''approval'' is the term that is applied to a new program when it is first recognized by the AOA.

Accordingly, given that the ACGME and the AOA use different terminology for accreditation status, we disagree with the commenter that the ''law is clear that the term as used in the regulation has the same meaning as is generally understood in the regulated community.'' We believe it is appropriate for us to use the term ''initial accreditation'' in our regulations and interpret it in a manner that reflects CMS' priorities. Unlike the ACGME which, based on its definition quoted above, may grant ''initial'' accreditation to a previously accredited program or to a program that applies for reaccreditation, we continue to interpret ''initial'' with respect to Medicare GME payment to mean ''for the first time.'' That is, as we stated in the August 29, 1997 final rule, a '' 'program' will be considered newly established if it is accredited *for the first time*, including provisional accreditation, on or after January 1, 1995'' (emphasis added, 62 FR 46006), and we continue to believe that FTE cap increases should be awarded to programs that are accredited ''for the first time,'' and not to programs for which granting new program status would create duplicate FTE slots.

Comment: One commenter remarked that hospitals already evaluate whether their teaching programs are sufficiently

new when they receive an initial letter of accreditation from the relevant accrediting body, as instructed by § 413.79(e)(1). The commenter also stated that those accrediting bodies are best positioned to determine whether or not a program is new; and a conflict of interest inherently exists when Medicare, which is not an expert in this area, makes that determination. Some commenters disagreed with CMS' statement in the proposed rule that CMS has provided this definition of new programs in previous regulations; and asserted that, if so, this proposal would not have been necessary. In addition, the commenters claimed that while the BBA indicated that Congress did not want the national cap level to increase above the levels at the time the BBA was passed, Congress did not require that CMS enact barriers to the creation of new residency programs, and CMS should recognize that the concern that there was a surplus of physicians at the time the BBA was passed is no longer relevant today.

Response: We recognize that the accrediting bodies are expert in identifying and ensuring programs that meet minimum standards for medical education. In fact, we recognize their expertise in our regulations regarding Medicare-approved residency training programs. However, accrediting bodies have different goals than CMS and may consider different factors when evaluating whether a particular residency training program is new. CMS is charged to protect the Medicare Trust Fund and carry out the relevant Medicare statutory provisions. Therefore, we must ensure that only appropriate cap increases are granted. Because our goals are not necessarily consistent with the goals of accrediting bodies, our perspective on the status of a program as ''new'' may sometimes differ from the accrediting bodies' assessment. In addition, we do not believe that a conflict of interest exists when we determine a residency program's new status. We are not dictating curricula requirements; rather, we simply wish to ensure that a program is truly new from Medicare's perspective before granting the hospital an increase in its FTE resident caps and the additional IME and GME funding that accompanies the increase.

We also disagree with the contention that our clarification will pose barriers to the establishment of new residency programs. Our proposal was intended to clarify Medicare policy with respect to the treatment of residency training programs when a previously existing program is involved. We continue to encourage the development of new training programs, and will continue to adjust hospitals' FTE resident caps for new programs in accordance with our regulations. However, we will only allow a hospital's FTE caps to be adjusted for programs that are truly new. In addition, as long as a national aggregate cap on FTE resident positions is in place, we continue to believe our policies should work to maintain that cap level.

Comment: One commenter expressed concern that CMS' criteria for identifying a new program could impinge on the quality of new programs by restricting their ability to hire experienced program directors and faculty, while also limiting the freedom of these individuals to teach and practice where they choose. The commenter argued that the ''mere presence'' of a program director or faculty member who worked for another residency training program does not make the second program identical to the first program; rather, the residents will have a different experience based on the clinical setting, regardless of who the director or teaching staff may be.

Response: It is not our intent to interfere with the direction of a medical education program or to inhibit the career choices of physicians. However, we disagree with the commenter that the ''mere presence'' of the same program director does not contribute to the similarity in a program that was operated at two sites. While it is true that each hospital setting provides somewhat of a different training experience, simply because no two hospitals are exactly the same, the implementation of the curriculum and the approach to teaching are very much influenced by the program director and the teaching staff. Moreover, when a program director (or faculty members) moves from a program that was in operation at one hospital to a program that is in operation at another hospital, we believe this strongly suggests that the second program is not a new one, but is the continuation of the first program. Therefore, in determining whether a program is new, we believe it is logical and appropriate to look at numerous factors, including whether the programs have in common the program directors and teaching staff.

Comment: Some commenters noted that, in the proposed rule, CMS used the term ''and/or'' in the list of supporting factors. Specifically, a residency program with a new program director and new residents, but also with some teaching staff who had taught at the ''original'' program, may or may not be considered ''new.'' The commenter argued that such rules are unclear, and may result in a situation where a hospital invests significant time and financial resources into what it believes is the creation of a new program, only to find out several years later that CMS does not believe the program is new. The commenters stated that if CMS believes that it must use the ''supporting criteria'' set forth in the proposed rule, then CMS should replace each use of the term ''and/or'' with the word ''and,'' and it should be added after each criterion, not just the first two. One commenter further stated that a determination of whether a program is ''new'' cannot be based on one single factor alone (such as the presence of a single program director from an ''original'' program). Instead, the commenter recommended that a program that is not new should be defined as one where, at a minimum, *all* of its program directors *and* faculty, *and* residents came from the ''original'' program, while still allowing the Secretary discretion to determine that such a program may still be new as a result of other circumstances. Another commenter asked whether a hospital must answer ''no'' to each of the supporting criteria or to just half of the criteria in order for the program to be considered new. Other commenters pointed out that medical schools can, and often do, support more than one program in the same specialty in different geographic areas of a State and with more than one hospital simultaneously. Therefore, the commenters added, CMS cannot assume that a second program in the same specialty is not a ''new medical residency training program.''

Response: We agree that the use of ''and/or'' in the list of supporting criteria could be confusing. Therefore, we are removing the ''or'' and only using ''and.'' Thus, the supporting factors to be considered in determining whether a program is new are (but not limited to) as follows:

—Is the program director new, and
—Is the teaching staff new, and
—Are there new residents?

We understand the commenters' concerns that these factors do not provide a test that is as clear as relying solely on a determination from the accrediting body. However, as explained earlier, we believe that our mission and goals are different from those of the accrediting bodies; and the ramifications of a determination as to whether a program is new for Medicare purposes are less significant to the accrediting bodies than they are to us. We also understand that, at least with the ACGME, a hospital has a fair

amount of latitude in requesting that an accrediting body accredits a program as a new program. We are wary of situations where one program has literally been moved in its entirety from one hospital to another, and is accredited as ''new'' in the second hospital. We believe that we must ensure that FTE cap increases are only made under appropriate circumstances. By employing these supporting factors, we will be able to gain a fuller picture of the program, and to make a determination based on case-specific evidence as to whether there are new program directors, new teaching staff, and new residents.

With respect to the comment that schools of medicine often sponsor residency programs in more than one geographic area and with more than one hospital at the same time, we do not believe that will necessarily affect whether a program is considered to meet the new program definition. As we stated in the proposed rule, we will consider the degree to which, and the way in which, two programs continue to operate simultaneously at the original hospital and the subsequent hospital. We understand that a medical school may sponsor two separate programs in the same specialty with different program directors, staff, and residents, but that is very different from the situation where a sponsoring school of medicine closes a program in one hospital and moves the program to another hospital. In the former situation, the fact that there are two separate programs operating simultaneously and continually is evidence that could support a determination that the two programs are, in fact, separate and distinct. However, in the latter situation, the closure of one program and the movement of the program director, faculty, and residents to another hospital are indicative of the relocation of an existing program for which no FTE cap increase is warranted. Accordingly, despite the commenters' concerns, we believe we should use the list of supporting factors to determine what constitutes a new program, rather than relying solely on the determination of an accrediting body.

Comment: One commenter opined that imposing more stringent standards for identifying new programs does not actually address CMS' concern that there could be an inappropriate increase in the aggregate total number of residency slots funded by Medicare when one hospital shifts an existing program to another hospital, and then the original hospital uses the open slots to count other residents (when the hospital had previously trained a number of residents that exceeded its FTE resident caps). The commenter noted that, just as a hospital may decide at any time to close one program and use those slots to count residents that were previously in excess of its caps, a nonteaching hospital may decide at any time to become a new teaching hospital and participate in training residents in its own new programs, thereby increasing the aggregate number of Medicare-funded positions.

Several commenters also mentioned alternative methods by which CMS can preserve the national aggregate cap without implementing the provisions of the proposed rule. One commenter suggested that the cap number can be kept neutral by removing old cap slots and reassigning them to new programs. Other commenters stated that, among other solutions, one way to maintain the national cap level is to promulgate rules stating that a hospital loses the caps attached to a closed teaching program, but that those caps can be added back into the system when a program opens in a new hospital. One commenter suggested that CMS work together with accrediting bodies to use the ''existing infrastructure'' to create a clear, unambiguous method for determining the criteria for a new program. Another commenter suggested creating a formal process by which hospitals can apply for and receive the ''new program'' designation.

Response: We disagree with the commenter's assertion that the rules regarding new programs do not address the underlying concern that the aggregate number of Medicare-funded positions should not, in general, increase over the levels in place when the BBA was passed. First, we believe caution is warranted to ensure that any increase in the aggregate level of resident slots relates only to truly new programs. Second, if a hospital that is training residents in excess of its FTE resident caps closes one of its programs and, as a result, the number of FTE residents the hospital is training equals its caps, there will be no increase in the number of FTE residents the hospital is permitted to count for IME and direct GME purposes, and no increase in the aggregate number of FTE resident positions. In other words, the closure of a program does not, by itself, allow for an increase in the aggregate levels of Medicare-funded resident slots. However, we do not believe it is appropriate for an increase to the aggregate FTE resident caps to occur as a result of a program that moves from one hospital to another, allowing the first hospital to receive the same amount of Medicare funding by filling the vacated slots, and allowing the second hospital to receive a ''new program'' increase in its FTE caps for that same residency program. In such a case, we do not believe it would be appropriate for the Medicare program to bear the additional costs associated with the transfer of an existing program to another hospital. Third, we believe that an implicit assumption in the BBA conference report language is that, while new teaching hospitals and new programs may open over time, some existing teaching hospitals and programs would close. Accordingly, this ''offset'' of resident slots would, to a certain extent, limit the growth in the levels of Medicare-funded residency positions in years subsequent to the BBA. Therefore, we believe it is appropriate to take a rigorous approach to determining whether a program is new for Medicare purposes, and whether an increase in the hospital's FTE resident caps is appropriate and consistent with the statutory FTE caps.

Nevertheless, we have considered the comments we received and whether the use of a list of ''supporting factors'' included in the proposed rule is the best approach to determine whether a program is actually new for purposes of Medicare IME and direct GME payments. We find compelling the comment that there may be alternative methods to preserve the national aggregate cap, while allowing for some flexibility in the application of the ''factors.'' We also considered the suggestion that the aggregate national cap could remain neutral by removing existing cap slots and reassigning them to new programs. One situation is of particular concern to us; when a teaching hospital closes a program but the hospital itself remains open, and that program is relocated to a hospital that may qualify for an FTE cap increase under § 413.79(e)(1) or (3) and applies for and receives new accreditation for the program. Because the first hospital continues to operate and retains the FTE cap positions relating to the program, there is the potential for Medicare to recognize the same residency cap positions twice—once for the program at the original hospital and again for the ''new'' program at the second hospital. Thus, there could be a form of ''double counting'' when the first hospital fills the same FTE slots that were vacated from the program that closed at the first hospital, while the new teaching hospital is permitted to count FTE residents in the ''new'' program as well. We do not believe such an increase in the aggregate number of FTE residents and the potential duplication of the FTE

resident cap adjustment would be consistent with the statutory mandate to adhere to the principles of the base-year FTE resident caps when devising rules to account for newly established medical residency training programs. However, in the instance where the first hospital actually closes (that is, its Medicare provider agreement and its FTE caps are retired and not used by another hospital), and its residency program(s) transition to another hospital(s) that qualifies for an FTE cap increase under § 413.79(e)(1) or (3), there would be no threat of duplicative FTE slots relating to the same program. Rather, the national aggregate FTE cap would remain approximately the same.

After considering the public comments concerning other means to maintain a steady national aggregate cap, we have decided that another important ''supporting factor'' to consider is whether the hospital from which the program was relocated has closed (terminated its provider agreement and its FTE caps are not being used by another hospital) prior to the transfer of the program. The fact that a program originated from a hospital that closed, where no other hospital retained the FTE caps, suggests that it would be appropriate to consider the program to be new for purposes of establishing IME and direct GME FTE caps.

Because our intent is to ensure that no duplicative FTE resident slots are created by virtue of an inappropriate ''new program'' adjustment, a hospital that is considering starting such a ''new'' program should ask several questions:

1. Has this program been relocated from a hospital that closed?
2. If so, was this program part of the closed hospital's FTE cap determination?
3. More generally, is this program part of any existing hospital's FTE cap determination?

Our goal in prompting hospitals to ask these questions is to have them assess whether the positions continue to be incorporated into the aggregate national FTE caps. If the answer to the first two questions is yes, and the answer to the third question is no, the FTE caps associated with the previous program had already been incorporated into the national aggregate cap (prior to the hospital's closure); and because the FTE caps associated with the previous program are no longer available for use at any other hospital, there is ''room'' under the national aggregate caps for a ''new program'' adjustment for the hospital with the successor program. Consequently, there would be no danger that an FTE cap adjustment to reflect a new program would result in duplicative FTE caps. Thus, even if there are significant similarities between the program in terms of the program director, teaching staff, or residents, we could consider the program that was transferred from the closed hospital to be new for Medicare direct GME and IME purposes without concern for undermining the national aggregate FTE caps. To determine whether the FTE residents associated with a program are part of the closed hospital's FTE cap determination, the hospital that seeks an adjustment to its FTE caps would refer to the closed hospital's FTE documentation associated with its cost reporting period ending on or before December 31, 1996, or, if applicable, the cost report for other permanent cap adjustments permissible under the regulations.

However, the same cannot be said of the situation where there are significant similarities between programs, and the first hospital remains open or the first hospital closes but the FTE caps remain available for use by another hospital (for example, the answer to the third question is yes). We do not believe it would be appropriate to consider a program that is substantially the same as a previous program at another hospital to be a new program where the first hospital remains open, or where the FTE cap slots for the previous program remain available for use by another hospital (for example, as a result of a merger).

Up to this point, we have discussed the situation where one hospital closes and a program that was part of the closed hospital's FTE cap determination transfers to a new teaching hospital. We have indicated that we would add to the list of supporting factors the condition under which the program in question originated at a hospital that closed because there would be no duplicative FTE caps due to the closure of the first hospital. However, because our primary concern in this instance is that there should be no duplicative FTE resident cap slots, our intent would be to ensure, to the extent possible, that no FTE cap increases are granted in instances where another ''active'' FTE cap still exists, of which the transferred program was a part. As we stated above, the hospital to which the program transfers would need to assess whether this program was part of any other hospital's FTE cap determination and, if so, whether this program is still reflected in the FTE caps of any existing hospital.

For example, we can envision a scenario where two teaching hospitals, Hospitals A and B, merge; Hospital B's Medicare provider agreement is retired (that is, it closes), and their respective FTE caps are combined under Hospital A's single Medicare provider agreement. Sometime subsequent to the merger, the merged facility decides that it no longer wishes to operate one of the programs that was part of Hospital B's FTE cap determination, and the program is transferred along with its program director, teaching staff, and residents to a new teaching Hospital C. In this case, it would not be appropriate to consider the program at Hospital C to be a new program because, although the program originated from Hospital B which closed, the FTE caps of which this program was a part are still in effect and available for use by the merged facility. Thus, if we were to adjust Hospital C's FTE caps for the transferred program, the adjustment would result in duplicative FTE resident slots relating to the same program. Similarly, there could be historical situations where a closed hospital's FTE caps were absorbed by another hospital through a termination clause in a Medicare GME affiliated group (prior to October 1, 2002) (67 FR 50070). In such a case, a third hospital might seek an adjustment to its FTE caps for a new program that is substantially the same as a program formerly operated by the closed hospital. However, it would not be appropriate for that hospital to receive FTE cap increases relating to that program because, again, the FTE caps of which the transferred program was originally a part still exist, and, therefore, an adjustment to the third hospital's FTE resident caps would result in duplicative FTE residents caps relating to the same program.

With respect to the commenter's suggestion that we could consider promulgating rules that would remove the slots from a hospital's FTE resident cap when it closes a program, but the hospital itself remains open, in addition to our concern about duplicative FTE caps, we do not believe we have the statutory authority to do this under section 1886(h)(4) of the Act. Each hospital's FTE resident cap is equal to the FTE count in a base year, which is usually the hospital's most recent cost reporting period ending on or before December 31, 1996, as adjusted for new programs under § 413.79(e) and other provisions, as applicable. Furthermore, each hospital's FTE cap is based on a total count of its allopathic and osteopathic residents, that is, a hospital-specific cap, and is not generally associated with any particular program or specialty. We have tried, to the extent possible, to implement our policies in a

way to maintain the fungibility of FTE slots within a hospital's caps in order to maximize a hospital's flexibility to modify the mix and type of residents it trains. Accordingly, it is acceptable for a hospital to decide to close one program to make room within its FTE resident caps for additional numbers of residents in another program. Furthermore, the focus of the clarification in the proposed rule was *not* that a hospital may close a program and fill those vacated slots with residents from another specialty, which, by itself, is acceptable, but rather, it was to address the point that an FTE cap increase should only be awarded to a hospital for starting a genuinely new program, not one that was merely transferred from another hospital.

Comment: Several commenters expressed surprise that CMS initiated a proposal that will have a ''chilling effect on primary care production'' at a time when the President has been so outspoken in his support for primary care. Other commenters similarly voiced their concerns regarding what they believed the detrimental and disproportionate effect the proposed rule may have on primary care residencies, which are already too few in aggregate number and which serve as the basis of America's healthcare system. One commenter noted that the shortage of primary care physicians extends to the available faculty for primary care residency programs, and this proposal would force closed primary care programs to find new faculty when they wish to reopen. Commenters also believed that the proposed rule is unrealistic for similar reasons, as it is unreasonable to suggest that the director, faculty, and residents in a closed residency program with Medicare-funded resident slots should relocate in order to continue their careers. The commenters stated that, by forcing closed primary care residency programs to relocate, the proposed rule will harm communities who are served by those residents. Another commenter specifically mentioned the retrospective nature of the proposed rule as posing a threat to primary care residencies that started after 1995, while other commenters mentioned the retrospective provision of the proposed rule as another example of its unreasonable nature.

Several commenters mentioned that primary care residencies are more costly to hospitals than other specialty programs and, thus, would be the first to close if hospitals were forced to cut GME costs. The commenters also noted that residents are increasingly training in ''newer, more community-based environments,'' specifically in the primary care field of family medicine, and CMS should attempt to regulate towards that new training style ''rather than continue to keep fitting training into the hospital.'' One commenter echoed the above statements by explaining that primary care residencies are often housed in community hospitals, which are prone to ''being rebuilt, bought and sold at a regular pace'' and, as such, would require their teaching programs to frequently switch locations. Another commenter remarked that CMS' previous efforts to enforce this clarification of its ''new program'' definition have already caused family medicine programs to spend much time and effort proving their new status to CMS, and such situations have even led to program closings.

In a similar vein, some commenters believed that the proposed rule expressly harmed teaching hospitals in underserved areas. One commenter explained that many teaching hospitals serve a disproportionate number of ''indigent and underinsured/uninsured patients,'' and thus many are forced to close due to financial strain. This commenter believed that those residency programs, which ''serve those who need health care the most,'' should not be penalized for having to relocate. Another commenter stated that the proposed rule is unnecessary and unfair to hospitals that ''have acted in good faith'' by establishing new programs where they are needed.

Response: We do not understand why the commenters viewed the proposed clarification regarding the definition of new programs as hindering the growth of primary care residency programs or residencies in underserved areas in particular. Neither of these types of residencies was specifically targeted in the proposed rule, nor were they mentioned at all. CMS had no intention of inappropriately inhibiting the growth of primary care residencies, or of ''harming'' teaching programs in underserved areas, with the proposed clarification of the definition of a new program. The supporting factors we identified as indicative of new programs, as described in the proposal, are meant to serve as general guidelines to hospitals for establishing new programs in all specialties. Furthermore, we believe that our revised policy allowing a hospital to receive FTE cap increases in the instance where it operates a program that is transferred from another hospital that closed should help provide some flexibility in situations where hospitals are closing and the community is struggling to maintain an adequate teaching presence and ensure sufficient access to care.

Comment: One commenter noted that the proposal states that ''the statute clearly requires [emphasis added by commenter] that our rules regarding adjustments to the hospitals FTE caps for newly established programs must adhere to the principles of the statutory provision limiting the count of FTE residents for direct GME and IME payments to the count for the most recent cost reporting period ending on or before December 31, 1996.'' The commenter observed that the statute says: ''(i) NEW FACILITIES—The Secretary shall, consistent with the principles [emphasis added by commenter] of subparagraphs (F) and (G), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.'' This commenter believed that the Secretary has not given special consideration to underserved rural areas, despite a ''mandate'' to do so, and ''it seems disingenuous to strongly assert one provision of law while not following other statutory requirements.''

Response: We disagree with the commenter that we are selectively focusing on certain aspects of the statute and the BBA conference report language, to the exclusion of others. It is clear that an overarching concern of Congress with respect to GME funding at the time that the BBA was passed was that a cap should be placed on the number of Medicare-funded resident positions, in an attempt to control spending while still addressing the needs of those areas of the country or those specialties where physicians were in shorter supply. Specifically, the BBA conference agreement includes ''* * * a requirement that the Secretary prescribe rules for limiting and counting the number of interns and residents in training programs established on or after January 1, 1995. In promulgating such rules, the Secretary would be required to give special consideration to facilities that meet the needs of underserved rural areas* * *. Among the specific issues that concerned the Conferees was application of a limit to new facilities, that is, hospitals or other entities which established programs after January 1, 1995. The Conferees understand that there are a sizeable number of hospitals that elect to initiate such programs (as well as terminate such programs) over any period of time, and the Conferees are concerned that within the principles

of the cap that there is proper flexibility to respond to such changing needs, including the period of time such programs would be permitted to receive an increase in payments before a cap was applied. Nonetheless, the Secretary's flexibility is limited by the conference agreement that the aggregate number of FTE residents should not increase over current levels. The Conferees are also concerned about the application of the limit on the number of residents to programs established to serve rural underserved areas, which the Conferees believe have special importance in easing physician shortages in such areas. The conference agreement provides the Secretary with statutory direction to provide special consideration to such programs.'' (House Conference Rept. No. 105–217, pp. 821–822)

Accordingly, in promulgating regulations implementing the statutory caps, we allowed those urban hospitals that did not have residents in the most recent cost reporting period ending on or before December 31, 1996, to adjust their caps for new programs only during a period of 3 years after the first new program began training residents (§ 413.79(e)(1)(iii)). Rural hospitals were not so limited. For those urban hospitals that had residents in the most recent cost reporting period ending on or before December 31, 1996, we allowed cap adjustments only for new programs established between January 1, 1995 and August 5, 1997 (§ 413.79(e)(2)). However, we allowed rural hospitals, even ones that already had FTE caps during the base period (that is, the most recent cost reporting period ending on or before December 31, 1996), to receive an increase to their FTE resident cap at any time for starting new programs (§ 413.79(e)(3)). Therefore, contrary to the commenter's assertion, we have given ''special consideration'' to programs established to serve underserved areas.

Comment: One commenter asked CMS for direction regarding a closed teaching program in a rural facility. The commenter desired to start another training program in that same specialty at a second facility and asked if this would meet the definition of a new program under the proposed clarification.

Response: The hospital should evaluate the circumstances relating to the second program by assessing the factors as described above and in our proposed rule in order to be considered a new program. It appears from the comment that the rural hospital itself remains open, and only the program closed. Thus, the hospital that is considering opening a program in the same specialty should focus its assessment on the other supporting factors (whether there is a new program director, new faculty, and new residents).

Comment: One commenter that represents dental residency programs stated that a number of dental programs were closed in the 1980s and 1990s, and there is interest in reopening the programs in the same hospitals and nonhospital dental school clinics in which they were previously operated. The commenter noted that a hospital may be associated with the same dental school, program director, and teaching staff that were involved in operation of the old program, even though about 10 years may have passed since the previous program closed. The commenter believed that programs that open after being closed for several years and that require accreditation by the Council on Dental Accreditation as a new program should be treated by CMS as new.

Response: We agree with the commenter that if a hospital wishes to begin training residents in a particular program in which it trained residents in the past, but the program has not trained residents for the past 10 years, the program could subsequently be considered a new program. We believe that a program that is closed for several years and then reopens is separate and distinct from the previous program, and would likely not involve any residents that had trained in the previous program, even though, as the commenter indicated, the directors and teaching staff may be the same. (However, we note that it may be necessary to determine whether the program director and the teaching staff have been training dental residents during the past 10 years at another training site in order to determine whether the program at the hospital that is beginning to train residents after a 10-year hiatus is truly a new program.)

Comment: One commenter found it ''interesting'' that CMS provided several supporting factors for identifying a new program, but did not propose to change the actual text of the regulation.

Response: Section 413.79(l) currently defines a new medical residency training program as ''a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.'' We did not propose to revise the language of the regulations text because we believe the existing language is sufficient in that it conveys the important point that a program must be ''initially'' accredited *for the first time* as new by the accrediting body. The supporting factors that we have provided for determining whether a program is to be considered as new by CMS further clarify and support the concept of ''initial'' accreditation.

Comment: One commenter was concerned that its hospital was negatively affected by an unfavorable interpretation of the statute related to training in nonprovider settings in cases where the program is jointly funded by two or more hospitals.

One commenter asked CMS to clarify the statement ''may count towards board certification'' in § 413.75 (b), and give specific examples of when a nonapproved program may count towards certification and when the interns and residents should be included in the FTE count.

Response: We appreciate the submission of these comments. However, because they are outside the scope of the proposed rule, we are not responding to them in this final rule.

In summary, in this final rule, we are clarifying our existing policy regarding the definition of a new medical residency training program. Under existing policy, to determine whether a program is new and whether, as a result, a hospital qualifies for an FTE cap adjustment, the supporting factors that a hospital should consider are (but not limited to) as follows:

—Is the program director new, and
—Is the teaching staff new, and
—Are there new residents?

In determining whether a particular program is a newly established one, it may also be necessary to consider factors such as the relationship between hospitals (for example, common ownership or a shared medical school or teaching relationship) and the degree to which the hospital with the original program continues to operate its own program in the same specialty. In addition, the following factors could also be considered:

—Has this program been relocated from a hospital that closed?
—If so, was this program part of the closed hospital's FTE cap determination?
—More generally, is this program part of any existing hospital's FTE cap determination?

We would not consider a transferred program to be new in the case where the program director, teaching staff, and residents are the same as another program that closed in another hospital and the first hospital remains open, or when an FTE cap that was associated

with the first program is still available for use by an existing provider.

3. Participation of New Teaching Hospitals in Medicare GME Affiliation Groups

Sections 1886(h)(4)(F) and 1886(d)(5)(B)(v) of the Act establish limits on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments and the IME adjustment, respectively. Accordingly, effective October 1, 1997, we established hospital-specific direct GME and IME FTE resident caps. Furthermore, under the authority granted by section 1886(h)(4)(H)(ii) of the Act, the Secretary issued rules to allow institutions that are members of the same affiliated group to elect to apply their direct GME and IME FTE resident caps on an aggregate basis. Accordingly, as specified in the regulations at §§ 413.79(f) and 412.105(f)(1)(vi), hospitals that are part of the same Medicare GME affiliated group are permitted to apply their direct GME and IME FTE resident caps on an aggregate basis, and to temporarily adjust each hospital's caps to reflect the rotation of residents among affiliated hospitals during an academic year. Under § 413.75(b), a Medicare GME affiliated group can be formed by two or more hospitals if they are under common ownership, or if they are jointly listed as program sponsors or major participating institutions in the same program. Furthermore, the existing regulations at § 413.79(f)(1) specify that each hospital in a Medicare GME affiliated group must submit a Medicare GME affiliation agreement (as defined under § 413.75(b)) to the CMS fiscal intermediary or MAC servicing the hospital and send a copy to CMS' Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect. For example, in order for a hospital to receive a temporary adjustment to its FTE resident caps to reflect participation in a Medicare GME affiliated group for the academic year beginning July 1, 2009, through June 30, 2010, each hospital in the affiliated group is required to submit a Medicare GME affiliation agreement to the fiscal intermediary or MAC servicing the hospital and to CMS' Central Office no later than July 1, 2009.

As we discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24193), it has recently come to CMS' attention that flexibility in the submission deadline for Medicare GME affiliation agreements due to an unanticipated need is warranted in situations where a hospital opens after July 1 and begins training residents for the first time prior to the following July 1. That is, the new hospital, because it did not train residents in the FTE cap base year, would have FTE resident caps of zero. Currently, if a new hospital begins training residents from another hospital's existing program, the new hospital would not be able to receive a temporary FTE resident cap adjustment through participation in a Medicare GME affiliated group because the existing regulations do not provide flexibility for a hospital that begins training residents after the start of an academic year to enter into and submit a Medicare GME affiliation agreement after the July 1 submission deadline. That is, a new hospital that opens after July 1 would not be able to enter into a Medicare GME affiliation agreement because the hospital did not exist before the submission deadline. We understand that the new hospital is likely to incur GME costs during the first year of training residents, and we believe it is reasonable to permit the new hospital that receives a new Medicare provider agreement and begins training residents for the first time after July 1 of an academic year to receive an adjustment to its FTE resident caps for IME and direct GME payments through participation in a Medicare GME affiliated group during its first year of training residents, even if the hospital completes and submits the Medicare GME affiliation agreement to CMS after July 1 of the academic year. Accordingly, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we proposed to amend § 413.79(f) by revising paragraph (f)(1) and adding a new paragraph (f)(6) (the existing paragraph (f)(6) would be redesignated as paragraph (f)(7)). In the proposed new paragraph (f)(6), we proposed to provide that a hospital that is new after July 1 and that begins training residents for the first time prior to the following July 1 would be permitted to receive a temporary adjustment to its FTE resident caps to reflect its participation in an existing Medicare GME affiliated group if the new hospital submits a Medicare GME affiliation agreement the earlier of June 30 of the residency program year during which the Medicare GME affiliation agreement will be in effect or the end of the first cost reporting period during which the hospital begins training residents. For this purpose, a new hospital is one for which a new Medicare provider agreement takes effect in accordance with § 489.13. We proposed to require that the Medicare GME affiliation agreement specify the effective period for the agreement, which in any case would begin no earlier than the date the affiliation agreement is submitted to CMS. Furthermore, we proposed that each of the other hospitals participating in the Medicare GME affiliated group with the new hospital would be required to submit an amended Medicare GME affiliation agreement that reflects the participation of the new hospital to the CMS contractor servicing the hospital and send a copy to the CMS Central Office no later than June 30 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

Comment: A number of commenters applauded CMS' efforts to provide flexibility in the Medicare GME affiliation agreement regulation. However, the majority of the commenters believed the regulations, even with the addition of the proposed policy, remain unduly narrow and urged CMS to create further flexibility. For example, several commenters suggested that CMS add a fourth criterion for affiliations, specifying that hospitals that are members of the same GME consortium may enter into a Medicare GME affiliation agreement. Specifically, as an example of GME consortia, the commenters cited Osteopathic Postdoctoral Training Institutions (OPTIs), which are community-based training consortia comprised of at least one college of osteopathic medicine and one or more teaching hospitals as well as community-based facilities such as ambulatory care centers, rehabilitation centers, or surgicenters. The commenters believed that OPTIs ''provide a natural basis for affiliations among teaching hospitals and other training venues'' and therefore members of the same OPTI should be allowed to adjust their FTE resident caps within an aggregate cap. Another commenter requested that CMS allow hospitals that are members of the same health system to enter into a Medicare GME affiliation agreement and adjust their FTE resident caps within an aggregate cap, ''irrespective of whether the hospital is designated as 'new' or whether the FTE resident cap at any given hospital is new since 1995.''

One commenter provided comments on our policy on counting FTE residents training in the nonhospital setting.

Response: We appreciate the commenters' support of the proposed change and the additional suggestions on creating further flexibility in the regulations for Medicare GME affiliated groups. In the May 12, 1998 final rule (63 FR 26336 through 26341), we

established the definition of a Medicare GME affiliated group and discussed the requirement for the timely submission of Medicare GME affiliation agreements. Specifically, the regulation at § 413.75(b) defines Medicare GME affiliated group to mean (1) two or more hospitals that are located in the same urban or rural area (as defined in subpart D of Part 412 of this chapter) or in a contiguous area, (2) two or more hospitals that are not located in the same or in a contiguous urban or rural area * * * and are jointly listed as the sponsor, primary clinical site, or major participating institution for one or more programs, or (3) two or more hospitals that are under common ownership. Furthermore, the regulations specify that hospitals in an affiliated group are required to have a shared rotational arrangement. These provisions permit hospitals that are members of the same affiliated group to elect to apply their FTE resident caps on an aggregate basis. To respond to the commenters' suggestion that we expand the definition of affiliated group to allow hospitals and other entities involved in a GME consortium, for example OPTIs, to affiliate as a Medicare GME affiliated group, we note that the regulations specifically only refer to *hospitals* as members of an affiliated group. The sole benefit gained from participating in a Medicare GME affiliated group is the ability to count FTE residents under an aggregate FTE resident cap for GME payment purposes. That is, by aggregating FTE resident caps in a Medicare GME affiliated group, a hospital that is currently training above its own FTE resident cap can receive a temporary cap adjustment from another hospital that is training below its own FTE resident cap. The training venues cited by the commenters (community-based facilities such as ambulatory care centers, rehabilitation centers, or surgicenters) typically are either already a part of the hospital, which means they would be included in the affiliated group, or are nonhospital training sites in which case there are separate rules for counting FTE residents training in the nonhospital setting. There would be no additional benefit for a nonprovider to be included as a member of an affiliated group because a nonprovider would not have FTE resident caps to share in an affiliated group. Furthermore, we note that the hospitals in an OPTI currently do have the ability to form an affiliated group under the current definition of Medicare GME affiliated group at § 413.75(b). In addition to the ability to qualify through geographic proximity, all hospitals that meet the rotation requirement and are listed as sponsors or listed under ''affiliations and outside rotations'' for a program in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs* also qualify to participate in an affiliated group.

In response to the commenter who suggested CMS allow hospitals that are members of the same health system to enter into a Medicare GME affiliation agreement and adjust their FTE resident caps within an aggregate cap, ''irrespective of whether the hospital is designated as 'new' or whether the FTE resident cap at any given hospital is new since 1995,'' we note first that hospitals under common ownership already qualify to form an affiliated group because, as we noted in the May 12, 1998 final rule, ''these systems functionally operate coordinated and centrally controlled GME programs and often rotate their residents among various facilities, depending on training needs and other considerations'' (63 FR 26337). In addition, the commenter suggested that hospitals in an affiliated group be allowed to temporarily give away as well as receive FTE caps ''whether the FTE resident cap at any given hospital is new since 1995.'' The regulations at § 413.79(e)(1)(iv) specify that a new urban teaching hospital that qualifies for an adjustment to its FTE caps for a newly approved program may enter into a Medicare GME affiliation agreement, but only if the resulting adjustments to its direct GME and IME caps are ''positive adjustments.'' ''Positive adjustment'' means, for the purpose of this policy, that there is an increase in the new teaching hospital's caps as a result of the affiliation agreement. At no time would the caps of a hospital located in an urban area that qualifies for adjustment to its FTE caps for a new program under § 413.79(e)(1) be allowed to decrease as a result of a Medicare GME affiliation agreement. In the FY 2006 IPPS final rule (70 FR 47453), we stated that we established this policy ''because of our concern that hospitals with existing medical residency training programs could otherwise, with the cooperation of new teaching hospitals, circumvent the statutory FTE resident caps by establishing new medical residency programs in the new teaching hospitals solely for the purpose of affiliating with the new teaching hospitals to receive an upward adjustment to their FTE cap under an affiliation agreement. This would effectively allow existing teaching hospitals to achieve an increase in their FTE resident caps beyond the number allowed by their statutory caps.''

Finally, we note that each hospital in an affiliated group is required to cross-train residents through a shared rotational arrangement with at least one other hospital in the affiliated group because the criteria for being members of the same affiliated group are intended to recognize that hospitals that have relationships for training their residents need flexibility to adjust their FTE resident cap. Hospitals that are geographically near each other, or operating as training sites under the same program, or are under common ownership have the greatest likelihood of being able to fulfill the cross-training requirement. Accordingly, we believe that the current definition of Medicare GME affiliated group is sufficiently broad to include hospitals that have relationships for training residents and are in need of the flexibility afforded under an aggregate FTE resident cap.

We consider the comment on the policy on counting FTE residents in the nonhospital setting to be outside the scope of the proposed rule; we did not propose any change in policy in this area. Therefore, we are not responding to it in this final rule.

After consideration of the public comments we received, we are adopting as final, without modification, our proposal to revise paragraph (f)(1) of § 413.79 and adding a new paragraph (f)(6) (the existing paragraph (f)(6) is redesignated as paragraph (f)(7)). In the new paragraph (f)(6), we provide that a hospital that is new after July 1 and that begins training residents for the first time prior to the following July 1 is permitted to receive a temporary adjustment to its FTE resident caps to reflect its participation in an existing Medicare GME affiliated group if the new hospital submits a Medicare GME affiliation agreement the earlier of June 30 of the residency program year during which the Medicare GME affiliation agreement will be in effect, or the end of the first cost reporting period during which the hospital begins training residents. For this purpose, a new hospital is one for which a new Medicare provider agreement takes effect in accordance with § 489.13. We are requiring that the Medicare GME affiliation agreement specify the effective period for the agreement, which in any case would begin no earlier than the date the affiliation agreement is submitted to CMS. Furthermore, each of the other hospitals participating in the Medicare GME affiliated group with the new hospital is required to submit an amended Medicare GME affiliation agreement that

reflects the participation of the new hospital to the CMS contractor servicing the hospital and send a copy to the CMS Central Office no later than June 30 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

4. Technical Corrections to Regulations

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24193), we indicated that we had discovered that in the existing § 413.79(k), under the provision on residents training in rural track programs, paragraph (k)(7) incorrectly appears as regulation text after paragraph (l) of § 413.79. To correct this error, we proposed to move paragraph (l) so that it appears as the last paragraph of the section after paragraph (k)(7).

We did not receive any public comments on this proposal and, therefore, we are adopting the proposed change as final.

In addition, the regulations at § 413.75(b), paragraph (1), define an ''approved medical residency program'' as a program that is ''approved by one of the national organizations listed in § 415.152''. Under § 415.152, in the definition of an ''approved graduate medical education (GME) program'', we reference a residency program approved by the ''Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association'' (AOA). In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24193), we indicated that it has come to our attention that the structure of the AOA has changed and that we should merely refer to a residency program approved by the AOA. Therefore, we proposed to make a technical change to paragraph (1) of the definition of an ''approved graduate medical education (GME) program'' under § 415.152, to remove the phrase ''the Committee on Hospitals of the Bureau of Professional Education of''. We did not receive any public comments on this proposal and therefore are adopting the proposed change as final.

H. Hospital Emergency Services Under EMTALA (§ 489.24)

1. Background

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on certain Medicare-participating hospitals and CAHs. (Throughout this section of this proposed rule, when we reference the obligation of a ''hospital'' under these sections of the Act and in our regulations, we mean to include CAHs as well.) These obligations concern an individual who comes to a hospital emergency department and requests examination or treatment for a medical condition, and apply to all individuals, regardless of whether they are beneficiaries of any program under the Act.

The statutory provisions cited above are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. Section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99–272, incorporated the responsibilities of Medicare hospitals in emergency cases into the Social Security Act. Congress incorporated these antidumping provisions within the Act as a part of the hospital's provider agreement to ensure that any individual with an emergency medical condition is not denied essential lifesaving services. Under section 1866(a)(1)(I)(i) of the Act, a hospital that fails to fulfill its EMTALA obligations under these provisions may be subject to termination of its Medicare provider agreement, which would result in loss to the hospital of all Medicare and Medicaid payments.

Section 1867 of the Act sets forth requirements for medical screening examinations for individuals who come to the hospital and request examination or treatment for a medical condition. The section further provides that if a hospital finds that such an individual has an emergency medical condition, it is obligated to provide that individual with either necessary stabilizing treatment or with an appropriate transfer to another medical facility.

The regulations implementing section 1867 of the Act are found at 42 CFR 489.24. The regulations at 42 CFR 489.20(l), (m), (q), and (r) also refer to certain EMTALA requirements outlined in section 1866 of the Act. The Interpretive Guidelines concerning EMTALA are found at Appendix V of the CMS State Operations Manual.

2. Changes Relating to Applicability of Sanctions Under EMTALA

Section 1135 of the Act authorizes the Secretary to temporarily waive or modify the application of several requirements of titles XVIII, XIX, or XXI of the Act (the Medicare, Medicaid, and Children's Health Insurance Program provisions), and their implementing regulations in an emergency area during an emergency period. Section 1135(g)(1) of the Act defines an ''emergency area'' as the geographical area in which there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act (subsection A) and a public health emergency declared by the Secretary pursuant to section 247d of Title 42 of the United States Code. Section 1135(g)(1) of the Act also defines an ''emergency period'' as the period during which such a disaster or emergency exists. Section 1135(b) of the Act lists the categories of otherwise applicable statutory and regulatory requirements that may be waived or modified. Included among these are the waiver of sanctions under EMTALA for, in subparagraph (b)(3)(A), a transfer of an individual who has not been stabilized (if the transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period) in violation of the EMTALA requirements governing transfer of an individual whose emergency medical condition has not been stabilized (section 1867(c) of the Act) and, in subparagraph (b)(3)(B), the direction or relocation of an individual to receive medical screening in an alternate location, pursuant to an appropriate State emergency preparedness plan. Section 1135(b) of the Act further states that, except for certain emergencies involving pandemic infectious disease (described in further detail below), a waiver or modification provided for under section 1135(b)(3) of the Act shall be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol.

Section 302(b) of the Pandemic and All-Hazards Preparedness Act, Public Law 109–417, made two specific changes that affect EMTALA implementation in instances where the Secretary has invoked the section 1135 waiver authority in an emergency area during an emergency period. Section 302(b)(1)(A) of Public Law 109–417 amended section 1135(b)(3)(B) of the Act to state that sanctions for the direction or relocation of an individual for screening may be waived where, in the case of a public health emergency that involves a pandemic infectious disease, that direction or relocation occurs pursuant to a State pandemic preparedness plan, or to an appropriate State emergency preparedness plan. In addition, sections 302(b)(1)(B) and (b)(1)(C) of Public Law 109–417 amended section 1135(b) of the Act to further state that ''if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification for such emergency shall be determined in accordance with section 1135(e) of the Act as such

subsection applies to public health emergencies.''

In the FY 2008 IPPS final rule with comment period (72 FR 47413), we amended the regulations at § 489.24(a)(2) (which refers to the nonapplicability of certain EMTALA provisions in an emergency area during an emergency period) to incorporate the changes made to section 1135 of the Act by the Pandemic and All-Hazards Preparedness Act. We amended the regulations to specify that, under a section 1135 waiver, the sanctions that do not apply are either those for the inappropriate transfer of an individual who has not been stabilized or those for the direction or relocation of an individual to receive medical screening at an alternate location. We also added a second sentence to paragraph (a)(2) to state that a waiver of these sanctions for EMTALA violations is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the duration of the waiver will be determined in accordance with section 1135(e) of the Act as it applies to public health emergencies. In the FY 2009 IPPS final rule (73 FR 28667), we made a technical change to the regulations at § 489.24(a)(2) by adding section 1135 language we had inadvertently left out when we made changes to the regulations at § 489.24(a)(2) in the FY 2008 IPPS final rule with comment period. Specifically, we added the phrases ''pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that includes a pandemic infectious disease, pursuant to a State pandemic preparedness plan'' and ''during an emergency period,'' to make the regulatory language consistent with the statutory text. Existing § 489.24(a)(2) states that ''Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan do not apply to a hospital with a dedicated emergency department located in an emergency area during an emergency period, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.''

As we discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24194 through 24195), after further review of the revised regulatory language as compared to the statutory language at section 1135 of the Act, we believe that further revisions to the language of § 489.24(a)(2) are necessary to make the language conform more closely to the language of section 1135 of the Act and better reflect how the section 1135 authority has been used in practice. Specifically, we stated that we believe that the regulatory language should be revised to be more consistent with the language in the statute to state that EMTALA sanctions for an inappropriate transfer may be waived only if the inappropriate transfer *arises out of the circumstances of the emergency.* We further proposed to amend the regulations to provide that the sanctions waived for both an inappropriate transfer and the redirection or relocation of an individual to receive a medical screening examination at an alternate location are only applicable *if the hospital does not discriminate on the basis of an individual's source of payment or ability to pay.* These additional requirements (which are underlined) are currently not included in the regulations text at § 489.24(a)(2). To ensure that the language of the regulations is fully consistent with the statutory language at section 1135 of the Act, we stated that we believe the regulations need to be clarified to include these provisions.

In addition, as we stated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we believe the existing regulations do not adequately reflect the Secretary's authority under section 1135 of the Act to waive or modify requirements for a single health care provider, a class of health care providers, or a geographic subset of health care providers located within an emergency area during an emergency period. The language at section 1135(b) of the Act states:

''To the extent necessary to accomplish the purpose specified in subsection (a), the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by *a health care provider* (or *classes of health care providers*) in any emergency area (*or portion of such an area*) during any portion of an emergency period, the requirements of titles XVIII, XIX, or XXI, or any regulation thereunder (and the requirements of this title other than this section, and regulations thereunder, insofar as they relate to such titles), pertaining to—'' (emphases added).

Thus, it is clear from the emphasized text that waivers under the section 1135 authority may be tailored and applied to one or more hospitals in the emergency area (or portion thereof) during some or all of the emergency period, as necessary. However, the existing regulations may inadvertently imply, contrary to the flexibility clearly contemplated in the statute, that all hospitals in all portions of an emergency area during an entire emergency period automatically receive a waiver of EMTALA sanctions. In the proposed rule, we proposed revisions to the regulation text to clarify this issue.

We proposed to revise the regulations to further clarify that the Secretary has the authority to implement a section 1135 waiver as necessary to ensure that the purpose of section 1135(a) of the Act can be achieved. That is, the Secretary is authorized to apply a section 1135 waiver, for example, to one or more hospitals in the emergency area (or portion thereof) during some or all of the emergency period, as necessary. The Secretary may delegate implementation of a waiver of EMTALA sanctions to CMS (as the Secretary has done in every instance in which the section 1135 waiver authority has been invoked thus far.)

In summary, we proposed to revise the regulations at § 489.24(a)(2) to state that a waiver of EMTALA sanctions pursuant to an inappropriate transfer only applies if the transfer arises out of the circumstances of the emergency. We also proposed to revise the regulations to provide that the sanctions waived for an inappropriate transfer or for the relocation or redirection of an individual to receive a medical screening examination at an alternate location are only in effect if the hospital to which the waiver applies does not discriminate on the source of an individual's payment or ability to pay. In addition, we proposed to revise the regulations to state that the Secretary has the authority to apply the waiver of EMTALA sanctions to one or more hospitals in a portion of an emergency area or a portion of an emergency period.

Comment: Several commenters supported the proposed changes to the regulations to make them conform more closely to the statutory text. The

commenters agreed with the addition to the regulations stating that a waiver of EMTALA sanctions would only apply if the hospital does not discriminate on an individual's insurance status or ability to pay. The commenters also stated that revising the regulations to clarify that the Secretary has the authority to waive EMTALA sanctions for a portion of hospitals in an emergency area during a portion of an emergency period will enable the Secretary to waive EMTALA sanctions in a more expeditious manner when a public health emergency is declared.

Response: We thank the commenters for their support of the proposals and are finalizing the provisions regarding a waiver of EMTALA sanctions only if the hospital does not discriminate based on an individual's source of payment and ability to pay and the Secretary's authority to waive EMTALA sanctions for a portion of an emergency area and during a portion of an emergency period.

Comment: One commenter supported the intent of the law that a waiver of sanctions under EMTALA only applies if the transfer does not discriminate based on insurance status. However, the commenter questioned whether the regulations need to be revised to include this provision because the law is already quite clear. The commenter questioned the involvement of the Secretary in declaring a public health emergency in order to invoke the waiver. Specifically, the commenter stated that ''It is not evident to us that the government is in a position to be able to determine which hospitals within a public health emergency declaration should be granted a waiver from the EMTALA requirements and which ones should not.'' The commenter further stated that emergency situations tend to be chaotic and it may be difficult to gather information. The commenter believed that efforts should be focused on patient care and not the applicability of waivers to specific hospitals. Therefore, the commenter requested that the waiver be granted to an entire area. The commenter also asked for clarification on the timeliness of the declaration of a public health emergency. Specifically, the commenter stated that ''We have an additional concern regarding the timeliness of a Secretary's declaration of a public health emergency, when in fact events are likely to be ahead of any such decision. We understand that such declarations can be retroactive to an earlier date, but this still begs the question of timeliness.'' The commenter requested information on how to obtain an extension of a waiver of EMTALA sanctions past 72 hours. The commenter stated that the rule is not clear and asked for simplicity and clarity on how, at the local level, the request for an extension or designation of a public health emergency can be communicated to the authorities.

Another commenter supported the proposed provision, which acknowledges the Secretary's authority to apply the waiver to particular hospitals because, for example, level I and II trauma centers may be better equipped to handle a public health emergency. The commenter further stated that ''We do have concerns with the process for the Secretary, DHHS to declare a public health emergency expeditiously enough to allow for emergency department readiness * * *. We ask CMS to be aware of this and enforce the law and regulations judiciously.''

Response: We believe that our proposal to amend the regulations to state that a waiver of sanctions can only be applied if the hospital does not discriminate on the basis of an individual's source of payment or ability to pay is necessary to ensure that the regulations reflect the entirety of statutory constraints related to a waiver of EMTALA sanctions under section 1135 of the Act and that hospitals are aware of the requirements they must meet in order to receive a waiver. Furthermore, we emphasize that the requirement not to discriminate on an individual's source of payment or ability to pay in order for a waiver of sanctions to be granted applies to both the waiver of sanctions governing an inappropriate transfer and the waiver of sanctions for the direction or relocation of an individual to receive a medical screening at an alternate location. In response to the involvement of the Secretary in declaring a public health emergency, the statute requires the Secretary to declare a public health emergency under 42 U.S.C. 247d in order to invoke the section 1135 waiver authority. In response to the comment regarding extending a waiver of EMTALA sanctions beyond 72 hours, section 1135(b) of the Act expressly limits the duration of the waiver to 72 hours (beginning with the implementation of a hospital disaster protocol) unless the public health emergency involves a pandemic infectious disease. Permitting a waiver of sanctions beyond that 72-hour period (except in the case of a pandemic infectious disease) would require a change in the law. We will continue to work with State and local officials to improve the communication that is needed to provide for timely and appropriate patient care during declared emergencies. We further note that a waiver of EMTALA sanctions can be implemented retroactive to the beginning of the emergency period.

Comment: The majority of commenters disagreed with the proposed language at § 489.24(a)(2)(i)(A) which specifies that ''If relating to an inappropriate transfer, the transfer arises out of the circumstances of the emergency.'' The commenters stated that this language is not consistent with the statute and could be interpreted too narrowly and misconstrued as only providing a waiver of sanctions if the individual's ''* * * emergency medical condition is the direct result of the public health emergency.'' The commenters stated that Congress' intent was not to provide a waiver of sanctions in scenarios where the individual's emergency medical condition was related to the declared emergency but to provide for a waiver of sanctions in cases where the hospital had to transfer the individual in a manner that is inconsistent with an appropriate transfer under EMTALA because of circumstance of the emergency. The commenters recommended that CMS revise the proposed regulation text at § 489.24(a)(2)(i)(A) so that it reads ''If relating to an inappropriate transfer, the transfer is necessitated by the circumstances of the declared emergency.''

Another commenter opposed the inclusion of the language ''If relating to an inappropriate transfer, the transfer arises out of the circumstances of the emergency'' ''* * * on the grounds that it is vague, likely to be arbitrary in its application, and not required by the language of the Act.'' The commenter further stated that such a regulatory requirement would necessitate that the hospital, its legal counsel, CMS, and the courts be able to determine the difference between the transfers that are due to the underlying disaster or emergency in the geographic area and those transfers that are not the result of the underlying disaster or emergency. The commenter stated that ''To distinguish between situations that do and do not arise out of the circumstances is likely to be arbitrary at best. Also the administrative and litigation proceedings that will result from adding such a vague condition will only hamper the purpose and requirements of the Act.''

Response: We agree with the commenters that the intent of the statute is to provide flexibility in cases where an inappropriate transfer may arise out of conditions relating to the declared emergency and that it is *not* a requirement that an individual's

emergency medical condition be a direct result of the public health emergency in order for sanctions to be waived. To address the commenters' concerns and minimize confusion regarding applicability of the policy described at § 489.24(a)(2)(i)(A), in this final rule, we are revising the regulatory text to state: ''The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.'' We are removing the phrase ''If relating to'' under both paragraphs (a)(2)(i)(A) and (a)(2)(i)(B) of § 489.24 to provide for further consistency with the statutory language and clarify that sanctions can only be waived for an inappropriate transfer and for the direction or relocation of an individual to receive a medical screening and not for any action ''related to'' these events. In response to the commenter who stated that including language pertaining to an inappropriate transfer would result in administrative and litigation proceedings, currently the statute limits the waiver related to inappropriate transfers to transfers necessitated by the circumstances of the declared emergency in the emergency area during the emergency period. This is not a new requirement under the law. Therefore, we do not believe that reflecting the statutory requirement in the regulations will have any effect on the likelihood of administrative and litigation proceedings.

Comment: One commenter stated that regulations governing the application of sanctions should be as flexible as possible because of the innumerable types of emergency situations that may occur and the varied hospital and State responses that may result. The commenter stated that emergency situations are unpredictable and that there may be ''* * * state or hospital actions that are critical for an effective emergency response, but may technically violate EMTALA.'' Therefore, the commenter requested that CMS adopt the EMTALA Technical Advisory Group's (TAG) high priority recommendation with respect to expansion of EMTALA waivers, which is referred to as recommendation number 18 of the final TAG report.

Response: The commenter is referring to the following recommendation made by the EMTALA TAG: ''The TAG recommends that HHS pursue statutory and regulatory changes, as well as changes to the Interpretive Guidelines, addressing waiving EMTALA obligations in an emergency as declared by a Federal, State, county, or city government or by an individual hospital.''

The EMTALA TAG report containing this recommendation can be found at the following Web site: *http://www.cms.hhs.gov/EMTALA/03_emtalatag.asp#TopOfPage.* The recommendation made by the EMTALA TAG would require a statutory change. Because implementing this recommendation would require Congressional action, based on existing statutory language, we are not revising the regulation in this final rule.

Comment: Several commenters stated that ''* * * lessons learned from recent disasters make it clear that changes to the law are needed in order to provide additional flexibility in regulatory enforcement and payment policy so that hospitals can maximize their ability to quickly and safely respond to the needs of their communities and patients in disasters.'' The commenters stated that they have developed examples of where changes and additional flexibilities are necessary and would be willing to work with CMS and the Secretary on legislative proposals to address these changes.

Response: We appreciate the commenters' interest in continuing to improve access to patient care during emergency situations and the commenters' offer to work with CMS and the Secretary on legislative changes and future rulemaking to address the need for increased flexibility for hospitals during emergency situations.

After consideration of the public comments we received, we are adopting as final the proposed change to § 489.24(a)(2) of the regulations, except that we are changing the language under paragraphs (a)(2)(i)(A) and (a)(2)(i)(B) as noted above. The revised § 489.24(a)(2) reads as follows:

''(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:

(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.

(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.

(C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.

(D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act.

(E) There is a determination that a waiver of sanctions is necessary.

(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act.''

I. Rural Community Hospital Demonstration Program

In accordance with the requirements of section 410A(a) of Public Law 108–173, the Secretary has established a 5-year demonstration program (beginning with selected hospitals' first cost reporting period beginning on or after October 1, 2004) to test the feasibility and advisability of establishing ''rural community hospitals'' for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that—

- Is located in a rural area (as defined in section 1886(d)(2)(D) of the Act) or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act;
- Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;
- Provides 24-hour emergency care services; and
- Is not designated or eligible for designation as a CAH.

Section 410A(a)(4) of Public Law 108–173 states that no more than 15 such hospitals may participate in the demonstration program.

As we indicated in the FY 2005 IPPS final rule (69 FR 49078), in accordance with sections 410A(a)(2) and (a)(4) of Public Law 108–173 and using 2002 data from the U.S. Census Bureau, we identified 10 States with the lowest population density from which to select hospitals: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming (Source: *U.S. Census Bureau Statistical Abstract of the United States: 2003*). Eleven rural community hospitals located within these States are currently participating in the demonstration program. (Of the 13

hospitals that participated in the first 2 years of the demonstration program, 4 hospitals located in Nebraska became CAHs and withdrew from the program.) In a notice published in the **Federal Register** on February 6, 2008 (73 FR 6971 through 6973), we announced a solicitation for up to six additional hospitals to participate in the demonstration program. The February 6, 2008 notice specified the eligibility requirements for the demonstration program. Four additional hospitals were selected to participate under this solicitation. These four additional hospitals began under the demonstration payment methodology with the hospital's first cost reporting period starting on or after July 1, 2008. The end date of participation for these hospitals is September 30, 2010. Two hospitals among the hospitals that began the demonstration at the project's inception withdrew from the demonstration between April and June 2009. These two hospitals stated that they preferred being paid under the SCH provision of the MIPPA (Pub. L. 110–275) instead of participating in the demonstration.

Under the demonstration program, participating hospitals are paid the reasonable costs of providing covered inpatient hospital services (other than services furnished by a psychiatric or rehabilitation unit of a hospital that is a distinct part), applicable for discharges occurring in the first cost reporting period beginning on or after the October 1, 2004 implementation date of the demonstration program (or the July 1, 2008 date for the newly selected hospitals). Payments to the participating hospitals will be the lesser amount of the reasonable cost or a target amount in subsequent cost reporting periods. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target amount, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period.

Covered inpatient hospital services are inpatient hospital services (defined in section 1861(b) of the Act), and include extended care services furnished under an agreement under section 1883 of the Act.

Section 410A of Public Law 108–173 requires that, ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' Generally, when CMS implements a demonstration program on a budget neutral basis, the demonstration program is budget neutral in its own terms; in other words, the aggregate payments to the participating hospitals do not exceed the amount that would be paid to those same hospitals in the absence of the demonstration program. This form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration program may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration program's participants. These reduced expenditures offset increased payments elsewhere under the demonstration program, thus ensuring that the demonstration program as a whole is budget neutral or yields savings. However, the small scale of this demonstration program, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration program could be viable under the usual form of budget neutrality. Specifically, cost-based payments to participating small rural hospitals are likely to increase Medicare outlays without producing any offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration program is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these hospitals.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24196), we proposed two measures to achieve budget neutrality for the demonstration program for FY 2010, which, when combined, would lead to an adjustment in the national inpatient PPS rates. We proposed to adjust the national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration program. We proposed to apply budget neutrality across the payment system as a whole rather than merely across the participants in this demonstration program. As we discussed in the FY 2005, FY 2006, FY 2007, FY 2008, and FY 2009 IPPS final rules (69 FR 49183; 70 FR 47462; 71 FR 48100; 72 FR 47392; and 73 FR 48670), we believe that the language of the statutory budget neutrality requirements permits the agency to implement the budget neutrality provision in this manner.

First, in the proposed rule, we estimated the cost of the demonstration program for FY 2010 for the 13 participating hospitals. We stated that the estimate of the portion of the budget neutrality adjustment that accounts for the costs of the demonstration for FY 2010 for 9 of the 13 hospitals (that is, the 9 hospitals that had participated in the demonstration since its inception and that were continuing to participate in the demonstration) was based on data from their first and second year cost reports—that is, cost reporting periods beginning in CY 2005 and CY 2006. We proposed to use these cost reports because they were the most recent complete cost reports and thus we believed they enabled us to estimate FY 2010 costs as accurately as possible. In addition, we estimated the cost of the demonstration for FY 2010 for the 4 hospitals that joined the demonstration in 2008 based on data for their cost reporting periods beginning October 1, 2005, through July 1, 2006 (that is, cost reporting periods that include CY 2006). When we added together the estimated costs of the demonstration for FY 2010 for the 9 hospitals that had participated in the demonstration since its inception and the 4 new hospitals selected in 2008, the proposed total estimated cost was $14,613,632. This proposed estimated amount reflected the difference between the participating hospitals' estimated costs under the methodology set forth in Public Law 108–173 and the estimated amount the hospitals would have been paid under the IPPS.

Second, for the proposed rule, because the cost reports of all hospitals participating in the demonstration in its first year (that is, FY 2005) had been finalized, we were able to determine how much the cost of the demonstration program exceeded the amount that was offset by the budget neutrality adjustment for FY 2005. For all 13 hospitals that participated in the demonstration in FY 2005, the amount was $7,179,461. The total proposed budget neutrality offset amount to be applied for the demonstration for the demonstration for FY 2010 was the sum of these two amounts, or $21,793,093. In addition, we stated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule that the budget neutrality offset amount may be different in the IPPS final rule to the extent that we have more recent data.

We did not receive any public comments on our proposal.

For this final rule, based on more recent data, we are estimating the cost of the demonstration program for FY 2010 for the 11 currently participating hospitals. (As indicated previously, two hospitals recently withdrew from the demonstration, and we are adjusting the estimation of the cost of the demonstration for FY 2010 for this final rule to reflect this.) The estimate of the portion of the budget neutrality adjustment that accounts for the costs of the demonstration for FY 2010 for 7 of the 11 currently participating hospitals (that is, the 7 hospitals that have participated in the demonstration since its inception and that continue to participate in the demonstration) is based on data from their second year cost reports—that is, cost reporting periods beginning in CY 2006. We used these cost reports because they are the most recent complete cost reports and, thus, we believe they enable us to estimate FY 2010 costs for this final rule as accurately as possible. (We note that, at the time of the proposed rule, we had completed cost reports for cost reporting periods beginning in CY 2005 for all of the hospitals that had participated in the demonstration since its inception and that were continuing to participate, and complete cost reports for cost reporting periods beginning in CY 2006 for most, but not all, such hospitals. Because we did not have all cost reports for cost reporting periods beginning in CY 2006, we used data from CYs 2005 and 2006 to best estimate FY 2010 costs for these hospitals. For this final rule, we had complete cost reports for cost reporting periods beginning in CY 2006 for all 7 currently participating hospitals. Therefore, we used these most recent data to estimate costs.) In addition, we estimate the cost of the demonstration for FY 2010 for the 4 hospitals that joined the demonstration in 2008. For 3 of the 4 hospitals that joined the demonstration in 2008, we estimate the cost of the demonstration for FY 2010 based on data for their cost reporting periods beginning January 1, 2007, through July 1, 2007. Similarly, we used these cost reports because they are the most recent cost reports and, thus, we believe they enable us to estimate FY 2010 costs for these 3 hospitals as accurately as possible. We believe that the estimates obtained from the Medicare inpatient cost amounts on these cost reports allow for the most accurate estimation of the cost of the program in FY 2010. The remaining hospital of the 4 that began in 2008 is an Indian Health Service (IHS) provider. Historically, the hospital has not filed standard Medicare cost reports. In order to estimate its costs, we used an analysis of Medicare inpatient costs and payments submitted by the hospital for the cost reporting period of October 1, 2005, through September 30, 2006. The Medicare cost amount from this analysis for the IHS provider is identical to that used in the proposed rule. We chose this approach because it is consistent with our overall methodology. When we add together the estimated costs of the demonstration for FY 2010 for the 7 hospitals that have participated in the demonstration since its inception and the 4 new hospitals selected in 2008 based on the more recent data, the total estimated cost is $15,081,251. This estimated amount reflects the difference between the participating hospitals' estimated costs under the methodology set forth in Public Law 108–173 and the estimated amount the hospitals would have been paid under the IPPS.

Second, for this final rule, because the FYs 2005 and 2006 cost reports of all hospitals participating in the demonstration in its first and second years have been finalized, we are able to determine how much the cost of the demonstration program exceeded the amount that was offset by the budget neutrality adjustment for FY 2005 and FY 2006. For all 13 hospitals that participated in the demonstration in FY 2005, the amount is $7,856,617. For the 10 hospitals with cost reporting periods that began in FY 2006, the amount is $4,203,947. The sum of these amounts, or the amount by which the cost of the demonstration program exceeded the offset of the budget neutrality adjustment for FY 2005 and FY 2006, is $12,060,564.

The total budget neutrality offset amount applied for the demonstration for FY 2010 is the sum of these two amounts, or $27,141,815. We discuss the payment rate adjustment that is required to ensure the budget neutrality of the demonstration program for FY 2010 in section II.A.4. of the Addendum to this final rule. This amount differs from that proposed in the proposed rule because we used more recent data, including the finalized FY 2006 cost reports of the hospitals that participated in the second year of the demonstration (these finalized reports enabled us to now include the amount by which the cost of the demonstration exceeded the amount that was offset by the FY 2006 budget neutrality adjustment).

J. Technical Correction to Regulations Relating to Calculation of the Federal Rate Under the IPPS

Section 412.63 of the regulations specifies the procedures for determining the standardized amounts for inpatient operating costs for Federal fiscal years 1984 through 2004. These standardized amounts included a ''large urban area'' standardized amount for large urban hospitals and an ''other area'' standardized amount for hospitals located in other areas. In the FY 1989 IPPS final rule, we established § 412.63(c)(5). Consistent with section 1886(d)(3)(C)(ii) of the Act, § 412.63(c)(5) states that, for FYs 1987 through 2004, CMS calculated the average standardized amounts by excluding an estimate for IME payments. Accordingly, beginning in FY 1989, we updated the standardized amounts using an IME adjustment factor that excludes an estimate of IME payments. For a complete discussion on this adjustment factor for IME, we refer readers to the FY 1989 IPPS final rule (53 FR 38538 through 38539).

Section 1886(d)(3)(A)(iv) of the Act, as amended by section 401(a) of Public Law 108–173, requires that, beginning with FY 2004 and thereafter, we compute the standardized amount for all hospitals in any area equal to the standardized amount for the previous fiscal year for large urban hospitals, updated by the applicable percentage update under section 1886(b)(3)(B)(i) of the Act. In other words, beginning in FY 2004, we no longer computed a ''large urban area'' standardized amount and a separate ''other area'' standardized amount. As a result of this statutory change, we established new regulations at § 412.64 to specify the computation of the single standardized amount for FY 2005 and subsequent fiscal years (69 FR 49077). With the exception of removing a separate standardized amount for non-large urban hospitals, the regulation text at § 412.64 virtually mirrors the regulation text at § 412.63. For FY 2005 and subsequent fiscal years, we excluded an estimate for IME payments from the calculation of the standardized amount in accordance with section 1886(d)(3)(A)(iv) of the Act. However, we inadvertently omitted from § 412.64 the language under paragraph (c)(5) of § 412.63 that implements the exclusion of an estimate for IME payments from the calculation of the standardized amount in accordance with section 1886(d)(3)(A)(iv) of the Act. Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24196 through 24197), we proposed to revise § 412.64(c) to include this language so that § 412.64(c) reflects the statutory requirement under section 1886(d)(3)(A)(iv) of the Act that calculation of the standardized amount excludes IME payments.

We did not receive public comment on this technical correction; therefore,

we are adopting our proposal without modification.

VI. Changes to the IPPS for Capital-Related Costs

A. Overview

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services ''in accordance with a prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs. We initially implemented the IPPS for capital-related costs in the Federal fiscal year (FY) 1992 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

FY 2001 was the last year of the 10-year transition period established to phase in the IPPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital IPPS payments are based solely on the Federal rate for almost all acute care hospitals (other than hospitals receiving certain exception payments and certain new hospitals). (We refer readers to the FY 2002 IPPS final rule (66 FR 39910 through 39914) for additional information on the methodology used to determine capital IPPS payments to hospitals both during and after the transition period.) The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312 of the regulations. For the purpose of calculating payments for each discharge, currently the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (COLA for hospitals located in Alaska and Hawaii) × (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable).

B. Exception Payments

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the FY 2003 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). Additional information on the exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 49186).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of the hospital (§ 412.348(c)), but were available only during the 10-year transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, eligible hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital IPPS transition period. Hospitals eligible for special exceptions payments are required to submit documentation to the fiscal intermediary or MAC indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), we refer readers to the FY 2002 IPPS final rule (66 FR 39911 through 39914) and the FY 2003 IPPS final rule (67 FR 50102).)

C. New Hospitals

Under the IPPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years. For example, the following hospitals are not considered new hospitals: (1) A hospital that builds new or replacement facilities at the same or another location, even if coincidental with a change of ownership, a change in management, or a lease arrangement; (2) a hospital that closes and subsequently reopens; (3) a hospital that has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years; and (4) a hospital that changes its status from a hospital that is excluded from the IPPS to a hospital that is subject to the capital IPPS. For more detailed information, we refer readers to the FY 1992 IPPS final rule (56 FR 43418). During the 10-year transition period, a new hospital was exempt from the capital IPPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because, as discussed in the FY 2003 IPPS final rule (67 FR 50101), we believe that special protection to new hospitals is also appropriate even after the transition period, we revised the regulations at § 412.304(c)(2) to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its Medicare allowable capital-related costs through its first 2 years of operation, unless the new hospital elects to receive full prospective payment based on 100 percent of the Federal rate. (We refer readers to the FY 2003 IPPS final rule (67 FR 50101 through 50102) for a detailed discussion of the special payment provisions for new hospitals under the capital IPPS after the 10-year transition period.)

D. Hospitals Located in Puerto Rico

Section 412.374 of the regulations provides for the use of a blended payment amount for prospective payments for capital-related costs to hospitals located in Puerto Rico. Accordingly, under the capital IPPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In general, hospitals located in Puerto Rico are paid a blend of the applicable capital IPPS Puerto Rico rate and the applicable capital IPPS Federal rate.

Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital IPPS rate that consisted of 75 percent of the capital IPPS Puerto Rico-specific rate and 25 percent of the capital IPPS Federal rate. However, effective October 1, 1997 (FY 1998), in conjunction with the change to the operating IPPS blend percentage for hospitals located in Puerto Rico required by section 4406 of Public Law 105–33, we revised the methodology for computing capital IPPS

payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the capital IPPS Puerto Rico rate and 50 percent of the capital IPPS Federal rate. Similarly, in conjunction with the change in operating IPPS payments to hospitals located in Puerto Rico for FY 2005 required by section 504 of Public Law 108–173, we again revised the methodology for computing capital IPPS payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the capital IPPS Puerto Rico rate and 75 percent of the capital IPPS Federal rate effective for discharges occurring on or after October 1, 2004.

E. Proposed and Final Changes

1. FY 2010 MS–DRG Documentation and Coding Adjustment

a. Background on the Prospective MS–DRG Documentation and Coding Adjustments for FY 2008 and FY 2009

In the FY 2008 IPPS final rule with comment period (72 FR 47175 through 47186), we adopted the MS–DRG patient classification system for the IPPS, effective October 1, 2007, to better recognize patients' severity of illness in Medicare payment rates. Adoption of the MS–DRGs resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008 (currently 746, including one additional MS–DRG created in FY 2009). By increasing the number of DRGs and more fully taking into account patients' severity of illness in Medicare payment rates, the MS–DRGs encourage hospitals to change their documentation and coding of patient diagnoses. In that same final rule with comment period (72 FR 47183), we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for changes in documentation and coding. Accordingly, we established adjustments to both the national operating standardized amount and the national capital Federal rate to eliminate the estimated effect of changes in documentation and coding resulting from the adoption of the MS–DRGs that do not reflect real changes in case-mix. Specifically, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010. However, to comply with section 7(a) of Public Law 110–90, enacted on September 29, 2007, in a final rule published in the **Federal Register** on November 27, 2007 (72 FR 66886 through 66888), we modified the documentation and coding adjustment for FY 2008 to −0.6 percent, and consequently revised the FY 2008 IPPS operating and capital payment rates, factors, and thresholds accordingly, with these revisions effective October 1, 2007.

For FY 2009, section 7(a) of Public Law 110–90 required a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment established in the FY 2008 IPPS final rule with comment period. As discussed in the FY 2008 IPPS final rule with comment period (72 FR 48447 and 48733 through 48774), we applied a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amounts and the capital Federal rate. The documentation and coding adjustments established in the FY 2009 IPPS final rule, as amended by Public Law 110–90, are cumulative. As a result, the −0.9 percent documentation and coding adjustment in FY 2009 was in addition to the −0.6 percent adjustment in FY 2008, yielding a combined effect of −1.5 percent. (For additional details on the development and implementation of the documentation and coding adjustments for FY 2008 and FY 2009, we refer readers to section II.D. of this preamble and the following rules published in the **Federal Register**: August 22, 2007 (72 FR 47175 through 47186 and 47431 through 47432); November 27, 2007 (72 FR 66886 through 66888); and August 19, 2008 (73 FR 48447 through 48450 and 48773 through 48775).)

b. Prospective MS–DRG Documentation and Coding Adjustment to the National Capital Federal Rate for FY 2010 and Subsequent Years

As discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24199 through 24200), consistent with the prospective adjustment to the national average operating IPPS standardized amounts (discussed in section II.D. of this preamble), under the capital IPPS we also continue to believe that it is appropriate to make adjustments to the capital IPPS rates to eliminate the effect of any documentation and coding changes as a result of the implementation of the MS–DRGs. These adjustments are intended to ensure that future annual aggregate IPPS payments are the same as payments that otherwise would have been made had the prospective adjustments for documentation and coding applied in FY 2008 and FY 2009 accurately reflected the change due to documentation and coding that occurred in those years. As noted above in section VI.A. of this preamble, under section 1886(g) of the Act, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs (that is, the capital IPPS). We have consistently stated since the initial implementation of the MS–DRG system that we do not believe it is appropriate for Medicare expenditures under the capital IPPS to increase due to MS–DRG related changes in documentation and coding. Accordingly, we believe that it is appropriate under the Secretary's broad authority under section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, to make adjustments to the capital Federal rate to eliminate the full effect of the documentation and coding changes resulting from the adoption of the MS–DRGs. We believe that this is appropriate because, in absence of such adjustments, the effect of the documentation and coding changes resulting from the adoption of the MS–DRGs results in inappropriately high capital IPPS payments because that portion of the increase in aggregate payments is not due to an increase in patient severity (and costs).

We have performed a thorough retrospective evaluation of the most recent available claims data, and the results of this evaluation were used by our actuaries to determine any necessary payment adjustments beyond the cumulative −1.5 percent adjustment applied in determining the FY 2009 capital Federal rate to ensure budget neutrality for the implementation of MS–DRGs. Specifically, as discussed in greater detail in section II.D.4. of the preamble of this final rule, for the proposed rule, we performed a retrospective evaluation of the FY 2008 claims data updated through December 2008. We updated that analysis for this final rule based on the FY 2008 claims data updated through March 2009, which confirmed our original analysis. Based on this evaluation, which is described in greater detail in section II.D.4. of this preamble, our actuaries have determined that the implementation of the MS–DRG system resulted in a 2.5 percent change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008.

The 2.5 percent change in FY 2008 case-mix due to documentation and coding changes that did not reflect real changes in case-mix for discharges occurring during FY 2008 exceeds the −0.6 percent prospective documentation and coding adjustment applied to the FY 2008 capital Federal rate (as established in the final rule

published in the **Federal Register** on November 27, 2007 (72 FR 66886 through 66888)) by 1.9 percentage points (2.5 percent minus 0.6 percent). Therefore, in the proposed rule, under the Secretary's broad authority under section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, we proposed to reduce the capital Federal rate in FY 2010 by −1.9 percent to account for the amount by which the 2.5 percent change in FY 2008 exceeds the established −0.6 percent adjustment. Furthermore, consistent with our proposal under the operating IPPS, we proposed to leave that proposed −1.9 percent adjustment in place for subsequent fiscal years to account for the effect in FY 2010 and subsequent years of the amount by which the 2.5 percent change in FY 2008 exceeds the established −0.6 percent adjustment.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we sought public comment on the proposed −1.9 percent prospective adjustments to address the effect of documentation and coding changes unrelated to changes in real case-mix in FY 2008. In addition, as we discussed in section II.D. of the preamble of the proposed rule, we sought public comment on addressing in the FY 2011 rulemaking cycle any differences between the increase in FY 2009 case-mix due to documentation and coding changes that do not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied in determining the FY 2009 capital Federal rate established in the FY 2009 IPPS final rule.

Comment: One commenter sought clarification whether or not the estimate of case-mix change related to documentation and coding fully considers the estimate of real case-mix change for FYs 2009 and 2010 under the capital IPPS.

Response: Our actuaries' estimate of real case-mix change under capital IPPS for FYs 2009 and FY 2010 represents a long-term projection of real case-mix growth. In contrast, as described above, our actuaries estimate of case-mix change related to documentation and coding changes in FY 2008 of 2.5 percent is based on a retrospective evaluation of actual FY 2008 claims data. Our estimate of case-mix change related to documentation and coding in FY 2008 does not require the consideration of real case-mix changes since the methodology for estimating the FY 2008 documentation and coding effect does not, by definition, include real case-mix, regardless of the actual real case-mix level because it uses only FY 2008 claims, as discussed in more detail in the comment responses in section II.D.4. of this preamble.

Comment: In addition to the comments on the methodology and economic impact of the proposed −1.9 percent documentation and coding adjustment discussed in section II.D.4. and section II.D.5. of this preamble, a few commenters specifically opposed the application of the proposed −1.9 percent adjustment to the capital Federal rate. The commenters noted that such a reduction in capital IPPS payments, coupled with the reductions to capital IPPS payments over the past few years, would be difficult to sustain in the current national economic environment and would affect hospitals' ability to fund much needed capital projects. Accordingly, the commenters recommended that the proposed adjustment for documentation and coding for FY 2010 not be applied to the capital Federal rate.

Response: As explained above, we believe that it is appropriate to make adjustments to the capital Federal rate to eliminate the full effect of the documentation and coding changes resulting from the adoption of the MS–DRGs, which in the absence of such adjustments, results in inappropriately high capital IPPS payments because that portion of the increase in aggregate payments is not due to an increase in patient severity of illness (and costs). Our actuaries have determined, and MedPAC has confirmed, that the implementation of the MS–DRG system resulted in a change of 2.5 percent, which represents the documentation and coding effect that does not reflect real changes in case-mix for discharges occurring during FY 2008. The impact of these changes is greater than the −0.6 percent prospective documentation and coding adjustments applied to the FY 2008 capital Federal rate. Therefore, as described in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we proposed to adjust the FY 2010 capital Federal rate by −1.9 percent.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we also discussed our examination of the differences in case-mix between the FY 2008 claims data in which cases were grouped through the FY 2008 GROUPER (Version 25.0) and the FY 2009 GROUPER (Version 26.0). As discussed in section II.D.5. of this preamble, this was to help inform our analysis of the potential for increase in the documentation and coding effect in FY 2009. In FY 2008, we were transitioning to the fully implemented MS–DRG relative weights and the fully implemented cost-based weights. We found that the use of the transition weights (that is, weights that were based on a 50/50 blend of the MS–DRG relative weights and the CMS DRG relative weights (72 FR 47276) mitigated the FY 2008 documentation and coding effect on expenditures. Specifically, our analysis of FY 2008 claims data shows that, even assuming no additional changes in documentation and coding in FY 2009, the use of the FY 2009 MS–DRG relative weights (which no longer were based on a blend of the MS–DRGs and the CMS DRGs) results in an additional 0.7 percent documentation and coding effect in FY 2009. Based on these analyses and other factors, our actuaries continue to estimate that the cumulative overall effect of documentation and coding changes under the MS–DRG system will be 4.8 percent. Our actuaries also estimate that these changes will be substantially complete by the end of FY 2009. Therefore, our current estimate of the MS–DRG documentation and coding effect is 2.3 percent for discharges occurring during FY 2009 (that is, the 4.8 percent total increase minus the 2.5 percent increase from FY 2008). Consistent with the national operating standardized amounts presented in section II.D.4. of this preamble, we proposed to address any differences between the increase in FY 2009 case-mix due to documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2009 and the −0.9 percent prospective documentation and coding adjustment applied to the FY 2009 capital Federal rate in a future rulemaking after a full evaluation of the overall national average changes in case-mix for FY 2009 can be completed.

We continue to believe it is appropriate to make adjustments to the capital Federal rate to eliminate the full effect of the documentation and coding changes resulting from the adoption of the MS–DRGs. However, after consideration of the public comments, consistent with the application of the documentation and coding adjustment to the operating IPPS standardized amounts discussed in section II.D.5. of this preamble, we have determined that it would be appropriate to postpone the adoption of any additional documentation and coding adjustments to the capital IPPS rates until a full analysis of FY 2009 case-mix changes can be completed. Although we only proposed to make a −1.9 percent adjustment to account for the portion of the estimated 2.5 percent change in FY

2008 case-mix due to documentation and coding changes that exceeds the −0.6 percent prospective documentation and coding adjustment applied to the FY 2008 capital Federal rate (that is, 2.5 percent minus 0.6 percent = 1.9 percent), as noted above, our current estimate of the MS–DRG documentation and coding effect for FY 2009 is 2.3 percent (that is, the 4.8 percent total increase minus the 2.5 percent increase from FY 2008). If the estimated documentation and coding effect determined based on a full analysis of FY 2009 claims data is more or less than our current estimates, it would change the anticipated cumulative adjustments that we currently estimate we would have to make for FY 2008 and FY 2009 combined. In future rulemaking, we will consider applying a prospective documentation and coding adjustment to the capital IPPS rates based on a complete analysis of FY 2008 and FY 2009 claims data.

c. Documentation and Coding Adjustment to the Puerto Rico-Specific Capital Rate

As discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, under § 412.74, Puerto Rico hospitals are currently paid based on 75 percent of the national capital Federal rate and 25 percent of the Puerto Rico-specific capital rate. In the FY 2009 IPPS final rule (73 FR 48775), consistent with our development of the FY 2009 Puerto Rico-specific operating standardized amount, we did not apply the additional −0.9 percent documentation and coding adjustment (or the cumulative −1.5 percent adjustment) to the FY 2009 Puerto Rico-specific capital rate. However, we discussed that the statute gives broad authority to the Secretary under section 1886(g) of the Act, with respect to the development of and adjustments to a capital PPS, and therefore we would not be outside the authority of section 1886(g) of the Act in applying the documentation and coding adjustment to the Puerto Rico-specific portion of the capital payment rate. As we explained in that same final rule, to date we had not yet applied a documentation and coding adjustment to the Puerto Rico-specific capital rate because we have historically made changes to the capital IPPS consistent with those changes made to the operating IPPS. We also stated that we may propose to apply such an adjustment to the Puerto Rico capital rates in the future.

As discussed in section II.D.10. of the preamble of the proposed rule and in this final rule, when we performed a retrospective evaluation of the FY 2008 claims data of hospitals located in Puerto Rico using the same methodology discussed above, we found that the change in case-mix due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 from hospitals located in Puerto Rico was approximately 1.1 percent. Given this case-mix increase due to changes in documentation and coding under the MS–DRGs, consistent with our proposal to adjust the FY 2010 capital Federal rate presented above and consistent with our proposed adjustment to the FY 2010 Puerto Rico-specific standardized amount discussed in section II.D.10. of the preamble of the proposed rule, in the proposed rule, under the Secretary's broad authority under section 1886(g) of the Act, we proposed to adjust the Puerto Rico-specific capital rate by −1.1 percent in FY 2010 for the FY 2008 increase in case-mix due to changes in documentation and coding under the MS–DRGs. In addition, consistent with our other proposals concerning prospective MS–DRG documentation and coding adjustments to the capital Federal rate and operating IPPS standardized amounts presented in the proposed rule, we proposed to leave that proposed −1.1 percent adjustment in place for subsequent fiscal years in order to ensure that changes in documentation and coding resulting from the adoption of the MS–DRGs do not lead to an increase in aggregate payments not reflective of an increase in real case-mix. We proposed that the proposed 1.1 percent adjustment would be applied to the capital Puerto Rico-specific rate that accounts for 25 percent of payments to hospitals located in Puerto Rico, with the remaining 75 percent based on the national capital Federal rate, which we proposed to adjust as described above. Consequently, the proposed overall reduction to the FY 2010 payment rates for hospitals located in Puerto Rico to account for documentation and coding changes would be slightly less than the reduction for IPPS hospitals paid based on 100 percent of the national capital Federal rate. As noted above, the Puerto Rico-specific capital rate was not adjusted for the effects of documentation and coding changes in FY 2008 or FY 2009 as were the FY 2008 and FY 2009 national capital Federal rates.

As stated in section II.D.10. of the preamble of the proposed rule, we sought public comment on the proposed −1.1 percent prospective adjustment to the Puerto Rico-specific IPPS rates in FY 2010 for the FY 2008 documentation and coding effect, including the methodology for determining these adjustments. In addition, we sought public comment on addressing in the FY 2011 rulemaking cycle any increase in FY 2009 case-mix due to documentation and coding changes that did not reflect real changes in case-mix for discharges occurring during FY 2009. We did not receive any public comments on the proposed −1.1 percent prospective adjustment to the Puerto Rico-specific IPPS rates in FY 2010 for the FY 2008 documentation and coding effect. However, as discussed in greater detail above, in this final rule, we have determined that it would be appropriate to postpone the adoption of any documentation and coding adjustments to the capital IPPS rates at this time until a full analysis of FY 2009 case-mix changes can be completed. Any future documentation and coding adjustment to the capital Puerto Rico-specific IPPS rates based on a complete analysis of FY 2008 and FY 2009 claims data for Puerto Rico hospitals would be established through the notice and comment rulemaking process.

2. Revision to the FY 2009 IME Adjustment Factor

In the FY 2008 IPPS final rule, we established a policy to phase out the capital IPPS teaching adjustment over a 3-year period because of the high positive aggregate capital IPPS Medicare margins for teaching hospitals. Under the regulations, as established at § 412.322(b), (c), and (d), teaching hospitals would receive the full capital IME adjustment for FY 2008, but the adjustment would be reduced by 50 percent in FY 2009, and there would be no capital IME adjustment for FY 2010 and thereafter.

As noted in section VI.A. of this preamble, section 4301(b)(1) of Public Law 111–5 requires that the phase-out of the capital IPPS teaching adjustment specified at § 412.322(c) of the regulations (that is, the 50-percent reduction for FY 2009) shall not be applied, and the Secretary shall apply § 412.322 without regard to paragraph (c) of that section. Furthermore, section 4301(b)(2) of the Public Law 111–5 specifies that the law has no effect on § 412.322(d), which eliminates the capital IPPS teaching adjustment for FY 2010 and thereafter. Therefore, in order to reflect the current statutory requirements as specified in section 4301(b)(1) of Public Law 111–5, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we proposed to delete § 412.322(c) of the existing regulations.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we solicited public comments on our proposed implementation of section 4301(b) of Public Law 111–5 concerning capital IME payments.

Comment: Numerous commenters addressed the proposal to implement section 4301(b) of Pub. L. 111–5. Specifically, the commenters unanimously opposed the elimination of the capital IME adjustment for FY 2010. Many commenters discussed the financial impact that eliminating the capital teaching adjustment would have on teaching hospitals across the country or in their States and for a particular hospital. Some commenters pointed out that the level of capital payments to hospitals is already projected to decrease in FY 2010 compared to FY 2009. The commenters advised that if CMS reversed the cut to the capital IME adjustment, it would mitigate what the commenters believed to be a substantial decrease in capital payments. A large number of commenters also believed any margin analysis should include both the operating and capital payment systems. They stated that IPPS is the only Medicare payment system that does not provide a single payment for total cost (operating and capital), and that hospitals have always used their operating and capital payments as if they were one payment. Therefore, margin analysis, as well, should include both payment systems.

The commenters indicated that teaching hospitals are the main providers of uncompensated care and often act as the community safety net and added that these responsibilities increase costs to teaching hospitals in addition to the more traditional sources of higher costs such as for training purposes. They also stated that these safety net teaching hospitals rely heavily upon Medicare capital payments as a source of stable revenue for capital improvements because it is often difficult for these types of hospitals to access affordable funding. One commenter indicated that Medicare capital payments are critical to safety net type hospitals as uncompensated costs have increased and that looking at capital margins in isolation is not indicative of the overall health of a hospital.

Some commenters also found CMS' proposed elimination of payment that supports medical education contradictory to CMS' emphasis on quality, preventive measures and improved clinical outcomes as a method of reducing cost. Several commenters also mentioned that CMS' proposal is at odds with Congress' intent when they established special payments for teaching hospitals as a means of Medicare supporting medical education until other insurers fill that role. This has not occurred, according to commenters; therefore, the requisite teaching adjustment allows Medicare to continue in this necessary role.

Response: We recognize the importance of hearing the opinions of the health care industry and other stakeholders, and we have found it valuable to review the many comments we received on this issue. We carefully considered our approach to eliminating the capital teaching adjustment and were aware of the reaction such an action would garner. As operators of the Medicare program, we not only have a responsibility to ensure quality of and access to care for Medicare beneficiaries, we also have a financial responsibility to the program to create policies that are not a detriment to its financial viability as well as to change or eliminate those policies that have a negative financial effect to the program. Consequently, we developed the policy to eliminate the capital teaching adjustment after conducting numerous analyses with particular attention given to capital Medicare costs and payments under the capital IPPS. It is never our intent to create financial hardship for hospitals, nor is it our purpose to enable some hospitals to experience consistently large positive margins. As we have discussed in previous rulemakings (72 FR 47393; 73 FR 48672), the statutory history of the capital IPPS suggests that the system in the aggregate should not provide for continuous, large positive margins. Our analyses indicated that the adjustments for teaching hospitals have been a contributor to the excessive capital payment levels in previous years.

While we continue to believe our margin analyses are accurate, we also acknowledge that the analyses covered the period from 1996 through 2006, using the most recently available data at the time that we proposed and adopted the 3-year phase-out of the capital IME adjustment. In consideration of numerous comments regarding the capital expenditure cycle, as well as commenters referencing other margin analyses by outside sources that indicated a decline in capital margins, we conducted further capital margin analysis given the availability of more recent data. Specifically, we looked at capital Medicare margins for FY 2007. Our analysis indicates that while teaching hospitals continue to experience positive capital margins, there is a decline in these margins in comparison to the last year in our previous analyses (2006). Accordingly, we do not believe eliminating the capital teaching adjustment is prudent at this time. As we stated in the FY 2008 IPPS final rule (72 FR 47397), we will continue to analyze the data concerning the adequacy of payments under the capital IPPS, and may propose adjustments in the future if our analysis indicates such adjustments are warranted. However, in light of our most recent analysis, and in consideration of some of the comments received, we are deleting the requirement at § 412.322(d) of the regulations, which eliminates the IPPS capital teaching adjustment for FY 2010.

We are adopting, as final, our proposal to delete § 412.322(c) of the existing regulations. In the absence of existing § 412.322(c), the capital IPPS teaching adjustment for FY 2009 will not be reduced by 50 percent but will be as determined under § 412.322(b) (that is, the full capital IME teaching adjustment). We also are deleting § 412.322(d) of the existing regulations, which eliminates the teaching adjustment for FY 2010. Therefore, the full capital IME teaching adjustment is restored for FY 2010 and will be determined under § 412.322(b). We note that we have issued instructions (Change Request 6444, dated March 27, 2009) to fiscal intermediaries and MACs to implement the change to the capital teaching adjustment for FY 2009, as specified in section 4301(b)(1) of Public Law 111–5.

In summary, as noted above, in this final rule, as we proposed, we are revising the existing regulations at § 412.322 by deleting the language of paragraph (c). In addition, as discussed above, we are deleting the language of paragraph (d) in § 412.322. Both paragraphs (c) and (d) will be labeled ''Repealed.''

3. Other Changes for FY 2010

The proposed and final annual update to the capital IPPS national and Puerto Rico-specific rates, as provided for at § 412.308(c), for FY 2010 is discussed in section III. of the Addendum to this final rule.

VII. Changes for Hospitals Excluded From the IPPS

A. Excluded Hospitals

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in

§ 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount was multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers, which included rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals.

Payment to children's hospitals and cancer hospitals that are excluded from the IPPS continues to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a) of the regulations, RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24201), we proposed that the percentage increase in the rate-of-increase limits for cancer and children's hospitals and RNHCIs was the percentage increase in the proposed FY 2010 IPPS operating market basket. In compliance with section 404 of the MMA, in the proposed rule, we proposed to replace the FY 2002-based IPPS operating and capital market baskets with the revised and rebased FY 2006-based IPPS operating and capital market baskets for FY 2010. Therefore, consistent with the current law, based on IHS Global Insight, Inc.'s 2009 first quarter forecast, with historical data through the 2008 fourth quarter, we proposed that the FY 2010 update to the IPPS operating market basket would be 2.1 percent (that is, the current estimate of the market basket rate-of-increase).

Consistent with our historical approach, we calculated the proposed IPPS operating market basket for FY 2010 using the most recent data available. However, we proposed that if more recent data became available for the final rule, we would use them to calculate the IPPS operating market basket for FY 2010. Therefore, based on IHS Global Insight, Inc.'s 2009 second quarter forecast, with historical data through the 2009 first quarter, the IPPS operating market basket update factor for FY 2010 is 2.1 percent. Moreover, consistent with our proposal that the percentage increase in the rate-of-increase limits for cancer and children's hospitals and RNHCIs would be the percentage increase in the FY 2010 IPPS operating market basket, the FY 2010 rate-of-increase percentage that is applied to FY 2009 target amounts in order to calculate the FY 2010 target amounts for cancer and children's hospitals and RNHCIs is 2.1 percent, in accordance with the applicable regulations in 42 CFR 413.40.

We note that IRFs, IPFs, and LTCHs, which were paid previously under the reasonable cost methodology, now receive payment under their own prospective payment systems, in accordance with changes made to the statute. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provided transition periods of varying lengths during which time a portion of the prospective payment was based on cost-based reimbursement rules under Part 413. (However, certain providers do not receive a transition period or may elect to bypass the transition period as applicable under 42 CFR Part 412, Subparts N, O, and P.) We note that the various transition periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended.

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We refer readers to section IV. of the Addendum to this final rule for the specific update changes to the Federal payment rates for LTCHs under the LTCH PPS for RY 2010. The annual updates for the IRF PPS and the IPF PPS are issued by the agency in separate **Federal Register** documents.

B. Criteria for Satellite Facilities of Hospitals

The regulations at 42 CFR 412.22(e) specify the criteria that a hospital that occupies space in a building also used by another hospital or in one or more separate buildings located on the same campus as buildings used by another hospital (also known as a hospital-within-hospital (HwH)) must meet in order to be excluded from the IPPS. Section 412.22(e)(1)(i) specifies that the HwH must have a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The HwH's governing body must not be under the control of the hospital with which it shares space in a building or on a campus, nor can it be under the control of any third entity that controls both hospitals.

As we discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24201 through 24202), it has come to our attention that there is an inadvertent inconsistency between the governance and control criteria at § 412.22(h)(2)(iii)(A) that satellite facilities must meet in order to be excluded from the IPPS and the separate governing body criteria at § 412.22(e)(1)(i) that HwHs must meet in order to be excluded from the IPPS. Specifically, the separate governing body requirement for satellite facilities at § 412.22(h)(2)(iii)(A) mistakenly omits language regarding a third entity. In particular, it fails to indicate that the governing body of the hospital of which the satellite facility is a part cannot be under the control of any third entity that controls both the hospital of which the satellite facility is a part and the hospital with which the satellite facility is co-located.

As explained in past rulemaking, we believe satellite facilities are similar enough to HwHs to warrant application of more closely related criteria to both types of facilities (67 FR 49982 and 50105 through 50106). Specifically, satellite facilities are like HwHs in that the satellite facilities are also physically located in acute care hospitals that are paid for inpatient services they furnish under the acute care IPPS. Moreover, both satellite facilities and HwHs provide hospital inpatient services that are generally paid for at higher rates than would apply if the facilities were treated by Medicare as part of the acute care hospitals. In view of these facts, we continue to believe that it is important to establish clear criteria for ensuring that a satellite facility is not merely a unit of the acute care hospital with which it is co-located, but rather is organizationally and functionally separate from the hospital. Therefore, we believe the separate governing body requirements for satellite facilities should include requirements that are similar to those we included at § 412.22(e)(1)(i) for HwHs; that is, that the governing body of the hospital of which the satellite facility is a part cannot be under the control of any third entity that controls both the hospital of which the satellite facility is a part and the hospital with which the satellite facility is co-located. Accordingly, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we proposed to amend the criteria for satellite facilities at § 412.22(h)(2)(iii)(A) by adding language under paragraph (*1*) to state that, except as provided in proposed paragraph (h)(2)(iii)(A)(*2*), the governing body of the hospital of which the satellite facility is a part cannot be under the control of any third entity that controls both the hospital of which the satellite facility is a part and the hospital with which the satellite facility is co-located. We proposed that the revised criteria would be effective with cost reporting periods beginning on or after October 1, 2009.

In addition, we proposed to add a ''grandfathering'' provision to the regulations at § 412.22(h)(2)(iii)(A)(*2*). Currently, an IPPS-excluded hospital with a satellite facility that has its governing body under the control of a third entity that controls the hospital of which the satellite facility is a part and the hospital with which the satellite facility is co-located can retain its IPPS-excluded status. An IPPS-excluded hospital that currently has a satellite facility already has its organizational structure and financial systems in place. We indicated that to require now that a hospital that currently has a satellite facility must meet the proposed new separate governance criteria with respect to that satellite facility could create undue financial and organizational difficulties. This could further result in the closure of the satellite facility and the discontinuation of services because of the inability of the hospital and its satellite facility to meet the proposed new separate governance criteria. Therefore, in proposed § 412.22(h)(2)(iii)(A)(2), we proposed the following: ''If a hospital and its satellite facility were excluded from the inpatient prospective payment system under the provisions of this section for the most recent cost reporting period beginning prior to October 1, 2009, the hospital does not have to meet the requirements of paragraph (h)(2)(iii)(A)(*1*) of this section, with respect to that satellite facility, in order to retain its IPPS-excluded status.'' However, we note that the corresponding preamble discussion of this proposed provision included an inadvertent error. Specifically, we stated that ''if a hospital and its satellite facility were excluded from the IPPS under the provision of § 412.22(h) for the most recent cost reporting period beginning before October 1, 2009, the hospital would be required to meet the new separate governance criteria at § 412.22(h)(2)(iii)(A)(*1*) with respect to that satellite facility in order to retain its IPPS-excluded status (proposed § 412.22(h)(2)(iii)(A)(*2*))'' (74 FR 24202). We inadvertently omitted the word ''not'' in the quoted sentence; therefore, the latter portion of the sentence should have read ''* * * the hospital would *not* be required to meet the new separate governance criteria at § 412.22(h)(2)(iii)(A)(*1*) with respect to that satellite facility in order to retain its IPPS-excluded status'' (emphasis added). We note that the regulation text presented accurately our proposed policy.

In addition, because we proposed that the proposed new separate governance criteria would be effective for cost reporting periods beginning on or after October 1, 2009, we indicated that a hospital that establishes an additional satellite facility in a cost reporting period beginning on or after October 1, 2009, will have knowledge of the requirements that must be met in order to retain its IPPS-excluded status prior to establishing the additional satellite facility, and it will be able to plan accordingly. Furthermore, no organizational or financial relationship would already be in place with respect to the additional satellite facility. Thus, there would not be a need for the hospital and its additional satellite facility to be grandfathered. This situation is distinguishable from a hospital with a satellite facility established in the most recent cost reporting period beginning prior to October 1, 2009, as discussed above.

Therefore, in proposed § 412.22(h)(2)(iii)(A)(*3*), we stated the following: ''A hospital described in paragraph (h)(2)(iii)(A)(*2*) of this section that establishes an additional satellite facility in a cost reporting period beginning on or after October 1, 2009, must meet the criteria in this section, including the provisions of paragraph (h)(2)(iii)(A)(*1*) of this section with respect to the additional satellite facility, in order to be excluded from the inpatient prospective payment system.'' Although the proposed regulation text, the preamble discussion of our rationale for not ''grandfathering'' such facilities, and the example set forth in the preamble (74 FR 24202) accurately captured the proposed policy, we note that a sentence in the preamble describing the proposed policy included an error. Specifically, the sentence indicated that if a hospital and its satellite facility were excluded from the IPPS under the provision of § 412.22(h) for the most recent cost reporting period prior to October 1, 2009, and the hospital establishes an additional satellite facility in a cost reporting period beginning on or after October 1, 2009, the hospital would not [sic] be required to meet the proposed new separate governance criteria at § 412.22(h)(2)(iii)(A)(*1*), with respect to the additional satellite facility, in order to be excluded from the IPPS. We note that there was an inadvertent inclusion of the word ''not'' in this sentence as the sentence was printed in the **Federal Register**. The latter portion of the sentence should have read ''* * * the hospital would be required to meet the new separate governance criteria at § 412.22(h)(2)(iii)(A)(*1*) with respect to that satellite facility in order to retain its IPPS-excluded status''; that is, the hospital and the new additional satellite facility would be required to meet the new separate governance criteria as well as the other applicable requirements in § 412.22(h), consistent with our longstanding policies.

In addition, we gave the following example of how the amended regulations at § 412.22(h)(2)(iii)(A)(*2*) and (h)(2)(iii)(A)(*3*) would work. Hospital A established a satellite facility (s-B) at Hospital B in a cost reporting period beginning prior to October 1, 2009, under the applicable criteria for hospitals and satellite facilities at § 412.22(h), and, therefore, the hospital and that satellite facility were excluded from the IPPS in the most recent cost reporting period beginning prior to October 1, 2009. If Hospital A establishes an additional satellite facility (s-C) at Hospital C in a cost reporting period beginning on or after October 1, 2009, Hospital A and its satellite facility at Hospital C must meet the applicable hospital and satellite facility criteria at § 412.22(h), including the new separate governance criteria at paragraph (h)(2)(iii)(A)(*1*), in order to be excluded from the IPPS. Thus, the governing body of Hospital A cannot be under the control of any third entity that controls both Hospital A and Hospital C. However, Hospital A and s-B must continue to meet the other applicable criteria in § 412.22(h) to be excluded from the IPPS.

Comment: One commenter pointed out that the language in the preamble of the proposed rule is contradictory to the proposed regulation text with respect to a hospital with an existing satellite facility for the most recent cost reporting period prior to October 1, 2009. The preamble text stated that if a hospital and its satellite facility were excluded from the IPPS for the most recent cost reporting period prior to October 1, 2009, and the hospital establishes an additional satellite after that date, the hospital *would not* be required to meet the proposed new separate governance criteria with respect to the new satellite(s) (emphasis added). However, in the proposed regulation text, we state that this hospital *would* be required to meet the new separate governance criteria. The commenter believed the error was made in the preamble language and that CMS' intent is correctly stated in the regulation text.

Response: The commenter is correct. We appreciate the commenter bringing the error to our attention. As the language in the proposed regulation text at § 412.22(h)(2)(iii)(A)(*2*) stated, ''If a hospital and its satellite facility were

excluded from the inpatient prospective payment system under the provisions of this section for the most recent cost reporting period beginning prior to October 1, 2009, the hospital does *not* have to meet the requirements of paragraph (h)(2)(iii)(A)(*1*) of this section, with respect to that satellite facility, in order to retain its IPPS-excluded status.'' However, as the proposed regulation text at § 412.22(h)(2)(iii)(A)(*3*) stated, ''A hospital described in paragraph (h)(2)(iii)(A)(*2*) of this section that establishes an additional satellite facility in a cost reporting period beginning on or after October 1, 2009, must meet the criteria in this section, including the provisions of paragraph (h)(2)(iii)(A)(*1*) of this section with respect to the additional satellite facility, in order to be excluded from the inpatient prospective payment system.''

Comment: Two commenters recommended that CMS withdraw the proposed change in the satellite facility requirements until CMS produces evidence that the proposed requirement is necessary in terms of the impact on the Medicare program or the provision of services to Medicare beneficiaries. The commenters stated that CMS considered this issue when the agency established the current ''separateness criteria,'' and that the language adopted was sufficient for the purpose. The commenters believed that the proposed language is unnecessary and adds complexity to an already complex regulation.

Response: As we discussed in the preamble of the proposed rule (74 FR 24201) and in other past rulemaking, we believe satellite facilities are similar enough to HwHs to warrant similar regulatory criteria that must be met for exclusion from the IPPS. Both satellite facilities and HwHs occupy space in, or are on the same campus as, another hospital. As IPPS-excluded providers, satellite facilities and HwHs receive Medicare payments that, in general, are higher than Medicare payments to IPPS providers. Clearly, there is an effect on the Medicare program if Medicare is making higher payments to a provider that is a satellite facility in name only. Therefore, to avoid the HwH or satellite facility from being, in reality, a unit of the hospital in which it is located, while being paid as an IPPS-excluded provider, we established the separateness and control criteria. Our intent was that the criteria for satellite facilities should be similar to the criteria for HwHs. The fact that the language regarding control by a third entity was not originally included in the satellite facility criteria was an oversight that we are now correcting.

Comment: Two commenters urged CMS to exempt children's hospitals from the proposed separate governance criteria for satellite facilities. They believed that exempting children's hospitals is appropriate because, unlike other IPPS-excluded types of providers, children's hospitals serve a small proportion of Medicare patients that would otherwise be patients in an acute care hospital. Therefore, the commenters stated that the concern over shifting patients to maximize reimbursement is not an issue.

In addition, according to the commenters, the proposed criteria would inhibit the ability of children's hospitals to expand in an efficient and effective manner when responding to community needs. The commenters stated that an exemption from the proposed separate governance criteria would allow children's hospitals to expand into space of an affiliated hospital for children's hospitals that are part of large integrated health care systems. They believed this would be the most ''efficacious patient-centric'' way of expansion as opposed to opening and operating a pediatric unit in another acute care hospital, which the commenters claimed is ''very challenging'' and makes it unlikely that community needs would be met.

The commenters suggested that CMS consider restrictions on referrals from the hospital in which the satellite facility is located as a means of alleviating the issues that the proposed separate governance criteria is intended to address. They believed this would be a better approach to restrict patient shifting without compromising expansion opportunities.

Response: While it is accurate that exempting children's hospitals from the proposed separate governance criteria would have little effect on Medicare costs because there are few Medicare patients in children's hospitals, we believe that it would have some effect on Medicare costs because, in general, Medicare payment for a discharge in an IPPS-excluded hospital is greater than Medicare payment for a discharge in an acute care hospital under IPPS. In addition, there are certainly ramifications on payments under the Medicaid program if CMS were to exempt children's hospitals from the proposed criteria. CMS administers the Medicare program and oversees the Medicaid program, and therefore, the agency needs to be concerned about inappropriate patient shifting to maximize payment. In regard to the commenters' portrayal that the patients in children's hospitals are predominantly very young—an illustration uses ''under age 2''—and, therefore, have different health care needs and facilities, we point out that children's hospitals are hospitals in which inpatients are predominantly individuals under the age of 18. Contrary to the commenters' assertion, this wide span of age makes it more conducive to patient shifting from an acute care hospital to a children's satellite facility, when that satellite facility has an affiliation with the host hospital. Furthermore, even without patient shifting, it would be inappropriate for Medicare and Medicaid to pay a hospital differently for treating patients in what in essence is a pediatric unit of an acute care hospital, rather than a ''separate'' children's hospital.

The commenters contend that creating and operating a children's satellite facility in an unrelated acute care hospital is so challenging that community needs could be compromised, but that this would not be the case if the children's satellite facility could operate in an acute care hospital with which it was affiliated. Further, the commenters believed the proposed criteria would inhibit the ability of children's hospitals to expand. We believe that establishing a satellite facility in an affiliated hospital would most likely be less challenging than in an unrelated acute care hospital. However, the ease or difficulty of establishing a children's satellite facility is not the issue. Regardless of whether a children's hospital could establish a satellite facility with more ease in an affiliated hospital, we believe the rules we have promulgated to demonstrate separateness, including the change to the separate governance criteria, are necessary to demonstrate that the co-located facility is not actually a department of the host hospital.

We also do not agree with the commenters who suggested that putting restrictions on referrals from the host hospital to the satellite will alleviate our concerns regarding patient shifting. This idea was previously discussed in the FY 2000 proposed rule (64 FR 24743) where we indicated that the hospital of which the satellite facility is a part could meet the referral restrictions, even though all of the satellite facility's patients could have been referred from the hospital in which it is located.

After consideration of the public comments received, we are adopting as final, with one change, the proposed additional separate governance criteria at § 412.22(h)(2)(iii)(A)(*1*), (*2*), and (*3*). We are correcting an inadvertent error

in the language of the provision under § 412.22(h)(2)(iii)(A)(*1*) by deleting the phrase ''the governing body of'' directly after the word ''both'' in the provision in order to conform the regulation text to the preamble. (Throughout the proposed rule preamble discussion at 74 FR 24201 through 24202, we articulated the provision correctly. However, the regulation text included an inadvertent repeat of the phrase ''the governing body of''.) Consequently, § 412.22(h)(2)(iii)(A)(*1*) will provide the following: ''Except as provided in paragraph (h)(2)(iii)(A)(*2*) of this section, effective for cost reporting periods beginning on or after October 1, 2009, the governing body of the hospital of which the satellite facility is a part is not under the control of any third party entity that controls both the hospital of which the satellite facility is a part and the hospital with which the satellite facility is co-located.''

C. Critical Access Hospitals (CAHs)

1. Background

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs) under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and that meet the CAH conditions of participation under 42 CFR part 485, Subpart F, will be certified as CAHs by CMS. Regulations governing payments to CAHs for services to Medicare beneficiaries are located in 42 CFR part 413.

2. Payment for Clinical Diagnostic Laboratory Tests Furnished by CAHs

Section 1834(g)(1) of the Act states that payment for outpatient services furnished by a CAH will be made at 101 percent of the reasonable costs to the CAH in providing those services, except for those CAHs that elect the optional reimbursement method outlined at section 1834(g)(2) of the Act. We refer to payment under the elective methodology described in section 1834(g)(2) of the Act as the ''optional method.'' (We discuss changes to the CAH optional method of payment regulations below in section VII.C.3. of this preamble.) Section 1834(g)(4) of the Act provides that there is no beneficiary cost-sharing for ''clinical diagnostic laboratory services furnished as an outpatient critical access hospital service.''

Section 148 of Public Law 110–275 (MIPPA) amended section 1834(g)(4) of the Act, effective for services furnished on or after July 1, 2009. Specifically, section 148(a)(1) of Public Law 110–275 changed the heading of section 1834(g)(4) of the Act to read ''Treatment of Clinical Diagnostic Laboratory Services.'' Section 148(a)(2) of Public Law 110–275 amended section 1834(g)(4) of the Act by adding, in relevant part, that ''* * * clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital, or in a skilled nursing facility or a clinic (including a rural health clinic) that is operated by a critical access hospital, at the time the specimen is collected.''

Regulations implementing section 1834(g) of the Act are set forth at § 413.70. Currently, the regulations at § 413.70(b)(2)(iii) state that payment to a CAH for clinical diagnostic laboratory services is made at 101 percent of reasonable cost ''only if the individuals [for whom the tests are performed] are outpatients of the CAH, as defined in § 410.2 * * * and are physically present in the CAH, at the time the specimens are collected.'' Clinical diagnostic laboratory tests performed for individuals who are not physically present in the CAH when the specimen is collected generally are paid on the basis of the Clinical Laboratory Fee Schedule (CLFS) in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24202 through 24203), we proposed to amend the regulations at § 413.70(b) in order to implement the changes made by section 148(a)(2) of Public Law 110–275. Section 148(a)(2) of Public Law 110–275 mandates that, effective for services furnished on or after July 1, 2009, individuals are no longer required to be physically present in the CAH at the time the specimen is collected in order for the CAH to receive payment based on reasonable cost for furnishing outpatient clinical diagnostic laboratory tests. Specifically, we believe the use of the phrase ''without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital'' means that as long as the tests are performed for individuals who are CAH outpatients as defined in § 410.2, payment based on reasonable cost must be made regardless of where the specimen is collected, even if the patient is not physically present in the CAH at the time the specimen is collected. Accordingly, we proposed to implement section 148(a)(2) by revising the existing regulations to reflect our interpretation of the statutory change.

We proposed to amend the regulations at § 413.70(b) by deleting existing § 413.70(b)(2)(iii) and adding a new § 413.70(b)(7) to state that, for services furnished on or after July 1, 2009, in order for a CAH to be paid based on reasonable cost for outpatient clinical diagnostic laboratory tests, a CAH outpatient is no longer required to be physically present in the CAH at the time the specimen is collected. However, we proposed that if the individual is not physically present in the CAH at the time the specimen is collected, the individual must continue to be an outpatient of the CAH, as defined at § 410.2. We stated that we consider an individual to be an outpatient of the CAH if the individual is receiving services directly from the CAH. This requirement is consistent with our definition of a CAH outpatient at § 410.2, which states that *outpatient* ''means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.'' Consistent with section 1834(g)(4) of the Act, we proposed to amend the regulations to provide that, in order to be receiving services directly from the CAH, either the individual must be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH. Accordingly, where the individual is an outpatient of the CAH as defined above, the individual would not be required to be physically present in the CAH at the time the specimen is collected.

In addition, we stated that we do not believe that the enactment of section 148 of Public Law 110–275 has any effect on the applicability of the requirements at section 1862(a)(18) of the Act and the implementing regulations at § 411.15(p), which set forth requirements for payment of services furnished to SNF patients. Accordingly, we proposed that in cases where Medicare rules otherwise require consolidated billing or bundling of payments (for example, for services furnished to SNF patients during a Medicare Part A covered stay), the CAH laboratory payment provision would only provide for separate payment to the CAH once consolidated billing no longer applies. Where consolidated billing is required by Medicare rules, a separate payment for bundled services furnished by another provider, including a CAH, is prohibited. For example, for purposes of payment to a

CAH for performing a clinical laboratory test on a specimen collected from a SNF patient, the proposed new CAH payment rules would apply only once the consolidated billing rules for SNF payments no longer apply. Coverage under Medicare Part A for services furnished to a SNF patient is limited to 100 days in a benefit period. During that period, the collection of a specimen by a CAH employee in the SNF and the CAH's performance of a laboratory test on the specimen would be bundled into the SNF payment. Once the SNF patient has exhausted his or her Medicare Part A SNF days (that is, after 100 days), payment for the specimen collection by a CAH employee and the test performance by the CAH would no longer be bundled into the SNF payment and the CAH could receive a reasonable cost-based payment for the collection of a specimen by a CAH employee and the performance of the laboratory test by the CAH.

In summary, we proposed that a CAH may receive reasonable cost-based payment for outpatient clinical diagnostic laboratory tests furnished to an individual who is an outpatient of the CAH (and therefore receiving services directly from the CAH) even if the individual with respect to whom the laboratory services are furnished is not physically present in the CAH at the time the specimen is collected. In order for the individual to be determined to be receiving services directly from the CAH, we proposed that either the individual must have received outpatient services in the CAH on the same day the specimen is collected or the specimen must be collected by an employee of the CAH. In either case, the individual would not need to be physically present in the CAH at the time the specimen is collected. We also noted that if the individual is physically present in the CAH or a facility that is provider-based to the CAH when the specimen is collected, the CAH would also receive a reasonable cost-based payment. In this case, the specimen would not need to be collected by an employee of the CAH. (We refer readers to section VII.D. of this preamble for further discussion of CAH provider-based facilities.)

Comment: The majority of commenters supported the proposal implementing section 148 of the MIPPA. One commenter stated that the proposal will provide assistance to less mobile elderly patients in rural communities. Another commenter stated that the proposed rule will have a positive impact on Nebraska's 65 CAHs and CAH patients. A third commenter fully supported recognizing that laboratory services provided by a CAH department should be paid on the same basis as the other departments.

However, many commenters, in addition to supporting the proposed policy, asked for clarification on two aspects of the proposal. Specifically, the commenters requested that CMS clarify: (1) That if a patient for whom laboratory services are performed is in a facility that is not provider-based to the CAH, the CAH will still receive 101 percent of the reasonable cost for these services as long as the patient receives outpatient services in the CAH on the same day the specimen is collected or an employee of the CAH collects the specimen; and (2) whether employees of a CAH's provider-based facility (including a provider-based rural health clinic (RHC)) are considered CAH employees for purposes of this policy, such that CAHs will receive payment at 101 percent of the reasonable cost for furnishing outpatient clinical diagnostic laboratory services if the specimen is collected by an employee of a CAH's provider-based facility.

Another commenter requested clarification on what it means to be an employee for CAHs that ''contract for laboratory services under arrangement or hire laboratory personnel on contract.'' The commenter requested that CMS clarify the definition of employee so that it includes individuals employed by the CAH or those who are under contract to provide laboratory services ''either personally or under arrangement with an independent laboratory.''

Another commenter agreed with CMS' efforts to ''establish applicable limits and controls to avoid 'gaming' and inequitable payments.'' However, the commenter suggested adding language to the employee provision so that it reads ''* * * or the specimen must be collected by an employee of the CAH or an agent of the CAH through contractual arrangement with the CAH.''

Response: We appreciate the commenters' support of the proposed policy, and we agree that it provides increased flexibility to CAHs in furnishing outpatient clinical diagnostic laboratory tests. We would like to clarify that not all services furnished by entities that are provider-based to a CAH are eligible to be paid based on reasonable cost. For example, psychiatric and rehabilitation distinct part units are paid under their prospective payment systems. We stated in the proposed rule that we believe the use of the statutory phrase ''* * * without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital * * *'' means that as long as the individual from whom the specimen is collected is an outpatient of the CAH, as outpatient is defined at 42 CFR 410.2, payment based on reasonable cost must be made, regardless of where the specimen is collected, even if the patient is not physically present in the CAH at the time the specimen is collected. We further stated that ''we also note that if the individual is physically present in the CAH or a facility that is provider-based to the CAH when the specimen is collected, the CAH would also receive a reasonable cost-based payment. In this case, the specimen would not need to be collected by an employee of the CAH'' (74 FR 24203).

In this final rule, we are clarifying that the individual does *not* need to be physically present in the CAH or a facility that is provider-based to the CAH at the time the specimen is collected for the CAH to receive payment based on reasonable cost as long as either: (1) the individual receives an outpatient service in the CAH (or facility that is provider-based to the CAH, including a provider-based RHC) on the same day the specimen is collected; or (2) the specimen collection is performed by a CAH employee. In cases where the individual is in the CAH or facility that is provider-based to the CAH when the specimen is collected, the individual does not need to receive another outpatient service on that same day nor does the specimen collection need to be performed by a CAH employee in order for the CAH to be paid based on reasonable cost.

Furthermore, we are clarifying in this final rule that we consider an employee of a CAH's provider-based department, but not an employee of a provider-based entity, to be an employee of the CAH for purposes of implementing section 148 of MIPPA. A provider-based department is integrated with the main provider and would not function as a freestanding provider of health care services, whereas a provider-based entity is paid differently than an entity that is not CAH-based. For example, a CAH-based RHC with 50 or more beds is a provider-based entity because it is paid based on the RHC payment methodology at 42 CFR 405.2462. Furthermore, as defined at § 413.65 of the regulations, a provider-based department furnishes the same type of health care services as the main provider, while a provider-based entity furnishes health care services of a different type than those furnished by the main provider. Because the health care services furnished by an individual employee at a provider-based

department are directly related to the health care services furnished by an individual employed at the same campus, those employees working in a CAH's provider-based department will be considered CAH employees for purposes of this provision. Therefore, the CAH can meet the requirement that the specimen collection be performed by a CAH employee, if the individual collecting the specimen is an employee of a department that is provider-based to the CAH.

In response to the commenters who suggested CMS allow for contracted employees to be considered employees of the CAH for purposes of this policy, we agree that if the individual performing the specimen collection is not employed by any other entity to provide services at the location where the specimen collection is taking place, that individual, even if a contracted employee, could be considered a CAH employee for purposes of this provision. However, if the individual collecting the specimen is employed at the facility where the specimen collection is being performed, other than by the CAH, to provide other services in addition to being contracted by the CAH to perform the specimen collection, the CAH cannot consider this individual an employee of the CAH for purposes of implementing section 148 of MIPPA. For example, if a SNF employee is employed at the SNF and is contracted as a CAH employee to collect blood samples from SNF patients, that individual could not be considered a CAH employee for purposes of this provision. We are not adopting the commenter's proposed language because we believe such a provision would enable a CAH to bypass the requirement that laboratory specimens be collected by an employee of the CAH simply by entering into contractual arrangements with the employees of other entities. Such a policy would be contrary to our determination that an individual must be an outpatient of the CAH, receiving services directly from the CAH, in order for laboratory services furnished by the CAH to be paid based on reasonable cost.

Comment: Several commenters asked for clarification on how specimen collection is defined and how the proposed policy is applied to different types of specimen collection. One commenter stated that, generally, a blood or sputum sample can be collected by a CAH laboratory employee, but the SNF nursing staff member or the patient usually performs the collection of a wound, urine, stool, or throat culture. The commenters asked which of these tests would be paid under reasonable cost-based payment. One commenter asked whether, in the situation where a CAH sends a CAH employee to a SNF to collect a blood specimen and then the CAH employee is also given a urine sample to test, would both the venipuncture and blood work be included on an 851 type of bill and the urine specimen put on a 141 type of bill or would both the blood and urine specimens be included on an 851 type of bill.

Another commenter asserted that although the MIPPA provided that all laboratory tests performed in the CAH laboratory department should be paid based on reasonable cost, the proposed rule has drawn a line whereby a CAH has to establish whether it meets the definition of collecting the specimen. The commenter stated that a patient may bring a urine specimen to a CAH on a doctor's orders: For example, while the CAH patient is in the emergency department, he or she may be told to collect a urine specimen and return it to the CAH the next day. The commenter asked whether, in this case, the CAH or RHC employee would meet the requirements of collecting the urine specimen. Commenters asked under what circumstances can a specimen collected in an outside HHA or SNF be paid on a reasonable cost basis.

One commenter asked would a Medicare beneficiary have to exhaust his or her Part A coverage before a specimen collected by a CAH employee for a home health patient qualified for reasonable cost-based payment. The commenter also stated that allowing the CAH to receive reasonable cost-based payment only for SNF patients who have exhausted their Part A services and billing the specimen collection on a separate bill under Part B will require more tracking and paperwork.

Response: We believe that the intent of section 148 of MIPPA is to pay CAHs on a reasonable cost basis for furnishing outpatient clinical diagnostic laboratory tests as long as the patient is an outpatient of a CAH. An outpatient is defined in the regulations at 42 CFR 410.2 as receiving services (rather than supplies alone) directly from the CAH. We do not believe that instances where the specimen is ''picked up'' by an employee of the CAH rather than collected by an employee of the CAH, and the individual does not also receive an outpatient service in the CAH on the same day, qualify as receiving services directly from the CAH. Rather, if the individual is not physically present in the CAH and the individual does not also receive an outpatient service in the CAH on the same day the specimen is collected, a CAH employee would need to physically perform the specimen collection in order for the CAH to receive payment based on reasonable cost.

To address the commenter's question on how to bill for a blood specimen that is collected by a CAH employee from a SNF patient (assuming consolidated billing no longer applies) and then the CAH employee is *given* the urine specimen, the individual could be considered an outpatient for purposes of billing for the analysis of the blood specimen, but would be considered a nonpatient for purposes of billing the urine specimen in the case where he or she does not also receive an outpatient service in the CAH on the same day the urine specimen is collected. Even though collection of a specimen may be performed by an individual (not a CAH employee) outside of the CAH based on a doctor's orders, the CAH would not receive reasonable cost-based payment for the analysis of the specimen unless the specimen is collected on the *same* day the individual received an outpatient service from the CAH. Therefore, if the individual comes to the CAH the day after the specimen collection, the CAH would not be paid for the analysis of the specimen based on reasonable cost. We emphasize that in instances where the CAH does not qualify to receive payment based on reasonable cost, the CAH still will receive payment for these services, but instead of receiving reasonable cost-based payment, it will be paid for the service under the CLFS.

In the proposed rule, we stated how the policy would apply in cases where an individual is located in a facility where consolidated billing rules apply. We stated: ''Accordingly, we are proposing that, in cases where Medicare rules otherwise require consolidated billing or bundling of payments (for example, for services furnished to SNF patients during a Medicare Part A covered stay), the CAH laboratory payment provision would only provide for separate payment to the CAH once consolidated billing no longer applies. Where consolidated billing is required by Medicare rules, a separate payment for bundled services furnished by another provider, including a CAH, is prohibited'' (74 FR 24203). Therefore, in cases where a CAH employee performs a laboratory service for a SNF patient, the CAH would only receive reasonable cost-based payment once the SNF patient has exhausted his or her Part A SNF days. For purposes of receiving reasonable cost-based payment for an individual receiving home health services, we understand that home health consolidated billing rules do not

apply to the provision of laboratory tests. Therefore, if a CAH employee performs the specimen collection from a patient who is receiving home health services, the CAH would not be limited by the consolidated billing rules from billing for that service.

In response to the commenter who stated that application of the policy to SNF patients would require more tracking and paperwork, the policy permitting CAHs to receive payment based on reasonable cost when a CAH employee collects a specimen from a patient of a SNF cannot be used to circumvent the statutory requirements for consolidated billing of SNF services. Therefore, a CAH must take SNF consolidated billing rules into consideration when it bills for specimen collection of a SNF patient.

Comment: One commenter argued that section 148 of MIPPA clearly states that regardless of whether or not the individual is physically present in the CAH, all laboratory services provided in a CAH's laboratory are to be viewed as outpatient CAH services. The commenter asserted that CMS' proposed policy would unnecessarily complicate billing procedures. The commenter stated that the intent of the legislation is that a CAH should receive payment based on reasonable cost for all laboratory services performed at the CAH as was the case when the CAH program was first implemented and that the MIPPA legislation was requested by CAHs to revert back to the former policy in which all laboratory services performed in the CAH laboratory would be paid based on reasonable cost. The commenter stated that section 148 of the MIPPA did not include any language pertaining to specimen collection by CAH employees or receiving another outpatient service on the same day or anything similar to the language that is being used in CMS Change Request 6395, Transmittal 1729. The commenter requested that CMS revise the proposed rule to state that all laboratory services performed in the CAH are paid based on reasonable cost and not based on the CLFS.

One commenter stated that the proposed policy concerning provider-based status of CAH laboratories would impact the policy implementing section 148 of the MIPPA. The commenter stated, ''We also understand that the proposed change in the regulations regarding the treatment of a clinical diagnostic laboratory of a CAH under the provider-based status of facilities and organizations would likewise impact this determination.'' The commenter also stated that ''conversely, with regard to reasonable cost payment to the CAH for the clinical diagnostic laboratory service(s), it would not matter where or by whom a specimen is collected if it is collected on the same date as a patient receives outpatient services at a CAH.'' Another commenter stated that the proposed rule adds complexity and confusion for CAHs and the commenter supported ''keeping CAHs intact and consistent with what we believe was the original congressional intent.'' In general, one commenter also stated that ''if you want to improve healthcare, you must consider access and cost. Most of the rules limit access and increase cost.''

Response: As stated previously, we believe our proposal provides for increased flexibility for CAHs to receive payment based on reasonable cost for furnishing outpatient clinical diagnostic laboratory tests because existing regulations require that an individual be physically present in the CAH to receive reasonable cost-based payment; otherwise, the CAH is paid on the basis of the CLFS. Section 148 of the MIPPA states ''* * * clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of *outpatient* critical access services without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital * * *'' (emphasis added). Therefore, we believe it is appropriate to require that an individual still has to be an outpatient of a CAH, that is, receiving services directly from the CAH, to be paid based on reasonable cost.

We would not consider an individual to be an outpatient of a CAH if the only relationship the individual has with the CAH is that his or her specimen is processed by the CAH. We do not believe the intent of section 148 of MIPPA was, for example, to allow a CAH in one State to process a laboratory specimen it receives from an individual in a distant State and receive payment on a reasonable cost basis for this service without the individual being physically present in the CAH or having any other direct relationship with the CAH. Allowing such a scenario to occur would convert a CAH into a reference laboratory and subvert the statutory laboratory fee schedule used to pay for clinical laboratory services. Our policy allows CAHs to be paid for outpatient clinical diagnostic laboratory tests where the individual is not physically present in the CAH at the time the specimen is being collected, consistent with the purpose of the provision, and avoids the problems that would result from a broader interpretation of the statutory language. Therefore, we stated if the individual is not physically present in a CAH when the specimen is collected, in order for the CAH to receive payment based on reasonable cost, either the individual has to receive other outpatient services in the CAH on the same day the specimen is collected or the specimen collection has to be performed by a CAH employee. If providers have questions about whether specific scenarios would qualify for reasonable cost-based payment, we encourage them to contact CMS or their Medicare contractor.

A commenter referenced Change Request 6395, Transmittal 1729. This document can be accessed at the following link: *http://www.cms.hhs.gov/Transmittals/downloads/R1729CP.pdf*. The purpose of this instruction was to implement section 148 of MIPPA on the statutory effective date of July 1, 2009. Because we are finalizing the policy as proposed, the instruction will continue to apply for purposes of payment to CAHs for clinical diagnostic laboratory tests after the effective date of this final rule. If we believe further instructions are needed, we will issue another change request. We stated in the proposed rule that we believe it will be important to develop a modifier that could assist CMS in tracking laboratory services paid to CAHs under this provision. We reiterate that when a modifier is developed, we will issue guidance regarding its use.

In regard to the comment concerning the impact of the proposed policy on provider-based status of CAH laboratories, we do not believe this policy has a direct impact on the policy implementing section 148 of the MIPPA because the individual does not need to be physically present in a facility that is provider-based to the CAH in order for the CAH to receive payment based on reasonable cost.

In summary, in this final rule, we are finalizing our proposed policy that a CAH can receive payment based on reasonable cost for furnishing clinical diagnostic laboratory tests even if the individual is not physically present in the CAH at the time the specimen is collected, provided either (1) the individual receives an outpatient service in the CAH on the same day the specimen is collected, or (2) the specimen collection is performed by a CAH employee. For purposes of section 148 of the MIPPA, a facility that is provider-based to the CAH is considered a CAH for purposes of determining where the specimen is collected. If the individual is in a facility or receiving services under which Medicare consolidated billing rules apply when

the specimen is collected, the CAH will receive reasonable cost-based payment only once the consolidated billing rules no longer apply.

3. CAH Optional Method of Payment for Outpatient Services

Section 1834(g) of the Act establishes the payment rules for outpatient services furnished by a CAH. Section 403(d) of Public Law 106–113 (BBRA) amended section 1834(g) of the Act to provide for two methods of payment for outpatient services furnished by a CAH. Specifically, section 1834(g)(1) of the Act, as amended by Public Law 106–113, provided that the amount of payment for outpatient services furnished by a CAH is equal to the reasonable cost of providing such services, unless the CAH made an election, under section 1834(g)(2) of the Act, to receive amounts that were equal to the reasonable cost of the CAH for facility services plus, with respect to the professional services, the amount otherwise paid for professional services under Medicare, less the applicable Medicare deductible and coinsurance amount. The election made under section 1834(g)(2) of the Act is sometimes referred to as ''Method II.'' Throughout this section of this preamble, we refer to this election as the ''optional method.''

Section 202 of Public Law 106–554 (BIPA) amended section 1834(g)(2)(B) of the Act to increase the payment for professional services under the optional method to 115 percent of the amount otherwise paid for professional services under Medicare. In addition, section 405(a)(1) of Public Law 108–173 (MMA) amended section 1834(g)(l) of the Act by inserting the phrase ''equal to 101 percent of'' before the phrase ''the reasonable costs''. However, section 405(a)(1) of Public Law 108–173 did not amend the phrase ''reasonable costs'' under the optional method at section 1834(g)(2)(A) of the Act.

Accordingly, section 1834(g) of the Act currently provides for two methods of payment for outpatient CAH services. Under the first method, as specified at section 1834(g)(1) of the Act, a CAH will be paid 101 percent of reasonable costs, unless it elects to be paid under the methodology specified at section 1834(g)(2) of the Act. Under the method specified at section 1834(g)(1) of the Act, facility services are paid at 101 percent of reasonable costs to the CAH through the Medicare fiscal intermediary or the Medicare Part A/B MAC, while payments for physician and other professional services are made to the physician under the Medicare Physician Fee Schedule (MPFS) through the Medicare carriers. However, under section 1834(g)(2) of the Act (the optional method), a CAH submits bills for both the facility and the professional services to its Medicare fiscal intermediary or its Medicare Part A/B MAC. If a CAH chooses this optional method for outpatient services, the physician or other practitioner must reassign his or her billing rights to the CAH to bill the Medicare program for those services. In accordance with section 1834(g)(2)(A) of the Act, under this optional method, the CAH receives reasonable cost payment for its facility costs and, with respect to the professional services, 115 percent of the amount otherwise paid for professional services under Medicare.

Regulations implementing section 1834(g) of the Act are set forth at § 413.70(b). Section 413.70(b) states that, unless a CAH elects the optional method, payment for outpatient CAH services is 101 percent of the reasonable costs of the CAH in providing CAH services to its outpatients. However, existing § 413.70(b)(3)(ii)(A) states that a CAH may elect, under the optional method, to be paid at 101 percent of the reasonable costs for facility services. As a result, we believe that the existing regulation is not consistent with the plain reading of section 1834(g)(2) of the Act, which provides for payment under the optional method of reasonable cost for facility services.

In order to ensure that the regulations are consistent with the plain reading of section 1834(g)(2)(A) of the Act, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24203 through 24204), we proposed to revise § 413.70(b)(3)(ii)(A) to state that CAHs that elect the optional method will receive payment based on reasonable cost for outpatient facility services. We indicated that the proposed change would not affect payment for the professional component as set forth under § 413.70(b)(3)(ii)(B).

Comment: Commenters opposed CMS' proposal to change payment for outpatient facility services for CAHs that elect the optional method of payment from 101 percent of reasonable cost to 100 percent of reasonable cost. Many commenters argued that the proposal to reduce payments to CAHs for outpatient facility services under the optional method is not in accordance with the intent of Congress. The commenters stated that section 405(a) of the MMA actually increased CAH payment to 101 percent of reasonable cost for outpatient facility services, regardless of whether or not a CAH elects the optional method. The commenters stated that while the statutory language of the MMA erroneously did not specify that CAHs that elect the optional method should be paid at 101 percent of reasonable cost, the proposed change goes against the intent of Congress as expressed in the conference report. Commenters stated that ''the conference report references both types of payment methods, stating that CAHs may elect either 'cost-based hospital outpatient service reimbursement or an all-inclusive rate, which is equal to reasonable cost reimbursement for facility services plus 115 percent of the fee schedule payment for professional services.' '' The commenters also stated that ''In summarizing the conference agreement, the report more generally refers to CAH payments, stating that 'outpatient * * * services provided by a CAH will be reimbursed at 101 percent of reasonable cost'.'' Furthermore, the commenters asserted that the summary of present law in the conference report distinguishes between the traditional method of payment and the optional method, but the summary of the conference agreement does not make this distinction, which the commenters believe makes it clear that the conference agreement applies to both methods.

Response: We have reviewed and have taken into consideration the commenters' concerns regarding our proposal to revise the regulatory text to be consistent with the plain reading of section 1834(g)(2)(A) of the Act. Despite the commenters' contentions that the statutory language of the MMA is erroneous, we continue to believe that the statutory text takes precedent over Conference report language. While the conference agreement does state that CAHs should be paid at 101 percent of reasonable cost for inpatient, outpatient, and covered SNF services, we believe the language in the conference agreement could be read not as an explicit expression of policy for CAHs that elect the optional method, but rather as a summary of CAH payment policy. We acknowledge the concerns raised by the commenters regarding the potential financial impact the proposal may have on CAHs. However, we are required to conform our payment policy to the statutory language and must revise the regulatory text to ensure it is consistent with the plain reading of the statute. If Congress makes a legislative change to allow CAHs that elect the optional payment method to receive 101 percent of reasonable cost for outpatient facility services, we will revise the regulations accordingly to implement such a change.

Comment: Many commenters urged CMS to perform a detailed and thorough impact analysis on the effect the proposal may have on CAHs before moving forward. The commenters stated that CMS could have obtained information on which CAHs elect the optional method in a timely manner from its Medicare contractors and performed a thorough impact analysis. The commenters stated that, on behalf of the AHA, State hospital associations contacted Medicare contractors once the proposed rule was released and requested from them a list of CAHs that elect the optional method in each State. One commenter stated that the information received from the Medicare contractors ''indicates that the vast majority of CAHs elect Method 2 payment. For example, 88 percent of the CAHs in Iowa, 71 percent of the CAHs in Kansas, and 86 percent of the CAHs in North Dakota have elected to be paid under Method 2.'' Many of the commenters believed the current proposal to reduce payment for outpatient facility services for CAHs that elect the optional method may have a significant financial impact for these small hospitals. Several commenters estimated that the proposal may cut payments to CAHs nationwide by $22 million in FY 2010. Several commenters noted estimated impacts for CAHs located in specific States for FY 2010: $2.4 million for CAHs in Iowa; $1.7 million for CAHs in Illinois; $700,000 for CAHs in Nebraska; $779,783 for CAHs in Kansas; and more than $1 million for CAHs in Kentucky. Another commenter stated that changing the payment under the optional method for outpatient facility services would cause its facility to lose $33,350 in payments for outpatient services. The commenter stated ''while not a huge amount of money, for a rural distressed facility, any cut in reimbursement may be catastrophic.'' The commenters urged that, because a detailed impact analysis was not performed, CMS should withdraw the proposed policy change.

Several commenters expressed concern over the misinterpretation the proposed policy change may have among Medicare contractors. One commenter stated that the cost report, as currently written, does not specifically designate which costs are outpatient facility costs for services provided under the optional method. The commenter expressed concern that Medicare contractors may interpret the change in payment for outpatient facility services under the optional method from 101 percent of reasonable cost to 100 percent of reasonable cost to apply to all outpatient facility services. The commenter also stated that such an interpretation would eliminate any benefit gained from the additional payment for professional services under the optional method. In addition, the commenter stated that making the change would defeat a CAH's incentive to elect the optional payment method and discourage medical providers and CAHs from working together. The commenter stated that ''Even if the intent of the proposed rule is to eliminate the additional 1% reimbursement on only the costs associated with the Method II outpatient facility charges, the loss of the 1% reimbursement via the cost report would cut our benefit of Method II billing by approximately 40%.'' The commenter stated that CAHs in Illinois ''* * * operate at negative operating margins'' and the average operating margin is only at about 1.25 percent.'' The commenter asserted that the smallest amount change in Medicare's payment policy for CAHs can adversely impact CAHs and recommended that the proposed rule language read as follows:

''Facility Fee 1834(g)(2)(A) With respect to facility services, 101% of the reasonable costs of the critical access hospital in providing such services.

''Fee Schedule for Professional Services 1834(g)(2)(B) With respect to professional services, 115 percent of such amounts.''

Another commenter stated that because the Medicare cost report does not provide for separate facility payment under the optional method, the commenter is concerned that Medicare contractors will apply 100 percent reasonable cost payment to all outpatient CAH services.

Response: With respect to the financial impact of the proposal, we did not conduct an in-depth impact analysis because our proposal is a revision to regulatory text that currently is contrary to the plain language of the statute. That is, we did not have a choice as to whether we would change payment for outpatient facility costs for CAHs that elect the optional method. Furthermore we do not believe we could necessarily estimate the impact of the proposed provision because election of the optional method is not permanent; CAHs are only required to make the election 30 days prior to the start of the cost reporting period for which it is effective. Therefore, we cannot estimate how many CAHs will choose to retain the optional method of payment if facility services are only paid at 100 percent of reasonable cost. Furthermore, the optional method is physician-specific. That is, for some physicians' outpatient services, a CAH may elect to be paid under the optional method and for other physicians' outpatient services, it may opt to be paid only at 101 percent of reasonable costs for facility services. The CAH's election is contingent on whether the physician is willing to reassign his or her billing rights to the CAH. Therefore, because it is the physician's decision as to whether he or she chooses to reassign billing rights to the CAH, we believe we cannot accurately determine which physicians would choose to opt out of the optional method upon implementation of the proposed provision.

To address the commenters' concerns regarding possible misinterpretation of the proposed regulatory change by Medicare contractors, we intend to issue instructions to ensure that contractors properly update the Fiscal Intermediary Share System (FISS). The instructions will include full and complete details to clarify that the regulatory text change is only applicable to services for which the CAH has elected to use the optional method. We are not adopting the commenter's proposed regulatory language because, as stated previously, the regulations pertaining to payment for outpatient facility services for CAHs that elect the optional method need to conform to the statutory text at section 1834(g)(2)(A) of the Act that references reasonable cost payment instead of ''101 percent of reasonable cost'' payment.

Comment: Many commenters requested that if the proposed policy is finalized, CMS specify an effective date for the proposed change. The commenters urged CMS to allow CAHs adequate time to evaluate their circumstances and make an informed decision as to whether or not to elect the optional method going forward. Several commenters recommended that, if the proposed policy is finalized, the effective date should be no earlier than cost reporting periods beginning on or after January 1, 2010.

Response: We believe we cannot delay implementation of this proposed policy as the regulation as currently written is not consistent with the plain reading of section 1834(g)(2)(A) of the Act. However, we recognize that it may be unfair to apply this change in the middle of an existing cost reporting period, when CAHs made their decision to elect the optional method under the existing regulatory text. Therefore, while we are finalizing the revisions to the regulations as proposed, the change will be effective for cost reporting periods beginning on or after October 1, 2009, and not in the middle of any CAH's cost reporting period. If a CAH

determines that, based on the percentage revision in the regulation, the CAH no longer wants to elect to use the optional method, the CAH may change its election beginning with its next cost reporting period that begins on or after October 1, 2009.

Comment: Commenters expressed concern that reducing payment for outpatient facility services for CAHs that elect the optional method from 101 percent of reasonable cost to 100 percent of reasonable cost would limit access to patient care. One commenter stated that ''* * * the option to use Method 2 billing was intended to be an additional incentive to attract physicians to provide services in communities where their services might not otherwise be available. Method 2 billing is meant to be an enhancement to what a CAH would otherwise receive as reimbursement, not a choice between what is received for professional services versus what is received for facility services.'' The commenter stated that if CMS believes the language describing payment for CAHs that elect the optional method is ambiguous, CMS should request clarification from Congress so that Congress' drafting error can be corrected, rather than proposing a rule that would prove harmful to the provision of physician services in the local community. Another commenter stated that ''This increased payment for physician services helps bring physicians to our areas. It would be counterproductive to then take away the add-on the hospital gets.'' One commenter stated that it would make more sense to reduce payment under the optional method for professional services and leave payment for facility services at 101 percent of reasonable cost. The commenter stated that using the optional method for physician services has allowed its CAH to simplify Medicare billing for providers' services. The commenter also asserted that using the optional method for physician services has made it easier for the patient to understand the bill he or she receives because the CAH can combine the facility service and the physician service onto one bill to the Medicare contractor. The commenter stated that, for example, the CAH can combine an X ray and the radiologist reading fee charges onto one bill to the Medicare contractor. However, the commenter indicated, under the proposed rule, it would have to bill the X ray to the Medicare contractor and the radiologist reading fee to the Medicare carrier. Under this scenario, the patient would receive two explanations of benefit forms as opposed to the one the patient receives under the current rules. In addition, under the proposed provision, the CAH would have increased billing costs because it would have to provide two explanations of benefits.

Response: We emphasize that the proposed provision to reduce payment for outpatient facility services for CAHs that elect the optional method from 101 percent of reasonable cost to 100 percent of reasonable cost does not affect payment to CAHs for professional services under the optional method. As a result, it would not be appropriate to change payment for professional services under the optional method of payment because the statute clearly states that payment for these services is 115 percent of the physician fee schedule amount. CAHs will continue to receive payment at 115 percent of the applicable physician fee schedule amount for professional services. Therefore, we do not agree that reducing payment for outpatient facility services will necessarily limit the provision of physician services. Furthermore, as stated previously, if Congress makes a legislative change to allow CAHs that elect the optional payment method to receive 101 percent of reasonable cost for outpatient facility services, CMS will revise the regulations accordingly to implement such a change.

In response to the commenter's concern regarding the billing process, we encourage the commenter to work with its Medicare contractor to resolve those concerns.

In summary, in order to ensure that the regulations are consistent with the plain reading of section 1834(g)(2)(A) of the Act, we are finalizing our proposal to revise the regulatory text at § 413.70(b)(3)(ii)(A) to state that CAHs that elect the optional method will receive payment at 100 percent of reasonable cost for outpatient facility services. The change is effective for cost reporting periods beginning on or after October 1, 2009. The change does not affect the existing policy for payment for the professional component as set forth under § 413.70(b)(3)(ii)(B).

4. Continued Participation by CAHs Located in Counties Redesignated as Urban

Under section 1820(c)(2)(B)(i) of the Act, a facility is eligible for designation as a CAH only if it is located in a county or equivalent unit of local government in a rural area (as defined in section 1886(d)(2)(D) of the Act), or is being treated as being located in a rural area pursuant to section 1886(d)(8)(E) of the Act. The regulations implementing this location requirement are located at 42 CFR 485.610(b). Currently, several CAHs are located in counties that were designated as ''rural areas'' in FY 2009 under section 1886(d)(2)(D) of the Act but will, as of October 1, 2009, be considered to be located in urban areas due to the redesignation of three Micropolitan Statistical Areas announced by the Office of Management and Budget (OMB) on November 20, 2008. (We refer readers to section III.C. of this preamble for a discussion of the changes in the three Micropolitan Statistical Areas that now qualify as MSAs that were announced in OMB Bulletin No. 09–01.) A facility that is located in an urban area cannot remain a CAH, unless it has been deemed rural under 42 CFR 412.103. In response to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule in which we discussed the OMB changes for purposes of determining the hospital wage index for FY 2010 (74 FR 24139), we received a number of public comments on this issue.

Comment: Many commenters urged CMS to exercise the same executive discretion that was applied in the FY 2005 IPPS final rule (69 FR 49221), in which CMS provided for special treatment for CAHs that were affected by OMB redesignations of MSAs by amending the regulations at § 412.103 and § 485.610 to allow CAHs that were located in counties that were considered rural in FY 2004, but urban in FY 2005, to maintain their CAH status through either the earlier of FY 2006 or when the CAH obtained a rural designation under § 412.103. The commenters stated that, under the amendment, CAHs were allowed to continue participation as a CAH for 2 years and were not required to convert to PPS hospitals unless they were not able to obtain a rural designation under § 412.103.

The commenters also requested that CMS not only take the same approach as it did in FY 2005, but also recommended that CMS make the regulation change permanent so that the agency does not have to address this issue each time the redesignation or creation of MSAs affects CAH status. To do so, the commenters recommended that CMS revise § 485.610(b)(3) to delete references to specific dates and instead incorporate general language to allow CAHs that have CAH status in one year, but are located in counties that will be considered urban in the next year, to retain their CAH status for a 2-year period. The commenters also suggested that CMS also revise § 412.103(a)(4) to delete references to specific dates and instead incorporate general language allowing CAHs that are located in counties that are reclassified from rural

to urban to have 2 years to obtain a rural designation under § 412.103.

Several commenters stated that if CMS is unwilling to take the same approach as it afforded CAHs in FY 2005, CAHs located mainly in Kansas and Missouri, as an unintended consequence, will lose their CAH status and will be forced to revert back to a PPS hospital. The commenters stated that if CAH participation were terminated, these facilities would likely need to seek State licensure and Medicare participation as hospitals in order to be able to continue operations. However, the commenters argued that this would have a profound effect on the communities that CAHs service and would place these facilities at significant financial risk in excess of more than $1 million per hospital per year.

Response: We understand the commenters' concerns and agree that providing a transition period for the CAHs that are located in counties that are reclassified from rural to urban to obtain a rural redesignation will mitigate the disruptive impact of this change. Accordingly, we believe it is appropriate to revise § 485.610 by adding a new paragraph (b)(4) and to revise § 412.103 by adding a new paragraph (a)(5) to provide special treatment for such facilities, as was done in FY 2005. Under the revision made to § 485.610(b) and § 412.103(a), a CAH that is located in a county that, in FY 2009, was not part of an MSA, as defined by the OMB, but as of FY 2010 was included as part of an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on November 20, 2008, would nevertheless be considered to meet the rural location requirement and, therefore, could continue participating without interruption as a CAH from October 1, 2009 through the earlier of the date on which the CAH obtains a rural designation under § 412.103, or September 30, 2011. Such a facility would be allowed to continue participating as a CAH and would not be required to convert back to being a PPS hospital unless it was not able to obtain rural designation under that section. We also will consider whether it is appropriate to propose, in future IPPS rulemaking, to revise § 485.610 and § 412.103 to provide for a transition period any time a CAH that was formerly considered to be located in a rural area is designated as being located in an urban area as a result of the redesignation of its county from rural to urban.

D. Provider-Based Status of Facilities and Organizations: Policy Changes

1. Background

Since the beginning of the Medicare program, some providers, which we refer to as ''main providers,'' have functioned as a single entity while owning and operating multiple provider-based departments, locations, and facilities that were treated as part of the main provider for Medicare purposes. Therefore, we have maintained that having clear criteria for provider-based status is important because by failing to properly distinguish between a provider-based facility and a freestanding facility, we risk additional program payments and increased beneficiary coinsurance liability with no commensurate benefit to the Medicare program or its beneficiaries. In addition, we jeopardize the delivery of safe and appropriate health care services to beneficiaries.

The Medicare policies regarding provider-based status of facilities and organizations are set forth at 42 CFR 413.65. The regulations at § 413.65 have been revised and updated on numerous occasions since they were originally issued on April 7, 2000 (65 FR 18504). We note that the implementation of the April 7, 2000 regulations was delayed by Public Law 106–554 (BIPA) for many providers. Public Law 106–554 also made changes in the criteria for determining provider-based status, which we implemented in a final rule published in the **Federal Register** on November 30, 2001 (66 FR 59956). The most recent revisions of § 413.65 were included in the FY 2006 IPPS final rule (70 FR 47457 through 47461 and 47487 through 47488) when we updated the rules with respect to the facilities for which provider-based determinations will not be made and clarified some of the provider-based definitions and requirements.

Currently, § 413.65(a) specifies the facilities and organizations for which provider-based status may be sought and lists those facilities for which determinations of provider-based status for Medicare payment purposes are not made. Section 413.65(b) describes the procedures for making provider-based determinations, and § 413.65(c) explains the requirements for reporting material changes in relationships between main providers and provider-based facilities and organizations. In § 413.65(d), we specify all of the requirements that any facility or organization for which provider-based status is sought must meet, whether located on or off the campus of a potential main provider. Section 413.65(e) specifies additional requirements applicable to off-campus facilities or organizations. These requirements include: Operation under the ownership and control of the main provider; administration and supervision; and location. Sections 413.65(f) through (o) set forth the policies regarding provider-based status for joint ventures, obligations of hospital outpatient departments and hospital-based entities, management contracts, furnishing of all services under arrangement, inappropriate treatment of a facility or organization as provider-based, temporary treatment as provider-based, correction of errors, status of Indian Health Service and Tribal facilities and organizations, FQHCs and ''look alikes,'' and effective dates of provider-based status.

2. Changes to the Scope of the Provider-Based Status Regulations for CAHs

(a) CAH-Based Clinical Diagnostic Laboratory Facilities

As we discussed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24204 through 24205), the provider-based status rules generally apply to situations where there is a financial incentive for a facility or organization to claim affiliation with a main provider. The provider-based status rules establish criteria for a facility or organization to demonstrate that it is integrated with the main provider for payment purposes. However, the regulation at § 413.65(a)(1)(ii) lists specific types of facilities and organizations for which CMS will not make provider-based determinations. Included on this list of facilities exempt from provider-based determinations are facilities that furnish only clinical diagnostic laboratory services (§ 413.65(a)(1)(ii)(G)).

As we have stated previously (that is, the FY 2006 IPPS final rule (70 FR 47457)), the list at § 413.65(a)(1)(ii) was created after we had concluded that ''provider-based determinations should not be made for these facilities because the outcome of the determination (that is, whether a facility, unit, or department is found to be freestanding or provider-based) would not affect the methodology used to make Medicare or Medicaid payment, the scope of benefits available to a Medicare beneficiary in or at the facility, or the deductible or coinsurance liability of a Medicare beneficiary in or at the facility.'' We note that we included a facility that furnishes only clinical diagnostic laboratory services in the list of facilities for which a determination of provider-based status is not made in § 413.65(a)(1)(ii)(G) because these

facilities are generally paid under the Clinical Laboratory Fee Schedule (CLFS), regardless of the setting in which the services are furnished. Consequently, we believed that whether a clinical diagnostic laboratory was freestanding or provider-based would not affect the amount of Medicare payment.

However, upon further review of existing § 413.65(a)(1)(ii), we believe that a clinical diagnostic laboratory, when operated as part of a CAH, generates a higher Medicare payment than when operating as a freestanding facility. When a clinical diagnostic laboratory is part of a CAH, the services furnished by the laboratory are generally paid 101 percent of reasonable cost. Otherwise, clinical diagnostic laboratory services provided by a freestanding diagnostic laboratory are paid under the CLFS. Currently, because the services of a clinical diagnostic laboratory of a CAH are paid at a higher rate by virtue of being provided by a CAH department, we believe they should be subject to the rules under the provider-based status regulations at § 413.65.

Therefore, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24205), we proposed to exclude a clinical diagnostic laboratory facility that operates as part of a CAH from the list of facilities for which we do not make provider-based determinations. That is, we proposed to revise the regulations to require facilities furnishing only clinical diagnostic laboratory tests that operate as part of CAHs to meet the applicable provider-based criteria in § 413.65 in order for the CAHs to receive payments for the services furnished at those facilities based on reasonable cost. Specifically, we proposed to revise the language of § 413.65(a)(1)(ii)(G) to state that CMS will not make a determination of provider-based status for payment purposes as to whether the following facilities are provider-based: ''Independent diagnostic testing facilities that furnish only services paid under a fee schedule, such as facilities that furnish only screening mammography services, facilities that furnish only clinical diagnostic laboratory tests, *other than those clinical diagnostic laboratory facilities operating as parts of CAHs*, or facilities that furnish only some combination of these services'' (emphasis added). In addition, we proposed to specify that ''Clinical diagnostic laboratories operating as parts of CAHs must meet the applicable provider-based requirements.''

Comment: One commenter questioned whether there is a financial incentive for a clinical diagnostic laboratory facility to be part of a CAH compared to a freestanding clinical diagnostic laboratory facility or a clinical diagnostic laboratory facility that is part of a hospital. The commenter questioned whether payment under reasonable cost for clinical diagnostic laboratory services is higher than payment under the CLFS. The commenter requested that CMS provide data that demonstrate that there is, in fact, a payment differential between a freestanding clinical diagnostic laboratory facility and a CAH-owned clinical diagnostic laboratory facility.

Response: CAHs are, by definition, limited-service facilities located in rural areas. CAH services are paid under 101 percent of reasonable cost (or, in some cases, reasonable cost) in order to ensure that these isolated, high-cost, rural hospitals are able to furnish critical health care services. Thus, it is reasonable to assume that the reasonable cost-based payment for clinical diagnostic laboratory services is, in some cases, higher than payment under the CLFS. As such, we believe that there is a financial incentive for clinical diagnostic laboratory facilities to be part of a CAH rather than a freestanding facility or a part of a hospital. Because of this financial incentive, we believe that a CAH-owned clinical diagnostic laboratory facility should demonstrate integration with the CAH under the provider-based status rules in order to receive the higher CAH payment rate.

Comment: Several commenters opposed the proposal to require that facilities that furnish only clinical diagnostic laboratory services as part of a CAH meet the provider-based status rules. The commenters were opposed to the proposal because they believed that CAH-based clinical diagnostic laboratory facilities would be unable to meet all of the provider-based rules at § 413.65. In addition, the commenters were concerned that these facilities would not be able to meet the distance requirement applicable to CAHs that requires that CAHs and their provider-based locations established after January 1, 2008, must be more than 35 miles from a hospital or another CAH (or more than 15 miles in areas with mountainous terrain or only secondary roads) in accordance with § 485.610(e). Another commenter requested that currently operating CAH-based clinical diagnostic laboratory facilities or those under development should be grandfathered to have provider-based status. Another commenter suggested that currently operating CAH-based clinical diagnostic laboratory facilities or those under development should be granted provider-based status if they meet the applicable provider-based status rules with the exception of the distance requirement.

Response: The intent of the provider-based status rules is to ensure that higher levels of Medicare payment are limited to situations where the facility or organization is clearly an integral and subordinate part of the main provider. Therefore, we believe it is reasonable for a CAH-owned clinical diagnostic laboratory facility to meet the provider-based status rules to demonstrate that the facility is fully integrated with the main provider in order for the clinical diagnostic laboratory services provided in the facility to be paid based on reasonable cost.

We understand the commenters' concerns that clinical diagnostic facilities that are currently operating as part of CAHs may not be able to meet the provider-based status rules. However, we do not agree that, because existing facilities cannot meet the provider-based rules, they should be exempt from those rules. We believe that these facilities should meet all of the requirements, including the provider-based status location requirement at § 413.65(e)(3) under which an off-campus provider-based department must be within 35 miles of the main provider or must meet other location requirements. In addition, under this policy, CAH-owned clinical diagnostic laboratory facilities would be required to meet the requirement at § 485.610(e)(2) that specifies that, for a CAH or a necessary provider CAH that operates an off-campus provider-based location that was created or acquired by the CAH on or after January 1, 2008, the off-campus provider-based location must be more than a 35-mile drive from a hospital or another CAH (or more than a 15-mile drive, in areas with mountainous terrain or only secondary roads). This regulation applies to the off-campus provider-based locations of CAHs created or acquired on or after January 1, 2008. If a CAH-owned clinical diagnostic laboratory facility cannot meet the location requirement, we believe the CAH-owned clinical diagnostic laboratory facility does not warrant the higher CAH payment rate. Accordingly, we are not amending the proposal to grandfather existing arrangements of CAH-owned clinical diagnostic laboratory facilities. However, in this final rule, we are allowing additional time, until October 1, 2010, for CAH-owned clinical diagnostic laboratory facilities to meet the provider-based status rules. If the CAH-based clinical diagnostic laboratory facility cannot meet the

provider-based status rules by that date, the clinical diagnostic laboratory services furnished at the facility will be paid under the CLFS.

Comment: One commenter believed that the proposal to require a clinical diagnostic laboratory facility that is part of the four walls of the CAH to meet the provider-based status rules was illogical. The commenter believed the proposal would be similar to requiring a radiology department of a CAH to meet the provider-based status rules so that the CAH could receive reasonable cost-based payment.

Response: The provider-based status rules were established to address main providers that function as a single entity while owning and operating multiple departments, locations, and facilities. We do not agree with the assertion that just because a department is within the four walls of a hospital or CAH, that the department should be exempt from the provider-based status rules. Hospitals can and have leased space on their campuses to physicians and other providers or suppliers of health services, and these providers or suppliers may have no connection to or integration with the hospital's operations other than a lease agreement and physical proximity. For example, under our existing regulations, a CAH can lease some of its space to a clinical diagnostic laboratory facility, and that facility could be paid more significantly for services as a provider-based department to the CAH than as a freestanding facility. Because of this payment difference, we believe that a clinical diagnostic laboratory facility must meet the provider-based status rules at § 413.65, even if it is located within the CAH, to demonstrate that it is fully integrated with the operations of the CAH and warrants the higher CAH payment rate. Therefore, in order for services to be paid under reasonable cost, a clinical diagnostic laboratory facility that is part of a CAH must meet the appropriate provider-based status rules, regardless of whether it is on or off the campus of the CAH.

Comment: Some commenters expressed concern about how the proposal would affect ''necessary provider'' CAHs. The commenters believed that clinical diagnostic laboratory facilities that are part of CAHs that received the ''necessary provider'' designation would not be able to meet the provider-based status rules. The commenters stated that necessary provider CAHs did not have to meet the mileage requirement; therefore, by requiring their clinical diagnostic laboratory facilities to meet the provider-based status rules, the facilities would not meet the distance requirement which would threaten the CAHs' status. The commenters were concerned that, as a result of this proposal, facilities may close, decreasing beneficiary access to these essential services.

Response: Under § 485.610(c) of the regulations, CAHs with the necessary provider designation are CAHs that, before January 1, 2006, were ''certified by the State as being a necessary provider of health care services to residents in the area'' and are exempt from the distance requirement that it is more than a 35-mile drive (or in the case of mountainous terrain or in areas with only secondary roads available, more than a 15-mile drive) from a hospital or another CAH. Designations for necessary provider CAHs were made until December 31, 2005, and these necessary provider CAHs were grandfathered and allowed to maintain that designation after January 1, 2006. Section 485.610(e) of the regulations requires that an off-campus provider-based location of a CAH or a necessary provider CAH that is created or acquired on or after January 1, 2008, must be more than a 35-mile drive (or in the case of mountainous terrain or in areas with only secondary roads available, more than a 15-mile drive) from another CAH or hospital. Because the regulation at § 485.610(e) did not exempt provider-based departments of necessary provider CAHs from the distance requirement, we do not believe that necessary provider CAHs that own off-campus clinical diagnostic laboratory facilities should be exempt from the distance requirement now that these clinical diagnostic laboratory facilities must meet the provider-based status rules. We note that § 485.610(e)(2) only applies the distance requirement to CAH-based, off-campus provider-based locations created or acquired on or after January 1, 2008. Therefore, only CAH-based, off-campus facilities furnishing clinical diagnostic laboratory services acquired or created on or after January 1, 2008, must meet the distance requirement at § 485.610(e)(2), which requires the off-campus provider-based location to be more than a 35-mile drive from another hospital or CAH. In contrast, CAH-based clinical diagnostic laboratory facilities acquired or created prior to January 1, 2008, must meet the location requirements at § 413.65 to be considered provider-based to the CAH, but are exempt from the distance requirement at § 485.610(e)(2).

Regarding the concern that clinical diagnostic laboratory facilities may close, decreasing beneficiary access to these essential services as a result of this policy, we believe this is an incorrect assumption. If a CAH owns a clinical diagnostic laboratory facility that does not meet the provider-based status rules at § 413.65 or the CAH distance requirements at § 485.610, the services provided in the clinical diagnostic laboratory facility will still be paid under the CLFS.

Comment: Commenters requested that CMS specify an effective date for the proposal to require CAH-owned facilities furnishing diagnostic laboratory tests to meet the provider-based rules. The commenters requested that CMS set an effective date no earlier than October 1, 2010, so that CAHs have adequate time to ensure that their clinical diagnostic laboratory facilities meet provider-based status rules and to allow for CAHs to attest to obtaining provider-based status.

Response: We agree with the commenters that CAHs may require time to ensure that their clinical diagnostic laboratory facilities meet the provider-based status rules at § 413.65 in order for services furnished in those facilities to be paid under reasonable cost. In addition, we understand that CAHs may want to file an attestation, although voluntary, with their CMS Regional Office to get a provider-based status determination. We encourage CAHs to work with their CMS Regional Office and contractor on how to file an attestation and request a provider-based determination. To allow CAHs the time they need to make organizational changes, if necessary, to comply with the provider-based status rules and to ensure that the CMS Regional Offices and contractors are able to process requests for provider-based determinations, we are delaying the effective date of our policy so that clinical diagnostic laboratory facilities that are part of a CAH will have to meet the provider-based status rules as of October 1, 2010. Beginning October 1, 2010, a clinical diagnostic laboratory facility will be considered as provider-based to a CAH only if it meets all of the requirements at § 413.65, and if, on that date, it either has a written determination from CMS that it is provider-based or is billing and being paid as a provider-based department or entity of the CAH. In this final rule, we are modifying our proposal to revise § 413.65(a)(1)(ii)(G) to reflect an effective date of October 1, 2010. In addition, the CAH distance requirement at § 485.610(e)(2) provides that off-campus provider-based locations of a CAH or a necessary provider CAH that were created or acquired on or after January 1, 2008, must be more than a 35-mile drive from a hospital or another

CAH as of October 1, 2010. Existing CAH-based clinical diagnostic laboratory facilities that were created on or after January 1, 2008, will also have to satisfy the CAH distance requirements for the CAH to retain its CAH certification, as well as meet the provider-based status rules in order to be paid based on reasonable cost.

Comment: One commenter asked whether the policy to require CAH-owned clinical diagnostic laboratory facilities to meet the provider-based rules would apply to open cost reports. In addition, the commenter asked whether Medicare contractors had to audit the facilities to determine provider-based status.

Response: As discussed above, we are specifying that the CAH-owned clinical diagnostic laboratory facilities must meet the provider-based status rules by October 1, 2010, in order for their services to be paid at reasonable cost. The policy will not apply to open cost reports; rather, CAH-based clinical diagnostic laboratory facilities will have to meet the provider-based status rules by October 1, 2010. Medicare contractors should use their standard audit procedures to review CAH cost reports for periods beginning on or after October 1, 2010, to ensure that their facilities furnishing clinical diagnostic laboratory tests meet the provider-based rules and are billing appropriately. In addition, Medicare contractors and CMS Regional Offices can expect to receive attestations for provider-based determinations of CAH-based clinical diagnostic laboratory facilities.

In adopting this change to the provider-based status rules, we recognize that there may be confusion between this provision that a clinical diagnostic laboratory facility that is part of a CAH must meet provider-based status rules in order to receive the higher reasonable cost-based payment and the provision discussed in section VII.C.2. of this preamble to implement section 148 of Public Law 110–275. In section VII.C.2. of this preamble, we are adopting as final our proposal to revise the regulations at § 413.70 to specify that CAHs can bill for outpatient clinical diagnostic laboratory services furnished to patients who are outpatients of the CAH, regardless of whether they are physically present in the CAH at the time the specimen is collected. Under the revision to § 413.70, in order for a CAH to bill based on the reasonable costs of outpatient clinical diagnostic laboratory services furnished to an individual, the individual must be an outpatient of the CAH, as defined at § 410.2, that is, be receiving services directly from the CAH. As a result, either the individual must be receiving outpatient services in the CAH on the same day that the specimen is collected or the specimen must be collected by an employee of the CAH. Under the final policy changes to the provider-based status rules under § 413.65 in this section of this final rule, if a CAH operates a provider-based clinical diagnostic laboratory facility, the facility must meet the provider-based status requirements under § 413.65 in order for the facility to be considered part of the CAH and in order for the CAH to be eligible to be paid based on reasonable cost for the clinical diagnostic laboratory services furnished by the laboratory facility. According to our finalized policy in section VII.C.2. of the preamble of this final rule, a CAH will have the option to bill for outpatient clinical diagnostic laboratory services based on reasonable cost for patients where the specimen was collected at non-CAH-based facilities as long as the patients are outpatients of the CAH, as defined above, and therefore, either the specimen is collected by an employee of the CAH or the individual is receiving outpatient services in the CAH on the same day that the specimen is collected. In addition, under our provider-based status finalized policy in this final rule, a CAH can also bill for clinical diagnostic laboratory services on a reasonable cost basis for patients who are furnished services in a clinical diagnostic laboratory facility that is owned and operated by the CAH as long as the clinical diagnostic laboratory facility meets the provider-based status requirements at § 413.65.

In summary, after consideration of the public comments we received, we still believe that clinical diagnostic laboratory facilities could generate an increase in Medicare payments when they are part of a CAH compared to when they are freestanding. Therefore, we are finalizing our proposal that these facilities, which are currently exempt from provider-based determinations, must meet the applicable provider-based status requirements at § 413.65 in order for the CAH to receive payment for their clinical diagnostic laboratory services based on reasonable cost. This requirement will apply to facilities that furnish clinical diagnostic laboratory services beginning on or after October 1, 2010. It is important to note that, in addition to meeting the provider-based status requirements at § 413.65, these provider-based facilities will also have to meet other requirements for provider-based facilities operated by CAHs, including the distance requirements under § 485.610(e). Generally, the regulations at § 485.610(e)(2) provide that off-campus provider-based locations of a CAH that were created or acquired on or after January 1, 2008, must be more than a 35-mile drive from a hospital or another CAH if the CAH is to continue meeting the location requirements under § 485.610(e)(2).

b. CAH-Based Ambulance Services

The existing regulations at § 413.70(b)(5) provide that ambulance services are paid at reasonable cost if the services are furnished by a CAH or by an entity owned and operated by a CAH, but only if the CAH or entity is the only supplier or provider of ambulance service within a 35-mile drive of the CAH or entity. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24205 and 24206), we solicited public comments regarding whether an ambulance service that is owned and operated by a CAH, and is eligible to receive reasonable cost-based payment, should be required to meet the provider-based status rules. It is important to consider that the regulation at § 413.70(b)(5) already specifies the proximity criteria that CAH-owned and operated ambulance services must meet in order to be paid at reasonable cost. However, these proximity requirements are used to ensure that CAH-owned and operated ambulance services do not receive higher payments in relation to a competing ambulance service that is not owned and operated by a CAH. It can be argued that CAH-owned and operated ambulance suppliers or providers should also be required to meet the provider-based status requirements to demonstrate that the ambulance services are integrated with the CAH because the CAH ambulance services are paid at a higher Medicare payment level when they are owned and operated by a CAH compared to when they are freestanding.

Comment: Several commenters disagreed that CAH-owned and operated ambulance services that are eligible to be paid at reasonable cost should be required to meet applicable provider-based rules. The commenters generally cited the unique role that CAHs serve in regions with limited medical service options. The commenters claimed that requiring ambulance services to meet provider-based status rules would result in an unnecessary administrative burden and would result in the loss of service in some areas. The commenters specifically cited the cases of ''necessary provider CAHs,'' which would be unable to meet the requirements that provider-based departments or facilities be located beyond 35 miles (15 miles if

located in mountainous terrain) from another CAH or hospital.

Response: While commenters may be concerned that an ambulance service based to a necessary provider CAH may not be able to meet the requirements set forth in § 485.610(e)(2) if we required CAH-based ambulances to meet the provider-based status rules, we point out that there are existing regulations at § 413.70(b)(5) that prohibit CAHs from receiving a cost-based payment for ambulance services if another provider or supplier of ambulance services is located within a 35-mile drive of the CAH. The main campus of a necessary provider CAH is not subject to CAH distance requirements and may be within 35 miles of another CAH or hospital. However, that distance exception does not apply to off-campus provider-based departments of necessary provider CAHs that were created or acquired on or after January 1, 2008. Under § 485.610(e)(2), off-campus, provider-based locations of CAHs and necessary provider CAHs that were created or acquired on or after January 1, 2008, must be more than a 35-mile drive from another CAH or hospital. We agree that a proposal to subject CAH-based ambulance services paid based on reasonable cost to provider-based determinations may result in some ambulance services not being able to meet the CAH distance requirements for provider-based facilities at § 485.610(e) and, as a result, ambulance services provided by the necessary provider CAH could not be paid under reasonable cost.

With respect to the unnecessary administrative burden that may be placed upon CAH-owned and operated ambulance services, we reiterate that any regulatory proposal would only apply to those ambulance services that are eligible to receive a reasonable cost payment, in accordance with § 413.70(b)(5); that is, ambulance services furnished by a CAH or an entity that is owned and operated by a CAH, where the CAH or the entity is the only provider or supplier of ambulance services within a 35-mile radius. Ambulance services that are paid under the fee schedule would not be subject to provider-based determinations. Furthermore, we are aware that some of the provider-based requirements at § 413.65 include required provisions that may not be applicable to ambulance services (for example, clinical privileges for professional staff, medical record retrieval system integration, among others). If, in the future, we propose to require that CAH-owned and operated ambulance services meet the provider-based status rules, we would propose the applicable provider-based status requirements that the ambulance services would need to meet for provider-based status.

In summary, while we still believe that it may be appropriate to require any part of a CAH to meet the provider-based rules in order to be paid at reasonable cost, we are not at this time proposing or adopting any changes to the regulations at § 413.65 to require CAH-owned and operated ambulance services that are eligible to be paid at reasonable cost to meet the provider-based status rules. We thank those commenters that responded to our solicitation of public comments.

3. Technical Correction to Regulations

Section 413.65(a)(1)(ii)(H) of the regulations specifies, among the facilities for which CMS does not make provider-based determinations for payment purposes, ''Facilities, other than those operating as parts of CAHs, furnishing only physical, occupational, or speech therapy to ambulatory patients, for as long as the $1,500 annual cap on coverage of physical, occupational, or speech therapy, as described in section 1833(g)(2) of the Act, remains suspended by the action of the subsequent legislation.'' In the FY 2010 IPPS/RY 2010 LTCH proposed rule (74 FR 24206), we proposed to make two basic changes to the language of § 413.65(a)(1)(ii)(H). First, we proposed to delete the phrase ''$1,500 annual cap'' and replace it with the generic phrase ''annual financial cap amount''. We proposed to make this change because we need to update our regulations to reflect that the $1,500 annual financial cap is no longer applicable and has been replaced with the cap amount described in section 1833(g)(2)(B) of the Act. Specifically, the $1,500 cap amount described in section 1833(g)(2)(A) of the Act was limited to 3 years (1999 through 2001). For years after 2001, in general, the amount of the annual cap on payment of physical, occupational, or speech therapy is the amount specified in the preceding year increased by the percentage increase in the Medicare economic index for the current year (section 1833(g)(2)(B) of the Act). However, we note that the annual cap amount did not apply to expenses incurred with respect to such therapy services during various years as set forth in the statute.

Second, we proposed to replace the phrase ''for as long as'' with the phrase ''throughout any period during which'' and to replace the phrase ''remains suspended by the action of subsequent legislation'' with the phrase ''is suspended by legislation''. We proposed to make this change because § 413.65(a)(1)(ii)(H), as currently written, may incorrectly suggest that the annual financial cap amounts on the therapy services described in sections 1833(g)(1) and 1833(g)(3) of the Act continue to be suspended. Although the financial caps on such services were suspended when the provision was added originally, they ceased to be suspended for a portion of 2003 and then beginning January 1, 2006. We indicated that we believe the proposed change would eliminate any confusion about whether the therapy caps were or were not currently suspended, as well as accomplish our goal of exempting facilities, other than those operating as parts of CAHs, that furnish only physical, occupational, or speech therapy to ambulatory patients from complying with the provider-based status requirements any time the annual financial cap amount as described in section 1883(g)(2) of the Act is suspended by legislation. In conclusion, we maintain that we would not make provider-based determinations for non-CAH operated facilities furnishing only physical, occupational, or speech therapy to ambulatory patients when the therapy cap is suspended.

We also are further clarifying a proposed regulation text change not fully detailed in the proposed rule. The term ''payment for'' was inserted between ''annual financial cap amount on'' and ''coverage of physical, occupational, or speech therapy'' in the regulatory text to more accurately describe the referenced financial cap on therapy services.

We did not receive any public comments on our proposals for correction of the regulatory language. Therefore, in this final rule, we are adopting the proposals as final.

E. Report of Adjustment (Exceptions) Payment

Section 4419(b) of Public Law 105–33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year.

The process of requesting, adjudicating, and awarding an adjustment payment is likely to occur over a 2-year period or longer. First, generally, an excluded hospital or excluded unit of a hospital must file its cost report for a fiscal year in accordance with § 413.24(f)(2). The fiscal intermediary or MAC reviews the cost report and issues a Notice of

Reimbursement (NPR). Once the hospital receives the NPR, if its operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment. After the fiscal intermediary or MAC receives the hospital's request in accordance with applicable regulations, the fiscal intermediary or MAC or CMS, depending on the type of adjustment requested, reviews the request and determines if an adjustment payment is warranted. This determination is sometimes not made until more than 6 months after the date the request is filed because there are times when the applications are incomplete and additional information must be requested in order to have a completed application. However, in an attempt to provide interested parties with data on the most recent adjustments for which we do have data, we are publishing data on adjustment payments that were processed by the fiscal intermediary or CMS during FY 2008.

The table below includes the most recent data available from the fiscal intermediaries or MACs and CMS on adjustment payments that were adjudicated during FY 2008. As indicated above, the adjustments made during FY 2008 only pertain to cost reporting periods ending in years prior to FY 2007. Total adjustment payments given to excluded hospitals and units during FY 2008 are $9,780,846. The table depicts for each class of hospitals, in the aggregate, the number of adjustment requests adjudicated, the excess operating cost over ceiling, and the amount of the adjustment payments.

Class of hospital	Number	Excess cost over ceiling	Adjustment payments
Psychiatric	14	$12,585,567	$3,429,244
Children's	3	1,326,989	1,183,486
Cancer	3	28,656,569	5,136,202
Religious Nonmedical Health Care Institution	1	40,961	31,914
Total			9,780,846

VIII. Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for RY 2010

A. Background of the LTCH PPS

1. Legislative and Regulatory Authority

Section 123 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) as amended by section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) provides for payment for both the operating and capital-related costs of hospital inpatient stays in long-term care hospitals (LTCHs) under Medicare Part A based on prospectively set rates. The Medicare prospective payment system (PPS) for LTCHs applies to hospitals that are described in section 1886(d)(1)(B)(iv) of the Social Security Act (the Act), effective for cost reporting periods beginning on or after October 1, 2002.

Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as ''a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.'' Section 1886(d)(1)(B)(iv)(II) of the Act also provides an alternative definition of LTCHs: specifically, a hospital that first received payment under section 1886(d) of the Act in 1986 and has an average inpatient length of stay (LOS) (as determined by the Secretary of Health and Human Services (the Secretary)) of greater than 20 days and has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in FY 1997.

Section 123 of the BBRA requires the PPS for LTCHs to be a ''per discharge'' system with a diagnosis-related group (DRG) based patient classification system that reflects the differences in patient resources and costs in LTCHs.

Section 307(b)(1) of the BIPA, among other things, mandates that the Secretary shall examine, and may provide for, adjustments to payments under the LTCH PPS, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment.

In the August 30, 2002 **Federal Register**, we issued a final rule that implemented the LTCH PPS authorized under the BBRA and BIPA (67 FR 55954). This system currently uses information from LTCH patient records to classify patients into distinct MS-long-term care diagnosis-related groups (MS–LTC–DRGs) based on clinical characteristics and expected resource needs. Payments are calculated for each MS–LTC–DRG and provisions are made for appropriate payment adjustments. Payment rates under the LTCH PPS are updated annually and published in the **Federal Register**.

The LTCH PPS replaced the reasonable cost-based payment system under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) for payments for inpatient services provided by a LTCH with a cost reporting period beginning on or after October 1, 2002. (The regulations implementing the TEFRA reasonable cost-based payment provisions are located at 42 CFR part 413.) With the implementation of the PPS for acute care hospitals authorized by the Social Security Amendments of 1983 (Pub. L. 98–21), which added section 1886(d) to the Act, certain hospitals, including LTCHs, were excluded from the PPS for acute care hospitals and were paid their reasonable costs for inpatient services subject to a per discharge limitation or target amount under the TEFRA system. For each cost reporting period, a hospital-specific ceiling on payments was determined by multiplying the hospital's updated target amount by the number of total current year Medicare discharges. (Generally, in section VIII. of this preamble, when we refer to discharges, the intent is to describe Medicare discharges.) The August 30, 2002 final rule further details the payment policy under the TEFRA system (67 FR 55954).

In the August 30, 2002 final rule, we provided for a 5-year transition period. During this 5-year transition period, a LTCH's total payment under the PPS was based on an increasing percentage of the Federal rate with a corresponding decrease in the percentage of the LTCH PPS payment that is based on reasonable cost concepts. However, effective for cost reporting periods beginning on or after October 1, 2006, total LTCH PPS payments are based on 100 percent of the Federal rate.

In addition, in the August 30, 2002 final rule, we presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates,

additional payments, and the budget neutrality requirements mandated by section 123 of the BBRA. The same final rule that established regulations for the LTCH PPS under 42 CFR part 412, Subpart O also contained LTCH provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements. We refer readers to the August 30, 2002 final rule for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS (67 FR 55954).

In the June 6, 2003 **Federal Register**, we published a final rule that set forth the FY 2004 annual update of the payment rates for the Medicare PPS for inpatient hospital services furnished by LTCHs (68 FR 34122). It also changed the annual period for which the payment rates were to be effective, such that the annual updated rates were effective from July 1 through June 30 instead of from October 1 through September 30. We refer to the July through June time period as a ''long-term care hospital rate year'' (LTCH PPS rate year). In addition, we changed the publication schedule for the annual update to allow for an effective date of July 1. The payment amounts and factors used to determine the annual update of the LTCH PPS Federal rate are based on a LTCH PPS rate year. While the LTCH payment rate updates were to be effective July 1, the annual update of the DRG classifications and relative weights for LTCHs continued to be linked to the annual adjustments of the acute care hospital inpatient DRGs and were effective each October 1.

As discussed in detail in section VIII.A.1. of the May 9, 2008 RY 2009 LTCH PPS final rule (73 FR 26788), we again changed the schedule for the annual updates of the LTCH PPS Federal payment rates beginning with RY 2010. We consolidated the rulemaking cycle for the annual update of the LTCH PPS Federal payment rates and description of the methodology and data used to calculate these payment rates with the annual update of the MS–LTC–DRG classifications and associated weighting factors for LTCHs so that the updates to the rates and the weights now occur on the same schedule and appear in the same publication. As a result, the updates to the rates and the weights are now effective on October 1 (on a Federal fiscal year schedule), and the annual updates to the LTCH PPS Federal rates will no longer be published with a July 1 effective date (73 FR 26797 through 26798).

Public Law 110–173 (MMSEA), enacted on December 29, 2007, included provisions that have various effects on the LTCH PPS. In addition to amending section 1861 of the Act to add a subsection (ccc) which provided an additional definition of LTCHs and facility criteria, Public Law 110–173 also required that no later than 18 months after the date of enactment of the law, the Secretary conduct a study and submit a report to Congress that included ''recommendations for such legislation and administrative actions, including timelines for the implementation of LTCH patient criteria or other actions, as the Secretary determines appropriate.'' The payment policy provisions under Public Law 110–173 also have varying timeframes of applicability. First, we note that certain provisions of Public Law 110–173 provided that the Secretary shall not apply, for cost reporting periods beginning on or after the date of the enactment of Public Law 110–173 (December 29, 2007) for a 3-year period: The extension of payment adjustments at § 412.534 to ''grandfathered LTCHs'' (a long-term care hospital identified by the amendment made by section 4417(a) of Pub. L. 105–33); and the payment adjustment at § 412.536 to ''freestanding'' LTCHs. In addition, Public Law 110–173 provided that the Secretary shall not apply, for the 3-year period beginning on the date of enactment of the Act, the revision to the short-stay outlier (SSO) policy that was finalized in the RY 2008 LTCH PPS final rule (72 FR 26904 and 26992) and the one-time adjustment to the payment rates provided for in § 412.523(d)(3). The statute also provided that the base rate for RY 2008 be the same as the base rate for RY 2007 (the revised base rate, however, does not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008); for a 3-year moratorium (with specified exceptions) on the establishment of new LTCHs, LTCH satellites, and on the increase in the number of LTCH beds. Public Law 110–173 also revised the threshold percentages for certain co-located LTCHs and LTCH satellites governed under § 412.534. Finally, Public Law 110–173 provided for an expanded review of medical necessity for admission and continued stay at LTCHs.

In the RY 2009 LTCH PPS final rule (73 FR 26801 through 26812), we established the applicable Federal rates for RY 2009 consistent with section 1886(m)(2) of the Act as amended by Public Law 110–173. We also revised the regulations at § 412.523(d)(3) to change the methodology for the one-time budget neutrality adjustment and to comply with section 114(c)(4) of Public Law 110–173. Other policy revisions necessitated by the statutory changes of Public Law 110–173 were addressed in separate interim final rulemaking documents with comment periods (73 FR 24871 and 73 FR 29699).

First, in the May 6, 2008 interim final rule with comment period (73 FR 24871), we implemented changes made by section 114(c)(3) and (e) of the MMSEA that affected payments to LTCHs for inpatient hospital services as follows:

- *Modification of payment adjustments to certain SSO cases.* Section 114(c)(3) of the MMSEA specified that the refinement of the SSO policy implemented in RY 2008 shall not apply for a 3-year period beginning with discharges occurring on or after December 29, 2007. Specifically, the fourth SSO payment option under § 412.529(c)(3)(i) shall not apply for a 3-year period.
- *Revision to the RY 2008 payment rate provision.* Section 114(e)(1) of the MMSEA provided that the base rate for RY 2008 ''shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.'' Furthermore, in accordance with section 114(e)(2) of the MMSEA, the revised payment rate will not be applicable to discharges occurring on or after July 1, 2007 and before April 1, 2008.

The May 22, 2008 interim final rule with comment (73 FR 29699) implemented changes made by section 114(c)(1) and (c)(2) and section 114(d) of the MMSEA as follows:

- *Modification of payment adjustments to LTCHs and LTCH satellite facilities for discharges of patients who were admitted from specific referring hospitals and that exceed various percentage thresholds.* Sections 114(c)(1) and (c)(2) of the MMSEA mandated specific changes for 3 years, beginning with cost reporting periods beginning on or after December 29, 2007, with respect to § 412.534 in existence as that time, which governs the ''25 percent threshold'' payment adjustment to LTCH hospitals-within-hospitals (HwHs) and LTCH satellite facilities for discharges of patients who were admitted from their co-located hosts (established in the FY 2005 IPPS final rule and amended in the RY 2008 LTCH PPS final rule), and § 412.536 in existence at that time, which applies a payment adjustment policy (that was in transition to 25 percent prior to the enactment of this law) to LTCH and LTCH satellite facilities for discharges of

patients who were admitted from any individual hospital not co-located with the LTCH or LTCH satellite facility (established in the RY 2008 LTCH PPS final rule).

• *Moratorium on new LTCHs, LTCH satellite facilities, and on increase in beds in existing LTCHs and LTCH satellite facilities.* Section 114(d) of the MMSEA established a 3-year moratorium, beginning on December 29, 2007, on the establishment and classification of new LTCHs, LTCH satellite facilities, and on any increase in beds in existing LTCHs and LTCH satellite facilities, with certain exceptions.

We received 6 timely pieces of correspondence in response to the May 6, 2008 interim final rule with comment period and 30 timely pieces of correspondence on the May 22, 2008 interim final rule with comment period. We are finalizing these two interim final rules with comment period in this **Federal Register** document and addressing the public comments that we received under section X. of the preamble of this document.

Section 4302 of the ARRA, Public Law 111–5, enacted on February 17, 2009, included several amendments to the provisions set forth in section 114 of Public Law 110–173 (the MMSEA). We have issued instructions to the fiscal intermediaries and MACs interpreting the provisions of section 4302 of Public Law 111–5 (Change Request 6444). As we stated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we are implementing the provisions of section 4302 of Public Law 111–5 through an interim final rule with comment period in this **Federal Register** document under section XI. of this preamble.

2. Criteria for Classification as a LTCH

a. Classification as a LTCH

Under the existing regulations at § 412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Act, to qualify to be paid under the LTCH PPS, a hospital must have a provider agreement with Medicare and must have an average Medicare inpatient length of stay (LOS) of greater than 25 days. Alternatively, § 412.23(e)(2)(ii) states that for cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the PPS in 1986 and can demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease must have an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days.

b. Hospitals Excluded From the LTCH PPS

The following hospitals are paid under special payment provisions, as described in § 412.22(c), and therefore, are not subject to the LTCH PPS rules:

• Veterans Administration hospitals.

• Hospitals that are reimbursed under State cost control systems approved under 42 CFR part 403.

• Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of the Social Security Amendments of 1967 (Pub. L. 90–248) (42 U.S.C. 1395b–1) or section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603) (42 U.S.C. 1395b–1 (note)) (Statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act).

• Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

3. Limitation on Charges to Beneficiaries

In the August 30, 2002 final rule, we presented an in-depth discussion of beneficiary liability under the LTCH PPS (67 FR 55974 through 55975). In the RY 2005 LTCH PPS final rule (69 FR 25676), we clarified that the discussion of beneficiary liability in the August 30, 2002 final rule was not meant to establish rates or payments for, or define Medicare-eligible expenses. Under § 412.507, if the Medicare payment to the LTCH is the full LTC–DRG payment amount, as consistent with other established hospital prospective payment systems, a LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts as specified under § 409.82, § 409.83, and § 409.87 and for items and services as specified under § 489.30(a). However, under the LTCH PPS, Medicare will only pay for days for which the beneficiary has coverage until the SSO threshold is exceeded. Therefore, if the Medicare payment was for a SSO case (§ 412.529) that was less than the full LTC–DRG payment amount because the beneficiary had insufficient remaining Medicare days, the LTCH could also charge the beneficiary for services delivered on those uncovered days (§ 412.507).

4. Administrative Simplification Compliance Act (ASCA) and Health Insurance Portability and Accountability Act (HIPAA) Compliance

Claims submitted to Medicare must comply with both the Administrative Simplification Compliance Act (ASCA) (Pub. L. 107–105), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191). Section 3 of the ASCA requires that the Medicare Program deny payment under Part A or Part B for any expenses incurred for items or services ''for which a claim is submitted other than in an electronic form specified by the Secretary.'' Section 1862(h) of the Act (as added by section 3(a) of the ASCA) provides that the Secretary shall waive such denial in two specific types of cases and may also waive such denial ''in such unusual cases as the Secretary finds appropriate'' (68 FR 48805). Section 3 of the ASCA operates in the context of the HIPAA regulations, which include, among other provisions, the transactions and code sets standards requirements codified as 45 CFR parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered health care providers, to conduct certain electronic healthcare transactions according to the applicable transactions and code sets standards.

B. Medicare Severity Long-Term Care Diagnosis-Related Group (MS–LTC–DRG) Classifications and Relative Weights

1. Background

Section 123 of the BBRA requires that the Secretary implement a PPS for LTCHs (that is, a per discharge system with a diagnosis-related group (DRG)-based patient classification system reflecting the differences in patient resources and costs). Section 307(b)(1) of the BIPA modified the requirements of section 123 of the BBRA by requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the long-term care hospital (LTCH) PPS] on the use of existing (or refined) hospital DRGs that have been modified to account for different resource use of LTCH patients, as well as the use of the most recently available hospital discharge data.''

When the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, we adopted the same DRG patient classification system (that is, the CMS DRGs) that was utilized at that time

under the IPPS. As a component of the LTCH PPS, we refer to this patient classification system as the ''long-term care diagnosis-related groups (LTC–DRGs).'' As discussed in greater detail below, although the patient classification system used under both the LTCH PPS and the IPPS are the same, the relative weights are different. The established relative weight methodology and data used under the LTCH PPS result in relative weights under the LTCH PPS that reflect ''the differences in patient resource use * * *'' of LTCH patients (section 123(a)(1) of the BBRA (Pub. L. 106–113)).

As part of our efforts to better recognize severity of illness among patients, in the FY 2008 IPPS final rule with comment period (72 FR 47130), the MS–DRGs and the Medicare severity long-term care diagnosis-related groups (MS–LTC–DRGs) were adopted under the IPPS and the LTCH PPS, respectively, effective beginning October 1, 2007 (FY 2008). For a full description of the development and implementation of the MS–DRGs and MS–LTC–DRGs, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175 and 47277 through 47299). (We note that, in that same final rule, we revised the regulations at § 412.503 to specify that for LTCH discharges occurring on or after October 1, 2007, when applying the provisions of 42 CFR part 412, Subpart O applicable to LTCHs for policy descriptions and payment calculations, all references to LTC–DRGs would be considered a reference to MS–LTC–DRGs. For the remainder of this section, we present the discussion in terms of the current MS–LTC–DRG patient classification system unless specifically referring to the previous LTC–DRG patient classification system that was in effect before October 1, 2007.) We believe the MS–DRGs (and by extension, the MS–LTC–DRGs) represent a substantial improvement over the previous CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption.

The MS–DRGs adopted in FY 2008 represent an increase in the number of DRGs by 207 (that is, from 538 to 745) (72 FR 47171). In FY 2009, an additional MS–DRG was adopted for a total of 746 distinct groupings (73 FR 48497). In addition to improving the DRG system's recognition of severity of illness, we believe the MS–DRGs are responsive to the public comments that were made on the FY 2007 IPPS proposed rule with respect to how we should undertake further DRG reform. The MS–DRGs use the CMS DRGs as the starting point for revising the DRG system to better recognize resource complexity and severity of illness. We have generally retained all of the refinements and improvements that have been made to the base DRGs over the years that recognize the significant advancements in medical technology and changes to medical practice.

Consistent with section 123 of the BBRA, as amended by section 307(b)(1) of the BIPA, and § 412.515, we use information derived from LTCH PPS patient records to classify LTCH discharges into distinct MS–LTC–DRGs based on clinical characteristics and estimated resource needs. We then assign an appropriate weight to the MS–LTC–DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.

In a departure from the IPPS, and as discussed in greater detail below in section VIII.B.3.e. of this preamble, we use low-volume MS–LTC–DRGs (that is, MS–LTC–DRGs with less than 25 LTCH cases) in determining the MS–LTC–DRG relative weights because LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. For purposes of determining the relative weights for the large number of low-volume MS–LTC–DRGs, we group all of the low-volume MS–LTC–DRGs into five quintiles based on average charge per discharge. (A detailed discussion of the application of the Lewin Group ''quintile'' model that was used to develop the LTC–DRGs appears in the August 30, 2002 LTCH PPS final rule (67 FR 55978).) We also account for adjustments to payments for SSO cases (that is, cases where the covered LOS at the LTCH is less than or equal to five-sixths of the geometric ALOS for the MS–LTC–DRG). Furthermore, we make adjustments to account for nonmonotonically increasing weights, when necessary. That is, theoretically, cases under the MS–LTC–DRG system that are more severe require greater expenditure of medical care resources and will result in higher average charges such that, in the severity levels within a base MS–LTC–DRG, the weights should increase monotonically with severity from the lowest to highest severity level. (We discuss nonmonotonicity in greater detail and our methodology to adjust the RY 2010 MS–LTC–DRG relative weights to account for nonmonotonically increasing relative weights in section VIII.B.3.f. (Step 6) of this preamble.)

2. Patient Classifications Into MS–LTC–DRGs

a. Background

The MS–DRGs (used under the IPPS) and the MS–LTC–DRGs (used under the LTCH PPS) are based on the CMS DRG structure. As noted above in this section, we refer to the DRGs under the LTCH PPS as MS–LTC–DRGs although they are structurally identical to the DRGs used under the IPPS.

The MS–DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are assigned based on a surgical hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. The GROUPER software program does not recognize all ICD–9–CM procedure codes as procedures affecting DRG assignment. That is, procedures that are not surgical (for example, EKG), or minor surgical procedures (for example, biopsy of skin and subcutaneous tissue (code 86.11)) do not affect the MS–LTC–DRG assignment based on their presence on the claim.

Generally, under the LTCH PPS, a Medicare payment is made at a predetermined specific rate for each discharge and that payment varies by the MS–LTC–DRG to which a beneficiary's stay is assigned. Cases are classified into MS–LTC–DRGs for payment based on the following six data elements:

- Principal diagnosis.
- Up to eight additional diagnoses.
- Up to six procedures performed.
- Age.
- Sex.
- Discharge status of the patient.

Upon the discharge of the patient from an LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). HIPAA Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162 require that no later than October 16, 2003, all covered entities must comply with the applicable requirements of Subparts A and I through R of Part 162. Among other requirements, those provisions direct covered entities to use the ASC X12N 837 Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, and the applicable standard medical data code sets for the institutional health care claim or

equivalent encounter information transaction (45 CFR 162.1002 and 45 CFR 162.1102). For additional information on the ICD–9–CM Coding System, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47241 through 47243 and 47277 through 47281). We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983). Additional coding instructions and examples are published in the *Coding Clinic for ICD–9–CM*, a product of the American Hospital Association.

To create the MS–DRGs (and by extension, the MS–LTC–DRGs), individual DRGs were subdivided according to the presence of specific secondary diagnoses designated as complications or comorbidities (CCs) into three, two, or one level, depending on the impact of the CCs on resources used for those cases. Specifically, there are sets of MS–DRGs that are split into 2 or 3 subgroups based on the presence or absence of a CC or a major complication and comorbidity (MCC). The original discussion about the creation of MS–DRGs and their severity levels is described in detail in the FY 2008 IPPS final rule with comment period (72 FR 47169). However, to reiterate the development of the CCs and MCCs, two of our major goals were to create DRGs that would more accurately reflect the severity of the cases assigned to them and to create groups that would have sufficient volume so that meaningful and stable payment weights could be developed. In designating an MS–DRG as one that will be divided into subgroups based on the presence of a CC or MCC, we developed a set of criteria to facilitate the decisionmaking process. The subgroup was required to meet all criteria, which are described in detail in the FY 2008 IPPS final rule with comment period (72 FR 47169). As a first step, each of the base MS–DRGs was subdivided into three subgroups: Non-CC, CC, and MCC. Each subgroup was then analyzed in relation to the other two subgroups, and the criteria were applied in the following hierarchical manner.

- If a three-way subdivision met the criteria, we divided the base MS–DRG into three CC subgroups.
- If only one type of two-way subdivisions met the criteria, we subdivided the base MS–DRG into two CC subgroups based on the type of two-way subdivision that met the criteria.
- If both types of two-way subdivisions met the criteria, we subdivided the base MS–DRG into two CC subgroups based on the type of two-way subdivision with the highest R^2 (most explanatory power to explain the difference in average charges).
- Otherwise, we did not subdivide the base MS–DRG into CC subgroups.

For any given base MS–DRG, our evaluation in some cases showed that a subdivision between a non-CC and a combined CC/MCC subgroup was all that was warranted (that is, there was not a sufficient difference between the CC and MCC subgroups to justify separate CC and MCC subgroups). Conversely, in some cases, even though an MCC subgroup was warranted, there was not a sufficient difference between the non-CC and CC subgroups to justify separate subgroups.

Based on this methodology, a base MS–DRG may be subdivided according to the following three alternatives:

- DRGs with three subgroups (MCC, CC, and non-CC).
- DRGs with two subgroups consisting of an MCC subgroup but with the CC and non-CC subgroups combined. These are referred to as ''with MCC'' and ''without MCC.''
- DRGs with two subgroups consisting of a non-CC subgroup but with the CC and MCC subgroups combined. We refer to these two groups as ''with CC/MCC'' and ''without CC/MCC.''

For example, under the MS–LTC–DRG system, multiple sclerosis and cerebellar ataxia with MCC is MS–LTC–DRG 58; multiple sclerosis and cerebellar ataxia with CC is MS–LTC–DRG 59; and multiple sclerosis and cerebellar ataxia without CC/MCC is MS–LTC–DRG 60. For purposes of discussion in this section, the term ''base DRG'' is used to refer to the DRG category that encompasses all levels of severity for that DRG. For example, when referring to the entire DRG category for multiple sclerosis and cerebellar ataxia, which includes the above three severity levels, we would use the term ''base DRG.'' (As noted above in this section, further information on the development and implementation of the MS–DRGs and MS–LTC–DRGs can be found in the FY 2008 IPPS final rule with comment period (72 FR 47138 through 47175 and 47277 through 47299).)

In developing the first MS–DRG GROUPER program (that is, Version 25.0 effective for FY 2008), the diagnoses comprising the CC list were completely redefined. The revised CC list is primarily comprised of significant acute disease, acute exacerbations of significant chronic diseases, advanced or end stage chronic diseases, and chronic diseases associated with extensive debility. In general, most chronic diseases were not included on the revised CC list. For a patient with a chronic disease, a significant acute manifestation of the chronic disease was required to be present and coded for the patient to be assigned a CC. In addition to the revision of the CC list, each CC was also categorized as an MCC or a CC based on relative resource use. Approximately 12 percent of all diagnoses codes were classified as an MCC, 24 percent as a CC, and 64 percent as a non-CC. Diagnoses closely associated with mortality (ventricular fibrillation, cardiac arrest, shock, and respiratory arrest) were assigned as an MCC if the patient lived, but as a non-CC if the patient died. The MCC, CC, and non-CC categorization was used to subdivide the surgical and medical DRGs into up to three levels, with a case being assigned to the most resource intensive level (for example, a case with two secondary diagnoses that are categorized as an MCC and a CC is assigned to the MCC level).

Medicare contractors (that is, fiscal intermediaries and MACs) enter the clinical and demographic information submitted by LTCHs into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a MS–LTC–DRG can be made. During this process, the following types of cases are selected for further development:

- Cases that are improperly coded. (For example, diagnoses are shown that are inappropriate, given the sex of the patient. Code 68.69 (Other and unspecified radical abdominal hysterectomy) would be an inappropriate code for a male.)
- Cases including surgical procedures not covered under Medicare. (For example, organ transplant in a nonapproved transplant center.)
- Cases requiring more information. (For example, ICD–9–CM codes are required to be entered at their highest level of specificity. There are valid 3-digit, 4-digit, and 5-digit codes. That is, code 262 (Other severe protein-calorie malnutrition) contains all appropriate digits, but if it is reported with either fewer or more than 3 digits, the claim will be rejected by the MCE as invalid.)

After screening through the MCE, each claim is classified into the appropriate MS–LTC–DRG by the Medicare LTCH GROUPER software on the basis of diagnosis and procedure codes and other demographic information (age, sex, and discharge status). The GROUPER software used under the LTCH PPS is the same

GROUPER software program used under the IPPS. Following the MS–LTC–DRG assignment, the Medicare contractor determines the prospective payment amount by using the Medicare PRICER program, which accounts for hospital-specific adjustments. Under the LTCH PPS, we provide an opportunity for LTCHs to review the MS–LTC–DRG assignments made by the Medicare contractor and to submit additional information within a specified timeframe as provided in § 412.513(c).

The GROUPER software is used both to classify past cases to measure relative hospital resource consumption to establish the MS–LTC–DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible MS–DRG and MS–LTC–DRG classification changes and to recalibrate the MS–DRG and MS–LTC–DRG relative weights during our annual update under both the IPPS (§ 412.60(e)) and the LTCH PPS (§ 412.517), respectively.

Although the LTCH PPS RYs 2004 through 2009 annual payment rate update cycles were effective July 1 through June 30 instead of October 1 through September 30 (with the exception of the 15-month RY 2009 payment rate update cycle, which is effective July 1, 2008 through September 30, 2009), because the patient classification system utilized under the LTCH PPS uses the same DRGs as those used under the IPPS for acute care hospitals, the annual update of the LTC–DRG classifications and relative weights continued to remain linked to the annual reclassification and recalibration of the DRGs used under the IPPS. Therefore, the payment rate update to the MS–LTC–DRG classifications and relative weights are effective for discharges occurring on or after October 1 through September 30 of each year (RYs 2004 through 2009), and we published the annual proposed and final update of the MS–LTC–DRGs in the same notice as the proposed and final update for the IPPS (69 FR 34122 through 34125).

In the RY 2009 LTCH PPS final rule, we amended the regulations at § 412.503 and § 412.535 in order to consolidate the rate year and fiscal year rulemaking cycles, effective October 1, 2009 (73 FR 26797 through 26798). Specifically, we revised the regulations to shift the payment rate update from a July 1 through June 30 cycle to an October 1 through September 30 cycle. We extended the 2009 rate year period to September 30, 2009, so that RY 2009 is 15 months; that is, July 1, 2008, through September 30, 2009. Consequently, after the conclusion of the 15-month RY 2009, both the annual update of the LTCH PPS payment rates (and the description of the methodology and data used to calculate these payment rates) and the annual update of the MS–LTC–DRG classifications and associated weighting factors for LTCHs will be updated on an October 1 through September 30 cycle and, thus, be effective on October 1 of each Federal fiscal year beginning October 1, 2009. Beginning with the RY 2010 LTCH PPS update, both the annual update of the LTCH PPS payment rate, including the annual update of the MS–LTC–DRGs, and policy changes will be presented along with the annual IPPS payment rate and policy changes in a single combined rulemaking document published in the **Federal Register** as was done in the proposed rule and in this final rule.

Prior to FY 2004, the annual update to the DRGs used under the IPPS had been based on the annual revisions to the ICD–9–CM codes and was effective each October 1. As discussed in past LTCH PPS and IPPS proposed and final rules (most recently in the FY 2009 IPPS final rule (73 FR 48530)), section 503(a) of Public Law 108–173 amended section 1886(d)(5)(K) of the Act by adding a new clause (vii) which states that ''the Secretary shall provide for the addition of new diagnosis and procedure codes in [sic] April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement improves the recognition of new technologies under the IPPS by accounting for those ICD–9–CM codes in the MedPAR claims data earlier than the agency had accounted for new technology in the past. In implementing the statutory change, the agency has provided that ICD–9–CM diagnosis and procedure codes for new medical technology may be created and assigned to existing DRGs in the middle of the Federal fiscal year, on April 1. Therefore, there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal fiscal year (that is, October 1 and April 1). However, we note that, as the statute permits, the DRG relative weights in effect for that fiscal year will continue to be updated only once a year (October 1).

The patient classification system used under the LTCH PPS is the same patient classification system that is used under the IPPS. Therefore, the ICD–9–CM codes currently used under both the IPPS and the LTCH PPS have the potential of being updated twice a year due to the implementation of section 503(a) of Public Law 108–173 for the IPPS (as explained above). Because we do not publish a midyear IPPS rule, any April 1 ICD–9–CM coding update will not be published in the **Federal Register**. Rather, consistent with the policy under the IPPS (discussed in section II.G.7. of the preamble of this final rule), we assign any new diagnosis or procedure codes to the same DRG in which its predecessor code was assigned, so that there is no impact on the DRG assignments. Any coding updates will be available through the Web sites provided in section II.G.7. of the preamble of this final rule and through the *Coding Clinic for ICD–9–CM.* Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software system. If new codes are implemented on April 1, revised code books and software systems, including the GROUPER software program, will be necessary because the most current ICD–9–CM codes must be reported. Therefore, for purposes of the LTCH PPS, because each ICD–9–CM code must be included in the GROUPER algorithm to classify each case under the correct LTCH PPS, the GROUPER software program used under the LTCH PPS would need to be revised to accommodate any new codes.

In implementing section 503(a) of Public Law 108–173, there will only be an April 1 update if new technology diagnosis and procedure code revisions are requested and approved. We note that any new codes created for April 1 implementation will be limited to those primarily needed to describe new technologies and medical services. However, we reiterate that the process of discussing updates to the ICD–9–CM is an open process through the ICD–9–CM Coordination and Maintenance Committee. Requestors will be given the opportunity to present the merits for a new code and to make a clear and convincing case for the need to update ICD–9–CM codes for purposes of the IPPS new technology add-on payment process through an April 1 update (as also discussed in section II.G.7. of the preamble of this final rule).

There were no mid-year codes added to the ICD–9–CM coding system as a result of the September 24–25, 2008 meeting of the ICD–9–CM Coordination and Maintenance Committee. The next update to the ICD–9–CM coding system will occur on October 1, 2009 (FY 2010), and the ICD–9–CM coding set implemented on October 1, 2009, will

continue through September 30, 2010 (FY 2010). The ICD–9–CM Coordination and Maintenance Committee met again on March 11–12, 2009. Because this meeting was for the purpose of informing the public of proposed changes to the ICD–9–CM code set as well as for requesting comment from the public, no decisions regarding coding changes were made at this meeting. Commenters were requested to submit comments by April 3, 2009, concerning the proposed code revisions discussed at the March 11–12, 2009 meeting. Any new codes or other revisions created as a result of this meeting were not included in the proposed rule because of the short turnaround time required for the publication of the proposed rule. However, new codes and any other revisions appear in this final rule in Tables 6A through 6F of the Addendum. The codes appearing for the first time in this final rule are identified with an asterisk leading to the following notation: ''These codes were discussed at the March 11–12, 2009 ICD–9–CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2009.'' The update to the ICD–9–CM coding system that is effective on October 1, 2009, is discussed in section II.G.7. of the preamble of this final rule.

b. Changes to the MS–LTC–DRGs for RY 2010

As we proposed, consistent with our historical practice of using the same patient classification system under the LTCH PPS as is used under the IPPS, in this final rule, we are modifying and revising the MS–LTC–DRG classifications effective October 1, 2009, through September 30, 2010 (RY 2010) consistent with the changes to specific MS–DRG classifications presented above in section II.G. of this final rule (that is, GROUPER Version 27.0). Therefore, the MS–LTC–DRGs for RY 2010 presented in this final rule are the same as the MS–DRGs that will be used under the IPPS for FY 2010 (that is, GROUPER Version 27.0 as described in section II.G. of the preamble of this final rule). In addition, because the MS–LTC–DRGs for RY 2010 are the same as the MS–DRGs for FY 2010, the other changes that will affect MS–DRG (and by extension MS–LTC–DRG) assignments under Version 27.0 of the GROUPER discussed in section II.G. of the preamble of this final rule, including the changes to the MCE software and changes to the ICD–9–CM coding system, will also be applicable under the LTCH PPS for RY 2010.

Comment: A few commenters supported the proposed revisions to the MS–DRG classifications and, by extension, the MS–LTC–DRG classifications that would apply under the LTCH PPS for RY 2010.

Response: We appreciate the commenters' support as we continue to refine the MS–DRG classifications and, by extension, the MS–LTC–DRG classifications. As stated above, in this final rule, we are adopting Version 27.0 of the MS–DRG GROUPER (as described in section II.G. of the preamble of this final rule) for use under the LTCH PPS for RY 2010.

3. Development of the RY 2010 MS–LTC–DRG Relative Weights

a. General Overview of the Development of the MS–LTC–DRG Relative Weights

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55984), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of medical care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we have annually adjusted the LTCH PPS standard Federal prospective payment system rate by the applicable relative weight in determining payment to LTCHs for each case. (As we have noted above, we adopted the MS–LTC–DRGs for the LTCH PPS beginning in FY 2008. However, this change in the patient classification system does not affect the basic principles of the development of relative weights under a DRG-based prospective payment system.)

Although the adoption of the MS–LTC–DRGs resulted in some modifications of existing procedures for assigning weights in cases of zero volume and/or nonmonotonicity, as discussed in the FY 2008 IPPS final rule with comment period (72 FR 47289 through 47295) and the FY 2009 IPPS final rule (73 FR 48542 through 48550) and as detailed in the following sections, the basic methodology for developing the RY 2010 MS–LTC–DRG relative weights in this final rule continues to be determined in accordance with the general methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). Under the LTCH PPS, relative weights for each MS–LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each MS–LTC–DRG that represents the resources needed by an average inpatient LTCH case in that MS–LTC–DRG. For example, cases in an MS–LTC–DRG with a relative weight of 2 will, on average, cost twice as much to treat as cases in an MS–LTC–DRG with a weight of 1.

b. Development of the Proposed MS–LTC–DRG Relative Weights for RY 2010

Beginning with the FY 2008 update, we established a budget neutral requirement for the annual update to the MS–LTC–DRG classifications and relative weights at 42 CFR 412.517(b) (in conjunction with § 412.503), such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the classification and relative weight changes. (See the May 11, 2007 LTCH PPS final rule (72 FR 26882 through 26884).)

Consistent with § 412.517(b), we apply a two-step budget neutrality methodology, which is based on the current year MS–LTC–DRG classifications and relative weights. (For additional information on the established two-step budget neutrality methodology, refer to the FY 2008 IPPS final rule (72 FR 47295 through 47296).) Thus, the annual update to the MS–LTC–DRG classifications and relative weights for RY 2010 is based on the FY 2009 MS–LTC–DRG classifications and relative weights. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24218 through 24227), we proposed RY 2010 MS–LTC–DRG relative weights based on the FY 2009 MS–LTC–DRG relative weights published in the FY 2009 IPPS final rule (73 FR 48528 through 48551 and 49041 through 49062). Through an interim final rule with comment period published in the **Federal Register** on June 3, 2009 (74 FR 26546 through 26569), we revised the published FY 2009 MS–LTC–DRG relative weights based on the appropriate application of the FY 2009 budget neutrality factor determined consistent with our established methodology. In section IX. of the preamble of this final rule, we respond to the public comments we received on that interim final rule with comment period and finalize the revised FY 2009 MS–LTC–DRG relative weights that are applicable for the period of June 3, 2009

through September 30, 2009. Based on the revised FY 2009 MS–LTC–DRG relative weights published in the June 3, 2009 interim final rule with comment period, in the RY 2010 LTCH PPS supplemental proposed rule published in the **Federal Register** on June 3, 2009 (74 FR 26600 through 26635), we presented both proposed RY 2010 MS–LTC–DRG relative weights and a proposed RY 2010 high-cost outlier (HCO) fixed-loss amount.

Comment: In response to the RY 2010 LTCH PPS supplemental proposed rule, a few commenters asserted that CMS did not establish good cause for deviating from the required ''notice and comment'' rulemaking procedures required by the Social Security Act (the Act) and the Administrative Procedures Act (APA). The commenters stated that, in order to submit meaningful comments, the public should have been given the full 60 days to evaluate the proposals contained in the RY 2010 LTCH PPS supplemental proposed rule, and asserted that there was sufficient time before the October 1, 2009 effective date to provide for the full 60-day comment period.

Response: We do not agree with the commenters that we did not establish good cause for deviating from the ''notice and comment'' rulemaking procedures required by section 1871 of the Act and section 553(d) of the APA. As discussed in the RY 2010 LTCH PPS supplemental proposed rule (74 FR 26603), we ordinarily publish a proposed rule and provide a 60-day period for public comment in accordance with section 1871(b)(1) of the Act and section 553(d) of the APA. However, section 1871(b)(2)(C) of the Act provides that this period may be shortened when the Secretary, for good cause, finds that such a comment period would be impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the notice issued. In this instance, we believe that a 60-day comment period would have been both impracticable and contrary to the public interest because it would not have allowed for coordinated consideration of the public comments on the RY 2010 LTCH PPS supplemental proposed rule with those on the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. Because the proposals presented in the RY 2010 LTCH PPS supplemental proposed rule were integral to our consideration of public comments on certain other LTCH PPS proposals presented in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we believe that it was necessary and appropriate to review public comments received on the proposals presented in the RY 2010 LTCH PPS supplemental proposed rule in conjunction with the public comments received on the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule.

With respect to the commenters' assertion that there was sufficient time before the October 1, 2009 effective date of the RY 2010 LTCH PPS annual update to provide for the full 60-day comment period, as we stated in the RY 2010 LTCH PPS supplemental proposed rule (74 FR 26603), a 60-day comment period would have been both impracticable and contrary to the public interest because it would not allow for coordinated consideration of the public comments on the RY 2010 LTCH PPS supplemental proposed rule with those on the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. Because the proposals contained in the RY 2010 LTCH PPS supplemental proposed rule were integral to our consideration of public comments on certain proposals in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we do not believe it would have been appropriate to review public comments on the proposals contained in the RY 2010 LTCH PPS supplemental proposed rule in isolation from the public comments received on the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. We also do not agree that the less than 60-day comment period deprived the public of an opportunity to submit meaningful comments on the proposals presented in the RY 2010 LTCH PPS supplemental proposed rule. We note that the proposed RY 2010 MS–LTC–DRG relative weights and the RY 2010 HCO fixed-loss threshold amount presented in the RY 2010 LTCH PPS supplemental proposed rule were developed consistent with the methodology described in the original FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24080), which had been available to the public for over 3 weeks at the time the supplemental proposed rule was published. For the reasons set forth above, we believe we provided the necessary and required timeframes for meaningful public comment on the proposals presented in the RY 2010 LTCH PPS supplemental proposed rule.

c. Data

In this final rule, to calculate the MS–LTC–DRG relative weights for RY 2010, we obtained total Medicare allowable charges from FY 2008 Medicare LTCH bill data from the March 2009 update of the MedPAR file, which are the best available data at this time, and used the finalized Version 27.0 of the GROUPER to classify LTCH cases (as discussed above). For the proposed rule, we used data from the December 2008 update of the MedPAR file, which was the best available we had at the time of publication of the proposed rule.

Consistent with our historical methodology, we excluded the data from LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 or section 222(a) of Public Law 92–603. (We refer readers to the FY 2009 IPPS final rule (73 FR 48532).) Therefore, in the development of the RY 2010 MS–LTC–DRG relative weights in this final rule, we excluded the data of 15 all-inclusive rate providers and the 2 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2008 MedPAR file.

c. Hospital-Specific Relative Value (HSRV) Methodology

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. This nonrandom distribution of cases with relatively high (or low) charges in specific MS–LTC–DRGs has the potential to inappropriately distort the measure of average charges. As we proposed, to account for the fact that cases may not be randomly distributed across LTCHs, in this final rule, we used a hospital-specific relative value (HSRV) methodology to calculate the MS–LTC–DRG relative weights instead of the methodology used to determine the MS–DRG relative weights under the IPPS described in section II.H. of the preamble of this final rule. We believe this method removed this hospital-specific source of bias in measuring LTCH average charges. Specifically, we reduced the impact of the variation in charges across providers on any particular MS–LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the HSRV methodology, we standardized charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusted those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, average 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In

this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

Comment: One commenter believes that it is inconsistent to utilize the HSRV methodology under the LTCH PPS when it is not utilized under the IPPS and recommended that the HSRV methodology not be used under either the LTCH PPS or the IPPS.

Response: Because different types of LTCH cases may not be randomly distributed across all LTCHs due to the specialized nature of LTCHs, as discussed above, we believe the HSRV methodology is appropriate to use under the LTCH PPS in order to remove this hospital-specific source of bias in measuring the LTCH average charges that are used in determining the relative weights for the MS–LTC–DRGs under the LTCH PPS. Therefore, we are not adopting the commenter's recommendation and, as proposed, have continued to utilize the HSRV methodology under the LTCH PPS to determine the MS–LTC–DRG relative weights for RY 2010. As discussed above in sections II.C. and II.E. of this preamble, we have evaluated the use of the HSRV methodology under the IPPS for future consideration and continue to explore refinement to the relative weight methodology used under the IPPS.

In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991), we continue to standardize charges for each case by first dividing the adjusted charge for the case (adjusted for SSOs under § 412.529 as described in section VIII.B.3.f. (step 3) of the preamble of this final rule) by the average adjusted charge for all cases at the LTCH in which the case was treated. SSO cases are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the MS–LTC–DRG (§ 412.529 and § 412.503). The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

Multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight at a LTCH with higher average costs than they would at a LTCH with low average costs, which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a $10,000 charge for a case at a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case at a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

d. Treatment of Severity Levels in Developing the MS–LTC–DRG Relative Weights

For purposes of determining the MS–LTC–DRG relative weights, as we discussed in the FY 2009 IPPS final rule (73 FR 48532 through 48533), there are three different categories of DRGs based on volume of cases within specific MS–LTC–DRGs. MS–LTC–DRGs with at least 25 cases are each assigned a unique relative weight; low-volume MS–LTC–DRGs (that is, MS–LTC–DRGs that contain between 1 and 24 cases based on a given year's claims data) are grouped into quintiles (as described below) and assigned the relative weight of the quintile. No-volume MS–LTC–DRGs (that is, no cases in the given year's claims data were assigned to those MS–LTC–DRGs) are crosswalked to other MS–LTC–DRGs based on the clinical similarities and assigned the relative weight of the crosswalked MS–LTC–DRG (as described in greater detail below). (We provide in-depth discussions of our policy regarding weight-setting for low-volume MS–LTC–DRGs in section VIII.B.3.e. of the preamble of this final rule and for no-volume MS–LTC–DRGs, under Step 5 in section VIII.B.3.f. of the preamble of this final rule.)

As noted above, in response to the need to account for severity and pay appropriately for cases, we developed a severity-adjusted patient classification system that we adopted for both the IPPS and the LTCH PPS in FY 2008. As described in greater detail above, the MS–LTC–DRG system can accommodate three severity levels: ''with MCC'' (most severe); ''with CC,'' and ''without CC/MCC'' (the least severe), with each level assigned an individual MS–LTC–DRG number. In cases with two subdivisions, the levels are either ''with CC/MCC'' and ''without CC/MCC'' or ''with MCC'' and ''without MCC.'' For example, under the MS–LTC–DRG system, multiple sclerosis and cerebellar ataxia with MCC is MS–LTC–DRG 58; multiple sclerosis and cerebellar ataxia with CC is MS–LTC–DRG 59; and multiple sclerosis and cerebellar ataxia without CC/MCC is MS–LTC–DRG 60. For purposes of discussion in this section, the term ''base DRG'' is used to refer to the DRG category that encompasses all levels of severity for that DRG. For example, when referring to the entire DRG category for multiple sclerosis and cerebellar ataxia, which includes the above three severity levels, we would use the term ''base DRG.''

As also noted above, while the LTCH PPS and the IPPS use the same patient classification system, the methodology that is used to set the DRG relative weights for use in each payment system differs because the overall volume of cases in the LTCH PPS is much less than in the IPPS. As a general rule, consistent with the methodology established when we adopted the MS–LTC–DRGs in the FY 2008 IPPS final rule with comment period (72 FR 47278 through 47281), we determined the RY 2010 relative weights for the MS–LTC–DRGs using the following steps: (1) If an MS–LTC–DRG had at least 25 cases, it was assigned its own relative weight; (2) if an MS–LTC–DRG had between 1 and 24 cases, it was assigned to a quintile for which we computed a relative weight for all of the MS–LTC–DRGs assigned to that quintile; and (3) if an MS–LTC–DRG had no cases, it was crosswalked to another MS–LTC–DRG based upon clinical similarities to assign an appropriate relative weight (as described below in detail in Step 5 of section VIII.B.3.f. of this preamble). Furthermore, in determining the RY 2010 MS–LTC–DRG relative weights, when necessary, we made adjustments to account for nonmonotonicity, as explained in greater detail below in Step 6 of section VIII.B.3.f. of this preamble.

Our methodology for determining relative weights for the MS–LTC–DRGs included an adjustment for nonmonotonicity because, theoretically, cases under the MS–LTC–DRG system that are more severe require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, weights should increase with severity, from lowest to highest. If the weights do not increase (that is, if based on the relative weight methodology outlined above, the MS–LTC–DRG with MCC would have a lower relative weight than one with CC, or the MS–LTC–DRG without CC/MCC would have a higher relative weight than either of

the others), there is a problem with monotonicity. Since the start of the LTCH PPS for FY 2003 (67 FR 55990), when determining the LTC–DRG relative weights, we have made adjustments in order to maintain monotonicity by grouping both sets of cases together and establishing a new relative weight for both LTC–DRGs. We continue to believe that utilizing nonmonotonic relative weights to adjust Medicare payments would result in inappropriate payments because, in a nonmonotonic system, cases that are more severe and require greater expenditure of medical care resources would be paid based on a lower relative weight than cases that are less severe and require lower resource use. The adopted methodology for making adjustments because of nonmonotonicity in determining the RY 2010 MS–LTC–DRG relative weights is discussed in greater detail below in section VIII.B.3.f. (Step 6) of the preamble of this final rule.

e. Low-Volume MS–LTC–DRGs

In order to account for MS–LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), consistent with the methodology we established when we implemented the LTCH PPS (67 FR 55984 through 55995) and the methodology that we established when we implemented the MS–LTC–DRGs in the FY 2008 IPPS final rule with comment period (72 FR 47283 through 47288), for purposes of determining the MS–LTC–DRG relative weights, we group those ''low-volume MS–LTC–DRGs'' (that is, MS–LTC–DRGs that contained between 1 and 24 cases annually) into one of five categories (quintiles) based on average charges. In determining the RY 2010 MS–LTC–DRG relative weights in this final rule, consistent with the methodology described above and the methodology we used to establish the FY 2009 MS–LTC–DRG relative weights in the FY 2009 IPPS final rule (73 FR 48533 through 48540), we continue to employ this quintile methodology for low-volume MS–LTC–DRGs. In addition, in cases where the initial assignment of a low-volume MS–LTC–DRG to quintiles results in nonmonotonicity within a base-DRG, in order to ensure appropriate Medicare payments, consistent with our historical methodology, we made adjustments to the treatment of low-volume MS–LTC–DRGs to preserve monotonicity, as discussed in detail below in section VIII.B.3.f. (Step 6) in this preamble.

In this final rule, using LTCH cases from the March 2009 update of the FY 2008 MedPAR file, we identified 281 MS–LTC–DRGs that contained between 1 and 24 cases. This list of MS–LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing a minimum of 56 MS–LTC–DRGs (281/5 = 56 with 1 MS–LTC–DRG as the remainder). We assigned a low-volume MS–LTC–DRG to a specific low-volume quintile by sorting the low-volume MS–LTC–DRGs in ascending order by average charge in accordance with our established methodology. Furthermore, because the number of MS–LTC–DRGs with less than 25 cases was not evenly divisible by 5, the average charge of the low-volume quintile was used to determine which of the low-volume quintiles would contain the 1 additional low-volume MS–LTC–DRG. Specifically, after sorting the 281 low-volume MS–LTC–DRGs by ascending order by average charge, we assigned the first fifth (1st through 56th) of low-volume MS–LTC–DRGs (with the lowest average charge) into Quintile 1. The MS–LTC–DRGs with the highest average charge cases were assigned into Quintile 5. Because the average charge of the 57th low-volume MS–LTC–DRG in the sorted list was closer to the average charge of the 56th low-volume MS–LTC–DRG (assigned to Quintile 1) than to the average charge of the 58th low-volume MS–LTC–DRG (assigned to Quintile 2), we placed it into Quintile 1 (such that Quintile 1 contains 57 low-volume MS–LTC–DRGs before any adjustments for nonmonotonicity, as discussed below). This process was repeated through the remaining low-volume MS–LTC–DRGs so that 1 of the 5 low-volume quintiles contain 57 MS–LTC–DRGs (Quintile 1) and the other 4 low-volume quintiles contain 56 MS–LTC–DRGs (Quintiles 2, 3, 4, and 5).

Accordingly, in order to determine the RY 2010 relative weights for the MS–LTC–DRGs with low volume, we used the five low-volume quintiles described above. The composition of each of the five low-volume quintiles shown in the chart below was used in determining the RY 2010 MS–LTC–DRG relative weights (as shown in Table 11 of the Addendum to this final rule). We determined a relative weight and (geometric) average length of stay for each of the 5 low-volume quintiles using the methodology that we applied to the MS–LTC–DRGs (25 or more cases), as described in section VIII.B.3.f. of the preamble of this final rule. We assigned the same relative weight and average length of stay to each of the low-volume MS–LTC–DRGs that make up an individual low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of MS–LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume MS–LTC–DRGs and to calculate the relative weights based on our methodology.

COMPOSITION OF LOW-VOLUME QUINTILES FOR RY 2010

MS–LTC–DRG	MS–LTC–DRG description
Quintile 1	
26	Craniotomy & endovascular intracranial procedures w CC.
53	Spinal disorders & injuries w/o CC/MCC.
60	Multiple sclerosis & cerebellar ataxia w/o CC/MCC.
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC.
68	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC.
69	Transient ischemia.
72	Nonspecific cerebrovascular disorders w/o CC/MCC.
78	Hypertensive encephalopathy w CC.
81	Nontraumatic stupor & coma w/o MCC.
89	Concussion w CC.
90	Concussion w/o CC/MCC.
93	Other disorders of nervous system w/o CC/MCC.
103	Headaches w/o MCC.
115	Extraocular procedures except orbit.
139	Salivary gland procedures.

COMPOSITION OF LOW-VOLUME QUINTILES FOR RY 2010—Continued

MS–LTC–DRG	MS–LTC–DRG description
149	Dysequilibrium.
184	Major chest trauma w CC.
198	Interstitial lung disease w/o CC/MCC.
201	Pneumothorax w/o CC/MCC.
203	Bronchitis & asthma w/o CC/MCC.
284	Circulatory disorders w AMI, expired w CC.*
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC.
313	Chest pain.
350	Inguinal & femoral hernia procedures w MCC.
370	Major esophageal disorders w/o CC/MCC.
376	Digestive malignancy w/o CC/MCC.
387	Inflammatory bowel disease w/o CC/MCC.
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC.
440	Disorders of pancreas except malignancy w/o CC/MCC.
443	Disorders of liver except malig, cirr, alc hepa w/o CC/MCC.
446	Disorders of the biliary tract w/o CC/MCC.
534	Fractures of femur w/o MCC.
536	Fractures of hip & pelvis w/o MCC.
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC.
547	Connective tissue disorders w/o CC/MCC.
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC.
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC.
601	Non-malignant breast disorders w/o CC/MCC.
645	Endocrine disorders w/o CC/MCC.
667	Prostatectomy w/o CC/MCC.
694	Urinary stones w/o esw lithotripsy w/o MCC.
696	Kidney & urinary tract signs & symptoms w/o MCC.
725	Benign prostatic hypertrophy w MCC.
726	Benign prostatic hypertrophy w/o MCC.
730	Other male reproductive system diagnoses w/o CC/MCC.
746	Vagina, cervix & vulva procedures w CC/MCC.
816	Reticuloendothelial & immunity disorders w/o CC/MCC.
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC.
880	Acute adjustment reaction & psychosocial dysfunction.
881	Depressive neuroses.
883	Disorders of personality & impulse control.*
895	Alcohol/drug abuse or dependence w rehabilitation therapy.
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC.
918	Poisoning & toxic effects of drugs w/o MCC.
964	Other multiple significant trauma w CC.
965	Other multiple significant trauma w/o CC/MCC.
976	HIV w major related condition w/o CC/MCC.
Quintile 2	
032	Ventricular shunt procedures w CC.
033	Ventricular shunt procedures w/o CC/MCC.
042	Periph & cranial nerve & other nerv syst proc w/o CC/MCC.
067	Nonspecific cva & precerebral occlusion w/o infarct w MCC.
080	Nontraumatic stupor & coma w MCC.
083	Traumatic stupor & coma, coma >1 hr w CC.*
087	Traumatic stupor & coma, coma <1 hr w/o CC/MCC.***
088	Concussion w MCC.
096	Bacterial & tuberculous infections of nervous system w/o CC/MCC.
102	Headaches w MCC.
125	Other disorders of the eye w/o MCC.
156	Nasal trauma & deformity w/o CC/MCC.***
159	Dental & Oral Diseases w/o CC/MCC.
182	Respiratory neoplasms w/o CC/MCC.***
183	Major chest trauma w MCC.
188	Pleural effusion w/o CC/MCC.
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC.
259	Cardiac pacemaker device replacement w/o MCC.
282	Circulatory disorders w AMI, discharged alive w/o CC/MCC.***
284	Circulatory disorders w AMI, expired w CC.**
285	Circulatory disorders w AMI, expired w/o CC/MCC.
294	Deep vein thrombophlebitis w CC/MCC.
311	Angina pectoris.
379	G.I. hemorrhage w/o CC/MCC.***
384	Uncomplicated peptic ulcer w/o MCC.
386	Inflammatory bowel disease w CC.
390	G.I. obstruction w/o CC/MCC.

COMPOSITION OF LOW-VOLUME QUINTILES FOR RY 2010—Continued

MS–LTC–DRG	MS–LTC–DRG description
418	Laparoscopic cholecystectomy w/o c.d.e. w CC.
433	Cirrhosis & alcoholic hepatitis w CC.
436	Malignancy of hepatobiliary system or pancreas w CC.
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC.
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC.
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC.
535	Fractures of hip & pelvis w MCC.
553	Bone diseases & arthropathies w MCC.
598	Malignant breast disorders w CC.
600	Non-malignant breast disorders w CC/MCC.
644	Endocrine disorders w CC.
663	Minor bladder procedures w CC.
675	Other kidney & urinary tract procedures w/o CC/MCC.
685	Admit for renal dialysis.
697	Urethral stricture.
700	Other kidney & urinary tract diagnoses w/o CC/MCC.
722	Malignancy, male reproductive system w MCC.
723	Malignancy, male reproductive system w CC.
747	Vagina, cervix & vulva procedures w/o CC/MCC.
759	Infections, female reproductive system w/o CC/MCC.
803	Other O.R. proc of the blood & blood forming organs w CC.
808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC.***
815	Reticuloendothelial & immunity disorders w CC.
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC.
842	Lymphoma & non-acute leukemia w/o CC/MCC.
864	Fever of unknown origin.
882	Neuroses except depressive.
894	Alcohol/drug abuse or dependence, left ama.
922	Other injury, poisoning & toxic effect diag w MCC.*
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC.
023	Craniotomy w major device implant or acute complex CNS PDX w MCC.
029	Spinal procedures w CC.
030	Spinal procedures w/o CC/MCC.
058	Multiple sclerosis & cerebellar ataxia w MCC.
075	Viral meningitis w CC/MCC.
083	Traumatic stupor & coma, coma >1 hr w CC.**
084	Traumatic stupor & coma, coma >1 hr w/o CC/MCC.**
099	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC.***
121	Acute major eye infections w CC/MCC.
124	Other disorders of the eye w MCC.
158	Dental & Oral Diseases w CC.
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC.
290	Acute & subacute endocarditis w/o CC/MCC.
327	Stomach, esophageal & duodenal proc w CC.
331	Major small & large bowel procedures w/o CC/MCC.
348	Anal & stomal procedures w CC.
381	Complicated peptic ulcer w CC.
382	Complicated peptic ulcer w/o CC/MCC.
383	Uncomplicated peptic ulcer w MCC.
424	Other hepatobiliary or pancreas O.R. procedures w CC.
472	Cervical spinal fusion w CC.
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC.
493	Lower extrem & humer proc except hip, foot, femur w CC.
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC.
511	Shoulder, elbow or forearm proc, exc major joint proc w CC.
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC.
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC.
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC.
581	Other skin, subcut tiss & breast proc w/o CC/MCC.
582	Mastectomy for malignancy w CC/MCC.
584	Breast biopsy, local excision & other breast procedures w CC/MCC.
597	Malignant breast disorders w MCC.
620	O.R. procedures for obesity w CC.
643	Endocrine disorders w MCC.
656	Kidney & ureter procedures for neoplasm w MCC.
660	Kidney & ureter procedures for non-neoplasm w CC.
666	Prostatectomy w CC.
668	Transurethral procedures w MCC.
669	Transurethral procedures w CC.
687	Kidney & urinary tract neoplasms w CC.
693	Urinary stones w/o esw lithotripsy w MCC.
695	Kidney & urinary tract signs & symptoms w MCC.

COMPOSITION OF LOW-VOLUME QUINTILES FOR RY 2010—Continued

MS–LTC–DRG	MS–LTC–DRG description
749	Other female reproductive system O.R. procedures w CC/MCC.
755	Malignancy, female reproductive system w CC.
760	Menstrual & other female reproductive system disorders w CC/MCC.
781	Other antepartum diagnoses w medical complications.
809	Major hematol/immun diag exc sickle cell crisis & coagul w CC.***
821	Lymphoma & leukemia w major O.R. procedure w CC.
835	Acute leukemia w/o major O.R. procedure w CC.
843	Other myeloprolif dis or poorly diff neopl diag w MCC.***
858	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC.
866	Viral illness w/o MCC.
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC.
903	Wound debridements for injuries w/o CC/MCC.
905	Skin grafts for injuries w/o CC/MCC.
906	Hand procedures for injuries.
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft.
941	O.R. proc w diagnoses of other contact w health services w/o CC/MCC.
028	Spinal procedures w MCC.
077	Hypertensive encephalopathy w MCC.
082	Traumatic stupor & coma, coma >1 hr w MCC.
084	Traumatic stupor & coma, coma >1 hr w/o CC/MCC.*
131	Cranial/facial procedures w CC/MCC.
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC.
157	Dental & Oral Diseases w MCC.
168	Other resp system O.R. procedures w/o CC/MCC.
237	Major cardiovascular procedures w MCC.
243	Permanent cardiac pacemaker implant w CC.
244	Permanent cardiac pacemaker implant w/o CC/MCC.
254	Other vascular procedures w/o CC/MCC.***
286	Circulatory disorders except AMI, w card cath w MCC.
287	Circulatory disorders except AMI, w card cath w/o MCC.
304	Hypertension w MCC.
338	Appendectomy w complicated principal diag w MCC.
344	Minor small & large bowel procedures w MCC.
347	Anal & stomal procedures w MCC.
353	Hernia procedures except inguinal & femoral w MCC.
354	Hernia procedures except inguinal & femoral w CC.
369	Major esophageal disorders w CC.***
380	Complicated peptic ulcer w MCC.
423	Other hepatobiliary or pancreas O.R. procedures w MCC.
466	Revision of hip or knee replacement w MCC.*
469	Major joint replacement or reattachment of lower extremity w MCC.*
471	Cervical spinal fusion w MCC.
480	Hip & femur procedures except major joint w MCC.*
487	Knee procedures w pdx of infection w/o CC/MCC.
488	Knee procedures w/o pdx of infection w CC/MCC.
490	Back & neck procedures except spinal fusion w CC/MCC or disc devices.
502	Soft tissue procedures w/o CC/MCC.***
503	Foot procedures w MCC.
505	Foot procedures w/o CC/MCC.***
510	Shoulder, elbow or forearm proc, exc major joint proc w MCC.
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC.
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC.
516	Other musculoskelet sys & conn tiss O.R. proc w CC.
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC.
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC.***
642	Inborn errors of metabolism.
671	Urethral procedures w CC/MCC.
691	Urinary stones w esw lithotripsy w CC/MCC.
711	Testes procedures w CC/MCC.
800	Splenectomy w CC.
814	Reticuloendothelial & immunity disorders w MCC.
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC.
834	Acute leukemia w/o major O.R. procedure w MCC.
844	Other myeloprolif dis or poorly diff neopl diag w CC.***
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC.
909	Other O.R. procedures for injuries w/o CC/MCC.
917	Poisoning & toxic effects of drugs w MCC.
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft.
928	Full thickness burn w skin graft or inhal inj w CC/MCC.
958	Other O.R. procedures for multiple significant trauma w CC.
963	Other multiple significant trauma w MCC.
983	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC.

COMPOSITION OF LOW-VOLUME QUINTILES FOR RY 2010—Continued

MS–LTC–DRG	MS–LTC–DRG description
011	Tracheostomy for face, mouth & neck diagnoses w MCC.
025	Craniotomy & endovascular intracranial procedures w MCC.
031	Ventricular shunt procedures w MCC.
037	Extracranial procedures w MCC.
038	Extracranial procedures w CC.
135	Sinus & mastoid procedures w CC/MCC.
148	Ear, nose, mouth & throat malignancy w/o CC/MCC.***
164	Major chest procedures w CC.
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC.
226	Cardiac defibrillator implant w/o cardiac cath w MCC.
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC.
242	Permanent cardiac pacemaker implant w MCC.
245	AICD generator procedures.
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC.
260	Cardiac pacemaker revision except device replacement w MCC.
326	Stomach, esophageal & duodenal proc w MCC.
330	Major small & large bowel procedures w CC.
335	Peritoneal adhesiolysis w MCC.
405	Pancreas, liver & shunt procedures w MCC.
406	Pancreas, liver & shunt procedures w CC.
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC.
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC.
420	Hepatobiliary diagnostic procedures w MCC.
453	Combined anterior/posterior spinal fusion w MCC.
454	Combined anterior/posterior spinal fusion w CC.
456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC.
457	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC.
459	Spinal fusion except cervical w MCC.
466	Revision of hip or knee replacement w MCC.**
467	Revision of hip or knee replacement w CC.
469	Major joint replacement or reattachment of lower extremity w MCC.**
470	Major joint replacement or reattachment of lower extremity w/o MCC.
480	Hip & femur procedures except major joint w MCC.**
481	Hip & femur procedures except major joint w CC.
485	Knee procedures w pdx of infection w MCC.
486	Knee procedures w pdx of infection w CC.
492	Lower extrem & humer proc except hip, foot, femur w MCC.
498	Local excision & removal int fix devices of hip & femur w CC/MCC.
507	Major shoulder or elbow joint procedures w CC/MCC.
619	O.R. procedures for obesity w MCC.
659	Kidney & ureter procedures for non-neoplasm w MCC.
662	Minor bladder procedures w MCC.
709	Penis procedures w CC/MCC.
713	Transurethral prostatectomy w CC/MCC.
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC.
776	Postpartum & post abortion diagnoses w/o O.R. procedure.
802	Other O.R. proc of the blood & blood forming organs w MCC.
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC.
824	Lymphoma & non-acute leukemia w other O.R. proc w CC.
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC.
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC.***
876	O.R. procedure w principal diagnoses of mental illness.
922	Other injury, poisoning & toxic effect diag w MCC.**
923	Other injury, poisoning & toxic effect diag w/o MCC.
957	Other O.R. procedures for multiple significant trauma w MCC.
969	HIV w extensive O.R. procedure w MCC.
970	HIV w extensive O.R. procedure w/o MCC.
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC.
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC.
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC.***

* One of the original 281 low-volume MS–LTC–DRGs initially assigned to this low-volume quintile but moved to a different low-volume quintile in addressing nonmonotonicity (refer to step 6 in section VIII.B.3.f. of the preamble of this final rule).

** One of the original 281 low-volume MS–LTC–DRGs initially assigned to a different low-volume quintile but moved to this low-volume quintile in addressing nonmonotonicity (refer to step 6 in section VIII.B.3.f. of the preamble of this final rule).

*** One of the original 281 low-volume MS–LTC–DRGs initially assigned to this low-volume quintile, but removed from this low-volume quintile in addressing nonmonotonicity (refer to step 6 in section VIII.B.3.f.of the preamble of this final rule).

We note that we will continue to monitor the volume (that is, the number of LTCH cases) in the low-volume quintiles to ensure that our quintile assignments used in determining the MS–LTC–DRG relative weights result in appropriate payment for such cases and do not result in an unintended financial

incentive for LTCHs to inappropriately admit these types of cases.

f. Steps for Determining the RY 2010 MS–LTC–DRG Relative Weights

In general, as we proposed, we determined the RY 2010 MS–LTC–DRG relative weights based on the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55995) and consistent with the methodology we used to determine the FY 2009 MS–LTC–DRG relative weights in the FY 2009 IPPS final rule (73 FR 48540 through 48551). (We note that, for FY 2009, we made a modification to our methodology for determining relative weights for MS–LTC–DRGs with no LTCH cases (73 FR 48542 through 48543), which is reflected in the adopted methodology for determining the RY 2010 MS–LTC–DRG relative weights presented below.)

In summary, for RY 2010, we grouped LTCH cases to the appropriate MS–LTC–DRG, while taking into account the low-volume MS–LTC–DRGs (as described above), in order to determine the RY 2010 MS–LTC–DRG relative weights. After grouping the cases to the appropriate MS–LTC–DRG (or low-volume quintile), we calculated the relative weights for RY 2010 by first removing statistical outliers and cases with a length of stay of 7 days or less (as discussed in greater detail below). Next, we adjusted the number of cases in each MS–LTC–DRG (or low-volume quintile) for the effect of SSO cases (as also discussed in greater detail below). The SSO adjusted discharges and corresponding charges are then used to calculate ''relative adjusted weights'' for each MS–LTC–DRG (or low-volume quintile) using the HSRV method (described above).

Below we discuss in detail the steps for calculating the RY 2010 MS–LTC–DRG relative weights. We note that, as we stated above in section VIII.B.3.c. of the preamble of this final rule, we excluded the data of all-inclusive rate LTCHs and LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2008 MedPAR file.

Step 1—Remove statistical outliers.

The first step in the calculation of the RY 2010 MS–LTC–DRG relative weights is to remove statistical outlier cases. Consistent with our historical relative weight methodology, we continue to define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each MS–LTC–DRG. These statistical outliers are removed prior to calculating the relative weights because we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the relative weights could result in an inaccurate relative weight that does not truly reflect relative resource use among the MS–LTC–DRGs.

Step 2—Remove cases with a length of stay of 7 days or less.

The MS–LTC–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay of 7 days or less do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. If we were to include stays of 7 days or less in the computation of the RY 2010 MS–LTC–DRG relative weights, the value of many relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate. We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH by including data from these very short-stays. Therefore, consistent with our historical relative weight methodology, in determining the RY 2010 MS–LTC–DRG relative weights, we removed LTCH cases with a length of stay of 7 days or less.

Step 3—Adjust charges for the effects of SSOs.

After removing cases with a length of stay of 7 days or less, we are left with cases that have a length of stay of greater than or equal to 8 days. As the next step in the calculation of the RY 2010 MS–LTC–DRG relative weights, consistent with our historical relative weight methodology, we adjusted each LTCH's charges per discharge for those remaining cases for the effects of SSOs (as defined in § 412.529(a) in conjunction with § 412.503).

We made this adjustment by counting an SSO case as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the MS–LTC–DRG for non-SSO cases. This has the effect of proportionately reducing the impact of the lower charges for the SSO cases in calculating the average charge for the MS–LTC–DRG. This process produces the same result as if the actual charges per discharge of an SSO case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the MS–LTC–DRG.

Counting SSO cases as full discharges with no adjustment in determining the RY 2010 MS–LTC–DRG relative weights would lower the RY 2010 MS–LTC–DRG relative weight for affected MS–LTC–DRGs because the relatively lower charges of the SSO cases would bring down the average charge for all cases within an MS–LTC–DRG. This would result in an ''underpayment'' for non-SSO cases and an ''overpayment'' for SSO cases. Therefore, we adjusted for SSO cases under § 412.529 in this manner because it results in more appropriate payments for all LTCH cases.

Step 4—Calculate the RY 2010 MS–LTC–DRG relative weights on an iterative basis.

Consistent with our historical relative weight methodology, we calculate the RY 2010 MS–LTC–DRG relative weights using the HSRV methodology, which is an iterative process. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the SSO adjusted charge per discharge (see Step 3) of the LTCH case (after removing the statistical outliers (see Step 1)) and LTCH cases with a length of stay of 7 days or less (see Step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio is then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each MS–LTC–DRG, the RY 2010 relative weight was calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the MS–LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated MS–LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (that is, its case-mix) was calculated by dividing the sum of all the LTCH's MS–LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above was multiplied by these hospital-specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values were then used to calculate a new set of MS–LTC–DRG relative weights across all LTCHs. This iterative process was continued until there was convergence between the weights produced at adjacent steps, for example, when the maximum difference was less than 0.0001.

Step 5—Determine a RY 2010 relative weight for MS–LTC–DRGs with no LTCH cases.

As we stated above, we determined the RY 2010 relative weight for each MS–LTC–DRG using total Medicare allowable charges reported in the best available LTCH claims data (that is, the March 2009 update of the FY 2008 MedPAR file for this final rule). Of the RY 2010 MS–LTC–DRGs, we identified a number of MS–LTC–DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2008 MedPAR file used for this final rule, no patients who would have been classified to those MS–LTC–DRGs were treated in LTCHs during FY 2008 and, therefore, no charge data were available for these MS–LTC–DRGs. Thus, in the process of determining the MS–LTC–DRG relative weights, we were unable to calculate relative weights for the MS–LTC–DRGs with no LTCH cases using the methodology described in Steps 1 through 4 above. However, because patients with a number of the diagnoses under these MS–LTC–DRGs may be treated at LTCHs, consistent with our historical methodology, we assigned a relative weight to each of the no-volume MS–LTC–DRGs based on clinical similarity and relative costliness (with the exception of ''transplant'' MS–LTC–DRGs and ''error'' MS–LTC–DRGs, as discussed below). In general, we determined RY 2010 relative weights for the MS–LTC–DRGs with no LTCH cases in the FY 2008 MedPAR file used in this final rule (that is, ''no-volume'' MS–LTC–DRGs) by crosswalking each no-volume MS–LTC–DRG to another MS–LTC–DRG with a calculated relative weight (determined in accordance with the methodology described above). Then, the ''no-volume'' MS–LTC–DRG was assigned the same relative weight of the MS–LTC–DRG to which it was crosswalked (as described in greater detail below).

Specifically, in this final rule, as stated above, we determined the relative weight for each MS–LTC–DRG using total Medicare allowable charges reported in the March 2009 update of the FY 2008 MedPAR file. Of the 746 MS–LTC–DRGs for RY 2010, we identified 218 MS–LTC–DRGs for which there were no LTCH cases in the database (including the 8 ''transplant'' MS–LTC–DRGs and 2 ''error'' MS–LTC–DRGs). As stated above, we assigned relative weights for each of the 218 no-volume MS–LTC–DRGs (with the exception of the 8 ''transplant'' MS–LTC–DRGs and the 2 ''error'' MS–LTC–DRGs, which are discussed below) based on clinical similarity and relative costliness to one of the remaining 528 (746 − 218 = 528) MS–LTC–DRGs for which we were able to determine relative weights based on FY 2008 LTCH claims data using the steps described above. (For the remainder of this discussion, we refer to one of the 528 MS–LTC–DRGs for which we were able to determine a relative weight as the ''crosswalked'' MS–LTC–DRG.) Then, we assigned the no-volume MS–LTC–DRG the relative weight of the crosswalked MS–LTC–DRG. (As explained below in Step 6, when necessary, we made adjustments to account for nonmonotonicity.)

In this final rule, as proposed, we used the following methodology for determining the RY 2010 relative weights for the no-volume MS–LTC–DRGs: We crosswalked the no-volume MS–LTC–DRG to an MS–LTC–DRG for which there were LTCH cases in the FY 2008 MedPAR file and to which it was similar clinically in intensity of use of resources and relative costliness as determined by criteria such as care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. As we explained in the FY 2009 IPPS final rule (73 FR 48543), we evaluated the relative costliness in determining the applicable MS–LTC–DRG to which a no-volume MS–LTC–DRG was crosswalked in order to assign an appropriate relative weight for the no-volume MS–LTC–DRGs in RY 2010. In general, most of the no-volume MS–LTC–DRGs historically have not had any cases in the LTCH claims data. Therefore, we typically are unable to evaluate relative costliness based on prior years' LTCH claims data. In evaluating the relative costliness for most of the no-volume MS–LTC–DRGs, a group of CMS medical officers who have extensive knowledge and familiarity with both the IPPS and LTCH DRG-based payment systems used their DRG experience to evaluate the relative costliness of the no-volume MS–LTC–DRGs. Specifically, the relative costliness of each of the no-volume MS–LTC–DRGs for RY 2010 was assessed by taking into consideration factors such as relative resource use, clinical cohesiveness, and the comparableness of services provided based on the collective IPPS and LTCH PPS experience of those medical officers. We also note, as discussed above, the no-volume MS–LTC–DRG crosswalks are based on both clinical similarity and relative costliness, including such factors as care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. We believe in the rare event that there would be a few LTCH cases grouped to one of the no-volume MS–LTC–DRGs in RY 2010, the relative weights assigned based on the crosswalked MS–LTC–DRGs will result in an appropriate LTCH PPS payment because the crosswalks, which are based on similar clinical similarity and relative costliness, generally require equivalent relative resource use.

We then assigned the relative weight of the crosswalked MS–LTC–DRG as the relative weight for the no-volume MS–LTC–DRG such that both of these MS–LTC–DRGs (that is, the no-volume MS–LTC–DRG and the crosswalked MS–LTC–DRG) would have the same relative weight for RY 2010. We note that if the crosswalked MS–LTC–DRG had 25 cases or more, its relative weight, which was calculated using the methodology described in Steps 1 through 4 above, was assigned to the no-volume MS–LTC–DRG as well. Similarly, if the MS–LTC–DRG to which the no-volume MS–LTC–DRG was crosswalked had 24 or less cases and, therefore, was designated to one of the low-volume quintiles for purposes of determining the relative weights, we assigned the relative weight of the applicable low-volume quintile to the no-volume MS–LTC–DRG such that both of these MS–LTC–DRGs (that is, the no-volume MS–LTC–DRG and the crosswalked MS–LTC–DRG) have the same relative weight for RY 2010. (As we noted above, in the infrequent case where nonmonotonicity involving a no-volume MS–LTC–DRG results, additional measures as described in Step 6 are required in order to maintain monotonically increasing relative weights.)

For this final rule, a list of the no-volume MS–LTC–DRGs and the MS–LTC–DRG to which it was crosswalked (that is, the crosswalked MS–LTC–DRG) for RY 2010 is shown in the chart below.

NO-VOLUME MS–LTC–DRG CROSSWALK FOR RY 2010

MS–LTC–DRG	MS–LTC–DRG description	Crosswalked MS–LTC–DRG
9	Bone marrow transplant	823
12	Tracheostomy for face, mouth & neck diagnoses w CC	146
13	Tracheostomy for face, mouth & neck diagnoses w/o CC/MCC	146
20	Intracranial vascular procedures w PDX hemorrhage w MCC	31
21	Intracranial vascular procedures w PDX hemorrhage w CC	32
22	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	32
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC	23
27	Craniotomy & endovascular intracranial procedures w/o CC/MCC	26
34	Carotid artery stent procedure w MCC	37
35	Carotid artery stent procedure w CC	38
36	Carotid artery stent procedure w/o CC/MCC	38
39	Extracranial procedures w/o CC/MCC	38
61	Acute ischemic stroke w use of thrombolytic agent w MCC	70
62	Acute ischemic stroke w use of thrombolytic agent w CC	71
63	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	72
76	Viral meningitis w/o CC/MCC	75
79	Hypertensive encephalopathy w/o CC/MCC	305
113	Orbital procedures w CC/MCC	146
114	Orbital procedures w/o CC/MCC	147
116	Intraocular procedures w CC/MCC	125
117	Intraocular procedures w/o CC/MCC	125
122	Acute major eye infections w/o CC/MCC	125
123	Neurological eye disorders	125
129	Major head & neck procedures w CC/MCC or major device	146
130	Major head & neck procedures w/o CC/MCC	148
132	Cranial/facial procedures w/o CC/MCC	133
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	133
136	Sinus & mastoid procedures w/o CC/MCC	133
137	Mouth procedures w CC/MCC	133
138	Mouth procedures w/o CC/MCC	133
150	Epistaxis w MCC	152
151	Epistaxis w/o MCC	153
165	Major chest procedures w/o CC/MCC	254
185	Major chest trauma w/o CC/MCC	184
215	Other heart assist system implant	254
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	237
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	253
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	254
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	237
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	254
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	254
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	243
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	242
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	243
228	Other cardiothoracic procedures w MCC	252
229	Other cardiothoracic procedures w CC	253
230	Other cardiothoracic procedures w/o CC/MCC	254
231	Coronary bypass w PTCA w MCC	237
232	Coronary bypass w PTCA w/o MCC	254
233	Coronary bypass w cardiac cath w MCC	237
234	Coronary bypass w cardiac cath w/o MCC	254
235	Coronary bypass w/o cardiac cath w MCC	237
236	Coronary bypass w/o cardiac cath w/o MCC	254
238	Major cardiovascular procedures w/o MCC	254
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC	252
247	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC	253
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC	252
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC	253
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	250
258	Cardiac pacemaker device replacement w MCC	259
261	Cardiac pacemaker revision except device replacement w CC	259
262	Cardiac pacemaker revision except device replacement w/o CC/MCC	259
263	Vein ligation & stripping	301
265	AICD lead procedures	259
295	Deep vein thrombophlebitis w/o CC/MCC	294
296	Cardiac arrest, unexplained w MCC	283
297	Cardiac arrest, unexplained w CC	284
298	Cardiac arrest, unexplained w/o CC/MCC	284
328	Stomach, esophageal & duodenal proc w/o CC/MCC	327
332	Rectal resection w MCC	356
333	Rectal resection w CC	357

NO-VOLUME MS–LTC–DRG CROSSWALK FOR RY 2010—Continued

MS–LTC–DRG	MS–LTC–DRG description	Crosswalked MS–LTC–DRG
334	Rectal resection w/o CC/MCC	357
336	Peritoneal adhesiolysis w CC	335
337	Peritoneal adhesiolysis w/o CC/MCC	335
339	Appendectomy w complicated principal diag w CC	372
340	Appendectomy w complicated principal diag w/o CC/MCC	373
341	Appendectomy w/o complicated principal diag w MCC	371
342	Appendectomy w/o complicated principal diag w CC	372
343	Appendectomy w/o complicated principal diag w/o CC/MCC	373
345	Minor small & large bowel procedures w CC	344
346	Minor small & large bowel procedures w/o CC/MCC	344
349	Anal & stomal procedures w/o CC/MCC	348
351	Inguinal & femoral hernia procedures w CC	350
352	Inguinal & femoral hernia procedures w/o CC/MCC	350
355	Hernia procedures except inguinal & femoral w/o CC/MCC	354
358	Other digestive system O.R. procedures w/o CC/MCC	357
407	Pancreas, liver & shunt procedures w/o CC/MCC	406
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	424
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	424
410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	424
411	Cholecystectomy w c.d.e. w MCC	418
412	Cholecystectomy w c.d.e. w CC	418
413	Cholecystectomy w c.d.e. w/o CC/MCC	418
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC	418
416	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	418
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	418
421	Hepatobiliary diagnostic procedures w CC	424
422	Hepatobiliary diagnostic procedures w/o CC/MCC	424
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	424
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC	433
455	Combined anterior/posterior spinal fusion w/o CC/MCC	457
458	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC	457
460	Spinal fusion except cervical w/o MCC	459
461	Bilateral or multiple major joint procs of lower extremity w MCC	480
462	Bilateral or multiple major joint procs of lower extremity w/o MCC	480
468	Revision of hip or knee replacement w/o CC/MCC	480
473	Cervical spinal fusion w/o CC/MCC	472
482	Hip & femur procedures except major joint w/o CC/MCC	480
483	Major joint & limb reattachment proc of upper extremity w CC/MCC	480
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	480
489	Knee procedures w/o pdx of infection w/o CC/MCC	488
491	Back & neck procedures except spinal fusion w/o CC/MCC	490
494	Lower extrem & humer proc except hip, foot, femur w/o CC/MCC	493
506	Major thumb or joint procedures	514
508	Major shoulder or elbow joint procedures w/o CC/MCC	507
509	Arthroscopy	505
512	Shoulder, elbow or forearm proc, exc major joint proc w/o CC/MCC	511
533	Fractures of femur w MCC	480
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	537
583	Mastectomy for malignancy w/o CC/MCC	582
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC	584
599	Malignant breast disorders w/o CC/MCC	598
614	Adrenal & pituitary procedures w CC/MCC	629
615	Adrenal & pituitary procedures w/o CC/MCC	629
618	Amputat of lower limb for endocrine, nutrit, & metabol dis w/o CC/MCC	617
621	O.R. procedures for obesity w/o CC/MCC	620
625	Thyroid, parathyroid & thyroglossal procedures w MCC	628
626	Thyroid, parathyroid & thyroglossal procedures w CC	629
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	629
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	629
653	Major bladder procedures w MCC	660
654	Major bladder procedures w CC	660
655	Major bladder procedures w/o CC/MCC	660
657	Kidney & ureter procedures forneoplasm w CC	656
658	Kidney & ureter procedures for neoplasm w/o CC/MCC	656
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	660
664	Minor bladder procedures w/o CC/MCC	663
665	Prostatectomy w MCC	669
670	Transurethral procedures w/o CC/MCC	669
672	Urethral procedures w/o CC/MCC	671
688	Kidney & urinary tract neoplasms w/o CC/MCC	687
692	Urinary stones w esw lithotripsy w/o CC/MCC	694

NO-VOLUME MS–LTC–DRG CROSSWALK FOR RY 2010—Continued

MS–LTC–DRG	MS–LTC–DRG description	Crosswalked MS–LTC–DRG
707	Major male pelvic procedures w CC/MCC	660
708	Major male pelvic procedures w/o CC/MCC	660
710	Penis procedures w/o CC/MCC	709
712	Testes procedures w/o CC/MCC	711
714	Transurethral prostatectomy w/o CC/MCC	669
715	Other male reproductive system O.R. proc for malignancy w CC/MCC	717
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	717
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	717
724	Malignancy, male reproductive system w/o CC/MCC	722
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	717
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	717
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	754
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	755
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	755
739	Uterine, adnexa proc for non-ovarian/adnexal malig w MCC	628
740	Uterine, adnexa proc for non-ovarian/adnexal malig w CC	755
741	Uterine, adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	755
742	Uterine & adnexa proc for non-malignancy w CC/MCC	755
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	755
744	D&C, conization, laparascopy & tubal interruption w CC/MCC	749
745	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	749
748	Female reproductive system reconstructive procedures	749
750	Other female reproductive system O.R. procedures w/o CC/MCC	749
756	Malignancy, female reproductive system w/o CC/MCC	755
761	Menstrual & other female reproductive system disorders w/o CC/MCC	760
765	Cesarean section w CC/MCC	629
766	Cesarean section w/o CC/MCC	629
767	Vaginal delivery w sterilization &/or D&C	629
768	Vaginal delivery w O.R. proc except steril &/or D&C	629
769	Postpartum & post abortion diagnoses w O.R. procedure	629
770	Abortion w D&C, aspiration curettage or hysterotomy	629
774	Vaginal delivery w complicating diagnoses	629
775	Vaginal delivery w/o complicating diagnoses	629
777	Ectopic pregnancy	629
778	Threatened abortion	759
779	Abortion w/o D&C	759
780	False labor	759
782	Other antepartum diagnoses w/o medical complications	781
789	Neonates, died or transferred to another acute care facility	781
790	Extreme immaturity or respiratory distress syndrome, neonate	781
791	Prematurity w major problems	781
792	Prematurity w/o major problems	781
793	Full term neonate w major problems	781
794	Neonate w other significant problems	781
795	Normal newborn	781
799	Splenectomy w MCC	800
801	Splenectomy w/o CC/MCC	800
804	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	803
810	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	812
820	Lymphoma & leukemia w major O.R. procedure w MCC	823
822	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	821
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	824
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	827
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	827
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	829
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC	835
838	Chemo w acute leukemia as sdx or w high dose chemo agent w CC	837
839	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC	837
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC	844
887	Other mental disorder diagnoses	881
915	Allergic reactions w MCC	918
916	Allergic reactions w/o MCC	918
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC	934
955	Craniotomy for multiple significant trauma	26
956	Limb reattachment, hip & femur proc for multiple significant trauma	480
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC	958

To illustrate this methodology for determining the relative weights for the RY 2010 MS–LTC–DRGs with no LTCH cases, we are providing the following example, which refers to the no-volume MS–LTC–DRGs crosswalk information for RY 2010 provided in the chart above.

Example: There were no cases in the FY 2008 MedPAR file used for this final rule for MS–LTC–DRG 61 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC). We determined that MS–LTC–DRG 70 (Nonspecific Cebrovascular Disorders with MCC) was similar clinically and based on resource use to MS–LTC–DRG 61. Therefore, we assigned the same relative weight of MS–LTC–DRG 70 of 0.8439 for RY 2010 to MS–LTC–DRG 61 (we refer readers to Table 11 of the Addendum to this final rule).

Furthermore, for RY 2010, consistent with our historical relative weight methodology, we established MS–LTC–DRG relative weights of 0.0000 for the following transplant MS–LTC–DRGs: Heart Transplant or Implant of Heart Assist System with MCC (MS–LTC–DRG 1); Heart Transplant or Implant of Heart Assist System without MCC (MS–LTC–DRG 2); Liver Transplant with MCC or Intestinal Transplant (MS–LTC–DRG 5); Liver Transplant without MCC (MS–LTC–DRG 6); Lung Transplant (MS–LTC–DRG 7); Simultaneous Pancreas/Kidney Transplant (MS–LTC–DRG 8); Pancreas Transplant (MS–LTC–DRG 10); and Kidney Transplant (MS–LTC–DRG 652). This is because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. Based on our research, we found that most LTCHs only perform minor surgeries, such as minor small and large bowel procedures, to the extent any surgeries are performed at all. Given the extensive criteria that must be met to become certified as a transplant center for Medicare, we believe it is unlikely that any LTCHs will become certified as a transplant center. In fact, in the more than 20 years since the implementation of the IPPS, there has never been a LTCH that even expressed an interest in becoming a transplant center.

If, in the future, a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to determine appropriate weights for the MS–LTC–DRGs affected. At the present time, we only include these eight transplant MS–LTC–DRGs in the GROUPER program for administrative purposes only. Because we use the same GROUPER program for LTCHs as is used under the IPPS, removing these MS–LTC–DRGs would be administratively burdensome. Again, we note that, as this system is dynamic, it is entirely possible that the number of MS–LTC–DRGs with no volume of LTCH cases based on the system will vary in the future. We used the most recent available claims data in the MedPAR file to identify no-volume MS–LTC–DRGs and to determine the relative weights in this final rule.

Step 6—Adjust the RY 2010 MS–LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As discussed above in this section, the MS–DRGs (used under the IPPS) and the MS–LTC–DRGs (used under the LTCH PPS) provide a significant improvement in the DRG system's recognition of severity of illness and resource usage. The MS–DRGs contain base DRGs that have been subdivided into one, two, or three severity levels. Where there are three severity levels, the most severe level has at least one code that is referred to as an MCC (that is, major complication or comorbidity). The next lower severity level contains cases with at least one code that is a CC (that is, complication or comorbidity). Those cases without an MCC or a CC are referred to as ''without CC/MCC.'' When data do not support the creation of three severity levels, the base DRG is subdivided into either two levels or the base DRG is not subdivided. The two-level subdivisions could consist of the with CC/MCC and the without CC/MCC. Alternatively, the other type of two-level subdivision may consist of the MCC and without MCC.

In those base MS–LTC–DRGs that are split into either two or three severity levels, cases classified into the ''without CC/MCC'' MS–LTC–DRG are expected to have a lower resource use (and lower costs) than the ''with CC/MCC'' MS–LTC–DRG (in the case of a two-level split) or both the ''with CC'' and the ''with MCC'' MS–LTC–DRGs (in the case of a three-level split). That is, theoretically, cases that are more severe typically require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, relative weights should increase by severity, from lowest to highest. If the relative weights decrease as severity decreased (that is, if within a base MS–LTC–DRG, an MS–LTC–DRG with CC has a higher relative weight than one with MCC, or the MS–LTC–DRG without CC/MCC has a higher relative weight than either of the others), they are nonmonotonic. We continue to believe that utilizing nonmonotonic relative weights to adjust Medicare payments would result in inappropriate payments because the payment for the cases in the higher severity level in a base MS–LTC–DRG (which are generally expected to have higher resource use and costs) would be lower than the payment for cases in a lower severity level within the same base MS–LTC–DRG (which are generally expected to have lower resource use and costs). Consequently, in general, consistent with our historical methodology, we combined MS–LTC–DRG severity levels within a base MS–LTC–DRG for the purpose of computing a relative weight when necessary to ensure that monotonicity was maintained. Specifically, in determining the RY 2010 MS–LTC–DRG relative weights in this final rule, we used the same methodology to adjust for nonmonotonicity that we used to determine the RY 2009 MS–LTC–DRG relative weights in the FY 2009 IPPS final rule (73 FR 48549 through 48550). In determining the RY 2010 MS–LTC–DRG relative weights in this final rule, under each of the example scenarios provided below, we combined severity levels within a base MS–LTC–DRG as follows:

The first example of nonmonotonically increasing relative weights for an MS–LTC–DRG pertains to a base MS–LTC–DRG with a three-level split and each of the three levels has 25 or more LTCH cases and, therefore, none of those MS–LTC–DRGs were assigned to one of the five low-volume quintiles. In this final rule, if nonmonotonicity was detected in the relative weights of the MS–LTC–DRGs in adjacent severity levels (for example, the relative weight of the ''with MCC'' (the highest severity level) was less than the ''with CC'' (the middle level), or the relative weight ''with CC'' was less than the ''without CC/MCC'' (lowest severity level)), we combined the nonmonotonic adjacent MS–LTC–DRGs and redetermined a relative weight based on the case-weighted average of the combined LTCH cases of the nonmonotonic MS–LTC–DRGs. The case-weighted average charge was calculated by dividing the total charges for all LTCH cases in both severity levels by the total number of LTCH cases for both MS–LTC–DRGs. The same relative weight was assigned to both affected levels of the base MS–LTC–DRG. If nonmonotonicity remained an issue because the above process resulted in a relative weight that was still nonmonotonic to the relative weight of the remaining MS–LTC–DRG within the base MS–LTC–DRG, we combined all three of the severity levels to

redetermine the relative weights based on the case-weighted average charge of the combined severity levels. This same relative weight was then assigned to each of the MS–LTC–DRGs in that base MS–LTC–DRG.

A second example of nonmonotonically increasing relative weights for a base MS–LTC–DRG pertains to the situation where there are three severity levels and one or more of the severity levels within a base MS–LTC–DRG has less than 25 LTCH cases (that is, low volume). If nonmonotonicity occurred in the case where either the highest or lowest severity level (''with MCC'' or ''without CC/MCC'') had 25 LTCH cases or more and the other two severity levels were low volume (and, therefore, the other two severity levels were otherwise assigned the relative weight of the applicable low-volume quintile(s)), we combined the data for the cases in the two adjacent low-volume MS–LTC–DRGs for the purpose of determining a relative weight. If the combination resulted in at least 25 cases, we redetermined one relative weight based on the case-weighted average charge of the combined severity levels and assigned this same relative weight to each of the severity levels. If the combination resulted in less than 25 cases, based on the case-weighted average charge of the combined low-volume MS–LTC–DRGs, both MS–LTC–DRGs were assigned to the appropriate low-volume quintile (discussed above in section VIII.B.3.e. of this preamble) based on the case-weighted average charge of the combined low-volume MS–LTC–DRGs. Then the relative weight of the affected low-volume quintile was redetermined and that relative weight was assigned to each of the affected severity levels (and all of the MS–LTC–DRGs in the affected low-volume quintile). If nonmonotonicity persisted, we combined all three severity levels and redetermined one relative weight based on the case-weighted average charge of the combined severity levels and this same relative weight was assigned to each of the three levels within that base MS–LTC–DRG.

Similarly, in nonmonotonic cases where the middle level had 25 cases or more but either or both of the lowest or highest severity level had less than 25 cases (that is, low volume), we combined the nonmonotonic low-volume MS–LTC–DRG with the middle severity-level MS–LTC–DRG (the ''with CC'') of the base MS–LTC–DRG. We redetermined one relative weight based on the case-weighted average charge of the combined severity levels, and assigned this same relative weight to each of the affected MS–LTC–DRGs. If nonmonotonicity persisted, we combined all three levels for the purpose of redetermining a relative weight based on the case-weighted average charge of the combined severity levels, and assigned that relative weight to each of the three severity levels within the base MS–LTC–DRG.

In the case where all three severity levels in the base-MS–LTC–DRGs were low-volume MS–LTC–DRGs and two of the severity levels were nonmonotonic in relation to each other, we combined the two adjacent nonmonotonic severity levels. If that combination resulted in less than 25 cases, both low-volume MS–LTC–DRGs were assigned to the appropriate low-volume quintile (discussed above in section VIII.B.3.e. of this preamble) based on the case-weighted average charge of the combined low-volume MS–LTC–DRGs. Then the relative weight of the affected low-volume quintile was redetermined, and that relative weight was assigned to each of the affected severity levels (and all of the MS–LTC–DRGs in the affected low-volume quintile). If the nonmonotonicity persisted, we combined all three levels of that base MS–LTC–DRG for the purpose of redetermining a relative weight based on the case-weighted average charge of the combined severity levels, and assigned that relative weight to each of the three severity levels. If that combination of all three severity levels resulted in less than 25 cases, we assigned that ''combined'' base MS–LTC–DRG to the appropriate low-volume quintile based on the case-weighted average charge of the combined low-volume MS–LTC–DRGs. Then the relative weight of the affected low-volume quintile was redetermined, and that relative weight was assigned to each of the affected severity levels (and all of the MS–LTC–DRGs in the affected low-volume quintile). If the combination of all three severity levels resulted in 25 or more cases, we redetermined one relative weight based on the case-weighted average charge of the combined severity levels, and assigned this same relative weight to all three of the severity levels within the base MS–LTC–DRG.

Similarly, in the case where all three severity levels in the base MS–LTC–DRGs were low-volume MS–LTC–DRGs and two of the severity levels were nonmonotonic in relation to each other, we combined the two adjacent nonmonotonic severity levels. If the combination resulted in at least 25 cases, we then redetermined one relative weight based on the case-weighted average charge of the combined severity levels, and assigned this same relative weight to both of the affected adjacent severity levels within the base MS–LTC–DRG. If the nonmonotonicity persisted, we combined all three levels of that base MS–LTC–DRG for the purpose of redetermining a relative weight based on the case-weighted average charge of the combined severity levels, and assigned that relative weight to each of the three severity levels within the base MS–LTC–DRG.

Another example of nonmonotonicity involved a base MS–LTC–DRG with three severity levels where at least one of the severity levels had no LTCH cases. As discussed above in Step 5, we crosswalked a no-volume MS–LTC–DRG to an MS–LTC–DRG that had at least one case based on resource use intensity and clinical similarity. The no-volume MS–LTC–DRG was assigned the same relative weight as the MS–LTC–DRG to which it was crosswalked. For many no-volume MS–LTC–DRGs, as shown in the chart above in Step 5, the application of our methodology resulted in a crosswalked MS–LTC–DRG that was the adjacent severity level in the same base MS–LTC–DRG. Consequently, in most instances, the no-volume MS–LTC–DRG and the adjacent MS–LTC–DRG to which it was crosswalked did not result in nonmonotonicity because both of these severity levels would have the same relative weight. (In this final rule, under our methodology for the treatment of no-volume MS–LTC–DRGs, in the case where the no-volume MS–LTC–DRG was either the highest or lowest severity level, the crosswalked MS–LTC–DRG was typically the middle level (''with CC'') within the same base MS–LTC–DRG, and, therefore, the no-volume MS–LTC–DRG (either the ''with MCC'' or the ''without CC/MCC'') and the crosswalked MS–LTC–DRG (the ''with CC'') have the same relative weight. Consequently, no adjustment for monotonicity was necessary.) However, if our methodology for determining relative weights for no-volume MS–LTC–DRGs resulted in nonmonotonicity with the third severity level in the base MS–LTC–DRG, all three severity levels were combined in order to redetermine one relative weight based on the case-weighted average charge of the combined severity levels. This same relative weight was assigned to each of the three severity levels in the base MS–LTC–DRG.

Thus far in the discussion, we have presented examples of nonmonotonicity in a base MS–LTC–DRG that has three severity levels. Under our methodology for the treatment of nonmonotonicity,

we applied the same process where the base MS–LTC–DRG contained only two severity levels. For example, if nonmonotonicity occurred in a base MS–LTC–DRG with two severity levels (that is, the relative weight of the higher severity level was less than the lower severity level), where both of the MS–LTC–DRGs had at least 25 cases or where one or both of the MS–LTC–DRGs were low volume (that is, less than 25 cases), we combined the two MS–LTC–DRGs of that base MS–LTC–DRG for the purpose of redetermining a relative weight based on the combined case-weighted average charge for both severity levels. This same relative weight was assigned to each of the two severity levels in the base MS–LTC–DRG. Specifically, if the combination of the two severity levels resulted in at least 25 cases, we redetermined one relative weight based on the case-weighted average charge, and assigned that relative weight to each of the two MS–LTC–DRGs. If the combination resulted in less than 25 cases, we assigned both MS–LTC–DRGs to the appropriate low-volume quintile (discussed above in section VIII.B.3.e. of this preamble) based on their combined case-weighted average charge. Then the relative weight of the affected low-volume quintile was redetermined, and that relative weight was assigned to each of the two severity levels within the base MS–LTC–DRG (and all of the MS–LTC–DRGs in the affected low-volume quintile).

Step 7—Calculate the RY 2010 budget neutrality factor.

As we established in the RY 2008 LTCH PPS final rule (72 FR 26882), under the broad authority conferred upon the Secretary under section 123 of Public Law 106–113, as amended by section 307(b) of Public Law 106–554, to develop the LTCH PPS, beginning with the MS–LTC–DRG update for FY 2008, the annual update to the MS–LTC–DRG classifications and relative weights is done in a budget neutral manner such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the MS–LTC–DRG classification and relative weight changes. Specifically, in that same final rule, we established a requirement under § 412.517(b) that the annual update to the MS–LTC–DRG classifications and relative weights be done in a budget neutral manner. (For a detailed discussion on the establishment of the budget neutrality requirement to update the MS–LTC–DRG classifications and relative weights, we refer readers to the RY 2008 LTCH PPS final rule (72 FR 26880 through 26884).) The MS–LTC–DRG classifications and relative weights are updated annually based on the most recent available LTCH claims data to reflect changes in relative LTCH resource use. Under the budget neutrality requirement, for each annual update, the MS–LTC–DRG relative weights are uniformly adjusted to ensure that estimated aggregate payments under the LTCH PPS would not be affected (that is, decreased or increased). Consistent with that provision, we updated the MS–LTC–DRG classifications and relative weights for RY 2010 based on the most recent available LTCH data, and included a budget neutrality adjustment that was applied in determining the RY 2010 MS–LTC–DRG relative weights.

To ensure budget neutrality in the update to the MS–LTC–DRG classifications and relative weights under § 412.517(b), consistent with the budget neutrality methodology we established in the FY 2008 IPPS final rule with comment period (72 FR 47295 through 47296), in determining the budget neutrality adjustment for RY 2010 in this final rule, as we proposed, we used a method that is similar to the methodology used under the IPPS. Specifically, for RY 2010, after recalibrating the MS–LTC–DRG relative weights as we do under the methodology as described in detail in Steps 1 through 6 above, we calculated and applied a normalization factor to those recalibrated relative weights to ensure that estimated payments were not influenced by changes in the composition of case types or the changes to the classification system. That is, the normalization adjustment is intended to ensure that the recalibration of the MS–LTC–DRG relative weights (that is, the process itself) neither increases nor decreases the average CMI.

To calculate the normalization factor for RY 2010, we used the following steps: (1) We used the most recent available LTCH claims data (FY 2008) and grouped them using the RY 2010 GROUPER (Version 27.0) and the RY 2010 MS–LTC–DRG relative weights (determined above in Steps 1 through 6 above) to calculate the average CMI; (2) we grouped the same LTCH claims data (FY 2008) using the FY 2009 GROUPER (Version 26.0) and FY 2009 MS–LTC–DRG relative weights (presented in Table 11 of the interim final rule with comment period published on June 3, 2009 in the **Federal Register** (74 FR 26550 through 26569)) and calculated the average CMI; and (3) we computed the ratio of these average CMIs by dividing the average CMI for FY 2009 (determined in Step 2) by the average CMI for RY 2010 (determined in Step 1). In determining the MS–LTC–DRG relative weights for RY 2010, each recalibrated MS–LTC–DRG relative weight is multiplied by 1.07341 in the first step of the budget neutrality methodology, which produces ''normalized relative weights.''

In the second step of the proposed RY 2010 budget neutrality methodology, we determined a budget neutrality factor to ensure that estimated aggregate LTCH PPS payments (based on the most recent available LTCH claims data) after reclassification and recalibration (the RY 2010 MS–LTC–DRG classifications and relative weights) are equal to estimated aggregate LTCH PPS payments (for the same most recent available LTCH claims data) before reclassification and recalibration (the RY 2009 MS–LTC–DRG classifications and relative weights). Therefore, similar to the methodology used to determine the IPPS DRG reclassification and recalibration budget neutrality factor discussed in section II.A.4.a. of the Addendum to this final rule, we used FY 2008 discharge data to simulate payments and compared estimated aggregate LTCH PPS payments using the FY 2009 MS–LTC–DRGs and relative weights to estimate aggregate LTCH PPS payments using the RY 2010 MS–LTC–DRGs and relative weights. Consistent with our historical policy of using the best available data, we used the most recently available claims data (that is, LTCH claims data from the March 2009 update of the FY 2008 MedPAR file) for determining the budget neutrality adjustment factor in this final rule.

Specifically, we determined the RY 2010 budget neutrality adjustment factor in this final rule using the following steps: (1) We simulated estimated total LTCH PPS payments using the normalized relative weights for RY 2010 and GROUPER Version 27.0 (as described above in this section); (2) we simulated estimated total LTCH PPS payments using the FY 2009 GROUPER (Version 26.0) and the revised FY 2009 MS–LTC–DRG relative weights shown in Table 11 of the June 3, 2009 interim final rule with comment period (74 FR 26550 through 26569)); and (3) we calculated the ratio of these estimated total LTCH PPS payments by dividing the estimated total LTCH PPS payments using the FY 2009 GROUPER (Version 26.0) and the revised FY 2009 MS–LTC–DRG relative weights (determined in Step 2) by the estimated total LTCH PPS payments using the RY 2010 GROUPER (Version 27.0) and the normalized MS–LTC–DRG relative weights for RY 2010 (determined in Step 1). In determining

the final RY 2010 MS–LTC–DRG relative weights, each normalized relative weight was multiplied by a budget neutrality factor of 0.9940041 in the second step of the budget neutrality methodology to determine the final budget neutral RY 2010 relative weight for each MS–LTC–DRG.

Accordingly, in determining the RY 2010 MS–LTC–DRG relative weights in this final rule, we applied a normalization factor of 1.07341 and a budget neutrality factor of 0.9940041, as described above. The final RY 2010 MS–LTC–DRG relative weights in Table 11 in the Addendum to this final rule reflect both the normalization factor of 1.07341 and the budget neutrality factor of 0.9940041. Table 11 in the Addendum to this final rule lists the MS–LTC–DRGs and their respective relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used in determining SSO payments under § 412.529) for RY 2010.

C. Changes to the LTCH Payment Rates and Other Changes to the RY 2010 LTCH PPS

1. Overview of Development of the LTCH Payment Rates

The LTCH PPS was effective beginning with a LTCH's first cost reporting period beginning on or after October 1, 2002. Effective beginning with that cost reporting period, LTCHs were paid, during a 5-year transition period, a total LTCH prospective payment that is comprised of an increasing proportion of the LTCH PPS Federal rate and a decreasing proportion based on reasonable cost-based principles, unless the hospital makes a one-time election to receive payment based on 100 percent of the Federal rate, as specified in § 412.533. New LTCHs (as defined at § 412.23(e)(4)) are paid based on 100 percent of the Federal rate, with no phase-in transition payments.

The basic methodology for determining LTCH PPS Federal prospective payment rates is set forth at § 412.515 through § 412.536. In this section, we discuss the factors that were used to update the LTCH PPS standard Federal rate for the 2010 LTCH PPS rate year that will be effective for LTCH discharges occurring on or after October 1, 2009 through September 30, 2010.

For further details on the development of the FY 2003 standard Federal rate, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037), and for subsequent updates to the LTCH PPS Federal rate we refer readers to the following final rules: RY 2004 LTCH PPS final rule (68 FR 34134 through 34140), RY 2005 LTCH PPS final rule (69 FR 25682 through 25684), RY 2006 LTCH PPS final rule (70 FR 24179 through 24180), RY 2007 LTCH PPS final rule (71 FR 27819 through 27827), RY 2008 LTCH PPS final rule (72 FR 26870 through 27029), and RY 2009 LTCH PPS final rule (73 FR 26800 through 26804). The update to the LTCH PPS standard Federal rate for RY 2010 is presented in section V.A. of the Addendum to this final rule. Two of the components of the update to the LTCH PPS standard Federal rate for RY 2010 are discussed below.

2. Market Basket for LTCHs Reimbursed Under the LTCH PPS

a. Overview

Historically, the Medicare program has used a market basket to account for price increases in the services furnished by providers. The market basket used for the LTCH PPS includes both operating and capital-related costs of LTCHs because the LTCH PPS uses a single payment rate for both operating and capital-related costs. The development of the initial LTCH PPS standard Federal rate for FY 2003, using the excluded hospital with capital market basket, is discussed in further detail in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56033).

In that final rule (67 FR 56016 through 56017 and 56030), which implemented the LTCH PPS, we established the use of the excluded hospital with capital market basket as the LTCH PPS market basket. The excluded hospital with capital market basket was also used to update the limits on LTCHs' operating costs for inflation under the TEFRA reasonable cost-based payment system. We explained that we believe the use of the excluded hospital with capital market basket to update LTCHs' payments for inflation was appropriate because the excluded hospital market basket (with a capital component) measures price increases of the services furnished by excluded hospitals, including LTCHs. For further details on the development of the excluded hospital with capital market basket, we refer readers to the RY 2004 LTCH PPS final rule (68 FR 34134 through 34137).

As discussed in the RY 2007 LTCH PPS final rule (71 FR 27810), based on our research, we did not develop a market basket specific to LTCH services. We were unable to create a separate market basket specifically for LTCHs at that time due to the small number of facilities and the limited amount of data that was reported (for instance, only approximately 15 percent of LTCHs reported contract labor cost data for 2002). In that same final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, we adopted the rehabilitation, psychiatric, long-term care (RPL) market basket as the appropriate market basket of goods and services under the LTCH PPS for discharges occurring on or after July 1, 2006. Specifically, beginning with the 2007 LTCH PPS rate year, for the LTCH PPS, we adopted the use of the RPL market basket which is based on FY 2002 cost report data. We chose to use the FY 2002 Medicare cost report data because those data were the most recent, relatively complete cost data for IRFs, IPFs, and LTCHs available at the time of rebasing.

The RPL market basket was determined based on the operating and capital costs of freestanding IRFs, freestanding IPFs, and LTCHs. As we explained in the RY 2007 LTCH PPS final rule, we believed a market basket based on the data of IRFs, IPFs, and LTCHs was appropriate to use under the LTCH PPS because those data were the best available data that reflect the cost structures of LTCHs. For further details on the development of the RPL market basket, including the methodology for determining the operating and capital portions of the RPL market basket, we refer readers to the RY 2007 LTCH PPS final rule (71 FR 27810 through 27817).

b. Market Basket Under the LTCH PPS for RY 2010

When we initially created the FY 2002-based RPL market basket, we were unable to create a separate market basket specifically for LTCHs due, in part, to the small number of facilities and the limited data that were provided in the Medicare cost reports. Over the last several years, however, the number of LTCH facilities submitting valid Medicare cost report data has increased. Based on this development, as well as our desire to move from one RPL market basket to three stand-alone and provider-specific market baskets (for IRFs, IPFs, and LTCHs, respectively), we plan to begin exploring the viability of creating these market baskets for future use. However, as we discussed in the FY 2010 IRF PPS proposed rule, we are conducting further research to assist us in understanding the reasons for the variations in costs and cost structure between freestanding IRFs and hospital-based IRFs. We also are researching the reasons for similar variations in costs and cost structure between freestanding IPFs and hospital-based IPFs. Therefore, as we continue to explore the

development of stand-alone market baskets for LTCHs, IRFs and IPFs, respectively, we believe that it is appropriate to continue to use the FY 2002-based RPL market basket for LTCHs, IRFs and IPFs under their respective PPSs. Accordingly, as we proposed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24228), in this final rule, we are continuing to use the FY 2002-based RPL market basket under the LTCH PPS for RY 2010 because we continue to believe it is the best available data that reflect the cost structure of LTCHs. We are hopeful that progress can be made in the near future with respect to creating stand-alone market baskets for LTCHs, IRFs, and IPFs and, as a result, may propose to rebase the appropriate market basket(s) for subsequent updates in the future.

Comment: Several commenters agreed with the original application of the RPL market basket due to the lack of data available for LTCHs. However, the commenters now believe that there are sufficient LTCH-specific cost data to develop a separate LTCH market basket that will accurately reflect the costs of providing LTCH goods and services. One commenter stated that a stand-alone LTCH market basket is necessary and warranted due to the unique nature of the patient populations served by LTCHs and the differences in care settings among LTCHs, IRFs, and IPFs.

Response: We appreciate the commenters' thoughts concerning the possible development of a stand-alone LTCH market basket. While the number of LTCHs submitting cost report data has increased, we believe that further research is required to determine the feasibility of developing stand-alone market baskets for LTCHs, IRFs, and IPFs. Therefore, we believe that it is appropriate to continue to use the FY 2002-based RPL market basket for LTCHs for RY 2010. However, as stated above, we will be exploring the viability and technical appropriateness of a stand-alone LTCH market basket.

c. Market Basket Update for LTCHs for RY 2010

Consistent with our historical practice, we estimate the RPL market basket update based on IHS Global Insight, Inc.'s forecast using the most recent available data. IHS Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the hospital market baskets. Based on IHS Global Insight, Inc.'s first quarter 2009 forecast, we proposed that the RY 2010 market basket estimate for the LTCH PPS using the FY 2002-based RPL market basket was 2.4 percent. Consistent with our historical practice of using market basket estimates based on the most recent available data, for this final rule, we used IHS Global Insight, Inc.'s second quarter 2009 forecast of the RY 2010 market basket estimate for the LTCH PPS using the FY 2002-based RPL market basket, which is 2.5 percent. This includes increases in both the operating section and the capital section of the FY 2002-based RPL market basket. (As discussed in greater detail in section V. of the Addendum to this final rule, for RY 2010, we updated the LTCH PPS standard Federal rate by 2.0 percent. The update reflects an adjustment based on the most recent market basket estimate (currently 2.5 percent as discussed above) and adjustments to account for the increase in case-mix in the prior periods (FYs 2007 through 2009) that resulted from changes in documentation and coding practices rather than increases in patients' severity of illness.)

d. Labor-Related Share Under the LTCH PPS for RY 2010

As discussed in section V.B. of the Addendum to this final rule, under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS Federal rate to account for differences in LTCH area wage levels at § 412.525(c). The labor-related portion of the LTCH PPS Federal rate, hereafter referred to as the labor-related share, is adjusted to account for geographic differences in area wage levels by applying the applicable LTCH PPS wage index.

The labor-related share is determined by identifying the national average proportion of operating and capital costs that are related to, influenced by, or vary with the local labor market. We continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market. In addition, as discussed above, we continued to use the FY 2002-based RPL market basket under the LTCH PPS for RY 2010. Given this, we continue to define the labor-related share as the national average proportion of operating costs that are attributable to wages and salaries, employee benefits, contract labor, professional fees, labor-intensive services, and a labor-related portion of capital based on the FY 2002-based RPL market basket. (Additional information on the development of the FY 2002-based RPL market basket used under the LTCH PPS can be found in the RY 2007 LTCH PPS final rule (71 FR 27809 through 27818).)

As we proposed (74 FR 24228 through 24229), the labor-related share for RY 2010 is the sum of the RY 2010 relative importance of each labor-related cost category, and reflects the different rates of price change for these cost categories between the base year (FY 2002) and RY 2010. Based on IHS Global Insight, Inc.'s first quarter 2009 forecast of the RY 2010 relative importance, we proposed that the RY 2010 labor-related share using the FY 2002-based RPL market basket would be 75.904 percent. For this final rule, we used more recent data, the IHS Global Insight, Inc.'s second quarter 2009 forecast of the RY 2010 relative importance, to determine the labor-related share. The sum of the relative importance for RY 2010 for operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) is 71.841 percent. The portion of capital that is influenced by the local labor market is estimated to be 46 percent. Because the relative importance for capital in RY 2010 is 8.560 percent of the FY 2002-based RPL market basket, we took 46 percent of 8.560 percent to determine the labor-related share of capital for RY 2010. The result is 3.938 percent, which we added to 71.841 percent for the operating cost amount to determine the total labor-related share for RY 2010. Thus, the labor-related share that we are using for the LTCH PPS in RY 2010 is 75.779 percent.

The chart below shows the RY 2010 relative importance labor-related share using the FY 2002-based RPL market basket.

RY 2010 LABOR-RELATED SHARE BASED ON THE FY 2002–BASED RPL MARKET BASKET

Cost category	FY 2002–based RPL market basket labor-related share relative importance (percent) RY 2010
Wages and Salaries	52.892
Employee Benefits	13.949
Professional Fees:	2.873
All Other Labor-Intensive Services	2.127
Subtotal	71.841
Labor-Related Share of Capital Costs (46 percent)	3.938
Total Labor-Related Share	75.779

We did not receive any public comments on the proposed labor-related share for the LTCH PPS for RY 2010.

3. Adjustment for Changes in LTCHs' Case-Mix Due to Changes in Documentation and Coding Practices That Occurred in a Prior Period

a. Background

Beginning in RY 2007, in updating the standard Federal rate for the LTCH PPS, we have accounted for increases in payments from a past period that were due to changes in documentation and coding practices. Specifically, in the RY 2007 LTCH PPS final rule (71 FR 27820), we explained that rather than solely using the most recent estimate of the LTCH PPS market basket increase as the basis of the update factor for the standard Federal rate for RY 2007, we believed that based on our ongoing monitoring of LTCHs' case mix, it was appropriate to also adjust the standard Federal rate to account for the changes in documentation and coding practices (rather than patients' severity of illness), in addition to the estimated increase in the LTCH PPS market basket. Accordingly, we established at § 412.523(c)(3)(iii) of the regulations that the update to the standard Federal rate for the 2007 LTCH PPS rate year was zero percent, based on the most recent estimate of the LTCH PPS market basket increase of 3.4 percent and an equivalent negative adjustment to account for changes in case-mix due to changes in documentation and coding practices in a prior period (FY 2004).

In the RY 2008 LTCH PPS final rule (72 FR 26880 through 26890), we continued to monitor and analyze LTCHs' case-mix and applied an update to the standard Federal rate of 0.71 percent, based on the most recent estimate of the market basket increase (3.2 percent) and an adjustment to account for changes in documentation and coding practices (−2.49 percent) in a prior period (FY 2005). Similarly, for RY 2009, as discussed in the RY 2009 final rule (73 FR 26805 through 26812), the standard Federal rate was updated using an update factor of 2.7 percent, based on the most recent estimate of the market basket increase (3.6 percent) and an adjustment to account for changes in case-mix due to documentation and coding practices (−0.9 percent) in a prior period (FY 2006).

b. Evaluation of FY 2007 Claims Data

For RY 2010, we continue to believe that changes in the LTCH PPS payment rates should accurately reflect changes in LTCHs' true cost of treating patients, and should not be influenced by changes in documentation and coding that do not reflect increases in patients' severity of illness. Accordingly, consistent with previous years, and as we stated in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24229 through 24230), we analyzed LTCHs' case-mix index (CMI) changes in the prior period, FY 2007, and if applicable, determined an appropriate adjustment to account for changes in documentation and coding practices. As we explained in the RY 2007 final rule (71 FR 27819 through 27823), an LTCH's CMI is defined as its case-weighted average LTC–DRG relative weight for all its discharges in a given period. Changes in CMI consist of two components: ''real'' CMI changes and ''apparent'' CMI changes. Real CMI increase is defined as the increase in the average LTC–DRG relative weights resulting from the hospital's treatment of more resource intensive patients. Apparent CMI increase is defined as the increase in CMI due to changes in documentation and coding practices (including better documentation of the medical record, for example, by physicians and more complete coding of the medical record by coders). In previous years, analysis of the most recent available LTCH CMI data focused on quantifying the portion of CMI change in a prior period that is attributable to apparent CMI change. However, beginning in RY 2010, we proposed to revise our methodology to determine the documentation and coding adjustment, consistent with the proposed methodology for case-mix analysis under the IPPS, which is discussed in detail in section II.D.4 of the preamble of this final rule. We note that section II.D.4 of the preamble of this final rule discusses the analysis in the context of the MS–DRG documentation and coding adjustments for FY 2008 and FY 2009 authorized by Public Law 110–90 *for the IPPS,* and we note that the requirements of Public Law 110–90 *do not* apply to the LTCH PPS. However, section 123(a)(1) of Public Law 106–113 (BBRA), as amended by section 307(b) of Public Law 106–554 (BIPA), provides broad authority to the Secretary in developing the LTCH PPS, including the authority for establishing appropriate adjustments. The stated purpose of the CMI analysis for the IPPS is to measure and corroborate the extent of the overall national average changes in case-mix since the adoption of the MS–DRGs, which we believe is also relevant in determining appropriate adjustments to account for changes in documentation and coding under the LTCH PPS because, as stated above, the same DRG-based patient classification system is used under both the LTCH PPS and the IPPS (referred to as the MS–LTC–DRGs and MS–DRGs, respectively). Accordingly, under the broad authority afforded by the statute to make appropriate adjustments for the LTCH PPS, we believe it is appropriate to use the same methodology under the LTCH PPS that we use under the IPPS as described in section II.D.4. of the preamble of this final rule and which is discussed in further detail below in this section.

Accordingly, consistent with the IPPS CMI analysis methodology, we conducted a thorough evaluation of LTCH claims data in order to assess the case-mix changes that do not reflect real changes in patients' severity of illness. The results of this evaluation were used by our actuaries to determine if any payment adjustments are necessary to ensure appropriate payments under the LTCH PPS. Specifically, to evaluate the FY 2007 LTCH claims data, for the proposed rule, we performed the analysis in the following manner. We first divided the CMI obtained by grouping the FY 2007 LTCH claims data from the December 2007 update of the MedPAR files through the FY 2007 GROUPER (Version 24.0) by the CMI obtained by grouping these same FY 2007 LTCH claims through the FY 2006 GROUPER (Version 23.0). This resulted in a value of 0.974. Because these are the same FY 2007 LTCH cases grouped using the two GROUPERs, we attributed this change primarily to two factors: (1) The effect of changes in documentation and coding; and (2) the measurement effect from the calibration of the GROUPER. We estimated the measurement effect from the calibration of the GROUPER by dividing the CMI obtained by grouping the FY 2006 LTCH claims through the FY 2007 GROUPER by the CMI obtained by grouping these same LTCH claims through the FY 2006 GROUPER. This resulted in a value of 0.969. In order to isolate the documentation and coding effect, we then divided the combined effect of the changes in documentation and coding and measurement (0.974) by the measurement effect (0.969) to yield 1.005. Therefore, our estimate of the documentation and coding increase that occurred in FY 2007 is 0.5 percent. We now have data available from the March 2009 update of the MedPAR files. Applying this analytical methodology to the FY 2008 LTCH claims data from the March 2009 update of the MedPAR files confirms the documentation and coding increase that occurred in FY 2007 was 0.5 percent.

As in prior years, the FY 2006 and FY 2007 MedPAR files are available to the public to allow independent analysis of the documentation and coding effect in

FY 2007. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we invited public comment on our proposed methodology and analysis. A summary of the public comments we received on the proposed adjustment for changes in LTCHs' CMI due to changes in documentation and coding practices that occurred in a prior period based on our evaluation of FY 2007 LTCH claims data, including any public comments on our proposed methodology and analysis, and our responses, as well as a statement of our final policy can be found in section VIII.C.3.d. of this preamble.

c. Evaluation of FY 2008 Claims Data

In prior years, we based documentation and coding adjustments on an analysis of the most recent available LTCH data and have established the adjustments in a timely manner, as the data became available, to account for each prior period where LTCHs were paid based on case-mix changes that do not reflect increased patients' severity of illness. Most recently, in updating the LTCH PPS payment rates for RY 2009, we accounted for the effects of documentation and coding improvements that occurred in FY 2006. Due to the change in the LTCH update cycle in RY 2010, we now have data available to analyze case-mix changes for FY 2008, as well as FY 2007. Accordingly, analogous to our evaluation of the FY 2007 LTCH claims data as discussed above, for the proposed rule (74 FR 24230), we analyzed the FY 2008 LTCH claims data from the December 2008 update of the MedPAR files as well. That is, we first divided the CMI obtained by grouping the FY 2008 LTCH claims through the FY 2008 GROUPER (Version 25.0) by the CMI obtained by grouping these same FY 2008 LTCH claims through the FY 2007 GROUPER (Version 24.0). This resulted in a value of 1.011. We estimated the measurement effect from the calibration of the GROUPER by dividing the CMI obtained by grouping the FY 2007 LTCH claims through the FY 2008 GROUPER by the CMI obtained by grouping these same LTCH claims through the FY 2007 GROUPER. This resulted in a value of 0.999. We then divided the combined effect of the changes in documentation and coding measurement (1.011) by the measurement effect (0.999) to yield 1.013. Therefore, based on the results of the analysis discussed in the proposed rule, the documentation and coding increase that occurred in FY 2008 was 1.3 percent. We now have data available from the March 2009 update of the MedPAR files. Applying this analytical methodology to the FY 2008 LTCH claims data from the March 2009 update of the MedPAR files confirms the documentation and coding increase that occurred in FY 2008 is 1.3 percent.

As noted above, the FY 2007 and FY 2008 MedPAR files are available to the public to allow independent analysis of the documentation and coding effect in FY 2008. In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we invited public comment on our methodology and analysis. A summary of the public comments we received on the proposed adjustment for changes in LTCHs' CMI due to changes in documentation and coding practices that occurred in a prior period based on our evaluation of FY 2008 LTCH claims data, including any public comments on our proposed methodology and analysis, and our responses, as well as a statement of our final policy can be found in section VIII.C.3.d. of this preamble.

d. RY 2010 Documentation and Coding Adjustment

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, based on analysis of the most recent available LTCH claims data as described above, we proposed to apply a cumulative adjustment for changes in documentation and coding that do not reflect an increase in patients' severity of illness of −1.8 percent (that is, −0.5 percent for FY 2007 plus −1.3 percent for FY 2008). Accordingly, as discussed in section V.A.2. of the Addendum to that proposed rule, we proposed to update the RY 2010 LTCH PPS standard Federal rate by 0.6 percent based on the most recent estimate of the market basket increase at that time (2.4 percent) and an adjustment to account for changes in documentation and coding practices (−1.8 percent). We note that an analysis of data from the March 2009 update of the FY 2007 and FY 2008 MedPAR files confirmed the cumulative effect of changes in documentation and coding that do not reflect an increase in patients' severity of illness of 1.8 percent (that is, 0.5 percent for FY 2007 and 1.3 percent for FY 2008.). In this final rule, as we discuss in greater detail below in this section, in determining the RY 2010 update to the LTCH PPS standard Federal rate, we are applying an adjustment for changes in documentation and coding that do not reflect an increase in patients' severity of illness of −0.5 percent. That is, we are are finalizing our proposal to apply an adjustment of −0.5 percent to account for the documentation and coding increase that occurred in FY 2007. However, after consideration of the public comments, and consistent with the decision to postpone the application of the prospective adjustment for estimated FY 2008 documentation and coding increases under the IPPS (discussed in section II.D.5. of this preamble), we have decided to delay the application of the FY 2008 documentation and coding adjustment of −1.3 percent that was proposed under the LTCH PPS for RY 2010. We intend to address any future documentation and coding adjustment to the LTCH PPS standard Federal rate based on our analysis of the FY 2008 LTCH claims data in the FY 2011 rulemaking cycle through the notice-and-comment rulemaking process. Below we present a summary of the public comments received on our proposed documentation and coding adjustment for RY 2010 and our responses to those comments.

Comment: Some commenters stated that section 7(b)(1) of Pub. L. 110–90 provides authority for CMS to impose adjustments for documentation and coding changes for hospitals subject to the IPPS but does not specifically refer to hospitals under the LTCH PPS. The commenters argued that the absence of any reference to the LTCH PPS in Public Law 110–90 suggests that CMS does not have the authority to make such adjustments, despite the broad authority under section 123(a)(1) of Pub. L. 106–113, as amended by section 307(b) of Public Law 1106–554.

Response: As we noted in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24229 through 24230), beginning in RY 2007 and for every annual update to the LTCH PPS standard Federal rate since RY 2007, we have accounted for increases in payments from a past period due to changes in documentation and coding practices that have occurred since we first implemented the LTCH PPS in 2003. As we have stated previously, section 123(a)(1) of Public Law 106–113 (BBRA), as amended by section 307(b) of Public Law 106–554 (BIPA), provides broad authority to the Secretary in developing the LTCH PPS, including the authority for establishing appropriate adjustments. Consequently, we did not need additional authority provided under Public Law 110–90 in order to make these adjustments for documentation and coding practices. In the discussion in the proposed rule, we included a reference to Public Law 110–90, which specifies the MS–DRG documentation and coding adjustments for the IPPS for FY 2008, FY 2009, and FY 2010. However, we did not apply the documentation and coding adjustments as prescribed in Public Law 110–90 to the LTCH PPS for RY 2009 and RY 2010

because we believed Public Law 110–90 did not apply to the LTCH PPS. Instead, we adhered to our historical practice of basing documentation and coding adjustments on an analysis of the most recent available LTCH data to account for each prior period where LTCHs were paid, based on case-mix changes that do not reflect increased patients' severity of illness. We noted in the proposed rule that due to the change in the LTCH update cycle in RY 2010, the data to analyze case-mix changes for FY 2008 as well as FY 2007 were available to us at the time we were proposing LTCH PPS rates for RY 2010 (74 FR 24230).

Comment: Several commenters questioned the proposed methodology for the evaluation of the FY 2007 and FY 2008 claims data which resulted in the adjustments due to documentation and coding changes. The commenters raised concerns that the calculations of the documentation and coding effect were unsupported and did not fully consider other potential causes for the observed increases in CMI. Specifically, the commenters noted that the methodology used in the proposed rule assumed that the calculated CMI contains both a measurement effect from calibrating the GROUPER and the effect of coding and documentation changes. That is, to derive the coding and documentation effect, the proposed rule subtracted (1) the measurement effect from (2) the combined effects of measurement and coding and documentation.

One commenter protested that the methodology assumed that real case-mix changes are not included in the calculated CMI. In addition, the commenter asserted that the methodology assumed that no real case-mix changes occurred during the period prior to the implementation of the MS–LTC–DRG in FY 2008. The commenter commissioned an analysis of the period prior to the implementation of MS–LTC–DRGs, stating that ''expanding the years of reviewed claims data is important because it expands the period of time analyzed during which there was, by CMS' own admission, no incentive for LTCHs to improve the coding of claims.'' In referring to this study that employed a different methodology to consider coding behavior over a longer period of time, the commenter believed this study was able to capture real case mix changes before and after the introduction of the MS–LTC–DRG. Specifically, the commenter stated that the study applied two different GROUPERs for claims data from 2005 through 2008 and observed that in the pre-implementation period (2005 through 2007) ''the [CMI] rate of increase for the 2005–2007 period using v25 [Version 25] GROUPER is sharper than the rate of increase for these years derived from running claims data through the v24 [Version 24] GROUPER.'' From this observation, the commenter concluded that ''the two GROUPERs measure claims data differently, which is what one would expect due to implementation of a newer, more refined GROUPER.''

Response: Although the commenters argued that the methodology made assumptions that were unsupported, we note that the methodology was also validated by MedPAC's independent analysis of claims data. In response to the commenter who protested that the methodology assumed that real case-mix changes was not included in the calculated CMI, we note that, although overall case-mix growth is predominately comprised of three factors (real case-mix growth, a documentation and coding effect, and a measurement effect), the methodology we have used to quantify the documentation and coding adjustment negates the need to consider the confounding effect of real case-mix growth in the calculated CMI differences. Because the same year of claims data is utilized in the comparisons, there is no component of real case-mix that needs to be identified. That is, there can be no case-mix growth measured if the same year's claims are used. We note that while commenters disagreed with the use of the more refined methodology for deriving the documentation and coding effect presented in the proposed rule, the commenters did not provide specific alternatives to use in the final rule.

Instead, one commenter attempted to compare the effects of applying the Version 24 (FY 2007) and Version 25 (FY 2008) GROUPERs to claims data from 2005 through 2008, believing that this methodology would show real case-mix changes over the years. Using this methodology, the commenter observed that, in the period before MS–LTC–DRGs were implemented (2005–2007), ''the [CMI] rate of increase for the 2005–2007 period using v25 GROUPER is sharper than the rate of increase for these years derived from running claims data through the v24 GROUPER.'' We believe what the commenter is actually observing is the measurement effect between grouping claims in the two different GROUPERs, which is accounted for in our more refined methodology that was presented in the proposed rule. Indeed, we do not disagree with the commenters' conclusion that ''the two GROUPERs measure claims data differently, which is what one would expect due to implementation of a newer, more refined GROUPER [that is, Version 25],'' and we believe this supports our implementation of the MS–LTC–DRG classification system because it better captures patient severity of illness.

Contrary to the commenters' statement that we have asserted that there were no financial incentives for documentation and coding improvements prior to the change to MS–LTC–DRGs, CMS never asserted that LTCHs had no financial incentives to improve documentation and coding prior the introduction of the MS–LTC–DRGs in 2008. In fact, to the contrary, analyses conducted by both CMS and MedPAC have found evidence of apparent case-mix increases during this period. It is for this reason that we have historically adjusted for CMI increases due to documentation and coding changes, including adjustments to account for apparent CMI increases that were found in FY 2004 (4.0 percent), FY 2005 (2.49 percent), and 2006 (0.9 percent). Consequently, we believe that the evidence does not support the commenters' assumption that the increases in CMI found when claims were grouped to Version 25 GROUPER were due solely to real case-mix increases. We continue to believe that the CMI increases over that period are attributable to both real case-mix changes due to increased patient severity of illness *and* documentation and coding changes and that the more refined methodology utilized in the proposed rule, and finalized in this final rule, accurately and appropriately quantifies the appropriate documentation and coding adjustments that should be applied to account for the effects of documentation and coding that occurred in FY 2007 and FY 2008.

Comment: Many commenters were disappointed that CMS was unable to obtain relevant findings based on CDAC data to quantify real case-mix change.

Response: As we stated in the proposed rule, when we attempted to use the CDAC data to distinguish real increase in case-mix growth from documentation and coding in the overall case-mix number, we found aberrant data and significant variation across the FY 1999 through FY 2007 analysis period. It was not possible to distinguish changes in documentation and coding from changes in real case-mix in the CDAC data. Therefore, we concluded that the CDAC data would not support analysis of real case-mix growth that could be used in our retrospective evaluation of the FY 2008 claims data. While we acknowledge the disappointment of the commenters, we

note that we did not receive any public comments suggesting an alternative analysis directly measuring real case-mix growth that did not rely on assumptions with respect to the other factors that influence overall case-mix growth.

Comment: Several commenters stated that CMS premised the documentation and coding adjustment on the existence of changes in severity level within each MS–LTC–DRG family. The commenters indicated that two-thirds of the case-mix change was attributable to changes across MS–LTC–DRGs. The commenters believed that these across MS–LTC–DRG changes refute CMS' documentation and coding analysis.

Response: Neither our MS–DRG nor our MS–LTC–DRG documentation and coding analysis was premised on the existence of changes in severity level within each DRG family. For the MS–DRGs, the analysis of changes in severity level was supplemental to the primary analysis and methodology described in the proposed rule. As we stated in the proposed rule concerning the MS–DRG analysis: ''We sought to *corroborate* (emphasis added) this 2.5 percent estimate by examining the increases in the within-base DRGs as compared to the increases in the across base DRGs * * *'' (74 FR 24094).

The fact that within MS–DRG changes are supportive of the MS–DRG documentation and coding analysis does not mean that lesser within MS–LTC–DRG changes refute the MS–LTC–DRG documentation and coding analysis. Across MS–LTC–DRG changes can occur for a variety of reasons, including documentation and coding. A higher proportion of across MS–LTC–DRG changes does not imply that documentation and coding increases were nonexistent. We note that the FY 2008 documentation and coding estimate for MS–LTC–DRGs was less than half of the FY 2008 estimate for MS–DRGs. This is entirely consistent with the differences in within and across base DRG changes observed under the two systems. Furthermore, we note that our analysis has found examples of across MS–LTC–DRG changes that would contribute to the documentation and coding increases. For example, documentation and coding changes that involve moving respiratory failure, pneumonia, and complicated heart failure from principal to secondary diagnosis slots would result in higher payments because each of these would serve as an MCC and would be assigned to the highest severity group. That is, this resequencing will not only change the base DRG assignment, but it will also frequently change the Major Diagnosis Category (MDC) assignment. Accordingly, given that across MS–LTC–DRG changes can occur for a variety of reasons, including documentation and coding, we disagree with commenters that the across MS–LTC–DRG changes observed between FY 2007 and FY 2008 refute our documentation and coding analysis.

Comment: Several commenters noted that the proposed rule did not account for DRG validations performed by CMS agents, such as QIOs, MACs, and RACs. During the validation process, these agents can make revisions to coding and recover funds. The commenters also expressed concerns that the proposed adjustments for coding and documentation would subject LTCHs to additional recovery of funds in cases where the DRG validation process resulted in a redesignation of the case to a lower MS–LTC–DRG severity level.

Response: We recognize that DRG validation reviews by the CMS contractors can identify cases that require changes in DRG assignment, which may ultimately reduce a hospital's average case-mix. However, these validations are performed on a sample basis and are not done for all LTCH claims. More significantly, they are done primarily to capture fraudulent coding activities, not to address changes in documentation and coding practices that skew the data, resulting in increases in the average MS–LTC–DRG relative weights that are not reflective of hospitals' treatment of more resource intensive patients. As we have noted previously, apparent CMI increase is defined as the increase in CMI due to changes in documentation and coding practices (including better documentation of the medical record by physicians and more complete coding of the medical record by coders). These types of changes in documentation and coding practices would not be addressed in the validations performed by the CMS contractors.

Comment: A number of commenters presented concern, in general, with the proposal to apply a documentation and coding adjustment in determining the update to the LTCH PPS rate for RY 2010. The commenters expressed concern that such an adjustment would reduce LTCH PPS payments and compound the economic woes that LTCHs are experiencing in the current economy.

Response: As discussed above, we fully understand that this documentation and coding adjustment would reduce the increased level of LTCH PPS payments that affected LTCHs are receiving in absence of the adjustment. As discussed above, we believe that it is appropriate to make adjustments to the LTCH PPS standard Federal rate to account for the changes in documentation and coding practices (rather than patients' severity of illness and costs). Therefore, we are finalizing our proposal to apply an adjustment of −0.5 percent in determining the RY 2010 update to the LTCH PPS standard Federal rate to account for the documentation and coding increase that occurred in FY 2007. In FY 2007, the CMS LTC–DRGs was the patient classification system used under the LTCH PPS. Making an adjustment to account for the documentation and coding increase that occurred in FY 2007 is consistent with our historical approach in accounting for increases in payments from a past period due to changes in documentation and coding practices that have occurred under the CMS LTC–DRGs since we first implemented the LTCH PPS in 2003.

After consideration of the public comments received and consistent with the decision to postpone the application of the prospective adjustment for estimated FY 2008 documentation and coding increases under the IPPS (discussed in section II.D.5. of this preamble), we have decided to delay the application of the FY 2008 documentation and coding adjustment that was proposed under the LTCH PPS for RY 2010. We intend to address any future documentation and coding adjustment to the LTCH PPS standard Federal rate based on our analysis of the FY 2008 LTCH claims data in the FY 2011 rulemaking cycle through the notice-and-comment rulemaking process.

In this final rule, we are applying an adjustment for changes in documentation and coding that do not reflect an increase in patients' severity of illness of −0.5 percent to account for the documentation and coding increase that occurred in FY 2007. Accordingly, as discussed in section V.A.2. of the Addendum to this final rule, we are updating the RY 2010 LTCH PPS standard Federal rate by 2.0 percent, which is based on the most recent estimate of the market basket increase (2.5 percent) and an adjustment to account for changes in documentation and coding practices (−0.5 percent).

D. Technical Corrections of LTCH PPS Regulations

While we did not propose any new payment policy changes in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we took the opportunity to propose two technical corrections to regulation text that we believe will clarify our existing policy at § 412.525 relating to

adjustments to the Federal prospective payment to LTCHs (74 FR 24232).

First, at § 412.525(a)(2), the regulations currently state that ''The fixed-loss amount is determined for the long-term care hospital rate year using the LTC–DRG relative weights that are in effect on July 1 of the rate year.'' As stated earlier, in the RY 2009 LTCH PPS final rule, we revised the LTCH PPS payment rate update cycle in order to consolidate the timing of the annual update of the payment rates with the update of the MS–LTC–DRG classifications to October 1, beginning October 1, 2009 (73 FR 26792 through 26798). At that time, at § 412.503, we specified a new definition for ''long-term care hospital prospective payment system rate year.'' Under § 412.503, the term ''long-term care hospital prospective payment system rate year'' means: (1) From July 1, 2003, and ending on or before June 30, 2008, the 12-month period of July 1 through June 30; (2) from July 1, 2008, and ending on September 30, 2009, the 15-month period of July 1, 2008, through September 30, 2009; and (3) beginning on or after October 1, 2009, the 12-month period of October 1 through September 30. At §§ 412.535(b) and (c), we described the resulting new publication schedule of Federal prospective payment rates. However, we neglected to make a conforming change to the regulations at § 412.525(a)(2) to reflect this new schedule. Currently, the language of § 412.525(a)(2) still links the determination of the fixed-loss amount to a July 1 effective date. The annual calculation of the fixed-loss amount, which is the amount used to limit the loss that a hospital will incur under the outlier policy for a case with unusually high costs, is directly linked to the calculation of the annual update of the Federal prospective payment rate (73 FR 26821). When we changed the annual update of the LTCH PPS rate year to coincide with the update in the MS–LTC–DRG relative weights to October 1, we should have changed the language at § 412.525(a)(2) regarding the calculation of the fixed-loss amount to conform with this new schedule.

We did not receive any public comments on our proposal to make this technical correction. Therefore, we are finalizing, without modification, our proposal to revise § 412.525(a)(2) to accurately reflect the basis (effective LTC–DRG relative weights) for calculating the annual fixed-loss amount for high-cost outlier payments, in order to cover the various update cycles that have been in effect under the LTCH PPS. Specifically, we are revising § 412.525(a)(2) to specify that the fixed-loss amount is determined for the LTCH rate year using the MS–LTC–DRG relative weights that are in effect at the start of the applicable LTCH PPS rate year, as defined in § 412.503. (We note that the regulation text at § 412.525(a)(2) uses the term ''LTC–DRG'' rather than ''MS–LTC–DRG'' because the term ''LTC–DRG'' includes ''MS–LTC–DRG'' generally applicable to any year. Specifically, in our regulations at § 412.503, we state that ''[a]ny reference to the term 'LTC–DRG' shall be considered a reference to the term 'MS–LTC–DRG' when applying the provisions of this subpart for policy descriptions and payment calculations for discharges from a long-term care hospital occurring on or after October 1, 2007.'')

We also proposed in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule a clarification of our existing policy at § 412.525(d) that would more accurately reflect existing policy regarding payment adjustments under the LTCH PPS. In paragraph (d) of § 412.525, we provide that CMS adjusts the Federal prospective payment to account for—(1) short-stay outliers at § 412.529; (2) a 3-day or less interruption of stay and a greater than 3-day interruption of stay, as provided for in § 412.531; (3) patients who are transferred to onsite providers and readmitted to a LTCH as provided for in § 412.532; and (4) long-term care HwHs and satellite facilities of LTCHs as provided in § 412.534.

We finalized the policy at § 412.525(d)(4), which refers to the percentage threshold payment adjustment for co-located long-term care HwHs and satellite facilities in the FY 2005 IPPS final rule (69 FR 49191 through 49214), and it was codified in the FY 2007 IPPS final rule (71 FR 48122). We adopted a similar policy in the RY 2008 LTC PPS final rule (72 FR 26910 through 26944) that provides for an adjustment to the LTCH PPS payment for LTCHs and satellite facilities of LTCHs that discharge Medicare patients admitted from hospitals *not* located in the same building or on the same campus as the LTCH or the satellite facility of the LTCH, as specified at § 412.536. We inadvertently omitted the inclusion of this policy in the regulation text at § 412.525(d).

We did not receive any public comments on our proposed clarification. Therefore, in order to ensure that the applicable regulatory text reflects existing policy, we are finalizing, without modification, our proposal to make this technical correction by adding a paragraph (d)(5) to § 412.525 to specifically provide that CMS adjusts the Federal LTCH PPS payment amount for LTCHs and satellite facilities of LTCHs that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the LTCH or the satellite facility of the LTCH, as provided in § 412.536.

IX. Revisions to the FY 2009 Medicare Severity-Long-Term Care Diagnosis-Related Group (MS–LTC–DRG) Relative Weights: Finalization of an Interim Final Rule With Comment Period

A. Overview

On June 3, 2009, we published in the **Federal Register** (74 FR 26546), an interim final rule with comment period that implemented revised MS–LTC–DRG relative weights for payment under the LTCH PPS for FY 2009. We revised the MS–LTC–DRG relative weights for FY 2009 due to the misapplication of our established methodology in the calculation of the budget neutrality factor. The revised FY 2009 MS–LTC–DRG relative weights are effective for the remainder of FY 2009 (that is, from June 3, 2009, through September 30, 2009). Below we summarize the provisions of the June 3, 2009 interim final rule with comment period, present a summary of the public comments received on the interim final rule with comment period and our responses, and state our final policy.

B. Changes to the FY 2009 MS–LTC–DRG Relative Weights

Beginning with the FY 2008 update, we established a budget neutrality requirement for the annual update to the MS–LTC–DRG classifications and relative weights at § 412.517(b) of our regulations (in conjunction with § 412.503), such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the classification and relative weight changes. (We refer readers to the May 11, 2007 LTCH PPS final rule (72 FR 26882 through 26884).)

Consistent with § 412.517(b), in the FY 2009 IPPS final rule (73 FR 48550 through 48551), using the most recent data available at that time (FY 2007 LTCH claims data from the March 2008 update of the MedPAR files), we established the MS–LTC–DRG classifications and relative weights for FY 2009 based on the application of budget neutrality adjustment factors determined using the two-step methodology of calculating and applying a normalization factor and a

budget neutrality factor, as initially established in the FY 2008 IPPS final rule (August 22, 2007, (72 FR 47295 through 47296)). Specifically, for FY 2009, under the first step of the established two-step budget neutrality methodology, after recalibrating the MS–LTC–DRG relative weights, we calculated and applied a normalization factor of 1.03887 to those relative weights to ensure that the average case-mix index (CMI) is not influenced by changes in the composition of case types or the changes to the classification system, such that the recalibration process itself neither increases nor decreases the average CMI. In doing so, each (recalibrated) MS–LTC–DRG relative weight was multiplied by 1.03887 to produce ''normalized relative weights.''

Under the second step of the established two-step budget neutrality methodology, we calculated and applied a ''budget neutrality adjustment factor'' to ensure that estimated aggregate LTCH PPS payments after reclassification and recalibration would be equal to estimated aggregate LTCH PPS payments before reclassification and recalibration. Specifically, as described in the FY 2009 IPPS final rule (73 FR 48551), we calculated a budget neutrality factor of 1.04186 by comparing estimated total payments using the normalized FY 2009 relative weights under GROUPER Version 26.0 to estimated total payments using the FY 2008 GROUPER (Version 25.0) and FY 2008 MS–LTC–DRG relative weights. Then, each of the normalized relative weights was multiplied by that budget neutrality factor to determine the budget neutral relative weight for each MS–LTC–DRG for FY 2009. Thus, the FY 2009 MS–LTC–DRG relative weights established in Table 11 of the Addendum of the FY 2009 IPPS final rule reflect the application of *both* the normalization factor of 1.03887 and the budget neutrality factor of 1.04186.

As we stated in the June 3, 2009 interim final rule with comment period, we discovered that, in determining the published FY 2009 MS–LTC–DRG relative weights, we did not properly apply the established methodology for calculating the budget neutrality factor (the second step of the budget neutrality methodology, as set forth in the FY 2009 IPPS final rule (73 FR 48550 through 48551). Specifically, upon recent review of the calculation of the budget neutrality factor of 1.04186, we found that it was determined using the *unadjusted* recalibrated relative weights rather than using the *normalized* relative weights. This is inconsistent with our stated methodology for the calculation of the FY 2009 budget neutrality factor (that is, the second step of the budget neutrality methodology). As described above and as we stated in the FY 2009 IPPS final rule (73 FR 48551), the FY 2009 budget neutrality factor is to be determined based on estimated total payments using the *normalized* (recalibrated) relative weights under GROUPER Version 26.0 (not the *unadjusted* recalibrated relative weights as were used in calculating the budget neutrality factor of 1.04186 published in the FY 2009 IPPS final rule). This misapplication of the rule's established methodology for calculating the budget neutrality factors resulted in relative weights that are higher, by approximately 3.9 percent. We estimate aggregate annualized LTCH PPS payments in FY 2009 (that is, for discharges occurring on or after October 1, 2008 through September 30, 2009) based on the MS–LTC–DRG relative weights published in the FY 2009 IPPS final rule to be approximately $130 million greater than what the increase would have been had the FY 2009 budget neutrality factor been calculated consistent with the established methodology described in that final rule. Thus, the FY 2009 MS–LTC–DRG relative weights shown in Table 11 of the FY 2009 IPPS final rule (73 FR 49041 through 49062) were inconsistent with the established budget neutrality methodology used for the annual update to the MS–LTC–DRG classifications and relative weights.

Consistent with our general and longstanding policy in PPS contexts, we do not make retroactive changes to correct past errors in PPS ratesetting, regardless of whether an error resulted in higher payments to providers (as in this situation) or lower payments to providers. We also do not make prospective adjustments to PPS rates to account for errors that occurred in prior periods, regardless of whether an error resulted in higher payments or lower payments to providers. In this instance, in the June 3, 2009 interim final rule with comment period, we revised the FY 2009 MS–LTC–DRG relative weights to ensure proper application of the established budget neutrality methodology in updating the FY 2008 MS–LTC–DRG relative weights to FY 2009 during the fiscal year that will be effective for the remainder of the fiscal year. We note that this prospective revision to the FY 2009 MS–LTC–DRG relative weights does not reflect a change in the established budget neutrality methodology itself but, rather, reflects the proper calculation of the relative weights under the rule's stated methodology.

In the June 3, 2009 interim final rule with comment period, we calculated revised FY 2009 MS–LTC–DRG relative weights (effective prospectively for the remainder of FY 2009) based on the proper application of the established budget neutrality methodology. Specifically, using the same data (FY 2007 LTCH claims data from the March 2008 update of the MedPAR files) and methodology presented in the FY 2009 IPPS final rule (73 FR 48551) described above, we determined a budget neutrality factor of 1.0030401, which was applied to the normalized relative weights (that is, the recalibrated relative weights adjusted by the normalization factor of 1.03887, as described above). As a result, we established revised FY 2009 MS–LTC–DRG relative weights (shown in Table 11 of the June 3, 2009 interim final rule with comment period) that are effective for LTCH PPS discharges occurring on or after June 3, 2009, through September 30, 2009. The revised FY 2009 MS–LTC–DRG relative weights in Table 11 of the June 3, 2009 interim final rule with comment period reflect the application of the revised FY 2009 budget neutrality factor 1.0030401 and the FY 2009 normalization factor of 1.03887 (established in the FY 2009 IPPS final rule (73 FR 48551)). (For the convenience of the reader, in addition to the revised budget neutral FY 2009 MS–LTC–DRG relative weights effective June 3, 2009 through September 30, 2009, we also included in Table 11 the geometric mean length of stay and five-sixths of the geometric mean length of stay (SSO threshold for payments under § 412.529) for each MS–LTC–DRG for FY 2009. The revision to the FY 2009 budget neutrality factor did not affect the calculations of the geometric mean length of stay and the SSO threshold for FY 2009 that were presented in Table 11 of the FY 2009 IPPS final rule.) (As noted previously in section VII.C. of this preamble, the revisions to the published FY 2009 MS–LTC–DRG relative weights discussed in the June 3, 2009 interim final rule with comment period affected the determination of the proposed RY 2010 MS–LTC–DRG relative weights and the proposed RY 2010 HCO fixed-loss amount that were presented in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. Therefore, we also presented proposed RY 2010 MS–LTC–DRG relative weights and the proposed RY 2010 HCO fixed-loss amount in the RY 2010 LTCH PPS supplemental proposed rule published in the **Federal Register** on June 3, 2009 (74 FR 26600 through 26635).)

C. Summary of Public Comments Received on the June 3, 2009 Interim Final Rule With Comment Period and Our Responses

We received 11 timely pieces of correspondence in response to the June 3, 2009 interim final rule with comment period. A summary of those public comments and our responses follow:

Comment: Several commenters objected to our revision of the FY 2009 MS–LTC–DRG relative weights. The commenters asserted that the revision that CMS made to the MS–LTC–DRG relative weights for the remainder of RY 2009 (June 3, 2009 through September 30, 2009) constituted ''impermissible retroactive rulemaking'' which is contrary to the principles underlying prospective payments as well as to quoted preamble language in the 1983 and 2007 IPPS final rules. One commenter questioned CMS' authority in establishing a ''retrospective evaluation and correction to a LTCH–PPS rate year,'' citing case law from the D.C. Circuit that the commenter suggested restricts CMS from making ''retroactive'' correction to published rates because of the prospective nature of a PPS.

Response: First, the revision to the FY 2009 MS–LTC–DRG relative weights is not retroactive in application. Rather, the revision is effective prospectively, based on the date of publication of the interim final rule with comment period in the **Federal Register**, that is, June 3, 2009 through September 30, 2009. Moreover, the revision does not reflect a correction to LTCH PPS payment rates in a previous year. Second, as provided for in section 1886(m) of the Act (discussing the statutory authority for the LTCH PPS), CMS has broad legal authority with respect to the LTCH PPS. We note that, as explained in the interim final rule with comment period, the prospective revision of the FY 2009 MS–LTC–DRG relative weights does not reflect a change in the established budget neutrality methodology itself, but rather reflects the proper calculation of the relative weights under the established methodology set forth in the FY 2009 IPPS final rule (73 FR 48550 through 48551).

Third, the principles underlying prospective payment systems often reflect competing considerations (for example, prospectivity, finality, certainty, and accuracy). We agree that, generally, mid-year revisions should be disfavored in a PPS. However, balancing the competing considerations under the unique circumstances presented in this situation, we believe that a mid-year prospective revision to the FY 2009 MS–LTC–DRG relative weights to ensure the proper application of the established budget neutrality methodology in updating the FY 2009 MS–LTC–DRG classifications and relative weights to FY 2009 is appropriate. For these reasons, we believe that the court decisions cited by the commenter are not on point.

Comment: Several commenters questioned CMS' use of the March 2008 update of the FY 2007 data in our recalculation of the budget neutrality factor to determine the revised FY 2009 MS–LTC–DRG relative weights. Citing section 307(b) of the BIPA of 2000, the commenters stated that CMS was required by statute to use ''the best available data'' and that because newer hospital discharge data, from the December 2008 update of the FY 2008 claims data, were available for our revised calculations, CMS was in violation of the statutory mandate by continuing to use the March 2008 update of the FY 2007 data. Data from FY 2008, the commenters asserted, capture changes in case-mix that occurred in 2008 and, therefore, more accurately reflect increases in patient resource use related to an increase in patient case-mix severity. Moreover, the commenters noted that use of the more recent data would result in estimated RY 2009 LTCH payments ''not significantly different than what RY 2009 LTCH payments are estimated to be without correcting the budget neutrality error'' for the remainder of FY 2009. The commenters state that using these FY 2008 data, therefore, would render the revision to the FY 2009 MS–LTC–DRG relative weights presented in the June 3, 2009 interim final rule with comment period unnecessary.

Response: We do not agree that we are violating section 307(b) of the BIPA of 2000 in using the March 2008 update of the FY 2007 MedPAR files in our revised calculation of the FY 2009 MS–LTC–DRG relative weights when FY 2008 claims data from the December 2008 update of the LTCH files were available at the time the misapplication of our established budget neutrality methodology was discovered. Section 307(b) of the BIPA of 2000 did indeed require that in *developing* the LTCH PPS system, in addition to accounting for ''different resource use of long-term care hospital patients,'' in setting DRG weights, we use the ''most recently available hospital discharge data.'' Consistent with our historical policy of using the best available data, our annual updates to each data-driven element of the LTCH PPS, such as relative weights, payment rates, market basket percentages, and HCO thresholds, are based on the most recently available hospital discharge data at the time those elements are developed. Thus, when we revised the FY 2009 MS–LTC–DRG relative weights in the interim final rule with comment period, the calculations were based on the specific data set used at the time the FY 2009 MS–LTC–DRG relative weights were initially established (73 FR 48550 through 48551). As noted in the interim final rule with comment period, we failed to follow our established methodology at that time, and we believe it is appropriate in revising the FY 2009 MS–LTC–DRG relative weights prospectively, to apply the correct methodology to the same data set. Therefore, we are not adopting the commenters' suggestion to utilize the December 2008 update of the FY 2008 MedPAR claims in determining the revised FY 2009 MS–LTC–DRG relative weights, as that was not the most recently available set of data used at the time the FY 2009 MS–LTC–DRG relative weights were established. However, we note that any changes in patient resource that may exist based on the FY 2008 LTCH claims data will be reflected in the RY 2010 MS–LTC–DRG relative weights, which were determined based upon those data, as discussed in section VIII.B.3. of this final rule.

Comment: Several commenters asserted that the June 3, 2009 interim final rule with comment period violated ''notice and comment'' rulemaking procedures as required by the Social Security Act and the Administrative Procedure Act (APA). A number of these commenters maintained that without notice and comment rulemaking, the public has not been given a sufficient opportunity to review the new methodology and determine if CMS' most recent effort to calculate budget neutrality for FY 2009 is correct. The commenters disagreed with the waiver of proposed rulemaking, the delay of the effective date, and the 60-day comment period and were not convinced that good cause was present in order to justify the use of emergency rulemaking procedures. In light of these concerns, two commenters suggested that CMS withdraw the interim final rule with comment period or at least convert it to a proposed rule which would serve as appropriate ''notice and comment.''

Response: We do not agree with the commenters that we have violated the ''notice and comment'' rulemaking requirements of section 553(d) of the APA and section 1871 of the Social Security Act. As we noted in the June 3, 2009 interim final rule with comment period, we ordinarily publish a proposed rule and provide a period for

public comment before the effective date of the rule. We also typically provide a 30-day delay in the effective date of a rule in accordance with section 553(d) of the APA, and section 1871 of the Act. However, both the prior notice-and-comment procedure and the delay in the effective date can be waived if the Secretary, for good cause, finds that it is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the notice issued. In the instant case, we believe that it was unnecessary to undertake prior notice-and-comment rulemaking or provide a delay in the effective date because the June 3, 2009 interim final rule with comment simply reflected the appropriate application of the established methodology set forth in the FY 2009 IPPS final rule (73 FR 48550 through 48551). Because section 307(b)(1) of the BIPA of 2000 authorizes the Secretary to provide for an annual update of the LTCH PPS MS–LTC–DRG relative weights, and the methodology used to update the MS–LTC–DRG relative weights have been previously subject to public comment, we do not believe that an additional comment period or a delay in the effective date was necessary. (We also note that, historically, our annual proposed update of the LTCH PPS proposed payment rates and MS–LTC–DRG relative weights are based upon established methodology, and it is expected that these numbers will be updated in the final rule based on more recent data, without being subject to additional public comment.) We continue to believe that an interim final rule with comment period was the appropriate vehicle for establishing the revised FY 2009 MS–LTC–DRG relative weights.

As noted in earlier responses, our revision of these relative weights was necessitated by a recently discovered misapplication of our established budget neutrality methodology. In response to the commenters who express concern that the absence of a 60-day comment period deprived them of an opportunity to review the new application of the methodology to determine if CMS' most recent effort to calculate the budget neutral FY 2009 MS–LTC–DRG relative weights is correct, we note that the methodology used to calculate budget neutrality for the MS–LTC–DRGs was originally established in the FY 2008 IPPS final rule (72 FR 26882 through 26884).

In addition, we continue to believe that it is impracticable to undertake prior notice-and-comment rulemaking or provide a delay in the effective date because, as stated above, the June 3, 2009 interim final rule with comment period makes a prospective revision to the FY 2009 MS–LTC–DRG relative weights to reflect proper application of the applicable established methodology and, therefore, should be applied in as timely a manner as possible. Therefore, we believe that we have good cause to waive notice-and-comment rulemaking procedures, as well as the 30-day delay in the effective date.

Comment: One commenter requested that CMS consider phasing in the revised MS–LTC–DRG relative weights over a 3-year period, given the anticipated impact on LTCHs of the estimated reduction in Medicare payments.

Response: We do not believe that a phase-in of the revised FY 2009 MS–LTC–DRG relative weights is either necessary or appropriate. For the first two-thirds of FY 2009, Medicare payments to LTCHs were higher than what they would have been had the misapplication of the budget neutrality methodology not occurred. In revising the FY 2009 MS–LTC–DRG relative weights, Medicare payments will be based on our established methodology and data analysis, and we believe that we will be properly making payments reflecting the actual LTCH resource use for LTCH cases for each MS–LTC–DRG. Therefore, we are not adopting the commenters' suggestion to phase in the revised MS–LTC–DRG relative weights.

We note that the public comments that we received on the RY 2010 LTCH PPS supplemental proposed rule, which was published on June 3, 2009 in the **Federal Register**, regarding the proposed RY 2010 MS–LTC–DRG relative weights and the proposed HCO fixed-loss amount for RY 2010 are addressed in section VIII.C.3 of the preamble and section V. of the Addendum to this final rule.

D. Finalization of the June 3, 2009 Interim Final Rule With Comment Period

After consideration of the public comments we received on the June 3, 2009 interim final rule with comment period, we are finalizing, without modification, the FY 2009 MS–LTC–DRG relative weights presented in that interim final rule with comment period, which are currently in effect.

E. Regulatory Impact Analysis for the June 3, 2009 Interim Final Rule With Comment Period

As we stated in the June 3, 2009 interim final rule with comment period, we examined the impacts of that interim final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804 (2)).

The regulatory impact analysis presented in the June 3, 2009 interim final rule with comment period remains the same. Therefore, we are not reprinting it in this document. We refer readers to that interim final rule with comment period (74 FR 26549 through 24950) for the details of that analysis.

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

X. Finalization of Two Interim Final Rules With Comment Period That Implemented Certain Provisions of Section 114 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) Relating to Payments to LTCHs and LTCH Satellite Facilities

A. Background

On May 6, 2008, we published in the **Federal Register** (73 FR 24871) an interim final rule with comment period to implement certain provisions of section 114 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (Pub. L. 110–173) relating to LTCHs. Specifically, the May 6, 2008 interim final rule with comment period (CMS–1493–IFC) implemented section 114(c)(3) and sections 114(e)(1) and (e)(2) of the MMSEA. Section 114(c)(3) of the MMSEA established a 3-year delay in the application of certain provisions regarding the payment adjustment for short-stay outliers. Sections 114(e)(1) and (e)(2) of the MMSEA made revisions to the RY 2008 standard Federal rate.

On May 22, 2008, we published in the **Federal Register** (73 FR 29699) another interim final rule with comment period to implement other provisions of section 114 of the MMSEA relating to LTCHs and LTCH satellite facilities. Specifically, the May 22, 2008 interim final rule with comment period (CMS–1493–IFC2) implemented sections 114(c)(1) and (c)(2) and section 114(d) of the MMSEA. Sections 114(c)(1) and (c)(2) of the MMSEA established a 3-year delay in the application of certain payment policies that apply payment adjustments for discharges from LTCHs and LTCH satellites that were admitted from certain referring hospitals in excess of various percentage thresholds. Section 114(d) of the MMSEA

established a 3-year moratorium on the establishment of new LTCHs and LTCH satellite facilities; and on increases in beds in existing LTCHs and LTCH satellite facilities, with certain exceptions.

The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111–5) modified several of the LTCH-related provisions set forth in sections 114(c) and (d) of the MMSEA implemented in the May 22, 2008 interim final rule with comment period. Specifically, section 4302 of the ARRA amended sections 114(c)(1), (c)(2), and (d)(3) of the MMSEA. We have issued instructions to the fiscal intermediaries and MACs interpreting the ARRA amendments (Change Request 6444). Section XI. of this document contains an interim final rule that addresses the specific modifications that section 4302 of the ARRA made to sections 114(c)(1), (c)(2) and (d)(3) of the MMSEA.

In this section of this final rule, we respond to comments and finalize policies implemented in the May 6 and the May 22, 2008 interim final rules with comment period relating to those provisions of sections 114(c), (d), and (e) of the MMSEA that were not otherwise modified by section 4302 of the ARRA.

B. May 6, 2008 Interim Final Rule With Comment Period Provisions Implementing Section 114(c)(3) of the MMSEA Regarding Certain Short-Stay Outlier Cases

1. Background

In the RY 2003 LTCH PPS final rule (67 FR 55995), we established at § 412.529 a special payment policy for short-stay outlier (SSO) cases. SSO cases are cases with a covered LOS that is less than or equal to five-sixths of the geometric average LOS for each LTC–DRG (67 FR 55995 through 56000). Under the SSO policy, we adjusted the per discharge payment for SSO cases under the LTCH PPS by the least of the following three options: (1) 120 percent of the estimated cost of the case; (2) 120 percent of the LTC–DRG specific per diem amount multiplied by the covered LOS of that discharge; or (3) the full LTC–DRG payment. Since the implementation of the LTCH PPS, we have continued to collect and evaluate data from the LTCH PPS claims, which revealed that a large percentage of SSO cases had a covered LOS of 14 days or less. Based on these findings, we further revised our payment policy for SSO cases in the RY 2007 LTCH PPS final rule for LTCHs defined by section 1886(d)(1)(B)(iv)(I) of the Act. (We refer the reader to the LTCH PPS final rule for RY 2007 (71 FR 27845 through 27870) for a detailed description of the revisions to our SSO policy for RY 2007.)

In the RY 2008 LTCH PPS final rule, we further revised the SSO policy based upon additional analysis of FY 2005 MedPAR data. At that time, we stated that LTCH SSO cases with LOS that are equal to or less than the IPPS average LOS plus one standard deviation for the same DRGs under the IPPS appeared to be comparable to typical stays at acute care hospitals (72 FR 26904 through 26918). Accordingly, in the RY 2008 LTCH PPS final rule we established an additional payment option for SSO cases under the LTCH PPS for discharges occurring on or after July 1, 2007. Specifically, the covered LOS of a SSO case which has been assigned to a particular MS–LTC–DRG is compared to the average LOS plus one standard deviation for the same DRG under the IPPS, which we call the ''IPPS comparable threshold'' (72 FR 26870 and 26906). Thus, for a LTCH SSO case that is within the ''IPPS comparable threshold,'' we added an additional payment option based on an amount comparable to the hospital IPPS per diem amount determined under § 412.529(d)(4). (For a detailed discussion of the RY 2008 revision to the SSO policy, we refer the reader to the RY 2008 LTCH PPS final rule (72 FR 26904 through 26918).

In summary, as established in § 412.529, for LTCH discharges occurring on or after July 1, 2008 from a LTCH defined under section 1886(d)(1)(B)(iv)(I), Medicare pays the least of the following:

- 100 percent of the estimated cost of the case;
- 120 percent of the LTC–DRG specific per diem amount multiplied by the covered LOS of the particular case;
- The full LTC–DRG payment; or by
- Comparing the covered LOS for a SSO case and the ''IPPS comparable threshold'' in one of the following manners:
- The blend of the 120 percent of the LTC–DRG specific per diem amount and an amount comparable to the IPPS per diem amount specified in § 412.529(c)(2)(iv) for cases where the covered LOS for a SSO case is greater than the ''IPPS comparable threshold''; or
- An amount comparable to the hospital IPPS per diem amount determined under § 412.529(d)(4) for cases where the covered LOS for a SSO is less than or equal to the ''IPPS comparable threshold.''

Revisions to the SSO policy payment options that were finalized in RY 2007 and RY 2008 were not applied to the unique situation of a hospital designated as a LTCH by Congress under section 1886(d)(1)(B)(iv)(II) of the Act, that is, (a ''subclause (II)'' LTCH) (71 FR 27863 and 72 FR 26907).

2. Public Comments Received on the May 6, 2008 Interim Final Rule With Comment Period Provisions Implementing Sections 114(e)(1) and (e)(2) of the MMSEA

Section 114(c)(3) of the MMSEA provides that ''[t]he Secretary shall not apply, for the 3-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 FR 26904, 26992) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.'' Accordingly, we stated in the May 6, 2008 interim final with comment period that, ''for discharges beginning on or after December 29, 2007 and before December 29, 2010, the fourth SSO payment option based on the 'IPPS comparable threshold' as discussed above shall not apply'' (73 FR 24875).

Specifically, in that interim final with comment period we noted that, ''during the 3-year period specified above, for each SSO case treated as a LTCH defined under section 1886(d)(1)(B)(iv)(I) of the Act, Medicare will pay the least of: (1) 100 percent of the estimated cost of the case; (2) 120 percent of the LTC–DRG specific per diem amount multiplied by the covered LOS of the particular case; (3) the full LTC–DRG payment; or (4) the blend of the 120 percent of the LTC–DRG specific per diem amount and an amount comparable to the IPPS per diem amount specified in § 412.529(c)(2)(iv)'' (73 FR 24875).

Comment: All of the commenters strongly supported our implementation of the modification to the SSO policy required by section 114(c)(3) of the MMSEA.

Response: We appreciate these comments.

Accordingly, we are finalizing our changes at §§ 412.529(c) and (f) of the regulations pertaining to the payment of SSO cases that implemented section 114(c)(3) of the MMSEA. Specifically, we are finalizing the following changes to our regulation text made in the May 6, 2008 interim final rule with comment period: revising paragraphs (c)(1) through (c)(3), redesignating paragraph (c)(4) as paragraph (f), and revising newly redesignated paragraph (f).

In the May 6, 2008 interim final rule with comment period, we also noted that we had not made any substantive

changes to the policy for reconciliation of SSO payment (other than those associated with implementing section 114(c)(3) of the MMSEA) and that the redesignation of the paragraph (c)(4) as paragraph (f), in addition the heading changes, are simply reorganizational changes intended to make the regulations in this section more accessible.

In the May 6, 2008 interim final rule with comment period, we also noted that in amending the regulations, we discovered that several citations under existing paragraph (c)(4) were incorrect, originating from the RY 2008 final rule when we redesignated this paragraph from (c)(3) to (c)(4) (which was also an organizational change and not a substantive policy change to the policy on reconciliation of SSO payment) but inadvertently did not change the citations to correspond to the redesignation. We are therefore finalizing the corrected citations in the redesignated paragraph (f) (73 FR 24875).

C. May 6, 2008 Interim Final Rule With Comment Period Provisions Implementing Sections 114(e)(1) and (e)(2) of the MMSEA Regarding the Standard Federal Rate for the 2008 LTCH PPS Rate Year

1. Background

Section 114(e)(1) of the MMSEA provides that the base rate for RY 2008 ''shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.'' Furthermore, section 114(e)(2) of the MMSEA provides that section 1886(m)(2) shall not be applicable to discharges occurring on or after July 1, 2007, and before April 1, 2008. We implemented this provision in the May 6, 2008 interim final rule with comment period at which time we also solicited public comments.

In the RY 2009 LTCH PPS proposed rule (73 FR 5362), we noted that consistent with our historical practice, we proposed to update the standard Federal rate for RY 2009 from the previous year based on our interpretation of section 114(e) of the MMSEA, as discussed in the interim final rule with comment period (73 FR 24871 through 24875). This proposed rate was finalized in the RY 2009 LTCH PPS final rule (73 FR 26804 through 26807). (For a description and chronology of our ratesetting policy under the LTCH PPS, we refer readers to section V.A.1. of the Addendum to this final rule.)

Section 114(e)(1) of the MMSEA revises the base rate for RY 2008. Specifically, section 114(e)(1) of the MMSEA adds a new section 1886(m)(2) to the Act, which provides that the base rate for RY 2008 ''shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.'' In addition, section 114(e)(2) of the MMSEA indicates that section 1886(m)(2) of the Act ''shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008'' (that is, the first 9 months of RY 2008). In the May 6, 2008 interim final rule with comment period, we noted that the statute uses the term ''base rate,'' which is not a defined term in either section 1886(m) of the Act or in 42 CFR part 412, Subpart O. As we explained in the LTCH PPS RY 2009 final rule (73 FR 26805), we interpret that term to refer to the standard Federal rate.

Under this interpretation, the standard Federal rate for RY 2008 would be the same as the standard Federal rate for RY 2007, that is, the 0.71 percent update finalized in the RY 2008 LTCH PPS final rule would be reversed. (In the RY 2008 LTCH PPS final rule (72 FR 26887 through 26890), we established (at § 412.523(c)(3)(iv) of the regulations) the revised standard Federal rate for RY 2008 at $38,086.04, the same as it had been for RY 2007.) As specified by section 114(e)(2) of the MMSEA, Medicare payments beginning on and after July 1, 2007, and before April 1, 2008 would be calculated based on the standard Federal rate that we established, in the RY 2008 LTCH PPS final rule, effective from July 1, 2007, through June 30, 2008, at $38,356.45 (72 FR 26890).

As we stated in the May 6, 2008 interim final rule with comment period, we do not believe that the term ''base rate'' could refer to the ''unadjusted rate'' because the unadjusted rate for RY 2008 would be updated by the current year's update factor in order to determine the standard Federal rate for RY 2008 (that is, to determine the standard Federal rate for any given rate year, the previous year's standard Federal rate, which we refer to as the ''unadjusted rate,'' is updated by the current year's update factor), and doing so would result in the same Federal rate for RY 2008 as was adopted in the RY 2008 LTCH PPS final rule. To illustrate this scenario mathematically, if ''base rate'' is interpreted to mean ''unadjusted rate,'' the ''unadjusted rate'' for RY 2008 ($38,086.04) would be the same as the RY 2007 ''unadjusted rate'' ($38,086.04). The RY 2008 ''unadjusted rate'' of $38,086.04 would subsequently be updated by the 0.71 percent update factor finalized in the RY 2008 final rule, resulting in a standard Federal rate for RY 2008 of $38,356.45, which is the same standard Federal rate that was originally finalized in the RY 2008 final rule. If we adopted this interpretation, we believe that LTCH PPS payments would be unaffected by section 114(e)(1) of the MMSEA. Therefore, we believe that the term ''base rate'' used in section 114(e)(1) of the MMSEA refers to the standard Federal rate.

In the RY 2008 LTCH PPS final rule (72 FR 26890), we originally established a standard Federal rate of $38,356.45 for the 2008 LTCH PPS rate year that was based on the best available data and policies established in that final rule. As discussed above, section 114(e) of the MMSEA revised the standard Federal rate for RY 2008. Specifically, section 114(e)(1) of the MMSEA provides that under the new section 1886(m)(2) of the Act, the standard Federal rate for RY 2008 shall be the same as the standard Federal rate for RY 2007. The standard Federal rate for RY 2007 was $38,086.04 (71 FR 27818). Thus, to implement 114(e)(1) of the MMSEA, in the May 6, 2008 interim final rule with comment period, we established that the RY 2008 standard Federal rate is $38,086.04 (the same as the standard Federal rate for 2007).

However, section 114(e)(2) of the MMSEA expressly delays the application of the revised RY 2008 standard Federal rate. Specifically, section 114(e)(2) of the MMSEA states that the revised RY 2008 standard Federal rate ''shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008.'' Therefore, we stated that LTCH payments for discharges occurring on or after July 1, 2007 through March 31, 2008, would continue to include an adjustment of 0.71 percent, that is, payments would be based on the standard Federal rate in § 412.523(c)(3)(iii), updated by 0.71 percent. Accordingly, for discharges occurring on or after April 1, 2008 through June 30, 2008, we would apply the revised RY 2008 standard Federal rate of $38,086.04, while payments for discharges occurring from July 1, 2007, through March 31, 2008 would be determined based on the standard Federal rate in § 412.523(c)(3)(iii) increased by 0.71 percent, that is, $38,356.45. In the May 6, 2008 interim final rule with comment period, we revised § 412.523(c)(iv) to conform to the revision of the standard Federal rate for RY 2008 under section 114(e) of the MMSEA and to specify how payments are determined during RY 2008.

In the May 6, 2008 interim final rule with comment period, we also noted that section 114(e) of the MMSEA

affected the HCO fixed-loss amount currently in effect since it revises the standard Federal rate for RY 2008 and the standard Federal rate is used to determine the fixed-loss amount. Specifically, the fixed-loss amount that was applied when the MMSEA was enacted (December 29, 2007) was determined based on a standard Federal rate of $38,356.45. (*See* the RY 2008 LTCH PPS final rule (72 FR 26896 through 26899), as amended by the RY 2008 correction notice (72 FR 36613) for a discussion of the methodology and data used to determine the current fixed-loss amount for RY 2008.) In that interim final rule with comment period, we stated that since payment for discharges occurring on or after April 1, 2008, through June 30, 2008, will be based on the revised RY 2008 standard Federal rate of $38,086.04, consistent with the existing regulations at § 412.525(a), in order to maintain estimated total payments for HCO cases at 8 percent of the estimated total payments, we were also revising the HCO fixed-loss amount. Accordingly, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of the BIPA, to make appropriate adjustments to the LTCH PPS, the revised HCO fixed-loss amount effective for discharges occurring on or after April 1, 2008, through June 30 2008, was set at $20,707. This revised fixed-loss amount was determined using the same data and methodology presented in the RY 2008 LTCH PPS final rule and takes into account the revised RY 2008 standard Federal rate as provided for in the MMSEA (discussed above).

2. Public Comments Received on the May 6, 2008 Interim Final Rule With Comment Period Provisions

Comment: Several commenters disagreed with our interpretation of section 114(e)(2) of the MMSEA, which specifies that ''for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.'' The commenters urged CMS to base the RY 2009 standard Federal rate update on the original RY 2008 rate when it finalizes the MMSEA provisions. The commenters further noted that section 114(e) of the MMSEA provides that the RY 2007 base rate only be utilized for the last three months of RY 2008, and that the initial RY 2008 base rate be utilized for July 1, 2007, through April 1, 2008. The commenters asserted that there is no statutory requirement that the RY 2009 standard Federal rate be calculated based on the RY 2007 rate. In fact, the commenters noted, that the language of the provision indicates that the RY 2007 standard Federal rate is to be applied only to ''discharges occurring during the rate year ending in 2008.'' They contended that when CMS used the ''revised'' RY 2008 standard Federal rate, this policy determination affected not only the RY 2009 standard Federal rate but every rate year thereafter and that Congress did not intend this. Therefore, the commenters asserted that our interpretation of section 114(e)(1) of the MMSEA constitutes retroactive rulemaking. Furthermore, the commenters stated that our interpretation of section 114(e)(2) of the MMSEA violates our existing regulations at §§ 412.523(a)(1) and (a)(2) that state that CMS uses the ''best Medicare data available'' to adjust the ''most recent estimate'' of increases in the market basket when computing the standard Federal rate, which is based on using data from the previous rate year.

Response: We disagree with the commenters that updating the RY 2008 standard Federal rate based on the MMSEA revised RY 2008 standard Federal rate of $38,086.04 represents a misinterpretation of section 114(e)(1) of the MMSEA. As we noted in response to similar comments that we received on this issue after we published the RY 2009 LTCH PPS proposed rule (73 FR 3560 through 3562), we continue to believe that the approach that we finalized in the RY 2009 LTCH PPS final rule (73 FR 26805) for calculating the RY 2009 standard Federal rate is appropriate, and consistent with a plain reading of the statute and our historic methodology for calculating the standard Federal rate.

Section 114(e)(1) of the MMSEA adds section 1886(m)(2) to the Act, which specifies the standard Federal rate for RY 2008. Specifically, section 1886(m)(2) provides that ''for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.'' Section 1886(m)(2) of the Act, on its face, explicitly provides for a single revised RY 2008 standard Federal rate. With respect to section 114(e)(2) of the MMSEA, this section provides that section 1886(m)(2) of the Act shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008. When read together, we believe that section 1886(m)(2) of the Act and section 114(e)(2) of the MMSEA provide that the revised RY 2008 standard Federal rate (which is the same as the RY 2007 standard Federal rate) is the standard Federal rate for all of RY 2008. However, for payment purposes, discharges occurring on or after July 1, 2007, and before April 1, 2008 simply will not be paid based on that revised RY 2008 standard Federal rate.

In contrast to the commenters' belief that section 114(e)(2) of the MMSEA limits the reduced standard Federal rate in section 1886(m)(2) of the Act to merely a 3-month period (that is, the part of RY 2008 not included in ''on or after July 1, 2007, and before April 1, 2008''), this section provides that the standard Federal rate specified in section 1886(m)(2) of the Act ''shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008.'' To the extent the MMSEA directs that the revised standard Federal rate in section 1886(m)(2) of the Act shall not apply during a specified period, it also necessarily means that the standard Federal rate in section 1886(m)(2) of the Act would otherwise apply for the entire RY 2008. We note that section 1886(m)(2) of the Act could have been explicitly revised to state this result. However, the actual structure of section 114(e) of the MMSEA contained two distinct provisions: at section 1886(m)(1) of the Act, an express indication of the statutory authority that established and implemented the LTCH PPS; and at section 1886(m)(2) of the Act, the establishment of the ''Update for Rate Year 2008'', which the statute specifically mandates ''shall be the same as the base rate for discharges for the hospital occurring during the rate year ending 2007.'' Following that statutory amendment at sections 1886(m)(1) and (m)(2) of the Act, specified in section 114(e)(1) of the MMSEA, section 114(e)(2) of the MMSEA (not included in the new subsection (m) of the Act) merely prohibits application of the revised RY 2008 standard Federal rate to discharges occurring prior to April 1, 2008. Therefore, contrary to the commenters' assertion, we believe a plain reading of the statute provides that the standard Federal rate for the long-term care hospital prospective payment system rate year beginning July 1, 2007 and ending June 30, 2008 (that is, RY 2008) is the same as the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by zero percent (that is, the same as the standard Federal rate for RY 2007).

In addition, Congress is aware that we determine the standard Federal rate for a given year by taking the standard Federal rate from the previous year and updating it. Our calculation of the

proposed (and final) RY 2009 standard Federal rate is consistent with our long-standing practice of calculating the standard Federal rate. Since Congress did not expressly direct us to deviate from that historical practice, the natural presumption is that we would take the revised RY 2008 standard Federal rate specified in section 1886(m)(2) of the Act and update it in order to calculate the RY 2009 standard Federal rate. In response to the comment that the MMSEA did not specifically grant CMS the authority to update the RY 2009 standard Federal rate based on the revised RY 2008 standard Federal rate specified in the MMSEA, we note that granting such authority was unnecessary. Congress had already conferred broad discretionary authority to the Secretary under § 307(b)(1) of Public Law 106–554 (also referenced under new section 1886(m)(1) of the Act) to provide for appropriate adjustment to the LTCH PPS, including updates.

We also disagree with commenters' assertions that the proposed RY 2009 standard Federal rate would produce a retroactive effect and is tantamount to retroactive rulemaking. We note that the RY 2009 standard Federal rate will be *prospectively* applied to discharges beginning on July 1, 2008.

In response to the commenters' statements that we are violating our own existing regulations at § 412.523(a)(1) which sets forth the methodology for calculating the annual Federal prospective payment rates based on the ''best Medicare data available,'' and utilizing ''the most recent estimate of increases in the prices of an appropriate market basket * * *,'' we note that the revised RY 2008 standard Federal rate, which we are required to use under section 1886(m)(2) of the Act for ''discharges occurring during the rate year ending in 2008'' was originally calculated based on those regulatory principles. Furthermore, the determination of $39,114.36 as the RY 2009 standard Federal rate was also established in full compliance with the established methodology set forth in our regulations at § 412.523, using, as Congress required, a RY 2008 rate which is ''* * * the same as the base rate for discharges * * * occurring during the rate year ending in 2007'' as set forth in the RY 2009 LTCH PPS final rule (73 FR 26812).

After consideration of these comments, we are finalizing the regulatory changes implementing sections 114(e)(1) and (e)(2) of the MMSEA made in the May 6, 2008 interim final rule with comment period without modification. Specifically, we are amending § 412.500 by revising paragraph (a) and § 412.523 by revising paragraph (c)(3).

D. May 22, 2008 Interim Final Rule With Comment Period Implementing Sections 114(c)(1) and (c)(2) of the MMSEA Regarding Payment Adjustment to LTCHs and LTCH Satellite Facilities

1. Background

Our regulations at § 412.534, implemented for cost reporting periods beginning on or after FY 2005, address our concern that the co-location of LTCHs with other hospital-level providers (in particular, acute care hospitals) as HwHs and as satellites provide an incentive for early discharges from the acute care hospital immediately followed by admissions to the on-site LTCH, resulting in two Medicare payments for what was essentially one episode of treatment.

Specifically, at § 412.534 of the regulations, we established the percentage threshold payment adjustment under which Medicare payments for discharges of patients from LTCHs who are admitted from the LTCHs' co-located hosts that exceeded a specified percentage would be paid the lesser of the amount otherwise payable under the LTCH PPS or an amount payable under the LTCH PPS that was equivalent to the amount that would be otherwise determined under the IPPS. At that time we provided for a 4-year transition to the full percentage payment threshold and also established higher percentage thresholds for certain LTCHs, that is, those located with rural, MSA-dominant or urban single hospitals. (For a thorough discussion of the regulations at § 412.534, see the FY 2005 IPPS final rule (69 FR 49292 through 49214).)

In the LTCH PPS RY 2008 final rule, we extended the percentage threshold payment adjustment to all LTCHs that had not already been governed under the original policy at § 412.534 (72 FR 26919 through 26944), including grandfathered LTCH HwHs and LTCH satellites at § 412.534(h), and non-co-located LTCHs. The policy also governed Medicare discharges from LTCH HwHs and satellites that were admitted from referral sources other than their co-located hosts at § 412.536(a)(1)(ii) and (iii). When we extended the policy in § 412.534 to grandfathered LTCH HwHs and LTCH satellite facilities in the RY 2008 LTCH PPS final rule, we provided for a parallel 3-year transition to the full percentage threshold for cost reporting periods beginning on or after July 1, 2007 at § 412.534(h) for ''grandfathered'' LTCHs and LTCH satellite facilities discharging patients admitted from their host hospitals and at § 412.536(f) for discharges that were admitted to a LTCH or LTCH satellite facility from any referring hospital with which they were not co-located (72 FR 26944).

2. Payment Adjustment to LTCHs and LTCH Satellite Facilities Specified by Section 114(c) of the MMSEA

The enactment of section 114(c) of the MMSEA required several modifications to payment provisions applicable to various types of LTCHs under the regulations at §§ 412.534 and 412.536. (Throughout this section, ''LTCH'' or ''LTCH satellite facility'' refers exclusively to ''subclause (I)'' LTCHs and LTCH satellite facilities, that is, LTCHs defined by section 1886(d)(1)(B)(iv)(I) of the Act. This is the case because the policies established at §§ 412.534 and 412.536 do not apply to a ''subclause (II)'' LTCH defined under section 1886(d)(1)(B)(iv)(II) (69 FR 49205 and 72 FR 26924).)

In the May 22, 2008 interim final rule with comment period, we revised our regulations at §§ 412.534 and 412.536 to implement the requirements of sections 114(c)(1) and (c)(2) of the MMSEA (73 FR 29699 through 29704).

On February 17, 2009, the ARRA of 2009 was enacted, which affected several of the policies established by the MMSEA that we implemented in the May 22, 2008 interim final rule with comment period. In the following discussion, we review the policies that we implemented in the May 22, 2008 interim final with comment period, note changes made by section 4302 of the ARRA, and respond to public comments that we received on our implementation of the MMSEA provisions that were not otherwise revised by the ARRA. In section XI. of this document, we have implemented the amendments made by section 4302 of the ARRA to certain provisions of section 114(c) and (d) of the MMSEA in an interim final rule with comment period.

We note that the modifications to our regulations at §§ 412.534 and 412.536 made by section 114(c) of the MMSEA were originally effective for cost reporting periods beginning on or after December 29, 2007, for a 3-year period. As discussed in greater detail in the interim final rule with comment period for the ARRA in section XI. of this document, sections 4302 (a)(1)(B) and (a)(2)(B) of the ARRA changed this effective date to cost reporting periods beginning on July 1, 2007 or October 1, 2007, as applicable. Therefore, the discussion below focuses on policy changes made by section 114(c) of the

MMSEA to our regulations at §§ 412.534 and 412.536, implemented in the May 22, 2008 interim final rule with comment period, that were otherwise unaffected by the amendments in section 4302 of the ARRA. (For a detailed description of each provision originally promulgated in section 114(c) of the MMSEA, the reader is directed to the May 22, 2008 interim final rule with comment period (73 FR 29699, 29701 through 29704).)

Section 114(c) of the MMSEA provided the following changes affecting our regulations at §§ 412.534 and 412.536:

- Section 114(c)(1)(A) of the MMSEA generally exempted ''freestanding'' LTCHs (that is, as newly defined in § 412.23(e)(5), from the percentage threshold payment adjustment at 412.536 (or any similar provision) for a 3-year period;
- Section 114(c)(1)(B) of the MMSEA exempted ''grandfathered'' LTCH HwHs (that is, ''a long-term care hospital identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (Pub L. 105–33)'') from the applicable percentage threshold policy established at § 412.536 or § 412.534, or any similar provision for a 3-year period;
- Section 114(c)(2)(A) of the MMSEA exempts certain LTCH HwHs and LTCH satellite facilities located in a rural area or which are co-located with an urban single or MSA-dominant hospital under § 412.534(d)(1), (e)(1), and (e)(4) that meet the definition of an ''applicable long-term care hospital or satellite facility,'' from certain payment adjustments if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in § 412.534(d)(2) or (e)(3), for example, HCO cases at the referring hospital) are admitted from a co-located hospital for a 3-year period; and
- Section 114(c)(2)(B)(i) of the MMSEA exempts an applicable long-term care hospital or satellite facility which is co-located with another hospital from certain payment adjustments under § 412.534, if no more than 50 percent of the hospital's Medicare discharges (other than discharges described in paragraph (c)(3) of such section, for example, HCO cases at the referring hospital) are admitted from a co-located hospital. Section 114(c)(2)(B)(ii) defined an ''applicable long-term care hospital or satellite facility'' as a hospital or satellite facility that is subject to the transition rules under § 412.534(g). We direct the reader to the May 22, 2008 interim final rule with comment period, which included a detailed description of those aspects of our regulations at §§ 412.534 and 412.536 that were unaffected by the MMSEA changes and specifies which LTCHs and LTCH satellites remain subject to the existing regulations (73 FR 29701 through 29704). (We note, however, that this description predated the amendments made by section 4302 of the ARRA to section 114(c) of the MMSEA, discussed in section XI. of this document.)

As noted above, section 4302(a)(1)(B) of the ARRA modified this provision by separating the establishment of the 3-year exemption from the implementation of the percentage threshold payment adjustments at § 412.534 and § 412.536 from the date of enactment of the MMSEA, that is, December 19, 2007. Specifically, section 4302(a)(1)(B) strikes ''the date of enactment of this Act * * *'' from section 114(c)(1) of the MMSEA, and inserts ''* * * July 1, 2007.'' This change is discussed in greater detail in the interim final rule with comment period on section 4302 of the ARRA, at section XI. of this document. Therefore, while regulations describing the 3-year delay in application of the 25 percent patient threshold payment adjustment for ''freestanding'' LTCHs and ''grandfathered'' LTCH HwHs implemented in the May 22, 2008 interim final rule with comment period are being finalized at this time, the change in the effective date of this provision is being implemented through the mechanism of the interim final rule with comment period found in section XI. of this document.

3. Public Comments Received on the May 22, 2008 Interim Final Rule With Comment Period Implementing Section 114(c)(1) and (c)(2) of the MMSEA Regarding Payment Adjustment to LTCHs and LTCH Satellite Facilities

We received a number of comments on the provisions of the May 22, 2008 interim final rule with comment period implementing sections 114(c)(1) and (c)(2) of the MMSEA, some of which were mooted by the subsequent enactment of the ARRA. For example, we received several public comments expressing concern that linking the MMSEA modifications to the percentage threshold payment adjustment (both the exemption from the policy at section 114(c)(1) of the MMSEA and the percentage increase at 114(c)(2) of the MMSEA) to cost reporting periods beginning on or after the December 29, 2007 date of enactment of the MMSEA forestalled relief to a significant number of LTCHs. Specifically, freestanding LTCHs and ''grandfathered'' LTCH HwHs with cost reporting periods beginning between October 1, 2007 and December 29, 2007 and to ''applicable'' LTCH HwHs and satellites with cost reporting periods beginning between July 1, 2007 and December 29, 2007 would become eligible for the MMSEA relief at only the start of their next cost reporting period. Sections 4302(a)(1)(B) and (a) (2)(B) of the ARRA amended sections 114(c)(1) and (c)(2) of the MMSEA, respectively, modifying the effective dates of the changes to the percentage threshold payment adjustment. Therefore, comments on this issue and others noted throughout this section that were addressed by the ARRA modifications of the MMSEA will not be addressed in this final rule. The ARRA provisions will be discussed and implemented through the interim final rule with comment period in section XI. of this document.

Comment: MedPAC indicated that it was aware that the percentage threshold payment policy was established ''to help ensure that LTCHs do not function as units of acute care hospitals, and that decisions about admission, treatment, and discharge in both acute care hospitals and LTCHs are made for clinical rather than financial reasons.'' MedPAC continued: ''[s]ome LTCHs—both freestanding and those with formal ties to other hospitals—may function as de facto step-down units of acute care hospitals. Research by MedPAC and others has found that patients who use LTCHs have shorter acute care hospital lengths of stay than similar patients who do not use these facilities, suggesting that LTCHs substitute for at least part of the acute care hospital stay.'' The Commission expressed concerns about the impact of such behavior on Medicare costs. Describing the percentage threshold policy as a ''useful but blunt tool'' until criteria can be developed, the commenter further stated that ''MedPAC favors using criteria to define the level of care typically furnished in LTCHs (as well as in step-down units of many acute-care hospitals, and some specialized skilled nursing and inpatient rehabilitation facilities) and to help ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions.''

Response: We thank MedPAC for their clear description of the rationale for our development of the percentage threshold payment adjustment and for endorsing its underlying principle. We also appreciate MedPAC's restatement of our two-fold mandate: our responsibility both to establish payment systems to pay providers for appropriate and high quality beneficiary care as well

as to ensure that Medicare funds are spent wisely and appropriately. In establishing payment adjustments, such as the ''25 percent'' threshold policy, we are responding to the same data cited by the commenter above regarding the phenomenon of shortened acute care hospital stays followed by admissions to on-site or near-by LTCHs, resulting in two separate Medicare payments for what, in effect, was one episode of treatment.

We are aware that MedPAC recommended the development of criteria for LTCH patients and facilities, as a more effective way to ensure that LTCHs meeting certain criteria treat a particular level of patients, specifically as set forth in its June 2004 Report to Congress. In response to MedPAC's recommendations, we awarded a contract to Research Triangle International (RTI) for a comprehensive evaluation of the feasibility of developing patient and facility level criteria for LTCHs that could distinguish LTCH patients from those treated in other hospitals. (Reports on this research are posted on our Web site at *http://www.cms.hhs.gov/LongTerm Care Hospital PPS/02a_RTIReports.asp#TopOfPage*.)

We also refer readers to the comment that MedPAC submitted on the RY 2009 LTCH PPS proposed rule which explained the rationale behind its June 2004 recommendation—''beneficiaries treated in LTCHs cost Medicare more than those treated in alternative settings; however, the cost differences narrowed considerably if LTCH care was targeted to patients who appeared most suitable for this level of care. That leads us to conclude that Medicare should ensure that LTCHs treat only appropriate patients.'' At that time, MedPAC took the significant step of amending its June 2004 recommendation by stating that:

''The types of cases treated by LTCHs can be (and are) treated in other settings, particularly in step-down units of many acute-care hospitals. Therefore, it is not possible (nor desirable) to develop criteria defining patients who can be cared for exclusively in LTCHs. Rather, CMS should seek to define the level of care typically furnished in LTCHs, step-down units of many acute-care hospitals, and some specialized skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs).'' (73 FR 26829)

A review of the annual proposed and final rules since 2005 indicates that RTI's research led it to similar conclusions (71 FR 4704 through 4726, 71 FR 27884, 72 FR 4818, 72 FR 4884 through 4886, 72 FR 26947 through 26948, 73 FR 5374 through 5376, 73 FR 26829). In this light, we would also note that section 114(b) of the MMSEA directs the Secretary to conduct a study and submit a report to the Congress on the establishment of national LTCH facility and patient criteria. The statute stipulates that in conducting the study and preparing the report, the Secretary shall consider the recommendations made by MedPAC in its June 2004 report as well as ongoing work by the Secretary to evaluate and determine the feasibility of such recommendations. In accord with this requirement, a report to Congress which takes into consideration MedPAC's original recommendations as well as both RTI's and the Commission's further analyses and findings is being prepared for submission by our Office of Research, Development, and Information by early Fall.

Comment: Six commenters challenged our implementation of the MMSEA changes to the percentage payment threshold policy presented in the May 22, 2008 interim final rule with comment period. A number of the commenters argued that we have interpreted the statutory language in the ''narrowest way possible'' with the result being the creation of ''different classes of LTCHs,'' only some of which benefit from the MMSEA provisions. Three commenters urged the Secretary to use discretion to apply both elements of sections 114(c)(1)(A) and (c)(2)(B) of the MMSEA to all LTCHs such that there would be a 3-year delay in any application of the regulations at § 412.536 to *any* type of LTCH and that for 3 years the percentage threshold increase would apply to *all* co-located LTCHs and LTCH satellites governed under the regulations at § 412.534. Several commenters urged CMS to use its discretionary authority to extend the percentage increase policy established by section 114(c)(2) to ''grandfathered'' satellites as described in our regulations at § 412.22(h)(3)(i). One commenter opined that the establishment of different classes of LTCHs by section 114(c) of the MMSEA was both inequitable and administratively burdensome for CMS. This commenter suggested that if CMS believed that the Secretary did not have the authority to interpret the relief provided by section 114(c) of the MMSEA to other LTCHs not addressed by the statute, that a legislative proposal be submitted to Congress urging passage of a more equitable and administratively reasonable policy. Two commenters also recommended that after 3 years the regulations at § 412.536 should not be ''reimposed'' and that § 412.534 should also be retired once criteria were developed. One of these commenters further suggested that once the 3-year exemption for LTCH HwHs and ''freestanding'' LTCHs sunsets, even if we reinstate the percentage threshold payment policy, we should also reinstate the 3-year transition period to the full 25 percent threshold for these groups.

Response: We believe that the regulations that we published in the May 22, 2008 interim final rule with comment period represented an accurate reading and appropriate interpretation of section 114(c) of the MMSEA. In that provision, Congress targeted specific types of LTCHs for particular sorts of relief. Specifically, the language at section 114(c)(1) of the MMSEA clearly provided a 3-year delay in application of §§ 412.534 and 412.536 to only two categories of LTCHs in section 114(c)(1)(A) of the MMSEA to freestanding LTCHs; and in section 114(c)(1)(B) to ''grandfathered'' LTCH HwHs.

Similarly, the 3-year relief from the full implementation of § 412.534 that Congress granted in section 114(c)(2) in the form of increased thresholds from 50 percent to 75 percent for LTCHs or LTCH satellites co-located with a rural, urban single, or MSA-dominant hospital and from 25 percent to 50 percent for LTCHs and LTCH satellites was narrowly targeted to only those ''applicable'' LTCHs and LTCH satellites, that is, those ''subject to the transition rules under section § 412.534(g) of title 42 Code of Federal Regulations.'' The percentage threshold payment adjustment policies were established to provide disincentives for LTCH and LTCH satellites to admit patients from referring hospitals with which they were either co-located in the case of § 412.534 or separate from, as in the case of § 412.536, for financial rather than clinical benefit. We continue to believe that it is inappropriate for Medicare to generate two payments, one to the referring (typically) acute care hospital and one to the LTCH, for what is essentially one episode of treatment. Congress was specific in providing areas and timeframes for relief. We have implemented those statutory provisions based on the plain language of the statute. The statutory directives parallel our existing policies.

In addition, section 4302 of the ARRA amended section 114(c) of the MMSEA. These amendments extended both types of relief, that is, the 3-year delay in implementation and the increase in the percentage threshold, to two additional specific categories of LTCHs. Specifically, section 4302(a)(1)(C) of the ARRA amended section 114(c)(1)(A) of

the MMSEA to provide a 3-year delay in the application of § 412.536 of the regulations, that is the 25 percent patient threshold payment adjustment to ''* * * a long-term care hospital, or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Social Security Act at the off-campus location * * *,'' as well as freestanding LTCHs. Additionally, section 4302(a)(2)(A) of the ARRA specifies that section 114(c)(2) of the MMSEA, regarding the increase of the percentage threshold established by the regulations at § 412.534, shall also apply to a hospital or satellite facility described in § 412.22(h)(3)(i) of the regulations (that is, grandfathered satellites). (Section 4302 of the ARRA is being implemented through the interim final rule with comment period in section XI. of this document.) These amendments to the MMSEA once again demonstrated Congress' ability to act in a clear and deliberate manner in providing relief for particular categories of LTCHs and LTCH satellites while leaving other aspects of §§ 412.534 and 412.536 in place.

For these reasons, we do not believe that a legislative proposal to Congress urging further expansion of either the 3-year delay in implementation or the 3-year increase in the percentage threshold is either necessary or appropriate. Furthermore, at present, we do not believe that the MMSEA policy changes or the ARRA amendments constitute an additional administrative burden for us. In response to the commenters' recommendations that both §§ 412.534 and 412.536 be retired once LTCH criteria are established, we are not considering such an action at this time. As noted above, the study on ''the establishment of national long-term care hospital facility and patient criteria * * *'' and the resulting report to Congress required by section 114(b) of the MMSEA is presently under way by our Office of Research, Development, and Information.

Finally, with regard to the suggestion that once the 3-year exemption from §§ 412.534 and 412.536 sunsets, that we reinstate the 3-year transition period to the full 25 percent threshold payment adjustment for freestanding LTCHs and ''grandfathered'' LTCH HwHs, we would note that we typically provide phase-ins or transitions to the full implementation of new or revised payment policies in order to give providers more time than the 60-day (or in some cases, 30-day) period between publication of our final rule and the implementation date of the new policies in order to fully understand them and to make whatever administrative and financial adjustments that are required. ''Freestanding'' LTCHs and ''grandfathered'' LTCH HwHs have had notice of our policies at § 412.534(h) and § 412.536 of the regulations since they were implemented for cost reporting periods beginning on or after July 1, 2007. Despite the fact that these policies were suspended for these types of LTCHs until cost reporting periods beginning on or after July 1, 2010 (resulting from the amendments made by section 4302(a)(1)(B) of the ARRA to section 114(c)(1) of the MMSEA), the LTCH industry has full knowledge and understanding of the percentage threshold payment adjustment. Therefore, we do not intend to propose such an action as we do not believe it is either necessary or appropriate.

Comment: Two commenters asserted that we incorrectly interpreted the increase in percentage thresholds for LTCHs or LTCH satellites co-located with MSA-dominant hospitals in section 114(c)(2)(A) of the MMSEA. The commenters argued that the statute sets the threshold percentage at 75 percent, but that under the policy that we set forth in the May 22, 2008 interim final rule with comment period, we inserted the 75 percent specified by the statute into the existing payment formula for LTCHs or LTCH satellites co-located with MSA-dominant hospitals in the regulations at § 412.534. In the interim final rule with comment period, we revised § 412.534(e)(2)(ii), which stated:

''(ii) Payments for long-term care hospitals and long-term care hospital satellite facilities subject to paragraph (g) of this section are determined using the methodology specified in paragraph (e)(1) of this section except that 75 percent is substituted for 50 percent.''

The methodology for setting the threshold for LTCHs HwHs or LTCH satellites co-located with MSA-dominant hospitals, as set forth in the regulations at § 412.534(e)(1), states, in pertinent part:

''(ii) For purposes of paragraph (e)(1)(i) of this paragraph, the percentage used is the percentage of total Medicare discharges in the Metropolitan Statistical Area in which the hospital is located that are from the co-located hospital for the cost reporting period for which the adjustment was made, but in no case is less than 25 percent or more than 50 percent.''

The commenters urged us to revisit our interpretation of section 114(c)(2)(A) of the MMSEA and to revise our regulations at § 412.534(e)(1)(ii) accordingly.

Response: We agree with the commenters' reading of the statute. The way in which we revised the regulations would appear to indicate that establishing the appropriate percentage threshold for LTCHs HwH or LTCH satellites co-located with a MSA-dominant hospitals set by the regulatory language at § 412.534 (e)(2)(ii) of the regulations referencing (e)(1)(ii) after the enactment of the MMSEA, would be based on the percentage ''* * * of total Medicare discharges in the Metropolitan Statistical Area in which the hospital is located that are from the co-located hospital for the cost reporting period for which the adjustment was made, but in no case is less than 25 percent or more than 50 percent.'' We agree that the section 114(c)(2)(A) of the MMSEA establishes the threshold for such LTCH facilities at 75 percent for 3-years, and we are making an appropriate technical correction to the regulations at § 412.534(e)(2)(ii). (We also note that section 4302(a)(2)(B) of the ARRA, discussed in our interim final rule with comment period in section XI. of this document, modified the effective date of this provision from cost reporting periods beginning on or after December 29, 2007, to cost reporting periods beginning on or after October 1, 2007, or July 1, 2007 in the case of satellite facilities described in § 412.22(h)(3)(i) of the regulations, that is grandfathered satellite facilities.)

Comment: Two commenters challenged our interpretation of section 114(c)(1)(A) of the MMSEA, which suspends the application of the percentage threshold payment adjustment at § 412.536 of the regulations (or any similar provision) to ''freestanding'' LTCHs for 3 years. The commenters asserted that this provision should also apply to discharges from LTCHs and LTCH satellites that were admitted from hospitals which are co-located with another LTCH or LTCH satellite. One commenter additionally rejects ''CMS' assertion'' that a LTCH located on a different campus from a referring hospital is functioning as a step-down unit. This commenter argues that our regulations at § 412.534 were directed at movement of patients between co-located LTCHs admitted from their host hospitals and our regulations at § 412.536 were developed to address the relationship between LTCH hospitals that were ''freestanding'' and their referring hospitals. This commenter additionally rejects ''CMS' assertion'' that a LTCH located on a different campus from a referring hospital can function as ''a

step-down unit'' of the referring hospital. One of the commenters requested that even if CMS does not exempt LTCH facilities co-located with a different host from the regulations at § 412.536 for 3 years, that CMS include LTCHs that are located on hospital campuses where there is no inpatient acute care hospital in the 3-year exemption from the regulations under § 412.536. Another commenter urged CMS to revisit our definition of ''freestanding'' at § 412.23(e)(5) of our regulations so that a LTCH or LTCH satellite that was co-located with a provider that did not offer inpatient care in the building or campus where the LTCH was located, could still be considered ''freestanding'', and therefore, covered by the 3-year exemption from the regulations at § 412.536, maintaining that this was Congress' intent in section 114(c)(1)(A) of the MMSEA.

Response: We disagree with the commenters' assertion that LTCH HwHs that are co-located with another hospital, as defined in our regulations at § 412.22(e) should be considered ''freestanding'' regarding patients admitted from referring hospitals with which they are not co-located. We believe that our existing regulations at § 412.22(e) which identify a HwH as ''* * * a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital * * *'' are clear and unambiguous. Section 114(c)(1)(A) of the MMSEA is directed at ''freestanding long-term care hospitals,'' and is equally clear and unambiguous. Although we initially focused on the movement of patients between ''host'' acute care hospitals and the co-located LTCH HwHs or satellites when we implemented the regulations at § 412.534 in the FY 2005 IPPS final rule (69 FR 48916), a comment that we received from MedPAC at that time, discussed previously in this section, identified similar problems between acute care hospitals and LTCHs with which they were not co-located (69 FR 49211).

We first expressed our concerns in the RY 2006 LTCH PPS final rule (71 FR 27798) that some LTCHs and referring hospitals (typically, acute care hospitals) with which they were not co-located had ''arrangements'' that, in effect, allowed both facilities to benefit financially from an early acute care discharge and admission to the LTCH. We recognized that these ''arrangements'' were strikingly similar to what we knew occurred between a ''host'' acute care hospital and its on-site LTCH, that is, as a step-down unit (71 FR 27878). At that time, we noted that we ''* * * had become increasingly aware that the intent of our existing policy is being thwarted by creative patient-shifting in some communities where there is more than one LTCH HwH or LTCH satellite. We have come to understand, based upon specific inquiries from LTCHs, and their attorneys or agents, and also from questions posed by our fiscal intermediaries (FIs), that some host hospitals within the same community are arranging to cross-refer to another's co-located LTCH * * *.'' (71 FR 27878). It was with these concerns in mind, that in the RY 2008 LTCH PPS proposed and final rules, our preamble discussion was entitled ''Expansion of Special Payment Provisions for LTCH Hospitals Within Hospitals (HwHs) and LTCH Satellites: Expansion of the 25 Percent Rule to Certain Situations Not Currently Covered Under Existing § 412.534'' (72 FR 4809; 72 FR 26919). Furthermore, when we developed our regulation at § 412.536 in the RY 2007 LTCH PPS final rule (72 FR 26870), we entitled the regulation, ''Special payment provisions for long-term care hospitals and satellites of long-term care hospitals that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite of the long-term care hospital.'' Clearly, it was always our intention for § 412.536 to apply the percentage threshold payment adjustment to patient shifting between LTCHs and LTCH satellites and referring hospitals with which they were not co-located, a fact that further supports our implementation of section 114(c)(1) of the MMSEA.

In response to the commenter who requested that even if we were not willing to exempt LTCHs co-located with a different host from the percentage threshold payment adjustment at § 412.536, we should include co-located LTCHs that are situated on hospital campuses where there is no inpatient acute care hospital in the 3-year exemption from regulation under § 412.536, we would note section 4302(a)(1)(C) of the ARRA addressed this concern and amended section 114(c)(1)(A) of the MMSEA to specify that LTCHs and LTCH satellites meeting this description be exempted from the percentage threshold payment adjustment at § 412.536 or any similar provision. (We discuss this provision in the interim final rule with comment period for section 4203 of the ARRA, in section XI. of this document.)

Finally, in response to the commenter that urged us to revisit our definition of ''freestanding'' at § 412.23(e)(5) so that a LTCH or LTCH satellite facility that was co-located with a provider that did not offer inpatient care in the building or campus where the LTCH was located, could still be considered ''freestanding,'' so that it would be exempted from compliance with § 412.536, we would note that such a change would directly contradict our long-standing, existing definitions of HwHs and satellites at § 412.22(e) and § 412.22(h), respectively. At § 412.22(e), we define a HwH as ''* * * a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital * * *'' At § 412.22(h),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.'' Neither of these definitions limits the buildings with which a HwH or a satellite is co-located to solely providing inpatient services.

When Congress enacted the ARRA, it amended section 114(a)(1)(A) of the MMSEA to delay the application of the percentage threshold payment adjustments at §§ 412.534 and 412.536 to certain LTCHs for 3-years. Specifically, at section 4302(a)(1)(C), the statute includes the following type of facility: ''* * *. a LTCH or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Social Security Act at the off-campus location * * *'' The statute expressly targets ''services payable under section 1886(d) of the Act,'' not ''inpatient services,'' in general and the plain language of the statute does not indicate that such a LTCH or satellite facility would be considered ''freestanding.'' Rather, the amendment identifies another category of LTCH or satellite facility that would be exempt from the percentage threshold payment adjustment for 3 years. Therefore, we believe that, in amending section 114(c)(1)(A) of the MMSEA through section 4302(a)(1)(C) of the ARRA, Congress expanded the 3-year exemption from the percentage threshold payment adjustment to a narrow category of LTCHs, while still maintaining the policy for LTCHs otherwise meeting the definition of either a HwH at § 412.22(e) or a satellite at § 412.22(h) of the regulations. Because Congress did not further

expand this exemption by way of statutory amendment, we do not believe that it would be appropriate for us to do so through the regulatory process.

Comment: Several commenters requested guidance regarding the procedures that CMS has in place to implement the changes to the percentage threshold payment adjustment required by the MMSEA. In particular, some of these commenters asked how CMS would recommend that they get information regarding the discharge percentages of MSA-dominant referring hospitals if the LTCH is serviced by a different fiscal intermediary/MAC than the referring hospital.

Response: We have provided our fiscal intermediaries/MACs with guidance on the actual implementation of this payment adjustment, which takes place upon cost report settlement, when all of the LTCHs data from a particular cost reporting period has been submitted and is being evaluated. Regarding the question of how a LTCH or satellite can acquire information about its MSA-dominant referring hospital's ''market share'' of Medicare patients if the facilities are serviced by a different fiscal intermediary/MAC, we have been informed that portals to communicate this figure, and much more, are typically open on an ongoing basis among hospitals that have referral arrangements, and therefore, we would encourage the sharing of such information for the benefit of both the discharging and the admitting hospitals.

In compliance with section 114(c) of the MMSEA and section 4302 of the ARRA, we have revised §§ 412.534 and 412.536 of the regulations to implement the 3-year delay in the application of the percentage patient threshold payment adjustment to ''freestanding and grandfathered LTCHs'' and the 3-year revision in the percentage payment thresholds adjustments for ''applicable'' LTCHs and satellite facilities. We have also revised the regulations at § 412.534(b) in order to clarify the effective dates of the percentage patient threshold policy for discharges from a LTCH HwH or from a LTCH satellite that were admitted from the hospital with which it is co-located.

We are finalizing the regulatory changes made in the May 22, 2008 interim final rule with comment period at §§ 412.534 and 412.536, which implemented the provisions of section 114(c) of the MMSEA that were otherwise unchanged by section 4302 of the ARRA. We also are implementing section 4302 of the ARRA through an interim final rule with comment period in section XI. of this document.

E. May 22, 2008 Interim Final Rule With Comment Period Implementing Section 114(d) of the MMSEA Regarding Moratorium on the Establishment of LTCHs, LTCH Satellite Facilities, and on the Increase in Number of Beds in Existing LTCHs or LTCH Satellite Facilities

1. Background

Section 114(d) of the MMSEA provides a 3-year moratorium with two distinct aspects, one regarding the establishment of new LTCHs and LTCH satellite facilities, and the other regarding the increase of hospital beds in existing LTCHs and LTCH satellite facilities. Specifically, section 114(d)(1)(A) of the MMSEA provides that the Secretary shall impose a moratorium ''subject to paragraph (2), on the establishment and classification of a long-term care hospital or satellite facility, other than an existing long-term care hospital or facility.'' Section 114(d)(1)(B) of the MMSEA provides that, the Secretary shall impose a moratorium ''subject to paragraph (3), on an increase of long-term care hospital beds in existing long-term care hospitals or satellite facilities.''

Sections 114(d)(2) and (d)(3) of the MMSEA provide for exceptions to both moratoria imposed by section 114(d)(1) of the MMSEA. The three exceptions specified in section 114(d)(2) of the MMSEA apply exclusively to the establishment and classification of certain LTCHs or LTCH satellite facilities while the exception at section 114(d)(3)(A) of the MMSEA only applies to the moratorium on increases in beds at certain existing LTCHs or LTCH satellites facilities. In the May 22, 2008 interim final rule with comment period, we implemented section 114(d) of the MMSEA.

Section 4302(b) of the ARRA amended section 114(d)(3)(A) of the MMSEA to establish an additional exception to the moratorium on increases in beds at LTCHs and LTCH satellite facilities at section 114(d)(3)(A) by stating that ''* * * if the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007''. This additional exception is being implemented through the interim final rule with comment period that is found in section XI. of this document.

2. Provisions of the May 22, 2008 Interim Final Rule With Comment Period Implementing Section 114(d) of the MMSEA That Established Moratoria on New LTCHs and LTCH Satellite Facilities and on Bed Increases in Existing LTCHs and LTCH Satellite Facilities

Section 114(d)(1)(A) of the MMSEA provides for a 3-year moratorium effective beginning on the date of enactment of the MMSEA, December 29, 2007, through December 28, 2010, on the establishment and classification of a long-term care hospital or satellite facility, other than an existing LTCH or facility. (The term ''existing,'' with respect to a hospital or satellite facility, is defined in section 114(d)(4) of the MMSEA as ''a hospital or satellite facility that received payment under the provisions of subpart O of part 412 of title 42, Code of Federal Regulations, as of the date of the enactment of this Act.'') Section 114(d)(2) of the MMSEA specified that the moratorium on the establishment and classification of a LTCH or LTCH satellite facility does not apply to a LTCH that, as of December 29, 2007, met one of the following three exceptions:

- The LTCH began ''its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal regulations, on or before the date of enactment of this Act'' (section 114(d)(2)(A) of the MMSEA).
- The LTCH has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a LTCH and has expended before December 29, 2007, at least 10 percent of the estimated cost of the project or, if less, $2,500,000 (section 114(d)(2)(B) of the MMSEA).
- The LTCH has obtained an approved certificate of need in a State where one is required on or before December 29, 2007 (section 114(d)(2)(C) of the MMSEA).

In the May 22, 2008 interim final rule with comment period, we noted that in implementing the provisions of section 114(d) of the MMSEA, we found that, in light of the unique nature of LTCHs as a category of Medicare providers, some of the terminology in the provision was internally inconsistent. Therefore, in that interim final rule with comment period, we included a comprehensive description of inconsistent terminology and our interpretations of the provisions in a way we believed reasonably reconciled seemingly inconsistent provisions and that resulted in an application of the provisions that is logical and workable and we would

direct the reader to that discussion (73 FR 29705).

The first exception to the moratorium at section 114(d)(2)(A) of the MMSEA addressed the circumstance of an existing hospital that was already in its qualifying period for LTCH designation, as governed by our regulations at § 412.23(e) on or before December 29, 2007 (73 FR 29705).

At section 114(d)(2)(B) of the MMSEA, a second exception to the moratorium was made for a long-term care hospital that, as of the date of the enactment of the MMSEA (December 29, 2007), satisfied the two prongs of the exception: (1) it has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital; and (2) it has expended, before the date of enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000).''

In the May 22, 2008 interim final rule with comment period, we implemented this provision in the following manner: With regard to the first prong, we believe that the use of the term ''actual'' in the context of the, ''actual construction, renovation, lease, or demolition,'' indicates that the provision focused only on the specific accomplishments cited in the MMSEA and did not include those that were contemplated or had not yet been executed. We noted that, although we were aware that a hospital or entity could have entered into binding written agreements regarding services and items (for example, feasibility studies or land purchase) and incur costs for those services and items prior to actual construction, renovation, lease or demolition, Congress did not include those services or items in the statute as a basis for the exception (73 FR 29706).

With respect to the second prong, we understood the statute to specify that the hospital or entity must have expended before December 29, 2007, at least 10 percent of the estimated cost of the project (or, if less, $2.5 million). By ''cost of the project,'' we believe the statute refers to the activities enumerated in the first prong: ''The actual construction, renovation, lease, or demolition for a long-term care hospital.'' The statute requires that the hospital or entity spend the amount specified in the statute on the actual construction, renovation, lease, or demolition for the contemplated LTCH.

Furthermore, because the statute uses the phrase ''has expended'' we believe that the statute required that a hospital or entity would have actually transferred funds as payment for the project as opposed to merely obligating capital and posting the cost of the project on its books as of December 29, 2007. We believe that the provision addressed the concept of ''obligate'' in the first prong of the test where the statute specifies ''a binding written agreement * * * for the actual construction, renovation, lease, or demolition of the long-term care hospital* * *'' and there is no reason to believe that the second prong of the test, which requires the ''expenditure'' of 10 percent of the project or if less, $2,500,000, was intended as a redundancy. We noted that the ability to post the expense on the hospital's or entity's books could be satisfied by merely having a binding written agreement under the first prong of section 114(d)(2)(B) of the MMSEA. The fact that a second requirement was included that involved an expenditure indicated to us that an additional threshold had to be met.

Finally, in the May 22, 2008 interim final rule with comment period, we stated that we believed that section 114(d)(2)(C) of the MMSEA provided an exception for a long-term care hospital that, as of the date of the enactment of the MMSEA, ''has obtained an approved certificate of need, in a State where one is required, on or before the date of the enactment of this Act.'' We do not believe that the provision limited the exception to only an existing long-term care hospital that had obtained an approved certificate of need to create a new satellite of the LTCH. We noted that in many instances, prior to being classified as a LTCH, a hospital is built by an entity with the express intention of making it into a LTCH as soon as possible. In those instances, it is not uncommon for the entity to obtain a certificate of need from the State prior to the development of the hospital (73 FR 29706).

We understood the certificate of need exception to apply to a hospital or entity that was actively engaged in developing a LTCH, as evidenced by the fact that either an entity that wanted to create a LTCH but did not exist as a hospital as of December 29, 2007, had obtained a certificate of need for a hospital by the date of enactment, or that an existing hospital had obtained a certificate of need to convert the hospital into a new LTCH by that date. However, this exception would not apply to a hospital that was already in existence prior to the date of enactment and that had previously obtained an approved certificate of need for a hospital (other than a LTCH) on or before December 29, 2007. The fact that a hospital may have had a certificate of need issued to it years before December 29, 2007, to operate a hospital (other than a LTCH) would not be a reason to grant it an exception, unless that certificate of need was specifically for a LTCH. Since the certificate of need process is controlled at the State level, in determining whether the hospital or entity has obtained an approved certificate of need on or before December 29, 2007, we stated that we would look to the State for that determination (73 FR 29706).

3. Public Comments Received on the May 22, 2008 Interim Final Rule With Comment Period Provisions Implementing the Exception to the Moratorium on the Increase in Number of LTCHs Beds in Existing LTCHs and LTCH Satellite Facilities

In the May 22, 2008 interim final rule with comment period, we implemented section 114(d)(1)(B) of the MMSEA, which imposed a moratorium on existing LTCHs or LTCH satellite facilities for the 3-year period beginning December 29, 2007, through December 28, 2010. The moratorium was on an increase of LTCH beds in existing LTCHs or LTCH satellite facilities. Therefore, during the 3-year moratorium, an existing LTCH or LTCH satellite facility would not be able to increase the number of beds in excess of the number of Medicare-certified beds at the hospital on December 29, 2007. Section 114(d)(3) of the MMSEA provided one exception to the moratorium on an increase of beds. Specifically, section 114(d)(3)(A) of the MMSEA states that the moratorium on an increase in beds shall not apply if an existing LTCH or LTCH satellite facility is ''located in a State where there is only one other long-term care hospital; and requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State.''

Section 114(d)(3)(B) of the MMSEA also specified that the exception to the moratorium on the increase in bed numbers for existing LTCHs or LTCH satellite facilities did not apply to the existing limit on the number of beds in ''grandfathered'' LTCH HwHs as specified at § 412.22(f), and LTCH satellite facilities, as specified at § 412.22(h)(3) of the regulations. Under § 412.22(f) and § 412.22(h)(3), respectively, ''grandfathered'' LTCH HwHs and LTCH satellite facilities, (that is, HwHs that were in existence on or before September 30, 1995, and LTCH satellite facilities that were in existence on or before September 30, 1999, and that meet certain specified conditions) are exempted from compliance with ''separateness and control'' policies as

long as they do not increase their bed numbers. (See the FY 2007 IPPS final rule (71 FR 48106 through 48115).) Therefore, even if a ''grandfathered'' LTCH HwH or LTCH satellite facility was located in a State where there was only one other LTCH and it requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State, it would not be able to maintain its grandfathered status if it would increase the number of beds at the LTCH under this exception.

We noted in the May 22, 2008 interim final rule with comment period that decisions regarding whether a specific situation would be considered to meet the exceptions to the establishment and classification of new LTCHs or new LTCH satellite facilities or the exceptions on increasing the number of beds in existing LTCHs or LTCH satellite facilities will be made on a case-by-case basis by the applicant's fiscal intermediary/MAC and the CMS Regional Office (RO). After the publication of the May 22, 2008 interim final rule with comment period, we issued specific instructions on implementing the moratorium in the form of memoranda to State Survey Agency Directors, CMS ROs, and fiscal intermediaries/MACs, the policy was added to the manual in Pub. 100–20 as change request (CR) 6172, and we provided specific policy interpretations and guidance to the regional offices.

As discussed more fully in section XI. of this document, section 4302(b) of the ARRA amended section 114(d)(3)(A) of the MMSEA by establishing an additional exception to the moratorium on the increase in beds at certain LTCHs and LTCH satellites. Specifically, this exception allows an existing LTCH to expand the number of beds at the hospital or satellite facility if it had obtained a certificate of need (CON) for an increase in beds in a State for which such a certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007. This additional exception is being implemented through the interim final rule with comment period in section XI. of this document by amending § 412.23(e)(7) of the regulations. Accordingly, we will not address those comments that urged us to establish this exception through regulation.

In the May 22, 2008 interim final rule with comment period, we revised our regulations at § 412.23 to include a description of the moratorium on the establishment of new LTCHs and LTCH satellites and the moratorium on increasing the number of beds in existing LTCHs and existing LTCH satellites and statutory exceptions at §§ 412.23(e)(5) and (e)(6). Additionally, in § 412.23(e)(5), we defined a freestanding LTCH.

Comment: Two commenters requested that CMS clarify its interpretation of section 114(d)(2)(C) of the MMSEA, which allowed the CON exception to apply to the development of a satellite. The particular circumstance described by the commenters involved issues of relocation of a planned satellite, for which a CON had been issued prior to December 29, 2007, but the planned host hospital had since been closed. Since the original CON had been issued prior to the enactment of the MMSEA, the commenters asked for an advance determination to allow the development of the planned satellite located in a hospital that has not as yet been determined.

Response: In the May 22, 2008 interim final rule with comment period, regarding the CON exception for the establishment of new LTCHs and LTCH satellites we stated ''[s]ince the certificate of need process is controlled at the State level, in determining whether the hospital or entity has obtained an approved certificate of need on or before December 29, 2007, we will look to the State for that determination'' (73 FR 29706). Regarding the specific situation presented by the commenters, we would note that when we were first made aware of this problem, we were in contact with the State agency and were informed that the LTCH that had obtained the CON for the planned satellite had not yet found a new ''host'' for its planned satellite. We have evaluated the situation that the commenters described in concert with the State agency responsible for issuing the CON and have instructed State agencies that if a CON has been modified, revised, amended or otherwise altered, the State Survey Agency would need to indicate to CMS whether it considered this modified, revised, amended or otherwise altered CON to be the ''same'' CON for purposes of meeting the requirements for the exception to the moratorium. The CMS RO will review and evaluate the CON documentation and determine whether it qualifies for the exception.

Comment: Two commenters endorsed CMS' interpretation of the statutory language in section 114(d) of the MMSEA, which included applying the provisions of the section to satellite facilities and/or to ''an entity that will develop a hospital that will ultimately become a LTCH.''

Response: We thank the commenters for their support.

Comment: One commenter stated that the exception to the moratorium stipulated in section 114(d)(2)(A) of the MMSEA for a LTCH in '' * * * qualifying period for payment under section 412.23(e) * * * on or before the date of enactment of this Act'' should be extended to include satellite facilities if it can be demonstrated that the satellite was under development prior to December 29, 2007.

Response: The exception to the moratorium specified at section 114(d)(2)(A) of the MMSEA is not applicable to a LTCH satellite because there is no qualifying period for the establishment of a satellite (73 FR 29705). Although there are delineated requirements that a LTCH must meet regarding the establishment of a satellite at § 412.22(h)(2) of the regulations, the ''qualifying period'' for a LTCH, is established in our regulations at § 412.23(e). Specifically, in order for to be designated as a LTCH, a facility must have a ''provider agreement under Part 489 [of the Medicare regulations] to participate as a hospital'' and the hospital must have a Medicare average length of stay greater than 25 days based on data for the hospital's most recent complete cost report. Once length of stay data are submitted to the hospital's fiscal intermediary or MAC and verified, (unless the hospital is co-located with another hospital, and then it must also meet the HwH criteria at § 412.22(e) of the regulations), it will be designated as a LTCH and paid under the LTCH PPS beginning with its next cost reporting period. The period of time beginning when a hospital begins participation in the Medicare program as a hospital and when it is designated as an LTCH is the ''qualifying'' period. A LTCH (or other excluded hospital) may establish a satellite if it demonstrates to its fiscal intermediary/MAC that it independently meets the regulatory requirements for the provider-type of the hospital of which it is a part at § 412.22(h)(ii) and also meets the separateness and control requirements set forth in § 412.22(h)(iii). Because the LTCH of which the satellite is a part has met the regulatory requirements at § 412.23(e), there would be no ''qualifying period'' for a LTCH satellite.

A new LTCH satellite, however, could qualify for an exception to the moratorium if it meets either of the exceptions established at section 114(d)(2)(B) or section 114(d)(2)(C) of the MMSEA and implemented in our regulations at §§ 412.23(e)(6)(ii)(B) and 412.23(e)(6)(ii)(C), respectively. Either of these exceptions could be applicable to a LTCH satellite. The regulations at § 412.23(e)(6)(ii)(B) specify that the

moratorium is not applicable if on or before December 29, 2007, the LTCH ''[h]as a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease or demolition for a long-term care hospital; and [h]as expended, before December 29, 2007, at least 10 percent (or, if less, $2.5 million) of the estimated cost of the project specified in paragraph (ii)(B)(1) of this paragraph.'' At § 412.23(e)(6)(ii)(C) of our regulations, we specify that the moratorium is not applicable if on or before December 29, 2007, the LTCH ''[h]ad obtained an approved certificate of need from the State, when required by State law.'' Therefore, although the ''qualifying period'' exception at section 114(d)(2)(A) to the moratorium is not relevant to the development of a LTCH satellite, it is possible that a new satellite could be completed under the moratorium if either of the above described exceptions were met.

Comment: Five commenters disagreed with CMS' interpretation of section 114(d)(2)(B) of the MMSEA. This section provides for an exception to the moratorium that specifies that the moratorium shall not apply to a LTCH (or satellite) that as of the date of enactment of the MMSEA (December 29, 2007) ''has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or if less, $2,500,000). * * *'' Three commenters argued that the sentence structure indicates that the two prongs of this exception are separate and that the second prong is not dependent upon the first. Under their interpretation, the ''binding contract'' clause is entirely separate from the ''has expended'' clause. Furthermore, the commenters stated that when Congress chose the term ''expended'' to describe the level of financial commitment required on the ''project'' in order to meet the second prong's test, the commenters believed that Congress meant to use the word ''obligated.'' Additionally, the five commenters stated that under their ''correct'' interpretation, Congress intended that the ''* * * at least 10 percent of the estimated cost of the project (or, if less, $2,500,000)'' refers to the entire costs of developing the planned LTCH, not the four activities specified in the first prong, that is, ''the actual construction, renovation, lease, or demolition for a long-term care hospital * * *.'' Several commenters argued that feasibility studies, land purchase, architectural fees, attorneys fees, appraisals, purchase of right-of-way, as well as other activities that occur during the development of a hospital, should be included in this definition. Several members of Congress urged CMS to extend the moratorium exceptions to several LTCHs in their districts that would otherwise not meet the second prong of the exception under our interpretation and note that opening these additional LTCHs is in the public interest. Two hospitals in a partnership to develop a LTCH and their Congressional representatives stated that, unless CMS revises its interpretation to include the purchase of land, these partnered hospitals would be subject to a great financial burden and their community would be deprived of a needed service.

Response: We continue to believe that our interpretation of section 114(d)(2)(B) of the MMSEA, as implemented in the May 22, 2008 interim final rule with comment period, accurately implements the statute in establishing an exception to the moratorium on new LTCHs and satellites. The policy takes into consideration, as of the date of enactment of the statute, the ''actual'' level of financial expenditures on the four specific, verifiable activities taken in preparation of the development of a LTCH or satellite that are cited in the statute. This exception states that the moratorium shall not apply to ''a long-term care hospital that as of the date of the enactment of this Act—* * *. (B) has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000).* * *''

We described this exception in the May 22, 2008 interim final rule with comment period, as having two prongs. The first prong is the clause prior to the ''and,'' that is, the ''binding written agreement with an outside, unrelated party for the 'actual' construction, renovation, lease, or demolition * * *.'' The second prong is the ''has expended'' clause and its limit, following the term ''and.'' We disagree with the commenters' assertions that in the second prong the ''has expended'' clause (following the ''and'' in the above statutory text) is separate from the first prong and not dependent upon it. The conjunctive ''and'' clearly makes meeting both prongs a requirement to qualify for this exception to the moratorium. We further disagree with the commenters' hypothetical arguments that the ''cost of the project'' in the second prong does not refer to the cost of the four activities Congress specified in the first prong (''actual construction, renovation, lease, or demolition * * *'').

We note again that Congress expressly specified only four ''actual'' activities in the statute. We also believe, as we stated in the May 22, 2008 interim final rule with comment period, that that the use of the term ''actual'' in the context of the phrase, ''actual construction, renovation, lease, or demolition,'' limited the activities that Congress considered to represent a significant benchmark in that particular project of developing a LTCH or a LTCH satellite facility.

With respect to the second prong, we also continue to understand the statute to specify that the hospital or entity must have expended before December 29, 2007, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000). By ''cost of the project,'' we believe the statute refers to the activities enumerated in the first prong: ''the actual construction, renovation, lease, or demolition for a long-term care hospital.'' We believe the statute requires that the hospital or entity ''* * * has expended * * *;'' the amount specified in the statute on the actual construction, renovation, lease, or demolition for the contemplated LTCH, not just that both prongs are met, with no intended interdependence. In other words, we believe that the two prongs of the exception at section 114(d)(2)(B) of the MMSEA are linked together, with the second clause detailing the conditions under which the first one would qualify.

Furthermore, because the statute uses the phrase ''has expended'' we continue to believe, as we indicated in the May 22, 2008 interim final rule with comment period, that the statute requires that a hospital or entity would have actually transferred funds as payment for the project as opposed to merely obligating capital and posting the cost of the project on its books as of December 29, 2007. As we noted, the ability to post the expense on the hospital's or entity's books could be satisfied by merely having a binding written agreement under the first prong of section 114(d)(2)(B) of the MMSEA. Had Congress allowed merely ''obligated'' funds to be included in the calculation of the 10 percent of the estimated cost of the project (or, if less, $2,500,000) we believe that the term ''obligated'' would have been chosen rather than the term ''expended.''

We understand the concerns expressed by several commenters,

including Congressional representatives, that our interpretation of the exception to the moratorium at section 114(d)(2)(B) may cause hardship to LTCHs under development that could not meet the ''expenditure'' prong unless cost of the purchase of land is included. However, as explained earlier, we continue to believe the statute clearly indicates what costs may be included. Furthermore, we note that the ARRA made several changes to the language in section 114 of the MMSEA. If Congress intended that other costs, such as the cost of the land should be considered, it could have amended the MMSEA accordingly.

Comment: One commenter urged CMS to use its discretion to authorize its fiscal intermediaries and MACs to evaluate and potentially approve other LTCH projects that do not fit perfectly within one of the enumerated exceptions to the moratorium but that ''meet the intent of the moratorium.''

Response: When we implemented the moratorium provision in the May 22, 2008 interim final rule with comment period, we noted that Congress was very specific in enumerating the conditions under which it granted exceptions to the moratorium on the development of new LTCHs and LTCH satellites and on the increase in the number of beds in existing LTCHs, in sections 114(d)(2) and (d)(3) of the MMSEA. The ARRA amended section 114(d)(3)(A) of the MMSEA, and established an additional CON exception for bed increases in LTCHs and LTCH satellites. (We discuss this amendment in detail in an interim final rule with comment period in section XI. of this document.) Congress made only the single change specified in the ARRA when it amended the moratorium provision in section 114(d) of the MMSEA. Because this was the sole change made by Congress in the exceptions to the moratorium established under section 114(d) of the MMSEA, we do not believe that it is appropriate for us to further interpret these exceptions through the regulatory process.

Comment: Several commenters asked us to clarify what activities on the part of either an existing LTCH or an existing satellite would continue to be permissible under section 114(d)(1) of the MMSEA. Specifically, the commenters asked the following questions: (1) Is an existing LTCH or an existing satellite permitted to relocate; (2) may a LTCH under development that meets the moratorium exception at section 114(d)(2)(A), (B), or (C) undergo a change in ownership without imperiling the exception; (3) may an existing LTCH merge with another LTCH; (4) are two satellites of the same LTCH permitted to consolidate; (5) how does the moratorium affect a remote location of a LTCH; (6) is a LTCH permitted to reduce its bed numbers and open a remote location (not a satellite) with those beds so that there is no increase in bed numbers under the LTCH's provider number; and (7) does the moratorium have any impact on the ability of a new IRF or IPF to co-locate with an existing LTCH without affecting its Medicare certification?

Response: In response the commenters' specific concerns regarding our implementation of section 114(d) of the MMSEA, we will take this opportunity to set forth the policy determinations on permissible actions by LTCHs and satellites during the moratorium that we have given individually to a number of targeted inquiries from LTCHs, trade associations, consultants, and attorneys. Specifically, following the numbering of the questions in the comment above, our responses are below:

(1) An existing LTCH or an existing LTCH satellite may relocate in accordance with State survey agency policies as long as there is no increase in the number of beds in the LTCH or in the satellite at the new site. For example, if the State surveyors would typically allow LTCH ''A'' with 100 beds to move to a building 8 miles away and it maintains the same provider agreement, the moratorium would not preclude the re-opening of the 100 bed LTCH in the new location. However if the LTCH has a new provider agreement at the new location, it would be a new LTCH and therefore subject to the moratorium.

(2) A new LTCH that meets one (or more of) the exceptions at sections 114(d)(2)(A), (B) and (C) of the MMSEA, may undergo a change of ownership and may still qualify for the exception, if certain requirements are met. Specifically, if meeting the ''qualifying period'' exception at section 114(d)(2)(A) of the MMSEA is the exception being claimed, a change of ownership where the new owner takes over the original provider agreement would not affect the hospital's qualification for an exception. If the hospital or entity is claiming that it meets the exception set forth at section 114(d)(2)(B), that is, that it has a ''binding written agreement * * * and * * * has expended * * * at least 10 percent of the estimated cost of the project (or if less, $2,500,000) * * *,'' but the developing entity was sold, eligibility for the exception can be granted to the original owner. However, a determination would be made by the CMS RO which initially granted the exception as to whether it is still the same LTCH or entity that would meet the requirements of section 114(c)(2)(B) of the MMSEA. Finally, if the hospital or entity that is developing the LTCH is basing its exception on section 114(c)(2)(C) of the MMSEA, that is, that a CON was obtained in a State where one was required on or before December 29, 2007, a determination would need to be made by the State Agency on whether the CON that was originally issued was transferable to a new owner or whether a new CON would be required in order to proceed. If a new CON is required, the hospital or entity would not meet the statutory December 29, 2007 deadline and therefore, would not qualify for an exception to the moratorium.

(3) We would apply CMS' longstanding policy regarding hospital mergers so that the merger of two LTCHs would result in one LTCH's provider number being voluntarily terminated and the other serving as the provider number for the new entity. The moratorium on the increase in hospital beds would apply to the sum of the beds that existed in both LTCHs as of December 29, 2007. This determination parallels our approach to determining appropriate caps on the number of residents under our GME payment adjustment when hospitals merge so that any additional statutory or regulatory limit on residency positions in the merged entity would be imposed on top of the sum of the positions that had been available in each hospital prior to the merger (64 FR 26329).

(4) Two satellites of the same LTCH would not be permitted to consolidate during the 3-year moratorium. The reason for this is that the result of the satellites consolidating would be an increase in the number of beds in one satellite, which is precluded by section 114(d)(1)(B) of the MMSEA.

(5) Section 114(d) of the MMSEA does not subject remote locations of a LTCH to the moratorium, but we emphasize that it would be essential to determine that the facility in question is actually a ''remote location'' and not a satellite of a LTCH. If the ''remote location'' is located on the campus of another hospital, it is defined as a satellite, under § 412.22(h) of the regulations, and, therefore, subject to the moratorium. A remote location of a LTCH that was not a satellite, because it is provider-based and not co-located with another hospital, however, would operate under the provider number of its main LTCH. Therefore, where establishing a remote location adds beds under that provider number, in the

aggregate, it is subject to the moratorium.

(6) If a LTCH adds a provider-based location that does not increase the aggregate number of beds at the LTCH, because it has decreased the number of beds at the main campus by at least an equivalent number of beds, the LTCH would not have violated the moratorium.

(7) The moratorium provision at section 114(d) of the MMSEA would have no impact on whether an IRF or an IPF could co-locate with an existing LTCH. All providers that would be affected by the co-location, however, would be required to comply with ''separateness and control'' regulations at § 412.22(e) and the existing LTCH would be required to meet the notification requirements at § 412.22(e)(3).

Comment: One commenter requested that CMS view ''obtaining a new provider number'' under circumstances where there is an acquisition of another facility as the same as when there is an assumption of an existing number and, therefore, covered by the exemption from the moratorium.

Response: As we stated in the previous response, under our existing regulations at § 489.18, which govern change of ownership and its effect on provider agreements, there is a significant difference between whether a LTCH is acquired and it functions under the same provider agreement as prior to the acquisition compared to a situation where a new provider agreement is sought when a hospital changes ownership. Since the cessation of service under an existing provider agreement is considered a termination of the provider agreement for the duration of the moratorium, obtaining a new provider agreement for a LTCH would be tantamount to developing a new LTCH, an activity that is precluded unless one of the statutory exceptions, discussed in detail above, was met. We encourage the commenter to review our regulations at 42 CFR part 489 Subpart E. These regulations address the distinction between these two alternatives and specify the requirements and consequences of both.

Comment: Three commenters stated that it is their understanding that an increase in ''non-Medicare certified beds'' is permitted under the moratorium established under section 114(d)(3) of the MMSEA.

Response: The commenters' understanding is incorrect. All beds in a LTCH with an agreement to participate in the Medicare program must be available to Medicare beneficiaries. We used the term ''Medicare certified beds'' in the May 22, 2008 interim final rule with comment period in order to specify how we would count the actual number of beds in an existing LTCH or satellite after the MMSEA was enacted. At that time, we noted that we were using the number of beds certified by Medicare, because this number could be verified by CMS and its contractors and this was currently referenced in our regulations at § 412.22(h)(2)(i), and similarly referenced in § 412.22(f)(1) (73 FR 29706 and 29707). We did not mean to imply that there could be some hospital beds that would be available for non-Medicare patients but would not be available for use by Medicare beneficiaries.

After considering the public comments we received, we are finalizing the regulatory changes at §§ 412.22.(e)(5) and (e)(6) implementing section 114(d) of the MMSEA that we included in the May 22, 2008 interim final rule with comment period.

We once again note that the amendments to both section 114(c) and (d) of the MMSEA made by the ARRA are being implemented in an interim final rule with comment period in section XI. of this document.

XI. Interim Final Rule With Comment Period Implementing Section 4302 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) Relating to Payments to LTCHs and LTCH Satellite Facilities

A. Background

Section 4302 of the American Recovery and Reinvestment Act (ARRA) (Pub. L. 111–5) affects several of the provisions of section 114 of the MMSEA (Pub. L. 110–173) that are discussed in section X. of the preamble of this document. Specifically, section 4302 of the ARRA amended several of the provisions of section 114 of the MMSEA, to be effective and applicable as if the amendments had been included in the MMSEA. Some of the ARRA amendments address issues raised by commenters regarding our May 22, 2008 interim final rule with comment period (73 FR 29699). (In section X. of the preamble of the final rule in this document, we respond to comments received on the May 22, 2008 interim final rule with comment period, and finalize the policies implementing section 114(c) of the MMSEA that were not amended by the ARRA.)

B. Amendments Relating to Payment Adjustment to LTCHs and LTCH Satellite Facilities Made by Section 4302 of the ARRA

Sections 114(c)(1)(A) and (B) of the MMSEA established a 3-year delay, for cost reporting periods beginning on or after December 29, 2007, for freestanding LTCHs (defined at § 412.23(e)(5) of the regulations) and ''grandfathered'' long-term care HwHs, from the application of the percentage threshold payment adjustment established under § 412.536 or § 412.534, respectively, or any similar provision. Section 4302(a)(1) of the ARRA amended the provisions of sections 114(c)(1)(A) and (B) of the MMSEA as follows:

First, under section 4302(a)(1)(A) of the ARRA, the heading of section 114(c)(1) is changed to ''Delay in Application of 25 Percent Patient Threshold Payment Adjustment'' from the original ''No Application of 25 Percent Patient Threshold Payment Adjustment to Freestanding and Grandfathered LTCHs.''

Second, under section 4302(a)(1)(B) of the ARRA, the effective date of the delay in application of the 25 percent patient threshold payment adjustment found in section 114(c)(1) of the MMSEA is changed from the date of enactment of the MMSEA (that is, December 29, 2007) to July 1, 2007. As a result, a ''grandfathered'' long-term care HwH or a ''freestanding'' LTCH with a cost reporting period beginning before December 29, 2007, would no longer be subject to the applicable payment adjustments at § 412.534(h) and § 412.536 until the start of its next cost reporting period. This is the case because our regulations at § 412.534(h), with respect to ''grandfathered'' LTCHs, and § 412.536 with respect to all LTCHs, were implemented for cost reporting periods beginning on or after July 1, 2007. Therefore, the amendment made by section 4302(a)(1)(B) of the ARRA to section 114(c)(1) of the MMSEA results in a uniform start of the application of the statutory 3-year relief from the 25 percentage threshold payment adjustment.

Third, section 4302(a)(1)(C) of the ARRA adds, for 3 years, a third category of LTCHs that will not be subject to §§ 412.534 and 412.536 of the regulations, or any similar provision of the regulations for a 3-year period for cost reporting periods beginning on or after July 1, 2007. Specifically, section 4302(a)(1)(C) of the ARRA extends the 3-year exemption from the percentage threshold payment adjustments at §§ 412.534 and 412.536 to include

''* * * a long-term care hospital, or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Social Security Act at the off-campus location * * *.'' Therefore, no percentage threshold (and therefore, no payment adjustment) will be applied for patients discharged from an acute care hospital who are admitted to a LTCH or LTCH satellite facility that is co-located with an entity that is a provider-based, off-campus location of an acute care hospital (as set forth in our regulations at § 413.65) as long as there are no inpatient acute care hospital services payable under section 1886(d) of the Act offered at that off-campus location. For example, this would apply to a situation where an acute care hospital, that Medicare pays under the IPPS, is located on the main campus of a multicampus entity and, on a second campus of that acute care hospital, the LTCH shares a building with an IRF unit or an outpatient clinic that is provider-based to the acute care hospital but there are no services payable under the IPPS hospital provided at that second campus.

Section 114(c)(2) of the MMSEA provided, for a 3-year period, increases in the percentage thresholds (''payment adjustments'') established under § 412.534 of the regulations for ''applicable'' LTCHs or satellite facilities for cost reporting periods beginning on or after December 29, 2007. Specifically, if the threshold percentage would have been 25 percent, for 3 years it will increase to 50 percent; and if the threshold would have been 50 percent prior to the enactment of the MMSEA, it will increase to 75 percent. The term ''applicable'' was defined as ''* * * a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42 of the Code of Federal Regulations.'' The revisions made by section 114(c)(2) of the MMSEA were limited to a hospital or a satellite subject to the transition rules at § 412.534(g) of the regulations. Because ''grandfathered'' LTCH satellite facilities were subject to the transition at § 412.534(h) of the regulations, not at § 412.534(g), the percentage increase resulting from the application of section 114(c)(2) did not apply to them (73 FR 29703).

Section 4302(a)(2)(A) of the ARRA modified the definition of ''applicable long term care hospital or satellite facility.'' This provision amended section 114(c)(2)(B)(ii) of the MMSEA by specifying that those ''grandfathered satellites'' described in § 412.22(h)(3)(i) of the regulations were to be included in the definition. (Under § 412.22(h)(3)(i), ''grandfathered'' satellites were exempted from compliance with the ''separateness and control'' rules specified in § 412.22(h) if they had been structured as a satellite facility on or before September 30, 1999.) However, we note that ''grandfathered satellites'' under § 412.22(h)(3) of the regulations continue to be subject to the applicable percentage thresholds outlined in § 412.536 for patients admitted from any individual hospital with which they were not co-located because there were no exceptions for such entities for purposes of payment as described at § 412.536 of the regulations.

Section 114(c)(2)(C) of the MMSEA applied the 3-year increase in the percentage thresholds at § 412.534 of the regulations for cost reporting periods beginning on or after the date of enactment of the MMSEA (December 29, 2007). Section 4302(a)(2)(B) of the ARRA revised the effective date of the MMSEA provisions to increase the applicable percentages to cost reporting periods beginning on or after October 1, 2007, for LTCHs and LTCH satellite facilities that were subject to the transition rules under § 412.534(g) and also established the effective date as cost reporting periods beginning on or after July 1, 2007, ''* * * in the case of a satellite facility described in section 412.22(h)(3)(i) of title 42 of the Code of Federal Regulations.'' (Different dates are applicable because the effective date for the 25 percent threshold payment adjustment policy for LTCHs and LTCH satellite facilities governed under § 412.534(g) of the regulations was October 1, 2005, while the percent threshold for ''grandfathered'' LTCH satellite facilities policy was effective for cost reporting periods beginning on or after July 1, 2007.)

The result of this modification in the effective date of the 3-year increase in the percentage threshold for ''applicable'' LTCHs and LTCH satellite facilities (now including ''grandfathered satellites'') is that LTCHs and LTCH satellite facilities will not have the fully phased-in 25 percentage threshold payment adjustment applied for cost reporting periods beginning on or after October 1, 2007, and ''grandfathered'' satellite facilities will not be subject to the transition to the 25 percentage threshold for cost reporting periods beginning on or after July 1, 2007.

To implement the provisions of section 4302 of the ARRA, in this interim final rule with comment period, we are revising our regulations at §§ 412.534 and 412.536 to reflect the statutory revisions described above.

C. Amendment to the Moratorium on the Increase in Number of Beds in Existing LTCHs or LTCH Satellite Facilities Made by Section 4302 of the ARRA

Section 114(d) of the MMSEA provided a 3-year moratorium on the increase of hospital beds in existing LTCHs and LTCH satellite facilities. (The definition of an existing LTCH and LTCH satellite facility for purposes of this policy is codified at § 412.23(e)(7)(i) of our regulations.) Section 114(d) of the MMSEA includes exceptions to the moratorium on the increase in hospital beds in existing LTCHs and LTCH satellite facilities. Specifically, section 114(d)(3)(A) of the MMSEA provided that the moratorium on the increase in beds in an existing LTCH or LTCH satellite facility would not apply to an increase in beds if an existing LTCH or LTCH satellite facility is ''located in a State where there is only one other long-term care hospital; and requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State.''

Section 4302(b) of the ARRA added an additional exception to the bed-increase moratorium in an existing LTCH or LTCH satellite facility ''* * * if the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which such certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007.''

Accordingly, in this interim final rule with comment period, we are revising our regulations at § 412.23(e)(7)(B) to include this new exception to the moratorium on an increase in the number of beds in existence in an existing LTCH or LTCH satellite facility beyond those in existence on December 29, 2007. In the May 22, 2008 interim final rule with comment period, in our discussion of the original exception to the moratorium on bed increases at section 114(d)(3)(A) of the MMSEA, and in our regulations at §§ 412.23(e)(7)(ii)(A) and (e)(7)(ii)(B)(*2*) added in that interim final rule with comment period, we noted that the baseline number of beds that existed on December 29, 2007, was the number of Medicare-certified beds because this number can be verified by CMS and its contractors and this is currently referenced in our regulations at § 412.22(h)(2)(i), and in a similar reference in § 412.22(f)(1) (73 FR 29706 and 29707). However, we emphasize that, in employing the term ''Medicare-

certified beds,'' we are not implying that there is distinction between ''Medicare-certified beds'' and some additional group of beds in the hospital that are reserved for non-Medicare patients and, therefore, not included in this total. A hospital participates in the Medicare program in its entirety; that is, all beds in a hospital with a provider agreement with the Medicare program are available for use by Medicare beneficiaries.

As we specified in our discussion in the May 22, 2008 interim final rule with comment period regarding implementation of the certificate of need exception to the development of new LTCHs and LTCH satellite facilities provided in section 114(d)(2)(C) of the MMSEA and codified at § 412.23(e)(6)(ii)(C) of our regulations, decisions regarding whether a specific situation will be considered to meet the certificate of need exception established by the section 4302(b) of the ARRA, which modifies section 114(d)(3)(A) of the MMSEA, on the increase in the number of beds in existing LTCHs or LTCH satellite facilities, will be determined on a case-by-case basis by the applicant's State agency, which will make recommendations to the CMS regional office. (The ARRA included no amendments to section 114(d) of the MMSEA regarding the moratorium on the development of new LTCHs and LTCH satellite facilities. Therefore, we have finalized our regulations regarding this provision at § 412.23(e)(6) as discussed in section X. of the preamble of the final rule in this document.)

Finally, section 4302(c) of the ARRA specifies that the ''* * * effective date of the amendments made by this section shall be effective and apply as if included in the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007'' (Pub. L. 110–173).

Accordingly, in this interim final rule with comment period, we are revising our regulations at § 412.23 to include a description of the additional exception to the moratorium on the establishment of new beds in existing LTCHs and LTCH satellite facilities.

D. Responses to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge and respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this document, and, when we proceed with a subsequent document, we will respond to the comments in the preamble of that document.

E. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking and invite public comment on a proposed rule in accordance with 5 U.S.C. 553(b) of the Administrative Procedure Act (APA). In addition, section 1871(b)(1) of the Act provides that the Secretary shall provide for notice of the proposed regulation in the **Federal Register** and a period of not less than 60 days for public comment thereon. Section 1871(b)(2) of the Act provides for an exception to the requirement that the Secretary provide for notice of a proposed rulemaking and a period of not less than 60 days for public comment. Specifically, section 1871(b)(2)(B) of the Act provides an exception to these requirements when a law establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained. Section 4302 of the ARRA amended sections 114(c) and (d) of the MMSEA and changed existing LTCH PPS policies. It affected the adjustment policies in § 412.534 and § 412.536 of our regulations. It also revised a moratorium on bed increases in existing LTCHs and LTCH satellite facilities affecting policies in § 412.23 of our regulations. These changes were required to be implemented as if included in the enactment of the MMSEA 2007, that is, December 29, 2007. Accordingly, these changes are required to be implemented: (1) Effective December 29, 2007 (section 4302(c) of the ARRA); (2) beginning with cost reporting periods beginning on or after December 29, 2007 (section 4302(b) of the ARRA); or beginning with cost reporting periods beginning on or after July 1, 2007, or October 1, 2007, as applicable (sections 4302(a)(1)(B) and (a)(2)(B) of the ARRA). The ARRA was enacted on February 17, 2009. Thus, section 4302 of the ARRA's deadlines for implementation of the MMSEA-related policies contained in this interim final rule with comment period were less than 150 days after the date of the enactment of the statute in which the deadlines were contained.

Therefore, under the authority of section 1871(b)(2)(B) of the Act, we are waiving notice and comment procedures for the AARA amendments to the MMSEA policy changes pertaining to §§ 412.534 and 412.536 of our regulations as well as the moratorium on increasing beds at an existing LTCH and an existing satellite facility of a LTCH in § 412.23.

We also find good cause to waive the requirement for publication of a notice of proposed rulemaking and comment on the grounds that it is unnecessary, impracticable and contrary to the public interest under the authority of 5 U.S.C. 553(b)(B). In general, this interim final rule with comment period sets forth nondiscretionary provisions of the amendments made by section 4302 of the ARRA to section 114 of the MMSEA with respect to a moratorium on the increase of long-term care hospital beds in existing LTCHs or LTCH satellite facilities, and payment policies pertaining to §§ 412.534 and 412.536 of our regulations. Therefore, we believe pursuing notice and comment is unnecessary.

Moreover, because that process would prevent timely implementation of congressionally mandated policy changes that are to be effective, as described previously in this section, we believe notice and comment procedures are impracticable and contrary to the public interest.

In addition, notice and comment would delay significantly the issuance of essential guidance to the public which is necessary to assist them in making complex, time-sensitive business decisions of significant financial consequence with respect to their efforts to comply with section 114 of the MMSEA as amended by section 4302 of the ARRA. Failure to provide this guidance would impede such business decisions.

Section 1871(e)(1)(A) of the Act provides that a substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change unless the Secretary determines that (i) such retroactive application is necessary to comply with statutory requirements; or (ii) failure to apply the change retroactively would be contrary to the public interest. As explained above, the amendments made by section 4302 of the ARRA to section 114 of the MMSEA requires the Secretary to implement various policy changes beginning with cost reporting periods beginning on or after July 1, 2007, October 1, 2007, or December 29, 2007 as applicable.

Therefore, under the authority of section 1871(e)(1)(A)(i) of the Act, we are making the provisions of this interim final rule with comment period that implement section 4302 of the ARRA effective for cost reporting periods beginning on or after July 1, 2007, October 1, 2007, or December 29, 2007, as applicable. Additionally, as

explained previously, the Secretary also finds that it would be contrary to the public interest if these provisions were not made effective on December 29, 2007 or for cost reporting periods beginning on or after July 1, 2007, October 1, 2007, or December 29, 2007, as indicated above. Therefore, under the authority of section 1871(e)(1)(A)(ii) of the Act, we are making these changes effective under the timeframes noted above.

For the same reasons noted above, we find good cause under section 553(d)(3) of the APA to waive the 30-day delay in the effective date of this interim final rule with comment period.

F. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

G. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

The enactment of section 4302 of the ARRA, which amended provisions of sections 114(c) and (d) of the MMSEA, requires several modifications to the regulations at §§ 412.534 and 412.536, which, as discussed in section XI.C. of this interim final rule with comment period, exempts an additional category of LTCHs and LTCH satellites from the applicability of the regulations at §§ 412.534 and 412.536 for 3 years and for the same 3 years, adds ''grandfathered'' LTCH satellites to those ''applicable'' LTCHs that, under the MMSEA, have an increase in the threshold percentage of patients that may be admitted from co-located referring hospitals (typically acute care hospitals) without a payment adjustment. The effective date of these MMSEA provisions was also amended by sections 4302(a)(1)(B) and (a)(2)(B) of the ARRA so that, rather than December 29, 2007, the effective dates for the section 114 of the MMSEA changes to the regulations at §§ 412.534 and 412.536 are set respectively, at July 1, 2007, or October 1, 2007, as applicable.

In the May 22, 2008 interim final rule with comment period, we estimated that the implementation of the MMSEA provisions pertaining to §§ 412.534 and 412.536 would result in a projected increase of approximately $30 million in estimated aggregate LTCH PPS payments for RY 2008 (73 FR 29708). Although we are unable to quantify the impact of the ARRA amendments to the MMSEA provisions, we believe that there will be a small increase in the number of LTCHs and LTCH satellites that will now be included in the 3-year delay in the application of §§ 412.534 and 412.536 and also the percentage threshold increase. We also believe that setting back the effective dates for those MMSEA provisions from December 29, 2007 to either July 1, 2007 or October 1, 2007, as applicable, will not, in the aggregate, have a significant impact on Medicare payments under the LTCH PPS.

Section 4302(b) of the ARRA amended section 114(d) of the MMSEA, which provided for a moratorium on the establishment of LTCHs, LTCH satellite facilities, and on the increase of LTCH beds in existing LTCHs or satellite facilities for a period of 3 years, by adding another exception to the 3-year moratorium. In the May 22, 2008 interim final with comment period, we noted that, in regard to section 114(d) of the MMSEA, we were unable to provide an estimate of the impact of the moratorium provisions because we had no way of determining how many LTCHs would have opened in the absence of the moratorium, nor did we have sufficient information at that time to determine how many new LTCHs will meet the exceptions criteria provided for in the statute (73 FR 29708). For the same reason, we are unable to provide an estimate of the impact of section 4302(b) of the ARRA, which added an additional exception to the moratorium on an increase in beds in existing LTCHs and LTCH satellites. However, we do not believe that distributional effects and estimated changes to the Medicare program payments resulting from section 4302 of the ARRA, which amended sections 114(c) and (d) of the MMSEA, would be greater than $100 million. Therefore, we have determined that this interim final rule with comment period would not be considered a major economic rule, as defined in this section.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7 million to $34.5 million in any 1 year. (For further information, see the Small Business Administration's regulation at 70 FR 72577, December 6, 2005.) Individuals and States are not included in the definition of a small entity. Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary LTCHs. Therefore, we assume that all LTCHs are considered small entities for the purpose of this impact discussion. Medicare fiscal intermediaries and MACs are not considered to be small entities. As we discuss in detail throughout the preamble of this interim final rule with comment period, we believe that the provisions specified by the MMSEA presented in this interim final rule with comment period would result in an increase in estimated aggregate LTCH PPS payments. Accordingly, the Secretary certifies that this interim final rule with comment period would not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. As stated above, implementing the provisions specified by the ARRA that are discussed in this interim final rule with comment period will result in an increase in estimated aggregate LTCH PPS payments. Therefore, we believe this rule will not have a significant impact on small rural hospitals. Accordingly, the Secretary certifies that this interim final rule with comment period would not have a significant economic impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also

requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2009, that threshold level is currently approximately $133 million. This interim final rule with comment period would not mandate any requirements for State, local, or tribal governments, nor would it result in expenditures by the private sector of $133 million or more in any 1 year.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because this regulation does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

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

XI. MedPAC Recommendations

Under section 1886(e)(4)(B) of the Act, the Secretary must consider MedPAC's recommendations regarding hospital inpatient payments. Under section 1886(e)(5) of the Act, the Secretary must publish in the annual proposed and final IPPS rules the Secretary's recommendations regarding MedPAC's recommendations. We have reviewed MedPAC's March 2009 ''Report to the Congress: Medicare Payment Policy'' and have given the recommendations in the report careful consideration in conjunction with the policies set forth in this final rule.

MedPAC's Recommendation 2A–1 states that ''[t]he Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2010 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.'' This recommendation is discussed in Appendix B to this final rule.

MedPAC's Recommendation 2A–2 states that ''[t]he Congress should reduce the indirect medical education adjustment in 2010 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the indirect medical education adjustment should be used to fund a quality incentive payment program.''

Response to Recommendation 2A–2: Redirecting funds obtained by reducing the IME adjustment to fund a quality incentive payment program is consistent with the value-based purchasing initiatives to improve the quality of care. However, section 502(a) of Public Law 108–173 modified the formula multiplier (c) to be used in the calculation of the IME adjustment beginning midway through FY 2004 and provided for a new schedule of formula multipliers for FYs 2005 and thereafter. Consequently, given the existing statutory requirement regarding the IME formula multiplier, CMS does not have the authority to implement MedPAC's recommendation to reduce the IME adjustment in FY 2010.

Comment: One commenter objected to MedPAC's recommendation 2A–2, although the commenter acknowledged that CMS does not have the authority to implement the recommendation. The commenter believed that it is ''highly inappropriate'' to reduce payments to teaching hospitals in order to fund a quality incentive program for all hospitals. The commenter stated that the impropriety of the recommendation is highlighted by MedPAC's own analysis of margin variation in hospitals, which the commenter believed supported the assertion that teaching hospitals are ''the class of hospitals least able to afford a reduction.'' While the commenter commended this margin analysis by MedPAC, the commenter remained disappointed that MedPAC restated its recommendation 2A–2 from 2008.

Response: We appreciate the commenter's input regarding MedPAC's recommendations. We remind the public that, as stated in the proposed rule, CMS does not have the authority to implement the changes to IME payments as recommended by MedPAC.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653–7226, or visit MedPAC's Web site at: *http://www.medpac.gov*.

XII. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are now available on compact disc (CD) format. However, many of the files are available on the Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS*. We listed the data files and the cost for each file, if applicable, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24233 through 24234).

Commenters interested in discussing any data used in constructing the proposed rule or this final rule should contact Nisha Bhat at (410) 786–5320.

B. Collection of Information Requirements

1. Legislative Requirement for Solicitation of Comments

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

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

2. Requirements in Regulation Text

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24234 through 24236), we solicited public comments on each of the issues listed in section XII.B.1. of this preamble for the following sections of this document that contain information collection requirements (ICRs). We discuss and respond to any public comments we received in each individual section.

a. ICRs Regarding Payment Adjustment for Medicare DSHs (§ 412.106)

As discussed in section V.E. of the preamble of this final rule, § 412.106(b)(4)(iv) permits hospitals to count Medicaid eligible inpatient days in the numerator of the Medicaid fraction of the DPP in the DSH payment adjustment calculation by one of the following methodologies, as long as no such days are counted more than once for any hospital in a cost reporting period: date of discharge; date of admission; or dates of service. To avoid ''double counting,'' a hospital is required to report to CMS any changes to the methodology it uses to count days in the numerator of the Medicaid fraction of the DPP. The burden

associated with this requirement is the time and effort necessary for a hospital to report to CMS changes to the methodology it uses to count days in the numerator of its Medicaid fraction of the DPP.

This requirement is subject to the PRA. While we believe the burden is minimal, we are unable to accurately quantify the burden because we cannot estimate the number of expected submissions from hospitals reporting changes to their respective methodology for counting days in the numerator of the Medicaid fraction of the DPP for the Medicare DSH payment adjustment calculation.

We did not receive any public comments on this ICR. While we are still not able to accurately quantify the burden associated with this ICR, because we cannot estimate the number of expected submissions from hospitals, we will review each submission on a case-by-case basis. If we determine that the number of submissions may exceed the threshold of 10 or more persons in a 12-month period, as defined in 5 CFR 1320.3(c)(4), we will develop an information collection request as part of the formal OMB approval process.

b. ICRs Regarding Payments for GME (§ 413.75)

Existing regulations at § 413.75(b) permit hospitals that share residents to elect to form a Medicare GME affiliated group if they are in the same or contiguous urban or rural areas, if they are under common ownership, or if they are jointly listed as program sponsors or major participating institutions in the same program. The purpose of a Medicare GME affiliated group is to provide flexibility to hospitals in structuring rotations under an aggregate FTE resident cap when they share residents. The existing regulations at § 413.79(f)(1) specify that each hospital in a Medicare GME affiliated group must submit a Medicare GME affiliation agreement (as defined under § 413.75(b)) to the Medicare fiscal intermediary or MAC servicing the hospital and send a copy to CMS' Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

In section V.G.3. of the preamble of this final rule, we discuss our proposed and final policy to amend the regulations to specify that a hospital that is new after July 1 and that begins training residents for the first time after the July 1 start date of that academic year is permitted to submit a Medicare GME affiliation agreement prior to the end of its cost reporting period in order to participate in an existing Medicare GME affiliated group for the remainder of the academic year. The burden associated with this requirement is the time and effort it would take for the new hospital to develop and submit the Medicare GME affiliation agreement. It is difficult for us to estimate the annual burden associated with this requirement because we cannot estimate the additional number of hospitals that will be permitted to submit Medicare GME affiliation agreements in any given year as a result of the change. However, we believe the number of affected hospitals will be very small because, under the change, a hospital will not only have to start training residents after July 1, but will also need to be a new hospital after July 1. We note that this requirement will merely apply established procedures to provide increased flexibility to a new hospital to join an existing GME affiliated group such that, in its first year, it may train and receive IME and direct GME payments relating to FTE for residents that could otherwise be counted for purposes of IME and direct GME at another hospital. We believe the expansion of the existing policy regarding the submission of Medicare GME affiliation agreements for hospitals that are new after July 1 and that begin to train residents after July 1 will amount to a minimal paperwork burden.

We did not receive any public comments on this ICR. While we are still not able to accurately quantify the burden because we cannot estimate the number of expected submissions from hospitals, we will review each submission on a case-by-case basis. If we determine that the number of submissions may exceed the threshold of 10 or more persons in a 12-month period, as defined in 5 CFR 1320.3(c)(4), we will develop an information collection request as part of the formal OMB approval process.

C. Additional Information Collection Requirements

This final rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this final rule also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

1. Present on Admission (POA) Indicator Reporting

Section II.F.6. of the preamble of this final rule discusses the POA indicator reporting program. As stated earlier, collection of POA indicator data is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision and for broader public health uses of Medicare data. Through Change Request 5499 dated May 11, 2007, CMS issued instructions that require IPPS hospitals to submit POA indicator data for all diagnosis codes on Medicare claims. The burden associated with this requirement is the time and effort necessary to place the appropriate POA indicator codes on Medicare claims. This requirement is subject to the PRA; however, the associated burden is currently approved under OMB control number 0938–0997 with an expiration date of August 31, 2009.

2. Add-On Payments for New Services and Technologies

Section II.I.1. of the preamble of this final rule discusses add-on payments for new services and technologies. Specifically, this section states that applicants for add-on payments for new medical services or technologies for FY 2011 must submit a formal request. A formal request includes a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement. In addition, the request must contain a significant sample of the data to demonstrate that the medical service or technology meets the high-cost threshold. We detailed the burden associated with this requirement in the September 7, 2001, IPPS final rule (66 FR 46902). As stated in that final rule, collection of the information for this requirement is conducted on an individual case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6). Similarly, we also believe the burden associated with this requirement is exempt from the PRA under 5 CFR 1320.3(c), which defines the agency collection of information subject to the requirements of the PRA as information collection imposed on 10 or more persons within any 12-month period. This information collection does not impact 10 or more entities in a 12-month period. In FYs 2008, 2009, and 2010, we received 1, 4, and 5 applications, respectively.

We did not receive any public comments on this ICF.

3. Reporting of Hospital Quality Data for Annual Hospital Payment Update

As discussed in section V.A. of the preamble of this final rule, the

RHQDAPU program was originally established to implement section 501(b) of Public Law 108–173, thereby expanding our voluntary Hospital Quality Initiative (HQI). The RHQDAPU program originally consisted of a ''starter set'' of 10 quality measures. OMB approved the collection of data associated with the original starter set of quality measures under OMB control number 0938–0918, with a current expiration date of January 31, 2010.

As part of our implementation of section 5001(a) of the DRA, we expanded the number of quality measures reported in the RHQDAPU program. Specifically, section 1886(b)(3)(B)(viii)(III) of the Act, added by section 5001(a) of the DRA, requires that the Secretary expand the ''starter set'' of 10 quality measures that were established by the Secretary as of November 1, 2003, to include measures ''that the Secretary determines to be appropriate for the measurement of the quality of care furnished by hospitals in inpatient settings.'' Under this provision, we established additional program measures to bring the total number of measures to 30. The burden associated with these reporting requirements is currently approved under OMB control number 0938–1022, with a current expiration date of June 30, 2011.

In the FY 2009 IPPS proposed rule (73 FR 23527), we solicited public comments on several considerations for expanding and updating quality measures. We responded to the public comments received in the FY 2009 IPPS final rule (73 FR 48433). We also expanded and finalized the RHQDAPU program measure set for FY 2010. As part of the expansion effort, two measures were finalized in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68781). In this FY 2010 IPPS final rule, as we proposed, we are adding a total of four new measures, to harmonize two existing measures, and to retire one measure, which will increase the total number of measures in the RHQDAPU program from 42 in FY 2010 to 46 in FY 2011. Specifically, we are adding four new measures, two new chart abstracted measures, and two new structural measures. The new chart abstracted measures include the addition of SCIP-Infection-9: Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2, and SCIPInfection-10: Perioperative Temperature Management to the existing SCIP measure set. As stated in V.A.3. of the preamble of this final rule, the new structural measures include (1) Participation in a Systematic Clinical Database Registry for Stroke Care; and (2) Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care. We are submitting a revised version of the information collection request approved under OMB control number 0938–1022, to obtain approval for the new measures.

Section V.A.9. of the preamble of the proposed rule and this final rule addresses the reconsideration and appeal procedures for a hospital that we believe did not meet the RHQDAPU program requirements. If a hospital disagrees with our determination, it may submit a written request to CMS to reconsider our decision. The hospital's letter must explain the reasons why it believes it did meet the RHQDAPU program requirements. While this is a reporting requirement, the burden associated with it is not subject to the PRA under 5 CFR 1320.4(a)(2). The burden associated with information collection requirements imposed subsequent to an administrative action is not subject to the PRA.

4. Occupational Mix Adjustment to the FY 2010 Index (Hospital Wage Index Occupational Mix Survey)

Section II.D. of the preamble of this final rule discusses the occupational mix adjustment to the FY 2010 wage index. While the preamble does not contain any new ICRs, it is important to note that there is an OMB approved information collection request associated with the hospital wage index. Section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data at least once every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program in order to construct an occupational mix adjustment to the wage index. We collect the data via the occupational mix survey.

The burden associated with this information collection requirement is the time and effort required to collect and submit the data in the Hospital Wage Index Occupational Mix Survey to CMS. The aforementioned burden is subject to the PRA; however, it is currently approved under OMB control number 0938–0907, with an expiration date of February 28, 2011.

We did not receive any public comments of this provision in the proposed rule.

5. Hospital Applications for Geographic Reclassifications by the MGCRB

Section III.I.3. of the preamble of this final rule discusses revisions to the wage index based on hospital redesignations. As stated in that section, under section 1886(d)(10) of the Act, the MGCRB has the authority to accept short-term IPPS hospital applications requesting geographic reclassification for wage index or standardized payment amounts and to issue decisions on these requests by hospitals for geographic reclassification for purposes of payment under the IPPS. The burden associated with this application process is the time and effort necessary for an IPPS hospital to complete and submit an application for reclassification to the MGCRB. While this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0573, with an expiration date of December 31, 2011.

We did not receive any public comments on the ICR for this provision in the proposed rule.

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs—health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

■ For the reasons stated in the preamble of this final rule, the Centers for Medicare & Medicaid Services is amending 42 CFR Chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Public Law 106–113 (113 Stat. 1501A–332).

■ 2. Section 412.22 is amended by revising paragraph (h)(2)(iii)(A) to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(h) * * *

(2) * * *

(iii) * * *

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it 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.

(*1*) Except as provided in paragraph (h)(2)(iii)(A)(*2*) of this section, effective for cost reporting periods beginning on or after October 1, 2009, the governing body of the hospital of which the satellite facility is a part is not under the control of any third entity that controls both the hospital of which the satellite facility is a part and the hospital with which the satellite facility is co-located.

(*2*) If a hospital and its satellite facility were excluded from the inpatient prospective payment system under the provisions of this section for the most recent cost reporting period beginning prior to October 1, 2009, the hospital does not have to meet the requirements of paragraph (h)(2)(iii)(A)(*1*) of this section, with respect to that satellite facility, in order to retain its IPPS-excluded status.

(*3*) A hospital described in paragraph (h)(2)(iii)(A)(*2*) of this section that establishes an additional satellite facility in a cost reporting period beginning on or after October 1, 2009, must meet the criteria in this section, including the provisions of paragraph (h)(2)(iii)(A)(*1*) of this section with respect to the additional satellite facility, in order to be excluded from the inpatient prospective payment system.

* * * * *

■ 3. Section 412.23 is amended by revising paragraph (e)(7)(ii) to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(e) * * *

(7) *Moratorium on increasing the number of beds in existing long-term care hospitals and existing long-term care hospital satellite facilities.*

* * * * *

(ii) Effective for the period beginning December 29, 2007 and ending December 28, 2010—

(A) Except as specified in paragraph (e)(7)(ii)(B) and (C) of this section, the number of Medicare-certified beds in an existing long-term care hospital or an existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section must not be increased beyond the number of Medicare-certified beds on December 29, 2007.

(B) Except as specified in paragraph (e)(7)(ii)(C) of this section, the moratorium specified in paragraph (e)(7)(ii)(A) of this section is not applicable to—

(*1*) An existing long-term care hospital or existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section that meets both of the following requirements:

(*i*) Is located in a State where there is only one other long-term care hospital that meets the criteria specified in § 412.23(e) of this subpart.

(*ii*) Requests an increase in the number of Medicare-certified beds after the closure or decrease in the number of Medicare-certified beds of another long-term care hospital in the State; or

(*2*) An existing long-term care hospital or existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section that obtained a certificate of need for an increase in beds and that meets both of the following requirements:

(i) Is in a State for which such certificate of need is required, and

(ii) Such certificate was issued on or after April 1, 2005, and before December 29, 2007.

(C) The exceptions specified in paragraph (e)(7)(ii)(B) of this section do not affect the limitation on increasing beds under § 412.22(f) and § 412.22(h)(3) of subpart.

* * * * *

■ 4. Section 412.64 is amended by revising paragraph (c) to read as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(c) *Computing the standardized amount.* CMS computes an average standardized amount that is applicable to all hospitals located in all areas, updated by the applicable percentage increase specified in paragraph (d) of this section. CMS standardizes the average standardized amount by excluding an estimate of indirect medical education payments.

* * * * *

§ 412.87 [Amended]

■ 5. In § 412.87, paragraph (b)(1), remove the word ''relating'' and add in its place the word ''relative''.

■ 6. Section 412.103 is amended by adding a new paragraph (a)(5) to read as follows:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) * * *

(5) For any period after September 30, 2009, and before October 1, 2011, a CAH in a county that, in FY 2009, was not part of an MSA as defined by the Office of Management and Budget, but, as of FY 2010, was included as part of an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on November 20, 2008, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement in § 485.610(b) of this chapter if it meets any of the requirements under paragraph (a)(1), (a)(2), or (a)(3) of this section.

* * * * *

■ 7. Section 412.105 is amended by revising paragraph (b)(4) to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(b) * * *

(4) Beds otherwise countable under this section used for outpatient observation services or skilled nursing swing-bed services, or ancillary labor/delivery services;

* * * * *

■ 8. Section 412.106 is amended by—

■ a. Revising paragraph (a)(1)(ii)(B).

■ b. Adding a new paragraph (b)(4)(iv).

The revision and addition read as follows:

§ 412.106 Special treatment: Hospitals that service a disproportionate share of low-income patients.

(a) * * *

(1) * * *

(ii) * * *

(B) Beds otherwise countable under this section used for outpatient observation services or skilled nursing swing-bed services;

* * * * *

(b) * * *

(4) * * *

(iv) For cost reporting periods beginning on or after October 1, 2009, the hospital must report the days in the numerator of the fraction in the second computation in a cost reporting period based on the date of discharge, the date of admission, or the dates of service. If a hospital seeks to change its methodology for reporting days in the numerator of the fraction in the second computation, the hospital must notify CMS, through its fiscal intermediary or MAC, in writing at least 30 days before the beginning of the cost reporting

period in which the change would apply. The written notification must specify the methodology the hospital will use, the cost reporting period to which the requested change would apply, and the current methodology being used. Such a change will be effective only on the first day of a cost reporting period. If a hospital changes its methodology for reporting such days, CMS or the fiscal intermediary or MAC may adjust the number of days reported for a cost reporting period if it determines that any of those days have been counted in a prior cost reporting period.

* * * * *

§ 412.113 [Amended]

■ 9. In paragraph (c)(2)(i)(B) of § 412.113, the cross-reference ''§ 410.66'' is removed and the cross-reference ''§ 410.69'' is added in its place.

§ 412.322 [Amended]

■ 10. Section 412.322 is amended by removing and reserving paragraphs (c) and (d) to read as follows:

■ 11. Section 412.523 is amended by adding a new paragraph (c)(3)(vi) to read as follows:

§ 412.523 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) * * *

(3) * * *

(vi) *For long-term care hospital prospective payment system rate year beginning October 1, 2009 and ending September 30, 2010.* The standard Federal rate for long-term care hospital prospective payment system rate year beginning October 1, 2009 and ending September 30, 2010 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by 2.0 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

* * * * *

■ 12. Section 412.525 is amended by—

■ a. Revising paragraph (a)(2).

■ b. Revising paragraph (d)(1).

■ c. Adding a new paragraph (d)(5).

The revisions and addition read as follows:

§ 412.525 Adjustments to the Federal prospective payment.

(a) * * *

(2) The fixed-loss amount is determined for the long-term care hospital rate year using the LTC–DRG relative weights that are in effect on the start of the applicable long-term care hospital prospective payment system rate year, as defined in § 412.503.

* * * * *

(d) * * *

(1) Short-stay outliers, as provided for in § 412.529.

* * * * *

(5) Long-term care hospitals and satellites of long-term care hospitals that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite of the long-term care hospital, as provided in § 412.536.

■ 13. Section 412.534 is amended by revising paragraphs (c) through (e), and (h) to read as follows:

§ 412.534 Special payment provisions for long-term care hospitals within hospitals and satellites of long-term care hospitals.

* * * * *

(c) *Patients admitted from the hospital located in the same building or on the same campus as the long-term care hospital or satellite facility.* Except for a long-term care hospital or a long-term care hospital satellite facility that meets the requirements of paragraphs (d) or (e) of this section, payments to the long-term care hospital for patients admitted to it or to its long-term care hospital satellite facility from the co-located hospital are made under either of the following:

(1) *For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2010.* (i) Except as provided in paragraphs (g) and (h) of this section, for any cost reporting period beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2010 in which the long-term care hospital or its satellite facility has a discharged Medicare inpatient population of whom no more than 25 percent were admitted to the hospital or its satellite facility from the co-located hospital, payments are made under the rules at §§ 412.500 through 412.541 in this subpart with no adjustment under this section.

(ii) Except as provided in paragraph (g) or (h) of this section, for any cost reporting period beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2010 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 25 percent threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that would be determined under the rules at § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at §§ 412.500 through 412.541 with no adjustment under this section.

(iii) In determining the percentage of patients admitted to the long-term care hospital or its satellite from the co-located hospital under paragraphs (c)(1)(i) and (c)(1)(ii) of this section, patients on whose behalf an outlier payment was made to the co-located hospital are not counted towards the 25 percent threshold.

(2) *For cost reporting periods beginning on or after October 1, 2007 and before October 1, 2010.* (i) Except for a long-term care hospital or a long-term care hospital satellite facility subject to paragraph (g) or (h) of this section, payments are determined using the methodology specified in paragraph (c)(1) of this section.

(ii) Payments for a long-term care hospital or long-term care hospital satellite facility subject to paragraph (g) of this section are determined using the methodology specified in paragraph (c)(1) of this section except that 25 percent is substituted with 50 percent.

(3) *For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010.* Payments for a long-term care hospital satellite facility described in § 412.22(h)(3)(i) are determined using the methodology specified in paragraph (c)(1) of this section except that 25 percent is substituted with 50 percent.

(d) *Special treatment of rural hospitals.* (1) *For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2010.* (i) Subject to paragraphs (g) and (h) of this section, in the case of a long-term care hospital or satellite facility that is located in a rural area as defined in § 412.503 and is co-located with another hospital for any cost reporting period beginning on or after October 1, 2004 and before October 1, 2007 and for any cost reporting period beginning on or after October 1, 2010 in which the long-term care hospital or long-term care satellite

facility has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for discharged patients who were admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that were otherwise payable under § 412.1(a). Payments for the remainder of the long-term care hospital's or long-term care hospital satellite facility's patients are made under the rules in this subpart at §§ 412.500 through 412.541 with no adjustment under this section.

(ii) In determining the percentage of patients admitted from the co-located hospital under paragraph (d)(1)(i) of this section, patients on whose behalf outlier payment was made at the co-located hospital are not counted toward the 50 percent threshold.

(2) *For cost reporting periods beginning on or after October 1, 2007, and before October 1, 2010.* (i) Except for a long-term care hospital or a long-term care hospital satellite facility subject to paragraph (g) or (h) of this section, payments are determined using the methodology specified in paragraph (d)(1) of this section.

(ii) Payments for long-term care hospitals and long-term care hospital satellite facilities subject to paragraph (g) of this section are determined using the methodology specified in paragraph (d)(1) of this section except that 50 percent is substituted with 75 percent.

(3) *For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010.* Payments for a long-term care hospital satellite facility described in § 412.22(h)(3)(i) are determined using the methodology specified in paragraph (d)(1) of this section except that 50 percent is substituted with 75 percent.

(e) *Special treatment of urban single or MSA-dominant hospitals.* (1) *For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2010.* (i) Subject to paragraphs (g) and (h) of this section, in the case of a long-term care hospital or a long-term care hospital satellite facility that is co-located with the only other hospital in the MSA or with a MSA-dominant hospital as defined in paragraph (e)(1)(iv) of this section, for any cost reporting period beginning on or after October 1, 2004, and before October 1, 2007 and for any cost reporting periods beginning on or after October 1, 2010, in which the long-term care hospital or long-term care hospital satellite facility has a discharged Medicare inpatient population of whom more than the percentage calculated under paragraph (e)(1)(ii) of this section were admitted to the hospital from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital to exceed the applicable threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that otherwise would be determined under § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart with no adjustment under this section.

(ii) For purposes of paragraph (e)(1)(i) of this section, the percentage used is the percentage of total Medicare discharges in the Metropolitan Statistical Area in which the hospital is located that are from the co-located hospital for the cost reporting period for which the adjustment was made, but in no case is less than 25 percent or more than 50 percent.

(iii) In determining the percentage of patients admitted from the co-located hospital under paragraph (e)(1)(i) of this section, patients on whose behalf outlier payment was made at the co-located hospital are not counted toward the applicable threshold.

(iv) For purposes of this paragraph, an ''MSA-dominant hospital'' is a hospital that has discharged more than 25 percent of the total hospital Medicare discharges in the MSA in which the hospital is located.

(2) *For cost reporting periods beginning on or after October 1, 2007 and before October 1, 2010.* (i) Except for a long-term care hospital or a long-term care hospital satellite facility subject to paragraph (g) or (h) of this section, payments are determined using the methodology specified in paragraph (e)(1) of this section.

(ii) Payments for a long-term care hospital or long-term care hospital satellite facilities subject to paragraph (g) of this section are determined using the methodology specified in paragraph (e)(1) of this section except that the percentage of Medicare discharges that may be admitted from the co-located hospital without being subject to the payment adjustment at paragraph (e)(1) of this section is 75 percent.

(3) *For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010.* Payments for a long-term care hospital satellite facility described in § 412.22(h)(3)(i), are determined using the methodology specified in paragraph (d)(1) of this section except that the payment adjustment under paragraph (e)(1) of this section is 75 percent.

* * * * *

(h) *Effective date of policies in this section for certain co-located LTCH hospitals and satellites of LTCHs.* The policies set forth in this section apply to Medicare patient discharges that were admitted from a hospital located in the same building or on the same campus as a long-term care hospital described in § 412.23(e)(2)(i) that meets the criteria in § 412.22(f) and a satellite facility of a long-term care hospital as described under § 412.22(h)(3)(i) for discharges occurring in cost reporting periods beginning on or after July 1, 2007.

(1) Except as specified in paragraph (h)(4) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that is described under this paragraph (h), the thresholds applied at paragraphs (c), (d), and (e) of this section are not less than the following percentages:

(i) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the lesser of 75 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or long-term care hospital satellite facility from its co-located hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted to the long-term care hospital or satellite from that co-located hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(ii) For cost reporting periods beginning on or after July 1, 2008 and before July 1, 2009, the lesser of 50 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or the long-term care hospital satellite facility from its co-located hospital or the percentage of Medicare discharges that had been admitted from that co-located hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(iii) For cost reporting periods beginning on or after July 1, 2009, 25 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or satellite from its co-located hospital during the cost reporting period.

(2) In determining the percentage of Medicare discharges admitted from the co-located hospital under this paragraph, patients on whose behalf a Medicare high cost outlier payment was made at the co-located referring hospital are not counted toward this threshold.

(3) Except as specified in paragraph (h)(4) of this section, for cost reporting periods beginning on or after July 1, 2007, payments to long term care hospitals described in § 412.23(e)(2)(i) that meet the criteria in § 412.22(f) and satellite facilities of long-term care hospitals described at § 412.22(h)(3)(i) are subject to the provisions of § 412.536 for discharges of Medicare patients who are admitted from a hospital not located in the same building or on the same campus as the LTCH or LTCH satellite facility.

(4) For a long-term care hospital described in § 412.23(e)(2)(i) that meets the criteria in § 412.22(f), the policies set forth in this paragraph and in § 412.536 of this part do not apply for discharges occurring in cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010.

(5) For a long-term care hospital or satellite facility that, as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Act at the off-campus location, the policies set forth in this paragraph and in § 412.536 of this part do not apply for discharges occurring in cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010.

■ 14. Section 412.536 is amended by revising paragraph (a)(2) to read as follows:

§ 412.536 Special payment provisions for long-term care hospitals and satellites of long-term care hospitals that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite of the long-term care hospital.

(a) *Scope.* * * *

(2) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, the policies set forth in this section are not applicable to discharges from:

(i) A long-term care hospital described in § 412.23(e)(5) of this part; or

(ii) A long-term care hospital described in § 412.23(e)(2)(i) of this part and that meet the criteria specified in § 412.22(f) of this part; or

(iii) A long-term care hospital or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Act at the off-campus location.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

■ 15. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106–133 (113 Stat. 1501A–332).

■ 16. Section 413.65 is amended by—
■ a. Revising paragraph (a)(1)(ii)(G).
■ b. Revising paragraph (a)(1)(ii)(H).

The revisions read as follows:

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) * * *

(1) * * *

(ii) * * *

(G) Independent diagnostic testing facilities furnishing only services paid under a fee schedule, such as facilities that furnish only screening mammography services (as defined in section 1861(jj) of the Act), facilities that furnish only clinical diagnostic laboratory tests, other than those clinical diagnostic laboratories operating as parts of CAHs on or after October 1, 2010, or facilities that furnish only some combination of these services.

(H) Facilities, other than those operating as parts of CAHs, furnishing only physical, occupational, or speech therapy to ambulatory patients, throughout any period during which the annual financial cap amount on payment for coverage of physical, occupational, or speech therapy, as described in section 1833(g)(2) of the Act, is suspended by legislation.

* * * * *

■ 17. Section 413.70 is amended by—
■ a. Revising paragraph (b)(1)(i).
■ b. Removing paragraph (b)(2)(iii).
■ c. Revising the heading of paragraph (b)(3).
■ d. Revising paragraph (b)(3)(ii)(A).
■ e. Adding a new paragraph (b)(7).

The revisions and addition read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(b) * * *

(1) * * *

(i) Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is determined under paragraph (b)(2) of this section.

* * * * *

(3) *Election to be paid reasonable costs for facility services plus fee schedule for professional services.*

* * *

(ii) * * *

(A) For cost reporting periods beginning on or after October 1, 2009, for facility services not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, the reasonable costs of the services as determined in accordance with the provisions of section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement specified in this part and in Part 415 of this subchapter, except that the lesser of costs or charges principle and the RCE payment principle are excluded when determining payment for CAH outpatient services; and

* * * * *

(7) *Payment for clinical diagnostic laboratory tests included as outpatient CAH services.* (i) Payment for clinical diagnostic laboratory tests is not subject to the Medicare Part B deductible and coinsurance amounts.

(ii) Subject to the provisions of paragraphs (b)(7)(iii) through (b)(7)(vi) of this section, payment to a CAH for clinical diagnostic laboratory tests will be made at 101 percent of reasonable costs of the services as determined in accordance paragraph (b)(2)(i) of this section.

(iii) For services furnished before July 1, 2009, payment to a CAH for clinical diagnostic laboratory tests will be made under paragraph (b)(7)(ii) of this section only if the individual is an outpatient of the CAH, as defined in § 410.2 of this chapter, and is physically present in the CAH at the time the specimen is collected.

(iv) Except as provided in paragraphs (b)(7)(iii) and (b)(7)(v) of this section, payment to a CAH for clinical diagnostic laboratory tests will be made under paragraph (b)(7)(ii) of this section only if the individual is an outpatient of the CAH, as defined in § 410.2 of this chapter, without regard to whether the individual is physically present in the CAH at the time the specimen is

collected and at least one of the following conditions is met:

(A) The individual is receiving outpatient services in the CAH on the same day the specimen is collected; or

(B) The specimen is collected by an employee of the CAH.

(v) Notwithstanding paragraph (b)(7)(iv) of this section, payment for outpatient clinical diagnostic laboratory tests will not be made under paragraph (b)(7)(ii) of this section if the billing rules under § 411.15(p) of this chapter apply.

(vi) Payment for clinical diagnostic laboratory tests for which payment may not be made under paragraph (b)(7)(iii) or paragraph (b)(7)(iv) of this section will be made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act.

* * * * *

■ 18. Section 413.79 is amended by—

■ a. Revising paragraph (f)(1).

■ b. Redesignating paragraph (f)(6) and paragraph (f)(7).

■ c. Adding a new paragraph (f)(6).

■ d. Moving paragraph (l), currently incorrectly placed between paragraphs (k)(6) and (7), so that it appears after paragraph (k)(7) and is the last paragraph in the section.

The revisions and addition read as follows:

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(f) * * *

(1) Except as provided in paragraph (f)(6) of this section, each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under § 413.75(b) of this section, to the CMS fiscal intermediary or MAC servicing the hospital and send a copy to the CMS Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

* * * * *

(6) Effective October 1, 2009, a hospital that is new after July 1 and begins training residents for the first time after the July 1 start date of an academic year may receive a temporary adjustment to its FTE resident cap to reflect its participation in an existing Medicare GME affiliated group by submitting the Medicare GME affiliation agreement, as defined under § 413.75(b), to the CMS fiscal intermediary or MAC servicing the hospital and sending a copy to the CMS Central Office by the earlier of June 30 of the residency program year during which the Medicare GME affiliation agreement will be in effect or the end of the first cost reporting period during which the hospital begins training residents. The Medicare GME affiliation agreement must specify the effective period for the agreement, which may begin no earlier than the date the affiliation agreement is submitted to CMS. Each of the other hospitals participating in the Medicare GME affiliated group must submit an amended Medicare GME affiliation agreement that reflects the participation of the new hospital to the CMS fiscal intermediary or MAC servicing the hospital and send a copy to the CMS Central Office no later than June 30 of the residency program year during which the Medicare GME affiliation agreement will be in effect. For purposes of this paragraph, a new hospital is one for which a new Medicare provider agreement takes effect in accordance with § 489.13 of this chapter.

* * * * *

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

■ 19. The authority citation for Part 415 continues to read as follows:

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

§ 415.152 [Amended]

■ 20. In § 415.152, under paragraph (1) of the definition of ''Approved graduate medical education (GME) program'', remove the phrase ''the Committee on Hospitals of the Bureau of Professional Education of''.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 21. The authority citation for part 485 continues to read as follows:

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

■ 22. Section 485.610 is amended by—

■ a. Revising paragraph (b)(3).

■ b. Adding a new paragraph (b)(4).

The addition and revision read as follows:

§ 485.610 Condition of participation: Status and location.

* * * * *

(b) * * *

(3) Effective for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but as of FY 2005 was included as part of such a Metropolitan Statistical Area as a result of the most recent census data and implementation of the new Metropolitan Statistical Area definitions announced by the Office of Management and Budget on June 3, 2003.

(4) Effective for October 1, 2009 through September 30, 2011, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2009, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but, as of FY 2010, was included as part of such a Metropolitan Statistical Area as a result of the most recent census data and implementation of the new Metropolitan Statistical Area definitions announced by the Office of Management and Budget on November 20, 2008.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

■ 23. The authority citation for Part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

■ 24. Section 489.24 is amended by revising paragraph (a)(2) to read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) * * *

(2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:

(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.

(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a

pandemic infectious disease, pursuant to a State pandemic preparedness plan.

(C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.

(D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act.

(E) There has been a determination that a waiver of sanctions is necessary.

(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act.

* * * * *

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

Dated: July 27, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: July 29, 2009.

Kathleen Sebelius,

Secretary.

[**Editorial Note:** The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Schedule of Standardized Amounts, Update Factors, and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2009

I. Summary and Background

In this Addendum, we are setting forth a description of the methods and data we used to determine the prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs for FY 2010 for acute care hospitals. We also are setting forth the rate-of-increase percentages for updating the target amounts for certain hospitals excluded from the IPPS for FY 2010. We note that, because certain hospitals excluded from the IPPS are paid on a reasonable cost basis subject to a rate-of-increase ceiling (and not by the IPPS), these hospitals are not affected by the figures for the standardized amounts, offsets, and budget neutrality factors. Therefore, in this final rule, we are establishing the rate-of-increase percentages for updating the target amounts for certain hospitals excluded from the IPPS that are effective for cost reporting periods beginning on or after October 1, 2009.

In addition, we are setting forth a description of the methods and data we used to determine the standard Federal rate that will be applicable to Medicare LTCHs for RY 2010.

In general, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS is based on 100 percent of the Federal national rate, also known as the national adjusted standardized amount. This amount reflects the national average hospital cost per case from a base year, updated for inflation.

Currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or for cost reporting periods beginning on or after January 1, 2009, the updated hospital-specific rate based on the FY 2006 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs historically have been paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever was higher. (MDHs did not have the option to use their FY 1996 hospital-specific rate.) However, section 5003(a)(1) of Public Law 109–171 extended and modified the MDH special payment provision that was previously set to expire on October 1, 2006, to include discharges occurring on or after October 1, 2006, but before October 1, 2011. Under section 5003(b) of Public Law 109–171, if the change results in an increase to an MDH's target amount, we must rebase an MDH's hospital-specific rates based on its FY 2002 cost report. Section 5003(c) of Public Law 109–171 further required that MDHs be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate. Further, based on the provisions of section 5003(d) of Pub. L. 109–171, MDHs are no longer subject to the 12-percent cap on their DSH payment adjustment factor.

For hospitals located in Puerto Rico, the payment per discharge is based on the sum of 25 percent of an updated Puerto Rico-specific rate based on average costs per case of Puerto Rico hospitals for the base year and 75 percent of the Federal national rate. (We refer readers to section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for acute care hospitals for FY 2010. In section III. of this Addendum, we discuss our policy changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2010. In section IV. of this Addendum, we are setting forth our changes for determining the rate-of-increase limits for certain hospitals excluded from the IPPS for FY 2010. In section V. of this Addendum, we are making changes in the determination of the standard Federal rate for LTCHs under the LTCH PPS for RY 2010. The tables to which we refer in the preamble of this final rule are presented in section VI. of this Addendum.

II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for Acute Care Hospitals for FY 2010

The basic methodology for determining prospective payment rates for hospital inpatient operating costs for acute care hospitals for FY 2005 and subsequent fiscal years is set forth at § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico for FY 2005 and subsequent fiscal years is set forth at §§ 412.211 and 412.212. Below we discuss the factors used for determining the prospective payment rates for FY 2010.

In summary, the standardized amounts set forth in Tables 1A, 1B, and 1C of section VI. of this Addendum reflect—

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv)(II) of the Act, updated by the applicable percentage increase required under sections 1886(b)(3)(B)(i)(XX) and 1886(b)(3)(B)(viii) of the Act.
- The labor-related share that is applied to the standardized amounts and Puerto Rico-specific standardized amounts to give the hospital the highest payment, as provided for under sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act.
- Updates of 2.1 percent for all areas (that is, the estimated full market basket percentage increase of 2.1 percent), as required by section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Public Law 109–171, and reflecting the requirements of section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Public Law 109–171, to reduce the applicable percentage increase by 2.0 percentage points for a hospital that fails to submit data, in a form and manner, and at the time specified by the Secretary, relating to the quality of inpatient care furnished by the hospital.
- An update of 2.1 percent to the Puerto Rico-specific standardized amount (that is, the full estimated rate-of-increase in the hospital market basket for IPPS hospitals), as provided for under § 412.211(c), which states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1), or the percentage increase in the market basket index for prospective payment hospitals for all areas.
- An adjustment to the standardized amount to ensure budget neutrality for DRG recalibration and reclassification, as provided for under section 1886(d)(4)(C)(iii) of the Act.
- An adjustment to ensure the wage index and labor share update and changes are budget neutral, as provided for under section 1886(d)(3)(E)(i) of the Act. We note that section 1886(d)(3)(E)(i) of the Act requires that we do not consider the labor-related share of 62 percent to compute wage index budget neutrality.
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section

1886(d)(8)(D) of the Act, by removing the FY 2009 budget neutrality factor and applying a revised factor.

- An adjustment to remove the FY 2009 outlier offset and apply an offset for FY 2010, as provided for in section 1886(d)(3)(B) of the Act.
- An adjustment to ensure the effects of the rural community hospital demonstration required under section 410A of Public Law 108–173 are budget neutral, as required under section 410A(c)(2) of Public Law 108–173.

We note that in this final rule, as discussed below and in section II. of the preamble to this final rule, we are opting to postpone adopting documentation and coding adjustments to the national standardized amount, as authorized under section 7(a) of Public Law 110–90 and section 1886(d)(3)(A)(vi) of the Act, and to the hospital-specific rates and Puerto Rico-specific standardized amount under our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act until a full analysis of FY 2009 case-mix changes can be completed.

We note that, beginning in FY 2008, we applied the budget neutrality adjustment for the rural floor to the hospital wage indices rather than the standardized amount. As we did for FY 2009, for FY 2010, we are continuing to apply the rural floor budget neutrality adjustment to hospital wage indices rather than the standardized amount. In addition, instead of applying the budget neutrality adjustment for the imputed floor adopted under section 1886(d)(3)(E) of the Act to the standardized amount, for FY 2010, we are continuing to apply the imputed floor budget neutrality adjustment to the wage indices. As we did for FY 2009, we also are continuing to apply the budget neutrality adjustments for the rural floor and imputed rural floor at the State level rather than the national level. For a complete discussion of the budget neutrality changes concerning the rural floor and the imputed floor, including the within-State budget neutrality adjustment, we refer readers to section III.B.2.b. of the preamble of the FY 2009 IPPS final rule and this final rule.

A. Calculation of the Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

In general, the national standardized amount is based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. For Puerto Rico hospitals, the Puerto Rico-specific standardized amount is based on per discharge averages of adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d)(9) of the Act. The September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established for urban and rural hospitals in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043 and 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and 1886(d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, IME costs, and costs to hospitals serving a disproportionate share of low-income patients.

In accordance with section 1886(d)(3)(E) of the Act, the Secretary estimates, from time-to-time, the proportion of hospitals' costs that are attributable to wages and wage-related costs. In general, the standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered to be the labor-related amount is adjusted by the wage index. Section 1886(d)(3)(E) of the Act requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made. (Section 1886(d)(9)(C)(iv)(II) of the Act extends this provision to the labor-related share for hospitals located in Puerto Rico.)

For FY 2010, we are rebasing and revising the national and Puerto Rico-specific labor-related and nonlabor-related shares from the percentages established for FY 2009. Specifically, under section 1886(d)(3)(E) of the Act, the Secretary estimates from time to time the proportion of payments that are labor-related: ''The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates. * * *'' We refer to the proportion of hospitals' costs that are attributable to wages and wage-related costs as the ''labor-related share.'' For FY 2010, as discussed in section IV.B.4. of the preamble of this final rule, we are establishing a labor-related share of 68.8 percent for the national standardized amounts and 62.1 percent for the Puerto Rico-specific standardized amount. Consistent with section 1886(d)(3)(E) of the Act, we are applying the wage index to a labor-related share of 62 percent for all non-Puerto Rico hospitals whose wage indexes are less than or equal to 1.0000. For all non-Puerto Rico hospitals whose wage indices are greater than 1.0000, we are applying the wage index to a labor-related share of 68.8 percent of the national standardized amount. For hospitals located in Puerto Rico whose Puerto Rico-specific wage index values are greater than 1.0000, we are applying a labor-related share of 62.1 percent. For hospitals located in Puerto Rico, we are applying a labor-related share of 62 percent if its Puerto Rico-specific wage index is less than or equal to 1.0000.

The standardized amounts for operating costs appear in Tables 1A, 1B, and 1C of the Addendum to this final rule.

2. Computing the Average Standardized Amount

Section 1886(d)(3)(A)(iv)(II) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Section 1886(d)(9)(A)(ii)(II) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we are calculating the FY 2010 national and Puerto Rico standardized amounts irrespective of whether a hospital is located in an urban or rural location.

3. Updating the Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv)(II) of the Act, we are updating the equalized standardized amount for FY 2010 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Public Law 109–171. The percentage increase in the market basket reflects the average change in the price of goods and services comprising routine, ancillary, and special care unit hospital inpatient services. The most recent forecast of the hospital market basket increase for FY 2010 is 2.1 percent. Thus, for FY 2010, the update to the average standardized amount is 2.1 percent for hospitals in all areas. The estimated market basket increase of 2.1 percent is based on Global Insight, Inc.'s 2009 first quarter forecast of the hospital market basket increase (as discussed in Appendix B of this final rule).

Section 1886(b)(3)(B) of the Act specifies the mechanism to be used to update the standardized amount for payment for inpatient hospital operating costs. Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Public Law 109–171, provides for a reduction of 2.0 percentage points from the update percentage increase (also known as the market basket update) for FY 2007 and each subsequent fiscal year for any ''subsection (d) hospital'' that does not submit quality data, as discussed in section V.A. of the preamble of this final rule. The standardized amounts in Tables 1A through 1C of section VI. of this Addendum reflect these differential amounts.

Section 412.211(c) states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1), or the percentage increase in the market basket index for prospective payment hospitals for all areas. We are applying the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is 2.1 percent.

Although the update factors for FY 2010 are set by law, we are required by section 1886(e)(4) of the Act to recommend, taking into account MedPAC's recommendations, appropriate update factors for FY 2010 for both IPPS hospitals and hospitals and hospital units excluded from the IPPS. Section 1886(e)(5)(A) of the Act requires that

we publish our proposed recommendations in the **Federal Register** for public comment. Our recommendation on the update factors is set forth in Appendix B of this final rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are adjusting the FY 2010 standardized amount to remove the effects of the FY 2009 geographic reclassifications and outlier payments before applying the FY 2010 updates. We then apply budget neutrality offsets for outliers and geographic reclassifications to the standardized amount based on FY 2010 payment policies.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, estimated aggregate payments after updates in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year's adjustment, we would not satisfy these conditions.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (for example, changes to DRG classifications, recalibration of the DRG relative weights, updates to the wage index, and different geographic reclassifications). We include outlier payments in the simulations because they may be affected by changes in these parameters.

In section II. of the preamble of this final rule, we discussed that we received some comments on whether Medicare Advantage claims were used in the FY 2010 IPPS proposed rule to calculate the MS–DRG relative weights. We responded to those comments by explaining that, historically, we have excluded data from Medicare Advantage claims from the calculation of the relative weights. However, the December 31, 2008 update of the FY 2008 MedPAR data that was used as the source for calculating the proposed FY 2010 relative weights contained a significant number of Medicare Advantage claims. This is because hospitals were required to submit informational only claims for all Medicare Advantage patients they treated for discharges occurring on or after October 1, 2006, under Change Request 5647 (Transmittal 1311). As a result, we inadvertently included claims from discharges of patients enrolled in Medicare Advantage plans in the calculation of the proposed FY 2010 relative weights. For this final rule, we have excluded the discharges of patients enrolled in Medicare Advantage plans in the calculation of the FY 2010 relative weights.

Similarly, in the proposed rule, we inadvertently included Medicare Advantage claims in the budget neutrality calculations. Thus, we unintentionally included the estimated full IPPS payments for the Medicare Advantage claims in the budget neutrality calculations and outlier payment estimates for the proposed rule. Although we are excluding Medicare Advantage claims from the relative weight calculations in this final rule, it is necessary to include IME payments for Medicare Advantage enrollees in the budget neutrality calculations (except for computing the outlier threshold, which we explain in section II.A.4.e. of this Addendum). Under § 412.105(g) of the regulations and as implemented in Transmittal A–98–21 (Change Request 332), hospitals that are paid under the IPPS and train residents in approved GME programs may submit claims associated with Medicare Advantage enrollees to the fiscal intermediary/MAC for the purpose of receiving an IME payment. No IPPS MS–DRG payments (or other add-on payment, such as DSH or outliers) are made for these Medicare Advantage enrollees.

As described in detail below, we make various budget neutrality adjustments to the standardized amount. Specifically, the budget neutrality adjustment under section 1886(d)(4)(C)(iii) of the Act requires that we ensure that the recalibration of the relative weights does not increase aggregate payments made under section 1886(d) of the Act. Similarly, section 1886(d)(3)(E) of the Act requires that the adjustment to the wage index shall be made in a manner that does not increase or decrease aggregate payments under section 1886(d) of the Act (subject to the requirement, explained below, that we must assume a uniform labor-related share). In addition, we make an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the BBA (Pub. L. 105–33) and the imputed floor under § 412.64(h)(4) of the regulations are made in a manner that ensures that aggregate payments to hospitals are not affected. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions for certain geographic reclassification under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. As discussed below, we also are adjusting the standardized amount for FY 2010 by an estimated amount to ensure that aggregate payments made by the Secretary under section 1886(d) of the Act do not exceed the amount of payments that would have been made in the absence of the rural community hospital demonstration program, consistent with section 410A of Public Law 108–173. Because IME Medicare Advantage payments are made to IPPS hospitals under section 1886(d) of the Act, we believe these payments must be part of these budget neutrality calculations. However, we note that it is not necessary to include Medicare Advantage IME payments in the outlier threshold calculation or the outlier offset to the standardized amount because the statute requires that outlier payments be not less than 5 percent nor more than 6 percent of total ''operating DRG payments,'' which does not include IME and DSH payments.

In order to account for these Medicare Advantage IME payments in determining the budget neutrality adjustments for this final rule, we identified Medicare Advantage claims from IPPS teaching hospitals in the MedPAR data. The GHO Paid indicator with a value of ''1'' on the MedPAR file indicates that the claim was paid by a Medicare Advantage plan (other than the IPPS IME payment specified at § 412.105(g)). For these Medicare Advantage claims from IPPS teaching hospitals, we computed a transfer-adjusted CMI by provider based on the FY 2009 MS–DRG GROUPER Version 26.0 assignment and relative weights. We also computed a transfer-adjusted CMI for these Medicare Advantage claims from IPPS teaching hospitals based on the FY 2010 MS–DRG GROUPER Version 27.0 assignments and relative weights. These transfer-adjusted CMIs (and corresponding case counts) were used to calculate an IME teaching add-on payment in accordance with § 412.105(g). The total Medicare Advantage IME payment amount was then added to the total Federal payment amount for each provider (where applicable) in order to account for the Medicare Advantage IME payment in determining the budget neutrality adjustments. We note that we did not include Medicare Advantage IME claims when estimating outlier payments for providers because Medicare Advantage claims are not eligible for outlier payments under the IPPS.

We also are adjusting the standardized amount for FY 2010 by an estimated amount to ensure that aggregate payments made by the Secretary do not exceed the amount of payments that would have been made in the absence of the rural community hospital demonstration program, as required under section 410A of Public Law 108–173. This demonstration is required to be budget neutral under section 410A(c)(2) of Public Law 108–173. For FY 2010, we are not applying budget neutrality for the imputed floor to the standardized amount, but instead are applying it to the wage index, as discussed in section III.B.2. of the preamble of this final rule.

Comment: One commenter requested that CMS completely and adequately describe the FY 2010 methods and data elements used in each budget neutrality adjustment calculation to allow a determination that the proposed budget neutrality adjustments and methodologies are appropriate and are not duplicated across the various budget neutrality adjustments. The commenter specifically requested clarification on whether the pre- or post-labor share adjusted rate is used in the budget neutrality calculations. The commenter also urged CMS to assure that any data necessary for commenters are available during the comment period (such as the data used to develop the CCR adjustment factors).

Response: In the discussion below, we explain our methodology for computing each individual budget neutrality adjustment. In addition, as stated above, budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (for example, changes to MS–DRG classifications, recalibration of the MS–DRG relative weights, updates to the wage index, and different geographic reclassifications). We include outlier payments in the simulations because they may be affected by changes in these parameters. We also take extra caution to ensure that all variables are correctly

inputted in our budget neutrality calculations in order that the various budget neutrality adjustments are not duplicated. In addition, because the commenter's remarks are very general, we are not sure where the inadequacy lies that the commenter references. However, we did clarify in the budget neutrality calculations below in which instances we used FY 2009 or FY 2010 pre- and post-reclassified wage indices, FY 2009 or FY 2010 relative weights, and FY 2009 or FY 2010 labor-related share percentages. We believe the discussions above and below adequately describe the methodology for budget neutrality.

In reference to the comment on assuring that any data necessary for the commenters are available during the comment period, we strive to ensure that all files are available to the public. Most data files are available on the CMS Web site, as we specified in the proposed. In addition, we have reorganized the IPPS Web site to make it easier for the end user to locate relevant data files for the proposed rule and this final rule in one central location.

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble of this final rule, we normalized the recalibrated DRG weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E)(i) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. In addition, under section 1886(d)(3)(E)(i) of the Act, as we established in the FY 2006 IPPS final rule (70 FR 47395), we are implementing the revised and rebased labor share in a budget neutral manner. Specifically, section 1886(d)(3)(E)(i) of the Act directs us to determine a labor-related share that reflects the ''proportion * * * of hospitals' costs which are attributable to wages and wage-related costs.'' In addition, section 1886(d)(3)(E)(i) of the Act requires that we implement the wage index adjustment in a budget neutral manner. However, section 1886(d)(3)(E)(ii) of the Act sets the labor-related share at 62 percent for hospitals with a wage index less than or equal to 1.0, and section 1886(d)(3)(E)(i) of the Act provides that the Secretary shall calculate the budget neutrality adjustment for the adjustments or updates made under that provision as if section 1886(d)(3)(E)(ii) of the Act had not been enacted. In other words, these two sections of the statute require that we implement the revision of the labor-related share of 68.8 percent (compared to 69.7 percent for FY 2009) (as well as the wage index updates) in a budget neutral manner, but that our budget neutrality adjustment should not take into account the requirement that we set the labor-related share for hospitals with indices less than or equal to 1.0 at the more advantageous level of 62 percent. Therefore, for purposes of this budget neutrality adjustment, section 1886(d)(3)(E)(i) of the Act prohibits us from taking into account the fact that hospitals with a wage index less than or equal to 1.0 are paid using a labor-related share of 62 percent. Consistent with current policy, for FY 2010, we are adjusting 100 percent of the wage index factor for occupational mix. We describe the occupational mix adjustment in section III.D. of the preamble of this final rule.

For FY 2010, to comply with the requirement that DRG reclassification and recalibration of the relative weights be budget neutral for the Puerto Rico standardized amount and the hospital-specific rates, we used FY 2008 discharge data to simulate payments and compared aggregate payments using the FY 2009 labor-related share percentages, the FY 2009 relative weights, and the FY 2009 pre-reclassified wage data to aggregate payments using the FY 2009 labor-related share percentages, the FY 2010 relative weights, and the FY 2009 pre-reclassified wage data. Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.997941. As discussed in section IV. of this Addendum, we would also apply the DRG reclassification and recalibration budget neutrality factor of 0.997941 to the hospital-specific rates that are to be effective for cost reporting periods beginning on or after October 1, 2009.

In order to meet the statutory requirements that we do not take into account the labor-related share of 62 percent when computing wage index budget neutrality and that we budget neutralize any changes in payments as a result of the FY 2010 rebased and revised labor-related share, it was necessary to use a three-step process to comply with the requirements that DRG reclassification and recalibration of the relative weights and the updated wage index and labor-related share have no effect on aggregate payments for IPPS hospitals. We first determined a DRG reclassification and recalibration budget neutrality factor of 0.997941 by using the same methodology described above to determine the DRG reclassification and recalibration budget neutrality factor for the Puerto Rico standardized amount and hospital-specific rates. Secondly, to compute a budget neutrality factor for wage index and labor-related share changes, we used FY 2008 discharge data to simulate payments and compared aggregate payments using FY 2010 relative weights and FY 2009 pre-reclassified wage indices, and applied the FY 2009 labor-related share of 69.7 percent to all hospitals (regardless of whether the hospital's wage index was above or below 1.0) to aggregate payments using the FY 2010 relative weights and the FY 2010 pre-reclassified wage indices, and applied the rebased and revised labor-related share for FY 2010 of 68.8 percent to all hospitals (regardless of whether the hospital's wage index was above or below 1.0). In addition, we applied the DRG reclassification and recalibration budget neutrality factor (derived in the first step) to the rates that were used to simulate payments for this comparison of aggregate payments from FY 2009 to FY 2010. By applying this methodology, we determined a budget neutrality factor for the wage index and labor-related share changes of 1.000407. Finally, we multiplied the DRG reclassification and recalibration budget neutrality factor of 0.997941 (derived in the first step) by the budget neutrality factor for wage index changes of 1.000407 (derived in the second step) to determine the DRG reclassification and recalibration and updated wage index and labor-related share budget neutrality factor of 0.998347.

Comment: One commenter requested that CMS explain why it has made changes to the budget neutrality calculation to segment various aspects of those calculations.

Response: As discussed above, in order to meet the statutory requirements of section 1886(d)(3)(E)(i) of the Act that we do not take into account the labor-related share of 62 percent when computing wage index budget neutrality and that we budget neutralize any changes in payments as a result of the FY 2010 rebased and revised labor-related share, it was necessary to use a three-step process (or segment various aspects of the calculation) to comply with the requirements for DRG reclassification and recalibration, wage index and labor-related share budget neutrality.

b. Reclassified Hospitals—Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. We note that the wage index adjustments provided under section 1886(d)(13) of the Act are not budget neutral. Section 1886(d)(13)(H) of the Act provides that any increase in a wage index under section 1886(d)(13) shall not be taken into account ''in applying any budget neutrality adjustment with respect to such index'' under section 1886(d)(8)(D) of the Act. To calculate the budget neutrality factor for FY 2010, we used FY 2008 discharge data to simulate payments and compared total IPPS payments with FY 2010 relative weights, FY 2010 labor share percentages, and FY 2010

wage data prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments with FY 2010 relative weights, FY 2010 labor share percentages, and FY 2010 wage data after such reclassifications. Based on these simulations, we calculated an adjustment factor of 0.991297 to ensure that the effects of these provisions are budget neutral, consistent with the statute.

The FY 2010 budget neutrality adjustment factor is applied to the standardized amount after removing the effects of the FY 2009 budget neutrality adjustment factor. We note that the FY 2010 budget neutrality adjustment reflects FY 2010 wage index reclassifications approved by the MGCRB or the Administrator.

c. Rural Floor and Imputed Floor Budget Neutrality Adjustment

CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the BBA (Pub. L. 105–33) and the imputed floor under § 412.64(h)(4) of the regulations are made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section III.B. of the preamble of the FY 2009 IPPS final rule (73 FR 48570 through 48574), we adopted as final State-level budget neutrality for the rural and imputed floors, effective beginning with the FY 2009 wage index. In response to the public's concerns and taking into account the potentially significant payment cuts that could occur to hospitals in some States if we implemented this change with no transition, we decided to phase in, over a 3-year period, the transition from the national rural floor budget neutrality adjustment on the wage index to the State-level rural floor budget neutrality adjustment on the wage index. In FY 2009, hospitals received a blended wage index that was comprised of 20 percent of the wage index adjusted by applying the State-level rural and imputed floor budget neutrality adjustment and 80 percent of the wage index adjusted by applying the national budget neutrality adjustment. For FY 2010, the blended wage index is determined by adding 50 percent of the wage index adjusted by applying the State-level rural and imputed floor budget neutrality adjustment and 50 percent of the wage index adjusted by applying the national budget neutrality adjustment. In FY 2011, the adjustment will be completely transitioned to the State-level methodology, such that the wage index will be determined by applying 100 percent of the State-level budget neutrality adjustment. As stated earlier, we note that the rural floor budget neutrality adjustment is applied to the wage index and not the standardized amount. However, because these blended wage indices reflecting the 50 percent State-level rural and imputed floor budget neutrality adjustment and the 50 percent national rural and imputed floor budget neutrality adjustment are used in calculating the FY 2010 outlier threshold (as discussed below), we are explaining our calculation of the rural floor budget neutrality adjustments (in this section) below.

In order to compute a budget neutral wage index that is a blend of 50 percent of the wage index adjusted by the State-level rural and imputed floor budget neutrality adjustment and 50 percent of the wage index adjusted by the national rural and imputed floor budget neutrality adjustment, similar to our calculation of the FY 2009 wage index (73 FR 48570 through 48574), we used FY 2008 discharge data with FY 2010 relative weights, FY 2010 labor share percentages, and FY 2010 post reclassified wage indices to simulate IPPS payments. First, we compared the national simulated payments without the rural and imputed floors applied to national simulated payments with the rural and imputed floors applied to determine the national rural and imputed floor budget neutrality adjustment factor of 0.996705. This national adjustment was then applied to the FY 2010 post reclassified wage indices to produce a national rural and imputed floor budget neutral wage index, which was used in determining the FY 2010 blended post reclassified wage indices for the second year of the transition (as described below). We then used the same methodology to determine each State's rural or imputed floor budget neutrality adjustment by comparing each State's total simulated payments with and without the rural or imputed floor applied. These State-level rural and imputed floor budget neutrality factors were then applied to the wage indices to produce a State-level rural and imputed floor budget neutral wage index, which was used in determining the FY 2010 blended wage indices for the second year of the transition (as described below).

To determine the FY 2010 wage indices for the second year of the transition, we then blended the national and State-level post reclassified wage index values (computed above) by taking 50 percent of the national rural and imputed floor budget neutral post reclassified wage index and 50 percent of the State-level rural and imputed floor budget neutral post reclassified wage index. Because of interactive effects between the payment factors applied under the IPPS and/or rounding issues, the blended post reclassified wage index calculated above does not necessarily result in overall budget neutrality. That is, aggregate IPPS payments simulated using the blended budget neutral post reclassified wage index may not be equal to aggregate IPPS payments simulated using the post reclassified wage index prior to the application of the rural and imputed floors. Therefore, in order to ensure that national payments overall remain budget neutral after application of the rural and imputed floors, an additional adjustment factor of 0.999995 must be applied to the blended post reclassified wage indices calculated as described above.

Comment: Several commenters pointed out that in the proposed rule CMS stated on page 24243 of the rule that it applied an additional budget neutrality factor of 1.00016 to the blended wage indexes, while on page 24663 of the rule CMS stated that this same additional budget-neutrality factor was 1.000017. The commenter requested that CMS clarify which factor is the correct additional budget neutrality factor related to the rural floor.

Response: We thank the commenter for pointing out the two different factors that were published in the proposed rule. The correct factor for the proposed rule is 1.00016. For this final rule, as described above, we applied an adjustment factor of 0.999995 to the blended wage indices calculated.

d. Case-Mix Budget Neutrality Adjustment

(1) Adjustment to the FY 2010 IPPS Standardized Amount

As stated earlier, beginning in FY 2008, we adopted the MS–DRG patient classification system for the IPPS to better recognize patients' severity of illness in Medicare payment rates. In the FY 2008 IPPS final rule with comment period (73 FR 47175 through 47186), we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for changes in documentation and coding. In that final rule, using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to maintain budget neutrality by adjusting the national standardized amounts to eliminate the effect of changes in documentation and coding that do not reflect real change in case-mix, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 (for a total adjustment of −4.8 percent). On September 29, 2007, Public Law 110–90 was enacted. Section 7 of Public Law 110–90 included a provision that reduces the documentation and coding adjustment for the MS–DRG system that we adopted in the FY 2008 IPPS final rule with comment period to −0.6 percent for FY 2008 and −0.9 percent for FY 2009. To comply with the provision of section 7(a) of Public Law 110–90, in a final rule that appeared in the **Federal Register** on November 27, 2007 (72 FR 66886), we changed the IPPS documentation and coding adjustment for FY 2008 to −0.6 percent, and revised the FY 2008 national standardized amounts (as well as other payment factors and thresholds) accordingly, with these revisions being effective as of October 1, 2007. For FY 2009, section 7(a) of Public Law 110–90 required a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment specified in the FY 2008 IPPS final rule with comment period. As required by statute, we applied a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amounts. The documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period are cumulative. As a result, the −0.9 percent documentation and coding adjustment in FY 2009 was in addition to the −0.6 percent adjustment in FY 2008, yielding a combined effect of −1.5 percent.

In the proposed rule, we discussed our analysis of FY 2008 claims data which shows an increase in case-mix of 2.5 percent due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008. For FY 2010, we proposed to reduce the average standardized amounts under section 1886(d) of the Act in FY 2010 by −1.9 percent,

which represents the difference between changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008 and the prospective adjustment applied under Public Law 110–90. As discussed in section II.D. of the preamble of this final rule, after consideration of the public comments we received on our analysis and proposals presented in the proposed rule, we have decided to postpone adopting documentation and coding adjustments as authorized under section 7(a) of Public Law 110–90 and section 1886(d)(3)(A)(vi) of the Act until a full analysis of FY 2009 case-mix changes can be completed. Accordingly, in this final rule, for FY 2010, we did not apply any additional documentation and coding adjustments to the average standardized amounts under section 1886(d) of the Act.

(2) Adjustment to the FY 2010 Hospital-Specific Rates for SCHs and MDHs

As discussed in section II.D. of the preamble of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule and this final rule, because hospitals (SCHs and MDHs) paid based in whole or in part on the hospital-specific rate use the same MS–DRG system as other hospitals, we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Under section 1886(d)(3)(A)(vi) of the Act, Congress stipulated that hospitals paid based on the standardized amount should not receive additional payments based on the effect of documentation and coding changes that do not reflect real changes in case-mix. Similarly, we believe that hospitals paid based on the hospital-specific rate should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. While we continue to believe that section 1886(d)(3)(A)(vi) of the Act does not provide explicit authority for application of the documentation and coding adjustment to the hospital-specific rates, we believe that we have the authority to apply the documentation and coding adjustment to the hospital-specific rates using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act.

As discussed in the proposed rule, we found that, independently for both SCHs and MDHs, the change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 slightly exceeded the 2.5 percent result discussed earlier, but did not significantly differ from that result.

Therefore, we proposed to use our authority under section 1886(d)(5)(I)(i) of the Act to prospectively adjust the hospital-specific rates by −2.5 percent in FY 2010 for our estimated documentation and coding effect in FY 2008 that does not reflect real changes in case-mix. We also noted that, unlike the national standardized rates, the FY 2009 hospital-specific rates were not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs.

Consistent with our approach for determining the national average standardized amounts discussed earlier, after consideration of the public comments we received on our analysis and proposals presented in the proposed rule, we also are postponing adoption of a documentation and coding adjustment to the hospital-specific rate until a full analysis of FY 2009 case-mix changes can be completed. Accordingly, in this final rule, for FY 2010, we will not apply a documentation and coding adjustment to the hospital-specific rates.

(3) Adjustment to the FY 2010 Puerto Rico Standardized Amount

As stated in section II.D. of the preamble of this final rule, we believe that we have the authority to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. Similar to SCHs and MDHs that are paid based on the hospital-specific rate, we believe that Puerto Rico hospitals that are paid based on the Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. In the proposed rule, we discussed our analysis of FY 2008 claims data for Puerto Rico hospitals, which shows that, for Puerto Rico hospitals, the increase in payments for discharges occurring during FY 2008 due to documentation and coding changes that did not reflect real changes in case-mix for discharges occurring during FY 2008 was approximately 1.1 percent. We note that, unlike the national standardized rates, the FY 2009 Puerto Rico-specific standardized amount was not previously reduced in order to account for anticipated changes in documentation and coding that do not reflect real changes in case-mix resulting from the adoption of the MS–DRGs. Therefore, we proposed to use our authority under section 1886(d)(5)(I)(i) of the Act to adjust the Puerto Rico-specific standardized amount by −1.1 percent in FY 2010 to account for the FY 2008 documentation and coding changes that are not due to changes in real case-mix and to leave that adjustment in place for subsequent fiscal years.

Consistent with our approach for determining the national average standardized amounts and hospital-specific rates of SCHs and MDHs discussed above, after consideration of the public comments we received on our analysis and proposals presented in the proposed rule, we also are postponing adoption of a documentation and coding adjustment to the Puerto Rico-specific rates until a full analysis of FY 2009 case-mix changes can be completed. Accordingly, in this final rule, for FY 2010, we will not apply a documentation and coding adjustment to the Puerto Rico-specific rates.

e. Outlier Payments

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the ''outlier threshold'' or ''fixed-loss'' amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). We refer to the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the outlier threshold as the outlier ''fixed-loss cost threshold.'' To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to estimated costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the estimated costs above the fixed-loss cost threshold. The marginal cost factor for FY 2010 is 80 percent, the same marginal cost factor we have used since FY 1995 (59 FR 45367).

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. We note that the statute requires outlier payments to be not less than 5 percent nor more than 6 percent of total ''operating DRG payments'' (which does not include IME and DSH payments) plus outlier payments. When setting the outlier threshold, we compute the 5.1 percent target by dividing the total operating outlier payments by the total operating DRG payments plus outlier payments. We do not include any other payments such as IME and DSH within the outlier target amount. Therefore, it is not necessary to include Medicare Advantage IME payments in the outlier threshold calculation. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amount applicable to hospitals located in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage*.

(1) FY 2010 Outlier Fixed-Loss Cost Threshold

For FY 2010, we proposed to continue to use the same methodology used for FY 2009 (73 FR 48763 through 48766) to calculate the outlier threshold. Similar to the methodology used in the FY 2009 IPPS final rule, for FY 2010, we proposed to apply an adjustment factor to the CCRs to account for cost and charge inflation (as explained below). As we have done in the past, to calculate the proposed FY 2010 outlier threshold we simulated payments by applying FY 2010 rates and policies using cases from the FY 2008 MedPAR files. Therefore, in order to determine the proposed FY 2010 outlier threshold, we inflated the charges on the MedPAR claims by 2 years, from FY 2008 to FY 2010.

We proposed to continue to use a refined methodology that takes into account the

lower inflation in hospital charges that are occurring as a result of the outlier final rule (68 FR 34494), which changed our methodology for determining outlier payments by implementing the use of more current CCRs. Our refined methodology uses more recent data that reflect the rate-of-change in hospital charges under the new outlier policy.

Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 2007 in combination with the first quarter of FY 2008 (July 1, 2007 through December 31, 2007) to the last quarter of FY 2008 in combination with the first quarter of FY 2009 (July 1, 2008 through December 31, 2008). This rate of change was 7.29 percent (1.0729) or 15.11 percent (1.1511) over 2 years.

As we have done in the past, we established the proposed FY 2010 outlier threshold using hospital CCRs from the December 2008 update to the Provider-Specific File (PSF)—the most recent available data at the time of the proposed rule. This file includes CCRs that reflect implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

As discussed in the FY 2007 IPPS final rule (71 FR 48150), we worked with the Office of Actuary to derive the methodology described below to develop the CCR adjustment factor. For FY 2010, we proposed to continue to use the same methodology to calculate the CCR adjustment by using the FY 2008 operating cost per discharge increase in combination with the actual FY 2008 operating market basket percentage increase determined by IHS Global Insight, Inc., as well as the charge inflation factor described above to estimate the adjustment to the CCRs. (We note that the FY 2008 actual (otherwise referred to as ''final'') operating market basket percentage increase reflects historical data, whereas the published FY 2008 operating market basket update factor was based on IHS Global Insight, Inc.'s 2007 third quarter forecast with historical data through the first quarter of 2008.) By using the operating market basket percentage increase and the increase in the average cost per discharge from hospital cost reports, we are using two different measures of cost inflation. For FY 2010, we determined the adjustment by taking the percentage increase in the operating costs per discharge from FY 2006 to FY 2007 (1.0460) from the cost report and dividing it by the final operating market basket percentage increase from FY 2007 (1.0360). This operation removes the measure of pure price increase (the market basket) from the percentage increase in operating cost per discharge, leaving the nonprice factors in the cost increase (for example, quantity and changes in the mix of goods and services). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the operating market basket percentage increase and the increase in cost per case from the cost report (the FY 2004 to FY 2005 percentage increase of operating costs per discharge of 1.0584 divided by the FY 2005 final operating market basket percentage increase of 1.0390, the FY 2005 to FY 2006 percentage increase of operating costs per discharge of 1.0578 divided by FY 2006 final operating market basket percentage increase of 1.0400). For FY 2010, we averaged the differentials calculated for FY 2005, FY 2006, and FY 2007, which resulted in a mean ratio of 1.0151. We multiplied the 3-year average of 1.0151 by the FY 2008 final operating market basket percentage increase of 1.0400, which resulted in an operating cost inflation factor of 5.56 percent or 1.056. We then divided the operating cost inflation factor by the 1-year average change in charges (1.072893) and applied an adjustment factor of 0.9840 to the operating CCRs from the PSF.

As stated in the FY 2009 IPPS final rule (73 FR 48763), we continue to believe it is appropriate to apply only a 1-year adjustment factor to the CCRs. On average, it takes approximately 9 months for a fiscal intermediary or MAC to tentatively settle a cost report from the fiscal year end of a hospital's cost reporting period. The average ''age'' of hospitals' CCRs from the time the fiscal intermediary or the MAC inserts the CCR in the PSF until the beginning of FY 2009 is approximately 1 year. Therefore, as stated above, we believe a 1-year adjustment factor to the CCRs is appropriate.

We used the same methodology for the capital CCRs and determined the adjustment by taking the percentage increase in the capital costs per discharge from FY 2006 to FY 2007 (1.0488) from the cost report and dividing it by the final capital market basket percentage increase from FY 2007 (1.0130). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the capital market basket percentage increase and the increase in cost per case from the cost report (the FY 2004 to FY 2005 percentage increase of capital costs per discharge of 1.0329 divided by the FY 2005 final capital market basket percentage increase of 1.0090, the FY 2005 to FY 2006 percentage increase of capital costs per discharge of 1.0467 divided by the FY 2006 final capital market basket percentage increase of 1.0110). For FY 2010, we averaged the differentials calculated for FY 2005, FY 2006, and FY 2007, which resulted in a mean ratio of 1.0314. We multiplied the 3-year average of 1.0314 by the FY 2008 final capital market basket percentage increase of 1.0140, which resulted in a capital cost inflation factor of 4.59 percent or 1.0459. We then divided the capital cost inflation factor by the 1-year average change in charges (1.072893) and applied an adjustment factor of 0.9748 to the capital CCRs from the PSF. We are using the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges. Therefore, we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

As stated above, for FY 2010, we applied the proposed FY 2010 rates and policies using cases from the FY 2008 MedPAR files in calculating the proposed outlier threshold. Therefore, for purposes of estimating the proposed outlier threshold for FY 2010, it is necessary to take into account the remaining projected case-mix growth when calculating the outlier threshold that results in outlier payments being 5.1 percent of total payments for FY 2010. As discussed above and in section II.D. of the preamble of this final rule, our actuaries estimate that maintaining budget neutrality for changes in case-mix due to the adoption of the MS–DRGs requires an adjustment of −4.8 percent to the national standardized amount. For FY 2008, our estimate of the case-mix increase due to documentation and coding in FY 2008 is 2.5 percent, which is already included within the claims data (FY 2008 MedPAR files) used to calculate the proposed FY 2010 threshold. In addition, we stated that, even with our assumption that there will be no continued changes in documentation and coding in FY 2009, the use of the FY 2009 relative weights will result in an additional 0.7 percent case-mix increase due to the documentation and coding effect in FY 2009. Therefore, we projected that an additional 1.6 percent case-mix growth occurred since 2008 (4.8 percent −2.5 percent (case-mix growth in FY 2008) −0.7 percent (FY 2009 relative weights effect) = 1.6 percent). As a result, we inflated the FY 2008 claims data by an additional 1.6 percent for the additional case-mix growth projected to have occurred since FY 2008. If we did not take into account the remaining 1.6 percent projected case-mix growth, our estimate of total FY 2010 payments would be too low, and as a result, our proposed outlier threshold would be too high, such that estimated outlier payments would be less than our projected 5.1 percent of total payments. While we assume 1.6 percent case-mix growth for IPPS hospitals in our outlier threshold calculations, the FY 2010 national standardized amounts used to calculate the proposed outlier threshold reflect the proposed cumulative adjustment of -3.4 percent (as described above in this section above).

Using this methodology, we proposed an outlier fixed-loss cost threshold for FY 2010 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $24,240.

In the proposed rule, we stated that as we did in establishing the FY 2009 outlier threshold (73 FR 57891), in our projection of FY 2010 outlier payments, we did not make any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We continue to believe that, due to the policy implemented in the June 9, 2003 outlier final rule (68 FR 34494), CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict the specific hospitals that will have CCRs and outlier payments reconciled in any given year. We also noted that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different than the interim CCRs used to calculate outlier payments when a bill is processed. Our simulations assume that CCRs accurately measure hospital costs based on information available to us at the time we set the outlier threshold. For these reasons, we proposed not to make any

assumptions about the effects of reconciliation on the outlier threshold calculation.

We also noted in the proposed rule that there were some factors that contributed to a higher proposed fixed loss outlier threshold for FY 2010 compared to FY 2009. First, as stated below in section II.A.4.e.(3) of this Addendum, we are currently projecting 5.4 percent of total IPPS payment will be paid as outliers in FY 2009 or 0.3 percentage points greater than the 5.1 percent originally estimated. If we do not increase the FY 2009 threshold in FY 2010, we would continue to make outlier payments in excess of the 5.1 percent target. In addition, because overall payments are projected to be lower in FY 2010 compared to FY 2009, even more cases would qualify for outlier payments. In order to maintain outlier payments at 5.1 percent, the outlier threshold must be further increased to decrease the amount of cases that would qualify as outliers. Together, we believe that the above factors cumulatively contributed to a higher proposed fixed-loss outlier threshold in FY 2010 compared to FY 2009.

Comment: Some commenters stated that it appears CMS is making conservative estimates and assumptions in the numbers and cost of outlier cases in order to be within or materially below the 5.1 percent target. Another commenter stated that CMS should not use FY 2009 projections to determine the FY 2010 threshold and instead CMS should use FY 2008 actual payments. The commenter further stated that underpayment in FY 2008 indicates that the proposed increase in the FY 2010 threshold is overstated.

One commenter objected to CMS' proposal to raise the outlier threshold in FY 2010 (compared to FY 2009). The commenter explained that it does not understand why CMS is proposing to raise the threshold if the FY 2009 threshold has clearly achieved Congress' stated goal. The commenter believed that raising the threshold will jeopardize CMS' ability to meet the outlier target for FY 2010. The commenter also noted that because there is a planned reduction to the rate for documentation and coding, CMS should lower the outlier threshold.

Response: As explained above, we use the most recent data available to set the outlier threshold. Specifically, to calculate the FY 2010 outlier threshold, we simulated payments by applying FY 2010 rates and policies using cases from the FY 2008 MedPAR files. Therefore, we did not use the FY 2009 projection in the modeling of the outlier threshold. In our discussion in the proposed rule of why we believe the threshold increased from FY 2009 to FY 2010, we observed from our analysis that the threshold we set in FY 2009 is currently projecting an outlier estimate of 5.4 percent for FY 2009. Based on this observation, it would seem if we maintained the FY 2009 threshold for FY 2010, we would continue to miss the 5.1 percent target and overpay outliers. Upon modeling the proposed outlier threshold using FY 2008 MedPAR claims and the methodology described above (not including the FY 2009 projection of the outlier estimate), the result was indeed an increased outlier threshold for FY 2010.

We note that in the proposed rule we proposed to reduce the proposed standardized amount by 1.9 percent due to documentation and coding. As stated above, the proposed FY 2010 national standardized amounts used to calculate the proposed outlier threshold reflected the proposed cumulative adjustment of −3.4 percent. We believe that the proposed cumulative documentation and coding adjustment applied to the proposed FY 2010 national standardized amounts to calculate the proposed outlier threshold also contributed to an increase in the proposed FY 2010 outlier threshold from FY 2009. Specifically, as a result of the reduction to the standardized amount for documentation and coding in the proposed rule, more cases would qualify for outliers. Therefore, it was necessary to increase the outlier threshold in the proposed rule to maintain outlier payments at 5.1 percent of overall payments. However, as stated below, for this final rule, the FY 2010 national standardized amounts used to calculate the final outlier threshold reflect the cumulative adjustment of −1.5 percent (from FY 2008 and FY 2009) with no further documentation and coding adjustment for FY 2010. Because we are no longer applying additional documentation and coding adjustments for FY 2010, fewer cases will qualify for outlier payments. Therefore, for this final rule, our use of a FY 2010 national standardized amount that reflects a cumulative adjustment of −1.5 percent rather than −3.4 percent resulted in a lower outlier threshold from the proposed rule in order to maintain outlier payments at 5.1 percent of overall payments.

Comment: One commenter recommended that CMS make a mid-year change to the outlier threshold if it appears that the 5.1 percent target will not be met. The commenter suggested that CMS use more recent CCR data for a mid-year correction to the outlier threshold and use thresholds such as if outlier payments less than 95 percent or greater than 105 percent of the 5.1 percent target to trigger a mid-year adjustment.

Response: We responded to a similar comment in the FY 2006 IPPS final rule (70 FR 47495). We refer readers to that final rule.

Comment: One commenter recommended that CMS use a multiyear trend analysis using actual outlier payments rather than estimating payments based a portion of payments from FY 2009 to determine the FY 2010 outlier threshold. The commenter noted that actual outlier payments for hospitals in its city do not match CMS' projections. The commenter opposed the increase to the outlier threshold and requested that CMS develop a methodology that better predicts the outlier threshold with less variability.

Response: The commenter did not provide an explanation on how to use actual payments to determine the outlier threshold for the coming fiscal year. Also, considering actual outlier payments in the modeling of the outlier threshold would result in our modeling the threshold based on high cost cases that are not relevant to the upcoming fiscal year. In addition, we use the latest data available (that is, the FY 2008 MedPAR) to model the FY 2010 outlier threshold as if we were making payments within FY 2010. We believe our outlier policies are consistent with the statute and the goals of the IPPS.

In response to the comments that actual outlier payments for hospitals in the commenter's city do not match CMS' projections, when we compute the outlier threshold, we set the threshold to meet the 5.1 percent target in the aggregate (on a national basis) and not on an individual hospital basis. It is possible that some hospitals may treat sicker patients than others, thus resulting in an individual outlier percentage that is higher than 5.1 percent, while other hospitals may treat more healthy patients, which results in an outlier percentage that is less than 5.1 percent. Our goal is to set an outlier threshold that meets the 5.1 percent target on a national level. In addition, for FY 2009, we are currently projecting outlier payment to be 5.4 percent of total payments, which is greater than the 5.1 percent target. We believe that the current methodology, which also adjusts the CCRs, has led to better accuracy in determining the outlier threshold in order to maintain outlier payments at 5.1 percent.

Comment: Many commenters stated that CMS currently estimates outlier payments in FY 2008 at 4.8 percent of total payments. The commenters commended CMS for making refinements such as applying an adjustment factor to CCRs when computing the outlier threshold but noted that, because CMS is still not reaching the 5.1 percent target, there is still room for improvement. The commenters further stated that although CMS currently projects outlier payments in FY 2009 to be estimated at 5.4 percent of total payments, which exceeds the 5.1 percent target, this estimate is based on discharges from a prior year and will likely not reflect the actual result. The commenters noted that in prior years when CMS provided its projected estimate of outlier payments for a given fiscal year, once the actual claims were available to determine the actual outlier payment (in the following fiscal year), the estimate declined between 0.2 percent and 0.3 percent from the projection. The commenters suggested that the methodology to develop the adjustment factor to the CCRs is unnecessarily complicated and does not lead to a more accurate result. The commenters urged CMS to adopt a methodology that uses recent historical industry wide average rate of change, similar to the methodology used to develop the charge inflation factor. Further, in addition to applying an adjustment to the CCRs based on historical data, the commenters suggested that the CCRs should be projected over different periods of time, some less or more than one year, based on variations in hospital fiscal year ends. The commenters believed this methodology would more accurately project the decline in CCRs. The commenters also compared its method and CMS' method to the actual FY 2008 rate of change in CCRs and found a variance of 0.6 percent (for the commenters' methodology) compared to 1.6 percent (CMS' methodology).

Response: For this final rule, similar to our response in the FY 2008 final rule (72 FR 47418), in response to the comment that CCRs should be projected over different periods of time, it is possible that some of the

CCRs in the March PSF will be used in FY 2009 for actual outlier payments, while other CCRs may be one year old. Therefore, we apply a 1-year adjustment to the CCRs. With respect to the comment on our methodology used to adjust the CCRs, as we stated in the FY 2008 IPPS final rule with comment period (72 FR 47418), we continue to believe this calculation of an adjustment to the CCRs is more accurate and stable than the commenter's methodology because it takes into account the costs per discharge and the market basket percentage increase when determining a cost adjustment factor. There are times where the market basket and the cost per discharge will be constant, while other times these values will differ from each other, depending on the fiscal year. Therefore, as mentioned above, using the market basket in conjunction with the cost per discharge takes into account two sources that measure potential cost inflation and ensures a more accurate and stable cost adjustment factor.

In addition, as stated below, we are currently projecting FY 2009 payments at an estimate of 5.4 percent of overall payments. As the commenters noted, however, in the past, once actual data is available to determine actual outlier payment, actual outlier payments tend to decline by 0.2 percent or 0.3 percent from CMS' original projection. If this trend holds for FY 2009, actual FY 2009 outlier payments would be very close to our target of 5.1 percent of overall payments. Therefore, we continue to believe that our methodology for adjusting the CCRs is an appropriate method for use in determining the outlier threshold.

Comment: One commenter was concerned that CMS did not include outlier reconciliations in developing the outlier threshold. The commenter requested that CMS disclose in the final rule and future proposed and final IPPS rules the amount of money it has recovered through reconciliation. The commenter explained that this information will allow others to comment specifically on how this provision would impact the threshold.

Response: We thank the commenter for the concern regarding not including outlier reconciliation within the development of the outlier threshold. However, as stated above, we continue to believe that, due to the policy implemented in the June 9, 2003 outlier final rule (68 FR 34494), CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict the specific hospitals that will have CCRs and outlier payments reconciled in any given year. We also noted that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different than the interim CCRs used to calculate outlier payments when a bill is processed. Our simulations assume that CCRs accurately measure hospital costs based on information available to us at the time we set the outlier threshold. For these reasons, we proposed and are finalizing our policy not to make any assumptions about the effects of reconciliation on the outlier threshold calculation.

Comment: Commenters questioned whether CMS Medicare Advantage claims were used in the FY 2010 IPPS proposed rule to calculate the outlier threshold. Commenters also questioned if the charges for organ acquisition costs and anti-hemophilic blood factor were excluded from the modeling of the outlier threshold.

Response: As stated above, we inadvertently included Medicare Advantage claims in the budget neutrality calculations. For this final rule, we have corrected this oversight in the calculation of the FY 2010 final relative weights.

In addition, in the proposed rule, we inadvertently included charges for organ acquisition costs within the budget neutrality calculations and the calculation of the outlier threshold. For the final rule, we excluded charges for organ acquisition costs within the budget neutrality calculations and the calculation of the outlier threshold.

Finally, charges for anti-hemophilic blood factor were included in the proposed budget neutrality calculations and the calculation of the outlier threshold. We examined the MedPAR file and have determined that charges for anti-hemophilic blood factor are contained within the pharmacy charges. Unfortunately, we are currently unable to break out charges for anti-hemophilic blood factor from the pharmacy charges within MedPAR. We will explore the possibility of identifying for anti-hemophilic blood factor charges in future fiscal years.

Because we are not making any changes to our methodology for this final rule, for FY 2010, we are using the same methodology we proposed to calculate the outlier threshold. We used the blended wage indices (as discussed above) when we simulated payments in our outlier modeling to determine the final outlier threshold for FY 2010. Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges per case from the first quarter of FY 2008 in combination with the second quarter of FY 2008 (October 1, 2007 through March 31, 2008) to the first quarter of FY 2009 in combination with the second quarter of FY 2009 (October 1, 2008 through March 31, 2009). This rate of change was 6.8570 percent (1.068570) or 14.184 percent (1.14184) over 2 years.

As we have done in the past, we established the final FY 2010 outlier threshold using hospital CCRs from the March 2009 update to the PSF—the most recent available data at the time of this final rule. This file includes CCRs that reflected implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

For FY 2009, we calculated the CCR adjustment by using the operating cost per discharge increase in combination with the market basket increase determined by IHS Global Insight, Inc., as well as the charge inflation factor described above to estimate the adjustment to the CCRs. We determined the operating CCR adjustment by taking the percentage increase in the operating costs per discharge from FY 2006 to FY 2007 (1.0463) from the cost report and dividing it by the final market basket increase from FY 2007 (1.036). This operation removes the measure of pure price increase (the market basket) from the percentage increase in operating cost per discharge, leaving the non-price factors in the cost increase (that is, quantity and changes in the mix of goods and services) to increase the projected market basket for estimating the future cost increase. We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the market basket rate-of-increase and the increase in cost per case from the cost report (FY 2004 to FY 2005 percentage increase of operating costs per discharge of 1.0585 divided by FY 2005 final market basket increase of 1.039, FY 2005 to FY 2006 percentage increase of operating costs per discharge of 1.0574 divided by FY 2006 final market basket increase of 1.04). For FY 2010, we averaged the differentials calculated for FY 2005, FY 2006, and FY 2007 which resulted in a mean ratio of 1.0151. We multiplied the 3-year average of 1.0151 by the FY 2008 final market basket percentage increase of 1.04, which resulted in an operating cost inflation factor of 5.58 percent or 1.0558. We then divided the operating cost inflation factor by the 1-year average change in charges (1.068570) and applied an adjustment factor of 0.988 to the operating CCRs from the PSF.

We used the same methodology for the capital CCRs and determined the adjustment by taking the percentage increase in the capital costs per discharge from FY 2006 to FY 2007 (1.0502) from the cost report and dividing it by the final capital market basket increase from FY 2007 (1.013). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the capital market basket rate-of-increase and the increase in cost per case from the cost report (FY 2004 to FY 2005 percentage increase of capital costs per discharge of 1.0323 divided by FY 2005 final capital market basket increase of 1.009, FY 2005 to FY 2006 percentage increase of capital costs per discharge of 1.0464 divided by FY 2006 final capital market basket increase of 1.0110). For FY 2010, we averaged the differentials calculated for FY 2005, FY 2006, and FY 2007, which resulted in a mean ratio of 1.0316. We multiplied the 3-year average of 1.0316 by the FY 2008 final capital market basket percentage increase of 1.0140, which resulted in a capital cost inflation factor of 4.61 percent or 1.0461. We then divided the capital cost inflation factor by the 1-year average change in charges (1.068570) and applied an adjustment factor of 0.9789 to the capital CCRs from the PSF. We are using the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges. Therefore, we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

As stated above, for FY 2010, we applied the final FY 2010 rates and policies using cases from the FY 2008 MedPAR files in calculating the outlier threshold. Therefore, for purposes of estimating the outlier threshold for FY 2010, it is necessary to take into account the remaining projected case-mix growth when calculating the outlier threshold that results in outlier payments being 5.1 percent of total payments for FY

2010. As discussed above and in section II.D. of the preamble of this final rule, our actuaries estimate that maintaining budget neutrality for changes in case-mix due to the adoption of the MS–DRGs requires an adjustment of −4.8 percent to the national standardized amount. For FY 2008, our estimate of the case-mix increase due to documentation and coding in FY 2008 is 2.5 percent, which is already included within the claims data (FY 2008 MedPAR files) used to calculate the proposed FY 2010 threshold. Based on the updated data used for this final rule (the March 2009 update to the FY 2008 MedPAR), even with our assumption that there will be no continued changes in documentation and coding in FY 2009, we now estimate that the use of the FY 2009 relative weights will result in an additional 0.76 percent case-mix increase due to the documentation and coding effect in FY 2009. (In the proposed rule, we estimated an additional 0.7 percent case-mix increase due to the documentation and coding effect in FY 2009). Therefore, for this final rule, we are projecting an additional 1.54 percent case-mix growth to have occurred since 2008 (4.8 percent −2.5 percent (case-mix growth in FY 2008) −0.76 percent (FY 2009 relative weights effect) = 1.54 percent). As a result, we inflated the FY 2008 claims data by an additional 1.54 percent for the additional case-mix growth projected to have occurred since FY 2008. If we did not take into account the remaining 1.54 percent projected case-mix growth, our estimate of total FY 2010 payments would be too low, and as a result, our outlier threshold would be too high, such that estimated outlier payments would be less than our projected 5.1 percent of total payments. While we assume 1.54 percent case-mix growth for IPPS hospitals in our outlier threshold calculations, as stated above, we are opting to postpone adopting documentation and coding adjustments as authorized under section 7(a) of Public Law 110–90 and section 1886(d)(3)(A)(vi) of the Act until a full analysis of FY 2009 case-mix changes can be completed. Therefore, the FY 2010 national standardized amounts used to calculate the final outlier threshold reflect the cumulative adjustment of −1.5 percent (from FY 2008 and FY 2009) with no further documentation and coding adjustment for FY 2010.

Using this methodology, we calculated a final outlier fixed-loss cost threshold for FY 2010 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $23,140. With this threshold, we project that outlier payments will equal 5.1 percent of total IPPS payments.

As we stated above and as we established the FY 2009 outlier threshold (72 FR 47419), in our projection of FY 2010 outlier payments, we are not making any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We continue to believe that, due to the policy implemented in the outlier final rule (68 FR 34494, June 9, 2003), CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict the specific hospitals that will have CCRs and outlier payments reconciled in any given year. We also noted that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different than the interim CCRs used to calculate outlier payments when a bill is processed. Our simulations assume that CCRs accurately measure hospital costs based on information available to us at the time we set the outlier threshold. For these reasons, we are not making any assumptions about the effects of reconciliation on the outlier threshold calculation.

We also note that the final threshold for FY 2010 is lower than the FY 2010 proposed outlier threshold. As stated above, we are opting to postpone adopting documentation and coding adjustments as authorized under section 7(a) of Public Law 110–90 and section 1886(d)(3)(A)(vi) of the Act until a full analysis of FY 2009 case-mix changes can be completed. Because we are not further reducing the standardized amount for documentation and coding in FY 2010, fewer cases will qualify for outlier payments thus requiring us to lower the threshold from the proposed rule to this final rule.

(2) Other Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2010 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.2 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are reducing the FY 2010 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The outlier adjustment factors that will be applied to the standardized amount for the FY 2010 outlier threshold are as follows:

	Operating standard-ized amounts	Capital Federal rate
National	0.948994	0.947689
Puerto Rico	0.957524	0.935958

We are applying the outlier adjustment factors to the FY 2010 rates after removing the effects of the FY 2009 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

The June 9, 2003 outlier final rule (68 FR 34494) eliminated the application of the statewide average CCRs for hospitals with CCRs that fell below 3 standard deviations from the national mean CCR. However, for those hospitals for which the fiscal intermediary or MAC computes operating CCRs greater than 1.179 or capital CCRs greater than 0.148, or hospitals for whom the fiscal intermediary or MAC is unable to calculate a CCR (as described at § 412.84(i)(3) of our regulations), we still use statewide average CCRs to determine whether a hospital qualifies for outlier payments.[13] Table 8A in this Addendum contains the statewide average operating CCRs for urban hospitals and for rural hospitals for which the fiscal intermediary or MAC is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2009, these statewide average ratios will replace the ratios published in the IPPS final rule for FY 2009 (73 FR 48994 through 48995). Table 8B in this Addendum contains the comparable statewide average capital CCRs. Again, the CCRs in Tables 8A and 8B will be used during FY 2010 when hospital-specific CCRs based on the latest settled cost report are either not available or are outside the range noted above. For an explanation of Table 8C, we refer readers to section V. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating and/or capital CCRs to work with their fiscal intermediary or MAC on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the fiscal intermediary or MAC can avoid possible overpayments or underpayments at cost report settlement, thus ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note that a hospital may request an alternative operating or capital CCR ratio at any time as long as the guidelines of Change Request 3966 are followed. To download and view the manual instructions on outlier and CCRs, we refer readers to CMS Web site: *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf*.

(3) FY 2008 and FY 2009 Outlier Payments

In the FY 2009 IPPS final rule (73 FR 48766), we stated that, based on available data, we estimated that actual FY 2008 outlier payments would be approximately 4.7 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2007 MedPAR file (discharge data for FY 2007 claims). That is, the estimate of actual outlier payments did not reflect actual FY 2008 claims, but instead reflected the application of FY 2008 rates and policies to available FY 2007 claims.

[13] These figures represent 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals.

Our current estimate, using available FY 2008 claims data, is that actual outlier payments for FY 2008 were approximately 4.8 percent of actual total DRG payments. Thus, the data indicate that, for FY 2008, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2008. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2008 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2009 will be approximately 5.4 percent of actual total DRG payments, 0.3 percentage points higher than the 5.1 percent we projected in setting the outlier policies for FY 2009. This estimate is based on simulations using the FY 2008 MedPAR file (discharge data for FY 2008 claims). We used these data to calculate an estimate of the actual outlier percentage for FY 2009 by applying FY 2009 rates and policies, including an outlier threshold of $20,045 to available FY 2008 claims.

Comment: One commenter simulated CMS' estimate of the FY 2008 outlier payment and determined an outlier payment percentage of 4.57 percent. The commenter noted that it is has consistently determined different actual outlier payout percentages for the last couple of years. The commenter requested that CMS revisit its calculations and publish an explanation to explain the discrepancy in FY 2008.

Response: We are not sure why there is a discrepancy between our estimate of the FY 2008 outlier payment and the commenter's estimate of the FY 2008 outlier payment. Perhaps the commenter used different data trims than we used when computing the FY 2008 outlier estimate. Without knowing the specifics of how the commenter computed their estimate, it is possible that CMS and the commenter can reach two different estimates. We invite the commenter to share its analysis in detail with us so we can distinguish any differences between CMS' calculation of the outlier estimate and the commenter's calculation of the outlier estimate.

f. Rural Community Hospital Demonstration Program Adjustment (Section 410A of Pub. L. 108–173)

Section 410A of Public Law 108–173 requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) of Public Law 108–173 requires that ''[i]n conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section V.I. of the preamble of this final rule, we have satisfied this requirement by making an adjustment to the national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $1,371,023. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that are participating in the demonstration program. For 11 participating hospitals, the projected total annual impact of the demonstration program for FY 2010 is $15,081,251. In addition, because the cost reports of all hospitals participating in the demonstration in its first and second years (that is, FY 2005 and FY 2006) have been finalized, we are able to determine how much the cost of the demonstration program exceeded the amount that was offset by the budget neutrality adjustment for FY 2005 and FY 2006. For all 13 hospitals that participated in the demonstration in FY 2005, the amount is $7,856,617. For the 10 hospitals that participated in the demonstration in FY 2006, the amount is $4,203,947. Therefore, the projected total annual impact of the demonstration program for FY 2010 is $27,141,815. The budget neutrality adjustment factor applied to the Federal rate to calculate Medicare inpatient prospective payments as a result of the demonstration is 0.999739.

In order to achieve budget neutrality, we are adjusting the national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are applying budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration, consistent with past practice. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. The statutory language requires that ''aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented,'' but does not identify the range across which aggregate payments must be held equal.

5. FY 2010 Standardized Amount

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B of this Addendum contain the national standardized amounts that we are applying to all hospitals, except hospitals located in Puerto Rico, for FY 2010. The Puerto Rico-specific amounts are shown in Table 1C of this Addendum. The amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is the revised labor-related share of 68.8 percent, and Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying a labor-related share of 62 percent, unless application of that percentage would result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we will apply a labor-related share of 62 percent for all hospitals (other than those in Puerto Rico) whose wage indices are less than or equal to 1.0000.

In addition, Tables 1A and 1B include standardized amounts reflecting the full 2.1 percent update for FY 2010, and the standardized amounts reflecting the 2.0 percentage point reduction to the update (a 0.1 percent update) applicable for hospitals that fail to submit quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (this amount is set forth in Table 1A). The labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2010 are set forth in Table 1C of this Addendum. This table also includes the Puerto Rico standardized amounts. The labor-related share applied to the Puerto Rico specific standardized amount is the labor-related share of 62.1 percent, or 62 percent, depending on which provides higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Pub. L. 108–173, provides that the labor-related share for hospitals located in Puerto Rico be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

The following table illustrates the changes from the FY 2009 national standardized amount. The second column shows the changes from the FY 2009 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (2.1 percent). The third column shows the changes for hospitals receiving the reduced update (0.1 percent). The first row of the table shows the updated (through FY 2009) average standardized amount after restoring the FY 2008 offsets for outlier payments, demonstration budget neutrality and the geographic reclassification budget neutrality. The DRG reclassification and recalibration wage index budget neutrality factors are cumulative. Therefore, the FY 2009 factor is not removed from this table. Additionally, the documentation and coding adjustments for FY 2008 and FY 2009 are cumulative. Therefore, the FY 2008 and FY 2009 adjustment factors are not removed from this table. We also have added separate rows to this table to reflect the different labor-related shares that apply to hospitals.

COMPARISON OF FY 2009 STANDARDIZED AMOUNTS TO THE FY 2010 STANDARDIZED AMOUNT WITH FULL AND REDUCED UPDATE

	Full update (2.1 percent); wage index is greater than 1.0000	Full update (2.1 percent); wage index is less than or equal to 1.0000	Reduced update (0.1 percent); wage index is greater than 1.0000	Reduced update (0.1 percent); wage index is less than or equal to 1.0000
FY 2009 Base Rate, after removing geographic reclassification budget neutrality, demonstration budget neutrality and outlier offset (based on the labor-related share percentage for FY 2010).	Labor: $3,748.52 ..... Nonlabor: $1,699.91 ..	Labor: $3,378.40 ..... Nonlabor: $2,070.40 ..	Labor: $3,748.52 ..... Nonlabor: $1,699.91 ..	Labor: $3,378.03. Nonlabor: $2,070.40.
FY 2010 Update Factor	1.021	1.021	1.001	1.001.
FY 2010 DRG Recalibration and Wage Index Budget Neutrality Factor.	0.998347	0.998347	0.998347	0.998347.
FY 2010 Reclassification Budget Neutrality Factor.	0.991297	0.991297	0.991297	0.991297.
FY 2010 Outlier Factor	0.948994	0.948994	0.948994	0.948994.
Rural Demonstration Budget Neutrality Factor.	0.999739	0.999739	0.999739	0.999739.
Rate for FY 2010	Labor: $3,593.52 ..... Nonlabor: $1,629.62 ..	Labor: $3,238.35 ..... Nonlabor: $1,984.79 ..	Labor: $3,523.13 ..... Nonlabor: $1,597.70 ..	Labor: $3,174.91. Nonlabor: $1,945.92.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national standardized amount (as set forth in Table 1A of this Addendum). The labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C of this Addendum. This table also includes the Puerto Rico standardized amounts. The labor-related share applied to the Puerto Rico standardized amount is 62.1 percent, or 62 percent, depending on which results in higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Pub. L. 108–173, provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as set forth in this Addendum, contain the labor-related and nonlabor-related shares that we are using to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2010. This section addresses two types of adjustments to the standardized amounts that are made in determining the proposed prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble of this final rule, we discuss the data and methodology for the FY 2010 wage index.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes the Secretary to make an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2010, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the applicable adjustment factor contained in the table below. These factors were obtained from the U.S. Office of Personnel Management (OPM) and are currently also used under the IPPS.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS

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

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

C. MS–DRG Relative Weights

As discussed in section II.H. of the preamble of this final rule, we have developed relative weights for each MS–DRG that reflect the resource utilization of cases in each MS–DRG relative to Medicare cases in other MS–DRGs. Table 5 of this Addendum contains the relative weights that we will apply to discharges occurring in FY 2010. These factors have been recalibrated as explained in section II. of the preamble of this final rule.

D. Calculation of the Prospective Payment Rates

General Formula for Calculation of the Prospective Payment Rates for FY 2010

In general, the operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, for FY 2010 equals the Federal rate.

Currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or for cost reporting periods beginning on or after January 1, 2009, the updated hospital-specific rate based on the FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

The prospective payment rate for SCHs for FY 2010 equals the higher of the applicable Federal rate, or the hospital-specific rate as described below. The prospective payment rate for MDHs for FY 2010 equals the higher of the Federal rate, or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate as described below. The prospective payment rate for hospitals located in Puerto Rico for FY 2010 equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate.

1. Federal Rate

The Federal rate is determined as follows:

Step 1—Select the applicable average standardized amount depending on whether the hospital submitted qualifying quality data (full update for qualifying hospitals, update minus 2.0 percentage points for nonqualifying hospitals).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the applicable cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if applicable, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the applicable MS–DRG (see Table 5 of this Addendum).

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment. In addition, for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act and 42 CFR 412.101(b), the payment in Step 5 would be increased by 25 percent.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that, for cost reporting periods beginning prior to January 1, 2009, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or for cost reporting periods beginning on or after January 1, 2009, the updated hospital-specific rate based on the FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

As discussed previously, we are required to rebase MDHs hospital-specific rates to their FY 2002 cost reports if doing so results in higher payments. In addition, effective for discharges occurring on or after October 1, 2006, MDHs are to be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent (changed from 50 percent) of the difference between the Federal national rate and the greater of the updated hospital-specific rates based on either FY 1982, FY 1987 or FY 2002 costs per discharge. Further, MDHs are no longer subject to the 12-percent cap on their DSH payment adjustment factor.

Hospital-specific rates have been determined for each of these hospitals based on the FY 1982 costs per discharge, the FY 1987 costs per discharge, or, for SCHs, the FY 1996 costs per discharge or the FY 2006 costs per discharge, and for MDHs, the FY 2002 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the FY 1984 IPPS interim final rule (48 FR 39772); the April 20, 1990 final rule with comment period (55 FR 15150); the FY 1991 IPPS final rule (55 FR 35994); and the FY 2001 IPPS final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor as discussed in section III. of this Addendum. The resulting rate will be used in determining the payment rate an SCH or MDH will receive for its discharges beginning on or after October 1, 2009.

b. Updating the FY 1982, FY 1987, FY 1996, FY 2002, and FY 2006 Hospital-Specific Rates for FY 2010

We are increasing the hospital-specific rates by 2.1 percent (the hospital market basket percentage increase) for FY 2010 for those SCHs and MDHs that submit qualifying quality data and by 0.1 percent for SCHs and MDHs that fail to submit qualifying quality data. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2009, is the market basket percentage increase for hospitals that submit qualifying quality data and the market basket percentage increase minus 2 percent for hospitals that fail to submit qualifying quality data. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided for under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2009, is the market basket percentage increase for hospitals that submit qualifying quality data and the market basket percentage increase minus 2 percent for hospitals that fail to submit qualifying quality data.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2009, and Before October 1, 2010

Section 1886(d)(9)(E)(iv) of the Act provides that, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount considering the applicable wage index (Table 1C of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable Puerto Rico-specific wage index.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (Table 5 of this Addendum).

Step 5—Multiply the result in Step 4 by 25 percent.

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount.

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the national average standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (Table 5 of this Addendum).

Step 5—Multiply the result in Step 4 by 75 percent.

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate would then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2010

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth

in the regulations at 42 CFR 412.308 through 412.352. Below we discuss the factors that we used to determine the capital Federal rate for FY 2010, which will be effective for discharges occurring on or after October 1, 2009.

The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under § 412.304(c)(2)) are paid based on the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provide that the capital Federal rate be adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor (GAF) are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the respective fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital Federal rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital Federal rate made in FY 1996 as a result of the revised policy for paying for transfers. In FY 1998, we implemented section 4402 of Public Law 105–33, which required that, for discharges occurring on or after October 1, 1997, the budget neutrality adjustment factor in effect as of September 30, 1995, be applied to the unadjusted capital standard Federal rate and the unadjusted hospital-specific rate. That factor was 0.8432, which was equivalent to a 15.68 percent reduction to the unadjusted capital payment rates. An additional 2.1 percent reduction to the rates was effective from October 1, 1997 through September 30, 2002, making the total reduction 17.78 percent. As we discussed in the FY 2003 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6), the 2.1 percent reduction was restored to the unadjusted capital payment rates effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the FY 2002 IPPS final rule (66 FR 39911), beginning in FY 2002, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because payments are no longer made under the regular exception policy effective with cost reporting periods beginning in FY 2002, we discontinued use of the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099).

Section 412.374 provides for blended payments to hospitals located in Puerto Rico under the IPPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals located in Puerto Rico were paid a blended operating rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. Similarly, prior to FY 1998, hospitals located in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable capital Puerto Rico-specific rate and 25 percent of the applicable capital Federal rate. However, effective October 1, 1997, in accordance with section 4406 of Public Law 105–33, the methodology for operating payments made to hospitals located in Puerto Rico under the IPPS was revised to make payments based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges occurring on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the national capital Federal rate.

As we discussed in the FY 2005 IPPS final rule (69 FR 49185), section 504 of Public Law 108–173 increased the national portion of the operating IPPS payments for hospitals located in Puerto Rico from 50 percent to 62.5 percent and decreased the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004 through September 30, 2004 (refer to the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Public Law 108–173 provided that the national portion of operating IPPS payments for hospitals located in Puerto Rico is equal to 75 percent and the Puerto Rico-specific portion of operating IPPS payments is equal to 25 percent for discharges occurring on or after October 1, 2004. Consistent with that change in operating IPPS payments to hospitals located in Puerto Rico, for FY 2005 (as we discussed in the FY 2005 IPPS final rule), we revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the Puerto Rico-specific capital rate and 75 percent of the national capital Federal rate for discharges occurring on or after October 1, 2004.

A. Determination of Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the **Federal Register** notice setting out the final wage indices for FY 2009 (73 FR 57892), we established the final capital Federal rate of $424.17 for FY 2009. In the discussion that follows, we explain the factors that we used to determine the capital Federal rate for FY 2010. In particular, we explain why the FY 2010 capital Federal rate will increase approximately 1.4 percent, compared to the FY 2009 capital Federal rate. Furthermore, we estimate that aggregate capital payments will increase during this same period (approximately $171 million), primarily due to the increase in the capital Federal rate. Total payments to hospitals under the IPPS are relatively unaffected by changes in the capital prospective payments. Because capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about a 0.1 percent change in actual payments to hospitals.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The update factor for FY 2010 under that framework is 1.40 percent based on the best data available at this time. The update factor under that framework is based on a projected 1.4 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2008 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. As discussed below in section III.C. of this Addendum, we continue to believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2010 CIPI

projection in that same section of this Addendum. We note, as discussed in section VI.E.1. of the preamble of this final rule, we are not applying any additional adjustments to the capital rates in FY 2010 to account for changes in documentation and coding under the MS–DRGs that do not correspond to changes in real increases in patients' severity of illness. Below we describe the policy adjustments that we applied in the update framework for FY 2010.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital documentation and coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in documentation and coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2004 IPPS proposed rule for FY 2005 (69 FR 28816)). (We no longer use an update framework to make a recommendation for updating the operating IPPS standardized amounts as discussed in section II. of Appendix B in the FY 2006 IPPS final rule (70 FR 47707).)

Absent the projected increase in case-mix resulting from changes in documentation and coding due to the adoption of the MS–DRGs, for FY 2010, we projected a 1.0 percent total increase in the case-mix index. We estimated that the real case-mix increase will also equal 1.0 percent for FY 2010. The net adjustment for change in case-mix is the difference between the projected real increase in case-mix and the projected total increase in case-mix. Therefore, the net adjustment for case-mix change in FY 2010 is 0.0 percentage points.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year's changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we have data available to evaluate the effects of the FY 2008 DRG reclassification and recalibration as part of our update for FY 2010. To adjust for reclassification and recalibration effects, under our historical methodology, we run the FY 2008 cases through the FY 2007 GROUPER and through the FY 2008 GROUPER. The resulting ratio of the case-mix indices should equate to 1.0. If not, under our historical methodology, in the update framework for FY 2010, we would make an adjustment to adjust for the reclassification and recalibration effects in FY 2008. As discussed in detail in section II.B. of the preamble of this final rule, however, when we adopted the MS–DRGs for FY 2008 to better recognize severity of illness in Medicare payment rates, we also recognized that changes in documentation and coding could potentially lead to increases in aggregate payments without a corresponding increase in patients' severity of illness (that is, increased case-mix index other than real case-mix index increase). To maintain budget neutrality for the adoption of the MS–DRGs, in the proposed rule, we proposed to apply a –1.9 percent adjustment to the capital Federal rate in FY 2010 to account for the effect of documentation and coding changes unrelated to changes in real case-mix in FY 2008. Therefore, in that same proposed rule, we proposed not to adjust for reclassification and recalibration effects from FY 2008 in the update framework for FY 2010 because it was already accounted for in the proposed documentation and coding adjustment to the capital Federal rates for FY 2010.

As discussed in greater detail in section II.D. of the preamble of this final rule, we are delaying any additional documentation and coding adjustment to the capital Federal rates until a full analysis of case-mix changes can be completed (as noted in section VI.E.1. of the preamble of this final rule, the capital Federal rate has already been adjusted by −0.6 percent and −0.9 percent to account for the effects of documentation and coding in FY 2008 and FY 2009, respectively, for a cumulative adjustment of −1.5 percent). Therefore, as proposed, we are not making any adjustment for the effects of FY 2008 DRG reclassification and recalibration in the update framework for FY 2010 because we will be accounting for it when an adjustment to the capital Federal rates for the additional documentation and coding effect that occurred in FY 2008 is made in future rulemaking.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the availability of data to develop a measurement of the forecast error. A forecast error of 0.1 percentage point was calculated for the FY 2010 update. That is, current historical data indicate that the forecasted FY 2008 CIPI (1.3 percent) used in calculating the FY 2008 update factor slightly understated the actual realized price increases (1.4 percent) by 0.1 percentage point. This slight underprediction was mostly due to the incorporation of newly available source data for fixed asset prices and moveable asset prices into the market basket. However, because this estimation of the change in the CIPI is less than 0.25 percentage points, it is not reflected in the update recommended under this framework. Therefore, we made a 0.0 percent adjustment for forecast error in the update for FY 2010.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that were used in the past under the framework for operating IPPS. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes within DRG severity, and for expected modification of practice patterns to remove noncost-effective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CIPI for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor; that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and the combination of quality-enhancing new technologies and complexity within the DRG system, we assume that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for increases within DRG severity and the adoption of quality-enhancing technology.

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (*Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988* by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady increase of 1.0 to 1.5 percent per year. However, we used 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services.

For FYs 1996 through 2001, we found that case-mix constant intensity was declining, and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2002 and 2003, we found that case-mix constant intensity was increasing, and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively. For FYs 2004 and 2005, we found that the charge data appeared to be skewed (as discussed in greater detail below) as a result of hospitals attempting to maximize outlier payments, while lessening costs, and we established a 0.0 percent adjustment in each of those years. Furthermore, we stated that we would continue to apply a 0.0 percent adjustment for intensity until any increase in charges can be tied to intensity rather than attempts to maximize outlier payments.

On June 9, 2003, we published in the **Federal Register** revisions to our outlier policy for determining the additional payment for extraordinarily high-cost cases (68 FR 34494 through 34515). These revised policies were effective on August 8, 2003, and October 1, 2003. While it does appear that a response to these policy changes is beginning to occur, that is, the increase in charges for FYs 2004 and 2005 are somewhat less than the previous 4 years, they still show a significant annual increase in charges without a corresponding increase in hospital case-mix. Specifically, the percent change in hospitals' charges in FY 2004 is approximately 12 percent, which is similar in magnitude to the large increases in charges that we found in the 4 years prior to FY 2004 and before our revisions to the outlier policy in FY 2003. For FY 2005, there is approximately an 8 percent change in charges, which is somewhat lower than the percent change in FY 2004. Nevertheless, the percent change in charges in both FYs 2004 and 2005 are still relatively high as compared to the change in charges prior to FY 2001. Moreover, the percent change in hospitals' case-mix in those years is not in proportion to the higher charges. The remaining 3 years in the 5-year average indicate that the change in hospitals' charges appears to be slightly moderating, and is lower than FYs 2004 and 2005. (We refer readers to a discussion regarding the intensity factor in the FY 2004 IPPS final rule (68 FR 45482), the FY 2005 IPPS final rule (69 FR 49285), the FY 2006 IPPS final rule (70 FR 47500), the FY 2007 IPPS final rule (72 FR 47500), the FY 2008 IPPS final rule with comment period (72 FR 47426), and the FY 2009 IPPS final rule (73 FR 48771.)

Our intensity measure is based on a 5-year average, and therefore, the intensity adjustment for FY 2010 is based on data from the 5-year period beginning with FY 2004 and extending through FY 2008. Based on the increases in charges for FYs 2004 through 2005 that remain in the 5-year average used for the intensity adjustment, we believe residual effects of hospitals' charge practices prior to the implementation of the outlier policy revisions established in the June 9, 2003 final rule continue to appear in the data, as it may have taken hospitals some time to adopt changes in their behavior in response to the new outlier policy. Thus, we believe that the FY 2004 and possibly the FY 2005 charge data may still be skewed.

The change in hospitals' charges for FY 2004 and to a somewhat lesser extent, FY 2005, remains similar to the considerable increase in hospitals' charges that we found when examining hospitals' charge data in determining the intensity factor in the update recommendations for the past few years. If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally, and it did not.

Although it appears that the change in hospitals' charges is more reasonable compared to data used in recent past rulemaking, using a 5-year average of the data tends to smooth out what might otherwise be more obvious effects of particular years such as FYs 2004 and 2005. Therefore, notwithstanding the gradual effect of the outlier policy over time, we believe the effect from hospitals attempting to maximize outlier payments prior to the implementation of the outlier policy continues, albeit to a smaller degree, to skew the charge data used in determining the intensity adjustment.

As we discussed most recently in the FY 2009 IPPS final rule (73 FR 48771), because our intensity calculation relies heavily upon charge data and we believe that these charge data for at least 1 if not 2 years of the 5-year average may be inappropriately skewed, as we proposed, we are establishing a 0.0 percent adjustment for intensity for FY 2010, as we did for FYs 2004 through 2009.

In the past (FYs 1996 through 2001) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to apply a zero intensity adjustment for FY 2010 until any increase in charges during the 5-year period upon which the intensity adjustment is based can be tied to intensity rather than to attempts to maximize outlier payments.

Above, we described the basis of the components used to develop the 1.4 percent capital update factor under the capital update framework for FY 2010 as shown in the table below.

CMS FY 2010 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	1.4
Intensity	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	−1.0
Projected Case-Mix Change	1.0
Subtotal	1.4
Effect of FY 2008 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Update	1.4

b. Comparison of CMS and MedPAC Update Recommendation

In its March 2009 Report to Congress, MedPAC did not make a specific update recommendation for capital IPPS payments for FY 2010. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2009, Section 2A.)

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier payment methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating IPPS DRG payments.

In the **Federal Register** notice setting out the final wage indices for FY 2009 (73 FR 57891), we estimated that outlier payments for capital will equal 5.35 percent of inpatient capital-related payments based on the capital Federal rate in FY 2009. Based on the thresholds as set forth in section II.A. of this Addendum, we estimate that outlier payments for capital-related costs will equal 5.23 percent for inpatient capital-related payments based on the capital Federal rate in FY 2010. Therefore, we applied an outlier adjustment factor of 0.9477 in determining the capital Federal rate. Thus, we estimate that the percentage of capital outlier payments to total capital standard payments for FY 2010 will be lower than the percentage for FY 2009. This decrease in capital outlier payments is primarily due to the increase in estimated aggregate capital IPPS payments. That is, because overall payments are projected to be higher in FY 2010 compared to FY 2009, as discussed in section VIII. of Appendix A to this final rule, fewer cases will qualify for outlier payments.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The FY 2010 outlier adjustment of 0.9477 is a 0.13 percent change from the FY 2009 outlier adjustment of 0.9465. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2010 is 1.0013 (0.9477/0.9465). Thus, the outlier adjustment increases the FY 2010 capital Federal rate by 0.13 percent compared with the FY 2009 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for

DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we no longer use the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the factors for FY 2010, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2009 MS–DRG classifications and relative weights and the FY 2009 GAF to estimated aggregate capital Federal rate payments based on the FY 2010 MS–DRG classifications and relative weights and the FY 2010 GAFs. In making the comparison, we set the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national GAFs, based on calculations using updated data, we applied an incremental budget neutrality adjustment of 0.9995 for FY 2010 to the previous cumulative FY 2009 adjustment of 0.9917, yielding an adjustment of 0.9912, through FY 2010. For the Puerto Rico GAFs, we applied an incremental budget neutrality adjustment of 1.0014 for FY 2010 to the previous cumulative FY 2009 adjustment of 0.9960, yielding a cumulative adjustment of 0.9974 through FY 2010.

We then compared estimated aggregate capital Federal rate payments based on the FY 2009 DRG relative weights and the FY 2010 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the FY 2010 MS–DRG classifications and relative weights and the FY 2010 GAFs. The incremental adjustment for DRG classifications and changes in relative weights is 0.9995 both nationally and for Puerto Rico. The cumulative adjustments for MS–DRG classifications and changes in relative weights and for changes in the GAFs through FY 2010 are 0.9907 nationally and 0.9969 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG Reclassifications and recalibration	Combined		Geographic adjustment factor	DRG Reclassifications and recalibration	Combined	
1992				1.00000				
1993			0.99800	0.99800				
1994			1.00531	1.00330				
1995			0.99980	1.00310				
1996			0.99940	1.00250				
1997			0.99873	1.00123				
1998			0.99892	1.00015				1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001 [1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
[2] 2001	[3] 0.99771	[3] 1.00009	[3] 0.99780	0.99922	[3] 1.00365	[3] 1.00009	[3] 1.00374	1.00508
2002	[4] 0.99666	[4] 0.99668	[4] 0.99335	0.99268	[4] 0.98991	[4] 0.99668	[4] 0.99662	0.99164
2003 [5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003 [6]	[7] 0.99896	[7] 0.99662	[7] 0.99558	0.98830	1.00809	0.99662	1.00468	0.99628
2004 [8]	[9] 1.00175	[9] 1.00081	[9] 1.00256	0.99083	1.00028	1.00081	1.00109	0.99736
2004 [10]	[9] 1.00164	[9] 1.00081	[9] 1.00245	0.99072	1.00028	1.00081	1.00109	0.99736
2005 [11]	[12] 0.99967	1.00094	[12] 1.00061	0.99137	0.99115	1.00094	0.99208	0.98946
2005 [13]	[13] 0.99946	1.00094	[12] 1.00040	0.99117	0.99115	1.00094	0.99208	0.98946
2006	[14] 1.00185	0.99892	[14] 1.00076	0.99198	1.00762	0.99892	1.00653	0.99592
2007	1.00000	0.99858	0.99858	0.99057	1.00234	0.99858	1.00092	0.99683
2008	1.00172	0.99792	0.99963	0.99021	1.00079	0.99792	0.99870	0.99554
[15]	1.00206	0.99945	1.00150	0.99170	1.00097	0.99945	1.00041	0.99595
2010 [16]	0.99950	0.99953	0.99902	0.99073	1.00141	0.99953	1.00094	0.99688

[1] Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3] Incremental factors are applied to FY 2000 cumulative factors.
[4] Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5] Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6] Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7] Incremental factors are applied to FY 2002 cumulative factors.
[8] Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9] Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10] Factors effective for the second half of FY 2004 (April 2004 through September 2004).
[11] Factors effective for the first quarter of FY 2005 (September 2004 through December 2004).
[12] Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.
[13] Factors effective for the last three quarters of FY 2005 (January 2005 through September 2005).
[14] Incremental factors are applied to average of the cumulative factors for 2005.
[15] Final factors for FY 2009, including the implementation of section 124 of Public Law 110–275, which affects wage indices and GAFs for FY 2009, as discussed above in this section.
[16] Final factors for FY 2010.

The methodology used to determine the recalibration and geographic adjustment factor (DRG/GAF) budget neutrality adjustment is similar to the methodology used in establishing budget neutrality adjustments under the IPPS for operating costs. One difference is that, under the operating IPPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital IPPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for DSH or IME.

For FY 2009, we calculated a final GAF/DRG budget neutrality factor of 1.0015 (73 FR 57892). For FY 2010, we established a GAF/DRG budget neutrality factor of 0.9990. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs. The incremental change in the adjustment from FY 2009 to FY 2010 is 0.9990. The cumulative change in the capital Federal rate due to this adjustment is 0.9907 (the product of the incremental factors for FYs 1995 though 2009 and the incremental factor of 0.9990 for FY 2010). (We note that averages of the incremental factors that were in effect during FYs 2005 and 2006, respectively, were used in the calculation of the cumulative adjustment of 0.9907 for FY 2010.)

The factor accounts for the MS–DRG reclassifications and recalibration and for changes in the GAFs. It also incorporates the effects on the GAFs of FY 2010 geographic reclassification decisions made by the MGCRB compared to FY 2009 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) of our regulations requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2010 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the FY 2002 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments are made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the exceptions adjustment used in calculating the FY 2010 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets the following criteria: (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries and MACs, six hospitals have qualified for special exceptions payments under § 412.348(g). One of these hospitals closed in May 2005. Because we have cost reports ending in FY 2007 for four of these five hospitals, we calculated the adjustment based on actual cost experience. (We note that the one hospital for which we do not have FY 2007 cost report data has had zero special exception payments for all available past cost reports. Consequently, we expect that this hospital would not have any special exceptions payments in FY 2007, and the lack of this hospital's FY 2007 cost report data would not distort the calculation of the adjustment.) Using data from cost reports ending in FY 2007 from the June 2009 update of the HCRIS data, we divided the capital special exceptions payment amounts for the four available hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2007, this ratio is rounded to 0.0002. We also computed the ratio for FYs 2005 and 2006, which rounds to 0.0002. Based on these data, we are making an adjustment of 0.0002. Because special exceptions are budget neutral, we offset the capital Federal rate by 0.02 percent for special exceptions payments for FY 2010. Therefore, the exceptions adjustment factor is equal to 0.9998 (1—0.0002) to account for special exceptions payments in FY 2010.

In the FY 2009 IPPS final rule (73 FR 48773), we estimated that total (special) exceptions payments for FY 2009 would equal 0.01 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9999 (1 − 0.0001) to determine the FY 2009 capital Federal rate. As we stated above, we are applying an exceptions payment adjustment factor of 0.9998 (1 − 0.0002) to the capital Federal rate for FY 2010 based on our estimate that exceptions payments in FY 2010 will equal 0.02 percent of aggregate payments based on the FY 2010 capital Federal rate. The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the exceptions adjustment factor used in determining the FY 2010 capital Federal rate is 0.9999 (0.9998/0.9999).

5. Capital Standard Federal Rate for FY 2010

For FY 2009, we established a final capital Federal rate of $424.17 (73 FR 57891). We are establishing an update of 1.4 percent in determining the FY 2010 capital Federal rate for all hospitals. As a result of the 1.4 percent update and other budget neutrality factors discussed above, we are establishing a national capital Federal rate of $430.15 for FY 2010. The national capital Federal rate for FY 2010 was calculated as follows:

- The FY 2010 update factor is 1.0140, that is, the update is 1.4 percent.
- The FY 2010 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for changes in the MS–DRG classifications and relative weights and changes in the GAFs is 0.9990.
- The FY 2010 outlier adjustment factor is 0.9477.
- The FY 2010 (special) exceptions payment adjustment factor is 0.9998.

Because the capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we did not make additional adjustments in the capital standard Federal rate for these factors, other than the budget neutrality factor for changes in the MS–DRG classifications and relative weights and for changes in the GAFs.

We are providing the following chart that shows how each of the factors and adjustments for FY 2010 affected the computation of the FY 2010 national capital Federal rate in comparison to the FY 2009 national capital Federal rate. The FY 2010 update factor has the effect of increasing the capital Federal rate by 1.4 percent compared to the FY 2009 capital Federal rate. The GAF/DRG budget neutrality factor has the effect of decreasing the capital Federal rate by 0.10 percent. The FY 2010 outlier adjustment factor has the effect of increasing the capital Federal rate by 0.13 percent compared to the FY 2009 capital Federal rate. The FY 2010 exceptions payment adjustment factor has the effect of decreasing the capital Federal rate by 0.01 percent compared to the FY 2009 capital Federal rate. (As discussed in section VI.E.1. of the preamble of this final rule, we are not applying an additional adjustment to the FY 2010 capital Federal rate for changes in documentation and coding that do not reflect real changes in patients' severity of illness. A permanent cumulative adjustment

of −1.5 percent (that is, a factor of 0.985) was applied in determining the FY 2009 capital Federal rate for changes in documentation and coding that do not reflect real changes in patients' severity of illness.) The combined effect of all the changes will increase the national capital Federal rate by approximately 1.4 percent compared to the FY 2009 national capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2009 CAPITAL FEDERAL RATE AND FY 2010 CAPITAL FEDERAL RATE

h	FY 2009	FY 2010	Change	Percent change
Update Factor [1]	1.0090	1.0140	1.0140	1.40
GAF/DRG Adjustment Factor [1]	1.0015	0.9990	0.9990	−0.10
Outlier Adjustment Factor [2]	0.9465	0.9477	1.0012	0.13
Exceptions Adjustment Factor [2]	0.9999	0.9998	0.9999	−0.01
MS–DRG Documentation and Coding Adjustment Factor	0.985	1.0000	1.0000	0.0
Capital Federal Rate	$424.17	$430.20	1.0142	1.42

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2009 to FY 2010 resulting from the application of the 0.9990 GAF/DRG budget neutrality factor for FY 2010 is 0.9990.

[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the FY 2010 outlier adjustment factor is 0.9477/0.9465, or 1.0013.

We also are providing the following chart that shows how the final FY 2010 capital Federal rate differs from the proposed FY 2010 capital Federal rates as presented in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24258).

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2010 CAPITAL FEDERAL RATE AND FINAL FY 2010 CAPITAL FEDERAL RATE

h	Proposed FY 2010	Final FY 2010	Change	Percent Change
Update Factor	1.0120	1.0140	1.0020	0.20
GAF/DRG Adjustment Factor	0.9994	0.9990	0.9996	−0.04
Outlier Adjustment Factor	0.9454	0.9477	1.002	0.24
Exceptions Adjustment Factor	0.9999	0.9998	0.9999	−0.01
MS–DRG Upcoding Adjustment Factor	0.9670	1.0000	1.0341	3.41
Capital Federal Rate	$420.67	$430.20	1.0227	2.27

6. Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments to hospitals located in Puerto Rico under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. Under the broad authority of section 1886(g) of the Act, as discussed in section VI. of the preamble of this final rule, beginning with discharges occurring on or after October 1, 2004, capital payments to hospitals located in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index, and varies depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated in section III.A.4. of this Addendum, both the national GAF budget neutrality factor and the DRG adjustment are 0.9995, for a combined cumulative adjustment of 0.9990.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (25 percent) is multiplied by the Puerto Rico-specific GAF for the labor market area in which the hospital is located, and the national portion of the capital rate (75 percent) is multiplied by the national GAF for the labor market area in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Public Law 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2009, before application of the GAF, the special capital rate for hospitals located in Puerto Rico is $198.77 for discharges occurring on or after October 1, 2008, through September 30, 2009 (73 FR 57893). Consistent with our development of the FY 2009 Puerto Rico-specific operating standardized amount, we did not apply the additional −0.9 percent documentation and coding adjustment (or the cumulative −1.5 percent adjustment) to the FY 2009 Puerto Rico-specific capital rate. We also noted in the FY 2009 IPPS final rule (73 FR 48449 through 48550) that we may propose to apply such an adjustment to the Puerto Rico operating and capital rates in the future.

With the changes we made to the other factors used to determine the capital rate, the FY 2010 special capital rate for hospitals in Puerto Rico is $204.01. As noted above and discussed in greater detail in section VI.E.1. of the preamble of this final rule, consistent with our development of the Puerto Rico-specific operating standardized amount, we are not applying an adjustment to account for changes in documentation and coding that resulted from the adoption of the MS–DRGs in determining the FY 2010 Puerto Rico-specific capital rate.

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2010

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except ''new'' hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2010.

For purposes of calculating payments for each discharge during FY 2010, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) x (DRG weight) x (GAF) x (COLA for hospitals located in Alaska and Hawaii) x (1 + DSH Adjustment Factor + IME Adjustment Factor, if

applicable). The result is the adjusted capital Federal rate. (As discussed in section VI.E.1. of this preamble of this final rule, at this time, we are no longer eliminating the IME adjustment under the capital IPPS.)

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2010 are in section II.A. of this Addendum. For FY 2010, a case will qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments is greater than the prospective payment rate for the MS–DRG plus the fixed-loss amount of $23,140.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) up through the 10th year beyond the end of the capital transition period if it meets the following criteria: (1) A project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) Any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

Currently, as provided in § 412.304(c)(2), we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input price indexes to reflect the changing composition of inputs for operating and capital expenses. In this final rule, we rebased and revised the CIPI to a FY 2006 base year to reflect the more current structure of capital costs in hospitals. A complete discussion of this rebasing is provided in section IV.D. of the preamble of this final rule. The CIPI was last rebased to FY 2002 in the FY 2006 IPPS final rule (70 FR 47387).

2. Forecast of the CIPI for FY 2010

Based on the latest forecast by IHS Global Insight, Inc. (second quarter of 2009), we forecast the FY 2006-based CIPI to increase 1.4 percent in FY 2010. This reflects a projected 1.8 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a 2.0 percent increase in other capital expense prices in FY 2010, partially offset by 2.1 percent decline in vintage-weighted interest expenses in FY 2010. The weighted average of these three factors produces the 1.4 percent increase for the FY 2006-based CIPI as a whole in FY 2010.

IV. Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount was multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers (rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals).

Payments for services furnished in children's hospitals and cancer hospitals that are excluded from the IPPS continue to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a), RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we proposed that the FY 2010 rate-of-increase percentage for cancer and children's hospitals and RNHCIs was the percentage increase in the FY 2010 IPPS operating market basket, estimated to be 2.1 percent, in accordance with applicable regulations at § 413.40. We also proposed to use more recent data when determining the estimated percentage increase for the FY 2010 IPPS market basket for the final rule, to the extent these data were available. For this final rule, we are using the most recent data available to determine the FY 2010 IPPS operating market basket. Based on IHS Global Insight, Inc.'s second quarter 2009 forecast, with historical data through the 2009 first quarter, the IPPS operating market basket increase is 2.1 percent for FY 2010. Therefore, for cancer and children's hospitals and RNHCIs, the FY 2010 rate-of-increase percentage that is applied to the FY 2009 target amounts in order to determine the FY 2010 target amounts is 2.1 percent.

IRFs, IPFs, and LTCHs were previously paid under the reasonable cost methodology. However, the statute was amended to provide for the implementation of prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provide transitioning periods of varying lengths of time during which a portion of the prospective payment is based on cost-based reimbursement rules under 42 CFR part 413 (certain providers do not receive a transitioning period or may elect to bypass the transition as applicable under 42 CFR part 412, Subparts N, O, and P.) We note that all of the various transitioning periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended.

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We refer readers to section VIII. of the preamble and section V. of the Addendum to this final rule for the update changes to the Federal payment rates for LTCHs under the LTCH PPS for RY 2010. The annual updates for the IRF PPS and the IPF PPS are issued by the agency in separate **Federal Register** documents.

V. Changes to the Payment Rates for the LTCH PPS for RY 2010

A. LTCH PPS Standard Federal Rate for FY 2010

1. Background

In section VIII. of the preamble of this final rule, we discuss our changes to the payment rates, factors, and specific policies under the LTCH PPS for RY 2010. At § 412.523(c)(3)(ii) of the regulations, for LTCH PPS rate years beginning RY 2004 through RY 2006, we updated the standard Federal rate by a rate increase factor to adjust for the most recent estimate of the increases in prices of an appropriate market basket of goods and services for LTCHs. We established that policy of annually updating the standard Federal rate because, at that time, we believed that was the most appropriate method for updating the LTCH PPS standard Federal rate annually for years after the initial implementation of the LTCH PPS in FY 2003. When we moved the date of the annual update of the LTCH PPS from October 1 to July 1 in the RY 2004 LTCH PPS final rule (68 FR 34138), we revised § 412.523(c)(3) to specify that, for LTCH PPS rate years beginning on or after July 1, 2003, the annual

update to the standard Federal rate for the LTCH PPS would be equal to the previous rate year's Federal rate updated by the most recent estimate of increases in the appropriate market basket of goods and services included in covered inpatient LTCH services. At that time, we believed that was the most appropriate method for updating the LTCH PPS standard Federal rate annually for years after RY 2004.

In the RY 2007 LTCH PPS final rule (71 FR 27818), we explained that rather than solely using the most recent estimate of the LTCH PPS market basket as the basis of the update factor for the standard Federal rate for RY 2007, we believed that, based on our ongoing monitoring activity, it was appropriate to adjust the standard Federal rate to account for the changes in documentation and coding practices (rather than patient severity of illness). We established regulations at § 412.523(c)(3)(iii) to specify that the update to the standard Federal rate for the 2007 LTCH PPS rate year is zero percent. This was based on the most recent estimate of the LTCH PPS market basket at the time, which was offset by an adjustment to account for changes in case-mix in prior periods due to changes in documentation and coding rather than increased patient severity of illness in FY 2004. For the following year, we also considered changes in documentation and coding practices rather than patient severity of illness in establishing the update to the standard Federal rate for the 2008 LTCH PPS rate year. In the RY 2008 LTCH PPS final rule (72 FR 26887 through 27890), we adjusted the standard Federal rate based on the most recent estimate of the increase in the market basket (3.2 percent) and an adjustment to account for changes in documentation and coding practices (2.49 percent) in FY 2005. Accordingly, we established regulations at § 412.523(c)(3)(iv) to specify that the update to the standard Federal rate for RY 2008 was 0.71 percent.

However, Public Law 110–173 (MMSEA), enacted on December 29, 2007, contained a provision that addressed the standard Federal rate for RY 2008. Specifically, section 114(e)(1) of Public Law 110–173 provided that under the added section 1886(m)(2) of the Act, the standard Federal rate for RY 2008 shall be the same as the standard Federal rate for RY 2007. In addition, section 114(e)(2) of Public Law 110–173 specifically stated that the revised standard Federal rate provided for under section 114(e)(1) ''shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008,'' effectively resulting in a delay of the application of the updated standard Federal rate for RY 2007 established in the LTCH PPS RY 2008 final rule (72 FR 26890). We implemented these statutory provisions in an interim final rule with comment period (73 FR 24875 through 24877), as discussed in further detail in section IX. of the preamble of this final rule. Accordingly, we revised § 412.523(c)(iv) to provide that: (1) the standard Federal rate for the LTCH PPS RY 2008 is the same as the standard Federal rate for the previous LTCH PPS RY, which is RY 2007; and (2) for discharges occurring on or after July 1, 2007, and before April 1, 2008, payments are based on the standard Federal rate for LTCH PPS RY 2007, updated by 0.71 percent. Thus, effectively, the standard Federal rate used to determine LTCH PPS payments for discharges occurring on or after July 1, 2007, through March 31, 2008, is the standard Federal rate for RY 2007 updated by 0.71 percent, while LTCH PPS payments for discharges occurring from April 1, 2008, through June 30, 2008, are determined based on the standard Federal rate set forth in section 114(e)(1) of Public Law 110–173 (that is, the same standard Federal rate as the previous rate year (RY 2007)).

Consistent with our historical practice, in the RY 2009 LTCH PPS final rule (73 FR 26806), we updated the standard Federal rate from the previous year (that is, the standard Federal rate for RY 2008 as established by section 1886(m)(2) of the Act) to determine the standard Federal rate for RY 2009. In that same final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an annual update to the standard Federal rate for RY 2009 based on the most recent estimate of the increase in the LTCH PPS market basket of 3.6 percent (for the 15-month rate year, which was based on the best available data at that time) and an adjustment of −0.9 percent to account for the increase in case-mix in a prior period (FY 2006) due to changes in documentation and coding practices rather than an increase in patient severity of illness. (As noted above, we established a 15-month period for RY 2009 (July 1, 2008 through September 30, 2009) in order to move the LTCH PPS annual rate update to an October 1 effective date beginning October 1, 2009. We refer readers to 73 FR 26797 through 26798). Accordingly, we established regulations at § 412.523(c)(3)(v) to specify that the update to the standard Federal rate for the 2009 LTCH PPS rate year is 2.7 percent.

2. Development of the RY 2010 LTCH PPS Standard Federal Rate

As we stated in the FY 2010 IPPS/RY 2010 proposed rule (74 FR 24261), while we continue to believe that an update to the LTCH PPS standard Federal rate should be based on the most recent estimate of the increase in the LTCH PPS market basket, we also believe it is appropriate that the standard Federal rate be offset by an adjustment to account for any changes in documentation and coding practices that do not reflect increased patient severity of illness. Such an adjustment protects the integrity of the Medicare Trust Funds by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients. Furthermore, as we discussed most recently in the RY 2009 LTCH final rule (73 FR 26805), we did not establish a case-mix budget neutrality factor (that is, a documentation and coding adjustment for changes in case-mix that are not due to changes in patient severity of illness) for the adoption of the severity adjusted MS–LTC–DRG patient classification system. Rather, we noted that, consistent with past LTCH payment policy, we would continue to monitor LTCH data and we could propose to make adjustments when updating the LTCH PPS standard Federal rate in the future to account for changes in documentation and coding that do not reflect any real changes in case-mix during these years that we are implementing MS–LTC–DRGs.

As we discussed in greater detail in section VIII.C.3. of the preamble of this final rule, we performed a CMI analysis using the most recent available LTCH claims data under both the current MS–LTC–DRG and former CMS LTC–DRG patient classification systems. Based on this evaluation, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24229 through 24230), we determined that there was a total increase in LTCH CMI of 1.8 percent due to changes in documentation and coding that did not reflect real changes in patient severity of illness for LTCH discharges occurring in FY 2007 and FY 2008. Specifically, our analysis showed an increase in CMI of 0.5 percent in FY 2007 and 1.3 percent in FY 2008 due to changes in documentation and coding that did not reflect increased patient severity of illness (or costs). As we discuss in section VIII.C.3. of the preamble of this final rule, we are applying a −0.5 percent adjustment to account for the increase in case-mix in FY 2007. However, we are delaying the application of the −1.3 percent adjustment to account for the increase in case-mix in FY 2008.

At this time, the most recent estimate of the increase in the LTCH PPS market basket (that is, the FY 2002-based RPL market basket) for RY 2010 is 2.5 percent, as discussed in section VIII.B.2. of the preamble of this final rule (compared to a proposed increase of 2.4 percent in the proposed rule). Consistent with our historical practice, in this final rule, as proposed, we are updating the LTCH PPS standard Federal rate for RY 2010 based on the full LTCH PPS market basket increase estimate of 2.5 percent and an adjustment to account for the increase in case-mix in a prior periods (FY 2007) that resulted from changes in documentation and coding practices of 0.5 percent. Therefore, the update factor to the standard Federal rate for RY 2010 is 2.0 percent (that is, we are applying a factor of 1.020 in determining the LTCH PPS standard Federal rate for RY 2010, calculated as 1.025×1 divided by 1.005 = 1.020 or 2.0 percent). That is, under the broad authority conferred upon the Secretary under the BBRA and the BIPA to determine appropriate updates under the LTCH PPS, we are specifying under § 412.523(c)(3)(vi) that, for LTCH discharges occurring on or after October 1, 2009, and on or before September 30, 2010, the standard Federal rate from the previous year will be updated by 2.0 percent. Accordingly, we are amending § 412.523 to add a new paragraph (c)(3)(vi) to specify that the standard Federal rate for RY 2010 is the standard Federal rate for the previous rate year updated by 2.0 percent. In determining the standard Federal rate for RY 2010, we applied the 1.020 update factor to the RY 2009 Federal rate of $39,114.36 (as established in the RY 2009 LTCH PPS final rule (73 FR 26812)). Consequently, the standard Federal rate for RY 2010 is $39,896.65.

B. Adjustment for Area Wage Levels Under the LTCH PPS for RY 2010

1. Background

Under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS standard Federal rate to account for differences in LTCH area wage levels at § 412.525(c). The labor-related share of the LTCH PPS standard Federal rate (discussed in greater detail in section VIII.C.2. of the preamble of this final rule), is adjusted to account for geographic differences in area wage levels by applying the applicable LTCH PPS wage index. The applicable LTCH PPS wage index is computed using wage data from inpatient acute care hospitals without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act.

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56015), when we implemented the LTCH PPS, we established a 5-year transition to the full wage index adjustment. The wage index adjustment was completely phased-in for cost reporting periods beginning in FY 2007. Therefore, for cost reporting periods beginning on or after October 1, 2006, the applicable LTCH wage index values are the full (five-fifths) LTCH PPS wage index values calculated based on acute care hospital inpatient wage index data without taking into account geographic reclassification under section 1886(d)(8) and section 1886(d)(10) of the Act. For additional information on the phase-in of the wage index adjustment under the LTCH PPS, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56017 through 56019) and the RY 2008 LTCH PPS final rule (72 FR 26891).

2. Updates to the Geographic Classifications/ Labor Market Area Definitions

a. Background

As discussed in the August 30, 2002 LTCH PPS final rule, which implemented the LTCH PPS (67 FR 56015 through 56019), in establishing an adjustment for area wage levels under § 412.525(c), the labor-related portion of a LTCH's Federal prospective payment is adjusted by using an appropriate wage index based on the labor market area in which the LTCH is located. In the RY 2006 LTCH PPS final rule (70 FR 24184 through 24185), in regulations at § 412.525(c), we revised the labor market area definitions used under the LTCH PPS effective for discharges occurring on or after July 1, 2005, based on the Executive OMB's CBSA designations, which are based on 2000 Census data. We made this revision because we believe that the CBSA-based labor market area definitions will ensure that the LTCH PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. We note that these are the same CBSA-based designations implemented for acute care hospitals under the IPPS at § 412.64(b), effective October 1, 2004 (69 FR 49026 through 49034). (For further discussion of the CBSA-based labor market area (geographic classification) definitions currently used under the LTCH PPS, we refer readers to the RY 2006 LTCH PPS final rule (70 FR 24182 through 24191).)

In the RY 2009 LTCH PPS final rule (73 FR 26814), we codified the definitions of ''urban'' and ''rural'' in 42 CFR part 412, Subpart O (the subpart of the regulations specific to the LTCH PPS). Prior to this codification, the application of the wage index adjustment under § 412.525(c)(2) was made on the basis of the location of the facility in either an urban area or a rural area as defined in § 412.64(b)(1)(ii)(A) through (C) of the regulations, which apply specifically to the IPPS. Under that regulatory construction, the then existing § 412.525(c) indicated that the terms ''rural area'' and ''urban area'' were defined according to the definitions of those terms under the IPPS in 42 CFR part 412, Subpart D. In that same final rule, we revised § 412.525(c) to specify that the application of the LTCH PPS wage index adjustment is made on the basis of the location of the LTCH in either an urban area or a rural area as defined in § 412.503 because we believe it is administratively simpler to have the LTCH PPS urban and rural labor market area definitions self-contained in the regulations of the subpart specific to the LTCH PPS (§ 412.503) rather than specifying a cross-reference to the definitions of urban area and rural area in the IPPS regulations in 42 CFR part 412, Subpart D. Thus, under § 412.503, for discharges occurring on or after July 1, 2008, an ''urban area'' under the LTCH PPS is defined as a Metropolitan Statistical Area, as defined by OMB and a ''rural area'' is defined as any area outside of an urban area.

In addition, in the RY 2009 LTCH PPS final rule (73 FR 26813 through 26814), we clarified the change regarding the treatment of Litchfield County, Connecticut (CT), and Merrimack County, New Hampshire (NH) CBSA-based labor market area definitions. Specifically, we discussed that, effective for LTCH PPS discharges occurring on or after July 1, 2008, Litchfield County, CT, and Merrimack County, NH, are considered ''rural'' and are no longer considered as being part of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT) and urban CBSA 31700 (Manchester-Nashua, NH), respectively, as these areas had been in the past as a result of a change to the regulations at § 412.64(b)(1)(ii)(B) established in the FY 2008 IPPS final rule with comment period (72 FR 47337 through 47338). In making this clarification, we noted that this policy is consistent with our policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS.

b. Update to the CBSA–Based Labor Market Area Definitions

The CBSA-based labor market area definitions used under the LTCH PPS were last updated in the RY 2009 LTCH PPS final rule (73 FR 26812 through 26813) based on the most recent OMB bulletin available at that time (December 18, 2006; OMB Bulletin No. 07–01). As discussed in the proposed rule (74 FR 24262 through 24263), since that time, there have been two OMB bulletins announcing revisions to the CBSA designations, and under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, we proposed to apply the changes from those two OMB bulletins to the current CBSA-based labor market area definitions and geographic classifications used under the LTCH PPS, effective for discharges occurring on or after October 1, 2009.

We did not receive any public comments on our proposed update to the CBSA-based labor market area definitions used under the LTCH PPS for RY 2010. Therefore, we are adopting those proposed changes as final in this final rule. Specifically, for RY 2010, we are establishing the following updates to the LTCH PPS CBSA-based labor market area definitions and geographic classifications:

First, on November 20, 2007, OMB announced the revision of titles for eight urban areas (OMB Bulletin No. 08–01). This OMB bulletin is available on the OMB Web site at: *http://www.whitehouse.gov/omb/assets/omb/bulletins/fy2008/b08–01.pdf*. The revised titles are as follows:

- Hammonton, New Jersey qualifies as a new principal city of the Atlantic City, New Jersey CBSA. The new title is Atlantic City-Hammonton, New Jersey CBSA (CBSA 12100).
- New Brunswick, New Jersey, located in the Edison, New Jersey Metropolitan Division, qualifies as a new principal city of the New York- Northern New Jersey-Long Island, New York, New Jersey, Pennsylvania CBSA. The new title for the Metropolitan Division is Edison-New Brunswick, New Jersey CBSA (CBSA 20764).
- Summerville, South Carolina qualifies as a new principal city of the Charleston-North Charleston, South Carolina CBSA. The new title is Charleston-North Charleston-Summerville, South Carolina (CBSA 16700).
- Winter Haven, Florida qualifies as a new principal city of the Lakeland, Florida CBSA. The new title is Lakeland-Winter Haven, Florida (CBSA 29460).
- Bradenton, Florida replaces Sarasota, Florida as the most populous principal city of the Sarasota-Bradenton-Venice, Florida CBSA (currently CBSA 42260). The new title is Bradenton-Sarasota-Venice, Florida. The new CBSA code is 14600.
- Frederick, Maryland replaces Gaithersburg, Maryland as the second most populous principal city in the Bethesda-Gaithersburg-Frederick, Maryland CBSA. The new title is Bethesda-Frederick-Gaithersburg, Maryland (CBSA 13644).
- North Myrtle Beach, South Carolina replaces Conway, South Carolina as the second most populous principal city of the Myrtle Beach-Conway-North Myrtle Beach, South Carolina CBSA. The new title is Myrtle Beach-North Myrtle Beach-Conway, South Carolina (CBSA 34820).
- Pasco, Washington replaces Richland, Washington as the second most populous principal city of the Kennewick-Richland-Pasco, Washington CBSA. The new title is Kennewick-Pasco-Richland, Washington (CBSA 28420).

In this final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, as

proposed, we are applying these changes to the current CBSA-based labor market area definitions and geographic classifications used under the LTCH PPS, effective for discharges occurring on or after October 1, 2009 (to the extent that they are not changed by the later OMB Bulletin No. 90–1 discussed below). We believe these revisions to the LTCH PPS CBSA-based labor market area definitions, which are based on the most recent available data, will ensure that the LTCH PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. Accordingly, the RY 2010 LTCH PPS wage index values presented in Tables 12A and 12B in the Addendum of this final rule reflect the revisions to the CBSA-based labor market area definitions described above. We note that the eight CBSA title revisions announced in OMB Bulletin No. 08–01 do not change the composition (constituent counties) of the affected CBSAs; they only revise the CBSA titles (and do not change the CBSA codes with the exception of the change in CBSA code 42260 to 14600). We also note that these revisions were applicable under the IPPS beginning October 1, 2008 (73 FR 48575).

Second, on November 20, 2008, OMB announced three Micropolitan Statistical Areas that now qualify as MSAs and changed the principal cities and titles of a number of CBSAs and a Metropolitan Division (OMB Bulletin No. 09–01). This OMB bulletin is available on the OMB Web site at: *http://www.whitehouse.gov/omb/assets/omb/bulletins/fy2009/09-01.pdf*. The new urban CBSAs are as follows:

- Cape Girardeau-Jackson, Missouri-Illinois (CBSA 16020). This CBSA is comprised of the principal cities of Cape Girardeau and Jackson, Missouri in Alexander County, Illinois; Bollinger County, Missouri, and Cape Girardeau County, Missouri.
- Manhattan, Kansas (CBSA 31740). This CBSA is comprised of the principal city of Manhattan, Kansas in Geary County, Pottawatomie County, and Riley County.
- Mankato-North Mankato, Minnesota (CBSA 31860). This CBSA is comprised of the principal cities of Mankato and North Mankato, Minnesota in Blue Earth County and Nicollet County.

The changes in the principal cities and the revised titles are as follows:

- Broomfield, Colorado qualifies as a new principal city of the Denver-Aurora, Florida CBSA. The new title is Denver-Aurora-Broomfield, Colorado (CBSA 19740).
- Chapel Hill, North Carolina qualifies as a new principal city of the Durham, North Carolina CBSA. The new title is Durham-Chapel Hill, North Carolina (CBSA 20500).
- Chowchilla, California qualifies as a new principal city of the Madera, California CBSA. The new title is Madera-Chowchilla, California (CBSA 31460).
- Panama City Beach, Florida qualifies as a new principal city of the Panama City-Lynn Haven, Florida CBSA. The new title is Panama City-Lynn Haven-Panama City Beach, Florida (CBSA 37460).
- East Wenatchee, Washington qualifies as a new principal city of the Wenatchee, Washington CBSA. The new title is Wenatchee-East Wenatchee, Washington (CBSA 48300).
- Rockville, Maryland replaces Gaithersburg, Maryland as the third most populous city of the Bethesda-Frederick-Gaithersburg, Maryland Metropolitan Division. The new title is Bethesda-Frederick-Rockville, Maryland Metropolitan Division (CBSA 13644).

In this final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, as proposed, we are applying these changes to the current CBSA-based labor market area definitions and geographic classifications used under the LTCH PPS effective for discharges occurring on or after October 1, 2009. We believe these revisions to the LTCH PPS CBSA-based labor market area definitions, which are based on the most recent available data, would ensure that the LTCH PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. Accordingly, the RY 2010 LTCH PPS wage index values presented in Tables 12A and 12B in the Addendum of this final rule reflect the revisions to the CBSA-based labor market area definitions described above. We note that the six CBSA title revisions noted above do not change the composition (constituent counties) of the affected CBSAs; they only revise the CBSA titles (and do not change the CBSA codes). We also note that we are currently aware of only one LTCH located in one of the three new CBSAs (CBSA 16020). As discussed in section III.C. of the preamble of this final rule, the revisions to the CBSA-based designations are also adopted under the IPPS effective beginning October 1, 2009.

3. LTCH PPS Labor-Related Share

As noted above in this section, under the adjustment for difference in area wage levels at § 412.525(c), the labor-related share of a LTCH's PPS payment is adjusted by the applicable wage index for the labor market area in which the LTCH is located. Specifically, as discussed in section VIII.C.2.d. of the preamble of this final rule, the LTCH PPS labor-related share is determined by our actuaries and is based on data for the labor-related share of operating costs and capital costs of the FY 2002-based RPL market basket. (Additional background information on the historical development of the labor-related share under the LTCH PPS can be found in the RY 2009 LTCH PPS final rule (73 FR 26815). In the RY 2007 final rule (71 FR 27829 through 27830), we established a labor-related share based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, postal services, and all other labor-intensive services) and capital costs of the RPL market basket based on FY 2002 data, as they are the best available data that reflect the cost structure of LTCHs. For the past 2 years (RYs 2008 and 2009), we updated the LTCH PPS labor-related share annually based on the latest available data for the RPL market basket. For RY 2009, the labor-related share is 75.662 percent, as established in the RY 2009 LTCH PPS final rule (73 FR 26815 through 26816), based on the sum of the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and a labor-related portion of capital costs of the FY 2002-based RPL market basket from the first quarter of 2008 forecast (the most recent available data at that time).

As discussed in section VIII.C. of the preamble of this final rule and as we proposed, we are continuing to use the FY 2002-based RPL market basket used under the LTCH PPS for RY 2010. Furthermore, for RY 2010, we are continuing to define the LTCH PPS labor-related share as the national average proportion of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and a labor-related portion of capital costs based on the FY 2002-based RPL market basket. (As noted above, additional information on the development of the FY 2002-based RPL market basket used under the LTCH PPS can be found in the RY 2007 LTCH PPS final rule (71 FR 27808 through 27818).) Accordingly, consistent with our historical practice of using the best available data, we used IHS Global Insight, Inc.'s second quarter 2009 forecast of the FY 2002-based RPL market basket for RY 2010 (in the proposed rule, we used IHS Global Insight, Inc's first quarter 2009 forecast) to determine the labor-related share for the LTCH PPS for RY 2010 that will be effective for discharges occurring on or after October 1, 2009, and through September 30, 2010, as these are the most recent available data. As shown in the chart in section VIII.C.2.d. of the preamble of this final rule, based on the latest available data (and the authority set forth in section 123 of the BBRA as amended by section 307(b) of the BIPA, we are establishing a labor-related share of 75.779 percent under the LTCH PPS for the RY 2010.

4. LTCH PPS Wage Index for RY 2010

Historically, under the LTCH PPS, we have established LTCH PPS wage index values calculated from acute care IPPS hospital wage data without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act. As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56019), hospitals that are excluded from the IPPS are not required to provide wage-related information on the Medicare cost report. Therefore, we would need to establish instructions for the collection of these LTCH data as well as develop some type of application and determination process before a geographic reclassification adjustment under the LTCH PPS could be implemented. The wage adjustment established under the LTCH PPS is based on a LTCH's actual location without regard to the urban or rural designation of any related or affiliated provider. Acute care hospital inpatient wage index data are also used to establish the wage index adjustment used in other Medicare PPSs, such as the IRF

PPS, the IPF PPS, the HHA PPS, and the SNF PPS.

In the RY 2009 LTCH PPS final rule (73 FR 26816 through 26817), we established LTCH PPS wage index values for RY 2009 calculated from the same data collected from cost reports submitted by IPPS hospitals for cost reporting periods beginning during FY 2004 that were used to compute the FY 2008 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act because these were the best available data at that time. The LTCH PPS wage index values applicable for discharges occurring on or after July 1, 2008, through September 30, 2009, were shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to the RY 2009 LTCH PPS final rule (73 FR 26840 through 26863).

In this final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS for RY 2010, as we proposed, we used the same data collected from cost reports submitted by IPPS hospitals for cost reporting periods beginning during FY 2006 that are being used to compute the FY 2010 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act to determine the applicable wage index values under the LTCH PPS in RY 2010 because these data (FY 2006) are the most recent complete data available at this time. (We note that due to the change in the annual LTCH PPS rate year update cycle from July 1 to October 1, effective October 1, 2009, established in the RY 2009 LTCH PPS final rule, there is no longer a lag-time in the availability of the IPPS hospital wage data used to develop the respective wage indices used under the IPPS and LTCH PPS. Consequently, because the annual update to the LTCH PPS and the IPPS now occurs on October 1 of each year, we are able to calculate wage index values using the same wage data to develop the LTCH wage index as is used to develop the IPPS wage index in a given year. Under the previous July 1 annual LTCH PPS rate year update cycle, due to the lag-time in the availability of data, there was a 1-year lag-time in the best available IPPS wage data to develop the LTCH PPS wage index each year (for example, as noted above, we established RY 2009 LTCH PPS wage index values from the same data collected from FY 2004 IPPS hospital cost reports that were used to compute the FY 2008 IPPS wage index). We are continuing to use IPPS wage data as a proxy to determine the LTCH wage index values for RY 2010 because both LTCHs and acute care hospitals are required to meet the same certification criteria set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program and they both compete in the same labor markets and, therefore, experience similar wage-related costs.)

We also note that using the IPPS wage data to determine the RY 2010 LTCH wage index values reflects our policy under the IPPS beginning in FY 2008 that apportions the wage data for multicampus hospitals that are located in different labor market areas (CBSAs) to each CBSA where the campuses are located. (For additional information, we refer readers to the FY 2008 IPPS final rule with comment (72 FR 47317 through 47320), the FY 2009 IPPS final rule (73 FR 48582), and section III.C. of the preamble of this final rule.) Specifically, for the RY 2010 LTCH PPS wage index values, which are computed from IPPS wage data submitted by hospitals for cost reporting periods beginning in FY 2006 (which are used to determine the FY 2010 IPPS wage index discussed in section III.F. of the preamble of this final rule), we allocated salaries and hours to the campuses of three multicampus hospitals with campuses that are located in different labor areas that are located in the following States: Massachusetts, Illinois, and Michigan. Thus, consistent with the FY 2010 IPPS wage index, the RY 2010 LTCH PPS wage index values for the following CBSAs will be affected by this policy: Boston-Quincy, MA (CBSA 14484); Providence-New Bedford-Falls River, RI–MA (CBSA 39300); Chicago-Naperville-Joliet, IL (CBSA 16974); Lake County-Kenosha County, IL–WI (CBSA 29404); Detroit-Livonia-Dearborn, MI (CBSA 19804); and Warren-Troy-Farmington-Hills, MI (CBSA 47644) (reflected in Tables 12A and 12B in the Addendum of this final rule).

The RY 2010 LTCH PPS wage index values were computed consistent with the urban and rural geographic classifications (labor market areas) discussed in section V.B.2. of the Addendum of this final rule and consistent with the pre-reclassified IPPS wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS). The RY 2010 wage index values also reflect our methodology for establishing wage index values in urban and rural areas in which there are no IPPS wage data from which to compute a wage index value (as described above in this section).

As previously noted, in the RY 2009 LTCH PPS final rule (73 FR 26817 through 26818), we established a methodology for determining a LTCH PPS wage index value for areas that have no IPPS wage data. Under this methodology, we stated that each year we would determine a wage index value for any area in which there is no IPPS wage data based on the methodologies described in that final rule. We believe it is appropriate to establish a methodology for determining LTCH PPS wage index values for areas with no IPPS wage data, if necessary, because IPPS hospitals may open or close at any time, and therefore the number of areas without any IPPS wage data may change from year to year. Even when an IPPS hospital opens in an area where there are currently no IPPS hospitals, there is a lag-time between the time a hospital opens or becomes an IPPS provider and when the hospital's cost report wage data are available to include in calculating the area wage index. The policies established for determining LTCH PPS wage index values for areas with no IPPS hospital wage data are consistent with the methodologies that have been established under other Medicare postacute care PPSs, such as SNF and HHA, as well as the IPPS. Below we discuss the application of our established methodology for determining a LTCH PPS wage index value for RY 2010 for any areas in which there is no IPPS wage data for cost reporting periods beginning during FY 2006 (that is, for the areas in which there is no data in the IPPS wage data that we used to compute the RY 2010 LTCH PPS wage index).

In this final rule, as we proposed, we determined RY 2010 LTCH PPS wage index values for labor market areas in which there is no IPPS hospital wage data from which to compute a wage index value consistent with the methodology we established in the RY 2009 LTCH PPS final rule (73 FR 26817). As was the case in RY 2009, there are no LTCHs located in labor areas where there is no IPPS hospital wage data (or IPPS hospitals) for RY 2010. However, we continue to believe it is appropriate to calculate LTCH PPS wage index values for these areas using our established methodology in the event that in the future a LTCH should open in one of those areas.

Therefore, we will continue to determine a LTCH PPS wage index value for urban CBSAs with no IPPS wage data by using an average of all of the urban areas within the State to serve as a reasonable proxy for determining the LTCH PPS wage index for an urban area without specific IPPS hospital wage index data. We believe that an average of all of the urban areas within the State is a reasonable proxy for determining the LTCH PPS wage index for an urban area in the State with no wage data because it is based on pre-reclassified IPPS wage data, it is easy to evaluate, and it uses the most geographically similar relative wage-related costs data available. Furthermore, as noted above, this methodology has been adopted by other Medicare PPSs, such as the SNF PPS and the HHA PPS.

Based on the FY 2006 IPPS wage data that we used to determine the RY 2010 LTCH PPS wage index values, there are no IPPS wage data for the urban area of Hinesville-Fort Stewart, GA (CBSA 25980). Consistent with our methodology for determining a LTCH PPS wage index value for urban areas with no IPPS wage data (discussed above), in this final rule, we calculated the RY 2010 wage index value for CBSA 25980 as the average of the wage index values for all of the other urban areas within the State of Georgia (that is, CBSAs 10500, 12020, 12060, 12260, 15260, 16860, 17980, 19140, 23580, 31420, 40660, 42340, 46660 and 47580) (reflected in Table 12A of the Addendum of this final rule). (As noted above, there are currently no LTCHs located in CBSA 25980.) As discussed in the RY 2009 final rule (73 FR 26817), as IPPS wage data are dynamic, it is possible that urban areas without IPPS wage data will vary in the future.

As we proposed, we also are continuing to determine a LTCH PPS wage index value for rural areas with no IPPS wage data using the unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties of the State to serve as a reasonable proxy in determining the LTCH PPS wage index for a rural area without

specific IPPS hospital wage index data. For this purpose, we are defining ''contiguous'' as sharing a border. We are not able to apply an averaging in rural areas with no wage data similar to what we are doing for urban areas with no wage data because there is no rural hospital data available for averaging on a statewide basis. We believe that using an unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties of the State is a reasonable proxy for determining the wage index for rural areas in a State with no wage data because it is based on pre-reclassified IPPS wage data, it is easy to evaluate, and it uses the most geographically similar relative wage-related costs data available.

Based on the FY 2006 IPPS wage data that we used to determine the RY 2010 LTCH PPS wage index values, there are no IPPS wage data for the rural area of Massachusetts (CBSA code 11). Consistent with our methodology for determining a LTCH PPS wage index value for rural areas with no IPPS wage data (discussed above), in this final rule, as we proposed, we calculated the RY 2010 wage index value for rural Massachusetts by computing the unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties in that State. Specifically, in the case of Massachusetts, the entire rural area consists of Dukes and Nantucket counties. We determined that the borders of Dukes and Nantucket counties are ''contiguous'' with Barnstable County, MA, and Bristol County, MA. Therefore, the RY 2010 LTCH PPS wage index value for rural Massachusetts is computed as the unweighted average of the RY 2010 wage indexes for Barnstable County and Bristol County (reflected in Tables 12A and 12B in the Addendum of this final rule). (There are currently no LTCHs located in rural Massachusetts.) As discussed in the RY 2009 final rule (73 FR 26817), as IPPS wage data are dynamic, it is possible that rural areas without IPPS wage data will vary in the future.

The RY 2010 LTCH wage index values that are applicable for LTCH discharges occurring on or after October 1, 2009, through September 30, 2010, are presented in Table 12A (for urban areas) and Table 12B (for rural areas) in the Addendum of this final rule.

We did not receive any public comments on our proposals for calculating the LTCH PPS wage index for RY 2010. Therefore, we are adopting those proposals in this final rule as described above.

5. LTCH PPS Cost-of-Living Adjustment for LTCHs Located in Alaska and Hawaii

In the August 30, 2002 final rule (67 FR 56022), we established, under § 412.525(b), a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. In the RY 2009 LTCH PPS final rule (73 FR 26819) (under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS), for RY 2009, we applied a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the factors listed in Table III of that same rule.

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24266), under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, we proposed to apply a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the most recent available factors listed in that same proposed rule. We did not receive any public comments on our proposed COLA to payments to LTCHs located in Alaska and Hawaii and, therefore, are adopting that proposal in this final rule. Therefore, for RY 2010, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA, to determine appropriate adjustments under the LTCH PPS, we are applying a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the factors listed in the chart below because they are the most recent available data at this time. These factors were obtained from the U.S. Office of Personnel Management (OPM) and are also used under the IPPS effective October 1, 2009 (section II.B.2. of the Addendum of this final rule).

COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE 2010 LTCH PPS RATE YEAR

Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
All other areas of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

C. Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases

1. Background

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA, in the regulations at § 412.525(a), we established an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. We refer to these cases as high cost outliers (HCOs). Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level. These additional payments reduce the financial losses that would otherwise be incurred when treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients. We set the outlier threshold before the beginning of the applicable rate year so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS.

Under § 412.525(a) in the regulations (in conjunction with the revised definition of ''LTC–DRG'' at § 412.503), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted LTCH PPS payment for the MS–LTC–DRG plus a fixed-loss amount. Specifically, in accordance with § 412.525(a)(3) (in conjunction with the revised definition of ''LTC–DRG'' at § 412.503), we pay outlier cases 80 percent of the difference between the estimated cost of the patient case and the outlier threshold, which is the sum of the adjusted Federal prospective payment for the MS–LTC–DRG and the fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that a hospital will incur under the outlier policy for a case with unusually high costs. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. Under the LTCH PPS HCO policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the outlier threshold (MS–LTC–DRG payment plus the fixed-loss amount). The fixed percentage of costs is called the marginal cost factor. We calculate the estimated cost of a case by multiplying the Medicare allowable covered charge by the hospital's overall hospital CCR.

Under the LTCH PPS, we determine a fixed-loss amount, that is, the maximum loss that a LTCH can incur under the LTCH PPS for a case with unusually high costs before the LTCH will receive any additional payments. We calculate the fixed-loss amount by estimating aggregate payments with and without an outlier policy. The fixed-loss amount results in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments. Currently, MedPAR claims data and CCRs based on data from the most recent provider specific file (PSF) (or from the applicable statewide average CCR if a LTCH's CCR data are faulty or unavailable) are used

to establish a fixed-loss threshold amount under the LTCH PPS.

2. Determining LTCH CCRs Under the LTCH PPS

a. Background

The following is a discussion of CCRs that are used in determining payments for HCO and SSO cases under the LTCH PPS, at § 412.525(a) and § 412.529, respectively. Although this section is specific to HCO cases, because CCRs and the policies and methodologies pertaining to them are used in determining payments for both HCO and SSO cases (to determine the estimated cost of the case at § 412.529(d)(2), we are discussing the determination of CCRs under the LTCH PPS for both of these types of cases simultaneously.

In determining both HCO payments (at § 412.525(a)) and SSO payments (at § 412.529), we calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. In general, we use the LTCH's overall CCR, which is computed based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period, in accordance with § 412.525(a)(4)(iv)(B) and § 412.529(c)(4)(iv)(B) for HCOs and SSOs, respectively. (We note that, in some instances, we use an alternative CCR, such as the statewide average CCR in accordance with the regulations at § 412.525(a)(4)(iv)(C) and § 412.529(c)(4)(iv)(C), or a CCR that is specified by CMS or that is requested by the hospital under the provisions of the regulations at § 412.525(a)(4)(iv)(A) and § 412.529(c)(4)(iv)(A).) Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs. Therefore, we compute a single ''overall'' or ''total'' LTCH-specific CCR based on the sum of LTCH operating and capital costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100–4)) as compared to total charges. Specifically, a LTCH's CCR is calculated by dividing a LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges).

b. LTCH Total CCR Ceiling

Generally, a LTCH is assigned the applicable statewide average CCR if, among other things, a LTCH's CCR is found to be in excess of the applicable maximum CCR threshold (that is, the LTCH CCR ceiling). This is because CCRs above this threshold are most likely due to faulty data reporting or entry, and, therefore, CCRs based on erroneous data should not be used to identify and make payments for outlier cases. Thus, under our established policy, generally, if a LTCH's calculated CCR is above the applicable ceiling, the applicable LTCH PPS statewide average CCR is assigned to the LTCH instead of the CCR computed from its most recent (settled or tentatively settled) cost report data.

In the FY 2009 IPPS final rule (73 FR 48682), in accordance with § 412.525(a)(4)(iv)(C)(*2*) for HCOs and § 412.529(c)(4)(iv)(C)(*2*) for SSOs, using our established methodology for determining the LTCH total CCR ceiling, based on IPPS total CCR data from the December 2007 update of the Provider Specific File (PSF), we established a total CCR ceiling of 1.262 under the LTCH PPS, effective October 1, 2008, through September 30, 2009. (For further detail on our current methodology for annually determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121).)

In this final rule, in accordance with § 412.525(a)(4)(iv)(C)(2) for HCOs and § 412.529(c)(4)(iv)(C)(2) for SSOs, using our established methodology for determining the LTCH total CCR ceiling (described above), based on IPPS total CCR data from the March 2009 update of the PSF, we are establishing a total CCR ceiling of 1.232 under the LTCH PPS that will be effective for discharges occurring on or after October 1, 2009, and on or before September 30, 2010.

c. LTCH Statewide Average CCRs

Our general methodology established for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling (described above) because it is based on ''total'' IPPS CCR data. Under the LTCH PPS HCO policy at § 412.525(a)(4)(iv)(C) and the SSO policy at § 412.529(c)(4)(iv)(C), the fiscal intermediary may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for an LTCH in one of the following circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling (as discussed above); and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the fiscal intermediary may consider in determining an LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as an LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

In Table 8C of the Addendum to the FY 2009 IPPS final rule (73 FR 48998), in accordance with the regulations at § 412.525(a)(4)(iv)(C) for HCOs and § 412.529(c)(4)(iv)(C) for SSOs, using our established methodology for determining the LTCH statewide average CCRs, based on using the most recent complete IPPS total CCR data from the March 2008 update of the PSF, we established the LTCH PPS statewide average total CCRs for urban and rural hospitals effective for discharges occurring on or after October 1, 2008, and on or before September 30, 2009. (For further detail on our current methodology for annually determining the LTCH statewide average CCRs, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121).)

In this final rule, using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS total CCR data from the March 2009 update of the PSF, we are establishing LTCH PPS statewide average total CCRs for urban and rural hospitals that will be effective for discharges occurring on or after October 1, 2009, and through September 30, 2010, in Table 8C of the Addendum to this final rule.

We also note that all areas in the District of Columbia, New Jersey, Puerto Rico, and Rhode Island are classified as urban; therefore, there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C of the Addendum to this final rule. This policy is consistent with the policy that we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121) and is the same as the policy applied under the IPPS. In addition, although Massachusetts has areas that are designated as rural, there are no short-term acute care IPPS hospitals or LTCHs located in those areas as of March 2009. Therefore, for this final rule, there is no rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum of this final rule.

In addition, as we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48120 through 48121), in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, in this final rule, we used, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We used this proxy because we believe that the CCR data on the PSF for Maryland hospitals may not be entirely accurate (as discussed in greater detail in that same final rule (71 FR 48120)).

d. Reconciliation of LTCH HCO and SSO Payments

We note, under the LTCH PPS HCO policy at § 412.525(a)(4)(iv)(D) and the LTCH PPS SSO policy at § 412.529(c)(4)(iv)(D), the payments for HCO and SSO cases, respectively, are subject to reconciliation. Specifically, any reconciliation of outlier payments is based on the CCR that is calculated based on a ratio of CCRs computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. For additional information, we refer readers to the RY 2009 LTCH PPS final rule (73 FR 26820 through 26821).

3. Establishment of the LTCH PPS Fixed-Loss Amount for RY 2010

When we implemented the LTCH PPS, as discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56026), under the broad authority of section 123 of the BBRA as amended by section 307(b) of BIPA, we established a fixed-loss amount so

that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS. To determine the fixed-loss amount, we estimate outlier payments and total LTCH PPS payments for each case using claims data from the MedPAR files. Specifically, to determine the outlier payment for each case, we estimate the cost of the case by multiplying the Medicare covered charges from the claim by the applicable CCR. Under § 412.525(a)(3) (in conjunction with the revised definition of ''LTC–DRG'' at § 412.503), if the estimated cost of the case exceeds the outlier threshold (the sum of the adjusted Federal prospective payment for the MS–LTC–DRG and the fixed-loss amount), we pay an outlier payment equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal prospective payment for the MS–LTC–DRG and the fixed-loss amount).

In the RY 2009 LTCH PPS final rule (73 FR 26823), we used claims data from the December 2007 update of the FY 2007 MedPAR claims data and CCRs from the December 2007 update of the PSF to determine a fixed-loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments for the 2009 LTCH PPS rate year. We determined the RY 2009 fixed-loss amount using the MS–LTC–DRG classifications and relative weights from the version of the GROUPER that was to be in effect as of the beginning of the 2009 LTCH PPS rate year (July 1, 2008), that is, Version 25.0 of the GROUPER (as established in the FY 2008 IPPS final rule (72 FR 47278). Furthermore, in using CCRs from the December 2007 update of the PSF to determine the RY 2009 fixed-loss amount, we used the FY 2008 applicable LTCH ''total'' CCR ceiling of 1.284 and LTCH statewide average ''total'' CCRs established in the FY 2008 IPPS final rule (72 FR 47404 and 48126 through 48127) such that the current applicable Statewide average CCR was assigned if, among other things, a LTCH's CCR exceeded the current ceiling (1.284).

Therefore, based on the data and policies described under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, in the RY 2009 LTCH PPS final rule, we established a fixed-loss amount of $22,960 for RY 2009. Accordingly, for RY 2009, we currently pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the MS–LTC–DRG and the fixed-loss amount of $22,960).

We note that in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24268 through 24269), we proposed an HCO fixed-loss amount of $16,059 for RY 2010 to maintain that total estimated HCO payments are projected to equal 8 percent of total estimated payments under the LTCH PPS, as required under § 412.523(d)(1). This proposed HCO fixed-loss amount of $16,059 for RY 2010 was calculated based, in part, on the proposed RY 2010 MS–LTC–DRG relative weights presented in Table 11 of that same proposed rule (74 FR 24589 through 24608). However, in the RY 2010 LTCH PPS supplemental proposed rule published in the **Federal Register** on June 3, 2009 (74 FR 26600 through 26635), we presented both proposed RY 2010 MS–LTC–DRG relative weights and a proposed RY 2010 HCO outlier fixed-loss amount based on the revised FY 2009 MS–LTC–DRG relative weights presented in an interim final rule with comment period also published in the **Federal Register** on June 3, 3009 (74 FR 26546 through 26569). Accordingly, based on the proposed RY 2010 MS–LTC–DRG relative weights presented in Table 11 (Amended) of the RY 2010 LTCH PPS supplemental proposed rule and on the data and policies described under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we proposed a fixed-loss amount of $18,868 for RY 2010 in order to maintain that total estimated HCO payments are projected to equal 8 percent of total estimated payments under the LTCH PPS in RY 2010.

In this final rule, we use the same methodology that we used in the RY 2009 LTCH PPS final rule and which was proposed in the RY 2010 LTCH PPS supplemental proposed rule, to calculate the fixed-loss amount for RY 2010 (using updated data and the rates and policies established in this final rule) in order to maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments. Consistent with our historical practice of using the best data available, in determining the fixed-loss amount for RY 2010, we used the most recent available LTCH claims data and CCR data. Specifically, for this final rule, we used LTCH claims data from the March 2009 update of the FY 2008 MedPAR files and CCRs from the March 2009 update of the PSF to determine a fixed-loss amount that will result in estimated outlier payments projected to be equal to 8 percent of total estimated payments in RY 2010 because these data are the most recent complete LTCH data currently available. We determined the RY 2010 fixed-loss amount based on the MS–LTC–DRG classifications and relative weights from the version of the GROUPER that will be in effect as of the beginning of the 2010 LTCH PPS rate year (October 1, 2009), that is, Version 27.0 of the GROUPER (discussed in section VIII.B. of the preamble of this final rule). Furthermore, in determining the RY 2010 fixed-loss amount using CCRs from the March 2009 update of the PSF, we used the RY 2010 LTCH ''total'' CCR ceiling of 1.232 and the applicable LTCH statewide average ''total'' CCRs presented in Table 8C in the Addendum of this final rule such that the applicable statewide average CCR was assigned if, among other things, an LTCH's CCR exceeded the ceiling (1.232).

In this final rule, based on the data and policies described earlier in this final rule under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we are establishing a fixed-loss amount of $18,425 for RY 2010. Thus, we will pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the MS–LTC–DRG and the fixed-loss amount of $18,425).

The fixed-loss amount for RY 2010 of $18,425 is significantly lower than the RY 2009 fixed-loss amount of $22,960. The decrease in the fixed-loss amount for RY 2010 is primarily due to the projected 3.3 percent increase in LTCH PPS payments from RY 2009 to RY 2010 (discussed in greater detail in section IX. of the Appendix A (the regulatory impact analysis) to this final rule), which includes our current estimate that we are paying less than the required 8 percent of total estimated LTCH PPS payments as HCO payments in RY 2009 (as discussed below). Specifically, an analysis of the most recent available LTCH PPS claims data (that is, FY 2008 claims from the March 2009 update of the MedPAR files) indicates that the RY 2009 fixed-loss amount of $22,960 may result in LTCH PPS HCO payments that fall below the estimated 8 percent requirement. Specifically, we currently estimate that HCO payments are approximately 6.8 percent of estimated total LTCH PPS payments in RY 2009.

In addition to the estimated increase in LTCH PPS payments in RY 2010 as compared to RY 2009 due to the projected increase in HCO payments, as we discuss in section IX. of Appendix A to this final rule, we estimate an increase in LTCH PPS payments in RY 2010 due to the update to the standard Federal rate and a projected increase in the payments for SSO cases that are paid based on the estimated cost of the case. For these reasons, we believe that establishing a lower fixed-loss amount is appropriate and necessary to maintain that estimated outlier payments will equal 8 percent of estimated total LTCH PPS payments as required under § 412.523(d)(1). Maintaining the fixed-loss amount at the current level would result in HCO payments that are significantly less than the current regulatory requirement that estimated outlier payments be projected to equal 8 percent of estimated total LTCH PPS payments. As we explained in past LTCH PPS rules (such as the RY 2006 LTCH PPS final rule (70 FR 24195 through 24196)), using a lower fixed-loss amount results in more cases qualifying as outlier cases as well as increases the amount of the additional payment for an HCO case because the maximum loss that an LTCH must incur before receiving an HCO payment (that is, the fixed-loss amount) would be smaller. Thus, in order to maintain that estimated HCO payments in RY 2010 will be equal to 8 percent of estimated total RY 2010 LTCH PPS payments, we believe it is appropriate to lower the fixed-loss amount.

In the August 30, 2002 final rule (67 FR 56022 through 56024), based on our regression analysis, we established the outlier ''target'' at 8 percent of estimated total LTCH PPS payments to allow us to achieve a balance between the ''conflicting considerations of the need to protect hospitals with costly cases, while maintaining incentives to improve overall efficiency.'' We continue to believe that an HCO target of 8 percent is appropriate, as discussed in greater detail below. However, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we solicited public comments on whether we should revisit the regression analysis noted above in this section that was

used to establish the existing 8 percent outlier target, using the most recent available data to evaluate whether the current outlier target of 8 percent should be adjusted, and which therefore may mitigate the magnitude of the proposed change in the fixed-loss amount for RY 2010. Below we provide a summation of the public comments we received and our applicable responses.

Comment: Several comments noted that the proposed fixed-loss amount of $18,868 that was presented in the RY 2010 LTCH PPS supplemental proposed rule was significantly higher than the originally proposed fixed-loss amount of $16,059 included in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24268 through 24269). The commenters expressed concern that the proposed fixed-loss amount presented in the RY 2010 LTCH PPS supplemental proposed rule will have a significant impact on the LTCH PPS payments to HCO cases, and believe that CMS should have provided for a full 60-day comment period to give the public time to conduct a meaningful study of the changes and submit meaningful comments for CMS to consider.

Response: As we stated in the RY 2010 LTCH PPS supplemental proposed rule, while we ordinarily publish a notice of proposed rulemaking in the **Federal Register** and permit a 60-day comment period, this period may be shortened when the Secretary finds good cause that a 60-day comment period would be impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. We further stated:

''Ordinarily, we begin our preparations for issuing an LTCH PPS proposed rule early so that our proposals may be on public display by May 1 of that year. This schedule allows for a 60-day comment period closing within a sufficient amount of time to also allow for a 1- to 2-month period to consider all comments received and appropriately respond to them. In this case, elsewhere in this **Federal Register** an interim final rule with public comment is issued that provides for revised FY 2009 MS–LTC–DRG relative weights. The revised MS–LTC–DRG relative weights affect some of the proposals contained in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, which went on display on May 1, 2009, and was published in the **Federal Register** on May 22, 2009. Therefore, we need to immediately replace those affected proposals. A 60-day comment period on this supplemental proposed rule would be both impracticable and contrary to the public interest because it would not allow for coordinated consideration of the comments on this supplemental proposed rule with those on the FY 2010 IPPS and RY 2010 LTCH PPS proposed rule. Because the issues raised in this supplemental proposed rule are integral to our consideration of comments on certain proposals in the FY 2010 IPPS and RY 2010 LTCH PPS proposed rule, we do not believe it would be appropriate to review comments on the issues raised in this supplemental proposed rule in isolation from the comments received on the FY 2010 IPPS and RY 2010 LTCH PPS proposed rule. We further note that a full 60-day comment period would end on a date that would not allow the agency sufficient time to process the comments and respond to them in a meaningful manner by the August 1, 2009 date for issuing the final rule. Timely filed comments would receive a shorter period of time for consideration by the agency, and the agency would be left with insufficient time to properly respond to comments and appropriately resolve whether any of the proposed policies should be modified in light of comments received. For all of these reasons, we find good cause to waive the 60-day comment period for this rule of proposed rulemaking, and we are instead providing for a comment period that coincides with the comment period provided for on the FY 2010 IPPS and RY 2010 LTCH PPS proposed rule (74 FR 24080).''

Finally, we note that while the proposed fixed-loss amount that was presented in the RY 2010 LTCH PPS supplemental proposed rule was significantly higher than the originally proposed fixed-loss amount included in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 FR 24268 through 24269), the methodology applied to determine the proposed fixed-loss amount in both rules is identical. That is, for each rule, we proposed the appropriate high cost outlier fixed-loss amount for RY 2010 that would maintain that total estimated HCO payments are projected to equal 8 percent of total estimated payments under the LTCH PPS as required under § 412.523(d)(1). We note that we received no comments on our historical methodology to determine a fixed-loss amount that results in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments.

As an alternative to using a lower fixed-loss amount for RY 2010, we also examined adjusting the marginal cost factor (that is, the percentage that Medicare will pay of the estimated cost of a case that exceeds the sum of the adjusted Federal prospective payment for the MS–LTC–DRG and the fixed-loss amount for LTCH PPS HCO cases as specified in § 412.525(a)(3)), as a means of ensuring that estimated outlier payments will be projected to equal 8 percent of estimated total LTCH PPS payments. As we established in the August 30, 2002 final rule (67 FR 56022 through 56026), under the LTCH PPS HCO policy at § 412.525(a)(3), the marginal cost factor is currently equal to 80 percent. As discussed in the RY 2007 LTCH PPS final rule (71 FR 4677 through 4678), a marginal cost factor equal to 80 percent means that, for an outlier case, we pay the LTCH 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal rate for the MS–LTC–DRG PPS payment and the fixed-loss amount). In addition, as we discussed in the August 30, 2002 final rule (67 FR 56023) that implemented the LTCH PPS, the marginal cost factor is designed to ensure ''a balance between the need to protect LTCHs financially, while encouraging them to treat expensive patients and maintaining the incentives of a prospective payment system to improve the efficient delivery of care.''

Increasing the marginal cost factor from the established 80 percent, without reducing the current fixed-loss amount, would increase total estimated outlier payments because we would pay a larger percentage of the estimated costs that exceed the outlier threshold (the sum of the adjusted Federal rate for the MS–LTC–DRG and the fixed-loss amount). For example, if we were to increase the marginal cost factor to 90 percent instead of lowering the fixed-loss amount, we could maintain HCO payments at 8 percent of estimated total LTCH PPS payments. However, while this alternative may ensure that outlier payments are projected to equal 8 percent of estimated total LTCH PPS payments by increasing estimated aggregate HCO payments, it may not maintain the existing balance between providing an incentive for LTCHs to treat expensive patients and improving the efficient delivery of care because a policy such as this would reduce the incentive to provide cost efficient care that is in effect under the current HCO policy (with an 80 percent marginal cost factor). Such a result would be inconsistent with the intent of the LTCH PPS HCO policy (noted above) as stated when we implemented the LTCH PPS in the August 30, 2002 final rule (67 FR 56025). As we discussed in that same final rule (67 FR 56023 through 56024), our analysis of payment-to-cost ratios for HCO cases showed that a marginal cost factor of 80 percent appropriately addresses cases that are significantly more expensive than nonoutlier cases, while simultaneously maintaining the integrity of the LTCH PPS. Accordingly, we did not propose to adjust the marginal cost factor under the LTCH PPS HCO policy in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule. However, as previously stated, in the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we solicited public comments on whether we should revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor, using the most recent available data to evaluate whether the current marginal cost factor of 8 percent in the current HCO policy should be adjusted, and therefore may mitigate the proposed change in the fixed-loss amount for RY 2010. In response to the solicitation, we did not receive any public comments in support of any option to revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor and existing outlier target of 8 percent. The commenters agreed that keeping the marginal cost factor at 80 percent and the outlier pool at 8 percent better identifies LTCH patients that are unusually costly cases, and that this policy appropriately addresses HCO cases that are significantly more expensive than nonoutlier cases.

After consideration of the public comments we received, in this final rule, we are establishing a fixed-loss amount of $18,425 for RY 2010 based on the best available LTCH data and the policies presented in this final rule because we believe a decrease in the fixed-loss amount for RY 2010 is appropriate and necessary to maintain estimated outlier payments equal to 8 percent of estimated total LTCH PPS payments, as required under § 412.525(a). As explained above in this section, in section IX of Appendix A to this final rule, we project an increase in total

LTCH PPS payments systemwide. In accordance with § 412.523(d)(1), we reduced the standard Federal rate by 8 percent for the estimated proportion of LTCH PPS HCO payments. Because we estimate an increase in the average payment per discharge, thereby increasing total estimated LTCH PPS payments, and because we are currently estimating that HCO payments in RY 2009 may fall below the 8 percent target, we believe the fixed-loss amount must be lowered in order to maintain total outlier payments that are projected to equal 8 percent of total payments under the LTCH PPS, in accordance with § 412.525(a).

4. Application of Outlier Policy to SSO Cases

As we discussed in the August 30, 2002 final rule (67 FR 56026), under some rare circumstances, a LTCH discharge could qualify as a SSO case (as defined in the regulations at § 412.529 in conjunction with the regulations at § 412.503) and also as a HCO case. In this scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific MS–LTC–DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the HCO threshold (that is, the SSO payment plus the fixed-loss amount), the discharge is eligible for payment as a HCO. Thus, for a SSO case in the 2010 LTCH PPS rate year, the HCO payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the fixed-loss amount of $18,425 and the amount paid under the SSO policy as specified in § 412.529).

D. Computing the Adjusted LTCH PPS Federal Prospective Payments for RY 2010

In accordance with § 412.525, the standard Federal rate is adjusted to account for differences in area wages by multiplying the labor-related share of the standard Federal rate by the appropriate LTCH PPS wage index (as shown in Tables 12A and 12B of the Addendum of this final rule). The standard Federal rate was also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the nonlabor-related share of the standard Federal rate by the appropriate cost-of-living factor (shown in the chart in section V.C.5. of the Addendum of this final rule). In this final rule, we are establishing a standard Federal rate for the 2010 LTCH PPS rate year of $39,896.65, as discussed in section V.A.2. of the Addendum of this final rule. We illustrate the methodology to adjust the Federal rate for the 2010 LTCH PPS rate year in the following example:

Example:

During the 2010 LTCH PPS rate year, a Medicare patient is in a LTCH located in Chicago, Illinois (CBSA 16974). The RY 2010 LTCH PPS wage index value for CBSA 16974 is 1.0471 (Table 12A of the Addendum of this final rule). The Medicare patient is classified into MS–LTC–DRG 28 (Spinal Procedures with MCC), which has a relative weight for RY 2010 of 1.0933 (Table 11 of the Addendum of this final rule).

To calculate the LTCH's total adjusted Federal prospective payment for this Medicare patient, we computed the wage-adjusted Federal prospective payment amount by multiplying the unadjusted standard Federal rate ($39,896.65) by the labor-related share (75.779 percent) and the wage index value (1.0471). This wage-adjusted amount was then added to the nonlabor-related portion of the unadjusted standard Federal rate (24.221 percent; adjusted for cost of living, if applicable) to determine the adjusted Federal rate, which was then multiplied by the MS–LTC–DRG relative weight (1.0933) to calculate the total adjusted Federal prospective payment for the 2010 LTCH PPS rate year ($45,175.85). The table below illustrates the components of the calculations in this example.

Unadjusted Standard Federal Prospective Payment Rate	$39,896.65
Labor-Related Share	× 0.75779
Labor-Related Portion of the Federal Rate	= $30,233.28
Wage Index (CBSA 16974)	× 1.0471
Wage-Adjusted Labor Share of Federal Rate	= $31,657.27
Nonlabor-Related Portion of the Federal Rate ($39,896.65 × 0.24221)	+ $9,663.37
Adjusted Federal Rate Amount	= $41,320.64
MS–LTC–DRG 28 Relative Weight	× 1.0933
Total Adjusted Federal Prospective Payment	= $45,175.85

VI. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 1E, 2, 3A, 3B, 4A, 4B, 4C, 4D–1, 4D–2, 4F, 4J, 5, 7A, 7B, 8A, 8B, 8C, 9A, 9C, 10, 11, 12A, and 12B are presented below. Table 6G.—Additions to the CC Exclusions List, Table 6H.—Deletions from the CC Exclusions List, Table 6I.—Complete List of Complication and Comorbidity (CC) Exclusions, Table 6J.—Major Complication and Comorbidity (MCC) List, and Table 6K.—Complications and Comorbidity (CC) List are available only through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/*. The tables presented below are as follows:

Table 1A.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (68.8 Percent Labor Share/31.2 Percent Nonlabor Share If Wage Index Is Greater Than 1)
Table 1B.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1)
Table 1C.—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D.—Capital Standard Federal Payment Rate
Table 1E.—LTCH Standard Federal Prospective Payment Rate
Table 2.—Acute Care Hospitals Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2008; Hospital Wage Indexes for Federal Fiscal Year 2010; Hospital Average Hourly Wages for Federal Fiscal Years 2008 (2004 Wage Data), 2009 (2005 Wage Data), and 2010 (2006 Wage Data); and 3-Year Average of Hospital Average Hourly Wages
Table 3A.—FY 2010 and 3-Year Average Hourly Wage for Acute Care Hospitals in Urban Areas by CBSA
Table 3B.—FY 2010 and 3-Year Average Hourly Wage for Acute Care Hospitals in Rural Areas by CBSA
Table 4A.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals in Urban Areas by CBSA and by State—FY 2010
Table 4B.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals in Rural Areas by CBSA and by State—FY 2010
Table 4C.—Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals That Are Reclassified by CBSA and by State—FY 2010
Table 4D–1.—Rural Floor Budget Neutrality Factors for Acute Care Hospitals—FY 2010
Table 4D–2.—Urban Areas with Acute Care Hospitals Receiving the Statewide Rural Floor or Imputed Floor Wage Index—FY 2010
Table 4E.—Urban CBSAs and Constituent Counties for Acute Care Hospitals—FY 2010
Table 4F.—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) for Acute Care Hospitals by CBSA—FY 2010
Table 4J.—Out-Migration Adjustment for Acute Care Hospitals—FY 2010
Table 5.—List of Medicare Severity Diagnosis-Related Groups (MS–DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay
Table 6A.—New Diagnosis Codes
Table 6B.—New Procedure Codes
Table 6C.—Invalid Diagnosis Codes
Table 6D.—Invalid Procedure Codes
Table 6E.—Revised Diagnosis Code Titles
Table 6F.—Revised Procedure Code Titles
Table 7A.—Medicare Prospective Payment System Selected Percentile Lengths of

Stay: FY 2008 MedPAR Update—March 2009 GROUPER V26.0 MS–DRGs
Table 7B.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2008 MedPAR Update—March 2009 GROUPER V27.0 MS–DRGs
Table 8A.—Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—July 2009
Table 8B.—Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—July 2009
Table 8C.—Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs—July 2009
Table 9A.—Hospital Reclassifications and Redesignations—FY 2010
Table 9C.—Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the Act—FY 2010
Table 10.—Geometric Mean Plus the Lesser of .75 of the National Adjusted Operating Standardized Payment Amount (Increased to Reflect the Difference Between Costs and Charges) or .75 of One Standard Deviation of Mean Charges by Medicare Severity Diagnosis-Related Group (MS–DRG)—July 2009
Table 11.—MS–LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for Discharges Occurring from October 1, 2009 through September 30, 2010 under the LTCH PPS
Table 12A.—LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2009 through September 30, 2010
Table 12B.—LTCH PPS Wage Index for Rural Areas for Discharges Occurring from October 1, 2009 through September 20, 2010

TABLE 1A—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (68.8 PERCENT LABOR SHARE/31.2 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)

Full update (2.1 percent)		Reduced update (1.1 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,593.52	$1,629.62	$3,523.13	$1,597.70

TABLE 1B—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)

Full update (2.1 percent)		Reduced update (1.1 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,238.35	$1,984.79	$3,174.91	$1,945.92

TABLE 1C—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if wage index is greater than 1		Rates if wage index is less than or equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,593.52	$1,629.62	$3,238.35	$1,984.79
Puerto Rico	1,542.72	941.52	1,540.23	944.01

TABLE 1D—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$430.20
Puerto Rico	204.01

TABLE 1E—LTCH STANDARD FEDERAL PROSPECTIVE PAYMENT RATE

	Rate
Standard Federal Rate	$39,896.65

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TABLE 2.--HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2008; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2010; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2008 (2004 WAGE DATA), 2009 (2005 WAGE DATA), AND 2010 (2006 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
010001	1.5845	0.8387	23.2195	25.0592	24.8712	24.3914
010005	1.1409	0.8558	23.0203	25.7771	24.9052	24.5783
010006	1.4912	0.7932	23.7502	25.1401	26.7013	25.1568
010007	1.0370	0.7389	21.3492	22.0185	20.0565	21.1223
010008	1.0647	0.7563	22.0793	23.2572	22.8443	22.7502
010009	0.9770	0.8558	25.9011	25.8420	26.1396	25.9552
010010	1.1371	0.8512	22.8602	24.8390	26.2416	24.6360
010011	1.6352	0.8512	27.4668	27.1997	28.6140	27.7686
010012	1.1886	0.8665	25.5767	26.4989	24.8944	25.6315
010015	0.9860	0.7435	27.0806	23.6821	22.9857	24.4256
010016	1.6043	0.8512	26.8611	28.9724	28.7392	28.1982
010018	1.3280	0.8512	24.8974	26.9514	26.7633	26.2058
010019	1.2610	0.7932	23.3460	25.0170	26.0567	24.7916
010021	1.3432	0.7441	21.0624	21.7601	24.3385	22.3603
010022	1.0016	0.9581	27.4318	28.7529	26.5348	27.4919
010023	1.7857	0.8459	26.1739	28.2135	30.0684	28.2501
010024	1.6439	0.8459	25.0715	26.6636	28.1766	26.6932
010025	1.3410	0.8454	23.6186	23.8617	20.1873	22.4609
010027	0.7493	0.7415	17.0513	18.2508	19.7740	18.4084
010029	1.5941	0.8454	25.0468	24.3622	28.3184	25.8259
010032	0.8590	0.7714	18.5545	20.8458	24.7706	21.8594
010033	2.2169	0.8512	29.1471	29.2036	29.3762	29.2486
010034	1.1255	0.8459	19.1549	21.3728	21.0565	20.5456
010035	1.2858	0.8512	24.2746	26.5299	28.0534	26.2286
010036	1.1369	0.7389	24.2887	23.3876	25.0011	24.2323
010038	1.3696	0.7650	27.0752	28.9646	29.7948	28.5749
010039	1.7148	0.8924	28.6462	29.8034	30.6619	29.7273
010040	1.6267	0.8411	24.7657	25.9856	25.2840	25.3460
010043	1.2118	0.8512	23.9121	25.3633	27.3636	25.4551
010044	1.0798	0.7389	24.4276	23.4020	27.3403	25.0195
010045	1.0348	0.7611	23.1695	24.2450	25.1108	24.1973
010046	1.5412	0.8411	25.9105	25.4465	33.3112	27.8297
010047	0.8784	0.7516	19.7542	21.7349	17.0984	19.5638
010049	1.1617	0.7415	22.4248	23.1194	25.4446	23.6306
010050	1.0933	0.8512	24.4060	25.3678	27.0365	25.5736
010051	0.8953	0.8942	18.0305	20.0765	21.4140	19.7507
010052	0.8833	0.8459	36.3638	22.7571	22.1386	27.5747
010054	1.1018	0.8558	24.4810	25.4209	24.6126	24.8365
010055	1.5977	0.8320	22.4145	25.3306	26.4706	24.7201
010056	1.5700	0.8512	24.5754	25.7290	28.5668	26.3145
010058	1.0845	0.8512	17.0150	31.1865	23.6860	22.7031
010059	1.0250	0.8558	24.8199	27.8613	29.5434	27.4641
010061	0.9502	0.8676	25.2454	25.7048	26.5035	25.8287
010062	1.0314	0.7499	21.7112	22.9491	20.8224	21.7809
010064	1.8036	0.8512	27.6149	26.6333	*	27.1325
010065	1.5107	0.8512	24.3346	24.4454	25.9433	24.9230
010066	0.8171	0.7389	25.4612	25.6052	25.9301	25.6623
010068	***	*	24.4145	*	*	24.4145
010069	0.9767	0.7389	23.6272	27.3438	29.4662	26.6107
010073	0.8929	0.7389	19.0046	20.7833	19.9743	19.9252
010078	1.6528	0.7650	24.3828	25.2897	24.5429	24.7419
010079	1.1836	0.8924	22.3034	23.1025	25.4118	23.6280
010083	1.1724	0.8068	24.0036	25.0422	25.2405	24.7843
010084	***	*	26.5079	27.5069	*	26.9470
010085	1.3476	0.8558	23.6280	24.0475	25.6072	24.4035
010086	1.1096	0.7389	21.5584	26.9753	24.9468	24.3212
010087	2.3204	0.7735	24.8320	27.4929	27.2725	26.4865
010089	1.2856	0.8512	26.2628	25.9719	26.9357	26.4004
010090	1.7636	0.8156	26.3957	25.6110	26.8029	26.2723
010091	0.9073	0.7435	22.5272	23.6555	27.8571	24.4933
010092	1.5002	0.8942	26.9959	28.8433	30.3263	28.7996
010095	0.8259	0.8942	17.0024	17.8248	21.6551	18.8630
010097	0.8004	0.8459	19.2481	18.4218	19.5147	19.0354
010099	0.9884	0.7389	20.6736	22.3686	20.8632	21.3012
010100	1.6800	0.8068	25.1460	25.4357	25.8178	25.4803
010101	1.1744	0.8512	25.0974	26.2744	25.0955	25.4896
010102	0.9450	0.8459	26.9859	26.6943	22.6883	25.4344
010103	1.9052	0.8512	28.9636	30.4032	27.9049	29.0899
010104	1.8083	0.8512	28.3126	30.4963	29.1001	29.2733
010108	1.1551	0.8459	25.4325	26.8900	27.7601	26.7696
010109	1.0126	0.7794	21.0449	21.9300	19.3990	20.6952
010110	0.8051	0.7604	19.8738	22.1175	17.9438	20.0583
010112	0.9695	0.7389	20.4027	21.3904	22.0927	21.3256
010113	1.6342	0.7735	24.7170	25.0704	25.7852	25.1927
010114	1.4449	0.8512	25.7090	25.3666	25.8015	25.6243
010118	1.2792	0.8512	22.7191	25.3689	25.7663	24.5849
010120	0.9724	0.7389	22.1868	22.8177	22.0809	22.3630
010125	1.0728	0.7865	22.8911	23.6549	24.1942	23.5860

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
010126	1.0958	0.8459	24.4957	25.7254	28.8995	26.2594
010128	0.8926	0.7435	24.9881	25.9421	25.1022	25.3655
010129	1.0914	0.7523	21.8502	24.4816	25.2104	23.9306
010130	0.9779	0.8512	24.5644	25.2790	23.8895	24.5175
010131	1.3668	0.8924	27.2707	28.0487	28.6759	28.0337
010137	1.3484	0.8512	28.5843	30.4361	30.7312	29.9815
010138	0.6311	0.7455	14.5551	15.0815	16.7541	15.5094
010139	1.5991	0.8512	28.1473	29.3560	29.3626	28.9577
010143	1.2004	0.8558	24.0674	25.0871	25.1522	24.7496
010144	1.6314	0.7735	22.3916	23.8601	25.4614	23.9059
010145	1.5498	0.8942	25.8293	27.3296	30.2093	27.7345
010146	1.0598	0.7650	22.6879	23.8076	24.6572	23.7085
010148	0.8908	0.7389	23.5714	25.0960	24.8409	24.4809
010149	1.3063	0.8459	25.4354	26.8920	28.1328	26.9313
010150	0.9874	0.7516	24.4098	25.0070	26.3342	25.2209
010152	1.2783	0.7735	23.7803	26.0793	23.0248	24.2087
010157	1.1477	0.7932	24.2206	27.1793	27.5674	26.1833
010158	1.3024	0.7932	25.5905	26.2363	26.8821	26.2368
010163	***	*	34.0325	*	*	34.0325
010164	1.1968	0.8512	23.2447	25.6759	24.4625	24.4744
010165	***	*	28.8040	*	*	28.8040
010166	***	*	29.7256	*	*	29.7256
010167	1.5552	0.8512	*	*	24.7643	24.7643
010168	1.4982	0.8781	*	*	30.2040	30.2040
010169	1.0218	*	*	*	*	*
020001	1.8167	1.1920	36.5298	38.1784	39.2651	38.0206
020006	1.3328	1.1920	37.0211	37.2853	40.5422	38.4153
020008	1.2471	1.1920	39.3432	40.6783	42.8075	40.9881
020012	1.4164	1.1636	33.9375	36.1911	37.0181	35.7416
020014	1.1716	*	30.9722	30.6343	*	30.7977
020017	2.1444	1.1920	35.8804	38.2157	41.2448	38.4881
020018	0.9300	1.9311	*	*	*	*
020024	1.1745	1.1636	38.6934	39.9943	35.9358	38.1698
020026	1.5704	1.9311	*	*	*	*
020027	1.0148	1.9311	*	*	*	*
020028	1.2652	1.1920	*	*	*	*
030001	1.5332	1.0472	33.4178	35.9083	38.1204	35.8255
030002	2.1075	1.0472	31.0818	32.9094	34.2998	32.7833
030006	1.7793	0.9686	27.7421	29.1248	32.1646	29.7571
030007	1.3822	1.1887	33.7213	35.5226	38.1199	35.8227
030010	1.5704	0.9686	30.6261	31.8640	33.3049	31.9861
030011	1.6034	0.9686	28.8203	30.2096	31.8532	30.3461
030012	1.5765	1.0169	29.1042	31.3068	33.4818	31.4121
030013	1.5440	0.9284	31.2815	31.9162	31.1767	31.4583
030014	1.5999	1.0472	29.8296	30.6308	31.8529	30.8215
030016	1.3369	1.0472	30.7896	31.1878	30.6196	30.8673
030017	2.1804	1.0472	34.4852	34.8488	34.9499	34.7649
030018	***	*	31.8056	31.7240	34.2870	32.6101
030019	1.2752	1.0472	30.1934	33.6553	36.3298	33.3216
030022	1.8479	1.0472	30.3746	35.0772	34.3377	33.3702
030023	1.8996	1.2450	35.8287	37.5523	41.8098	38.3552
030024	2.1838	1.0472	33.1797	35.3556	38.5575	35.8571
030027	0.9841	*	*	*	*	*
030030	1.7560	1.0472	34.4166	36.4772	38.9056	36.6612
030033	1.3387	1.1887	29.9383	32.0362	33.9716	32.0575
030036	1.4973	1.0472	33.0523	35.7464	37.1271	35.4196
030037	1.9164	1.0472	34.1079	35.1342	35.8129	35.0008
030038	1.7202	1.0472	31.7238	31.2928	33.8052	32.3972
030043	1.3165	0.8801	27.3856	28.3158	29.0816	28.2528
030055	1.5121	1.0590	27.1621	31.0806	37.2632	31.8399
030061	1.6594	1.0472	28.1337	33.0847	34.2000	31.8030
030062	1.2990	0.8801	28.9587	29.9359	30.3859	29.7832
030064	2.0752	0.9686	29.8226	31.6632	33.1535	31.6021
030065	1.6659	1.0472	31.0817	31.4602	33.8941	32.1759
030067	1.0036	0.9099	27.4497	27.0784	27.4410	27.3241
030068	1.1336	0.8801	23.8792	26.0296	26.8369	25.6216
030069	1.4754	1.1147	29.7802	30.7723	35.1793	32.0595
030071	0.9382	1.4424	*	*	*	*
030073	1.1721	1.4424	*	*	*	*
030074	0.8683	1.4424	*	*	*	*
030077	0.8290	1.4424	*	*	*	*
030078	1.2740	1.4424	*	*	*	*
030080	***	*	28.6568	30.7682	34.2723	31.2782
030083	1.4547	1.0472	33.5302	35.8521	39.0888	36.1864
030084	1.0279	1.4424	*	*	*	*
030085	1.5874	0.9686	28.1388	29.0774	30.7160	29.2792
030087	1.7637	1.0472	31.2331	31.1094	33.0362	31.8921
030088	1.3982	1.0472	29.9758	30.5738	33.5408	31.4072
030089	1.6261	1.0472	30.1591	31.3179	32.8874	31.4849
030092	1.5069	1.0472	30.6343	30.4394	31.6471	30.9450
030093	1.3713	1.0472	27.8821	33.0720	33.5029	31.6305
030094	1.5484	1.0472	33.4050	34.2040	35.9213	34.5882
030099	1.0041	*	26.9227	24.9127	*	25.9405
030100	2.1888	0.9686	34.7532	35.0981	36.9783	35.6058

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
030101	1.4298	1.1523	30.6764	33.2139	34.1060	32.7119
030102	2.5350	1.0472	33.6247	36.9539	39.4617	36.7168
030103	1.7849	1.0472	32.2833	34.2770	41.6469	36.2802
030105	2.4535	1.0472	32.7449	33.9875	37.6952	34.8549
030106	***	*	36.4667	40.1657	43.9022	40.0063
030107	2.0233	1.0472	35.5386	35.4562	35.9171	35.6334
030108	2.3003	1.0472	29.9395	34.8507	33.2799	33.1021
030110	1.6728	1.0472	29.7949	36.2158	38.0468	34.7295
030111	1.1217	0.9686	33.3711	28.5146	33.3314	31.7560
030112	2.0296	1.0472	36.6601	33.4810	36.1513	35.3527
030113	0.9902	1.4424	*	*	*	*
030114	1.3424	0.9686	*	28.8466	30.2128	29.5486
030115	1.5005	1.0472	*	32.5885	34.8409	33.8326
030117	1.4722	1.0590	*	*	34.5349	34.5349
030118	1.2518	1.0169	*	*	28.2945	28.2945
030119	1.4947	1.0472	*	*	38.2362	38.2362
030120	0.8758	1.0472	*	*	39.7676	39.7676
030121	1.4550	1.0472	*	*	*	*
030122	1.3140	1.0472	*	*	*	*
030123	1.5497	1.0472	*	*	*	*
030124	2.6277	1.0472	*	*	*	*
030125	3.2446	1.0472	*	*	*	*
040001	1.1460	0.8787	22.9948	24.4962	25.0147	24.1493
040002	1.2229	0.7559	25.0000	24.0487	26.2100	25.0839
040004	1.7027	0.8787	28.1117	29.2714	30.1320	29.1917
040007	1.7278	0.8683	29.1941	28.3305	29.3146	28.9264
040010	1.4340	0.8787	26.5287	28.2375	28.1618	27.6655
040011	0.9797	0.7559	22.2431	22.6327	25.6224	23.4885
040014	1.3398	0.8455	28.9855	34.8279	24.1271	27.0301
040015	1.1006	0.7559	20.1061	22.3148	23.2134	21.9435
040016	1.7116	0.8683	26.5911	26.4806	27.6568	26.9328
040017	1.0997	0.8164	23.8768	24.3772	25.3390	24.5297
040018	1.1868	0.7994	25.6751	26.2521	25.3362	25.7513
040019	1.0300	0.8936	24.9113	26.4932	25.5468	25.6449
040020	1.6095	0.8936	23.9470	26.1529	25.9754	25.3556
040021	1.4842	0.8683	26.1853	27.6799	28.7690	27.5158
040022	1.4773	0.8787	27.9902	30.0250	29.5992	29.1801
040026	1.5873	0.9115	29.5299	31.8588	32.2814	31.2252
040027	1.5645	0.8586	23.8220	25.7935	27.2441	25.6461
040029	1.4566	0.8683	25.1479	27.8882	27.8412	26.9707
040036	1.6862	0.8683	29.7150	30.4906	32.0772	30.7579
040039	1.2327	0.8164	21.4819	22.9807	23.4456	22.6302

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
040041	1.1879	0.8455	26.4964	26.4435	27.8594	26.9329
040042	1.2983	0.9265	19.8709	23.1661	23.5768	22.1179
040047	1.0151	0.7676	23.0358	23.3557	25.0102	23.8201
040050	1.2063	0.7559	18.5119	19.6946	21.0178	19.7283
040051	0.9553	0.7559	22.0394	22.1981	23.4783	22.5835
040054	***	*	19.5353	*	*	19.5353
040055	1.5801	0.7994	24.9164	26.0150	26.3370	25.7592
040062	1.6460	0.7994	25.2303	25.6554	28.5888	26.4624
040067	1.1206	0.7566	18.9872	20.9700	21.3492	20.3711
040069	1.0228	0.8936	24.9996	23.3117	23.0880	23.7806
040071	1.5589	0.8455	25.2840	26.6645	25.0185	25.6335
040072	1.2213	0.7559	22.1058	22.9671	23.3205	22.8095
040074	1.2546	0.8683	26.2661	27.3897	27.4614	27.0447
040076	1.0391	0.8972	23.0954	24.7903	25.7464	24.5137
040078	1.7561	0.9115	26.1937	25.6886	27.9394	26.5898
040080	1.0191	0.7796	24.8760	26.5905	26.9354	26.1946
040081	0.8928	0.7916	17.2536	18.4759	18.5265	18.0707
040084	1.1838	0.8683	26.6449	28.1570	28.7379	27.8412
040085	0.9628	0.8936	25.7215	26.6987	25.4981	25.9791
040088	1.6482	0.7925	23.6276	24.7119	26.7050	25.0332
040091	1.2277	0.8153	23.1913	22.3311	27.7747	24.3759
040100	***	*	22.6131	24.5458	24.7712	24.0053
040114	1.8912	0.8683	27.7928	28.5702	29.1200	28.4889
040118	1.4432	0.7559	26.8908	26.5783	27.3360	26.9375
040119	1.4207	0.8455	24.2419	25.6779	26.9632	25.6908
040126	***	*	17.3715	*	*	17.3715
040132	***	*	22.0054	21.8140	*	21.8932
040134	2.3335	0.8683	32.2832	34.9673	35.2045	34.1832
040137	1.3572	0.8683	27.7360	27.7638	28.2123	27.9174
040138	1.4653	0.8787	28.3342	33.0073	31.1138	30.8620
040141	***	*	30.3475	33.8791	34.8500	33.1069
040142	1.5793	0.9115	23.8620	23.1302	24.4876	23.8493
040145	2.0152	0.7796	24.4367	20.3878	22.1731	22.2323
040146	***	*	33.7876	*	*	33.7876
040147	1.9243	0.8683	*	35.7669	33.6215	34.5458
040149	2.8606	0.7758	*	*	*	*
040150	3.5552	0.8683	*	*	*	*
040151	0.8493	*	*	*	*	*
050002	1.5196	1.6059	41.7336	43.1760	42.3825	42.4362
050006	1.6996	1.3428	37.1639	41.7714	43.8923	40.7743
050007	1.5151	1.5600	45.8773	49.5271	55.1636	50.1454
050008	1.4465	1.5454	46.8706	50.9569	50.4751	49.4532

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
050009	1.7181	1.4473	46.2186	49.7177	51.5510	49.2875
050013	1.9116	1.4473	43.5623	43.4906	46.3422	44.4978
050014	1.2225	1.3354	37.4135	42.2044	42.7255	40.8879
050016	1.3829	1.1990	31.0653	34.3863	36.3674	34.0765
050017	2.0091	1.3594	42.2200	44.4857	46.6209	44.4925
050018	1.3631	1.1890	31.8310	34.0338	34.7941	33.4827
050022	1.6861	1.1745	33.0592	36.6360	38.9203	36.3343
050024	1.1893	1.1745	33.4334	33.5247	34.6921	33.8896
050025	1.8351	1.1745	32.7476	36.9233	39.5330	36.4669
050026	1.6001	1.1745	33.1277	35.0306	36.3315	34.8703
050028	1.2936	1.1745	28.5736	28.1584	28.5839	28.4402
050030	1.2416	1.1745	30.9014	33.5654	33.2455	32.5839
050036	1.6646	1.1745	36.0905	37.4298	39.2616	37.6682
050038	1.6570	1.6059	48.7483	55.2197	58.4851	54.2999
050039	1.5904	1.1745	36.6943	34.9262	37.8559	36.4390
050040	1.4532	1.1890	35.7054	38.1665	41.9767	38.6398
050042	1.5233	1.3428	40.3326	40.5791	45.6660	42.2088
050043	1.6918	1.6059	48.2283	51.9529	55.4677	51.9199
050045	1.3659	1.1745	27.0676	28.5952	27.8903	27.8521
050046	1.2228	1.2216	29.1125	34.2529	34.0106	32.3249
050047	1.8073	1.5454	45.1675	48.5961	51.4298	48.4721
050054	1.2588	1.1745	24.0338	27.1320	27.9082	26.4594
050055	1.4222	1.5454	44.2926	48.2796	51.9993	48.1322
050056	1.4442	1.1890	32.7693	34.7964	33.2655	33.6015
050057	1.7461	1.1745	31.7467	33.7574	35.6340	33.7435
050058	1.6682	1.1890	37.2538	38.9843	41.4811	39.3075
050060	1.5631	1.1745	32.0196	34.1183	35.3108	33.8337
050063	1.5708	1.1890	36.3085	36.6301	40.9558	37.9234
050065	***	*	38.2421	42.0085	*	40.1992
050067	1.2534	1.2337	40.1393	41.8988	41.1549	41.0569
050069	1.7808	1.1766	35.3850	38.1339	40.0498	37.8939
050070	1.2439	1.5600	46.4009	48.9362	53.8300	49.9343
050071	1.4802	1.6059	49.6495	52.0696	55.3995	52.4757
050072	1.4521	1.5857	50.0343	51.4538	54.7774	52.2508
050073	1.3603	1.5857	49.0069	50.6523	54.2296	51.3925
050075	1.3951	1.6059	49.8290	51.1187	54.8332	52.0419
050076	1.7639	1.5857	50.2039	50.5761	53.8043	51.6052
050077	1.6289	1.1745	36.5384	37.4989	38.5242	37.6430
050078	1.3063	1.1890	30.4274	37.1940	38.9256	35.3281
050079	1.6133	1.5857	48.8994	48.3017	50.6578	49.2639
050082	1.7923	1.2216	37.8905	42.0181	41.8861	40.5697
050084	1.5813	1.3354	39.5748	41.1276	42.4418	41.0939

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
050089	1.3725	1.1766	36.4018	39.6297	39.9711	38.6925
050090	1.4013	1.5541	37.7421	41.6026	44.0838	41.1606
050091	1.0100	1.1890	37.1223	40.1063	34.8170	37.2721
050093	1.5711	1.1745	36.8486	37.7244	38.5686	37.7313
050095	***	*	*	44.2400	*	44.2400
050096	1.4421	1.1890	33.1322	33.3803	27.6236	31.3753
050099	1.5777	1.1766	32.0650	34.3507	35.4717	33.9237
050100	1.7931	1.1745	33.3959	34.2839	37.1606	34.9452
050101	1.4703	1.5857	47.9327	48.7495	54.5185	50.5640
050102	1.3981	1.1745	32.8434	33.2837	35.4740	33.8520
050103	1.6019	1.1890	35.6773	37.3608	38.8446	37.3578
050104	1.4962	1.1890	33.6204	37.4417	39.1121	36.8286
050107	1.5857	1.1972	33.5687	36.5843	40.5315	36.9068
050108	1.9026	1.3594	42.0131	45.3460	48.8199	45.3586
050110	1.2987	1.1972	28.0670	30.9054	32.3171	30.4533
050111	1.1580	1.1890	31.8766	31.9394	31.1160	31.6503
050112	1.5420	1.1890	38.9483	39.9951	41.8195	40.3254
050113	1.2549	1.5600	42.8884	46.3471	45.1998	44.8244
050114	***	*	35.7274	37.5924	36.6541	36.6705
050115	1.5039	1.1745	32.5257	33.3013	37.7614	34.4870
050116	1.6781	1.1890	37.6018	45.7510	40.6863	41.4893
050117	***	*	35.0531	*	*	35.0531
050118	1.1957	1.2377	41.6701	41.8191	43.4432	42.3359
050121	1.2641	1.1745	34.6244	35.1135	36.9069	35.7123
050122	1.5158	1.2377	34.0259	36.8821	40.4510	37.0790
050124	1.2944	1.1890	29.9944	31.7690	33.3080	31.7155
050125	1.4989	1.6059	47.7578	53.6300	57.6242	53.5759
050126	1.5931	1.1890	32.6686	35.1909	34.9807	34.3233
050127	1.4551	1.3594	40.7610	42.5226	46.9648	43.5687
050128	1.5539	1.1745	33.4233	34.2364	36.6986	34.8511
050129	1.9164	1.1766	36.9887	40.3786	41.4256	39.6589
050131	1.4334	1.5857	47.5257	52.8228	56.6586	52.5377
050132	1.5288	1.1890	39.6807	43.6747	42.8187	42.0853
050133	1.5143	1.3354	33.1814	35.2433	36.8254	35.2410
050135	0.9807	1.1890	25.3209	25.4431	28.5118	26.3905
050136	1.4274	1.5541	46.6619	51.8508	52.5398	50.5779
050137	1.4648	1.1890	40.2457	43.5305	45.2088	43.0519
050138	1.8689	1.1890	40.6343	45.1011	47.3839	44.4017
050139	1.3088	1.1890	38.7385	43.0734	44.5753	42.1915
050140	1.4429	1.1766	39.4954	42.7590	44.8911	42.4513
050144	***	*	38.2424	40.4760	*	39.2990
050145	1.6200	1.5301	48.0796	49.4479	54.8909	50.8987

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
050146	1.8067	*	*	*	*	*
050149	1.5452	1.1890	37.3616	43.1926	42.8003	41.2044
050150	1.2599	1.3354	37.9946	43.5937	44.3354	41.9111
050152	1.5144	1.5857	51.6567	54.7176	55.9738	54.2085
050153	1.5122	1.6059	47.6374	50.4884	53.5925	50.7672
050155	***	*	16.7756	*	*	16.7756
050158	1.3845	1.1890	39.9160	42.7874	42.9454	41.9375
050159	1.4248	1.2216	34.6915	35.0153	40.4701	36.9374
050167	1.5002	1.2377	34.0418	38.0742	39.9946	37.4081
050168	1.6098	1.1766	40.5973	40.8362	37.9746	39.7308
050169	1.5655	1.1890	31.4115	33.1130	35.4836	33.4714
050173	1.4207	1.1766	31.6717	32.3265	31.5434	31.8479
050174	1.6658	1.5541	48.1740	53.7113	54.7960	52.3550
050175	***	*	35.0152	*	*	35.0152
050179	1.2229	1.2337	31.6651	34.6558	36.2060	34.2237
050180	1.6323	1.5857	45.7099	48.7425	51.1836	48.6966
050188	1.5131	1.6059	43.7381	45.8501	49.6669	46.1928
050189	1.0309	1.5301	28.7580	31.5805	27.5311	29.3162
050191	1.6446	1.1890	37.8756	41.7185	40.0694	39.9276
050192	0.9710	1.1745	27.8386	27.4611	29.4203	28.2565
050193	1.2713	1.1766	29.0623	36.7240	39.0111	34.3157
050194	1.3831	1.6191	49.0030	49.8539	49.9857	49.6231
050195	1.6096	1.6059	53.5583	57.6563	61.8312	57.7939
050196	1.1775	1.1745	32.8293	41.1300	43.7415	39.0851
050197	2.0396	1.6059	52.9998	55.3173	59.0280	55.8935
050204	1.4472	1.1890	35.3954	38.8689	37.5591	37.3221
050205	1.4418	1.1890	30.6322	30.6117	30.2818	30.5103
050207	***	*	31.3431	*	*	31.3431
050211	1.3307	1.6059	35.0289	42.9254	44.8773	41.1567
050215	***	*	50.7578	*	*	50.7578
050219	1.4820	1.1890	25.8378	26.7061	26.9022	26.4629
050222	1.6843	1.1745	33.7510	35.4045	36.0221	35.1304
050224	1.6925	1.1766	35.7280	37.3442	39.7119	37.6583
050225	1.5265	1.1745	35.1227	37.5252	38.9288	37.2722
050226	1.5128	1.1766	35.4597	36.5354	38.4952	36.8620
050228	1.3094	1.5454	47.1430	49.9063	54.5580	50.6395
050230	1.7510	1.1766	35.8490	38.8901	39.8582	38.1992
050231	1.8197	1.1890	33.7139	37.0245	38.7280	36.5662
050232	1.6133	1.1990	34.3242	35.4055	39.4290	36.5180
050234	1.5286	1.1745	34.8308	37.7125	37.6811	36.8277
050235	1.4931	1.1890	37.0858	39.1744	40.0962	38.8107
050236	1.4684	1.2216	32.6462	34.4257	42.5939	36.3695

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
050238	1.6730	1.1890	34.0823	35.1268	36.4272	35.2648
050239	1.6564	1.1890	35.9041	36.3257	37.2939	36.5336
050240	***	*	40.7427	*	*	40.7427
050242	1.4639	1.6191	50.9882	53.8385	58.5684	54.5402
050243	1.6149	1.1745	36.1209	37.8538	40.0490	37.9780
050245	1.3581	1.1766	33.2556	34.7153	36.9270	35.0229
050248	1.1522	1.5301	40.4941	46.0329	47.7637	44.8139
050254	1.3280	1.3594	33.0865	33.5069	34.8262	33.8455
050256	***	*	32.7159	32.6841	*	32.7009
050257	0.8700	1.1745	24.0737	29.2651	30.7766	28.1655
050261	1.2833	1.1745	30.8704	33.7196	34.8188	33.2168
050262	2.1742	1.1890	41.4835	43.7709	40.8071	41.9324
050264	1.4465	1.6059	43.4181	50.1691	54.4052	49.3536
050270	***	*	36.0111	*	*	36.0111
050272	1.4714	1.1766	30.9290	32.2584	35.0624	32.7944
050276	1.0620	1.5857	43.7943	47.2432	53.7552	48.2806
050277	1.2188	1.1890	35.0079	*	48.9698	41.4641
050278	1.5881	1.1890	34.3798	38.5689	39.5929	37.5509
050279	1.3431	1.1766	31.6738	32.1695	31.0888	31.6403
050280	1.8076	1.3428	41.3912	43.6243	46.2628	43.8671
050281	1.4591	1.1890	31.6639	31.0706	31.4166	31.3825
050283	1.6751	1.6059	43.6855	45.1132	50.3066	46.4248
050289	1.6482	1.5600	50.1762	52.0918	53.8571	52.0937
050290	1.7628	1.1890	40.6192	42.0099	42.2249	41.6247
050291	2.1154	1.5541	41.2100	44.6102	49.6427	45.3868
050292	1.0695	1.1745	27.3365	35.0372	34.6404	32.6120
050295	1.4457	1.1745	38.4256	39.7399	39.3961	39.2311
050296	1.1929	1.6059	42.5405	44.8135	48.2583	45.2607
050298	1.2155	1.1756	33.7864	33.6947	31.7374	33.0204
050299	***	*	32.3707	*	*	32.3707
050300	1.3876	1.1766	33.6821	37.1275	39.2722	36.7802
050301	1.3188	1.5033	37.1103	36.3681	36.7568	36.7455
050305	1.4748	1.6059	48.5339	56.9756	55.7229	53.7704
050308	1.5475	1.6059	46.4180	49.0132	51.0183	48.9172
050309	1.4681	1.3594	40.1499	42.9280	46.6901	43.2658
050313	1.1794	1.2377	37.5024	39.0663	42.3998	39.6954
050315	1.4955	1.1745	32.5538	37.3560	40.3132	36.9209
050320	1.2617	1.6059	46.2071	50.6708	50.9692	49.3657
050324	1.7981	1.1745	36.3474	37.1883	38.9511	37.5499
050325	0.7197	1.1778	37.0441	34.0343	24.8273	31.6045
050327	1.7444	1.1766	35.9349	36.9550	37.7681	36.9187
050329	1.3362	1.1745	33.0390	36.7669	37.6975	35.8747

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
050333	1.8307	*	18.6534	*	*	18.6534
050334	1.6541	1.6059	47.2968	50.9834	54.9338	51.1753
050335	1.4391	1.2337	34.7192	37.2347	*	35.9903
050336	1.2541	1.2377	31.5480	33.0325	35.3658	33.3909
050342	1.3022	1.1745	30.4226	29.8389	31.6852	30.6669
050348	1.8134	1.1766	32.7107	33.5276	35.1080	33.7908
050349	0.9151	1.1745	25.4266	23.1095	23.5190	23.9313
050350	1.3978	1.1890	31.7908	34.6747	36.1856	34.1757
050351	1.5717	1.1890	33.3064	35.0042	35.6083	34.6718
050352	1.4089	1.3594	37.0807	38.6265	41.5370	39.0816
050353	1.5551	1.1890	30.4206	37.1716	37.4560	34.8185
050357	1.4846	1.1972	36.2089	38.9244	40.9999	38.6827
050359	1.2193	1.1745	31.3391	30.3988	30.9732	30.8940
050360	1.5683	1.5857	52.3811	55.3738	59.2147	55.9372
050366	1.1372	1.1760	37.1527	41.8324	43.0169	40.6263
050367	1.5054	1.5857	40.1904	40.0453	41.1059	40.4546
050369	1.4846	1.1890	32.2467	33.3357	34.7337	33.4803
050373	1.4160	1.1890	34.3737	37.6695	40.8506	37.5947
050376	1.7385	1.1890	35.2837	36.7270	40.0354	37.4530
050378	1.0804	1.1890	40.1923	42.0480	50.0875	43.7435
050380	1.7334	1.6059	49.4258	52.5804	58.6395	53.6461
050382	1.5274	1.1890	32.6683	32.9248	34.3636	33.3497
050385	1.3823	1.5541	36.4188	36.5644	38.9773	37.2273
050390	1.2352	1.1745	27.9359	33.0463	31.4134	30.7029
050393	1.4095	1.1890	35.6356	35.1887	35.5678	35.4632
050394	1.7539	1.2216	32.1894	32.9572	37.2557	34.1198
050396	1.6051	1.1972	37.3972	38.9944	41.2602	39.2611
050397	0.8791	1.1745	29.6825	31.1621	32.3700	31.2139
050407	1.1109	1.5454	44.6839	47.5591	47.7943	46.7101
050411	1.3188	1.1890	38.6328	42.9884	44.3404	42.1148
050414	1.2606	1.3594	41.8688	45.1621	48.5863	45.3571
050417	1.3676	1.1745	36.1222	37.9951	38.8418	37.6627
050420	***	*	39.9237	*	*	39.9237
050423	0.9097	1.1745	31.9751	32.4108	41.3130	35.2260
050424	1.8835	1.1745	36.6091	37.5246	39.8802	38.1014
050425	1.4006	1.3594	46.6628	45.3743	52.0378	48.0395
050426	1.5848	1.1766	34.9855	37.6505	*	36.2570
050430	1.0024	1.1745	24.5327	25.9368	28.7102	26.6632
050432	***	*	35.2416	*	*	35.2416
050433	***	*	21.1287	23.0949	*	21.8861
050434	1.0072	1.1745	33.7794	35.4807	34.4698	34.5577
050435	1.2399	1.1745	33.0372	35.7427	35.3040	34.7304

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
050438	1.5712	1.1890	36.2044	38.2855	36.8507	37.1089
050441	2.0461	1.6059	46.6160	49.2129	50.0652	48.7409
050444	1.4405	1.2086	37.6821	39.3947	39.4231	38.9035
050447	***	*	29.0780	27.1271	*	28.1938
050448	1.3163	1.1745	32.7748	32.6682	32.9244	32.7905
050454	2.0707	1.5454	40.2811	43.5230	46.9602	43.7234
050455	1.5338	1.1745	34.5445	35.0232	38.9871	36.1689
050456	***	*	27.7659	27.9702	28.1444	27.9251
050457	1.6229	1.5454	50.0282	53.3175	54.6802	52.7341
050464	1.8237	1.2337	41.6235	42.6699	44.9128	43.0400
050468	1.6473	1.1890	35.7409	37.3416	35.7136	36.2585
050470	***	*	31.0466	32.5041	*	31.8030
050471	1.7355	1.1890	36.8680	36.8185	37.6641	37.1228
050476	1.4978	*	41.1042	41.7566	*	41.4396
050477	***	*	40.1566	*	*	40.1566
050478	0.9651	1.1972	41.1668	41.5635	44.3775	42.4263
050481	1.6084	1.1890	38.8650	42.8536	47.2326	43.0173
050485	1.6760	1.1890	34.6219	34.7078	37.4203	35.6422
050488	1.5050	1.6059	45.0630	49.3604	53.8013	49.5790
050492	1.3426	1.1745	30.7718	32.6609	35.6838	33.0853
050494	1.3521	*	40.6384	*	*	40.6384
050496	1.8005	1.5857	51.6363	56.7446	57.1030	55.2305
050498	1.3732	1.3594	41.0350	45.3508	46.6560	44.2998
050502	1.6773	1.1890	31.8872	32.9791	40.2876	34.8874
050503	1.5669	1.1745	37.3605	37.7210	40.7324	38.6886
050506	1.4880	1.1990	39.8586	40.6534	42.3670	40.9594
050510	1.2416	1.5857	49.4533	51.3143	54.8690	52.0438
050512	1.4151	1.6059	48.8057	50.1470	53.9292	51.1330
050515	1.3519	1.1745	40.2957	42.0106	45.0972	42.4993
050516	1.5617	1.3594	43.0249	45.6228	48.5267	45.8170
050517	1.3003	1.1766	22.4096	29.3694	29.8385	27.1486
050523	1.3076	1.5857	43.4579	46.9870	49.5029	46.8182
050526	1.3356	1.1766	33.3964	35.5457	*	34.4882
050528	1.1847	1.1745	36.2908	38.3051	41.9922	38.8610
050531	1.1644	1.1890	28.3348	28.4890	28.4921	28.4411
050534	1.4960	1.1745	36.6447	38.1892	39.7655	38.2236
050535	***	*	37.8174	*	*	37.8174
050537	1.5653	1.3594	38.2145	41.5275	43.1765	40.9277
050541	1.5957	1.6059	48.0867	51.4545	55.2594	51.6557
050543	0.7581	1.1766	24.4913	32.8367	29.0470	28.4715
050545	0.8643	1.1890	35.3209	*	27.4889	30.7617
050546	0.9013	1.1745	36.5099	*	*	36.5099

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[4] (3 years)
050547	1.0661	1.5541	33.8036	*	*	33.8036
050548	0.8853	1.1766	41.1075	*	*	41.1075
050549	1.6842	1.2216	38.3927	40.6796	44.6715	41.2518
050550	***	*	34.9476	39.2163	*	37.0016
050551	1.3734	1.1766	37.2506	37.6223	39.4047	38.1084
050552	0.9575	1.1890	33.9810	35.3468	38.6658	35.9958
050557	1.6013	1.2337	35.7023	39.2224	41.9292	38.9741
050561	1.3332	1.1890	38.2543	40.1567	43.1147	40.5698
050567	1.4772	1.1766	37.6384	39.0114	41.7247	39.5088
050568	1.2403	1.1745	26.0908	26.7733	28.7691	27.2379
050570	1.6746	1.1766	38.4373	40.6761	40.3411	39.7870
050571	***	*	39.0649	*	*	39.0649
050573	1.5704	1.1745	35.2842	36.8561	38.0175	36.7515
050575	1.3669	1.1890	23.7990	22.1018	32.1046	25.7398
050578	***	*	31.3639	43.4917	*	37.7526
050580	1.2357	1.1766	34.1531	35.0966	36.7968	35.3668
050581	1.4706	1.1890	37.7567	40.0909	41.9698	39.9280
050583	***	*	37.4450	40.5845	41.3920	39.8225
050584	***	*	30.7839	31.9910	30.8650	31.2225
050586	1.5377	1.1766	31.3513	31.1932	32.7348	31.7623
050588	1.4009	1.1890	37.7387	39.4251	39.0347	38.7483
050589	1.2342	1.1766	37.6886	37.2056	39.2646	38.0657
050590	1.4082	1.3594	41.7519	44.3382	50.0371	45.4193
050591	***	*	34.7133	*	*	34.7133
050592	***	*	31.8053	32.2376	*	31.9918
050594	***	*	42.0788	*	*	42.0788
050597	1.3924	1.1890	31.5625	32.8987	35.6567	33.3968
050599	1.9445	1.3594	34.7187	36.6146	38.9877	36.8236
050601	1.5350	1.1890	39.7717	43.2404	43.3329	42.1191
050603	1.4831	1.1766	35.0279	35.4809	37.4348	36.0743
050604	1.3745	1.6059	49.4446	49.6068	54.1687	51.1383
050608	1.3372	1.1745	31.2909	30.7280	28.3794	30.0916
050609	1.5110	1.1766	39.7397	43.4555	45.2475	42.8887
050613	***	*	42.9930	*	*	42.9930
050615	***	*	39.1299	*	*	39.1299
050616	1.5516	1.2216	37.1200	40.7388	45.2614	40.9054
050618	0.9849	1.1745	33.1472	34.9177	34.0584	34.0420
050624	1.4376	1.1890	35.9346	39.2553	40.2253	38.5781
050625	1.8200	1.1890	41.0439	44.8482	48.1826	44.7873
050633	1.2200	1.1990	38.4916	40.7383	41.1786	40.1476
050636	1.3104	1.1745	33.0718	35.4565	38.8844	35.8008
050641	1.1910	1.1890	32.3586	32.0508	33.1417	32.5223

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[4] (3 years)
050644	1.0129	1.1890	30.7981	33.2777	32.1513	32.1019
050660	1.7720	*	*	*	*	*
050662	***	*	38.3017	*	*	38.3017
050663	1.3408	1.1890	17.7035	17.7252	30.4117	21.1168
050667	0.9232	1.4473	25.9161	25.8460	30.1039	27.2382
050668	1.2168	1.5857	51.6049	52.7011	62.7714	55.8802
050674	1.3224	1.3594	47.0720	48.6880	51.3517	49.1852
050677	1.4663	1.1890	39.2161	41.8130	44.4567	41.9179
050678	1.3068	1.1766	33.7633	35.8411	38.3361	36.1388
050680	1.3167	1.5857	37.9856	39.0389	40.7514	39.2907
050682	0.9113	1.1745	22.2193	22.3903	22.4419	22.3441
050684	1.2784	1.1745	28.8378	33.5915	33.0982	31.9255
050686	1.3842	1.1745	39.7757	42.1444	45.2231	42.4511
050688	1.2433	1.6059	49.4062	53.2741	54.5423	52.4920
050689	1.5846	1.5857	48.8533	48.9935	50.2942	49.4089
050690	1.2351	1.5541	49.0226	51.6179	55.1002	52.0146
050693	1.3762	1.1766	39.6838	42.8266	41.9594	41.4885
050694	1.1180	1.1745	32.1065	34.8486	33.8553	33.6246
050695	***	*	49.0340	*	*	49.0340
050696	2.3948	1.1890	39.8963	39.4353	41.2315	40.1546
050697	1.1598	1.3428	22.1441	26.7600	29.0854	25.7538
050699	***	*	21.5725	*	*	21.5725
050701	1.3618	1.1745	34.9876	37.2839	38.4382	36.9906
050704	1.0676	1.1890	31.6097	32.2017	31.7051	31.8425
050707	***	*	43.5555	44.0254	49.4684	45.9236
050708	1.7654	1.1745	31.8442	28.3074	34.4063	31.2579
050709	1.5764	1.1766	24.5621	29.5364	30.4570	28.2554
050710	1.4735	1.1745	44.2482	46.2533	51.1460	47.3139
050713	***	*	21.4825	*	*	21.4825
050714	1.4691	1.6191	34.1542	42.9797	45.2746	40.9203
050717	1.6051	1.1890	38.8773	37.0875	42.2736	39.4753
050718	***	*	31.9622	*	*	31.9622
050720	1.5874	1.1766	30.3595	32.1173	33.8712	32.0728
050722	0.9344	1.1745	33.7991	35.6741	35.2177	34.9402
050723	1.4007	1.1890	38.7140	42.1571	43.3875	41.4779
050724	1.9522	1.1745	35.2344	35.1020	35.5224	35.2811
050725	0.9466	1.1890	30.0580	28.8389	27.8565	28.8141
050726	1.5877	1.2337	28.6361	30.6105	35.3964	31.5331
050727	1.2979	1.1890	32.7783	33.0932	29.0789	31.5703
050728	***	*	41.8263	*	*	41.8263
050729	***	*	38.1882	*	*	38.1882
050730	***	*	39.2046	*	*	39.2046

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
050732	2.3521	1.1745	33.6831	34.3475	37.4333	35.2452
050733	1.6232	1.3428	40.1517	40.6320	44.7509	41.6960
050734	***	*	31.2883	*	*	31.2883
050735	1.4251	1.1890	*	36.6081	34.3859	35.4553
050736	1.3360	1.1890	*	41.8938	38.0913	39.9668
050737	1.6114	1.1890	*	38.0424	36.4535	37.2372
050738	1.6097	1.1890	*	43.9259	40.3081	42.0920
050739	1.7028	1.1890	*	57.2480	44.0540	49.3570
050740	1.6572	1.1890	*	54.0370	44.8439	48.6228
050741	***	*	*	51.1526	44.0305	47.5915
050742	1.5424	1.1890	*	39.2532	41.0036	40.1164
050744	1.8433	1.1766	*	48.4951	56.5911	52.3032
050745	1.4422	1.1766	*	42.5523	48.2903	45.4522
050746	1.7960	1.1766	*	43.2015	46.3622	44.7916
050747	1.6108	1.1766	*	44.5887	47.8242	46.1426
050748	1.2906	1.2377	*	43.1008	50.6390	46.9312
050749	1.3957	1.2216	*	28.2000	39.6030	32.7016
050750	***	*	*	33.9915	*	33.9915
050751	3.0315	1.1890	*	29.5488	34.0436	31.4112
050752	1.3624	1.1890	*	39.8035	41.3783	40.5970
050753	1.5385	1.1890	*	*	*	*
050754	1.2776	1.5600	*	*	56.3628	56.3628
050755	1.6247	1.1890	*	*	36.5212	36.5212
050756	***	*	*	*	33.4951	33.4951
050757	1.7287	1.1745	*	*	*	*
050758	1.5404	1.1766	*	*	17.6509	17.6509
050759	3.0472	1.1745	*	*	*	*
050760	***	1.5857	*	*	*	*
050761	***	1.1890	*	*	*	*
060001	1.4560	1.0394	31.0018	32.4226	32.5239	31.9803
060003	1.4711	1.0394	31.3616	31.8637	33.6264	32.3000
060004	1.1952	1.0563	32.0095	34.8428	34.5727	33.8316
060006	1.3126	0.9642	27.2057	27.6453	30.5664	28.4711
060008	1.4079	0.9642	26.5175	27.2071	26.0851	26.5793
060009	1.4709	1.0563	32.4208	34.0151	35.8398	34.0845
060010	1.4511	0.9818	29.5304	30.6424	33.5549	31.2886
060011	1.5392	1.0563	32.1001	34.4171	34.6239	33.7555
060012	1.5450	0.9642	28.7724	29.4365	29.6957	29.2971
060013	1.5050	0.9642	27.9145	28.0800	29.5100	28.5157
060014	1.9395	1.0563	31.9389	33.0366	35.6231	33.5243
060015	1.9029	1.0563	32.2927	36.3296	36.6824	35.0115
060016	1.2360	0.9642	27.1430	28.3055	30.0601	28.4777

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
060018	1.2844	*	25.3897	26.5788	*	25.9769
060020	1.6066	0.9642	25.9147	26.7362	27.3823	26.6923
060022	1.6032	0.9642	29.3379	31.9376	32.0594	31.1472
060023	1.6803	1.0394	31.1556	32.7922	33.4798	32.4804
060024	1.9044	1.0563	31.5411	32.8206	36.1736	33.5876
060027	1.5644	1.0394	30.9212	31.6134	33.4869	31.9215
060028	1.5999	1.0563	32.1656	33.4966	35.8222	33.8025
060030	1.4402	0.9818	29.9513	31.2932	31.2752	30.8371
060031	1.5476	1.0394	29.3907	30.7381	32.0153	30.6967
060032	1.6158	1.0563	32.7383	34.6447	35.6500	34.2970
060034	1.7000	1.0563	32.1252	33.3656	34.6615	33.3888
060036	1.1593	0.9642	22.8256	20.9370	24.8220	22.8343
060041	0.8805	*	25.9710	31.4739	*	28.4919
060043	0.9166	0.9642	21.9955	23.3908	19.9611	21.8475
060044	1.1810	0.9642	24.8352	28.9200	32.0455	28.3597
060049	1.3879	0.9818	30.2192	32.1589	34.5262	32.3656
060054	1.4378	0.9923	25.0980	24.6721	29.2998	26.5646
060064	1.7366	1.0563	33.2428	37.2407	34.7448	35.0351
060065	1.4969	1.0563	33.8538	34.9205	36.2377	35.0099
060071	1.1517	0.9642	28.1762	31.5388	32.1367	30.7106
060075	1.3373	0.9923	37.6023	35.8081	37.3019	36.8955
060076	1.2429	0.9642	30.7808	31.6044	31.5032	31.2855
060096	1.8177	1.0394	37.8243	38.2249	39.9302	38.7551
060100	1.7223	1.0563	33.2145	33.5356	35.7861	34.1636
060103	1.4470	1.0394	32.9690	33.7542	34.9964	33.9347
060104	1.3977	1.0563	35.4409	37.1434	37.4598	36.7028
060107	0.7177	1.0563	28.0660	30.3991	30.0308	29.5183
060112	1.7334	1.0563	34.7116	35.1308	36.4093	35.4983
060113	1.4690	1.0563	32.6073	35.2097	36.0794	34.6716
060114	1.5251	1.0563	34.8536	35.3056	37.1394	35.8915
060115	0.9100	0.9642	*	*	*	*
060116	1.4165	1.0394	*	33.1547	36.3560	34.9043
060117	1.4845	0.9642	*	28.3112	31.6734	30.1751
060118	1.5547	0.9642	*	*	40.2136	40.2136
060119	1.9723	0.9818	*	*	*	*
060120	1.1273	*	*	*	*	*
060121	1.6971	1.0394	*	*	*	*
070001	1.6437	1.2236	37.0403	37.9438	38.4864	37.8311
070002	1.7686	1.2236	34.7636	36.4269	36.6624	35.9556
070003	1.1240	1.2236	35.6320	36.0524	36.6553	36.1198
070004	1.2203	1.2236	29.9557	31.2115	34.3803	31.8426
070005	1.5631	1.2236	34.9404	36.5502	37.3430	36.3145

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
070006	1.5739	1.2624	39.3935	41.2165	41.9550	40.8714
070007	1.3316	1.2236	36.2914	37.0984	38.9830	37.4764
070008	1.2975	1.2236	30.7305	35.4969	34.0603	33.4306
070009	***	*	35.5670	36.6382	38.1380	36.8177
070010	1.6536	1.2624	36.7227	38.6114	38.7345	38.0240
070011	1.4419	1.2236	31.6843	32.6835	33.7313	32.7182
070012	1.3909	1.2236	31.9345	33.2477	35.4738	33.5967
070015	1.5383	1.2624	37.3454	39.9249	42.4738	39.9522
070016	1.5279	1.2236	33.2391	34.1266	34.5418	33.9804
070017	1.4330	1.2236	35.6456	37.5855	38.1713	37.1482
070018	1.4603	1.2624	41.8460	42.4771	44.1370	42.8524
070019	1.4701	1.2236	33.7246	35.8618	37.0666	35.5301
070020	1.3518	1.2236	32.9714	35.6542	40.4989	36.5717
070021	1.1698	1.2236	38.5623	39.7793	41.9076	40.0655
070022	1.6796	1.2236	40.2283	41.4721	41.5553	41.1102
070024	1.4602	1.2236	34.7419	36.8997	38.6301	36.7528
070025	1.7451	1.2236	34.5887	36.1322	38.7067	36.4407
070027	1.5357	1.2236	30.4433	33.5979	35.7677	33.3449
070028	1.5644	1.2624	38.0855	40.9645	41.2950	40.1488
070029	1.3106	1.2236	31.0662	32.8504	35.4716	33.1552
070031	1.3370	1.2236	30.4054	30.5924	33.2618	31.4426
070033	1.4800	1.2624	41.7955	44.6717	46.5982	44.4108
070034	1.4667	1.2624	40.1685	42.4111	45.7694	42.8155
070035	1.3288	1.2236	32.2766	33.4047	38.2298	34.6855
070036	1.6717	1.2236	42.3391	43.6374	44.0756	43.3656
070038	***	*	35.8053	29.9516	33.5109	32.5913
070039	1.0328	1.2236	34.7219	32.7153	35.9137	34.6139
070040	1.0864	1.2236	*	*	26.3824	26.3824
080001	1.6614	1.0786	33.5310	34.9507	37.4441	35.3708
080002	***	*	31.3391	33.0404	33.3472	32.5972
080003	1.5758	1.0786	34.3048	30.5132	29.0166	31.2316
080004	1.6244	1.0636	32.2443	34.3854	33.6190	33.4391
080006	1.3945	0.9998	28.8862	31.0327	30.7985	30.2661
080007	1.6231	1.0402	31.1645	33.4782	35.5425	33.4433
090001	1.7367	1.0733	38.3043	40.1658	38.3876	38.8906
090003	1.3179	1.0733	32.1960	34.4430	37.2088	34.4929
090004	2.0841	1.0771	37.3798	38.5681	39.9027	38.6823
090005	1.4076	1.0733	33.7448	35.2884	35.1327	34.7213
090006	1.4218	1.0733	31.3562	32.3654	32.5988	32.1073
090008	1.4753	1.0733	33.7471	36.6633	40.3260	36.5403
090011	2.0832	1.0771	38.0654	39.0111	39.5389	38.8946
100001	1.6239	0.9102	27.2809	27.8526	30.5213	28.6108

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
100002	1.5154	1.0378	28.7068	30.6668	33.1103	30.8336
100006	1.6602	0.8961	28.3673	28.9769	29.2697	28.8874
100007	1.6163	0.8961	29.0472	30.3379	30.6689	30.0329
100008	1.7215	1.0026	30.3392	32.1679	32.3397	31.6247
100009	1.4498	1.0026	27.8618	30.0492	32.0145	29.9172
100012	1.6667	0.9047	29.8353	30.8626	30.2066	30.3142
100014	1.5339	0.8961	27.4019	27.4064	28.8679	27.9044
100015	1.2213	0.9006	27.2483	28.6825	29.9757	28.5511
100017	1.5765	0.8961	28.2402	29.8705	31.2313	29.7997
100018	1.7327	0.9751	30.6545	32.8642	34.2077	32.6158
100019	1.6305	0.9156	30.3008	31.4549	32.2496	31.3486
100022	1.6564	1.0378	36.7912	36.3355	40.4664	37.8232
100023	1.6300	0.8961	25.4270	27.1032	27.7860	26.8374
100024	1.3715	1.0026	29.5423	29.8918	31.5160	30.2756
100025	1.7470	0.8594	26.7013	27.1665	28.7604	27.5658
100026	1.6150	0.8594	26.0147	27.3044	28.5877	27.3355
100028	1.4075	0.9156	27.5664	28.7801	28.1509	28.1569
100029	1.3318	1.0026	30.5382	31.6006	33.2920	31.7927
100030	1.3934	0.8961	25.3513	26.3113	27.0977	26.2741
100032	1.7893	0.9006	26.9275	27.8942	29.3641	28.0673
100034	1.8072	1.0026	27.2915	28.9387	29.8997	28.7371
100035	1.5991	0.9490	30.2382	32.5593	31.2325	31.3320
100038	1.6243	1.0378	31.6657	32.8392	37.0928	33.8741
100039	1.7946	1.0378	29.3699	29.0236	32.6863	30.4312
100040	1.6868	0.9102	27.2835	28.3366	29.8029	28.4733
100043	1.3901	0.9006	27.0054	26.8417	29.1014	27.5705
100044	1.5505	0.9899	33.1141	34.3920	34.4743	34.0036
100045	1.3385	0.8961	26.5413	25.5621	27.8526	26.6565
100046	1.5479	0.9006	26.7702	27.7878	29.7844	28.2311
100047	1.6638	0.9490	29.9729	31.4072	31.8998	31.1099
100048	0.9362	0.8594	20.2657	21.7693	22.7260	21.5702
100049	1.3363	0.8594	24.5571	27.6316	26.9145	26.3320
100050	1.2006	1.0026	25.3354	23.5222	23.7419	24.1608
100051	1.4271	0.8961	28.6225	30.1492	28.7367	29.1645
100052	1.4136	0.8594	23.4036	25.1110	27.6591	25.4475
100053	1.3706	1.0026	31.7415	31.9268	33.6936	32.4323
100054	1.3650	0.8653	30.5515	30.9840	33.2237	31.6007
100055	1.4441	0.9006	27.3826	29.7027	28.5830	28.5119
100057	1.4403	0.8961	26.3134	27.7045	30.4258	28.1682
100061	1.5941	1.0026	30.4528	31.9174	33.9803	32.1190
100062	1.6563	0.8647	25.9597	26.3067	28.0821	26.7679
100063	1.3785	0.9006	26.4139	27.0769	29.5864	27.7069

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
100067	1.4230	0.9006	27.4762	27.5501	30.0555	28.3302
100068	1.7586	0.8961	27.6576	27.7707	28.5177	27.9887
100069	1.5924	0.9006	27.2108	29.0486	33.4008	29.8085
100070	1.6608	0.9490	29.2005	29.1117	27.1313	28.4651
100071	1.3154	0.9006	25.3667	25.1883	25.6870	25.4259
100072	1.4374	0.8961	27.1889	27.6947	28.6435	27.8655
100073	1.7718	1.0378	29.4165	31.0395	33.8783	31.4675
100075	1.5331	0.9006	27.6534	26.7571	29.2992	27.8937
100076	1.2369	1.0026	24.0412	24.0280	23.7078	23.9205
100077	1.3998	0.9490	30.7564	27.9783	28.0178	28.9147
100079	1.6119	*	*	*	*	*
100080	1.5873	1.0378	29.5346	31.0516	33.2091	31.2493
100081	1.0165	0.8594	19.5711	19.7406	17.2548	18.8849
100084	1.6823	0.8961	32.7503	30.6301	30.7165	31.3018
100086	1.4021	1.0378	29.9072	31.3187	33.0726	31.4531
100087	1.8527	0.9490	30.5938	32.1314	33.4104	32.0461
100088	1.6483	0.9102	28.2825	29.4952	30.3481	29.4746
100090	1.4460	0.9102	27.6175	28.9581	27.4996	28.0357
100092	1.5851	0.9156	26.6315	28.6782	29.1433	28.1632
100093	1.7028	0.8594	22.5555	23.4847	24.9505	23.6782
100099	1.0617	0.8594	26.2395	28.0688	28.2871	27.5669
100102	1.0999	0.8594	27.8551	29.0396	30.0754	29.0002
100105	1.5979	0.9761	30.9915	30.8936	31.5294	31.1583
100106	1.0802	0.8594	24.8098	25.6288	20.6449	23.6268
100107	1.2020	0.9047	30.5764	31.2954	30.9662	30.9644
100108	0.8283	0.8594	22.6270	22.8153	17.9561	20.9190
100109	1.3250	0.8961	26.2446	26.7380	29.1403	27.4371
100110	1.5831	0.8961	29.5985	30.3758	32.4083	30.8327
100113	2.0689	0.9196	29.2429	30.6037	30.9741	30.3025
100114	***	*	30.2544	32.3956	34.3630	32.2185
100117	1.2538	0.9102	28.4928	30.0281	30.6894	29.7963
100118	1.4293	0.8594	27.0981	28.3201	31.3833	29.0176
100121	1.1867	0.8594	27.9353	25.0320	20.0814	24.0503
100122	1.2620	0.8653	26.7175	27.6178	27.9970	27.4499
100124	1.1606	0.8594	24.8880	26.2329	28.2667	26.4077
100125	1.2889	1.0026	31.7749	33.3499	35.2588	33.5418
100126	1.3306	0.9006	28.3213	28.9164	30.3912	29.1646
100127	1.5987	0.9006	27.4632	27.0686	29.3856	27.9821
100128	2.1643	0.9006	30.0324	30.6202	29.6793	30.1051
100130	1.1574	1.0378	28.3651	29.5763	29.9727	29.3222
100131	1.4319	1.0026	29.7647	30.9614	32.2086	31.0762
100132	1.2971	0.9006	27.8180	27.6632	29.3380	28.2861

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
100134	0.8177	0.8594	21.6544	22.9635	24.7863	23.1451
100135	1.6606	0.8594	29.1856	29.8452	30.2093	29.7510
100137	1.4036	0.8594	26.8391	28.3000	27.8783	27.6855
100139	0.8320	0.9196	21.1310	21.4418	22.1683	21.5302
100140	1.1339	0.9102	27.8352	28.5485	29.7482	28.7313
100142	1.1823	0.8594	25.6999	26.8995	26.8829	26.5041
100150	1.2240	1.0026	27.7740	29.3711	33.0132	29.9693
100151	1.8286	0.9102	29.7267	31.3846	33.1725	31.4093
100154	1.6366	1.0026	29.7332	31.3640	32.3793	31.1658
100156	1.1428	0.9196	28.3927	28.3060	29.9029	28.8988
100157	1.6070	0.9006	30.3086	30.3359	30.4870	30.3793
100160	1.2338	1.0026	30.6902	32.3136	33.8433	32.3363
100161	1.5819	0.8961	29.5673	30.8984	32.6427	31.0405
100166	1.5769	0.9490	30.1811	31.9072	33.0019	31.6499
100167	1.3065	1.0378	31.7813	32.4740	34.8085	32.9889
100168	1.6446	1.0378	27.0938	28.0543	31.1427	28.8706
100172	***	*	22.2183	20.5518	*	21.5848
100173	1.6179	0.9006	28.6402	30.2491	30.3599	29.7634
100175	1.0537	0.8594	25.0913	26.1723	26.8828	26.0429
100176	1.8175	1.0378	33.3181	35.5849	35.7433	34.8922
100177	1.4181	0.9156	29.6284	31.0085	31.3830	30.6944
100179	1.7523	0.9102	29.2795	30.5439	31.8790	30.5809
100180	1.4569	0.9006	31.0099	31.5485	32.3796	31.6678
100181	1.3100	1.0026	23.9656	26.0682	26.0880	25.3723
100183	1.2700	1.0026	30.5042	32.9893	31.6760	31.7110
100187	1.4704	1.0026	30.7705	31.6660	31.8020	31.4228
100189	1.4257	1.0378	29.9376	30.5516	32.8847	31.1338
100191	1.3320	0.9006	29.4533	30.9212	31.6024	30.6364
100200	1.3674	1.0378	29.6400	29.0731	32.5611	30.4188
100204	1.5813	0.9196	27.2819	29.9334	30.6252	29.3190
100206	1.3174	0.9006	27.7551	28.8625	30.4576	29.0688
100209	1.6080	1.0026	28.5336	29.0462	30.5582	29.3607
100210	1.5330	1.0378	32.0830	32.4566	33.3016	32.6013
100211	1.1826	0.9006	26.2859	28.8328	30.5902	28.5407
100212	1.5297	0.8647	27.7960	29.2500	30.5141	29.1925
100213	1.5712	0.9490	29.5218	30.2271	31.4309	30.3993
100217	1.2729	0.9761	27.7683	30.3325	33.5767	30.4921
100220	1.6219	0.9047	29.3601	30.8292	31.8393	30.6702
100223	1.5879	0.8653	26.1115	27.6775	28.6449	27.4851
100224	1.2677	1.0378	28.0455	29.2008	31.0307	29.4168
100225	***	*	30.8782	32.6906	31.8048	31.8054
100226	1.3583	0.9102	28.8791	30.2857	30.8904	30.0365

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
100228	1.4394	1.0378	30.1635	31.0222	32.2672	31.1510
100230	1.3169	1.0378	31.9448	34.6133	35.9319	34.2793
100231	1.6836	0.8594	26.6773	28.3652	28.8912	27.9680
100232	1.3171	0.9102	28.3892	29.3797	30.3768	29.3630
100234	1.3548	1.0378	28.8835	29.7818	33.1508	30.5618
100236	1.4614	0.9490	28.3017	30.5719	31.4385	30.1218
100237	1.8253	1.0378	33.1536	33.9626	33.9696	33.6775
100238	1.6104	0.9006	31.4198	31.6353	32.8745	31.9925
100239	1.4042	0.9006	29.0650	30.3234	32.7150	30.7136
100240	1.1217	1.0026	29.7000	31.0951	35.3888	32.1535
100242	1.5321	0.8594	26.1988	27.8169	28.5034	27.5143
100243	1.5327	0.9006	28.3894	29.8323	31.4863	29.8852
100244	1.4475	0.9047	28.2881	29.8287	29.1611	29.0937
100246	1.5751	0.9899	30.1061	30.0467	32.5063	30.8914
100248	1.5512	0.9006	30.2133	32.4725	33.7659	32.1364
100249	1.3608	0.9006	26.4676	28.5117	29.7981	28.2850
100252	1.2125	0.9761	27.1639	29.1448	31.5631	29.2785
100253	1.4480	1.0378	28.7770	28.5617	29.4959	28.9507
100254	1.5411	0.8594	27.4900	28.5262	28.9095	28.3137
100255	1.2773	0.9006	27.3866	29.5172	30.0466	29.0076
100256	1.7058	0.9006	30.2093	33.3936	34.6637	32.6784
100258	1.6302	1.0378	33.8630	35.2225	34.2862	34.4746
100259	1.2698	0.9006	29.0612	29.9294	32.2273	30.4192
100260	1.4306	0.9899	28.2301	29.4907	31.5667	29.7570
100264	1.5318	0.9006	28.0370	30.1980	31.5050	29.9424
100265	1.3376	0.9006	26.3326	26.6940	28.6915	27.3172
100266	1.4423	0.8594	24.2517	25.6382	26.4488	25.5169
100267	1.2193	0.9490	28.9674	30.6051	32.3955	30.6391
100268	1.2375	1.0378	30.5750	33.6225	33.5314	32.5801
100269	1.3939	1.0378	27.8407	28.3745	30.9572	29.0345
100271	2.1578	*	*	*	*	*
100275	1.3788	1.0378	28.7797	31.0487	31.5424	30.5143
100276	1.3254	1.0378	30.5720	31.7067	32.3992	31.5729
100277	1.5878	1.0026	24.1122	25.5926	27.0942	25.7527
100279	5.1231	*	29.2257	31.1951	31.6691	30.7706
100281	1.3398	1.0378	30.9131	32.8840	36.3173	33.4685
100284	1.1491	1.0026	25.2637	21.4420	24.4155	23.4784
100285	1.2090	1.0378	41.9481	34.7999	36.2107	38.5420
100286	1.5263	0.9751	25.8085	26.5809	26.1494	26.1933
100287	1.4739	1.0378	29.7536	30.3085	32.3704	30.7631
100288	1.5913	1.0378	31.0506	32.9587	35.3363	33.0536
100289	1.6516	1.0378	31.9011	31.4727	31.7699	31.7109

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
100290	1.2455	0.8932	28.7111	29.7588	31.7110	30.1639
100291	1.3472	0.9156	28.1515	28.3780	28.3455	28.3036
100292	1.4035	0.8594	27.7644	28.5807	29.8156	28.7769
100296	1.3598	1.0026	29.3870	31.1475	31.8730	30.8675
100297	***	*	32.1536	*	*	32.1536
100298	0.9638	0.8594	19.0297	21.9247	17.8678	19.3037
100299	1.3862	0.9490	34.3697	31.6840	31.5048	32.5820
100300	***	*	*	33.1693	*	33.1693
100301	***	*	*	*	33.6261	33.6261
100302	1.1378	0.8961	*	*	27.9362	27.9362
100303	3.3572	0.8594	*	*	*	*
100305	2.9508	0.9196	*	*	*	*
100306	2.1590	0.8594	*	*	*	*
100307	1.3368	0.9102	*	*	*	*
100308	3.5561	0.9006	*	*	*	*
100309	2.8615	0.9746	*	*	*	*
110001	1.4065	0.8676	26.5640	27.6480	28.5465	27.5849
110002	1.3243	0.9581	26.2228	28.9013	32.2910	29.1013
110003	1.3116	0.7819	24.2097	25.0089	26.0330	25.0922
110004	1.3526	0.8856	25.1846	27.2528	26.8828	26.3972
110005	1.3270	0.9581	27.2826	29.6009	30.4924	29.3130
110006	1.5835	0.9205	*	30.8495	32.2597	31.5854
110007	1.6372	0.8931	26.3133	28.0684	29.8618	28.0712
110008	1.4386	0.9581	30.9757	31.8387	33.5616	32.1916
110010	2.3056	0.9581	33.2396	33.9848	33.7073	33.6507
110011	1.3616	0.9581	28.5892	30.3534	32.2028	30.4315
110015	1.0999	0.9581	28.8796	30.5016	31.7245	30.4450
110016	1.3018	0.8454	24.3563	25.9209	26.3449	25.5338
110018	1.3150	0.9581	30.1849	30.9422	30.8295	30.6726
110020	***	*	27.5559	29.4641	30.4725	29.2903
110023	1.3954	0.9581	29.3282	29.2018	31.1890	29.9364
110024	1.4809	0.8967	27.3357	28.5660	30.7207	28.8740
110025	1.5127	0.9338	30.2845	31.8968	31.0532	31.0790
110026	1.1131	0.7819	22.8820	24.3863	25.6943	24.2843
110027	1.0277	0.7819	25.5291	25.6532	26.2689	25.7981
110028	1.7942	0.9445	31.4568	32.8706	34.0699	32.8134
110029	1.7961	0.9581	29.2134	30.1146	31.6425	30.2862
110030	1.4207	0.9581	29.9531	32.0275	33.2158	31.8235
110031	1.2725	0.9581	29.5533	30.7462	30.4811	30.2708
110032	1.2052	0.7819	25.1896	24.4968	23.1156	24.2208
110033	***	*	32.4178	32.7039	31.9373	32.3600
110034	1.7484	0.9445	28.7915	29.6819	30.4053	29.6396

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
110035	1.7606	0.9581	30.1852	31.5737	31.8545	31.2344
110036	1.9336	0.8967	27.2280	28.4041	29.4915	28.3976
110038	1.5425	0.8205	22.9685	23.3669	24.2742	23.5610
110039	1.3284	0.9445	26.2485	28.4376	28.9594	27.7614
110040	1.0813	0.9581	23.9526	21.5762	21.1939	22.1282
110041	1.2739	0.9581	26.1948	27.6609	29.2068	27.6866
110042	1.0764	0.9581	33.4391	34.5137	34.0568	34.0168
110043	1.7850	0.8967	28.8551	30.3728	31.1628	30.1291
110044	1.1359	0.7819	24.3772	27.0431	25.0449	25.4614
110045	1.1037	0.9581	27.7619	28.2232	31.6766	29.1573
110046	1.2115	0.9581	*	28.6286	28.4212	28.5202
110050	1.0606	0.8526	27.0651	27.1533	29.2759	27.8460
110051	1.1292	0.7819	21.4898	22.1491	23.3866	22.3993
110054	1.4414	0.9581	29.4691	31.5798	27.9775	29.6364
110059	1.1390	0.7819	24.7838	24.9271	24.4436	24.7137
110064	1.6805	0.8781	26.9363	28.7296	30.0182	28.5621
110069	1.3820	0.9873	29.9098	30.6465	31.0168	30.5353
110071	1.0432	0.7819	21.2041	23.6499	22.6384	22.5381
110073	1.1060	0.7819	23.3571	23.0072	23.4570	23.2749
110074	1.5120	0.9205	31.0062	29.0310	30.4310	30.1231
110075	1.3815	0.8967	24.8244	26.1089	26.7302	25.8772
110076	1.5636	0.9581	29.4344	31.0661	30.4815	30.2901
110078	2.1084	0.9581	30.5196	32.0516	35.8457	32.7726
110079	1.5339	0.9581	27.3274	29.0905	28.9872	28.4653
110082	1.9797	0.9581	30.1072	31.1478	33.1144	31.5010
110083	2.0534	0.9581	34.0610	34.5798	34.7446	34.4671
110086	1.1613	0.7819	22.9959	23.4772	23.1298	23.1991
110087	1.5144	0.9581	31.0403	32.8029	33.9036	32.6448
110089	1.1643	0.7819	24.3327	26.0116	25.4960	25.2777
110091	1.3568	0.9581	27.0994	28.0637	29.4898	28.2142
110092	1.0634	0.7819	21.4168	22.8602	24.5262	22.8788
110095	1.4660	0.8387	28.0526	28.0480	31.2298	29.1793
110100	0.9836	0.8609	20.8201	20.0638	22.9014	21.4346
110101	0.9840	0.7886	21.0983	23.8601	25.5998	23.4706
110104	1.2142	0.7819	21.8966	22.2596	22.3707	22.1787
110105	1.2672	0.8387	23.4010	23.7752	24.6128	23.9332
110107	1.9376	1.0175	30.1027	31.5783	34.3508	32.0385
110109	1.0740	0.7819	21.6023	21.6019	22.5719	21.9327
110111	1.2026	0.9445	25.7084	27.6501	25.7188	26.3264
110112	1.0229	0.8387	26.4089	24.2935	23.2426	24.5677
110113	0.9454	0.9445	22.0793	22.0472	24.2980	22.7809
110115	1.8004	0.9581	32.7927	33.3902	34.4864	33.5520

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
110121	1.0646	0.8205	23.4571	24.5653	27.4406	25.1438
110122	1.5890	0.8205	25.4439	26.3071	28.0334	26.5715
110124	1.0579	0.7819	22.9571	24.8552	28.7544	25.5342
110125	1.2945	0.9873	24.7347	26.5006	29.4103	26.8341
110128	1.2492	0.8967	25.4190	24.5284	27.1987	25.6825
110129	1.5637	0.8781	30.0444	29.7332	26.8229	28.8295
110130	0.8834	0.7819	20.4349	21.7089	21.0352	21.0505
110132	1.0641	0.7819	21.2642	21.6039	22.3816	21.7486
110135	1.3125	0.7819	24.0945	25.1027	25.6594	24.9435
110142	0.9770	0.8004	21.6286	22.2164	21.2836	21.6949
110143	1.4290	0.9581	29.9139	30.9621	31.3623	30.7702
110146	0.9861	0.9338	29.0193	30.1181	32.7307	30.6287
110150	1.3165	0.9581	26.9884	27.7920	28.7549	27.8353
110153	1.1832	0.9873	29.3305	30.5108	30.2843	30.0411
110161	1.5735	0.9581	31.5001	32.0002	32.9894	32.1748
110163	1.4631	0.8931	27.7679	29.5693	30.7798	29.3945
110164	1.7364	1.0175	30.0145	31.2830	32.7865	31.3967
110165	1.5150	0.9581	28.7902	28.7925	28.4324	28.6750
110168	1.7935	0.9581	29.7774	30.8750	31.8921	30.8530
110172	***	*	31.3999	33.0452	34.0243	32.7861
110177	1.8711	0.9445	29.7079	30.5526	31.9338	30.7334
110183	1.3392	0.9581	28.3505	29.6622	32.0200	30.0208
110184	1.2398	0.9581	29.4071	30.2920	30.8380	30.2222
110186	1.3207	0.8781	28.2880	29.6503	32.0599	29.9580
110187	1.2008	0.9581	26.9638	31.0164	27.6729	28.5075
110189	1.0914	0.9581	26.2799	27.4207	28.9465	27.5873
110190	1.0719	0.8060	24.5224	29.4198	28.7747	27.3870
110191	1.3815	0.9581	30.9481	28.7505	30.0142	29.8296
110192	1.4382	0.9581	30.0843	31.6627	32.6403	31.5162
110194	0.8548	0.7819	21.0826	20.5267	23.2382	21.6185
110198	1.4743	0.9581	32.8171	34.0050	33.2450	33.3630
110200	2.1135	0.8781	27.2974	29.4633	29.6256	28.8416
110201	1.5189	1.0175	32.0967	33.4292	35.8335	33.7728
110203	0.9714	0.9581	32.3441	32.0594	33.0119	32.4903
110205	1.1841	0.8326	23.9738	26.1973	25.5319	25.2426
110209	0.7357	0.7819	21.2428	22.4549	21.6681	21.7985
110212	1.2022	0.8126	*	*	23.4398	23.4398
110215	1.4674	0.9581	29.5238	30.1793	31.2779	30.3933
110219	1.4192	0.9581	32.2603	33.4481	34.8875	33.5273
110223	***	*	25.3071	*	*	25.3071
110224	***	*	33.6464	*	*	33.6464
110225	1.3692	0.9581	29.5373	28.9773	29.6272	29.3773

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
110226	1.2006	0.9581	*	32.1840	30.2150	31.1782
110229	1.3761	0.9581	*	*	*	*
110230	1.4757	0.8676	*	*	*	*
110231	1.4634	0.9205	*	*	*	*
120001	1.8604	1.1467	39.6348	39.0371	39.2838	39.3027
120002	1.3740	1.1282	34.1709	37.7287	38.3420	36.8633
120004	1.3430	1.1467	31.3555	32.5164	33.3874	32.4396
120005	1.2475	1.1282	33.6942	35.1996	38.2915	35.7843
120006	1.3846	1.1467	34.2231	35.7089	37.6360	35.9117
120007	1.6210	1.1467	30.8773	35.0193	34.8231	33.5196
120010	2.0845	1.1467	30.8526	34.3371	37.3680	33.7959
120011	1.6378	1.1467	39.1941	43.7527	45.9848	43.2167
120014	1.3808	1.1282	30.9839	34.2127	38.1372	34.3370
120019	1.1661	1.1282	33.0114	36.1879	37.4564	35.6050
120022	1.9295	1.1467	32.5326	34.9048	35.3877	34.3087
120026	1.5069	1.1467	34.2244	35.8413	38.2128	36.1112
120027	1.4759	1.1467	29.5825	31.8177	32.7112	31.3717
120028	1.3762	1.1282	34.0451	34.6354	34.7783	34.4982
120029	***	*	44.6382	*	*	44.6382
130002	1.4568	0.9140	24.7266	24.3501	26.4728	25.2150
130003	1.6576	0.9989	28.6136	29.8793	31.4275	29.9302
130006	1.7740	0.9324	28.0048	29.0504	30.0002	29.0488
130007	1.7510	0.9324	30.4958	31.2268	33.4536	31.7981
130013	1.4063	0.9324	36.1570	33.8928	33.6160	34.5447
130014	1.2651	0.9324	27.5936	28.2831	29.1200	28.3409
130018	1.7751	0.9418	28.4041	30.2047	31.8735	30.1395
130024	1.2050	0.8318	24.8035	25.3197	24.4757	24.8603
130025	1.2542	0.7643	22.7962	23.8592	24.2424	23.6580
130028	1.6133	0.9085	28.4934	29.3374	30.5090	29.4688
130049	1.6098	1.0242	29.0185	29.7211	30.8293	29.8725
130062	***	*	29.1925	28.3419	38.1416	32.3995
130063	1.4761	0.9324	27.7607	27.7697	28.8897	28.1397
130065	2.0455	0.9418	30.4547	25.8998	29.4957	28.2273
130066	2.1453	0.9380	28.9883	28.1502	29.3049	28.8031
130067	2.0677	0.9418	21.3867	26.8285	28.6474	25.2321
130068	***	*	*	*	25.8399	25.8399
130069	2.0001	0.9324	*	*	*	*
130070	2.0028	0.9324	*	*	*	*
140001	1.1968	0.8691	22.2003	23.2233	23.7481	23.0887
140002	1.4373	0.9043	27.4779	29.1097	29.6312	28.7974
140007	1.4343	1.0385	31.4024	32.4449	34.2607	32.7585
140008	1.5299	1.0394	31.8008	32.7618	33.2563	32.5978

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
140010	1.5470	1.0394	40.1360	39.3727	39.7245	39.7446
140B10	***	*	40.1360	39.3727	39.7245	39.7440
140011	1.2026	0.8322	25.8864	26.2135	27.0019	26.4070
140012	1.2222	1.0385	31.8213	31.9613	33.0198	32.3072
140013	1.4258	0.9268	25.0951	26.4199	28.2787	26.6085
140015	1.3548	0.8924	24.6409	25.2504	25.8304	25.2467
140018	1.3811	1.0394	30.7398	31.5624	31.2535	31.1810
140019	0.9180	0.8322	22.3179	22.2907	22.9179	22.5132
140026	1.1635	0.8637	26.0493	28.1718	28.5497	27.6099
140029	1.5829	1.0385	36.7722	34.8938	37.7285	36.4684
140030	1.5871	1.0385	31.6822	32.1135	32.8927	32.2094
140032	1.2418	0.8924	27.5367	28.5242	28.4605	28.1777
140033	***	*	29.5256	31.4347	32.3417	30.3318
140034	1.2070	0.8924	24.4653	26.7250	27.6121	26.2891
140040	1.2491	0.9268	24.5589	28.5016	30.5814	27.6351
140043	1.2990	0.8471	29.8633	31.3754	34.4429	31.9224
140046	1.4501	0.8924	25.6230	25.7925	26.8384	26.0834
140048	1.3597	1.0394	30.6686	31.6290	34.4373	32.2714
140049	1.5303	1.0394	30.8617	32.0239	33.6104	32.1312
140051	1.5483	1.0394	32.1730	32.6517	32.7898	32.5476
140052	1.3745	0.9043	26.9907	26.7916	27.7932	27.1869
140053	1.7906	0.9323	28.4513	29.9487	32.7126	30.2918
140054	1.4833	1.0394	34.2378	34.5369	36.9786	35.2609
140058	1.2026	0.9323	25.2568	26.5671	28.6945	26.8636
140059	1.0395	0.9043	21.6230	22.8597	24.6248	23.0779
140062	1.4017	1.0394	36.8271	36.6718	38.3407	37.2993
140063	1.4656	1.0394	30.5465	31.1266	34.4732	32.0675
140064	1.2770	0.9268	25.7551	26.6249	28.5964	27.0196
140065	1.4644	1.0394	31.5510	32.4661	34.3988	32.8042
140066	1.0275	0.9043	22.0225	23.6304	24.3856	23.3522
140067	1.8393	0.9268	29.8982	30.6911	31.9470	30.8766
140068	1.3420	1.0394	26.7166	31.3463	32.8724	30.2088
140075	1.1673	1.0394	35.9507	33.6872	34.9376	34.7952
140077	1.0274	0.9043	21.6468	22.5074	24.2006	22.7805
140080	1.4942	1.0394	29.9067	30.3788	33.0275	31.0912
140082	1.5906	1.0394	31.0516	32.0562	33.4686	32.1963
140083	1.0481	1.0394	27.2189	26.1639	29.5034	27.6508
140084	1.3364	1.0394	30.7251	31.3307	32.1286	31.4293
140088	1.9984	1.0394	32.6866	34.4137	36.6991	34.6171
140089	1.2277	0.8322	24.9120	26.6955	27.5295	26.3995
140091	1.7572	1.0003	28.2095	29.7381	33.7851	30.5790
140093	1.2900	0.8737	28.6709	31.2973	29.3377	29.8076

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
140094	0.8432	1.0394	28.7647	28.8621	28.0819	28.5752
140095	1.2220	1.0394	29.7385	29.9626	35.7876	31.7401
140100	1.3593	1.0394	37.2961	37.3044	39.0405	37.8906
140101	1.2669	1.0385	28.9723	31.0070	32.4260	30.8211
140103	1.1553	1.0394	24.0926	25.3630	26.4236	25.3201
140105	***	*	29.6590	30.7154	*	30.0527
140110	1.0813	1.0385	30.3432	31.3486	33.7263	31.8466
140113	1.5529	1.0003	30.2542	31.6191	33.2262	31.7291
140114	1.5397	1.0394	29.8316	31.1412	31.7038	30.9086
140115	1.2560	1.0394	25.4576	26.2606	30.2062	27.2029
140116	1.4609	1.0399	34.3876	34.2519	35.6726	34.7900
140117	1.5999	1.0394	30.9679	28.5809	34.6766	31.2737
140118	1.4773	1.0394	33.1987	33.8168	34.9352	33.9822
140119	1.8620	1.0394	32.2185	34.6543	35.5146	34.1040
140120	1.2800	0.9268	25.9275	26.2418	27.0681	26.4505
140122	1.5436	1.0385	30.2888	32.4750	34.2512	32.3347
140124	1.2526	1.0394	38.2191	38.8976	39.9267	39.0079
140125	1.1804	0.9043	26.5801	27.6352	28.3533	27.5158
140127	1.5423	0.9475	27.8363	29.3352	30.9124	29.3654
140130	1.2912	1.0394	32.5425	34.9907	35.8275	34.4126
140133	1.3502	1.0394	30.3259	32.8941	34.0222	32.4207
140135	1.4166	0.9055	24.6645	25.9057	26.6854	25.7583
140137	1.0416	0.9043	31.4349	*	27.0616	28.6011
140143	1.1345	1.0385	26.1126	27.0312	27.2878	26.8345
140145	1.1239	0.9043	25.2040	26.9344	28.3622	26.8720
140147	1.1010	0.8322	21.1817	22.1035	22.6508	21.9892
140148	1.6734	0.9323	27.0038	28.9471	30.1467	28.7501
140150	1.7461	1.0394	35.5951	39.0316	41.6125	38.7627
140151	0.8556	1.0394	26.0825	27.3552	28.0758	27.2000
140152	***	*	29.8647	32.2803	*	31.0650
140155	1.3090	1.0385	32.7960	35.0825	36.2360	34.7289
140158	1.3728	1.0394	30.4445	32.0137	31.7570	31.4181
140160	1.2165	1.0000	27.6905	28.9043	30.0100	28.8966
140161	1.2955	1.0385	28.8266	28.8150	33.5158	30.3906
140162	1.6006	0.9475	32.1810	33.0995	33.2372	32.8580
140164	1.7393	0.8924	25.9726	27.3133	27.5981	26.9922
140166	1.2159	0.9055	26.2875	27.6725	27.5406	27.1929
140167	1.1516	0.8322	24.9904	24.2749	21.2479	23.4239
140172	1.3717	1.0394	33.0926	33.4616	36.8394	34.4712
140174	1.6566	1.0385	31.2231	33.9382	35.1535	33.4959
140176	1.2318	1.0399	32.6145	33.2235	34.3901	33.4294
140177	0.9941	1.0394	25.5725	26.0727	28.0720	26.6128

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
140179	1.3153	1.0394	30.2944	31.3624	30.6997	30.7730
140180	1.3265	1.0394	29.1352	29.8009	31.4683	30.1021
140181	1.2527	1.0394	27.6835	27.5414	29.0862	28.0913
140182	1.4679	1.0394	32.8972	26.4103	34.4971	30.8740
140184	1.3467	0.8322	26.6104	27.5858	28.2155	27.4911
140185	1.4600	0.9043	26.5398	27.9433	29.7742	28.0814
140186	1.5201	1.0385	30.7212	32.8063	32.5128	32.0087
140187	1.5738	0.9043	25.5873	26.9265	29.2345	27.2917
140189	1.1746	0.8322	24.7013	29.1371	25.9192	26.5401
140191	1.3429	1.0394	31.9943	29.7684	31.4076	31.0261
140197	1.0562	1.0394	24.9103	24.8715	26.9930	25.5643
140200	1.5427	1.0385	30.6641	31.3712	33.2897	31.7654
140202	1.5085	1.0394	32.9433	34.3789	38.4323	35.3556
140206	1.1540	1.0394	29.6275	31.1406	31.5212	30.7437
140207	1.0074	1.0394	28.2262	31.6818	25.8073	28.4469
140208	1.7124	1.0394	31.4035	26.1749	26.2434	27.6869
140209	1.5941	0.9268	29.7965	28.8774	31.5349	30.0575
140210	1.0347	0.8322	19.2053	22.2512	24.1193	21.9390
140211	1.3464	1.0385	31.4539	34.5917	36.0400	34.0479
140213	1.2507	1.0385	32.1031	33.3932	33.6351	33.0750
140217	1.5109	1.0385	32.9404	33.2172	34.8475	33.7201
140223	1.5276	1.0394	33.5083	34.6997	36.6437	34.9323
140224	1.3933	1.0394	31.2237	30.2241	34.4001	31.8217
140228	1.4678	1.0142	28.2855	28.7462	30.7381	29.3359
140231	1.5434	1.0385	34.8291	35.6724	36.3601	35.6613
140233	1.6775	1.0142	31.5168	32.3376	35.7752	33.2487
140234	1.0951	0.8637	25.7353	25.7660	26.9670	26.1658
140239	1.6308	1.0142	31.0918	33.7264	35.6391	33.4299
140240	1.4039	1.0394	32.7986	28.0986	32.9491	31.2555
140242	1.6003	1.0385	35.2351	36.8032	40.7474	37.6454
140250	1.2801	1.0394	31.2533	32.9414	33.7382	32.6355
140251	1.4311	1.0394	28.3598	29.5941	31.5378	29.7910
140252	1.4971	1.0394	35.8762	36.1531	37.6031	36.5794
140258	1.6797	1.0394	33.0093	34.5696	34.9198	34.1878
140275	1.3417	0.8471	28.5064	26.7394	26.7114	27.2977
140276	1.9321	1.0394	32.1048	32.7073	33.1620	32.6640
140280	1.5051	0.8471	26.6536	26.9835	28.0388	27.2536
140281	1.7385	1.0394	35.6589	37.5700	38.6663	37.3671
140286	1.1924	1.0385	32.0048	32.2246	38.2039	34.1757
140288	1.5250	1.0385	31.5944	32.5472	34.1167	32.7523
140289	1.3211	0.9043	25.6847	26.0872	26.7573	26.1899
140290	1.4213	1.0394	32.5247	35.9679	34.5766	34.3723

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
140291	1.5611	1.0394	33.8706	32.7884	34.2987	33.6506
140292	1.2497	1.0385	30.6917	32.4496	32.9675	32.0376
140294	1.1689	0.8322	26.1595	26.9789	27.4105	26.8897
140300	1.1828	1.0394	42.5240	37.4508	35.5837	38.3752
140301	1.1272	1.0394	39.4295	35.9742	*	37.7232
140303	2.1772	1.0394	*	33.0359	31.4718	32.2202
140304	1.4432	1.0385	*	*	*	*
150001	1.1725	0.9593	31.8089	32.9804	32.5348	32.4652
150002	1.5533	1.0383	27.6481	28.1076	28.3271	28.0250
150003	1.5959	0.9115	26.9771	29.3660	30.1317	28.7552
150004	1.5569	1.0383	30.9626	31.7867	34.4889	32.3386
150005	1.3308	0.9593	30.5367	31.6090	32.6541	31.6209
150006	1.4297	0.9269	27.1364	28.3403	29.7289	28.4270
150007	1.5164	0.9710	30.0500	31.0384	32.4836	31.2119
150008	1.4773	1.0383	27.0525	29.1492	30.9426	29.0487
150009	1.5117	0.8900	25.7616	26.1517	25.9625	25.9561
150010	1.5927	0.9710	28.4118	28.2616	32.8116	29.7583
150011	1.3847	0.9593	26.7686	27.7870	27.8089	27.4399
150012	1.5407	0.9599	31.2282	31.6762	32.0116	31.6382
150015	1.4286	0.9196	27.3811	30.2516	32.6995	29.9450
150017	1.7920	0.8950	26.3379	27.1262	27.4538	26.9906
150018	1.6508	0.9463	29.1137	30.0928	30.9511	30.0858
150021	1.7310	0.8950	30.0030	31.1158	33.1505	31.4248
150022	1.0299	0.8671	23.8971	26.9525	29.7752	26.7675
150023	1.5518	0.9593	27.7520	30.3667	30.8457	29.6790
150024	1.5122	0.9593	28.4170	30.6154	32.1844	30.3874
150026	1.2976	0.9463	30.4967	31.9397	33.1225	31.8955
150029	1.2806	0.9599	29.9307	31.0692	32.1154	31.0199
150030	1.2271	0.9593	29.3588	31.1986	34.5137	31.7256
150033	1.4617	0.9593	29.7744	32.9469	31.7314	31.4591
150034	1.4759	1.0383	28.0434	30.0048	30.9961	29.7427
150035	1.4912	0.9196	27.8904	29.2039	27.9432	28.3404
150037	1.4136	0.9593	29.0161	30.4640	32.2960	30.6163
150038	1.1309	0.9593	33.0112	31.9552	32.2545	32.3824
150042	1.3349	0.8637	25.1403	25.2456	25.2218	25.2017
150044	1.4816	0.8900	25.2685	25.9284	26.6389	25.9821
150045	1.0021	0.8950	27.5340	29.4323	30.0052	28.9703
150046	1.5321	0.9078	26.5876	27.6228	29.7184	27.9614
150047	1.7080	0.8950	25.8497	27.1847	27.9365	26.9811
150048	1.4729	0.9397	28.1525	29.5588	30.5008	29.4322
150051	1.6481	0.9593	28.9157	30.3764	31.2746	30.2060
150056	2.0611	0.9593	29.3500	30.5777	30.8461	30.2665

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
150057	2.1160	0.9593	30.3287	29.2358	30.4490	30.0007
150058	1.5993	0.9599	29.1255	31.7558	32.4036	31.0853
150059	1.4572	0.9593	31.3362	36.2570	30.4189	32.4855
150061	1.1780	0.8513	22.6746	23.2427	24.7808	23.6139
150064	1.2134	0.8513	28.7978	28.9430	29.7898	29.1791
150065	1.2860	0.9593	30.2053	30.7970	31.7556	30.9459
150069	1.1710	0.9397	26.0909	27.0740	28.6514	27.3010
150072	1.1684	0.8618	21.7644	23.0619	24.6596	23.1412
150074	1.4549	0.9593	28.5655	29.4135	31.6043	29.9527
150075	1.0841	0.8950	25.7245	26.5987	27.1412	26.5061
150076	1.2653	0.9269	30.1120	30.2972	29.4643	29.9429
150082	1.5853	0.8513	26.4544	28.1302	28.0003	27.5653
150084	1.8740	0.9593	33.1784	35.0288	35.4818	34.5825
150086	1.2710	0.9397	26.6745	27.2580	28.8279	27.6085
150088	1.3096	0.9593	29.1509	30.2396	31.9171	30.3919
150089	1.6750	0.8709	24.8045	26.7290	28.0389	26.5237
150090	1.4701	1.0383	30.6412	30.9274	33.6812	31.7075
150091	1.1835	0.8950	32.1627	33.0421	32.9027	32.7076
150097	1.2026	0.9593	29.1359	29.4797	29.9967	29.5450
150100	1.6289	0.8513	26.9724	27.6339	30.0246	28.2157
150101	1.0273	0.8950	30.5475	31.6031	32.5860	31.5849
150102	1.1055	0.9196	25.8742	25.4717	30.4952	27.1707
150104	1.1612	0.9593	28.7788	30.8984	31.2245	30.3310
150109	1.5142	0.9115	26.8464	29.0076	31.0757	28.8914
150112	1.4838	0.9546	29.8540	31.7966	32.0659	31.2591
150113	1.2401	0.9593	25.9814	26.9098	29.0485	27.3194
150115	1.3437	0.8513	22.5793	22.3571	25.0221	23.3536
150125	1.5271	1.0383	29.3596	30.7113	31.6959	30.6163
150126	1.3364	1.0383	29.4300	32.6488	34.5086	32.1231
150128	1.4890	0.9593	29.5008	31.1071	30.7549	30.4978
150129	1.3316	0.9593	31.4317	32.9629	36.4709	33.7020
150133	1.1303	0.9269	24.2538	23.0662	25.1415	24.1509
150134	***	*	21.6740	27.3983	30.4440	25.8409
150146	1.1710	0.9463	30.3343	31.8757	32.9491	31.7507
150147	***	*	26.1646	28.9269	28.9204	28.1172
150149	1.0401	0.8513	24.9629	25.3350	26.4595	25.6422
150150	1.3415	0.8950	26.7700	26.5984	26.5020	26.6087
150153	2.3006	0.9593	35.0617	37.3948	38.6948	37.2023
150154	2.5281	0.9593	29.8894	30.5775	32.3383	30.9924
150157	1.7766	0.9593	32.3106	32.9167	35.4134	33.5906
150158	1.3191	0.9593	*	30.4355	31.5245	31.0109
150159	***	*	*	27.5595	*	27.5595

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
150160	2.0916	0.9593	*	27.6375	31.2957	29.5436
150161	1.6725	0.9593	*	*	32.3409	32.3409
150162	1.8560	0.9593	*	*	32.2317	32.2317
150163	1.0425	0.8900	*	*	26.0437	26.0437
150164	1.1932	0.9311	*	*	*	*
150165	1.5320	1.0383	*	*	*	*
150166	1.1615	1.0383	*	*	*	*
150167	2.3410	0.8950	*	*	*	*
150168	2.1329	0.8950	*	*	*	*
150169	1.5371	0.9593	*	*	*	*
150171	1.8740	0.8950	*	*	*	*
150174	***	0.9196	*	*	*	*
160001	1.3686	0.9521	25.7255	25.8686	27.4207	26.3437
160005	1.2953	0.8564	24.7755	24.8597	25.6204	25.1248
160008	1.0200	0.8564	22.4758	24.1282	24.3704	23.6309
160013	1.2284	0.8743	24.4099	25.5162	26.6913	25.5251
160016	1.6000	0.9274	27.1460	26.6537	27.9879	27.2616
160024	1.5372	0.9521	29.3756	32.4253	32.7762	31.5361
160028	1.4010	0.9541	30.0576	29.8343	32.4639	30.8418
160029	1.5012	0.9407	30.6687	32.2035	33.7679	32.2197
160030	1.3995	0.9546	30.9415	30.4779	32.0333	31.1630
160032	1.0291	0.8799	26.2935	28.5645	29.0326	28.0265
160033	1.6484	0.8564	27.2060	27.4810	27.6537	27.4485
160040	1.3622	0.8564	26.8110	28.2982	27.9810	27.6998
160045	1.6809	0.8908	27.5289	28.1681	30.0063	28.6143
160047	1.3087	0.9541	28.1280	29.4286	31.2897	29.5490
160057	1.4489	0.9152	25.6274	27.7969	28.3640	27.2815
160058	2.0218	0.9407	28.9924	29.8975	31.2742	30.0761
160064	1.5270	0.9259	28.4209	33.6082	32.7787	31.5360
160067	1.4504	0.8564	26.0243	26.7679	27.2055	26.6734
160069	1.4998	0.8626	27.6157	28.4081	29.0981	28.3339
160079	1.4987	0.8908	26.1618	28.5034	29.8338	28.1658
160080	1.2451	0.8564	27.2370	27.8745	27.4136	27.5090
160082	1.7794	0.9521	28.7831	31.7508	34.0609	31.5753
160083	1.6421	0.9521	28.3921	29.9489	31.0514	29.8208
160089	1.3192	0.9152	23.2888	23.9194	25.0810	24.0885
160101	1.1734	0.9521	25.4740	26.8515	27.1889	26.5158
160104	1.5904	0.8564	29.8126	27.0538	27.8486	28.1145
160110	1.5327	0.8564	28.8134	29.9094	30.8876	29.9205
160112	1.2320	0.8564	25.2886	26.1721	26.7136	26.0920
160117	1.3972	0.8626	27.3927	24.3326	28.8434	26.7322
160122	1.1643	0.8564	24.4996	25.3192	26.6212	25.5052

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
160124	1.0816	0.8564	24.3063	25.5048	27.2937	25.7008
160146	1.4455	0.8937	24.8485	25.1834	27.1213	25.7257
160147	1.2432	0.9274	29.8992	33.6394	37.2058	33.4681
160153	1.6868	0.8937	30.6173	30.4356	32.1357	31.0451
160155	***	*	*	*	30.2301	30.2301
170001	1.1832	0.8183	23.8863	24.5942	26.2914	24.9283
170006	1.3263	0.8485	27.1033	28.3527	30.5591	28.7050
170009	1.1077	0.9555	29.6386	32.2847	29.3342	30.3537
170010	1.1872	0.8183	25.5573	28.1802	28.6734	27.4651
170012	1.5885	0.8743	27.1195	28.7878	30.0388	28.6598
170013	1.6593	0.8743	26.7124	28.3051	29.6511	28.2216
170014	1.0016	0.9555	24.2322	25.8165	27.2909	25.7779
170016	1.6196	0.9180	26.7536	28.6817	31.9998	29.0858
170017	1.1826	0.8962	27.2925	29.1463	29.5447	28.7248
170020	1.5366	0.8743	24.1149	25.0561	26.1258	25.1235
170023	1.4632	0.8743	23.9812	24.8827	24.9932	24.6412
170027	1.4283	0.8183	23.4037	24.1133	24.6748	24.0688
170033	1.2548	0.8743	24.1882	25.0404	26.9830	25.3537
170039	0.9519	0.8962	26.0952	23.5975	24.1339	24.5119
170040	1.9435	0.9555	30.2468	30.0828	33.3813	31.2065
170049	1.4916	0.9555	26.4086	31.8595	34.8212	31.1346
170058	1.0749	0.8183	26.5949	28.1330	28.6239	27.7857
170068	1.1475	0.8468	23.8812	23.8509	25.6803	24.4755
170074	1.2012	0.8183	23.0567	24.8871	26.7280	24.8946
170075	0.8714	0.8183	19.9351	21.1965	20.9091	20.6679
170086	1.5733	0.9180	26.3615	28.5260	30.0102	28.3717
170094	0.9310	0.8183	16.5136	17.1719	26.4808	19.4257
170103	1.3484	0.8962	24.2003	25.5671	26.2628	25.3582
170104	1.4224	0.9555	27.6211	29.7793	31.7058	29.7314
170105	1.0731	0.8183	22.7412	23.4332	24.4249	23.5400
170109	1.0775	0.9555	23.8515	29.0197	33.0257	28.8409
170110	0.9253	0.8183	23.9572	24.7927	26.7359	25.1733
170120	1.4309	0.8485	22.2805	23.5287	24.9819	23.6378
170122	1.7614	0.8962	28.7175	29.6337	31.0839	29.8194
170123	1.7329	0.8962	27.0843	28.7627	29.1591	28.3587
170133	1.0294	0.9555	25.2301	25.7129	27.6138	26.1892
170137	1.4194	0.8183	25.3395	26.8029	28.6556	26.9670
170142	1.4654	0.8963	24.6019	25.5567	26.4060	25.5260
170145	1.1012	0.8183	23.3967	25.3745	26.5981	25.1199
170146	1.5770	0.9555	29.0720	31.7023	31.6451	30.7933
170147	***	*	24.3268	21.4581	*	23.4961
170150	1.1485	0.8349	19.6160	22.0265	22.2379	21.2881

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
170166	0.9665	0.8183	22.6968	24.1079	24.4570	23.7582
170175	1.3259	0.8743	26.7229	31.7600	30.1456	29.5409
170176	1.6402	0.9555	29.0735	30.1135	31.4048	30.2116
170182	1.5125	0.9555	28.9710	30.3805	32.3903	30.5959
170183	2.0035	0.8962	26.1890	27.7207	27.5559	27.1528
170185	1.3066	0.9555	28.1780	29.3226	31.0813	29.6228
170186	2.4251	0.8962	30.2613	30.7673	36.3546	32.4429
170187	1.6254	0.8183	24.1461	24.6419	26.2236	25.0537
170188	1.9992	0.9555	32.2573	33.7247	34.0134	33.3628
170190	1.0256	0.8183	26.2625	27.3041	28.7392	27.4713
170191	1.8703	0.8183	24.3813	26.0305	26.2347	25.6315
170192	1.8190	0.8962	27.7421	30.9230	31.7531	30.3002
170193	***	*	24.8531	24.4131	21.9349	23.8067
170194	1.4669	0.9555	27.6989	28.2004	29.8055	28.4794
170195	2.3084	0.9555	29.5947	29.1787	31.0187	30.0282
170196	2.3898	0.8962	32.1832	29.9671	29.9241	30.5752
170197	2.2189	0.8962	*	*	*	*
170198	1.9441	0.8183	*	*	*	*
180001	1.2683	0.9399	29.7423	29.9674	29.7832	29.8319
180002	1.0743	0.8101	26.5488	27.3344	28.4044	27.4059
180004	1.1352	0.7961	20.8805	22.0626	25.7454	22.8633
180005	1.1988	0.8725	25.6159	27.4317	27.9687	27.0218
180007	***	*	27.1924	26.9440	29.3465	27.7484
180009	1.7730	0.9036	27.3228	28.7048	28.9804	28.3804
180010	1.9559	0.8842	27.7600	28.2168	29.8818	28.6059
180011	1.6685	0.8732	24.9909	25.0372	26.6072	25.6014
180012	1.4949	0.8902	26.7279	27.2851	27.8386	27.2889
180013	1.5314	0.9351	24.8125	26.8108	28.6307	26.7348
180016	1.2951	0.8902	24.7091	26.9539	28.2975	26.6063
180017	1.3225	0.8080	21.9715	25.4174	26.0927	24.4704
180018	1.4070	0.7961	23.3035	24.9874	25.0082	24.4724
180019	1.1812	0.7961	24.6279	27.6801	27.5969	26.6718
180020	1.0377	0.8101	25.9975	26.8865	29.8100	27.5353
180021	0.9692	0.7961	22.0740	22.3768	24.2127	22.8931
180024	1.1508	0.8902	26.3532	26.9553	27.8181	27.0434
180025	1.3182	0.8902	28.5935	28.4172	30.2576	29.1127
180027	1.2165	0.8143	21.7639	23.3881	24.0032	22.9965
180029	1.4620	0.8732	26.1528	26.3907	29.1400	27.1461
180035	1.4925	0.9399	32.8461	34.0370	36.6577	34.5502
180036	1.3978	0.9036	25.6959	30.2643	31.9987	29.1866
180037	***	*	27.8506	33.1897	28.5734	29.8984
180038	1.6241	0.7961	26.9752	28.2430	28.5219	27.9439

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
180040	1.8495	0.8902	28.5162	30.2471	28.9562	29.1990
180043	1.0886	0.7961	20.6439	24.0582	25.0444	23.2147
180044	1.6560	0.8725	25.8060	25.7990	27.7934	26.4853
180045	1.4039	0.9399	29.4127	29.9366	29.9395	29.7644
180046	1.1591	0.8842	27.0962	28.5568	30.0536	28.5844
180048	1.3827	0.8902	24.3696	24.6800	25.3490	24.8076
180049	1.4334	0.8732	24.3699	23.5756	25.8921	24.5960
180050	1.1349	0.8123	25.9557	26.7726	29.9911	27.5275
180051	1.3017	0.8143	24.3916	25.2369	26.2560	25.3289
180053	0.9566	0.7961	22.1921	23.0302	24.6694	23.3444
180056	1.1811	0.8456	24.5326	26.3973	26.6223	25.8492
180064	1.2187	0.8275	20.1799	21.9517	22.5090	21.5833
180066	1.1276	0.9351	23.7860	24.9542	27.2184	25.3439
180067	1.8774	0.8842	27.9852	29.6053	28.9896	28.8949
180069	1.0872	0.8725	26.6714	27.6785	29.9406	27.9869
180070	1.2363	0.8201	20.2189	21.3707	22.8450	21.5185
180078	1.0786	0.8725	28.2762	29.2136	27.4672	28.3056
180079	1.1090	0.8220	23.6005	24.9911	27.2710	25.2310
180080	1.3026	0.7961	23.7788	25.3013	27.2402	25.4627
180087	1.2455	0.7961	22.0302	22.1063	23.2617	22.4636
180088	1.7132	0.8902	28.6107	30.7954	31.8151	30.4217
180092	1.1404	0.8842	23.7866	25.2900	27.0330	25.4093
180093	1.6091	0.8152	21.4392	22.3330	23.5805	22.4845
180095	1.0495	0.7961	21.5639	21.2162	23.9869	22.3006
180101	1.2826	0.8842	28.1621	28.8772	29.6176	28.9237
180102	1.4734	0.8143	25.2343	27.3901	28.3445	26.9882
180103	1.9527	0.8842	28.1734	29.7648	31.7171	29.8793
180104	1.5623	0.8143	25.9689	27.1292	28.7669	27.3214
180105	0.9802	0.7961	23.1917	24.3663	22.9902	23.5224
180106	0.8947	0.7961	20.7220	21.2271	20.1899	20.7142
180115	0.9015	0.7961	20.3089	22.7095	24.9627	22.6495
180116	1.2135	0.8143	25.8927	26.8850	26.9052	26.5806
180117	0.9102	0.7961	24.7378	24.9571	25.9593	25.1973
180124	1.3557	0.9351	25.4664	27.1359	28.2511	26.9378
180127	1.2937	0.8902	26.3947	28.3635	29.8610	28.2066
180128	0.9315	0.7961	23.8144	23.7778	23.9098	23.8348
180130	1.7038	0.8902	29.1712	29.6751	31.2746	30.0638
180132	1.4745	0.8732	25.3789	29.0563	29.5884	28.0465
180138	1.1991	0.8902	28.6871	29.2603	30.7144	29.5828
180139	1.0549	0.7961	24.7575	26.2450	28.3450	26.3761
180141	1.8400	0.8902	27.5912	28.7329	29.5347	28.6370
180143	1.7056	0.8842	30.8734	28.0780	29.0323	29.2275

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
180147	***	*	31.1615	*	*	31.1615
180148	***	*	30.1250	*	*	30.1250
180149	1.0505	0.7961	*	16.4918	16.3670	16.4254
180150	***	*	*	*	27.9388	27.9388
180151	1.4008	0.8842	*	*	*	*
190001	1.1659	0.7824	22.1569	22.5331	25.3862	23.4848
190002	1.6796	0.8569	24.6984	25.9387	27.1770	25.9332
190003	1.3683	0.8569	26.7844	28.0899	30.5381	28.4594
190004	1.4950	0.8006	25.0803	24.6563	27.0776	25.6360
190005	1.5995	0.9010	24.2899	28.3308	32.9927	27.0163
190006	1.3700	0.8569	24.8836	25.4826	28.9179	26.6118
190007	1.1835	0.7824	23.1426	24.0538	24.6117	23.9473
190008	1.6815	0.8006	26.3638	27.2683	28.1194	27.2574
190009	1.1266	0.8152	24.0696	25.0269	24.8263	24.6631
190011	1.0093	0.7925	21.6991	21.9174	24.2068	22.5652
190013	1.5045	0.7971	23.7333	22.8380	25.2468	23.9478
190014	1.1670	0.7824	22.6405	24.5410	25.6064	24.1852
190015	1.3378	0.9010	25.1767	26.9591	29.5241	27.2784
190017	1.4681	0.8569	24.7537	25.5477	26.9640	25.8080
190019	1.7143	0.8152	25.4624	27.6057	28.6311	27.3149
190020	1.3331	0.8239	23.4602	24.2361	25.9262	24.6042
190025	1.2924	0.7824	24.5024	26.5949	26.6296	25.8633
190026	1.6151	0.8152	24.1556	25.3752	27.0875	25.5388
190027	1.6608	0.7971	26.7132	31.5047	29.4789	29.1954
190034	1.1465	0.8013	21.2130	22.9920	24.3969	22.8818
190036	1.7573	0.9010	25.6551	29.1818	27.7969	27.4252
190037	0.6682	0.7971	20.7271	28.0463	19.5982	23.0593
190039	1.5103	0.9010	25.4003	24.6848	29.0738	26.5099
190040	1.4304	0.9010	28.0169	28.2444	29.0914	28.4723
190041	1.4935	0.8465	28.0050	28.7702	29.3296	28.7072
190044	1.3050	0.8085	21.2604	22.2462	23.1701	22.2470
190045	1.6126	0.9010	27.1996	27.5873	29.2569	28.0483
190046	1.5640	0.9010	24.7370	25.1890	30.9760	27.0736
190050	1.2007	0.7868	20.9142	22.7962	23.6921	22.4518
190053	1.2337	0.7925	18.5819	20.6289	22.1404	20.4292
190054	1.3269	0.7909	22.7011	23.5137	26.5586	24.2996
190060	1.4394	0.7971	22.6291	19.8911	25.1496	22.3800
190064	1.6731	0.8239	23.7298	26.9960	28.6273	26.5224
190065	1.6818	0.8239	23.1202	22.9861	24.3651	23.5078
190078	1.0789	0.8011	22.2346	25.6943	26.0185	24.7759
190079	1.1872	0.9010	23.8192	25.3344	28.0268	25.8258
190081	0.8642	0.7824	21.4510	20.4111	21.2224	21.0111

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
190086	1.2487	0.7925	22.2895	22.2852	24.2040	22.8667
190088	1.1204	0.8465	23.1638	24.7450	29.5999	25.8159
190090	0.9966	0.7824	24.3303	25.8610	25.0681	25.0724
190098	1.7782	0.8465	25.7449	27.5058	27.8846	27.0710
190099	1.0635	0.8013	23.2343	25.7488	25.7136	24.9054
190102	1.5406	0.8569	26.9700	28.3090	28.6165	27.9315
190106	1.0697	0.8152	26.6227	24.2759	25.5188	25.4707
190111	1.7194	0.8465	26.5722	27.3192	28.8406	27.6044
190114	1.0893	0.7824	19.1586	20.3651	21.1463	20.2391
190115	0.7557	0.8465	26.0797	26.0285	25.7014	25.9440
190116	1.1912	0.7909	23.4013	24.2154	24.4439	24.0256
190118	1.0069	0.8465	21.2580	22.6572	22.3386	22.1127
190122	1.2753	0.8239	22.2371	22.8681	24.5686	23.3145
190124	***	*	27.9484	28.6713	*	28.2761
190125	1.5619	0.7925	24.8256	26.6269	26.9761	26.2656
190128	1.0861	0.8239	29.6682	31.1819	32.2095	31.0707
190131	1.3145	0.8239	28.6795	28.5946	29.9837	29.0885
190133	0.8928	0.7926	22.4311	23.9550	27.2643	24.6327
190135	1.4861	0.9010	30.5646	35.0547	43.3956	32.5962
190140	0.9899	0.7859	23.0485	23.6713	23.2346	23.3096
190144	1.2770	0.8465	23.7875	24.8866	25.8501	24.8635
190145	0.9612	0.7914	20.8579	21.3988	22.1298	21.4711
190146	1.6525	0.9010	28.7200	28.5984	29.8336	29.0734
190151	0.9246	0.7824	18.8391	20.6970	23.0032	20.7532
190152	***	*	30.8512	34.6508	34.6962	33.2471
190158	***	*	30.6450	21.5594	*	28.7353
190160	1.5983	0.7925	24.7822	25.8646	26.4460	25.6888
190161	1.1846	0.7971	22.9035	23.8073	24.8249	23.8713
190164	1.2139	0.8152	26.6207	27.7265	28.2630	27.5624
190167	1.2453	0.8569	25.3283	27.1981	29.3971	27.2483
190175	1.3371	0.9010	27.4256	30.5948	31.4039	29.7933
190176	1.8725	0.9010	26.2596	28.2192	32.2906	28.5344
190177	1.6458	0.9010	28.2751	29.7252	30.9158	29.6564
190182	***	*	29.8656	30.7058	*	30.2958
190183	1.2897	0.8006	22.0119	23.3462	25.0395	23.5195
190184	0.9825	0.7925	24.1626	22.6144	22.5006	23.1018
190185	***	*	28.9759	36.7317	*	32.3103
190190	0.9308	0.7925	26.7043	27.5051	27.5875	27.2778
190191	1.3231	0.8569	26.1628	26.9656	28.1116	27.0708
190196	0.8194	0.8569	25.8472	27.7824	28.4697	27.3957
190197	***	*	26.4825	28.7044	29.4072	28.0869
190199	1.1099	0.8239	32.0194	36.7128	29.8286	32.8655

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
190200	***	*	27.4781	*	*	27.4781
190201	1.1055	0.7971	24.4563	26.8550	27.8244	26.4092
190202	1.4668	0.8239	29.6612	27.6463	27.8790	28.2439
190203	***	*	29.9753	*	*	29.9753
190204	1.4472	0.9010	30.5140	32.9140	31.9034	31.7471
190205	1.6616	0.8569	28.2484	30.1687	31.6103	30.0145
190206	***	*	29.2371	32.0180	30.4228	30.5599
190208	0.8276	0.7824	27.9908	24.9405	27.5238	26.7290
190218	0.8972	0.8465	28.1039	26.5251	26.9305	27.1540
190236	1.4436	0.8465	26.4614	26.9059	28.6472	27.3614
190241	1.8680	0.8006	25.7906	26.5320	27.5130	26.6421
190242	1.2094	0.8239	25.0035	26.9729	28.7307	27.0159
190245	1.7537	0.7925	26.7642	26.4166	26.6403	26.6021
190246	2.0632	0.7899	22.7833	31.7158	31.5003	28.9108
190249	1.2200	0.8239	25.2523	27.0975	28.3211	26.8144
190250	2.0955	0.9010	33.3302	32.8381	35.2699	33.8515
190251	1.3383	0.8239	23.8389	25.1594	27.3657	25.6325
190253	***	*	23.8037	22.2227	*	23.2564
190255	0.7839	0.8569	16.1593	23.8035	27.8066	21.9255
190256	0.8683	0.9010	25.9577	25.9365	28.7148	27.0062
190257	1.7413	0.7925	26.5505	22.7512	24.2936	24.5515
190258	1.4357	0.8465	26.1141	25.1993	27.7948	26.2674
190259	2.1970	0.8569	26.5084	27.5518	28.9188	27.6659
190260	***	*	29.3947	33.6227	*	31.1721
190261	1.5148	0.7925	27.0441	25.4757	28.7987	27.1183
190262	***	*	30.3719	*	*	30.3719
190263	2.2819	0.8569	26.4202	29.7063	36.3082	30.5072
190264	***	*	26.5842	*	*	26.5842
190265	***	*	22.6231	30.9260	*	27.1327
190266	2.7287	0.8239	*	24.3809	32.3423	28.2715
190267	1.5630	0.9010	*	24.2794	27.6254	26.0704
190268	1.7733	0.8569	*	29.1425	25.8619	27.2296
190270	1.8922	0.9010	*	*	28.5382	28.5382
190272	1.3385	0.8569	*	28.4558	28.4184	28.4326
190273	1.7562	0.8239	*	*	22.7627	22.7627
190274	1.6650	0.9010	*	*	*	*
190275	1.4932	0.9010	*	*	*	*
190278	2.0229	0.8465	*	*	*	*
190297	1.1945	0.7824	*	*	*	*
200001	1.3760	1.0025	26.3045	28.1145	28.9839	27.8234
200002	1.1755	0.9743	27.1151	33.2695	30.4965	30.1504
200008	1.3944	1.0200	29.1836	29.3538	32.3955	30.3491

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
200009	1.9174	1.0200	32.5812	35.0743	36.9995	34.8195
200018	1.2559	0.8555	22.5027	24.6790	25.4228	24.2178
200019	1.2986	1.0200	27.7896	28.3413	30.1233	28.7407
200020	1.3309	1.0206	34.0916	34.5762	36.9185	35.2227
200021	1.2135	1.0200	29.2054	28.7614	31.8322	29.9786
200024	1.7091	0.9743	29.7817	31.0799	31.6913	30.8971
200025	1.1787	1.0200	28.5750	29.3607	30.2866	29.4788
200031	1.2947	0.8555	22.2151	23.7553	25.5973	23.8951
200032	1.1200	0.8922	26.8993	27.2276	27.8426	27.3337
200033	1.8345	1.0025	31.7007	33.6293	34.8017	33.4076
200034	1.4504	0.9743	27.0103	28.0417	28.5612	27.9041
200037	1.1852	0.8555	24.9418	26.7815	27.9167	26.6737
200039	1.3100	0.9743	26.6409	28.8043	29.9958	28.5071
200040	1.1326	1.0200	27.8053	25.5519	29.6104	27.6215
200041	1.2416	0.8555	26.6777	27.5067	28.7604	27.6482
200050	1.2105	1.0025	29.5033	30.1473	32.0363	30.6029
200052	1.0760	0.8555	24.4204	25.6238	24.4545	24.8152
200063	1.2086	0.8555	27.9748	28.2203	29.6832	28.6815
210001	1.4210	0.9433	29.3471	31.2355	30.9218	30.5135
210002	1.9785	1.0148	33.7388	36.0252	36.8782	35.5860
210003	1.6023	1.0718	30.7334	28.2566	34.4117	31.0346
210004	1.4965	1.0789	31.7132	33.9037	32.4548	32.7027
210005	1.3091	1.0789	29.5835	32.4081	32.2224	31.4417
210006	1.0998	1.0148	27.3620	27.9859	31.8510	29.1144
210007	1.7809	1.0148	30.7124	31.4125	35.3019	32.4455
210008	1.4329	1.0148	28.8850	31.8535	33.0343	31.3102
210009	1.8235	1.0148	30.2661	31.8273	34.4385	32.2369
210011	1.4984	1.0148	31.0966	30.7547	29.7694	30.5113
210012	1.6726	1.0148	31.1778	32.5327	33.8099	32.5669
210013	1.3739	1.0148	28.9917	32.1180	35.6347	32.2733
210015	1.3195	1.0148	32.2774	31.6903	34.7961	32.9816
210016	1.7595	1.0789	33.5493	35.3253	37.1478	35.3017
210017	1.2898	0.9246	26.8592	26.6208	27.9652	27.1544
210018	1.2384	1.0789	29.6521	31.5460	33.7284	31.6501
210019	1.7723	0.9246	28.7844	30.5485	30.8121	30.0658
210022	1.5208	1.0789	37.3092	36.1833	35.8394	36.4007
210023	1.5173	1.0227	33.0212	34.1664	35.8243	34.3707
210024	1.8013	1.0148	32.9434	34.5548	36.7920	34.8149
210025	1.2731	0.9246	24.8570	23.5175	28.3956	25.5473
210027	1.3801	0.9246	24.4821	25.2143	25.6339	25.1369
210028	1.0688	0.9629	26.7462	28.5214	31.7636	29.1286
210029	1.3454	1.0148	31.8539	32.9100	33.9139	32.9337

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
210030	1.2154	0.9246	32.2033	29.1790	33.8729	31.7470
210032	1.2238	1.0760	27.9359	29.2785	31.6516	29.6480
210033	1.2363	1.0148	29.2504	28.4350	33.0982	30.2708
210034	1.3227	1.0148	32.3827	33.0407	35.1533	33.5681
210035	1.2998	1.0718	27.3901	30.6692	28.7165	28.8774
210037	1.2209	0.9246	27.8394	28.8708	31.0096	29.2713
210038	1.3087	1.0148	32.3206	31.1563	32.7411	32.0849
210039	1.1428	1.0718	32.4139	35.1172	33.7557	33.7766
210040	1.2377	1.0148	29.2390	31.0882	30.5834	30.3223
210043	1.3476	1.0227	32.6961	29.2762	31.9196	31.2197
210044	1.3966	1.0148	30.3349	31.5463	31.9067	31.2823
210045	0.9757	0.9246	16.3724	19.6112	23.8454	19.7628
210048	1.4318	1.0148	26.0650	29.2464	30.6650	28.6045
210049	1.2521	1.0148	27.0161	28.5970	31.5740	29.2139
210051	1.3607	1.0718	29.5219	30.7954	33.0355	31.1733
210054	1.2815	1.0718	27.7607	28.6905	32.3079	29.6218
210055	1.2774	1.0718	31.4905	30.2010	36.7615	32.6861
210056	1.3575	1.0148	32.3518	33.2271	35.5593	33.6946
210057	1.3739	1.0789	32.8299	33.7287	34.3643	33.6471
210058	1.2373	1.0148	31.1988	32.0669	32.9569	32.0727
210060	1.2126	1.0718	29.9626	32.5141	34.1974	32.3005
210061	1.4139	0.9434	25.0253	26.6842	28.6561	26.8377
220001	1.2996	1.1577	31.2316	32.0843	34.3993	32.6222
220002	1.3969	1.1577	33.6649	35.9765	37.9204	35.9189
220006	***	*	33.6438	*	*	33.6438
220008	1.3364	1.1577	34.7924	35.8680	37.3794	36.0313
220010	1.2171	1.1577	32.0925	33.7392	36.1759	34.0029
220011	1.1564	1.1577	36.5640	39.1234	41.0183	38.9805
220012	1.4525	1.2580	39.7564	41.7080	43.0551	41.5126
220015	1.3026	1.0433	32.4903	35.2373	36.6427	34.8288
220016	1.0694	1.0433	32.5863	33.1424	34.9714	33.5941
220017	1.2802	1.2293	33.3020	34.6575	38.0626	35.3429
220019	1.1270	1.1577	25.7855	26.3018	28.0084	26.7035
220020	1.1520	1.1577	30.8458	32.1528	33.6332	32.2145
220024	1.2872	1.0433	31.9491	33.0415	33.8692	32.9848
220025	1.0399	1.1577	30.4369	27.6973	26.6082	28.1395
220028	***	*	39.3089	*	*	39.3089
220029	1.2058	1.1577	31.6363	32.6792	34.8311	33.0952
220030	1.1143	1.0433	28.1347	29.3714	28.8797	28.7955
220031	1.5285	1.2293	38.9433	39.4214	43.7983	40.7963
220033	1.1898	1.1577	32.3495	34.7005	36.1938	34.4472
220035	1.4387	1.1577	34.8739	36.1799	37.2879	36.2777
220036	1.5378	1.2293	35.9124	37.7301	37.0998	36.9160
220046	1.4893	1.0735	31.4510	33.8604	36.3356	33.9253
220049	1.2094	1.1577	32.4652	35.1134	35.7550	34.4838
220050	1.0888	1.0433	29.5194	30.3176	32.4636	30.8095
220051	1.3228	1.0358	30.1022	32.8693	34.7850	32.5322
220052	1.2230	1.2293	32.3532	34.9151	34.9505	34.0652
220058	0.9683	1.1577	27.8893	30.0344	31.9532	29.9443
220060	1.1933	1.2293	34.7336	36.8668	39.1180	37.0242
220062	0.6748	1.1577	25.4224	27.4755	27.3983	26.7764
220063	1.1771	1.1577	32.9283	32.2442	34.6004	33.2997
220065	1.2214	1.0433	30.1103	32.3814	33.6328	32.0471
220066	1.3670	1.0433	29.9736	*	32.6289	31.2823
220067	1.2580	1.2293	32.4019	33.9836	35.7611	34.0837
220070	1.1593	1.1577	34.2598	35.6271	37.4036	35.7788
220071	1.8640	1.2293	37.4087	40.0313	44.2752	40.5175
220073	1.2461	1.1577	36.0289	37.4249	38.9942	37.4751
220074	1.3644	1.1577	31.4730	33.2081	34.5531	33.1069
220B74	***	*	31.4731	33.2082	34.5530	33.1105
220075	1.4356	1.2293	32.2957	33.3578	33.9698	33.2086
220077	1.6077	1.1179	34.0168	34.7345	36.4382	35.0974
220080	1.2605	1.1577	31.1268	33.1640	36.8086	33.6188
220082	1.2811	1.1577	30.8230	32.2124	33.0780	32.0614
220083	1.0634	1.2293	34.5969	35.2758	37.6415	35.9286
220084	1.2120	1.1577	31.6955	34.6275	36.1148	34.1424
220086	1.7507	1.2293	35.3451	36.2385	38.7853	36.8569
220088	1.9620	1.2293	34.7637	37.0840	37.3891	36.4653
220089	***	*	34.8205	*	*	34.8205
220090	1.2313	1.1577	34.1963	35.8969	36.8628	35.7062
220095	1.1639	1.1577	30.8626	31.1644	34.1504	32.0797
220098	1.1179	1.1577	31.5403	31.1288	32.1864	31.6182
220100	1.3276	1.2293	34.6599	35.7309	36.5606	35.6866
220101	1.3167	1.1577	37.7809	37.7292	39.3939	38.3297
220105	1.2140	1.1577	34.4029	35.8179	36.6444	35.6432
220108	1.2329	1.2293	33.8854	35.7009	37.1981	35.6375
220110	2.0220	1.2293	40.7382	43.8444	45.3683	43.3739
220111	1.2485	1.2293	34.2498	35.6223	36.8788	35.6103
220116	1.9010	1.2293	38.8799	40.0982	44.6345	41.1705
220119	1.1248	1.2293	32.0863	33.7200	36.2751	34.0555
220126	1.2024	1.2293	32.6938	35.6278	40.5321	36.1633
220133	***	*	34.9182	*	*	34.9182
220135	1.3106	1.2580	37.5189	39.0296	40.3011	38.9703
220153	***	*	19.8085	20.5063	17.4773	19.4282

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
220154	***	*	28.7680	*	*	28.7680
220162	1.6601	*	*	*	*	*
220163	1.6658	1.1577	37.4968	39.4893	41.6485	39.6071
220171	1.6226	1.1577	35.9948	36.4567	39.7385	37.4768
220174	1.2524	1.1577	30.9503	32.9140	35.8880	33.2586
220175	1.3049	1.1577	*	34.1572	36.6376	35.3624
220176	1.6163	1.1577	*	31.4220	36.2759	33.7046
220177	0.9179	1.0358	*	*	*	*
230002	1.3653	0.9871	32.7578	33.9708	34.2904	33.7044
230003	1.3339	0.9370	28.4716	28.9886	28.5041	28.6494
230004	1.7143	0.9830	31.5136	33.4644	33.1555	32.7274
230005	1.2516	0.9270	27.7463	29.0634	30.5550	29.1517
230013	1.2969	1.0139	27.2075	28.6430	29.9019	28.5291
230015	1.0886	0.9092	27.2541	28.9601	29.8884	28.7179
230017	1.6711	1.0251	32.5396	36.8045	35.5276	34.9899
230019	1.6269	1.0139	34.3213	35.1440	34.8302	34.7681
230020	1.7176	0.9871	29.5324	29.9492	30.4302	29.9707
230021	1.6015	0.9900	28.6169	29.5414	30.4315	29.5378
230022	1.1811	0.9564	30.1195	25.7846	29.5713	28.3420
230024	1.6944	0.9871	32.5892	34.5278	35.1416	34.0899
230029	1.6738	1.0139	32.3845	33.1482	35.5257	33.7375
230030	1.3489	0.9407	25.1100	25.1929	27.8555	26.0258
230031	1.4455	0.9858	30.0120	30.8870	30.9321	30.6162
230034	1.2847	0.8797	24.4141	29.1098	29.8711	27.6510
230035	1.2673	0.9294	25.6715	25.7099	27.0372	26.1408
230036	1.3868	0.9176	29.9642	31.0938	31.9872	31.0261
230037	1.2270	0.9871	28.5311	28.8547	31.4423	29.6304
230038	1.7965	0.9370	29.1263	30.1040	31.5536	30.2925
230040	1.1648	0.9294	26.3190	27.2850	27.6894	27.1137
230041	1.5679	0.9498	27.9569	30.3082	31.7229	29.9993
230046	1.9506	1.0243	32.2924	33.5304	34.3952	33.4461
230047	1.5115	0.9879	31.7075	32.0248	33.2300	32.3335
230053	1.6981	0.9871	32.1566	33.5440	34.1884	33.3299
230054	1.8082	0.9327	26.3251	28.1229	28.5274	27.6386
230055	1.2584	0.8797	28.4787	28.1881	28.2657	28.3130
230058	1.1460	0.8797	27.3156	27.9643	29.2185	28.1648
230059	1.5781	0.9370	28.5875	28.3602	30.3935	29.1235
230060	1.2083	0.8797	27.0288	28.7760	30.7515	28.9062
230066	1.3615	0.9830	30.2104	32.3582	32.8383	31.8144
230069	1.2825	1.0139	31.3406	31.9675	33.3136	32.2349
230070	1.6531	0.9594	26.8315	28.0366	32.2151	28.9911

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
230071	1.0770	1.0139	29.6728	28.8879	29.6172	29.3892
230072	1.4691	0.9370	27.4742	28.8024	29.3214	28.5566
230075	1.3842	1.0121	30.9525	32.1166	33.2981	32.1337
230077	1.8322	1.0139	30.5567	31.0123	32.2274	31.2649
230078	1.1465	0.8797	25.7232	27.0069	27.7143	26.7677
230080	1.2636	0.9176	24.5432	25.6204	25.9082	25.3732
230081	1.2772	0.8797	26.4337	27.8106	27.9649	27.4001
230085	1.2079	1.0251	25.4289	27.6474	28.1395	27.1055
230089	1.3866	0.9871	32.8450	32.2311	34.4092	33.1529
230092	1.4181	0.9871	29.3442	30.5417	29.5262	29.8010
230093	1.2002	0.8855	27.4463	27.0572	27.7275	27.4120
230095	1.2581	0.9176	25.1854	25.9210	25.9787	25.6964
230096	1.1833	0.9900	31.7399	29.7225	30.9326	30.7841
230097	1.6992	0.9294	29.8962	31.5174	32.2990	31.2518
230099	1.2143	1.0193	29.3720	29.0975	30.7388	29.7558
230100	1.2821	0.8797	25.2118	25.6594	25.9480	25.6153
230101	1.1829	0.8797	28.4372	28.8608	29.4146	28.9075
230104	1.6700	0.9871	32.4125	34.0195	34.0176	33.4534
230B04	***	*	*	34.0195	34.0176	34.0188
230106	1.1444	0.9370	27.8584	30.0223	29.0344	28.9557
230108	1.1871	0.8797	24.4337	25.7477	25.4728	25.2396
230110	1.2150	0.8797	25.7196	27.0280	29.0921	27.2910
230117	1.8015	1.0251	33.0602	33.9176	33.6962	33.5649
230118	1.0293	0.8797	24.8890	24.8638	27.1359	25.6364
230119	***	*	31.9696	33.2050	33.6503	32.9903
230121	1.3052	0.9564	26.8361	27.7512	28.9511	27.8628
230130	1.7088	1.0139	31.2744	32.5613	33.6704	32.5257
230132	1.6088	1.1087	35.5304	38.2454	39.2894	37.6683
230133	1.3924	0.8797	25.0647	25.8537	26.1806	25.7150
230135	0.9986	0.9871	23.6005	31.5194	32.6527	28.8400
230141	1.5949	1.1087	33.2553	36.3124	36.2647	35.2763
230142	1.2859	0.9871	29.7417	29.9911	30.2157	29.9906
230144	1.8441	1.0243	*	*	*	*
230146	1.4613	0.9871	27.2621	29.0218	29.3346	28.5595
230151	1.3841	1.0139	29.8366	28.6724	28.6413	29.0208
230156	1.6904	1.0243	33.9034	34.7865	35.1696	34.6253
230165	1.6175	0.9871	31.4242	32.2855	31.9887	31.9046
230167	1.5521	0.9719	31.0657	32.8092	35.8019	33.2354
230174	1.3602	0.9370	29.7488	31.2469	31.6387	30.8815
230176	1.3618	0.9871	28.9798	29.2688	29.5281	29.2638
230180	1.1855	0.8797	24.9696	24.6007	28.1401	25.7940
230190	***	*	33.8229	33.6724	30.7924	32.8153

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
230193	1.4013	0.9858	26.4728	28.4641	29.1474	28.0426
230195	1.4731	0.9788	30.9702	32.5549	33.4975	32.3707
230197	1.6702	1.1087	33.7128	34.8066	36.4129	35.0114
230204	1.4671	0.9879	32.2882	30.1982	31.5389	31.3353
230207	1.3807	1.0139	25.1983	26.8231	27.2054	26.4037
230208	1.1715	0.9294	24.3476	25.2481	25.8892	25.1748
230212	1.0373	1.0243	32.8567	33.4379	34.3917	33.5662
230216	1.4786	0.9858	29.2061	28.9586	30.7478	29.6388
230217	1.4588	1.0121	31.9732	33.0839	35.4957	33.5972
230222	1.6119	0.9176	30.6482	32.4404	30.6277	31.2239
230223	***	*	29.8430	31.8146	34.2971	31.9711
230227	1.5648	0.9879	33.6716	34.2762	35.4364	34.4510
230230	1.4716	0.9719	31.1712	31.4953	31.2614	31.3109
230236	1.5563	0.9370	30.8556	31.9100	32.1973	31.6842
230239	1.3079	0.8797	22.1579	23.5461	26.8301	24.1527
230241	1.2163	0.9858	28.5516	30.0248	28.4771	28.9836
230244	1.4512	0.9871	30.0405	32.5586	33.0082	31.8915
230254	1.5715	1.0139	29.5874	31.6332	33.3035	31.5673
230257	1.0951	0.9879	30.6372	30.0674	32.6298	31.1727
230259	1.4025	1.0243	27.5982	27.9572	28.7672	28.1194
230264	2.2388	0.9879	28.5416	29.2202	35.0990	30.9139
230269	1.4995	1.0139	31.3800	34.2694	34.4514	33.4474
230270	1.3974	0.9871	28.8173	29.2408	29.0416	29.0333
230273	1.4572	0.9871	31.5396	32.5730	32.6874	32.2769
230275	0.5680	0.9594	25.2133	22.3740	*	23.7200
230277	1.5259	1.0139	31.4023	32.2545	33.8036	32.5016
230279	0.6319	1.0139	27.9726	26.8552	26.8567	27.1888
230296	***	*	34.2107	*	*	34.2107
230297	1.8300	0.9871	*	*	35.4246	35.4246
230300	***	*	*	*	40.1731	40.1731
230301	1.1204	0.9883	*	*	*	*
240001	1.5407	1.0945	34.7673	37.2211	38.3979	36.7859
240002	1.8403	1.0641	33.1051	34.6368	36.8748	34.9314
240004	1.7019	1.0945	32.5777	33.4596	36.5476	34.2387
240006	1.2343	1.0912	33.4777	32.8229	29.6609	31.0326
240010	1.9915	1.0912	32.7261	35.9131	37.5473	35.4660
240014	1.0912	1.0945	30.7519	33.4492	35.0675	33.1203
240018	1.3882	1.0071	29.4995	30.5645	32.3271	30.8453
240019	1.1417	1.0641	32.7052	34.2547	36.7033	34.5893
240020	1.0989	1.0945	33.2449	34.5703	34.6135	34.1497
240022	1.0878	0.9266	27.3137	28.5905	29.9313	28.5917
240030	1.5345	1.0773	27.1312	27.6596	29.4253	28.0679

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
240036	1.6080	1.1685	34.2980	37.2207	39.2407	37.0501
240038	1.5699	1.0945	33.0554	34.7357	35.8365	34.5707
240040	1.0499	1.0641	28.9009	30.0255	31.3287	30.1186
240043	1.2037	0.9266	24.0708	25.7424	27.1539	25.6889
240044	1.0928	0.9891	26.8681	28.5705	29.8375	28.4489
240047	1.4761	1.0641	29.7835	35.6763	36.7122	33.8642
240050	1.1785	1.0945	30.9805	33.7964	34.6160	33.2043
240052	1.1849	0.9266	29.4617	31.0934	33.1438	31.2545
240053	1.5445	1.0945	33.1148	34.4210	35.4738	34.3708
240056	1.3198	1.0945	34.0845	35.8603	36.1085	35.3780
240057	1.8467	1.0945	33.4713	34.8374	35.4436	34.6122
240059	1.1242	1.0945	32.4803	32.5958	33.5784	32.9078
240061	1.8540	1.0912	32.0828	34.6031	36.2545	34.3976
240063	1.6095	1.0945	35.2877	36.9822	38.3735	36.9562
240064	1.2967	1.0641	27.2407	29.9917	34.2284	30.3948
240066	1.6088	1.0945	36.0705	39.6609	38.4941	38.1098
240069	1.1933	1.0945	30.9719	31.1673	31.6325	31.2685
240071	1.1508	1.0945	31.7754	32.5460	33.1094	32.4820
240075	1.2475	1.0773	29.1171	30.3230	31.5984	30.3834
240076	1.0247	1.0945	33.1439	33.7950	35.4135	34.1353
240078	1.6596	1.0945	34.6118	36.2276	37.3608	36.1114
240080	2.0358	1.0945	34.8064	36.5390	37.7353	36.3766
240084	1.0372	1.0641	27.0995	29.0275	30.3789	28.7998
240088	1.3085	1.0773	29.1387	30.7240	31.4165	30.4498
240093	1.5000	1.0945	29.1717	30.4744	31.3517	30.3876
240100	1.3149	0.9266	31.5774	30.9481	32.5307	31.6817
240101	1.2397	0.9266	26.8849	28.5503	28.7121	28.0867
240104	1.2748	1.0945	35.0736	35.8839	36.0711	35.7066
240106	1.6319	1.0945	32.8156	33.9984	36.8942	34.5764
240115	1.4874	1.0945	33.5288	36.2788	37.5802	35.9017
240117	1.1412	0.9793	27.6950	29.0894	30.4437	29.0767
240132	1.3479	1.0945	34.6191	36.4252	37.0941	36.0429
240141	1.1588	1.0945	32.8689	34.2473	35.8696	34.3409
240166	1.1875	0.9266	26.5328	26.1732	27.3184	26.6990
240187	1.2635	0.9266	29.1582	30.9646	33.5186	31.2458
240196	0.9062	1.0945	34.3743	35.0345	35.4472	34.9598
240206	0.8906	1.4424	*	*	*	*
240207	1.3031	1.0945	34.6792	36.4569	37.7179	36.3413
240210	1.3246	1.0945	34.4184	36.5950	37.7064	36.2868
240211	0.9904	1.0078	17.4044	16.6158	16.1460	16.7321
240213	1.3869	1.0945	35.7818	37.4608	38.4222	37.2899
250001	2.0968	0.8191	23.7773	24.3404	26.7079	24.9396

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
250002	0.9022	0.7717	25.4201	25.0342	31.2353	27.1180
250004	1.7651	0.8936	25.8722	24.8086	29.1096	26.5101
250006	1.1447	0.8936	25.9199	27.0511	26.9193	26.6467
250007	1.2274	0.8723	27.7665	29.3479	32.6672	29.9107
250009	1.4375	0.8410	23.4866	24.9118	25.9247	24.7825
250010	1.0238	0.7717	21.8665	22.7988	23.8749	22.8452
250012	0.9577	0.9265	23.4837	26.4110	29.8873	26.3678
250015	1.2101	0.7717	22.2803	22.3685	22.7775	22.4806
250017	1.0550	0.7717	33.6840	25.7404	25.5007	27.8779
250018	0.8861	0.7717	17.9025	19.1108	19.5527	18.8720
250019	1.5888	0.8723	26.2199	27.7230	28.4743	27.4559
250020	0.9937	0.7717	23.7245	23.1521	26.9602	24.6041
250023	0.8371	0.8300	18.5067	19.5081	22.2932	20.2223
250025	1.1810	0.7717	23.1738	23.0555	26.0579	24.0627
250027	0.9354	0.7717	26.9922	32.5451	26.7593	28.6729
250031	1.3374	0.8191	25.9189	26.7507	28.6356	27.0954
250034	1.6208	0.8936	26.7996	27.9279	29.3365	28.0767
250035	0.8389	0.7717	19.1038	20.5251	24.0653	21.2787
250036	1.0214	0.8284	19.7951	22.5676	22.6781	21.6096
250038	0.9810	0.8191	26.9621	30.7960	27.1958	28.1719
250040	1.5419	0.8300	27.3366	26.2268	28.4423	27.3181
250042	1.2623	0.8936	26.1190	27.4610	25.8791	26.4753
250043	1.0002	0.7717	20.8841	21.1265	22.4618	21.5024
250044	1.0099	0.7717	24.9199	26.1732	26.9451	26.0337
250048	1.6049	0.8191	24.7659	27.6339	27.4186	26.5927
250049	0.9197	0.7717	20.4775	24.2227	24.2129	22.8505
250050	1.2726	0.7717	21.1657	22.4429	22.6843	22.1187
250051	0.8114	0.7717	13.9532	14.1662	15.6982	14.6375
250057	1.1770	0.7717	24.3654	22.9683	22.5524	23.2120
250058	1.2723	0.7717	18.9970	19.6720	20.4748	19.7237
250059	0.9451	0.7717	26.7491	25.5982	24.8145	25.7285
250060	0.8105	0.7717	25.4779	27.0354	31.0689	27.5302
250061	0.8608	0.7717	18.7413	25.1495	23.3006	22.3052
250067	1.0828	0.7717	25.2189	23.8027	28.2894	25.7080
250069	1.5677	0.8402	22.4194	23.4495	25.8456	23.9255
250072	1.6307	0.8191	25.5337	27.5791	30.5382	27.8695
250077	1.0270	0.7717	19.0416	19.6333	19.3962	19.3590
250078	1.5964	0.8300	22.8430	23.9598	26.5481	24.4597
250079	0.8380	0.8191	43.0845	46.0349	32.3758	41.1228
250081	1.4224	0.8402	25.6808	24.8281	23.1385	24.4903
250082	1.4526	0.7767	23.5399	25.6218	27.8096	25.8047
250084	1.1762	0.7717	19.1604	19.5694	20.1192	19.6259

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
250085	0.9510	0.7717	24.2915	24.6757	24.5765	24.5152
250093	1.2290	0.7717	23.9128	26.4351	27.0937	25.9270
250094	1.5708	0.8300	24.7718	25.4232	26.1331	25.4563
250095	1.0321	0.7717	23.6140	25.9021	30.7505	26.6686
250096	1.2796	0.8191	26.3743	27.7291	27.5206	27.2328
250097	1.5772	0.8239	22.0211	22.7916	23.6607	22.8668
250099	1.3926	0.8191	21.5656	27.5757	25.0076	24.6030
250100	1.3860	0.8402	27.0286	27.5484	28.2019	27.5965
250102	1.5609	0.8191	25.4050	25.5327	27.8758	26.2726
250104	1.4240	0.8402	24.4311	25.4008	26.3140	25.3901
250112	0.9669	0.7717	26.3357	27.4162	29.6978	27.8332
250117	1.1609	0.8300	23.7337	24.5706	26.0965	24.8279
250120	***	*	26.6522	*	*	26.6522
250122	1.1460	0.7717	27.4424	23.4908	27.3606	26.0897
250123	1.3636	0.8723	27.9058	29.8299	29.5520	29.0976
250124	0.8867	0.8191	20.5667	21.9420	22.4247	21.6647
250125	1.3275	0.8723	26.7687	32.7411	29.0819	29.1808
250126	0.9988	0.9265	25.0019	25.2581	26.8712	25.8035
250127	0.8968	1.4424	*	*	*	*
250128	0.9732	0.8163	21.7882	23.5918	24.7051	23.6810
250134	0.9334	0.8191	21.0211	22.0846	40.7995	27.2256
250136	0.9910	0.8191	25.2241	27.1479	27.8270	26.7373
250138	1.3815	0.8191	25.2642	27.3132	27.0688	26.5405
250141	1.5321	0.9265	30.5112	33.4413	32.1496	32.0762
250149	0.9588	0.7717	17.2268	17.0964	17.2423	17.1921
250151	0.6092	0.7717	22.8238	*	17.3962	20.4556
250152	0.9322	0.8191	26.4559	28.5526	29.8216	28.1432
250156	***	*	16.8659	*	*	16.8659
250157	***	*	29.6398	*	*	29.6398
250161	***	*	*	*	26.0070	26.0070
250162	1.0984	0.8737	*	*	*	*
260001	1.7138	0.8486	29.5271	31.1866	28.6690	29.7450
260004	0.9623	0.8164	21.3629	23.9584	24.1764	23.2419
260005	1.6825	0.9043	27.9477	31.1050	33.1020	30.8375
260006	1.4754	0.8164	27.3754	33.8253	34.3548	32.0541
260009	1.1937	0.9555	25.7546	26.6685	26.2248	26.2216
260011	1.6354	0.8868	27.5762	31.2612	31.4415	30.1665
260015	1.1583	0.8164	25.0640	25.0250	25.1585	25.0839
260017	1.3478	0.8868	25.0461	26.2621	27.4586	26.2580
260020	1.7345	0.9043	29.3080	30.9599	32.0889	30.8198
260021	1.5210	0.9043	32.6735	19.5810	19.3770	22.9709
260022	1.2836	0.8570	24.8713	25.9391	25.6866	25.4984

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
260023	1.4153	0.9043	25.4314	25.5899	26.7586	25.9551
260024	1.1686	0.8164	19.2199	20.7136	22.4347	20.7987
260025	1.4287	0.8924	24.0358	24.5042	24.4959	24.3405
260027	1.7446	0.9555	29.3811	31.0236	32.3066	30.8152
260032	1.8891	0.9043	27.4857	28.7183	29.8257	28.6938
260034	0.9891	0.8164	27.1685	28.7736	29.7821	28.6040
260040	1.7348	0.8586	25.9074	27.3680	28.5035	27.2455
260047	1.4174	0.8164	26.6343	27.2667	27.1986	27.0392
260048	1.2162	0.9555	28.1515	29.6969	30.1691	29.3742
260050	1.1266	0.8164	26.2346	27.8065	27.6085	27.2807
260052	1.3082	0.9043	27.6360	29.6998	31.5722	29.7020
260057	1.1162	0.9555	21.5925	23.8181	27.0128	24.3353
260059	1.3213	0.8241	22.3885	25.3025	26.9521	24.9482
260061	1.1521	0.8164	22.8589	23.6717	24.7824	23.7431
260062	1.2852	0.9555	28.4975	29.6156	30.7159	29.6514
260064	1.3734	0.8444	23.3498	21.4932	23.6002	22.8283
260065	1.7136	0.8586	29.3564	28.3411	29.9325	29.2185
260068	1.6419	0.8571	27.3475	28.1246	29.3972	28.2866
260070	0.9228	0.8164	21.9701	25.2997	26.2370	24.6742
260074	1.1892	0.8444	28.0468	28.6216	28.4171	28.3743
260077	1.6916	0.9043	27.6624	28.7204	28.9940	28.4720
260078	1.2647	0.8164	21.1539	23.1785	24.7794	23.0607
260080	1.1006	0.8164	18.6070	18.6813	19.0041	18.7557
260081	1.5997	0.9043	29.1890	32.0799	34.8761	32.0815
260085	1.5578	0.9555	28.0306	29.6514	30.4727	29.3632
260091	1.5380	0.9043	28.5473	30.2636	32.9623	30.6422
260094	1.7350	0.8586	23.8654	25.1491	27.0127	25.3574
260095	1.5171	0.9555	27.6196	29.9090	30.9142	29.4345
260096	1.5480	0.9555	30.7267	32.9383	33.1804	32.3036
260097	1.1909	0.8464	25.5634	27.3129	28.2444	27.0631
260102	1.0197	0.9555	26.7624	30.7678	29.1467	28.8755
260104	1.6558	0.9043	28.0235	29.5891	32.0122	29.9289
260105	1.7897	0.9043	29.4766	32.4292	33.4278	31.7109
260107	***	*	27.9710	29.7775	38.3668	31.7478
260108	1.8342	0.9043	27.0758	28.5654	30.1064	28.5847
260110	1.6498	0.8940	26.6030	28.0381	28.5364	27.7426
260113	1.2035	0.8322	21.8884	23.0826	23.6758	22.8417
260115	1.1975	0.9043	24.6389	25.5658	26.5268	25.5835
260116	1.0586	0.8322	20.7479	22.5536	25.1758	22.7061
260119	1.3354	0.8684	31.5490	31.5003	26.4382	29.7128
260137	1.8051	0.8486	27.6592	31.4091	28.3521	29.1269
260138	1.9625	0.9555	30.6284	31.7582	33.4156	31.9600

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
260141	2.0088	0.8571	25.5663	26.6684	28.3492	26.9580
260142	1.1792	0.8164	21.7609	22.8205	25.0940	23.3047
260147	0.8853	0.8164	22.1928	22.9689	22.8326	22.6481
260159	***	*	23.9515	24.3027	25.5039	24.5914
260160	1.0657	0.8308	25.5096	26.6715	27.9585	26.8675
260162	1.4366	0.9043	28.4660	30.5761	32.3673	30.4711
260163	1.2937	0.8251	21.5566	23.8644	25.0443	23.5119
260166	***	*	28.5858	29.5259	30.6020	29.5760
260175	1.0799	0.9555	24.6064	25.7069	26.5767	25.6404
260176	1.6938	0.9043	31.1056	30.6205	32.4957	31.4251
260177	1.2460	0.9555	28.7942	29.0815	31.1662	29.7008
260178	2.0287	0.8571	27.1201	26.9902	28.9170	27.7063
260179	1.5715	0.9043	28.3234	29.6316	30.3276	29.4304
260180	1.6616	0.9043	29.3820	30.7336	31.4721	30.5093
260183	1.6669	0.8940	29.2684	31.4916	32.2621	31.0410
260186	1.4540	0.8868	28.8610	29.1874	30.8706	29.6519
260190	1.2417	0.9555	30.5343	30.9003	32.2069	31.2048
260191	1.5435	0.9043	26.3244	27.8648	28.7185	27.6896
260193	1.2592	0.9555	28.1060	29.5436	30.5190	29.3869
260195	1.3064	0.8164	24.0411	25.0294	25.6697	24.9047
260198	***	*	27.2555	27.9093	31.4660	28.7621
260200	1.4024	0.9043	27.4784	30.5032	32.0910	30.2458
260207	1.1350	0.8586	22.9579	23.6392	22.8308	23.1539
260209	1.1108	0.8868	25.0749	26.4203	33.7185	28.4829
260210	1.2388	0.9043	30.5975	36.4055	33.5701	33.2794
260211	1.3993	0.9555	35.9113	37.1557	42.4297	38.2821
260213	***	*	34.8953	*	*	34.8953
260214	1.2467	0.9555	*	31.0175	31.7957	31.3933
260216	1.3063	0.9555	*	*	32.4039	32.4039
260217	***	*	*	*	12.2879	12.2879
260219	1.2780	0.9043	*	*	*	*
260220	3.6835	0.8486	*	*	*	*
260221	2.3337	0.8586	*	*	*	*
260222	2.2476	0.9555	*	*	*	*
270002	1.2003	0.8296	25.2907	28.3379	26.9419	26.8653
270003	1.2487	0.8364	29.1938	28.0543	28.5127	28.5447
270004	1.6838	0.9021	26.6779	28.5869	29.4694	28.2746
270011	1.1209	*	24.4696	*	*	24.4696
270012	1.5883	0.8364	26.5854	28.0672	27.9087	27.5357
270014	1.9544	0.9066	27.4811	28.2582	30.1101	28.6210
270017	1.2846	0.8916	27.4150	29.3542	29.4260	28.6983
270023	1.5407	0.9066	26.3076	28.1896	30.9908	28.4312

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
270032	1.0024	0.8296	20.4330	21.6360	21.5106	21.2040
270049	1.7989	0.9021	28.6880	29.8891	31.3941	30.0459
270051	1.5007	0.8916	24.9371	29.3941	29.1163	27.7801
270057	1.3472	0.8296	27.1838	28.3627	29.5317	28.4309
270074	0.9280	1.4424	*	*	*	*
270081	1.0515	*	20.0438	*	*	20.0438
270086	1.4294	0.8364	20.7976	21.9017	27.3995	23.1322
270087	1.5455	0.8296	24.8022	24.9197	24.2168	24.6113
270088	1.6143	0.9021	*	*	*	*
280003	1.7510	0.9405	30.1057	32.3780	33.7700	32.0041
280009	1.8003	0.9257	29.3634	28.1559	31.9280	29.8086
280013	1.7312	0.9547	27.9523	30.3120	31.9793	30.1149
280020	1.6230	0.9405	32.3896	29.4831	30.3731	30.6730
280023	1.3434	0.9257	29.5132	30.0717	31.9420	30.5140
280030	1.8262	0.9547	30.6991	31.8758	33.4544	31.9803
280032	1.3492	0.9257	24.7539	25.6549	25.8707	25.4247
280040	1.6103	0.9547	29.5276	30.7406	32.1005	30.7877
280060	1.7504	0.9547	30.3049	30.4625	32.0607	30.9598
280061	1.4769	0.9209	26.4824	28.9591	29.2231	28.2494
280065	1.2898	0.9439	28.0132	29.5470	30.1143	29.2024
280077	1.3185	0.9257	28.2206	29.9223	29.7362	29.3142
280081	1.6725	0.9547	31.1212	28.9696	31.0768	30.3818
280105	1.2192	0.9547	29.8488	30.0472	33.3196	31.1284
280111	1.1563	0.8662	27.4853	28.3541	29.0865	28.3037
280119	0.8360	1.4424	*	*	*	*
280123	***	*	22.2185	20.2741	20.6384	20.8926
280125	1.5106	0.8662	23.2900	24.7466	25.1212	24.4228
280127	1.8858	0.9405	25.6806	26.5659	28.4607	27.0728
280128	2.8447	0.9405	28.8734	27.1024	19.2781	24.8563
280129	2.0467	0.9547	27.8793	27.9511	30.4258	28.8742
280130	1.4113	0.9547	29.8588	29.9645	32.4243	30.8836
280131	***	0.9547	*	*	*	*
290001	1.7319	1.0270	35.5113	33.3318	32.3610	33.6801
290002	0.9345	1.0145	23.9348	22.7362	25.4458	24.0582
290003	1.7724	1.1812	32.8182	34.6433	36.8494	34.8131
290005	1.5214	1.1812	31.7107	34.2373	34.2514	33.3753
290006	1.0892	1.0270	31.9838	33.3243	32.9232	32.7695
290007	1.7953	1.1812	39.7323	41.2395	44.0851	41.7270
290008	1.2515	1.0026	31.1116	33.2473	36.1620	33.5079
290009	1.6985	1.0270	32.3348	34.2103	38.6692	34.8333
290012	1.4489	1.1812	35.7988	38.3731	38.1494	37.4471
290019	1.5018	1.0315	30.5964	32.2817	34.3215	32.5048

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
290020	0.9720	1.0026	27.6277	27.2908	25.3592	26.7660
290021	1.6492	1.1812	36.7310	36.8728	39.5976	37.7346
290022	1.7381	1.1812	33.5330	38.8262	40.9896	37.6742
290027	0.8915	1.0026	23.9818	29.1123	25.1315	25.7779
290032	1.4063	1.0270	34.6589	36.9175	38.9632	36.8201
290039	1.5566	1.1812	34.9622	34.6359	37.5722	35.7977
290041	1.5093	1.1812	37.6077	38.4445	40.0602	38.7894
290042	***	*	22.4859	*	*	22.4859
290045	1.7766	1.1812	34.4584	38.2560	38.5440	37.1800
290046	1.4656	1.1812	38.7966	38.3112	41.5550	39.6568
290047	1.5656	1.1812	33.4695	35.6381	38.6892	35.9431
290049	1.4106	1.0270	26.0725	33.4278	33.2014	31.1789
290051	2.0373	1.0315	*	32.5277	37.2727	34.7328
290053	1.6839	1.1812	*	*	*	*
290054	1.2788	1.1812	*	*	*	*
290055	***	1.0315	*	*	*	*
300001	1.5197	1.0525	29.8145	31.0122	31.4533	30.8159
300003	2.0504	1.0525	37.0886	37.7246	37.3007	37.3733
300005	1.4019	1.0525	27.8431	28.8402	29.4927	28.7597
300011	1.3668	1.0961	31.8928	33.0785	32.7459	32.5825
300012	1.3995	1.0961	31.2655	33.0569	34.8519	33.1365
300014	1.2275	1.0525	29.1847	30.7735	32.8211	30.9923
300017	1.2612	1.0867	31.6699	33.4164	35.2028	33.4385
300018	1.3426	1.0525	31.7891	31.5028	32.7008	32.0403
300019	1.2770	1.0961	28.2287	28.3114	30.5332	29.1012
300020	1.2596	1.0961	30.9783	32.4655	34.7678	32.8202
300023	1.4921	1.0525	31.2726	32.3202	34.2636	32.6727
300029	1.8723	1.0867	31.4429	32.0033	35.3112	32.9675
300034	1.8110	1.0961	31.6880	33.5537	33.7397	33.0325
310001	1.8211	1.3005	39.3391	41.4946	44.8619	41.9014
310002	1.8480	1.2694	37.8652	37.9484	39.7599	38.5483
310003	1.2851	1.3005	39.0785	40.1543	39.8679	39.7203
310005	1.3653	1.1341	33.6311	34.7657	34.4087	34.2878
310006	1.4778	1.3005	28.7321	30.4296	29.1025	29.4421
310008	1.4124	1.3005	33.3172	34.3268	36.2903	34.6668
310009	1.4222	1.2694	33.6165	35.4624	37.9098	35.6657
310010	1.3029	1.1341	33.7009	36.0823	34.1071	34.6216
310011	1.2635	1.1341	34.3497	37.4855	34.0850	35.2683
310012	1.5820	1.3005	39.8568	41.9630	41.3814	41.0788
310013	***	*	35.6260	32.9488	*	34.3351
310014	1.8604	1.1341	32.9016	35.0124	39.7527	35.9945
310015	1.9526	1.2694	39.2928	40.8229	39.5076	39.8655

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
310016	1.3298	1.3005	38.2740	41.0363	39.7563	39.6602
310017	1.3448	1.2694	35.7308	35.9806	34.8881	35.5276
310018	1.1786	1.2694	32.9704	32.6956	33.5069	33.0673
310019	1.5544	1.3005	30.6369	31.8930	34.6618	32.3826
310020	***	*	37.3372	38.4266	34.8440	36.8977
310021	1.6643	1.1341	31.6562	32.2064	33.2554	32.3743
310022	1.3422	1.1341	31.1951	32.8079	32.8154	32.2740
310024	1.4475	1.1341	33.8622	36.8666	34.7011	35.1512
310025	1.4099	1.3005	32.2630	32.1481	35.2564	33.1779
310026	1.2488	1.3005	30.1392	30.1321	31.9905	30.7353
310027	1.5509	1.1341	31.5967	34.6471	34.1653	33.4733
310028	1.1675	1.1341	33.9911	34.8332	37.2987	35.4152
310029	1.8232	1.1341	33.6695	35.2084	36.5179	35.1406
310031	2.8500	1.1341	39.3783	39.5911	38.2643	39.0903
310032	1.3727	1.1341	33.0258	35.2402	35.8019	34.6881
310034	1.4456	1.1341	32.7523	36.8614	37.1191	35.5466
310037	1.3090	1.3005	38.2865	40.4642	44.3134	40.8592
310038	1.9228	1.2694	36.3344	39.8707	40.7395	39.0018
310039	1.3348	1.2694	33.2100	32.6425	33.4253	33.0853
310040	1.2607	1.3005	37.7945	41.2246	38.3232	39.0618
310041	1.3298	1.1341	33.9799	35.2009	34.4308	34.5396
310044	1.3853	1.1341	33.7614	33.5868	35.9981	34.4361
310045	1.6244	1.3005	38.4424	39.2097	40.3222	39.3542
310047	1.3194	1.1341	37.3695	37.7220	38.1213	37.7451
310048	1.4282	1.1341	33.9506	34.5256	33.9641	34.1448
310050	1.3393	1.2694	32.3686	37.9214	32.5213	34.0930
310051	1.5305	1.1341	38.1174	39.7671	37.9104	38.5967
310052	1.3898	1.1341	33.5849	36.5494	36.2042	35.4734
310054	1.4187	1.2694	36.9095	38.2432	37.2851	37.4826
310057	1.4337	1.1341	31.8933	34.2052	32.8649	32.9659
310058	1.0839	1.3005	30.4080	30.4436	32.1349	30.9797
310060	1.2940	1.1341	27.8242	27.9134	30.4626	28.7274
310061	1.2783	1.1341	39.0538	33.5586	33.6084	35.5102
310063	1.4103	1.1341	33.8519	38.1481	36.7131	36.1697
310064	1.5678	1.1341	38.6310	39.8091	39.9456	39.4895
310069	1.2298	1.1341	34.4669	35.1376	36.9367	35.5109
310070	1.4413	1.2694	36.3279	36.9999	36.8951	36.7447
310073	1.7924	1.1341	34.2858	36.9249	37.5317	36.2733
310074	1.3726	1.3005	39.6196	39.0729	35.9044	38.2126
310075	1.3970	1.1341	32.5338	33.5253	33.8979	33.3200
310076	1.7144	1.2694	37.5163	38.1671	39.0325	38.2365
310081	1.3099	1.1341	31.0699	31.7981	32.1241	31.6676
310083	1.3697	1.2694	31.9151	28.3406	28.2875	29.3819
310084	1.2852	1.1341	32.6051	34.9626	34.3130	33.9543
310086	1.2532	1.1341	29.8794	30.9467	31.4837	30.7820
310088	1.1450	1.1341	30.3552	31.2437	28.1703	29.9380
310090	***	*	33.4615	33.9174	36.2502	34.5191
310091	1.1575	1.1341	31.9762	35.2913	34.8679	34.0174
310092	1.5445	1.1341	32.7054	32.8431	34.8028	33.4700
310093	1.2441	1.2694	30.2860	32.3860	33.4460	32.0464
310096	1.8766	1.2694	35.0707	34.2014	36.3201	35.2111
310105	1.2394	1.3005	32.5672	32.0277	31.3423	31.9709
310108	1.4508	1.2694	34.5866	36.2848	38.3403	36.4174
310110	1.3335	1.1341	33.4809	35.6825	36.5227	35.2678
310111	1.2838	1.1341	34.8284	36.0748	38.3519	36.4531
310112	1.3354	1.1341	32.2676	34.5337	33.6207	33.4521
310113	1.3080	1.1341	33.6771	35.0245	38.0066	35.6459
310115	1.3215	1.1341	31.9208	32.1197	33.7061	32.6067
310116	1.2914	1.3005	29.8144	27.8677	35.3805	30.7994
310118	1.4057	1.3005	31.2296	32.8286	33.2234	32.4388
310119	1.8872	1.2694	41.5702	41.2997	46.1339	42.9802
310120	1.1045	1.1341	33.3861	35.1661	36.3365	34.9295
310122	***	*	41.9029	*	*	41.9029
310123	***	*	37.1022	*	*	37.1022
310124	***	*	41.8827	*	*	41.8827
310125	***	*	36.2186	*	*	36.2186
310126	***	*	*	34.3189	*	34.3189
310127	***	*	*	*	40.1255	40.1255
320001	1.7469	0.9554	30.0077	31.4193	33.6433	31.7555
320002	1.4888	1.0574	33.1342	34.1610	35.6036	34.3278
320003	1.1527	1.0144	31.4473	31.5792	31.4445	31.4921
320004	1.2873	0.8964	26.2073	28.2407	30.5543	28.3918
320005	1.5147	0.9371	28.7893	25.2168	26.4658	26.7181
320006	1.2953	0.9371	28.0964	28.5177	31.6888	29.4892
320009	1.6468	0.9554	27.8084	31.3296	31.7240	30.2848
320011	1.2204	0.9301	27.9522	28.9951	30.6151	29.1908
320013	1.1896	1.0144	30.5865	31.2890	31.7159	31.2149
320014	1.0312	0.8964	28.7089	30.4803	29.8578	29.6819
320016	1.1768	0.8964	27.1492	26.6392	27.7121	27.1840
320017	1.3330	0.9554	33.3496	30.5787	30.9261	31.4180
320018	1.5219	0.8988	25.9248	28.3465	29.9038	28.0213
320019	***	*	35.0217	28.7067	31.8205	32.0035
320021	1.6334	0.9554	28.8504	29.6464	31.3577	30.0573
320022	1.1405	0.8964	25.3707	27.5152	28.7195	27.2388

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
320030	1.0707	0.8964	24.4497	25.5267	28.5145	26.3182
320033	1.2166	1.0144	30.1471	30.1846	32.8631	31.0776
320037	1.2619	0.9554	25.2876	27.8982	28.6968	27.3028
320038	1.2265	0.8964	32.7192	31.6526	33.2147	32.5293
320057	0.8499	1.4387	*	*	*	*
320058	0.8144	1.4387	*	*	*	*
320059	1.0060	1.4387	*	*	*	*
320060	1.0476	1.4387	*	*	*	*
320061	0.9434	1.4387	*	*	*	*
320062	0.9142	1.4387	*	*	*	*
320063	1.3091	0.9458	26.0104	27.4946	30.2997	27.9382
320065	1.2953	0.9458	25.7945	26.9130	27.9999	26.9172
320067	0.9186	0.8964	24.7025	25.4121	23.6677	24.5902
320069	1.0456	0.8964	23.9863	25.3151	26.5521	25.2741
320070	0.9494	1.4387	*	*	*	*
320074	1.3074	0.9554	28.4396	28.8088	29.8317	29.0615
320079	***	*	27.6877	31.5661	30.3600	29.9031
320083	2.2696	0.9554	29.5483	32.9476	35.1125	32.3921
320084	0.9736	0.8964	22.7706	24.2902	25.9161	24.4550
320085	1.6864	0.8988	27.4100	28.4537	28.7114	28.2195
320086	1.3534	0.8964	*	*	*	*
320087	1.7232	1.0574	*	*	*	*
320088	2.6497	0.8988	*	*	*	*
330002	1.6978	1.3190	32.1956	34.7270	35.3553	34.1020
330003	1.4220	0.8805	25.2223	26.8363	27.7173	26.5905
330004	1.3373	1.0983	30.2236	30.3221	30.8305	30.4614
330005	1.6639	0.9800	31.5030	33.2851	34.1019	32.9703
330006	1.3884	1.3190	34.2001	36.3305	38.6645	36.3822
330008	1.1656	0.9800	25.2005	26.2141	26.7882	26.0607
330009	1.4044	1.3190	38.9166	41.3797	42.4137	40.9294
330010	1.0215	0.8541	19.7098	20.5805	24.3033	21.5043
330011	1.3068	0.8965	27.4747	26.8269	29.2672	27.8770
330013	1.9166	0.8805	26.8382	28.8039	29.2399	28.3223
330014	1.3853	1.3190	45.7619	46.3170	48.1054	46.7312
330016	***	*	23.0769	*	*	23.0769
330019	1.2623	1.3190	39.7429	44.5669	46.8153	43.6523
330023	1.5109	1.2875	36.4736	37.5135	40.9595	38.3939
330024	1.9004	1.3190	43.2342	44.8070	46.2954	44.8044
330025	1.0358	0.9800	23.2424	24.2702	26.5550	24.6990
330027	1.3567	1.2875	45.1920	45.9571	49.0573	46.6599
330028	1.6539	1.3190	36.2901	38.0149	38.7770	37.7002
330029	0.5859	0.9800	24.0679	22.9332	23.7555	23.5734

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
330030	1.2250	0.8814	25.3454	25.5089	27.4344	26.1077
330033	1.1279	0.8697	24.8022	25.0215	26.7551	25.5245
330036	1.2319	1.3190	30.3757	30.4659	31.2701	30.7186
330037	1.1440	0.8814	21.9246	23.4915	24.4428	23.2696
330041	1.4242	1.3190	36.9934	37.1651	41.2299	38.3061
330043	1.4450	1.2718	38.8060	40.6094	42.4560	40.5594
330044	1.3944	0.8695	28.2293	28.2638	29.4872	28.6660
330045	1.4592	1.2718	40.0326	41.6565	44.7551	42.1422
330046	1.4134	1.3190	47.4975	52.2397	53.4532	50.9912
330047	1.2124	0.8541	24.9934	22.9948	27.4392	25.1831
330049	1.5474	1.2515	34.8585	34.9740	38.0110	36.0057
330053	1.1418	0.8814	21.8383	20.1303	21.4837	21.0993
330055	1.6065	1.3190	42.2007	44.2343	44.6905	43.7371
330056	1.6186	1.3190	38.8910	39.9662	40.5499	39.7928
330057	1.6698	0.8805	27.7121	30.1821	30.5006	29.4794
330058	1.2904	0.8814	22.6852	23.6296	25.3712	23.9194
330059	1.5820	1.3190	44.9162	45.3691	47.7115	46.0330
330061	1.2140	1.3190	37.8828	37.8649	38.8790	38.2197
330064	1.3838	1.3190	38.2332	41.5737	39.5994	39.8301
330065	1.0754	0.9800	24.4004	26.2288	28.6809	26.4269
330066	1.3306	0.8805	25.8174	27.2085	30.7011	27.8429
330067	1.4022	1.2515	29.2571	30.7537	31.5572	30.4995
330072	1.4768	1.3190	39.6996	41.4605	40.5965	40.5759
330073	1.1738	0.8814	23.4020	25.1392	24.8055	24.4584
330074	1.1760	0.8814	23.4576	23.1016	24.6973	23.7220
330075	1.1863	0.9854	24.2552	23.7522	27.5360	25.1965
330078	1.4914	0.9800	27.2870	27.6682	30.8157	28.5988
330079	1.3765	0.9404	24.9941	27.9479	28.7349	27.2020
330080	1.2022	1.3190	38.9405	40.2067	47.4529	42.2944
330084	1.1086	0.8474	25.6880	27.3434	28.8661	27.3153
330085	1.1677	0.9492	26.6235	27.1707	27.7050	27.1897
330086	1.5104	1.3190	35.5269	40.9768	44.0362	40.2496
330088	1.0072	1.2718	35.3871	37.4716	41.8635	38.1566
330090	1.4753	0.9261	26.8730	27.7306	29.5626	28.0577
330091	1.3851	0.9800	27.0040	28.3034	30.9457	28.7618
330094	1.2726	1.0260	26.9148	28.6213	33.0706	29.5088
330096	1.1944	0.8474	24.2422	24.7895	24.8667	24.6342
330100	1.0959	1.3190	39.6244	39.3170	38.6625	39.1932
330101	1.9607	1.3190	43.7944	45.5412	49.6431	46.3448
330102	1.4768	0.9800	26.6887	27.2543	31.6270	28.4487
330103	1.2692	0.8605	24.5585	25.4919	26.1064	25.3901
330104	1.4086	1.3190	35.1076	36.5894	38.4254	36.6691

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
330106	1.6464	1.2841	46.3657	48.2903	47.2240	47.2955
330107	1.2407	1.2718	35.7384	38.0262	40.2541	37.9769
330108	1.1153	0.8474	23.9368	25.3023	25.5480	24.9093
330111	0.9946	0.9800	40.4349	23.2134	25.1572	27.3535
330115	1.2014	0.9854	23.8235	24.3898	27.0362	25.1062
330119	1.8425	1.3190	42.2901	41.2365	43.8894	42.4467
330125	1.8230	0.8814	28.0584	29.4817	30.4389	29.3549
330126	1.3626	1.2875	36.5689	37.7807	40.0542	38.1472
330127	1.3966	1.3190	45.2993	45.2554	51.8817	47.4771
330128	1.2789	1.3190	41.7790	43.3437	41.7875	42.2926
330132	1.1340	0.8605	21.7648	22.1452	23.4437	22.4489
330133	1.3595	1.3190	38.5228	39.9025	*	39.1945
330135	1.2423	1.1908	32.0525	33.2314	35.3624	33.5938
330136	1.5602	0.9492	26.6680	25.4198	27.9525	26.6853
330140	1.8110	0.9854	29.3461	31.1333	32.7905	31.1114
330141	1.3420	1.2718	39.3741	39.1733	41.4127	40.0138
330144	0.9667	0.8530	23.3874	24.9304	26.0623	24.7483
330151	1.3372	0.8530	19.7959	21.6339	23.4664	21.6185
330152	1.3918	1.3190	38.2079	39.5754	45.9310	40.9912
330153	1.6674	0.8805	28.4446	28.9944	31.7611	29.7361
330154	1.6868	*	*	*	*	*
330157	1.3318	0.9492	27.1432	29.7622	30.2745	29.0548
330158	1.8491	1.3190	41.7010	39.5946	41.6800	40.9928
330159	1.3442	0.9854	31.7835	33.8484	35.6944	33.7894
330160	1.5891	1.3190	37.1915	39.0970	42.1789	39.4648
330162	1.3012	1.3190	37.6226	38.7638	39.3460	38.6041
330163	1.1499	0.9800	28.3910	28.6252	26.3050	27.7728
330164	1.5125	0.8814	27.8746	29.8458	30.3023	29.3919
330166	0.9895	0.8474	20.7121	22.8506	23.2773	22.2899
330167	1.6734	1.2875	39.1251	39.2421	40.8753	39.7618
330169	1.4033	1.3190	46.4939	47.5404	49.7924	47.8578
330171	***	*	35.1577	*	*	35.1577
330175	1.1400	0.8734	24.1005	26.7883	28.2085	26.3622
330177	1.0241	0.8474	22.9834	23.4299	26.0397	24.1397
330180	1.2656	0.8805	25.4170	26.8658	28.0975	26.8172
330181	1.3412	1.2875	43.0977	46.2181	47.2523	45.4811
330182	2.2325	1.2875	41.3033	42.7962	46.6346	43.5697
330184	1.4050	1.3190	39.0437	39.7242	41.3935	40.0548
330185	1.3391	1.2718	38.4002	39.6724	41.3543	39.8210
330188	1.2661	0.9800	27.5988	29.7318	30.7222	29.3714
330189	0.9949	0.8805	22.4383	25.8125	26.4233	24.9033
330191	1.3428	0.8805	26.4328	28.2949	29.3753	28.0871

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
330193	1.4968	1.3190	39.8910	40.0280	40.7257	40.2246
330194	1.7547	1.3190	46.8880	49.8886	49.9208	48.9052
330195	1.6714	1.3190	41.7885	43.3213	46.0878	43.7114
330196	1.4204	1.3190	38.2525	38.6949	42.8106	39.9769
330197	1.0795	0.8474	25.9872	26.5525	27.6437	26.7546
330198	1.4522	1.2875	34.8985	35.8715	37.9641	36.3109
330199	1.1689	1.3190	40.3948	39.4076	47.5059	42.4501
330201	1.7436	1.3190	42.6707	46.5114	51.2179	46.8656
330202	1.3173	1.3190	37.4158	38.7624	42.1074	39.4801
330203	1.4671	0.9854	34.0499	34.6525	33.9161	34.2036
330204	1.4490	1.3190	41.9953	39.5324	44.8153	42.1096
330205	1.2381	1.1908	33.9418	35.3792	37.0171	35.4769
330208	1.2740	1.3190	33.5287	37.1735	38.7279	36.4281
330211	1.1795	0.8474	25.8752	24.9432	25.6929	25.5080
330213	1.0900	0.8474	27.4890	28.5370	30.0957	28.7098
330214	1.8808	1.3190	42.1339	43.3229	43.6872	43.1105
330215	1.3047	0.8695	23.9583	26.3978	28.0026	26.0582
330218	1.0903	0.9854	26.9982	28.4113	28.4369	27.9701
330219	1.7322	0.9800	32.5658	33.2147	38.3321	34.6200
330221	1.4805	1.3190	40.0514	42.5486	40.5201	41.0685
330222	1.3615	0.8805	27.7198	28.7858	30.5142	29.0607
330223	0.9895	0.8474	26.1264	27.1970	28.2638	27.2171
330224	1.2541	1.0983	29.1738	30.4784	32.4518	30.6996
330225	1.2075	1.2875	35.7651	32.9036	33.7052	34.1540
330226	1.4006	0.8814	24.8471	26.3685	25.7981	25.6774
330229	1.2695	0.8474	23.0577	23.9243	24.9977	23.9950
330230	***	*	38.6569	39.3863	39.5043	39.1837
330231	1.1030	1.3190	44.9422	48.9021	49.1983	47.6814
330232	1.2198	0.8805	27.4639	27.9615	28.7263	28.0514
330233	1.5719	1.3190	52.7070	40.8539	43.4873	44.8326
330234	2.3835	1.3190	49.3219	49.8804	55.2159	51.5786
330235	1.1996	0.8474	29.4346	30.8034	31.2218	30.4554
330236	1.5677	1.3190	42.8981	42.6205	45.0321	43.5088
330238	1.2127	0.8814	21.8386	23.3953	24.7086	23.3363
330239	1.2587	0.8474	23.1885	24.6391	24.7255	24.1734
330240	1.2517	1.3190	40.5001	41.6132	42.5871	41.6001
330241	1.8174	0.9854	32.7683	32.9275	34.7013	33.4609
330242	1.3282	1.3190	36.9015	38.7875	40.2224	38.6288
330245	1.6935	0.8695	27.4326	28.6698	29.3183	28.5061
330246	1.3355	1.2718	35.7416	35.9577	39.4705	37.0856
330247	1.0217	1.3190	39.0219	41.3465	39.8390	40.0457
330249	1.3619	0.9854	24.6091	26.9856	29.4003	27.0031

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
330250	1.3872	1.0206	29.0080	29.6186	32.1740	30.2746
330259	1.5187	1.2875	36.4788	39.0213	38.5914	37.9800
330261	1.2797	1.3190	40.2579	38.0216	37.9563	38.6164
330263	1.0225	0.8474	24.1333	24.2125	25.5991	24.6614
330264	1.4062	1.1908	31.0557	32.5050	35.1876	32.9336
330265	1.2565	0.8814	23.9081	22.7433	22.8141	23.1292
330267	1.5240	1.3190	34.9885	35.3907	38.1619	36.2725
330268	0.8926	0.8474	23.8793	23.9135	25.7738	24.5382
330270	2.1208	1.3190	55.2136	52.3154	55.7360	54.4653
330273	1.3931	1.3190	35.9298	39.7880	41.3568	39.0446
330276	1.0990	0.8510	26.0935	27.0445	28.5781	27.2435
330277	1.1935	0.9261	30.9053	30.8156	30.8543	30.8592
330279	1.7026	0.9800	29.6385	31.2393	33.7210	31.5272
330285	1.9061	0.8814	31.1235	31.8987	33.0830	32.0621
330286	1.3472	1.2718	37.6040	38.8556	40.3250	38.9536
330290	1.6594	1.3190	40.6933	39.8036	43.2989	41.2518
330304	1.3013	1.3190	37.3537	39.4632	39.7987	38.9114
330306	1.4666	1.3190	38.7713	39.0409	40.3216	39.3904
330307	1.2798	1.0014	29.5885	30.8121	33.6277	31.3238
330314	***	*	28.1788	22.6885	38.7241	26.5095
330316	1.3040	1.3190	37.1766	37.9357	40.3783	38.5215
330331	1.3291	1.2875	41.2694	44.1734	44.3947	43.3044
330332	1.3587	1.2875	37.0111	38.6932	40.8557	38.8521
330339	1.3992	0.8805	24.3066	25.0057	26.8982	25.3891
330340	1.2799	1.2718	37.4161	38.4726	38.4180	38.0983
330350	1.5276	1.3190	44.4617	44.2389	47.8575	45.5826
330353	1.3608	1.3190	45.0977	46.0215	45.8432	45.6691
330354	2.0360	*	*	*	*	*
330357	1.4087	1.3190	40.3850	40.2132	45.4617	41.4880
330372	1.2862	1.2875	35.1297	37.0323	40.3348	37.4455
330385	1.1438	1.3190	49.0859	47.4017	51.5393	49.3819
330386	1.3174	1.1238	33.3216	32.9990	35.2560	33.8458
330389	1.7997	1.3190	39.6871	37.5908	39.3586	38.8672
330390	1.3413	1.3190	35.5562	38.7652	35.4546	36.5011
330393	1.7006	1.2718	39.2186	38.9324	40.1511	39.4590
330394	1.6089	0.8965	28.4597	28.8074	30.5684	29.2988
330395	1.4434	1.3190	37.5791	50.1316	41.6484	42.5301
330396	1.4391	1.3190	39.4904	39.1956	41.6293	40.1402
330397	1.5843	1.3190	41.4448	41.1682	41.0651	41.2407
330399	1.2438	1.3190	36.7626	39.8023	41.7487	39.4273
330401	1.3730	1.2718	40.4485	41.7839	47.0780	43.0587
330403	0.9708	0.8814	25.2937	28.7282	26.7473	26.7852

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
330404	1.0396	1.3190	*	36.1069	36.8792	36.4853
330405	1.0229	1.3190	*	35.2720	38.6588	36.5260
330406	1.0353	0.8805	*	28.2733	28.0950	28.1837
330407	1.0352	0.8805	*	*	*	*
340001	1.5066	0.9320	29.5709	29.9718	30.6910	30.1025
340002	1.7529	0.9082	29.6622	30.7403	31.6973	30.7139
340003	1.3269	0.8593	26.0888	26.6831	28.0732	27.0128
340004	1.4984	0.9151	27.5283	27.9200	30.6110	28.7026
340008	1.2936	0.9310	27.7206	29.0661	30.7569	29.2058
340010	1.4513	0.9241	28.7544	29.5232	31.0327	29.8051
340011	1.1552	0.8593	22.0047	22.5152	23.6040	22.7123
340012	1.2986	*	24.7576	24.9271	*	24.8430
340013	1.2840	0.9320	26.3607	26.9152	29.2509	27.5121
340014	1.6688	0.8960	27.8384	29.5350	29.4771	28.9759
340015	1.4709	0.9320	28.3928	30.0979	30.7573	29.7457
340016	1.3780	0.8593	27.2365	27.9651	27.2226	27.4702
340017	1.3498	0.9082	27.5672	28.4866	28.4785	28.1787
340020	1.2554	0.8749	27.5473	28.3461	30.5510	28.8310
340021	1.4180	0.9320	29.3835	31.3630	32.5625	31.1411
340023	1.4340	0.9308	26.2716	27.6921	29.5911	27.8946
340024	1.2572	0.8770	26.4001	26.9001	27.4770	26.9269
340025	1.2846	0.9082	24.0101	25.2846	25.8195	25.0532
340027	1.2932	0.9242	26.3840	26.6528	27.2788	26.7742
340028	1.5251	0.9458	30.7591	31.9872	31.7634	31.4999
340030	2.0257	0.9590	30.4591	31.2051	31.5786	31.1002
340032	1.5629	0.9320	28.7636	29.2080	29.3927	29.1302
340035	1.0591	0.8593	24.6262	26.0846	26.8821	25.8659
340036	1.2453	0.9535	27.3860	29.0646	29.9160	28.8281
340037	1.2327	0.8755	29.0618	30.5362	32.0484	30.6131
340038	1.2027	0.8846	24.2111	26.2600	26.9487	25.8553
340039	1.2981	0.8960	27.8228	29.5069	30.2952	29.2140
340040	1.8720	0.9346	28.7434	30.1280	31.3866	30.1209
340041	1.4092	0.8937	26.8314	27.1285	27.8408	27.2766
340042	1.2511	0.8593	25.6349	27.0597	27.0729	26.6107
340047	1.7947	0.8960	28.4968	28.7620	30.6701	29.2970
340049	1.8486	0.9590	29.6826	31.5555	35.4171	32.3050
340050	1.3256	0.9310	27.5274	29.2290	30.4447	29.1009
340051	1.2515	0.8741	24.4561	25.4981	25.4162	25.1278
340053	1.5897	0.9320	28.9355	30.8342	30.9274	30.2606
340055	1.3259	0.8937	26.5752	29.0116	29.5040	28.3036
340060	1.1252	0.9151	25.1791	26.8387	27.3403	26.4757
340061	1.7855	0.9590	29.8574	31.2910	33.4821	31.5724

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
340064	1.2448	0.8593	23.9701	25.0814	27.2184	25.4849
340068	1.3681	0.8680	23.6757	24.7409	27.3499	25.3073
340069	1.8150	0.9590	31.4951	32.2171	32.5361	32.1086
340070	1.2650	0.9042	26.6546	27.7679	29.0391	27.8531
340071	1.1624	0.9535	27.9748	29.7343	31.3756	29.8358
340072	***	*	24.1350	*	*	24.1350
340073	1.7585	0.9590	31.6803	33.1054	33.2705	32.6950
340075	1.3200	0.8937	25.1438	26.8315	29.1504	27.0648
340084	1.1597	0.9320	23.1300	25.6885	27.4289	25.3764
340085	1.2417	0.9151	27.9572	29.1095	29.9176	29.0170
340087	1.2422	0.8593	25.4730	23.8360	25.0091	24.7827
340090	1.3516	0.9535	26.7428	28.3615	28.6805	27.9903
340091	1.6405	0.9151	28.8044	30.4371	31.2643	30.1852
340096	1.3172	0.9151	26.5438	26.5814	26.8103	26.6494
340097	1.2054	0.8593	29.8005	27.9810	29.8702	29.2104
340098	1.5287	0.9320	29.7180	31.3916	31.8472	31.0114
340099	1.3223	0.8593	23.9702	26.0077	28.1143	26.0182
340104	0.5942	0.8755	17.0165	19.9492	20.2901	19.1559
340106	1.1370	0.8593	26.1340	24.5154	24.4254	24.9477
340107	1.2404	0.8910	26.5626	27.3565	28.5859	27.5258
340109	1.2682	0.8930	26.6383	26.6479	28.6310	27.3195
340113	1.9563	0.9320	30.3841	32.3786	32.4983	31.7837
340114	1.5702	0.9590	28.1311	30.1207	32.3730	30.2667
340115	1.6831	0.9590	27.2781	28.0974	28.9265	28.1064
340116	1.6608	0.8937	29.3698	29.9447	30.8834	30.0672
340119	1.3211	0.9320	29.4470	27.2938	28.1090	28.2335
340120	1.1057	0.8593	25.5399	26.1465	26.6358	26.1106
340121	1.2208	0.9125	23.8854	25.1577	25.7488	24.9492
340123	1.3839	0.9151	28.5669	28.7150	29.9077	29.0909
340124	***	*	23.5480	25.7294	25.2498	24.6686
340126	1.3640	0.9535	28.2247	30.6902	31.7266	30.2633
340127	1.2348	0.9590	28.2161	28.8675	30.8152	29.3516
340129	1.3579	0.9320	26.7606	31.7863	27.7470	28.6367
340130	1.3664	0.9320	28.1594	29.5294	30.4887	29.4624
340131	1.4244	0.9242	28.8542	29.6571	32.1743	30.2582
340132	1.2471	0.8593	24.6162	25.3264	25.9153	25.3007
340133	1.0373	0.8853	24.8579	26.8850	27.2630	26.4263
340137	***	*	28.9672	27.0874	28.8723	28.3105
340138	0.8080	0.9590	*	*	*	*
340141	1.7271	0.9125	29.3171	29.3372	30.8628	29.8506
340142	1.2764	0.8593	27.7555	28.2413	28.4951	28.1780
340143	1.5556	0.8937	27.9777	29.3861	30.7162	29.3957

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
340144	1.2884	0.9320	27.0150	27.6548	26.5581	27.0662
340145	1.3595	0.9320	26.7482	28.0647	28.4230	27.7569
340147	1.3647	0.9535	28.2626	29.6960	30.2620	29.4121
340148	1.6298	0.8960	25.8325	27.9136	28.6607	27.5044
340151	1.2296	0.8645	23.2158	24.5782	25.9633	24.6026
340153	2.0094	0.9320	28.5979	29.8278	30.9065	29.7927
340155	1.5164	0.9590	30.9501	31.7570	31.6719	31.4648
340156	0.9295	1.4424	*	*	*	*
340158	1.1630	0.9125	27.6526	29.4110	29.2570	28.8163
340159	1.2553	0.9590	25.3108	28.1706	27.8427	27.1175
340160	1.3943	0.8593	23.4631	24.2016	24.9127	24.2270
340166	1.4417	0.9320	28.5395	29.9122	31.0779	29.8321
340168	0.6145	0.9125	*	*	*	*
340171	1.2285	0.9320	27.4701	31.1954	31.7831	30.2724
340173	1.3175	0.9590	30.2815	30.9843	30.9025	30.7396
340183	1.2409	0.9320	*	30.1261	31.4691	30.8592
340184	1.2239	0.9082	*	*	*	*
350002	1.8663	0.7968	23.5869	23.6051	25.2966	24.1518
350003	1.2813	0.7968	24.9975	24.5812	27.3546	25.6245
350006	1.5976	0.7968	22.4626	23.4343	26.6508	24.1391
350009	1.1664	*	24.5737	23.9795	*	24.2883
350010	***	*	20.4198	*	*	20.4198
350011	1.9612	0.8325	24.1135	26.0201	27.3884	25.8527
350014	***	*	17.5837	*	*	17.5837
350015	1.8126	0.7968	21.3342	22.9120	27.6960	24.0856
350017	1.2005	*	21.6187	24.0968	*	22.8560
350019	1.6853	0.8055	24.9615	24.9890	27.0960	25.7249
350030	1.0422	*	22.5976	23.1023	*	22.8546
350063	0.9123	1.4400	*	*	*	*
350064	0.6955	1.4400	*	*	*	*
350070	1.8205	0.8325	26.2454	26.2871	28.1430	26.9107
360001	1.5607	0.9395	28.8623	30.1038	31.8522	30.2849
360002	1.3364	0.8656	25.4859	25.2209	26.7549	25.8270
360003	1.8114	0.9395	30.7812	31.8976	31.9294	31.5538
360006	1.8697	1.0105	30.9806	31.8814	35.3579	32.7573
360008	1.3625	0.8720	27.5683	28.0202	28.5988	28.0813
360009	1.5514	0.9340	27.0618	28.2423	30.2452	28.5199
360010	1.2748	0.8839	24.7352	26.6040	27.3194	26.2399
360011	1.3533	0.9837	31.5587	29.9882	31.3142	30.9277
360012	1.4002	1.0105	31.0526	31.9837	32.9127	31.9734
360013	1.1420	0.9340	29.8412	30.2406	30.9331	30.3466
360014	1.1103	0.9837	27.0743	28.1811	28.9635	28.1263

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
360016	1.5707	0.9395	29.6298	30.2190	30.5892	30.1502
360017	1.7815	1.0105	31.7081	32.6006	34.8774	33.0507
360019	1.3183	0.8934	27.2997	28.8568	29.3536	28.5126
360020	1.6075	0.8934	25.6328	27.8079	29.5312	27.6267
360025	1.4739	0.9281	27.1546	28.4761	29.5329	28.3991
360026	1.3689	0.9220	25.2945	27.5757	27.3618	26.7443
360027	1.5095	0.8934	28.2923	29.9449	30.8898	29.7347
360029	1.1798	0.9455	26.4208	28.0191	29.0633	27.8577
360032	1.2136	0.8515	25.9916	27.2636	27.4896	26.9184
360035	1.6664	1.0105	31.3181	32.0858	32.5622	31.9776
360036	1.2235	0.9073	29.3514	29.9410	31.5027	30.2756
360037	1.5599	0.8934	30.0446	30.6552	31.5221	30.7317
360038	1.5793	0.9395	31.0611	31.3776	32.3095	31.5427
360039	1.4810	0.9837	24.7873	25.8216	27.3636	25.9921
360040	1.1869	0.8902	25.5337	26.7450	28.4404	26.9606
360041	1.4027	0.8934	26.6755	28.4439	29.3331	28.1333
360044	1.1592	0.8642	24.3840	24.7698	25.7011	24.9522
360046	1.2922	0.9395	26.2417	28.2972	28.5624	27.7330
360048	1.7868	0.9455	29.4378	30.0390	33.3273	30.9512
360051	1.7014	0.9220	28.1167	29.4434	30.5937	29.3959
360052	1.6230	0.9220	26.8806	28.4731	29.8072	28.3725
360054	1.3757	0.8720	24.8248	23.6606	26.8828	25.1265
360055	1.4300	0.8934	30.0143	31.4794	31.2738	30.9021
360056	1.5521	0.9395	30.3677	31.3936	31.8378	31.2300
360058	1.1201	0.8515	24.5003	25.9295	27.7073	26.0470
360059	1.6226	0.8934	30.6173	30.6294	31.3956	30.8917
360062	***	*	32.8893	32.9025	35.2065	33.6855
360064	1.6626	0.8662	27.7795	28.6101	28.5325	28.3117
360065	1.2596	0.9281	29.7155	31.5066	31.6781	30.9852
360066	1.4393	0.9340	29.7605	30.9652	32.1991	31.0056
360068	1.8538	0.9455	26.6933	28.6335	30.0212	28.4128
360070	1.7423	0.8666	27.8891	28.8739	30.0192	28.9289
360071	1.1536	0.8550	26.4081	25.7956	26.6139	26.2769
360072	1.4856	1.0105	27.2286	29.1514	29.8851	28.7621
360074	1.3374	0.9455	27.5328	28.0283	30.1333	28.5615
360075	1.3141	0.8934	26.1657	28.3930	29.8181	28.1928
360076	1.6092	0.9395	29.0148	29.5342	28.8462	29.1307
360077	1.5667	0.8934	28.0133	28.3022	26.2961	27.4910
360078	1.3208	0.8934	27.4689	27.3652	28.2973	27.7267
360079	1.8157	0.9220	30.1230	31.3132	32.0935	31.1869
360080	1.1597	0.8515	22.7020	21.8806	22.9825	22.5189
360081	1.3545	0.9455	29.5312	31.4293	33.2532	31.4016

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
360082	1.3992	0.8934	28.7925	30.5837	29.7447	29.6929
360084	1.6359	0.8666	28.5402	29.2489	29.2527	29.0256
360085	1.9807	1.0105	32.8502	33.1295	35.9664	34.0304
360086	1.6056	0.9220	27.3124	29.1579	31.9690	29.4342
360087	1.4318	0.8934	28.4185	28.6336	30.0084	29.0053
360089	1.2023	0.8515	25.5608	28.0779	28.5192	27.3210
360090	1.4398	0.9455	30.7530	29.2662	30.3175	30.0982
360091	1.3141	0.8934	27.6809	28.2009	29.6324	28.5131
360092	1.2645	1.0105	25.4055	28.0813	28.3576	27.2592
360095	1.5273	0.9340	29.3787	30.2138	30.0996	29.9024
360096	1.1435	0.8586	26.8653	27.9514	29.8687	28.2194
360098	1.4309	0.8934	26.6382	26.5839	27.6752	26.9749
360100	***	*	23.6167	25.8143	25.9628	25.0982
360101	1.4105	0.8934	29.7817	30.6650	29.4661	29.9666
360107	1.1328	0.8634	26.0534	26.8180	29.9869	27.6997
360109	1.0726	0.9837	30.1382	30.4643	30.7873	30.4698
360112	1.7901	0.9956	31.1356	32.4403	34.6063	32.7300
360113	1.2521	0.9395	30.2871	30.3914	33.3293	31.3812
360115	1.3555	0.8934	26.1821	27.9711	29.0971	27.7753
360116	1.3242	0.9395	26.4968	26.8632	29.3122	27.5366
360118	1.4846	0.9073	28.5643	29.9823	30.1189	29.5131
360121	1.2447	0.9281	28.3835	31.6766	22.1967	26.6669
360123	1.4144	0.8934	28.0334	28.5435	30.0862	28.9076
360125	1.2911	0.8515	25.9067	27.1776	28.8237	27.2834
360130	1.3791	0.8934	26.3986	28.1811	28.5433	27.6935
360131	1.4538	0.8666	26.6635	27.3426	28.3618	27.4679
360132	1.4465	0.9395	29.4070	29.8411	29.5751	29.6107
360133	1.6852	0.9395	31.7521	33.1812	33.9534	32.9691
360134	1.7627	0.9395	28.5141	29.9198	31.9438	30.1677
360137	1.7979	0.8934	27.6894	30.3116	32.2727	30.1259
360141	1.6707	0.8662	31.1778	31.9397	32.0733	31.7211
360143	1.3738	0.8934	26.9394	28.0693	27.0053	27.3502
360144	1.3538	0.8934	28.9177	29.6547	29.5081	29.3657
360145	1.6090	0.8934	28.1835	29.3271	29.8688	29.1441
360147	1.3579	0.8515	27.5548	29.2371	28.0794	28.2825
360148	1.2348	0.8515	26.3399	25.7460	28.4538	26.8308
360150	1.4290	0.8934	28.2561	27.8840	27.8860	27.9972
360151	1.3190	0.8666	26.5636	26.9672	28.3917	27.3628
360152	1.5536	1.0105	31.5377	33.1017	35.3636	33.3224
360153	1.0022	0.8515	20.2147	21.8416	22.3028	21.4281
360155	1.4579	0.8934	28.9521	29.1711	30.0263	29.3869
360156	1.1646	0.8634	25.0833	26.2268	27.4185	26.2854

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
360159	1.3993	0.9837	28.6174	29.0187	29.1683	28.9556
360161	1.3911	0.8673	27.0875	27.7423	29.4713	28.1236
360163	1.8912	0.9395	30.0724	31.2087	31.1214	30.8091
360170	1.2489	1.0105	29.5954	30.0688	30.9891	30.2518
360172	1.3460	0.8934	28.8283	30.2330	31.2620	30.0981
360174	1.2888	0.9220	28.3143	28.3769	29.2419	28.6559
360175	1.3249	0.9837	28.3054	29.7499	31.8340	29.9866
360179	1.5580	0.9395	29.8299	31.3540	30.6820	30.6192
360180	2.3340	0.8934	31.4342	32.0225	30.3025	31.2206
360185	1.3620	0.8515	26.1080	26.4210	27.4008	26.6480
360187	1.4761	0.9220	25.7600	27.3745	28.2630	27.0966
360189	1.0867	1.0105	27.5097	28.3738	28.8931	28.2762
360192	1.3888	0.8934	27.5991	29.1999	31.7957	29.6356
360195	1.1185	0.8934	27.6155	27.2630	28.4907	27.7976
360197	1.1653	0.9837	28.9207	28.5267	30.3316	29.2815
360203	1.1852	0.8515	25.3692	27.7569	28.7975	27.3127
360210	1.2436	1.0105	29.6476	31.8182	35.1678	32.3199
360211	1.5170	0.8589	26.5459	27.5081	26.9504	27.0034
360212	1.3260	0.8934	26.6976	28.5882	28.8865	28.0376
360218	1.2766	1.0105	30.0101	31.1641	31.4458	30.9017
360230	1.5326	0.8934	30.0661	30.5995	29.9181	30.1959
360234	1.4273	0.9395	31.0656	30.7926	29.5412	30.4544
360236	1.3148	0.9395	29.5321	29.9367	31.7585	30.4372
360239	1.3753	0.9220	30.7728	31.7938	32.3401	31.6831
360241	***	*	25.7290	25.8137	28.0304	26.4969
360242	1.9371	*	*	*	*	*
360245	0.7356	0.8934	20.3426	20.4589	20.8560	20.5755
360247	0.6145	1.0105	*	*	*	*
360253	2.1310	0.9220	34.3347	34.6887	33.3121	34.1048
360259	1.3348	0.9455	27.2902	28.0886	29.3681	28.2511
360261	1.1020	0.9031	25.6332	26.6262	28.2317	26.8712
360262	1.2865	0.9455	30.1559	31.5637	33.1908	31.6648
360263	1.9394	0.9340	25.4864	28.1671	25.5127	26.3376
360266	2.1261	1.0105	31.7565	29.8385	31.3706	30.9187
360267	***	*	34.0936	*	*	34.0936
360268	***	*	34.0526	*	*	34.0526
360269	1.9404	0.9395	24.8552	25.5191	26.3965	25.7802
360270	1.1419	0.8515	*	28.8677	30.0580	29.6018
360271	1.7291	0.9395	*	28.4353	30.8070	29.6451
360272	***	*	*	38.1014	*	38.1014
360273	***	*	*	37.6645	*	37.6645
360274	1.6487	0.9220	*	*	*	*

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
360275	2.8444	0.9455	*	*	*	*
360276	1.1953	0.8662	*	*	*	*
360346	3.5298	1.0105	*	*	*	*
360347	1.2385	1.0105	*	*	*	*
360348	1.1501	1.0105	*	*	*	*
360349	***	0.9455	*	*	*	*
370001	1.6674	0.8758	26.8884	28.4907	27.2881	27.5718
370002	1.1318	0.7807	23.6886	26.2486	26.5804	25.5063
370004	1.1954	0.8486	26.8521	28.2804	27.2378	27.4661
370006	1.2536	0.8744	23.9935	25.2307	27.5299	25.4487
370007	0.9573	0.7807	20.3706	21.1260	25.7680	22.4658
370008	1.3634	0.8895	26.6563	27.9944	29.1467	27.9828
370011	0.9976	0.8895	22.3391	23.1761	24.5886	23.3707
370013	1.5272	0.8895	27.2667	28.3502	29.7899	28.5378
370014	1.1835	0.8299	26.4488	28.8962	29.3407	28.2695
370015	1.0245	0.8758	25.5815	27.8061	27.6086	27.0204
370016	1.5401	0.8734	29.8284	30.4672	29.6737	29.9892
370018	1.4891	0.8758	24.6868	31.2335	29.3285	28.4555
370019	1.1668	0.7807	25.2814	26.7613	30.4599	27.4907
370020	1.5207	0.8734	22.7566	24.7520	24.7484	24.0786
370022	1.2432	0.7926	22.2289	26.4836	24.4735	24.2826
370023	1.3253	0.7897	24.0376	24.9580	27.4272	25.5131
370025	1.3266	0.8758	24.5547	24.8336	27.0211	25.4187
370026	1.4828	0.8734	25.5172	26.0203	26.8057	26.1087
370028	1.9032	0.8895	28.5619	29.9849	31.9029	30.1958
370029	1.1436	0.7807	28.5309	30.0134	30.3712	29.6060
370030	1.0184	0.8758	25.8212	26.0831	26.5853	26.1546
370032	1.5257	0.8895	26.2642	28.0739	30.2497	28.1093
370034	1.2292	0.7807	20.4106	23.2192	23.9679	22.5773
370036	1.1324	0.7807	19.8162	21.1544	22.1686	21.1526
370037	1.6188	0.8895	25.2350	26.8992	28.9215	27.0269
370039	1.0938	0.8758	23.5745	25.3422	26.7579	25.2075
370040	1.0031	0.7994	26.7395	19.7644	21.6739	22.8162
370041	0.8542	0.8758	22.9834	29.5074	26.4346	26.0969
370047	1.4823	0.8734	24.4766	27.8937	29.6739	27.4387
370048	0.9921	0.7807	22.0627	23.4848	24.2668	23.2504
370049	1.3679	0.8734	22.8755	24.2099	22.8526	23.2828
370051	1.0644	0.7807	19.3222	21.8716	22.8411	21.2867
370054	1.2403	0.7807	25.2142	23.4644	25.4821	24.7146
370056	1.7228	0.8153	25.5453	27.6178	26.9562	26.7144
370057	1.0595	0.8758	22.1337	23.1814	21.0790	22.1008
370060	***	*	23.3858	25.5571	29.0333	25.8847

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
370065	0.9985	0.7903	23.5815	24.0062	23.7889	23.7851
370072	0.8313	0.8065	13.0963	22.8598	17.3061	16.6167
370078	1.6683	0.8758	26.6972	30.4837	28.7496	28.5901
370080	0.9725	0.7807	22.4113	23.7231	22.4258	22.8236
370083	0.9363	0.7858	20.9878	21.9162	21.3677	21.4243
370084	1.0542	0.7807	20.7326	17.4202	17.7119	18.5269
370089	1.4348	0.7807	22.1523	22.0607	23.8318	22.7670
370091	1.6433	0.8758	25.8697	28.0487	28.3945	27.4516
370093	1.8009	0.8895	27.5356	26.7272	29.0161	27.7529
370094	1.3942	0.8895	26.5265	28.3512	29.5931	28.1559
370097	1.3342	0.8153	26.8138	28.0911	28.1234	27.6650
370099	1.0499	0.8734	26.7206	30.5437	28.8908	28.7274
370100	0.8729	0.7907	19.4002	20.6298	18.2493	19.4124
370103	1.0384	0.7807	19.4273	22.2675	23.4746	21.6719
370105	2.0833	0.8895	26.6399	30.5438	30.9068	29.1242
370106	1.4250	0.8895	28.5957	29.6797	31.4433	29.9106
370112	1.0152	0.7994	16.7888	19.0130	20.2239	18.7064
370113	1.1336	0.8787	26.4608	30.0061	28.3511	28.2682
370114	1.6767	0.8758	25.9841	27.1348	32.9928	28.5435
370138	1.1124	0.7807	22.1675	23.6348	24.7631	23.4792
370139	0.9455	0.7807	20.5156	21.0759	19.3691	20.2992
370148	1.4441	0.8895	28.1933	29.3447	30.8781	29.5564
370149	1.2955	0.8734	23.3423	23.0764	25.0025	23.7862
370153	1.0986	0.7807	24.1667	25.9238	30.0891	26.7605
370156	0.9997	0.7928	23.0104	22.7140	22.3940	22.7035
370158	0.9448	0.8895	21.5228	22.0056	22.2823	21.9440
370166	0.8775	0.8758	24.7251	26.3420	22.9735	24.6756
370169	0.8182	0.7970	16.6752	24.5389	20.5348	20.8469
370170	0.8438	1.4424	*	*	*	*
370171	1.0650	1.4424	*	*	*	*
370172	0.8359	1.4682	*	*	*	*
370173	0.9508	1.4424	*	*	*	*
370176	***	*	24.9650	26.6687	27.2899	26.3288
370178	0.9123	0.7807	16.0747	15.6720	17.3536	16.3476
370180	1.1032	1.4424	*	*	*	*
370183	0.9814	0.8758	23.8419	30.3850	25.4218	26.6338
370190	1.3985	0.8758	34.6942	32.5635	35.6046	34.2861
370192	1.9077	0.8895	19.0638	19.1346	28.9574	22.5251
370196	***	*	20.8296	24.6984	*	23.0172
370199	0.9892	0.8895	23.7412	23.9376	25.9775	24.6248
370200	***	*	21.7153	19.7060	27.9940	23.0346
370201	1.6485	0.8895	24.2364	25.5882	30.4213	26.6553

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
370202	1.4854	0.8758	25.7966	25.8261	29.3845	27.0814
370203	2.0990	0.8895	25.7770	30.3641	31.6266	29.8623
370206	1.8396	0.8895	27.5752	30.8151	28.9491	29.1050
370210	1.9798	0.8758	27.2111	25.7905	29.4082	27.4918
370211	1.1954	0.8895	28.6537	30.9656	32.7888	31.0654
370212	1.9460	0.8895	20.3495	20.0919	23.4166	21.3383
370214	1.2047	0.7928	21.0732	20.1495	22.3796	21.2113
370215	2.2509	0.8895	32.4087	32.0950	32.7257	32.4238
370216	2.1463	0.8758	25.8260	29.6658	29.1189	28.3021
370218	1.3377	0.8758	30.3445	23.7517	29.6378	27.5214
370219	***	*	*	41.4392	*	41.4392
370220	1.8290	0.8895	*	21.3168	22.2077	21.7751
370222	1.8621	0.8895	*	26.9175	28.6123	27.7662
370223	***	*	*	24.0154	*	24.0154
370224	***	*	*	*	21.5542	21.5542
370225	1.4917	0.8895	*	*	*	*
370227	1.0366	0.8758	*	*	*	*
370228	1.2798	0.8758	*	*	*	*
370229	1.0388	0.7807	*	*	*	*
380001	1.3168	1.1195	32.0770	33.8490	36.3316	34.1194
380002	1.2815	1.0235	31.5246	32.6830	32.7006	32.3180
380004	1.6919	1.1195	34.5432	36.1021	37.7310	36.1451
380005	1.4524	1.0235	33.2849	33.5765	33.5424	33.4667
380007	2.0141	1.1195	35.1697	36.4222	37.9358	36.5037
380009	2.1647	1.1195	34.5635	36.5688	36.8442	36.0281
380014	1.8988	1.0836	33.1928	35.7101	36.4373	35.1436
380017	1.8124	1.1195	35.3734	36.8103	37.5098	36.5843
380018	1.8952	1.0235	31.8181	32.4884	32.3945	32.2400
380020	1.4172	1.0974	34.6183	35.7392	37.4343	35.9319
380021	1.5544	1.1195	32.6142	33.0628	33.3855	33.0383
380022	1.2889	1.0460	29.6224	30.9181	32.6138	31.0757
380025	1.2048	1.1195	36.4910	38.1507	38.7401	37.8082
380027	1.3998	1.0974	28.0247	31.4398	33.7027	31.1047
380029	1.3234	1.0915	29.4461	33.3368	34.4907	32.6100
380033	1.7495	1.0974	34.0094	36.0798	36.6589	35.6170
380037	1.4160	1.1195	32.7922	34.0321	36.0715	34.4785
380038	1.3481	1.1195	35.1105	35.0350	36.3586	35.5130
380040	1.4954	1.0235	32.9081	34.4500	37.3200	34.9724
380047	1.8726	1.1268	32.8188	35.8165	37.9901	35.6494
380050	1.4313	1.0235	29.7329	31.3088	32.4377	31.2351
380051	1.7773	1.1195	32.8545	35.0114	37.3363	35.1032
380052	1.3051	1.0235	28.6119	27.7656	29.1449	28.5104

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
380056	1.2196	1.0915	29.1686	31.0210	31.9034	30.6364
380060	1.4828	1.1195	33.8863	35.1106	36.9581	35.3642
380061	1.6939	1.1195	34.5230	35.8922	37.9554	36.1277
380071	1.3673	1.1195	31.0901	31.6821	32.7466	31.8311
380075	1.4129	1.0235	31.6884	34.0197	36.0119	33.9209
380082	1.3018	1.1195	35.7821	37.7268	38.8914	37.4976
380089	1.3615	1.1195	35.4850	37.0017	37.7878	36.7926
380090	1.3115	1.0974	35.5535	41.4540	41.3541	39.4545
380091	1.4122	1.1195	40.5066	39.7431	47.7003	42.8601
380100	***	*	*	45.3882	*	45.3882
380101	1.3251	1.1195	*	*	*	*
380102	1.7411	1.0974	*	*	*	*
390001	1.6169	0.8363	24.3251	25.4188	27.9772	25.8495
390002	1.4033	0.8592	25.0860	25.9827	26.9670	26.0296
390003	1.2336	0.8363	24.5099	26.2872	26.6558	25.7801
390004	1.6450	0.9186	25.2424	26.5054	29.3249	26.9235
390006	1.9180	0.9186	28.6926	30.9914	32.8108	30.9565
390008	1.0760	0.8423	22.6297	22.9417	25.0200	23.5268
390009	1.7957	0.8748	26.7234	29.0286	29.4416	28.4123
390010	1.1457	0.8592	24.8196	26.0966	27.8944	26.2532
390011	***	*	20.2291	*	*	20.2291
390012	1.2596	1.0708	32.4856	34.2004	35.6251	34.0781
390013	1.4529	0.9186	26.2323	28.3039	26.8792	27.1583
390016	1.2851	0.8592	24.3488	26.1802	25.6660	25.3793
390019	1.1517	0.9811	25.7515	25.3185	25.2047	25.4375
390022	***	*	29.6308	*	*	29.6308
390023	1.2533	1.0708	34.7787	36.2618	37.9254	36.3142
390024	***	*	38.8750	37.4815	*	38.0669
390025	0.5781	1.0708	20.3878	*	*	20.3878
390026	1.2082	1.0708	31.8309	36.0608	36.6927	34.7727
390027	1.7604	1.0708	39.2158	40.9110	42.5592	40.8743
390028	1.6878	0.8592	27.1451	29.6218	31.3868	29.2906
390030	1.1978	0.8984	24.6343	26.5678	26.9684	26.1031
390031	1.2183	0.8984	27.2033	26.1258	27.5747	26.9778
390032	1.3069	0.8592	24.5243	25.3756	27.3294	25.7500
390035	1.1997	1.0708	29.5417	27.2130	27.6331	28.0697
390036	1.5305	0.8592	24.4917	26.1956	30.1286	26.8856
390037	1.4665	0.8592	25.2296	27.0788	31.6832	27.9152
390039	1.3053	0.8400	23.2300	22.1531	23.3456	22.8928
390041	1.2718	0.8592	24.2257	25.1190	26.4415	25.2981
390042	1.4569	0.8592	28.0996	29.6213	30.6691	29.4884
390043	1.2182	0.8363	24.2087	24.3590	26.4451	25.0113

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
390044	1.5285	1.0545	29.4057	29.9959	30.6946	30.0647
390045	1.5159	0.8363	24.6495	25.8800	26.4450	25.6635
390046	1.7411	0.9466	30.5115	32.5273	32.1156	31.7491
390048	1.1562	0.9186	28.3152	28.4563	29.0278	28.6089
390049	1.5732	0.9811	30.7431	31.0290	32.7809	31.5286
390050	2.0707	0.8592	27.3481	29.6715	32.0935	29.7214
390052	1.1760	0.8410	25.1462	26.3700	27.4028	26.3426
390054	***	*	27.4805	27.5696	*	27.5206
390056	1.1684	0.8399	23.5821	24.7038	25.5903	24.6309
390057	1.3193	1.0708	30.9198	31.0279	33.9576	31.9635
390058	1.3916	0.9186	27.7296	29.6620	29.4647	28.9793
390061	1.5690	0.9612	30.0597	30.9208	30.2319	30.4038
390062	1.2310	0.8821	21.0713	22.8856	37.2849	27.1978
390063	1.8685	0.8748	26.8381	28.3987	30.3687	28.5723
390065	1.3538	1.0769	29.5654	31.8841	31.2628	30.9315
390066	1.4364	0.9186	25.4407	29.0033	28.3747	27.6160
390067	1.8037	0.9466	30.6128	32.2891	30.5601	31.1554
390068	1.3698	0.9612	29.0962	29.6984	28.2183	28.9555
390070	1.3003	1.0708	34.4935	34.5501	33.4969	34.1776
390071	0.9975	0.8363	24.8467	26.3830	27.8695	26.3372
390072	1.0792	0.8363	26.2568	28.8145	28.0714	27.6866
390073	1.6900	0.8821	26.4083	27.0876	28.8519	27.4781
390074	***	*	25.4098	*	*	25.4098
390076	1.3445	1.0708	32.7671	33.9908	34.0355	33.5972
390079	1.8256	0.8746	24.4452	26.0199	26.9676	25.8133
390080	1.4385	1.0708	29.2645	31.6210	33.0003	31.3027
390081	1.3085	1.0708	33.6247	36.4788	37.7643	35.9769
390084	1.1829	0.8363	24.3372	24.3191	24.8010	24.4832
390086	1.6557	0.8363	25.0992	24.7454	25.3096	25.0504
390090	1.8906	0.8592	27.0122	30.1256	31.9282	29.6513
390091	1.2331	0.8404	23.3562	23.2118	23.9434	23.5151
390093	1.2064	0.8404	22.6023	23.8846	23.5291	23.3370
390095	1.1995	0.8363	24.6290	25.3859	25.9594	25.3026
390096	1.6052	1.0545	28.6055	30.3910	31.7443	30.2624
390097	1.2827	1.0708	27.9858	28.1285	30.4946	28.8540
390100	1.6602	0.9612	30.0234	32.7836	32.8949	31.9670
390101	1.3166	0.9310	24.8377	25.9850	28.6622	26.5229
390102	1.4447	0.8592	24.4589	25.5336	26.3716	25.4804
390103	***	*	20.4446	*	*	20.4446
390104	1.0655	0.8363	19.6630	20.4552	26.8407	22.6287
390107	1.6613	0.8592	24.6565	25.6790	26.6305	25.7184
390108	1.3060	1.0708	28.5928	34.3066	33.3017	32.0204

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
390110	1.6335	0.8592	25.3407	25.7159	28.5314	26.6592
390111	2.3129	1.0708	34.8756	37.7322	34.5571	35.7144
390112	1.2372	0.8400	21.5439	18.4185	19.5361	19.7345
390113	1.3526	0.8404	24.2593	24.8669	25.9952	25.0517
390114	1.5644	0.8592	27.9184	28.5336	28.2039	28.2309
390115	1.4438	1.0708	30.8063	32.5058	32.8427	32.0867
390116	1.3384	1.0708	33.2562	33.9295	34.5119	33.9072
390117	1.1540	0.8365	21.5038	22.2327	26.0642	23.2899
390118	1.2083	0.8363	21.8917	23.6535	23.7128	23.0909
390119	1.3594	0.8363	24.3245	25.3907	25.9784	25.2330
390122	1.1601	0.8416	23.3220	24.6434	24.0424	23.9972
390123	1.2056	1.0708	34.0062	35.1244	34.1121	34.4185
390125	1.2420	0.8385	22.8816	24.0199	24.4654	23.8055
390127	1.4603	1.0708	33.6557	33.1227	34.6488	33.7924
390128	1.2836	0.8592	24.1390	25.1858	26.0441	25.1413
390130	1.2719	0.8363	23.2504	30.7083	26.7324	26.7544
390131	1.3964	0.8592	23.5783	27.7146	26.9190	26.1180
390132	1.4785	1.0708	31.1168	30.0751	33.1853	31.4335
390133	1.7733	1.0545	32.9812	33.0604	35.0046	33.7377
390137	1.5165	0.8363	26.1457	26.9156	27.9033	27.0044
390138	1.2426	0.9176	27.4231	27.7565	29.0224	28.0890
390139	1.3995	1.0708	34.0836	36.5001	36.8337	35.8435
390142	1.5455	1.0708	34.5773	33.3509	38.1793	35.3739
390145	1.6077	0.8592	25.6980	26.9212	27.6510	26.7671
390146	1.1785	0.8385	25.1805	23.9878	27.5267	25.5615
390147	1.4284	0.8592	28.6606	29.0995	30.4797	29.4247
390150	1.0895	0.8394	22.7668	22.6483	27.2922	24.3319
390151	1.4035	1.0769	31.4067	31.8967	35.0627	32.8283
390153	1.3781	1.0708	33.2427	36.0287	37.0995	35.5230
390154	1.2729	0.8363	23.3559	23.9785	24.6857	24.0198
390156	1.4011	1.0708	32.8999	33.7057	34.9903	33.8533
390157	1.2643	0.8592	22.1112	23.0989	23.7167	22.9916
390160	1.3626	0.8592	22.9696	25.2043	27.5196	25.2346
390162	1.5460	1.1235	34.5809	35.1844	36.7008	35.4805
390163	1.2612	0.8592	22.8341	24.8761	25.4594	24.4071
390164	2.1723	0.8592	27.1950	29.7778	29.0556	28.6758
390166	***	*	23.3255	28.2178	*	25.5801
390168	1.5829	0.8592	26.9816	27.3674	28.2578	27.5467
390169	1.4104	0.8363	26.2643	26.6063	28.4619	27.1533
390173	1.2404	0.8400	25.6455	27.6039	28.0999	27.1414
390174	1.7449	1.0708	34.8999	35.1118	36.5352	35.5394
390176	1.1253	0.8592	24.1247	*	27.5270	25.5558

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
390178	1.4030	0.8665	23.1452	23.9166	25.2325	24.0960
390179	1.4269	1.0708	30.1219	31.5498	33.9916	31.9587
390180	1.4618	1.0708	35.5291	38.2997	37.8677	37.2529
390181	***	*	26.6021	27.8833	*	27.2407
390183	1.1518	0.8363	27.8358	28.2211	28.8361	28.3030
390184	1.0990	0.8592	23.9736	23.9973	24.1461	24.0406
390185	1.2411	0.9636	27.1119	25.5318	28.1346	26.9989
390189	1.1261	0.8363	23.6215	23.4902	25.3686	24.1728
390192	1.0514	0.8363	23.6171	23.7958	24.7427	24.0524
390194	1.2334	0.9811	26.3152	23.7367	27.8231	25.8739
390195	1.5690	1.0708	34.5594	37.2504	36.8626	36.2345
390196	1.5711	*	*	*	*	*
390197	1.3634	0.9811	27.2455	27.7303	28.1999	27.7343
390198	1.0232	0.8748	20.4350	21.0861	21.3574	20.9627
390199	1.1065	0.8363	23.0046	24.5469	24.9642	24.1863
390201	1.5128	0.9636	27.3542	28.5668	28.7755	28.2475
390203	1.5048	1.0708	29.1370	30.7244	33.0056	30.9850
390204	1.3453	1.0708	30.7346	32.0242	33.8120	32.1643
390211	1.3591	0.8665	26.5052	27.7875	28.0796	27.4549
390217	1.2357	0.8592	24.1886	26.2706	25.6917	25.3900
390219	1.3585	0.8592	26.1196	26.3263	27.2812	26.5785
390220	1.1379	1.0708	30.7435	32.0891	33.0323	31.9318
390222	1.3721	1.0708	31.7361	32.7077	34.5835	33.0510
390223	1.9067	1.0708	34.3280	36.5784	35.8030	35.5960
390225	1.3113	0.9612	27.2555	26.3642	*	26.7274
390226	1.7263	1.0708	32.6508	35.4683	35.5564	34.5675
390228	1.4809	0.8592	24.2242	25.5120	28.4321	26.0658
390231	1.4354	1.0708	32.8353	35.2312	35.0675	34.4329
390233	1.4672	0.8363	27.2597	28.3660	29.5938	28.4432
390236	1.0126	0.8366	23.1290	24.5574	25.1866	24.2548
390237	1.6731	0.8363	28.4337	29.9748	29.6917	29.3990
390246	***	*	26.0179	*	*	26.0179
390256	1.9014	0.9186	28.8970	28.5887	31.6455	29.7471
390258	1.4759	1.0708	31.7164	32.0551	33.7330	32.5224
390263	1.5401	0.9811	29.9850	30.2069	31.1718	30.5040
390265	1.5596	0.8592	25.0166	27.7795	27.8241	26.8716
390266	1.1766	0.8665	22.2228	23.0142	23.5248	22.9191
390267	1.3552	0.8592	24.8309	25.7571	28.4250	26.3307
390268	1.4249	0.8951	26.7342	28.4200	30.0652	28.4460
390270	1.6993	0.8363	26.5010	27.0301	29.3622	27.7268
390272	0.6254	1.0708	*	32.9918	29.4836	31.1010
390278	0.6753	1.0708	28.6323	28.8318	33.9596	30.4976

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
390285	***	*	37.6669	38.4703	43.0793	39.5197
390286	***	*	31.3393	31.7337	32.6998	31.9284
390287	***	*	42.2401	*	*	42.2401
390290	1.8452	1.0708	41.1426	47.7663	41.9121	43.5142
390304	1.3235	1.0708	32.1633	33.4134	35.0741	33.5411
390305	***	*	29.3217	*	*	29.3217
390306	***	*	40.3789	*	*	40.3789
390307	2.0351	0.8665	24.5393	22.9474	27.2053	24.8304
390308	***	*	36.1737	*	*	36.1737
390309	***	*	37.8924	*	*	37.8924
390310	***	*	44.3991	*	*	44.3991
390311	***	*	*	49.9027	*	49.9027
390312	1.3269	1.0708	*	51.3372	42.3481	46.0946
390313	1.1428	0.8984	*	*	27.3018	27.3018
390314	1.9236	0.9811	*	*	*	*
390316	2.0583	0.9403	*	*	*	*
390317	0.9463	1.0708	*	*	*	*
390318	1.2983	0.9811	*	*	*	*
390319	0.8794	0.8592	*	*	*	*
390320	1.1450	1.0708	*	*	*	*
400001	1.3957	0.4355	14.9151	15.4249	15.9192	15.4274
400002	***	*	12.9440	12.9793	14.2946	13.3765
400003	1.4540	0.4216	15.7906	14.6859	15.8816	15.4534
400004	1.2236	0.4355	12.5928	13.5197	14.5542	13.5879
400005	1.2316	0.4355	11.1152	11.7590	12.6516	11.8653
400006	1.2983	0.4355	8.1381	*	*	8.1381
400007	1.3357	0.4355	12.0743	10.4934	10.7767	11.1306
400009	1.1438	0.3533	9.5114	10.1212	14.0016	10.9165
400010	0.9453	0.3364	10.7993	10.4206	12.8584	11.2364
400011	1.1843	0.4355	8.5503	9.4068	10.7620	9.5779
400012	1.5766	0.4355	10.1156	*	11.1553	10.6502
400013	1.3294	0.4355	11.4222	12.3073	12.7900	12.1954
400014	1.4402	0.3664	9.9395	12.3301	11.0722	11.0731
400015	1.3375	0.4355	22.2017	21.9225	17.6943	20.4554
400016	1.5904	0.4355	16.1931	17.9107	19.1577	17.7512
400017	***	*	9.9185	10.0590	*	9.9834
400018	1.2773	0.4355	12.3942	13.1572	13.6091	13.0714
400019	1.4801	0.4355	14.7133	15.2364	15.0604	14.9878
400021	1.4966	0.4735	13.9217	14.9779	16.3677	15.0813
400022	1.5237	0.4216	15.3625	15.2124	15.3660	15.3143
400024	0.9101	0.3664	12.6226	13.7215	14.2708	13.3756
400026	1.2146	0.3533	7.1179	8.9064	9.8155	8.5696

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
400028	1.0865	0.4216	10.6711	9.6941	11.1923	10.4831
400032	1.1891	0.4355	10.7141	10.7844	11.9013	11.1571
400044	1.5933	0.4216	11.3551	12.1393	13.4579	12.3287
400048	1.4706	0.3533	9.6860	10.5176	11.5766	10.6023
400061	2.2278	0.4355	18.0093	17.4504	18.5327	17.9900
400079	1.2798	0.3364	10.4599	10.6127	11.3550	10.8205
400087	1.3984	0.4355	11.4162	12.0034	12.6233	12.0137
400098	1.2954	0.4355	13.7878	12.8756	13.2365	13.2769
400102	1.1382	0.4355	12.1761	12.1257	12.6314	12.3094
400103	1.9028	0.3664	11.7488	11.3314	12.7285	11.9274
400104	1.2065	0.4355	12.8404	12.6934	12.9616	12.8320
400105	1.1950	0.4355	16.9029	17.0463	25.3823	18.7978
400106	1.2536	0.4355	12.9272	14.8544	14.1766	13.9717
400109	1.4018	0.4355	14.8208	14.5713	15.4910	14.9662
400110	1.2776	0.3344	9.9278	10.8214	11.2311	10.6665
400111	1.1860	0.3364	10.2141	10.7892	11.0467	10.6893
400112	1.3018	0.4355	13.5177	11.2303	9.6181	11.3251
400113	1.2682	0.4216	10.9503	11.5948	11.9672	11.5248
400114	1.2012	0.4355	10.8913	11.6872	11.5514	11.3986
400115	1.1375	0.4355	9.6200	10.6809	12.0201	10.9084
400117	1.1338	0.4355	11.6258	12.1540	12.2159	11.9944
400118	1.3427	0.4355	12.7861	12.6199	13.3983	12.9418
400120	1.3341	0.4355	14.0817	14.5205	14.6591	14.4292
400121	1.0481	0.4355	9.1826	9.9713	11.7462	10.4349
400122	2.0582	0.4355	9.5814	10.0966	13.1851	10.6819
400123	1.2393	0.3664	12.5609	13.8601	13.4317	13.2749
400124	2.6950	0.4355	17.9140	19.1704	21.9082	19.6595
400125	1.2469	0.3786	13.5394	13.1078	12.7141	13.0689
400126	1.2047	0.4735	16.5726	*	14.2108	15.0677
400127	1.7226	0.4355	20.7775	*	12.0796	14.9826
400128	1.0695	0.4355	12.3520	*	23.6366	16.5277
410001	1.3432	1.1577	30.0315	30.5865	30.8038	30.4772
410004	1.3679	1.1577	31.3023	35.2384	33.7118	33.4391
410005	1.2848	1.1577	31.4387	34.2846	38.2842	34.6404
410006	1.3437	1.0783	32.8456	33.9961	35.4462	34.0980
410007	1.5997	1.1577	32.0730	34.4774	37.0287	34.5460
410008	1.3264	1.0783	32.5889	33.6384	34.6138	33.6230
410009	1.2503	1.0783	32.8422	34.3427	36.0892	34.4520
410010	1.1448	1.1577	32.7379	34.9330	38.4603	35.3886
410011	1.4804	1.1577	30.1941	36.7668	38.5007	35.1203
410012	1.5315	1.1577	37.0299	36.5207	37.5223	37.0259
410013	1.2162	1.1562	41.0010	39.8659	38.2253	39.6688

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
420002	1.5952	0.9316	30.5111	31.2247	32.3569	31.3720
420004	1.9950	0.9212	28.9250	30.0764	31.8610	30.3408
420005	1.2093	0.8389	24.6968	26.5044	28.0173	26.3085
420006	1.2439	0.9212	27.7764	29.1404	31.5368	29.4536
420007	1.6919	0.9303	29.0901	28.9557	31.1080	29.7356
420009	1.4100	0.9303	29.9378	28.6648	29.1084	29.2186
420010	1.1520	0.8389	25.5710	26.5523	27.0435	26.3875
420011	1.1710	0.9733	25.5130	26.0585	25.9484	25.8446
420015	1.2753	0.9733	26.3499	27.4929	27.9759	27.2837
420016	0.9421	0.8389	22.5681	23.4323	23.2125	23.0759
420018	1.8675	0.8850	27.5563	29.0923	28.9660	28.5545
420019	1.0673	0.8547	25.4954	25.8119	23.7910	25.0571
420020	1.3243	0.9212	27.5000	29.2935	28.9093	28.5788
420023	1.7895	0.9733	28.9321	30.4492	31.2602	30.2902
420026	1.8472	0.8850	28.0647	29.5066	31.2504	29.6183
420027	1.6396	0.9303	28.5621	31.3797	30.6779	30.1900
420030	1.4016	0.9212	28.4433	30.3424	31.3260	30.0576
420033	1.1867	0.9733	31.1608	32.4287	33.8157	32.4529
420036	1.2522	0.9315	24.6505	26.3480	27.1715	26.0603
420037	1.4533	0.9733	30.9556	32.7124	33.5291	32.3771
420038	1.3251	0.9733	26.6435	27.1524	29.5673	27.7906
420039	1.0882	0.8985	26.5582	26.3127	24.5270	25.7896
420043	1.1537	0.8546	25.7951	25.8366	24.2727	25.2822
420048	1.2904	0.8850	26.9625	27.4353	29.9094	28.1511
420049	1.3235	0.8668	25.7060	28.0920	28.4801	27.4734
420051	1.7878	0.8389	26.4710	27.6130	28.0711	27.3913
420053	1.1780	0.8424	24.4793	25.4820	26.4997	25.4881
420054	1.1731	0.8391	25.6444	26.7900	27.1580	26.5075
420055	1.0934	0.8389	25.1738	25.3144	25.9899	25.4736
420056	1.3359	0.8389	28.4512	29.7774	27.8175	28.6759
420057	1.2491	0.8389	26.2489	27.7137	29.5662	27.7788
420062	1.0594	0.9315	25.9569	27.2263	28.3129	27.1885
420064	1.5168	0.8668	24.6507	25.0654	26.4352	25.4019
420065	1.4283	0.9212	26.8118	28.1896	28.2922	27.7787
420066	1.0159	0.8389	25.0932	20.5743	26.0307	23.6377
420067	1.3662	0.8962	26.5658	27.7167	29.0379	27.7867
420068	1.4370	0.9332	27.7315	28.0316	28.1555	27.9645
420069	1.2663	0.8389	23.7494	24.4656	25.1993	24.4928
420070	1.3418	0.8850	27.5988	27.6431	28.4000	27.8833
420071	1.4302	0.9303	27.6371	28.1099	28.6098	28.1257
420072	1.0532	0.8389	21.6587	20.7716	24.4951	22.3025
420073	1.4257	0.8850	26.1120	28.2671	29.5999	28.0384

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
420078	1.9124	0.9733	30.9001	32.8731	34.3181	32.6841
420079	1.5300	0.9212	28.6374	30.5981	31.7686	30.3654
420080	1.4118	0.8962	31.5670	32.8712	33.8785	32.7544
420082	1.4714	0.9442	33.9874	34.8864	33.5290	34.1123
420083	1.4280	0.9303	28.9007	29.6587	29.2264	29.2667
420085	1.5563	0.9120	29.1127	29.9085	31.3391	30.1473
420086	1.5261	0.8850	27.9523	29.6349	30.1406	29.2824
420087	1.7716	0.9212	26.8409	28.4632	28.8860	28.0631
420089	1.4538	0.9212	29.5862	31.7367	33.0906	31.5000
420091	1.4931	0.8389	27.2520	27.9062	28.0471	27.7467
420093	***	*	33.0474	*	*	33.0474
420098	1.2157	0.8668	27.1939	27.6722	28.2058	27.7548
420099	***	*	30.3089	*	*	30.3089
420100	***	*	*	29.2979	*	29.2979
420101	1.1099	0.8962	*	33.1995	33.1158	33.1603
420102	1.8338	0.9733	*	*	*	*
430005	1.4026	0.8360	23.8694	25.4385	27.1759	25.4879
430008	1.1374	0.8895	26.0873	27.2275	27.2961	26.9056
430012	1.3131	0.9040	25.2030	27.0195	28.5808	26.9442
430013	1.2349	0.9040	27.0427	28.4962	28.3679	27.9783
430014	1.5014	0.8360	27.9288	28.9295	29.2921	28.7277
430015	1.3340	0.8360	26.5787	28.0414	28.0093	27.5536
430016	1.6001	0.9040	32.8765	31.1336	31.5894	31.8077
430027	1.7563	0.9040	27.5759	29.2617	29.2432	28.7331
430048	1.2370	0.8489	25.1715	25.6428	26.9537	25.9320
430060	0.7994	0.8360	*	*	11.7801	11.7801
430064	1.0087	*	16.4916	17.7334	*	17.1129
430077	1.7546	1.0279	27.2116	31.1945	35.3480	31.1559
430081	0.7923	1.4424	*	*	*	*
430082	0.8617	1.4424	*	*	*	*
430083	0.9252	1.4424	*	*	*	*
430084	0.8708	1.4424	*	*	*	*
430089	1.9427	0.8943	23.2467	24.9060	28.3217	25.6660
430090	1.8687	0.9040	29.0197	32.7395	33.8350	31.9285
430091	2.1343	1.0279	24.7274	26.7258	28.3496	26.5869
430092	1.9037	0.8360	21.9197	23.2527	26.6750	23.8829
430093	1.0219	1.0279	26.0232	24.7426	30.7398	27.0442
430094	1.9087	0.8489	23.2894	23.6624	23.9005	23.6313
430095	2.4076	0.9040	32.2326	32.5881	31.8141	32.2115
430096	2.0558	0.8360	24.6041	24.9623	28.0608	25.8247
440001	1.1681	0.7890	21.5755	25.4855	23.9380	23.6551
440002	1.7170	0.8923	26.3802	26.9133	28.4828	27.2894

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
440003	1.3870	0.9588	28.3557	26.0115	31.4162	28.4431
440006	1.5532	0.9588	31.5533	31.7394	32.6924	32.0216
440007	0.9755	0.8109	18.8273	22.7571	23.4825	21.6106
440008	0.9856	0.8339	27.3732	26.8857	26.2003	26.7710
440009	1.2062	0.7890	23.8148	24.4423	25.1184	24.4601
440010	0.9257	0.7890	19.6231	20.2497	23.8087	21.0805
440011	1.3574	0.7890	23.6698	24.8300	25.7912	24.7898
440012	1.5621	0.8120	23.7871	24.9261	26.2076	25.0346
440015	1.9489	0.7890	26.0601	27.1603	28.1389	27.1257
440016	1.0608	0.8034	24.5812	25.2512	25.4197	25.0955
440017	1.8022	0.8120	24.6707	26.1820	28.6110	26.5714
440018	1.1314	0.7890	25.0780	24.8568	26.0748	25.3481
440019	1.7874	0.7890	25.2230	26.2464	28.0387	26.4696
440020	1.0614	0.8546	24.7785	27.5626	28.0269	26.7501
440024	***	*	24.7705	26.2534	25.4398	25.5222
440025	1.2362	0.8580	22.6571	24.0289	25.5605	24.1012
440026	***	*	26.8153	28.4615	26.5911	27.3434
440029	1.4909	0.9588	31.2310	31.4652	31.8872	31.5392
440030	1.3360	0.7890	22.2607	22.3144	23.1116	22.5589
440031	1.1971	0.7909	22.6790	22.0711	23.0937	22.6115
440032	1.2087	0.8111	21.0380	23.8030	25.4122	23.4923
440033	1.0945	0.7917	22.7991	23.9792	24.3197	23.7153
440034	1.6950	0.7890	25.5061	25.9138	26.7987	26.0831
440035	1.4003	0.9337	26.2451	27.9217	26.8725	26.9978
440039	2.0964	0.9588	30.1790	30.1918	32.4190	30.9651
440040	0.8811	0.7890	20.8817	21.1288	21.3795	21.1297
440046	1.3511	0.9588	29.7377	30.7334	31.5146	30.6878
440047	0.9600	0.8228	22.8323	25.2150	26.8032	24.9297
440048	1.8069	0.9251	29.3187	30.6725	31.5584	30.5016
440049	1.6962	0.9251	28.8742	29.8623	31.7148	30.1520
440050	1.3689	0.7899	24.9694	26.3825	27.1284	26.2037
440051	0.9664	0.7972	23.4866	23.6560	23.1773	23.4345
440052	1.0071	0.7890	22.6128	24.4071	28.1868	24.9007
440053	1.3336	0.9588	27.8180	30.3907	31.3189	29.8831
440054	1.1938	0.7890	23.7931	21.9641	25.7785	23.7447
440056	1.2197	0.7890	23.2313	24.0635	25.2050	24.1764
440057	1.2124	0.7911	17.2176	19.3546	25.1519	20.2005
440058	1.1849	0.8663	26.0706	29.1184	28.5093	27.9179
440059	1.5133	0.9337	27.9467	29.4532	30.4489	29.3316
440060	1.1743	0.8228	25.0795	26.5867	26.5518	26.0649
440061	1.1467	0.7890	23.7360	25.4134	25.9969	25.0583
440063	1.6800	0.7923	23.9644	26.0763	25.4344	25.1913
440064	0.9901	0.8844	26.1246	26.7957	26.9014	26.5999
440065	1.3793	0.9588	25.8536	25.6111	27.3501	26.2562
440067	1.1389	0.8111	24.6553	26.0866	26.5062	25.7727
440068	1.1768	0.8663	26.1071	27.9082	27.2646	27.0984
440070	1.0041	0.7999	21.9166	23.2228	24.4477	23.1577
440072	1.0622	0.7890	25.7089	26.1661	27.6990	26.5274
440073	1.3762	0.9337	27.6154	27.5133	28.3950	27.8396
440081	1.2013	0.7942	20.7688	21.9681	23.3000	22.0280
440082	1.9325	0.9588	32.2479	32.8941	34.4535	33.1514
440083	0.9661	0.7890	23.6356	25.7074	25.5397	24.9485
440084	1.2160	0.7915	18.8699	19.8950	21.3873	20.0620
440091	1.7700	0.8844	28.1989	28.9697	30.0650	29.0959
440102	1.0501	0.7890	21.6762	22.1114	23.5525	22.4271
440104	1.9269	0.8844	27.9756	28.0905	29.7326	28.6019
440105	0.9836	0.7923	22.7962	23.7154	24.6039	23.7339
440109	1.0056	0.7960	21.4629	22.5878	23.8465	22.7050
440110	1.0908	0.7890	22.5929	23.6275	23.8010	23.4286
440111	1.3335	0.9588	28.8453	29.7461	33.0828	30.4705
440115	1.0344	0.8228	23.7107	24.9778	25.2508	24.6327
440120	1.5542	0.7890	24.7572	26.0621	28.0271	26.2971
440125	1.7960	0.7890	23.6328	24.0934	24.7908	24.1753
440130	1.0491	0.7890	25.1262	26.3192	27.5525	26.3049
440131	1.1167	0.9251	26.9649	28.3162	29.0546	28.0858
440132	1.2305	0.7890	24.0708	29.3377	26.1823	26.4549
440133	1.7145	0.9588	29.6093	32.5726	33.2319	31.7113
440135	***	*	27.7037	27.2094	28.7658	27.7531
440137	1.0334	0.8628	22.9547	24.6143	25.6931	24.4010
440141	1.0392	0.7890	24.9917	24.8737	24.3575	24.7396
440144	1.2864	0.9337	25.2293	26.3225	26.6282	26.0759
440147	***	*	34.8199	36.6978	33.5900	35.1193
440148	1.1629	0.9337	22.6188	28.0708	26.2483	25.5461
440150	1.5147	0.9588	29.4381	30.5513	32.9854	31.0235
440151	1.2049	0.9337	28.2203	28.6585	28.8412	28.5703
440152	2.0822	0.9251	28.4612	29.0588	28.7357	28.7553
440153	1.1009	0.7890	24.9388	23.3790	23.8797	24.0473
440156	1.7122	0.8844	28.5645	30.5161	31.0506	30.0399
440159	1.4313	0.9251	25.8289	27.2785	26.2728	26.4630
440161	1.9816	0.9588	29.9894	31.0667	32.2343	31.0945
440162	***	*	24.8705	24.6425	27.8605	25.6835
440168	0.9921	0.9251	29.4028	31.3316	37.0865	32.5354
440173	1.4718	0.7890	24.0621	23.1370	23.5486	23.5411
440174	0.8237	0.8923	26.2087	27.4579	27.4578	27.0580

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
440175	1.0356	0.7890	24.7869	26.7705	29.2713	26.9024
440176	1.3859	0.8120	23.7695	24.9420	26.1477	24.9622
440180	1.1931	0.7917	22.3070	24.3376	26.9310	24.4679
440181	0.9704	0.8255	25.9450	26.4763	26.2247	26.2208
440182	0.9597	0.8034	25.0111	24.9899	24.4173	24.7842
440183	1.6032	0.9251	30.6599	30.9923	31.9159	31.1964
440184	1.1026	0.7923	23.3970	26.9086	25.3287	25.1937
440185	1.1910	0.8663	26.7473	26.3974	25.6005	25.9994
440186	1.0070	0.9588	28.9124	28.2840	30.0775	29.2175
440187	1.0742	0.7890	25.8238	27.4034	27.2669	26.8312
440189	1.3762	0.8516	28.8974	30.5786	29.9065	29.8102
440192	1.0644	0.9337	29.6272	30.6533	32.0772	30.7921
440193	1.3049	0.9588	25.2124	25.9726	27.8132	26.3285
440194	1.3381	0.9588	30.8593	32.3020	32.1073	31.7956
440197	1.4319	0.9588	30.1184	31.4317	32.3241	31.2730
440200	1.0491	0.9588	23.8654	23.8288	23.3049	23.6647
440203	***	*	17.9041	*	*	17.9041
440217	1.4535	0.9251	29.8888	31.6650	33.8684	31.8214
440218	2.2276	0.9588	18.7275	36.9273	31.7847	28.6646
440222	0.4461	0.9251	29.0062	30.5148	32.4230	30.6504
440225	0.9600	0.7890	27.8860	26.9687	29.8273	28.4540
440226	1.6528	0.7890	27.1348	28.3199	28.4491	27.9540
440227	1.3377	0.9588	30.7785	31.9119	32.1862	31.6656
440228	1.5956	0.9251	28.3687	29.5372	31.2049	29.8345
450002	1.5341	0.8641	28.8521	29.7180	30.0562	29.5206
450005	1.1780	0.8325	24.5405	27.3473	27.9825	26.6743
450007	1.3224	0.8913	23.9490	24.4630	26.2568	24.8938
450008	1.4626	0.8757	24.5965	24.4372	26.1215	25.0328
450010	1.6138	0.9519	25.5582	30.1034	32.9053	29.4001
450011	1.6453	0.9133	28.5329	29.9302	30.9903	29.8097
450015	1.6528	0.9731	29.4919	30.3168	30.3228	30.0599
450018	1.6259	0.9934	30.7852	31.3131	32.9922	31.6815
450021	1.9128	0.9731	31.3107	31.7360	34.5462	32.5704
450023	1.3772	0.7944	25.5346	25.1683	25.6361	25.4489
450024	1.6424	0.8641	28.2047	27.3814	27.8816	27.8238
450028	1.6054	0.9301	29.5792	29.5689	29.8049	29.6529
450029	1.5777	0.8378	26.9361	28.6465	27.2662	27.6085
450031	***	*	30.3542	29.2141	28.8891	29.4756
450032	1.2893	0.8239	25.5785	26.3159	25.7989	25.8817
450033	1.6290	0.9301	27.8680	29.7668	31.6557	29.7124
450034	1.5775	0.8325	27.6929	29.6309	28.2761	28.5871
450035	1.5658	0.9934	28.8049	30.3369	30.8574	29.9707

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
450037	1.5618	0.8239	28.3403	28.2622	26.8661	27.7968
450039	1.7271	0.9578	28.2081	29.8145	29.5097	29.2092
450040	1.7040	0.8813	26.8412	28.5469	30.0844	28.4892
450042	1.7439	0.8608	26.5429	27.6131	28.3649	27.5546
450044	1.7966	0.9731	29.4293	32.9921	36.3786	32.9373
450046	1.6278	0.8661	25.5903	27.2439	28.4297	27.1379
450047	1.4946	0.9301	23.8457	24.9670	24.6290	24.4417
450051	1.9896	0.9731	29.9038	30.3976	31.0740	30.4714
450052	1.0420	0.7944	23.0007	24.3964	25.8142	24.3377
450054	1.7644	0.8757	26.5599	30.2211	30.7196	29.1912
450055	1.0273	0.7944	23.6382	24.1418	24.6436	24.1474
450056	1.7042	0.9515	31.4971	32.0902	33.7634	32.4957
450058	1.6192	0.8913	26.9918	27.7318	27.8963	27.5664
450059	1.2657	0.8988	27.3856	28.5645	29.9336	28.6174
450064	1.5627	0.9578	28.2786	29.0495	30.6704	29.3616
450068	2.1541	0.9934	30.5001	32.0372	34.9179	32.5258
450072	1.2471	0.9934	27.1081	28.0921	28.7063	28.0049
450073	0.8985	0.7944	26.1567	22.2322	23.1471	23.7807
450076	1.6978	*	*	*	*	*
450078	0.8990	0.7944	20.0758	20.7800	21.0876	20.6891
450079	1.6161	0.9731	30.5968	36.8936	34.1533	33.8021
450080	1.2896	0.9578	26.2439	26.8111	28.6334	27.2075
450082	1.1750	0.7944	24.2018	25.5654	27.1314	25.5425
450083	1.7873	0.8449	32.6462	30.2054	28.6628	30.4147
450085	1.0884	0.7944	25.6440	26.3610	28.1669	26.7018
450087	1.5138	0.9578	31.2668	32.6556	34.2493	32.7595
450090	1.2553	0.8594	21.8839	22.7822	22.2148	22.3070
450092	1.3425	0.7944	26.2781	28.2278	28.3891	27.6760
450096	***	*	28.1902	*	*	28.1902
450097	1.5629	0.9934	29.8734	31.9782	33.8910	31.8839
450099	1.3638	0.8469	31.7829	29.8491	25.5799	28.9998
450101	1.6205	0.8608	26.7457	28.4220	29.3777	28.2179
450102	1.7298	0.8449	26.4161	27.3364	27.5145	27.1220
450104	1.1987	0.8913	28.8063	27.7851	30.4631	28.9966
450107	1.6306	0.8641	27.8177	29.0328	29.6790	28.8492
450108	1.2102	0.8913	19.3245	22.4293	21.7619	21.2044
450119	1.5818	0.8883	31.1026	34.4161	31.0699	31.9515
450121	***	*	27.7472	*	*	27.7472
450123	1.1626	0.8325	26.2469	24.0433	27.6445	26.0567
450124	1.8022	0.9515	30.9140	31.9797	32.9774	32.0199
450126	1.4041	0.9934	30.5540	32.0370	32.9729	31.9011
450128	1.3154	0.8883	26.3296	28.3171	28.9733	27.8237

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
450130	1.2560	0.8913	24.3842	26.9208	28.3786	26.6105
450132	1.5872	0.9837	31.9981	31.1361	34.8719	32.6641
450133	1.5731	0.9348	30.0648	30.9622	31.3911	30.7940
450135	1.6951	0.9578	30.1385	30.7909	30.8734	30.6150
450137	1.6389	0.9578	31.9644	35.7775	33.8235	33.9369
450143	1.0079	0.9515	23.6834	24.4346	25.1702	24.4377
450144	1.0148	0.9348	29.2987	31.1552	31.4041	30.6148
450147	1.5111	0.8661	24.7221	26.3032	27.3607	26.1124
450148	1.2965	0.9578	29.6777	30.0542	29.9522	29.8983
450151	***	*	26.2011	22.8768	*	24.4313
450152	1.2361	0.8757	23.1056	24.3442	25.7523	24.4538
450154	1.3803	0.7944	22.9357	24.2582	23.2210	23.4578
450155	0.9665	0.7944	24.8052	24.8773	25.2546	24.9665
450162	1.2136	0.8813	32.9317	33.7823	27.1453	31.3191
450163	1.0701	0.7998	24.7857	27.0967	27.6273	26.4577
450165	1.1140	0.8913	29.1839	30.2236	30.3796	29.9469
450176	1.5142	0.8883	24.4338	25.8587	28.4561	26.3668
450177	1.1276	0.7944	24.4064	26.0895	27.7791	26.1268
450178	0.9422	0.9482	27.1184	28.5990	27.5779	27.7487
450184	1.6571	0.9934	29.5940	30.9726	32.7090	31.0735
450187	1.2029	0.9934	27.7374	29.2749	29.3048	28.7781
450188	0.9059	0.7944	23.2280	24.6823	23.0844	23.6821
450191	1.2724	0.9515	28.3937	31.1339	30.0686	29.8492
450192	1.0798	0.8215	26.4722	26.9884	27.5539	27.0243
450193	2.1739	0.9934	36.4793	37.1906	38.2891	37.3364
450194	1.2833	0.8157	24.3531	30.4381	28.6816	27.5562
450196	1.4613	0.7944	23.4577	25.4842	29.8107	26.1490
450200	1.6242	0.8153	25.6413	27.9843	27.5112	27.0045
450201	0.8832	*	23.2800	22.5464	*	22.8923
450203	1.2705	0.9434	27.8795	28.0986	29.4706	28.5080
450209	1.8398	0.8594	30.6146	31.9882	30.4150	30.9801
450210	1.0572	0.8095	22.5736	22.9055	23.7777	23.0259
450211	1.3669	0.8239	28.3770	28.8485	27.7427	28.3006
450213	1.8582	0.8913	26.8566	28.0307	29.2061	28.0652
450214	1.2733	0.9934	27.9913	28.2261	27.0761	27.7693
450219	0.9895	0.7944	23.9636	24.7274	28.0584	25.5336
450221	1.0409	0.7944	21.3721	20.7118	23.9462	21.9168
450222	1.7247	0.9934	30.3801	31.9255	33.2164	31.8255
450224	1.3848	0.8449	28.4382	28.7931	29.8428	29.0119
450229	1.6517	0.8336	25.1370	26.8039	27.2189	26.3503
450231	1.6810	0.8594	26.9783	27.0545	27.7289	27.2535
450234	0.9997	0.7944	20.4659	21.6799	23.2715	22.0290

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
450235	0.9717	0.7944	21.8967	23.8001	24.3335	23.3234
450236	1.1613	0.8333	22.9622	24.5942	24.1409	23.8937
450237	1.7146	0.8913	30.5885	31.2197	36.8412	32.7355
450239	0.9716	0.8757	19.1359	18.4234	19.1203	18.8870
450241	1.0885	0.7944	21.3641	28.4948	24.3518	24.7248
450243	0.9550	0.7944	17.2966	19.0180	19.9804	18.7968
450253	0.8958	0.9934	24.1056	22.9918	24.3618	23.8228
450270	1.2553	0.8215	19.8180	12.9999	19.0341	16.6811
450271	1.4195	0.9434	24.1269	23.9534	27.4614	25.2835
450272	1.1688	0.9515	27.0521	29.0917	29.5124	28.5634
450280	1.5642	0.9731	31.6575	34.9349	33.8297	33.4749
450283	1.0776	0.9578	24.1754	28.2094	24.3428	25.4325
450289	1.4997	0.9934	32.6533	32.6137	32.4591	32.5747
450292	1.2632	0.9731	26.8110	29.0243	29.2485	28.3699
450293	0.8881	0.7944	24.0827	24.1556	23.7577	23.9982
450296	1.0740	0.9934	31.5596	33.4545	34.1708	33.0235
450299	1.5616	0.9133	28.4171	29.4593	30.3493	29.4809
450306	0.9008	0.8336	22.9486	22.6818	25.9877	23.7667
450315	1.9177	0.9731	*	31.4227	32.3840	31.9584
450324	1.6449	0.9578	26.6093	27.9899	26.8023	27.1406
450330	1.2720	0.9934	27.1100	27.7419	29.4471	28.1010
450340	1.3442	0.8068	25.6791	29.6617	28.7672	28.0047
450346	1.5153	0.8325	23.8720	24.8434	26.7809	25.2176
450347	1.2846	0.9934	30.7825	28.5789	30.0644	29.8229
450348	0.9987	0.7944	21.0484	22.6828	23.1190	22.2864
450351	1.1913	0.9434	29.2560	29.9598	30.3441	29.8443
450352	1.1072	0.9731	27.2983	27.6480	29.3516	28.1235
450353	***	*	27.9576	*	*	27.9576
450358	2.0165	0.9934	32.5922	33.9103	36.9859	34.5038
450369	0.9205	0.7944	22.8525	24.1953	22.7433	23.2001
450370	1.3004	0.9934	26.3235	29.0816	28.8348	28.0415
450372	1.4118	0.9731	29.5022	30.9345	33.7023	31.4119
450373	0.8443	0.7944	27.0726	27.4251	25.3691	26.6276
450378	1.2317	0.9934	32.2278	33.0583	33.9891	33.0955
450379	1.3439	0.9731	35.3807	35.0637	35.9067	35.4398
450388	1.7199	0.8913	27.8155	29.5386	30.3720	29.2611
450389	1.1353	0.9578	26.9638	26.8499	24.6733	26.1617
450393	0.6145	0.8299	*	39.0266	12.9286	23.0125
450395	1.0959	0.8385	26.7743	28.4272	27.2714	27.4941
450399	0.9053	0.7944	22.1731	20.6307	23.2716	22.0164
450400	1.0937	0.7944	26.2871	29.5020	29.8965	28.4062
450403	1.3474	0.9731	29.8643	31.7065	33.1710	31.6519

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
450411	1.0156	0.7944	21.5746	21.7877	20.9108	21.4211
450419	1.4465	0.9578	34.2427	34.9972	33.6834	34.2792
450422	1.0342	0.9731	31.3454	32.4669	36.7309	33.3794
450424	1.4314	0.9934	30.7228	29.8290	32.4674	31.0243
450431	1.7394	0.9515	27.3926	28.5289	29.6446	28.5457
450438	1.1937	0.9934	26.5223	27.7734	25.1006	26.4737
450446	0.7700	0.9934	17.2871	15.4641	12.4405	15.0188
450447	1.1800	0.9578	26.5238	28.3724	29.9936	28.3029
450451	1.1077	0.8480	26.5477	25.8836	26.5422	26.3265
450460	0.9546	0.7997	24.9870	25.2165	27.6224	25.9432
450462	1.6663	0.9731	30.1466	30.6516	31.7311	30.8439
450465	1.2032	0.9934	27.0835	28.1853	28.0105	27.7846
450469	1.4654	0.9578	26.3445	31.1348	29.2172	28.8575
450475	1.2340	0.8239	24.5176	24.7037	25.0642	24.7745
450484	1.4622	0.8239	28.3913	27.7792	29.4306	28.5230
450488	1.3668	0.8239	23.7985	24.9109	26.6089	24.9764
450489	0.9673	0.7944	25.2680	26.9543	25.3695	25.8549
450497	1.0350	0.8319	23.1860	23.0712	24.6056	23.6315
450498	0.9862	0.7944	20.2475	20.6873	19.3077	20.0710
450508	1.4188	0.8239	27.2850	29.1519	30.4829	29.0025
450514	***	*	27.3043	26.4196	*	26.8548
450518	1.4298	0.8325	29.1322	27.5880	28.9969	28.5032
450530	1.3209	0.9934	29.9720	30.7745	31.5033	30.7512
450537	1.5827	0.9731	28.7448	30.9167	33.1500	30.8952
450539	1.1649	0.8011	24.2151	25.0191	25.5268	24.9160
450547	0.9435	0.9578	34.3349	25.4140	24.6575	27.5535
450558	1.7672	0.8336	28.0655	28.7747	30.9433	29.2592
450563	1.5301	0.9578	32.0507	32.6875	35.8856	33.5364
450565	1.2719	0.9434	28.1741	27.4774	28.0400	27.8916
450571	1.6075	0.8068	27.4605	26.5313	26.2046	26.7210
450573	1.1286	0.8070	22.1492	24.6750	28.8508	25.2439
450578	0.9834	0.7944	25.0498	25.2478	25.7938	25.3861
450580	1.0385	0.7944	23.9004	25.9881	23.7932	24.5461
450584	1.0287	0.7944	22.5204	23.6044	23.7329	23.2726
450586	0.9974	0.7944	20.6699	18.3289	19.8656	19.6250
450587	1.1871	0.7944	25.0174	25.9364	27.1505	26.0061
450591	1.1634	0.9934	27.1744	27.9867	26.8802	27.3410
450596	1.2725	0.9434	29.8462	31.6590	30.9701	30.8601
450597	0.9831	0.7944	24.2586	24.8443	26.3300	25.1065
450604	1.4107	0.7944	25.9133	29.1543	27.9983	27.7150
450605	1.0350	0.8661	23.9332	14.8039	23.3169	20.2003
450610	1.5957	0.9934	28.3713	30.5977	32.1314	30.2856

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
450615	1.0208	0.7977	24.1902	22.6331	25.1269	23.9621
450617	1.5930	0.9934	28.8323	30.2923	31.5691	30.2388
450620	1.0663	0.7944	20.3723	21.2535	21.7871	21.1315
450630	1.5593	0.9934	29.8431	31.8014	32.3195	31.3152
450634	1.6794	0.9731	30.3274	31.8008	31.9667	31.3593
450638	1.6656	0.9934	32.4911	33.3237	34.1802	33.2981
450639	1.5194	0.9578	32.6255	34.3754	33.3962	33.4626
450641	0.9429	0.8319	20.2483	21.7292	20.0231	20.6572
450643	1.3395	0.8378	24.4999	27.2538	28.7747	26.8447
450644	1.5683	0.9934	30.7815	31.6874	33.5265	32.0374
450646	1.5571	0.8641	26.8060	27.4631	27.8352	27.3616
450647	1.9320	0.9731	32.4236	34.1016	35.2696	33.9611
450651	1.7455	0.9731	31.9261	33.6498	34.9917	33.4903
450653	1.1436	0.7944	26.1756	26.5361	27.8569	26.8554
450654	0.9489	0.7944	22.5447	25.0755	23.5856	23.7098
450656	1.4697	0.8239	28.1493	29.7290	30.0651	29.2769
450658	0.9753	0.7944	24.7856	22.7090	21.8183	23.0156
450659	1.5238	0.9934	34.2380	34.2657	35.0007	34.4823
450661	1.5198	0.9837	30.0751	29.2381	29.1701	29.4733
450662	1.6918	0.9301	29.0532	30.9630	32.8936	31.0032
450668	1.5626	0.8641	30.6114	30.2083	30.7673	30.5246
450669	1.2242	0.9731	30.2374	32.1244	32.6777	31.6620
450670	1.5707	0.9934	26.4266	26.2954	28.8285	27.2168
450672	1.7704	0.9578	31.8420	33.0858	34.5171	33.1836
450674	1.0249	0.9934	29.8971	31.9316	33.4719	31.8222
450675	1.4724	0.9578	30.9562	32.6380	34.4049	32.7257
450677	1.2959	0.9578	27.2760	27.1603	29.5819	28.0301
450678	1.5536	0.9731	33.3386	33.5513	33.6167	33.5018
450683	1.1546	0.9731	21.1737	24.8440	28.7984	24.1904
450684	1.3944	0.9934	30.2139	31.2765	31.8794	31.1227
450686	1.6274	0.8813	25.8530	26.4871	28.8211	27.1416
450688	1.4836	0.9731	26.9897	29.4393	30.4156	28.8321
450690	1.4246	0.8449	26.1743	30.0577	31.8607	29.0551
450694	1.1525	0.7944	24.0031	27.0862	28.3456	26.2524
450697	1.5110	0.8913	26.4132	28.3002	29.0148	27.9322
450698	0.9076	0.8071	21.5742	23.3062	21.5450	22.0600
450702	1.5383	0.8239	26.3696	27.1318	26.9753	26.8294
450709	1.5117	0.9934	27.1077	31.3239	31.0331	29.8756
450711	1.5475	0.8883	27.5622	28.1040	29.2934	28.3187
450713	1.6625	0.9515	29.4980	30.4933	31.3274	30.4671
450715	1.2672	0.9731	17.0235	*	27.0982	20.6530
450716	1.4238	0.9934	33.7096	33.9926	33.4960	33.7318

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
450718	1.5519	0.9515	28.1560	29.7609	30.6623	29.5783
450723	1.4975	0.9731	30.1704	31.0481	32.1316	31.1335
450730	1.3480	0.9731	32.7293	32.8920	34.9137	33.4736
450742	1.2318	0.9731	30.0583	30.4204	31.4270	30.6452
450743	1.4610	0.9731	28.4736	29.5098	30.3302	29.5107
450746	1.0168	0.7944	22.7873	23.3484	22.7535	22.9663
450747	1.2242	0.8449	25.8175	28.3935	27.1975	27.1094
450749	0.9484	0.7944	22.1562	23.9269	23.0265	23.0070
450751	***	*	21.4223	*	*	21.4223
450754	0.9626	0.7944	24.7797	22.8572	23.4607	23.6054
450755	0.9619	0.8220	22.2006	24.7428	22.4195	23.0470
450758	***	*	28.2803	28.3305	29.5013	28.6021
450760	***	*	25.1637	23.7157	24.0691	24.3311
450766	1.9124	0.9731	30.2341	31.2084	33.3435	31.5447
450770	1.2334	0.9515	24.3244	23.6093	25.5863	24.5042
450771	1.5931	0.9731	32.0500	32.5014	32.6206	32.4010
450774	1.7583	0.9934	25.7436	27.5065	29.1151	27.5419
450775	1.4383	0.9934	29.8230	31.6656	33.1582	31.6041
450779	1.3582	0.9578	31.8403	32.0770	31.4350	31.7632
450780	2.1986	0.8913	27.0084	28.5560	29.4960	28.3799
450788	1.5370	0.8661	28.3759	29.7667	31.5593	29.8889
450795	1.2428	0.9934	32.9803	43.8574	31.1871	36.0870
450796	1.9000	0.8594	37.6274	39.4762	31.6590	36.0571
450797	***	0.9934	24.8598	26.0302	29.7074	26.8190
450801	1.5512	0.8153	23.6072	25.6379	27.2635	25.5050
450803	1.2318	0.9934	29.0106	28.7041	28.4345	28.7228
450804	1.9634	0.9934	29.1282	31.1891	33.2767	31.2471
450808	1.9079	0.9515	23.0312	29.6476	27.4132	26.6467
450809	1.6269	0.9515	27.3080	29.4696	30.4031	29.0998
450811	1.0131	0.8883	31.2208	31.3007	32.5513	31.6760
450813	1.0733	0.8070	22.9289	26.5803	24.0804	24.5011
450820	1.6399	0.9934	33.9030	34.7445	36.4796	35.1468
450822	1.4897	0.9731	32.2145	34.4060	34.7760	33.8531
450824	2.6241	0.9515	33.3653	31.8413	34.8301	33.3115
450825	1.4589	0.8883	25.1521	25.8006	23.6674	24.8630
450827	1.4259	0.9519	24.1984	24.3659	23.6628	24.0692
450828	1.3210	0.7944	24.8236	26.9553	26.3231	25.9968
450829	***	*	19.5842	*	*	19.5842
450830	1.0676	*	27.8005	28.4007	*	28.0974
450831	1.5344	0.9934	23.9467	24.4141	24.2732	24.1921
450832	1.4673	0.9934	27.3290	28.1389	31.2830	29.0578
450833	1.2357	0.9731	27.9649	29.0256	30.3604	29.1582

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
450834	1.5917	0.9133	27.4844	26.7253	28.1564	27.4378
450838	0.9160	0.8070	18.9620	19.2949	20.3039	19.4912
450839	0.9870	0.7944	27.2199	27.5330	28.0060	27.5802
450840	1.3170	0.9731	32.2538	32.4162	34.1412	33.0764
450841	2.0854	0.9301	20.9424	24.4389	24.6321	23.4298
450844	1.3785	0.9934	33.7978	33.0758	34.7070	33.8874
450845	1.8836	0.8641	29.9265	28.5039	30.9556	29.7787
450847	1.3062	0.9934	29.7356	30.7431	31.6028	30.7341
450848	1.3685	0.9934	30.5546	31.1476	32.0471	31.2633
450850	***	*	31.9606	27.2653	*	29.4295
450851	2.1789	0.9731	35.1102	32.8377	35.2085	34.3481
450853	1.9978	0.9731	37.1043	38.3600	37.5237	37.6872
450855	1.6791	0.9301	32.6916	30.7353	33.0196	32.0840
450856	2.2420	0.8913	37.7362	35.5006	35.5221	36.2139
450860	1.8054	0.9934	29.1075	33.3404	36.0060	32.7588
450862	1.6682	0.9934	31.8095	33.7962	34.2163	33.3748
450864	2.2651	0.8449	24.5049	25.3535	26.6579	25.6140
450865	1.1199	0.9515	29.9559	31.9200	34.6338	32.2797
450867	1.2503	0.9515	29.5879	31.4953	33.8712	31.6906
450868	***	*	25.3486	27.7501	28.4524	27.1225
450869	2.0556	0.8883	26.1616	28.7422	27.9532	28.0482
450871	1.8884	0.9515	28.9150	32.3990	35.2470	32.1760
450872	1.4202	0.9578	27.2833	31.7345	30.7510	30.2016
450873	***	*	14.8821	*	*	14.8821
450874	2.0151	0.9731	34.6083	35.6839	37.4432	36.0736
450875	1.8486	0.8594	23.2763	23.2962	26.9904	24.4507
450876	1.8214	0.8813	28.4343	30.3515	30.7721	29.9322
450877	1.5117	0.8641	26.1867	29.2353	28.0504	27.8234
450878	2.5628	0.8913	31.6750	33.6269	33.5225	32.9489
450879	***	*	35.5672	36.4874	31.1510	34.0526
450880	1.7282	0.9578	35.9572	32.6713	32.1245	33.3470
450881	***	*	24.5464	*	*	24.5464
450882	***	*	26.6910	*	*	26.6910
450883	2.9981	0.9731	35.2646	37.1525	38.5954	37.1234
450884	0.9428	0.8288	27.8213	23.5799	25.0230	25.3642
450885	1.4667	0.9731	34.1148	36.0954	33.7612	34.6323
450886	1.4731	0.9578	*	30.1571	33.2011	31.7408
450887	***	*	*	25.5590	*	25.5590
450888	1.8917	0.9458	*	28.5995	26.3027	27.2930
450889	2.0193	0.9731	*	35.6151	29.1149	31.7649
450890	1.5522	0.9731	*	32.2000	33.9068	33.1681
450891	1.7321	0.9731	*	39.0890	29.7832	33.7188

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
450892	***	*	*	39.5333	*	39.5333
450893	1.5130	0.9731	*	36.2660	37.8279	37.0922
450894	2.2251	0.9731	*	25.9441	34.3388	30.3271
450895	***	*	18.4142	*	*	18.4142
460001	1.9740	0.9444	30.0040	30.7040	32.3262	31.0505
460003	1.6340	0.9450	32.3427	29.6450	31.8128	31.2758
460004	1.7841	0.9450	29.6342	29.8773	32.2759	30.6290
460005	1.5557	0.9450	26.0731	29.4188	29.6947	28.4160
460006	1.6503	0.9450	28.3678	28.9653	30.3798	29.2376
460007	1.2729	0.9386	28.0035	29.1191	30.8583	29.3990
460008	***	*	31.5485	27.6906	30.5351	29.9030
460009	1.9058	0.9450	28.3836	29.4705	31.5120	29.8433
460010	2.0519	0.9450	30.4606	30.9813	32.8157	31.4456
460011	1.3313	0.8442	24.9677	26.5486	27.0189	26.1914
460013	1.4545	0.9444	29.2731	29.7252	31.2945	30.1031
460014	1.1400	0.9450	29.5963	30.6450	30.0229	30.0846
460015	1.4607	0.9014	29.1318	28.8014	30.7369	29.5808
460017	1.3646	0.8825	26.1589	28.7126	29.8556	28.2650
460018	1.0089	0.8442	22.8028	22.0935	24.7761	23.2405
460019	1.1464	0.8442	23.2202	25.1615	24.9579	24.4662
460021	1.8769	1.1523	29.5761	29.7397	31.5207	30.3172
460023	1.3298	0.9444	28.5884	28.9473	30.5888	29.4321
460026	0.9996	0.9443	27.9487	29.2775	31.3552	29.5594
460030	1.1111	0.8442	24.4218	26.8979	30.0714	27.0882
460033	0.8479	0.8442	26.6606	27.9108	29.0346	27.8794
460035	0.9356	0.8442	21.9115	23.8682	23.4736	23.0722
460039	1.0362	0.9414	30.4912	30.0677	32.8010	31.1589
460041	1.4614	0.9450	26.3807	26.7356	29.4568	27.5035
460042	1.5794	0.9450	26.8389	36.2903	35.5686	32.5483
460043	1.1877	0.9444	28.6668	29.5660	31.2717	29.8856
460044	1.3504	0.9450	28.7023	29.5079	31.4469	29.9083
460047	1.6969	0.9450	29.9990	31.0020	33.0291	31.3339
460049	2.0061	0.9450	28.4884	28.6267	32.0329	29.8125
460051	1.4927	0.9450	27.8841	28.1140	28.6559	28.2613
460052	1.6830	0.9444	27.1995	28.7455	30.2613	28.8219
460054	1.6314	0.9014	25.7870	26.3939	28.1478	26.7778
470001	1.2744	1.0004	29.7540	32.2887	34.5891	32.0548
470003	1.8557	1.0456	30.1973	30.0535	35.8753	32.2869
470005	1.3232	0.9590	33.1981	33.9969	32.1087	33.0909
470011	1.1987	0.9590	29.6269	30.8742	32.1668	30.9241
470012	1.2633	1.0260	27.0751	29.8259	30.9839	29.3181
470024	1.2604	1.0456	26.6351	27.3106	28.9203	27.6164

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
490001	1.0881	0.8101	24.0368	24.6883	25.2705	24.6827
490002	0.9770	0.8104	21.7092	24.0672	26.2533	23.9078
490004	1.3432	0.9141	27.5890	28.8660	30.6657	29.0473
490005	1.6316	1.0700	30.5349	31.4909	32.7159	31.6193
490007	2.0639	0.8930	29.3098	30.7411	31.5954	30.5805
490009	2.0365	0.9245	28.4642	31.4260	30.5748	30.1489
490011	1.5989	0.8930	27.4764	28.8780	30.5522	28.9359
490012	1.0707	0.8101	22.9922	21.8322	22.3339	22.3878
490013	1.3957	0.9590	25.5560	27.3486	27.4108	26.7616
490017	1.5008	0.8930	27.5902	29.6784	29.5853	28.9560
490018	1.3696	0.9141	27.2644	27.8682	28.8491	28.0010
490019	1.1960	1.0700	25.8264	29.8891	33.5636	29.5310
490020	1.3234	0.9369	29.3468	30.6013	32.5621	30.8119
490021	1.4594	0.8323	27.0641	28.1254	28.1343	27.7739
490022	1.4481	1.0700	30.1203	31.7985	34.5366	32.2948
490023	1.3489	1.0700	30.9920	32.6308	33.4561	32.3822
490024	1.6983	0.8840	27.9689	29.0407	29.9188	28.9972
490027	1.2394	0.8101	23.0017	24.3834	23.6876	23.5951
490032	2.0591	0.9369	28.5897	28.0120	30.0331	28.8893
490033	1.1536	1.0700	31.8282	30.9910	32.1854	31.6637
490037	1.2278	0.8101	25.2859	26.2951	28.9020	26.8443
490038	1.1734	0.8104	22.6504	24.0852	25.7219	24.1531
490040	1.5211	1.0700	34.1841	35.6822	36.5546	35.4761
490041	1.6040	0.8930	27.1613	29.1244	30.4198	28.9376
490042	1.3335	0.8721	25.7333	26.6078	28.1989	26.8374
490043	1.3812	1.0771	35.8872	36.5982	33.4364	35.2326
490044	1.4387	0.8930	23.3793	24.1763	30.3606	25.9954
490045	1.3576	1.0700	30.3772	32.8774	34.0289	32.4468
490046	1.5600	0.8930	27.9604	29.3882	30.5445	29.3251
490048	1.4892	0.8840	27.0620	28.0320	29.1952	28.0886
490050	1.5406	1.0700	32.2993	31.1370	33.3979	32.2722
490052	1.7255	0.8930	25.0046	25.4179	26.5858	25.6598
490053	1.2093	0.8123	23.8004	24.6206	25.5300	24.6561
490057	1.6632	0.8930	27.4918	29.0700	30.5163	29.0742
490059	1.7112	0.9369	30.8669	32.1031	32.7894	31.9415
490060	1.0553	0.8101	24.3192	25.7765	26.2620	25.4412
490063	1.8888	1.0771	31.6069	34.1179	35.7722	33.8561
490066	1.4008	0.9369	29.5917	31.4298	31.1949	30.7538
490067	1.2778	0.9369	25.9497	26.7802	27.5172	26.7391
490069	1.6622	0.9369	29.1527	30.1482	33.1140	30.8306
490071	1.4811	0.9369	31.7061	33.7118	36.1311	33.8122
490073	***	*	34.5774	46.4210	*	38.3199

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
490075	1.3989	0.8298	25.7323	27.3424	27.8663	26.9133
490077	1.4740	0.9245	28.1506	31.0016	33.5266	30.9254
490079	1.3080	0.8960	25.2340	24.2066	25.3814	24.9293
490084	1.2031	0.8288	25.7657	26.3234	28.0861	26.7498
490088	1.0737	0.8323	25.0619	26.0285	26.5138	25.8817
490089	1.1556	0.8840	25.9902	27.4587	28.7200	27.4152
490090	1.1096	0.8101	25.5418	27.0760	28.1280	26.9253
490092	1.0140	0.8101	25.7405	27.5277	26.9546	26.7455
490093	1.5421	0.8930	26.7886	28.7122	29.2159	28.2637
490094	1.0235	0.9369	28.9155	29.7990	33.4960	30.8345
490097	1.0939	0.9369	27.1470	27.4608	27.3832	27.3345
490098	1.2631	0.8101	25.1625	26.7152	29.1195	27.0537
490101	1.4788	1.0771	32.3695	32.9516	36.2501	33.9005
490104	0.8552	0.9369	17.0548	19.0056	21.5140	19.0764
490105	0.7736	0.8104	26.3827	*	*	26.3827
490106	0.8850	0.8101	25.7352	26.2318	28.0073	26.6295
490107	1.4508	1.0771	33.5430	35.0272	36.5156	35.0651
490108	1.0375	0.8323	23.3204	27.8717	26.8474	26.0300
490109	0.8876	0.8930	24.2296	21.6711	26.3100	24.0657
490110	1.4059	0.8534	24.9861	26.3089	28.6114	26.6064
490111	1.1788	0.8101	22.7336	26.4297	25.9801	24.8668
490112	1.8421	0.9369	29.0816	31.2549	32.6940	30.9721
490113	1.3312	1.0700	32.4547	34.7841	34.3609	33.8935
490114	1.2331	0.8101	22.1387	23.0533	23.6217	22.9871
490115	1.1689	0.8101	23.5718	23.2118	24.2056	23.6642
490116	1.1350	0.8101	24.3853	25.0351	26.8981	25.4473
490117	1.0820	0.8101	18.1138	20.3038	19.0627	19.1474
490118	1.6707	0.9369	29.0569	31.2407	32.7697	30.9818
490119	1.3137	0.8930	27.8866	29.5222	30.2401	29.2569
490120	1.4783	0.8930	25.9610	27.1990	29.8199	27.7041
490122	1.6156	1.0771	33.3719	35.2234	36.8356	35.1656
490123	1.1418	0.8101	24.2254	24.6011	25.9018	24.9121
490126	1.2742	0.8101	24.0908	25.3294	26.4277	25.2588
490127	1.1263	0.8101	23.5161	23.1399	23.5161	23.3911
490130	1.2723	0.8930	25.3352	25.9782	27.8912	26.4178
490134	0.8132	0.8101	33.2405	31.1495	36.6290	33.6266
490135	0.7928	0.8840	25.9998	27.2795	29.4817	27.5770
490136	1.4979	0.9369	*	31.2911	33.2256	32.4123
490137	***	*	*	*	33.7203	33.7203
490138	2.2840	0.8323	*	*	*	*
490139	2.7551	0.9369	*	*	*	*
500001	1.6102	1.1384	33.0901	37.5323	34.4057	34.9332

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
500002	1.4327	1.0119	29.1448	30.1872	32.8317	30.8058
500003	1.3632	1.1236	32.1262	32.7983	34.5869	33.2512
500005	1.8826	1.1384	35.0997	36.0918	36.7598	35.9756
500007	1.3163	1.1236	30.5263	31.0313	32.8189	31.4980
500008	1.9890	1.1384	33.5666	34.7810	37.6578	35.3344
500011	1.4404	1.1384	32.6223	38.3979	35.9571	35.5224
500012	1.6881	1.0119	33.8101	33.1685	34.1650	33.7191
500014	1.7126	1.1384	36.5833	37.2698	36.3915	36.7438
500015	1.4132	1.1384	37.5724	40.8683	41.8914	40.1038
500016	1.6525	1.1236	32.9177	34.2828	35.1946	34.1760
500019	1.2624	1.0250	31.6242	33.8882	33.3151	32.9645
500021	1.3087	1.1236	32.4702	33.5610	34.1696	33.4270
500024	1.6981	1.1174	36.1647	37.4529	38.1144	37.2454
500025	1.9310	1.1384	40.6369	44.7105	45.7929	43.8482
500026	1.5367	1.1384	34.5881	35.5080	38.9294	36.2903
500027	1.5037	1.1384	39.2906	42.4974	43.3521	41.7614
500030	1.6550	1.1279	34.9174	36.9489	37.8938	36.6136
500031	1.3350	1.1174	33.2391	34.1651	37.1418	34.9064
500033	1.2905	1.0119	31.8891	32.6753	33.5611	32.7471
500036	1.3216	1.0119	30.5938	31.9164	33.0937	31.9624
500037	1.0778	1.0119	31.2654	29.1773	31.5221	30.6541
500039	1.5611	1.1236	33.5606	34.5739	35.7525	34.6892
500041	1.4894	1.1205	34.2017	36.9273	37.1754	36.2462
500044	1.9133	1.0435	31.0936	32.0743	32.9066	32.0639
500049	1.4338	1.0119	29.8189	30.8135	32.9904	31.2359
500050	1.6242	1.1205	33.7713	35.7254	35.8576	35.1367
500051	1.8035	1.1384	34.7610	36.4764	38.1805	36.4718
500052	1.3105	1.1384	*	*	*	*
500053	1.2195	1.0266	30.2811	28.5664	35.5776	31.7702
500054	1.9866	1.0435	32.5105	34.8114	36.0163	34.4612
500058	1.6170	1.0266	30.7034	32.6843	33.9116	32.4979
500060	1.3185	1.1384	38.7682	40.3040	33.4139	37.1003
500064	2.0432	1.1384	32.3581	34.7925	36.5889	34.6273
500072	1.3287	1.0482	32.5269	33.1148	33.7689	33.1475
500077	1.5291	1.0435	33.2223	34.3114	35.6352	34.4322
500079	1.4138	1.1236	32.5809	34.2420	35.0285	33.9265
500084	1.2876	1.1384	32.7883	33.3072	35.9603	34.0376
500088	1.4753	1.1384	36.7953	38.5194	39.5328	38.3346
500108	1.6440	1.1236	34.3872	35.8918	36.9874	35.7469
500119	1.4085	1.0435	31.2233	31.7125	33.2862	32.1744
500124	1.5218	1.1384	34.4790	36.3338	36.2555	35.7223
500129	1.6514	1.1236	34.4447	37.3189	39.0479	36.9829

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
500134	***	*	28.1374	28.9759	27.6000	28.2147
500138	2.5522	*	*	*	*	*
500139	1.5705	1.1174	34.6412	37.5709	37.3065	36.4397
500141	1.3048	1.1384	33.7532	34.2384	35.0996	34.3749
500143	0.6636	1.1174	25.3099	26.3893	27.6976	26.4518
500148	1.2444	1.0119	37.7830	24.6347	29.1435	30.5542
500150	1.3442	1.1205	*	34.8480	37.1238	36.0045
510001	1.8311	0.8583	25.8693	26.7924	27.6648	26.8130
510002	1.2656	0.8710	23.7270	24.8846	25.3769	24.6482
510006	1.3698	0.8571	24.8777	26.6421	27.5033	26.3125
510007	1.6741	0.9025	27.1149	28.5783	29.7125	28.4782
510008	1.3748	0.9167	27.5241	27.4709	30.6397	28.6009
510012	0.9673	0.7594	20.8455	22.9038	23.9222	22.5456
510013	1.1468	0.7470	22.8779	22.9612	22.1864	22.6740
510018	1.1290	0.8184	23.1043	23.7736	22.6582	23.1832
510022	1.8740	0.8297	26.8328	27.6119	28.4911	27.6593
510023	1.2667	0.7470	21.0940	23.1461	21.1483	21.7758
510024	1.7025	0.8583	26.6621	31.1327	32.3022	30.0824
510026	0.9969	0.7470	19.2025	17.8275	18.6662	18.5424
510029	1.3627	0.8297	24.0872	25.3925	24.6743	24.7016
510030	1.1655	0.7470	24.2007	25.5600	26.0174	25.2793
510031	1.5328	0.8297	24.0237	26.7872	29.5993	26.6802
510033	1.5122	0.7656	24.0796	24.2839	24.4150	24.2598
510038	1.0712	0.7470	20.9180	21.7545	21.1103	21.2664
510039	1.2959	0.7470	20.4719	21.3819	21.7158	21.2010
510046	1.3878	0.7522	22.2935	24.7187	23.2634	23.4223
510047	1.2046	0.8583	27.6859	28.8794	30.0461	28.9178
510048	1.2529	0.7470	22.7930	23.6396	25.0987	23.8227
510050	1.6608	0.8583	21.9009	23.5794	24.3081	23.2370
510053	0.9858	0.7470	21.5338	22.6288	24.3853	22.8597
510055	1.5437	0.9025	29.4111	30.7382	32.3284	30.8687
510058	1.3729	0.7656	25.3248	24.8770	24.9360	25.0450
510059	0.7523	0.8297	20.8847	21.9053	20.5651	21.0652
510062	1.1932	0.7470	26.7066	27.7971	30.4515	28.3064
510067	***	*	25.2130	25.2248	25.4499	25.2847
510070	1.2990	0.8184	23.9742	25.4981	26.1227	25.1763
510071	1.3043	0.7522	23.2954	23.4553	21.7085	22.8403
510072	1.0095	0.7470	19.4370	20.2387	20.1981	19.9461
510077	1.0677	0.8714	25.9515	27.1611	24.7849	25.9584
510082	1.1525	0.7470	20.3279	21.1665	24.7558	22.2109
510085	1.3595	0.8297	26.2617	26.8133	27.6206	26.8691
510086	1.1870	0.7470	19.2606	20.1965	21.2628	20.1982

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage[2] (3 years)
510090	***	*	*	39.0787	*	39.0787
520002	1.2941	0.9467	29.0501	28.3413	28.2765	28.5003
520004	1.5470	0.9943	28.9857	30.9212	32.9848	30.9710
520008	1.5742	1.0158	33.8057	33.6774	36.6697	34.8261
520009	1.6203	0.9245	28.8591	29.6290	31.0683	29.8748
520011	1.3143	0.9226	28.0224	29.5024	31.8421	29.7770
520013	1.5238	1.0943	30.1834	32.1721	33.9209	32.1439
520017	1.1684	0.9496	29.3278	31.0537	31.8512	30.7715
520019	1.2905	0.9226	29.8640	30.2189	28.8256	29.5186
520021	1.3449	1.0392	29.1129	29.7809	29.0525	29.3150
520027	1.4473	1.0158	32.4137	33.5836	33.5264	33.1918
520028	1.3295	1.0990	28.0813	29.4694	28.1055	28.5736
520030	1.6907	0.9644	30.5724	31.6807	32.0646	31.4365
520033	1.2332	0.9226	29.0236	30.2631	29.5690	29.6252
520034	1.3278	0.9226	26.8886	28.1819	30.4913	28.5675
520035	1.5013	0.9334	28.1048	29.4076	31.0972	29.5916
520037	1.7070	0.9467	32.2144	32.2206	33.1606	32.5445
520038	1.2120	1.0158	29.6339	30.5267	32.6502	30.9444
520040	***	*	31.2038	35.9652	*	33.6870
520041	1.1136	1.1221	25.3764	26.1586	28.3889	26.6401
520044	1.2966	0.9334	28.2382	28.6620	*	28.4590
520045	1.6508	0.9248	29.2556	30.0856	29.6250	29.6558
520048	1.5494	0.9248	29.1870	30.1483	31.8604	30.3220
520049	1.9346	0.9447	28.0936	29.4238	29.8707	29.1461
520051	1.5293	1.0158	31.5974	32.4131	32.5510	32.2842
520057	1.2514	0.9419	29.1158	29.1597	31.7777	30.0703
520059	1.4089	1.0031	30.4491	31.1798	32.1905	31.2796
520062	1.3074	1.0158	32.8584	32.7015	37.5630	34.4572
520063	1.1993	1.0158	30.3391	31.5200	32.6383	31.5371
520064	1.5393	1.0158	31.5723	33.1269	34.1899	32.9715
520066	1.4451	0.9448	31.0644	31.6793	31.2257	31.3101
520070	1.7850	0.9496	28.2059	30.0475	30.2454	29.5398
520071	1.2686	1.0031	30.6930	31.5452	32.9974	31.7906
520075	1.7166	0.9447	30.1582	32.2773	33.5393	31.9871
520076	1.2100	1.0031	27.4423	26.8943	28.0857	27.4825
520078	1.4660	1.0158	31.6606	32.0200	32.8377	32.1530
520083	1.7208	1.1221	32.7728	34.7230	36.8165	34.8180
520087	1.7034	0.9943	30.5659	31.9771	33.5759	32.0481
520088	1.3258	0.9797	30.6657	30.7482	32.9061	31.4556
520089	1.5580	1.1221	33.4098	34.9357	36.3819	34.9244
520091	1.3038	0.9226	27.3442	28.7180	29.9318	28.6971
520095	1.2320	1.0990	32.0381	33.2426	33.3298	32.8475

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
520096	1.3908	1.0031	29.5985	29.2895	31.5023	30.1746
520097	1.3771	0.9447	29.9998	30.5442	32.2225	30.9341
520098	2.0135	1.1221	36.5776	38.0993	39.1444	37.9718
520100	1.3408	0.9448	29.9458	31.7772	32.4038	31.3812
520102	1.2398	1.0031	30.7990	31.5756	31.9275	31.4306
520103	1.5202	1.0158	32.6269	34.5640	35.3825	34.2275
520107	1.3548	0.9641	29.4178	30.0354	31.6500	30.3663
520109	1.0568	0.9226	25.0697	25.9740	27.2739	26.1298
520113	1.3020	0.9325	33.3475	33.3040	34.9718	33.8684
520116	1.2949	1.0031	30.2156	31.6702	32.7105	31.5573
520132	***	*	27.3431	*	*	27.3431
520136	1.6767	1.0158	32.1479	32.3504	32.8906	32.4683
520138	1.9040	1.0158	31.6581	32.5677	33.5487	32.6101
520139	1.3339	1.0158	30.4903	31.7086	32.9369	31.7704
520140	***	*	31.1315	*	*	31.1315
520160	1.8053	0.9245	29.5582	30.3052	31.0392	30.2940
520170	1.4915	1.0158	31.4710	31.7610	35.2627	32.7660
520173	1.1280	*	31.0599	*	*	31.0599
520177	1.6716	1.0158	32.5714	33.1243	34.6960	33.5326
520189	1.2359	1.0392	29.0295	29.2229	29.0333	29.0965
520193	1.8217	0.9447	29.2007	29.4737	30.8077	29.8928
520194	1.6744	1.0158	31.4379	31.0015	36.9520	33.1944
520195	0.4461	*	36.2900	41.6120	37.8891	38.5598
520196	1.8260	0.9496	31.1175	33.4890	32.0197	32.2468
520197	***	*	30.1917	*	*	30.1917
520198	1.3475	0.9248	28.5975	29.9803	30.6303	29.7432
520199	2.0244	1.0158	36.5699	37.0128	45.5967	40.3607
520202	1.6987	0.9644	*	*	33.6427	33.6427
520204	***	1.0158	*	*	*	*
530002	1.1129	0.9390	29.2069	29.2418	32.5654	30.3686
530006	1.2627	0.9390	29.2104	30.3724	32.8615	30.7746
530008	1.0872	0.9390	26.5180	30.6010	30.6600	29.2133
530009	0.8947	0.9390	26.0490	27.0555	27.3359	26.8083
530010	1.3091	0.9390	27.4121	28.5534	30.1134	28.7213
530011	1.1542	0.9390	27.8613	31.1329	31.8923	30.1412
530012	1.6535	0.9390	28.7524	30.6109	31.1738	30.2056
530014	1.5359	0.9439	28.5469	29.6724	31.2573	29.8902
530015	1.3590	0.9390	29.8306	33.4903	36.0871	33.1263
530017	0.9126	0.9390	31.1105	25.8183	24.0911	26.6137
530025	1.2867	0.9390	29.4346	28.8963	31.4614	29.9296
530032	1.0953	0.9390	24.6580	25.4267	26.7025	25.6150
530033	1.4679	0.9390	*	*	*	*

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
640001	0.8517	*	*	*	*	*
650001	1.3472	*	*	*	*	*
660001	0.9578	*	*	*	*	*
670002	1.2742	0.9731	*	29.1376	29.9545	29.5441
670003	***	*	*	33.8986	33.4713	33.6770
670004	1.1443	0.7944	*	25.3706	25.5671	25.4623
670005	1.2663	0.9934	*	31.9464	41.2085	36.4120
670006	2.2324	0.9515	*	27.1064	34.6785	30.1948
670007	***	*	*	*	29.5985	29.5985
670008	1.5756	0.9934	*	*	30.3978	30.3978
670009	***	*	*	*	31.8096	31.8096
670010	0.7783	0.9731	*	*	35.6620	35.6620
670011	1.0303	0.9515	*	*	32.1855	32.1855
670012	2.0379	0.9934	*	*	24.1597	24.1597
670013	***	*	*	*	29.4886	29.4886
670014	***	*	*	*	34.6108	34.6108
670015	***	*	*	*	35.3054	35.3054
670017	1.0751	0.9934	*	*	*	*
670018	0.9086	0.9934	*	*	*	*
670019	1.8140	0.9934	*	*	*	*
670021	1.4912	0.8913	*	*	*	*
670022	***	*	*	*	32.9889	32.9889
670023	1.3728	0.9434	*	*	*	*
670024	1.4630	0.9934	*	*	*	*
670025	3.1528	0.9731	*	*	*	*
670026	1.3704	0.8641	*	*	*	*
670027	1.8146	0.9934	*	*	*	*
670028	0.7323	0.8813	*	*	*	*
670029	1.2035	0.9934	*	*	*	*
670030	2.2698	0.8757	*	*	*	*
670031	1.3282	0.9934	*	*	*	*
670032	1.2566	0.9934	*	*	*	*
670033	1.3535	0.9731	*	*	*	*
670034	1.3447	0.9515	*	*	*	*
670038	1.5668	0.9934	*	*	*	*
670039	1.2235	0.9731	*	*	*	*
670040	1.0329	0.9934	*	*	*	*
670041	1.4480	0.9515	*	*	*	*
670042	2.3956	0.9434	*	*	*	*
670043	1.2067	0.9515	*	*	*	*
670044	1.3399	0.9731	*	*	*	*
670046	1.1866	0.9434	*	*	*	*

Provider No.	Case-Mix Index[2]	FY 2010 Wage Index	Average Hourly Wage FY 2008	Average Hourly Wage FY 2009	Average Hourly Wage FY 2010[1]	Average Hourly Wage** (3 years)
670047	1.2390	0.8641	*	*	*	*
670048	1.1884	0.9934	*	*	*	*
670049	1.3626	0.9731	*	*	*	*
670051	***	0.9133	*	*	*	*

1. Based on salaries adjusted for occupational mix, according to the calculation in section III.D.2. of this proposed rule.
2. The case-mix index is based on the billed MS-DRGs in the FY 2008 MedPAR file. It is not transfer-adjusted.
3. Provider 140010 is part of a multi-campus provider (MCH) that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 140B10, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 29404; provider number 140010 indicates the portion of wages and hours of the MCH that is allocated to CBSA 16974.
4. Provider 220074 is part of a MCH that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 220B74, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 14484; provider number 220074 indicates the portion of wages and hours of the MCH that is allocated to CBSA 39300.
5. Provider 230104 is part of a MCH that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 230B04, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 47644; provider number 230104 indicates the portion of wages and hours of the MCH that is allocated to CBSA 19804.

Notes:
* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2008, 2009, and 2010.
*** Denotes MedPAR data not available for the provider for FY 2008.

TABLE 3A.--FY 2010 and 3-YEAR* AVERAGE HOURLY WAGE FOR ACUTE CARE HOSPITALS IN URBAN AREAS BY CBSA

[*Based on the salaries and hours computed for Federal FYs 2008, 2009, and 2010.]

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
10180	Abilene, TX	27.9943	26.8752
10380	Aguadilla-Isabela-San Sebastián, PR	11.2992	10.7914
10420	Akron, OH	29.6981	28.4151
10500	Albany, GA	29.9930	28.2511
10580	Albany-Schenectady-Troy, NY	29.5686	28.3370
10740	Albuquerque, NM	32.1686	30.9215
10780	Alexandria, LA	27.3741	26.1142
10900	Allentown-Bethlehem-Easton, PA-NJ	32.9549	31.7503
11020	Altoona, PA	29.6321	27.4521
11100	Amarillo, TX	28.8615	28.7500
11180	Ames, IA	32.0333	31.1630
11260	Anchorage, AK	39.7817	38.1529
11300	Anderson, IN	30.6186	29.0438
11340	Anderson, SC	30.6779	30.1900
11460	Ann Arbor, MI	34.3973	33.5663
11500	Anniston-Oxford, AL	25.5331	25.3585
11540	Appleton, WI	31.0512	30.1271
11700	Asheville, NC	30.4998	29.5696
12020	Athens-Clarke County, GA	30.9123	30.4110
12060	Atlanta-Sandy Springs-Marietta, GA	32.1765	31.3940
12100	Atlantic City-Hammonton, NJ	38.3246	38.0303
12220	Auburn-Opelika, AL	28.3184	25.8259
12260	Augusta-Richmond County, GA-SC	31.7192	30.8274
12420	Austin-Round Rock, TX	31.9557	30.7551
12540	Bakersfield, CA	38.1126	36.4988
12580	Baltimore-Towson, MD	34.0219	32.4817
12620	Bangor, ME	33.6664	32.3336
12700	Barnstable Town, MA	42.2455	40.7738
12940	Baton Rouge, LA	27.6703	26.3414
12980	Battle Creek, MI	33.8319	32.4800
13020	Bay City, MI	31.7229	29.9993
13140	Beaumont-Port Arthur, TX	27.9565	27.4813
13380	Bellingham, WA	37.8938	36.6136
13460	Bend, OR	37.8880	35.5449
13644	Bethesda-Frederick-Rockville, MD	34.1080	33.5061
13740	Billings, MT	30.2933	29.0271
13780	Binghamton, NY	30.1087	28.8018
13820	Birmingham-Hoover, AL	28.5866	28.1205
13900	Bismarck, ND	26.5764	24.1174
13980	Blacksburg-Christiansburg-Radford, VA	28.0388	26.4661
14020	Bloomington, IN	31.2746	30.2060
14060	Bloomington-Normal, IL	31.8189	30.6600

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
14260	Boise City-Nampa, ID	31.3102	30.3055
14484	Boston-Quincy, MA	41.2813	38.9225
14500	Boulder, CO	34.5469	32.8567
14540	Bowling Green, KY	28.5408	26.8102
14600	Bradenton-Sarasota-Venice, FL	31.8949	31.2357
14740	Bremerton-Silverdale, WA	35.7525	34.6892
14860	Bridgeport-Stamford-Norwalk, CT	43.1294	41.5379
15180	Brownsville-Harlingen, TX	31.2324	29.8222
15260	Brunswick, GA	31.0532	31.0790
15380	Buffalo-Niagara Falls, NY	32.9092	31.1896
15500	Burlington, NC	29.0391	27.8531
15540	Burlington-South Burlington, VT	35.1121	31.7125
15764	Cambridge-Newton-Framingham, MA	37.9035	36.2253
15804	Camden, NJ	34.7031	33.7508
15940	Canton-Massillon, OH	29.1019	28.4428
15980	Cape Coral-Fort Myers, FL	30.4058	30.1881
16020	[2]Cape Girardeau-Jackson, MO-IL	30.0225	29.2764
16180	Carson City, NV	34.6403	32.6977
16220	Casper, WY	31.1738	30.2056
16300	Cedar Rapids, IA	29.9360	28.4266
16580	Champaign-Urbana, IL	33.5923	30.9666
16620	Charleston, WV	27.8979	27.0206
16700	Charleston-North Charleston-Summerville, SC	30.9520	29.6627
16740	Charlotte-Gastonia-Concord, NC-SC	31.3000	30.5792
16820	Charlottesville, VA	31.0461	30.2770
16860	Chattanooga, TN-GA	29.7406	28.7197
16940	Cheyenne, WY	31.2573	29.8902
16974	Chicago-Naperville-Joliet, IL	34.8734	33.6603
17020	Chico, CA	36.9018	35.6089
17140	Cincinnati-Middletown, OH-KY-IN	31.5440	30.8273
17300	Clarksville, TN-KY	26.5967	26.2806
17420	Cleveland, TN	25.5273	25.7090
17460	Cleveland-Elyria-Mentor, OH	30.0163	29.6529
17660	Coeur d'Alene, ID	30.4285	29.7128

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
17780	College Station-Bryan, TX	30.6698	29.5963
17820	Colorado Springs, CO	32.0420	30.9615
17860	Columbia, MO	28.7811	27.5366
17900	Columbia, SC	29.7392	28.7348
17980	Columbus, GA-AL	29.4912	28.9104
18020	Columbus, IN	32.0659	31.2591
18140	Columbus, OH	33.9523	32.3520
18580	Corpus Christi, TX	29.0831	27.5756
18700	Corvallis, OR	36.4373	35.1436
19060	Cumberland, MD-WV	27.1076	25.3644
19124	Dallas-Plano-Irving, TX	32.6790	31.6289
19140	Dalton, GA	28.6312	27.6149
19180	Danville, IL	29.3377	29.8076
19260	Danville, VA	27.8663	26.9133
19340	Davenport-Moline-Rock Island, IA-IL	27.7431	27.4204
19380	Dayton, OH	30.9774	29.9500
19460	Decatur, AL	25.8404	24.9158
19500	Decatur, IL	26.9606	26.2142
19660	Deltona-Daytona Beach-Ormond Beach, FL	29.8103	28.6957
19740	Denver-Aurora-Broomfield, CO	35.6220	34.0839
19780	Des Moines-West Des Moines, IA	31.9961	30.3660
19804	Detroit-Livonia-Dearborn, MI	32.8328	32.1562
20020	Dothan, AL	25.1815	24.3910
20100	Dover, DE	33.6190	33.4391
20220	Dubuque, IA	28.9884	27.6529
20260	Duluth, MN-WI	35.7360	33.6499
20500	Durham-Chapel Hill, NC	32.2061	31.2432
20740	Eau Claire, WI	31.8959	30.7528
20764	Edison-New Brunswick, NJ	36.7196	35.7462
20940	El Centro, CA	29.5222	29.0233
21060	Elizabethtown, KY	27.8386	27.2889
21140	Elkhart-Goshen, IN	31.6952	30.7085
21300	Elmira, NY	28.2369	26.9849
21340	El Paso, TX	29.0171	28.6439

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
21500	Erie, PA	29.3845	28.0188
21660	Eugene-Springfield, OR	36.7957	35.6753
21780	Evansville, IN-KY	28.3956	27.4173
21820	Fairbanks, AK	37.0181	35.7416
21940	Fajardo, PR	12.7141	13.0689
22020	Fargo, ND-MN	27.5815	26.1228
22140	Farmington, NM	26.4658	26.7181
22180	Fayetteville, NC	31.7634	31.4999
22220	Fayetteville-Springdale-Rogers, AR-MO	29.5091	28.8236
22380	Flagstaff, AZ	41.8098	38.3552
22420	Flint, MI	37.2320	35.9006
22500	Florence, SC	27.9083	27.2283
22520	Florence-Muscle Shoals, AL	26.6049	25.1737
22540	Fond du Lac, WI	32.9061	31.4556
22660	Fort Collins-Loveland, CO	32.9358	31.1626
22744	Fort Lauderdale-Pompano Beach-Deerfield	34.1954	32.3572
22900	Fort Smith, AR-OK	26.8441	25.6939
23020	Fort Walton Beach-Crestview-Destin, FL	29.0807	28.0286
23060	Fort Wayne, IN	29.9763	28.9879
23104	Fort Worth-Arlington, TX	31.6817	30.9563
23420	Fresno, CA	37.7285	35.9246
23460	Gadsden, AL	28.0411	26.3446
23540	Gainesville, FL	30.9067	30.1048
23580	Gainesville, GA	31.6425	30.2862
23844	Gary, IN	30.7933	29.8141
24020	Glens Falls, NY	29.3753	28.0871
24140	Goldsboro, NC	31.0327	29.8051
24220	Grand Forks, ND-MN	27.0961	25.7249
24300	Grand Junction, CO	32.5937	31.3345
24340	Grand Rapids-Wyoming, MI	31.2112	30.0910
24500	Great Falls, MT	27.8990	27.4403
24540	Greeley, CO	32.5239	31.9803
24580	Green Bay, WI	31.7286	30.6094
24660	Greensboro-High Point, NC	30.7293	29.5006

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
24780	Greenville, NC	31.3866	30.1209
24860	Greenville-Mauldin-Easley, SC	32.7066	31.3678
25020	Guayama, PR	11.8662	10.3190
25060	Gulfport-Biloxi, MS	29.2908	28.1834
25180	Hagerstown-Martinsburg, MD-WV	30.8210	29.8325
25260	Hanford-Corcoran, CA	37.7510	35.6927
25420	Harrisburg-Carlisle, PA	30.7640	29.6343
25500	Harrisonburg, VA	30.6657	29.0473
25540	Hartford-West Hartford-East Hartford, C	38.1370	36.1387
25620	Hattiesburg, MS	26.4517	24.7092
25860	Hickory-Lenoir-Morganton, NC	30.0125	28.9019
25980	[1]Hinesville-Fort Stewart, GA		
26100	Holland-Grand Haven, MI	29.6547	29.0480
26180	Honolulu, HI	38.5096	37.0248
26300	Hot Springs, AR	30.6110	29.4481
26380	Houma-Bayou Cane-Thibodaux, LA	26.8841	25.6900
26420	Houston-Sugar Land-Baytown, TX	33.3602	32.1287
26580	Huntington-Ashland, WV-KY-OH	30.3462	29.1310
26620	Huntsville, AL	29.9697	28.9929
26820	Idaho Falls, ID	31.6288	29.8720
26900	Indianapolis-Carmel, IN	32.2237	31.3867
26980	Iowa City, IA	31.6123	30.3730
27060	Ithaca, NY	33.6277	31.3238
27100	Jackson, MI	29.5262	29.8010
27140	Jackson, MS	27.5087	26.0334
27180	Jackson, TN	28.6380	27.5607
27260	Jacksonville, FL	30.5902	29.4153
27340	Jacksonville, NC	27.0729	26.6107
27500	Janesville, WI	31.7324	31.3422
27620	Jefferson City, MO	29.7822	28.6874
27740	Johnson City, TN	25.3940	25.0801
27780	Johnstown, PA	28.4373	26.0020
27860	Jonesboro, AR	26.0941	25.5645
27900	Joplin, MO	28.4993	29.4198

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
28020	Kalamazoo-Portage, MI	34.4244	34.0706
28100	Kankakee-Bradley, IL	33.9021	32.9919
28140	Kansas City, MO-KS	32.0886	30.5197
28420	Kennewick-Pasco-Richland, WA	34.4876	32.2600
28660	Killeen-Temple-Fort Hood, TX	29.4071	27.9357
28700	Kingsport-Bristol-Bristol, TN-VA	27.1019	25.5639
28740	Kingston, NY	31.6133	30.5773
28940	Knoxville, TN	26.4144	25.5801
29020	Kokomo, IN	32.6154	30.6023
29100	La Crosse, WI-MN	33.3953	31.7108
29140	Lafayette, IN	30.6163	28.8248
29180	Lafayette, LA	28.7755	27.2775
29340	Lake Charles, LA	26.7693	25.1385
29404	Lake County-Kenosha County, IL-WI	34.9042	33.7594
29420	Lake Havasu City-Kingman, AZ	35.5647	32.2607
29460	Lakeland-Winter Haven, FL	28.7332	28.1171
29540	Lancaster, PA	32.2876	31.0058
29620	Lansing-East Lansing, MI	32.6375	31.9159
29700	Laredo, TX	28.1351	27.6425
29740	Las Cruces, NM	29.4322	28.0962
29820	Las Vegas-Paradise, NV	39.6704	37.6356
29940	Lawrence, KS	28.6556	26.9670
30020	Lawton, OK	27.3767	27.0909
30140	Lebanon, PA	28.3747	27.6160
30300	Lewiston, ID-WA	31.4275	29.9302
30340	Lewiston-Auburn, ME	30.5922	29.8784
30460	Lexington-Fayette, KY	29.6955	28.8525
30620	Lima, OH	31.3828	30.0463
30700	Lincoln, NE	31.5849	31.0653
30780	Little Rock-N.Little Rock-Conway,AR	29.1599	28.4497
30860	Logan, UT-ID	30.2708	29.0579
30980	Longview, TX	26.6295	27.0643
31020	Longview, WA	37.1754	36.2462
31084	Los Angeles-Long Beach-Santa Ana, CA	40.0995	38.4432
31140	Louisville-Jefferson County, KY-IN	29.8958	29.2594
31180	Lubbock, TX	29.5970	28.1916
31340	Lynchburg, VA	27.9513	27.5427
31420	Macon, GA	34.1699	32.0338
31460	Madera-Chowchilla, CA	28.7691	27.2380
31540	Madison, WI	37.6901	36.2367
31700	Manchester-Nashua, NH	34.1924	32.9463
31740	[2]Manhattan, KS	26.6393	25.4114
31860	[2]Mankato-North Mankato, MN	31.3517	30.3876
31900	Mansfield, OH	30.1189	29.5131
32420	Mayagüez, PR	12.3050	12.0565
32580	McAllen-Edinburg-Mission, TX	29.8334	29.1906
32780	Medford, OR	33.6042	32.8873
32820	Memphis, TN-MS-AR	31.1123	30.0298
32900	Merced, CA	39.9733	38.8034
33124	Miami-Fort Lauderdale-Pompano Beach, FL	33.6974	32.2039
33140	Michigan City-La Porte, IN	30.9337	29.0972
33260	Midland, TX	31.3911	30.7625
33340	Milwaukee-Waukesha-West Allis, WI	34.1191	32.9869
33460	Minneapolis-St. Paul-Bloomington, MN-WI	36.7552	35.3647
33540	Missoula, MT	30.4471	28.5460
33660	Mobile, AL	25.9765	25.3215
33700	Modesto, CA	41.6068	39.3114
33740	Monroe, LA	26.6141	25.5969
33780	Monroe, MI	30.7388	29.7558
33860	Montgomery, AL	28.4081	26.8873
34060	Morgantown, WV	28.8207	27.6413
34100	Morristown, TN	24.3693	23.6388
34580	Mount Vernon-Anacortes, WA	34.0241	32.6743
34620	Muncie, IN	28.0389	26.5266
34740	Muskegon-Norton Shores, MI	33.0120	32.3129
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	29.1259	28.0351
34900	Napa, CA	48.0242	45.6110

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
34940	Naples-Marco Island, FL	32.7713	31.4791
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	32.2468	30.8738
35004	Nassau-Suffolk, NY	42.7114	41.2312
35084	Newark-Union, NJ-PA	37.7388	37.1024
35300	New Haven-Milford, CT	38.8132	38.0282
35380	New Orleans-Metairie-Kenner, LA	30.2567	28.5571
35644	New York-White Plains-Wayne, NY-NJ	44.2951	42.4635
35660	Niles-Benton Harbor, MI	30.1960	29.2812
35980	Norwich-New London, CT	38.8275	37.1524
36084	Oakland-Fremont-Hayward, CA	53.4760	50.6689
36100	Ocala, FL	29.0604	27.6922
36140	Ocean City, NJ	34.0850	35.2683
36220	Odessa, TX	33.0341	31.4278
36260	Ogden-Clearfield, UT	31.5974	29.8423
36420	Oklahoma City, OK	29.8726	28.3727
36500	Olympia, WA	37.5405	36.6528
36540	Omaha-Council Bluffs, NE-IA	32.0619	30.5914
36740	Orlando-Kissimmee, FL	30.1169	29.5462
36780	Oshkosh-Neenah, WI	30.4534	29.8740
36980	Owensboro, KY	28.5219	27.9439
37100	Oxnard-Thousand Oaks-Ventura, CA	41.1993	37.9188
37340	Palm Bay-Melbourne-Titusville, FL	30.7701	30.0929
37380	Palm Coast, FL	31.3833	29.0176
37460	Panama City-Lynn Haven-Panama City Beach, FL	28.5600	27.4216
37620	Parkersburg-Marietta-Vienna, WV-OH	25.7410	25.7623
37700	Pascagoula, MS	27.8215	26.7180
37764	Peabody, MA	36.5430	34.6202
37860	Pensacola-Ferry Pass-Brent, FL	27.4593	26.2817
37900	Peoria, IL	31.1233	29.9388
37964	Philadelphia, PA	35.9674	35.0659
38060	Phoenix-Mesa-Scottsdale, AZ	35.1660	33.3195
38220	Pine Bluff, AR	25.0185	25.6335
38300	Pittsburgh, PA	28.8584	27.5859

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
38340	Pittsfield, MA	36.0530	33.6534
38540	Pocatello, ID	30.5090	29.4688
38660	Ponce, PR	14.1569	13.5589
38860	Portland-South Portland-Biddeford, ME	34.2560	32.4155
38900	Portland-Vancouver-Beaverton, OR-WA	37.6440	36.2555
38940	Port St. Lucie, FL	33.2675	32.1420
39100	Poughkeepsie-Newburgh-Middletown, NY	37.8357	35.7710
39140	Prescott, AZ	34.1517	32.7828
39300	Providence-New Bedford-Fall River, RI-M	36.2131	34.4840
39340	Provo-Orem, UT	31.7144	30.4509
39380	Pueblo, CO	28.2854	27.7366
39460	Punta Gorda, FL	30.4559	30.0368
39540	Racine, WI	31.5940	30.3287
39580	Raleigh-Cary, NC	32.0228	31.1065
39660	Rapid City, SD	34.5185	30.6086
39740	Reading, PA	30.9421	30.1127
39820	Redding, CA	45.2856	42.3212
39900	Reno-Sparks, NV	34.4895	33.9626
40060	Richmond, VA	31.4617	29.9442
40140	Riverside-San Bernardino-Ontario, CA	37.4323	35.9597
40220	Roanoke, VA	29.6874	28.6489
40340	Rochester, MN	36.6457	34.9537
40380	Rochester, NY	29.5960	28.6755
40420	Rockford, IL	34.0586	32.1108
40484	Rockingham County, NH	33.9280	32.4157
40580	Rocky Mount, NC	29.9235	29.0390
40660	Rome, GA	29.6974	30.1870
40900	Sacramento--Arden-Arcade--Roseville, CA	45.8454	43.0131
40980	Saginaw-Saginaw Township North, MI	32.2201	29.8539
41060	St. Cloud, MN	39.2407	37.0501
41100	St. George, UT	31.5207	30.3172
41140	St. Joseph, MO-KS	34.3548	32.0541
41180	St. Louis, MO-IL	30.3692	29.0928
41420	Salem, OR	36.7029	34.5755

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
41500	Salinas, CA	51.6020	48.3970
41540	Salisbury, MD	30.2686	29.1909
41620	Salt Lake City, UT	31.7375	30.3601
41660	San Angelo, TX	27.0939	27.1475
41700	San Antonio, TX	29.9314	28.8142
41740	San Diego-Carlsbad-San Marcos, CA	38.5661	36.5952
41780	Sandusky, OH	29.5329	28.3991
41884	San Francisco-San Mateo-Redwood City, CA	52.1162	49.0822
41900	San Germán-Cabo Rojo, PR	15.9029	15.0796
41940	San Jose-Sunnyvale-Santa Clara, CA	54.0423	51.1362
41980	San Juan-Caguas-Guaynabo, PR	14.6240	14.2921
42020	San Luis Obispo-Paso Robles, CA	40.4357	38.7101
42044	Santa Ana-Anaheim-Irvine, CA	39.5661	37.9048
42060	Santa Barbara-Santa Maria-Goleta, CA	40.3738	37.8977
42100	Santa Cruz-Watsonville, CA	54.6008	51.6746
42140	Santa Fe, NM	35.6037	34.3278
42220	Santa Rosa-Petaluma, CA	52.2143	48.9011
42340	Savannah, GA	30.1129	28.8512
42540	Scranton--Wilkes-Barre, PA	28.0077	26.8387
42644	Seattle-Bellevue-Everett, WA	38.2489	36.9682
42680	Sebastian-Vero Beach, FL	32.0094	30.9861
43100	Sheboygan, WI	31.0972	29.2005
43300	Sherman-Denison, TX	27.5637	27.9907
43340	Shreveport-Bossier City, LA	28.4267	27.5218
43580	Sioux City, IA-NE-SD	30.0337	28.8312
43620	Sioux Falls, SD	30.3600	30.0953
43780	South Bend-Mishawaka, IN-MI	32.2432	31.2630
43900	Spartanburg, SC	30.7047	29.6614
44060	Spokane, WA	35.0579	33.7830
44100	Springfield, IL	31.3082	29.4927
44140	Springfield, MA	35.0346	33.8158
44180	Springfield, MO	28.8321	27.9089
44220	Springfield, OH	30.0318	28.1929
44300	State College, PA	30.0652	28.4460

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
44700	Stockton, CA	41.2964	38.9516
44940	Sumter, SC	28.4000	27.8833
45060	Syracuse, NY	33.0922	31.9306
45104	Tacoma, WA	37.2556	35.7209
45220	Tallahassee, FL	28.6793	28.5642
45300	Tampa-St. Petersburg-Clearwater, FL	30.2516	29.1690
45460	Terre Haute, IN	30.4918	29.1200
45500	Texarkana, TX-Texarkana, AR	27.3440	25.9183
45780	Toledo, OH	31.7700	30.1344
45820	Topeka, KS	30.8304	28.6837
45940	Trenton-Ewing, NJ	35.0676	34.2466
46060	Tucson, AZ	32.5281	30.8004
46140	Tulsa, OK	29.4085	27.8681
46220	Tuscaloosa, AL	30.0290	28.2973
46340	Tyler, TX	28.3730	28.5146
46540	Utica-Rome, NY	29.1985	28.1851
46660	Valdosta, GA	27.2871	26.3868
46700	Vallejo-Fairfield, CA	48.8096	46.4843
47020	Victoria, TX	26.3831	25.7434
47220	Vineland-Millville-Bridgeton, NJ	35.8019	34.6881
47260	Virginia Beach-Norfolk-Newport News, VA	29.9892	28.6304
47300	Visalia-Porterville, CA	34.6890	33.2005
47380	Waco, TX	28.9053	27.9147
47580	Warner Robins, GA	30.9006	30.4569
47644	Warren-Troy-Farmington-Hills, MI	33.1036	32.1477
47894	Washington-Arlington-Alexandria DC-VA	35.9329	34.5258
47940	Waterloo-Cedar Falls, IA	28.6247	27.9278
48140	Wausau, WI	32.3950	31.6154
48260	Weirton-Steubenville, WV-OH	24.5719	25.0215
48300	Wenatchee-East Wenatchee, WA	32.7723	32.6937
48424	West Palm Beach-Boca Raton-Boynton FL	32.7553	31.1884
48540	Wheeling, WV-OH	23.1612	22.5115
48620	Wichita, KS	30.0985	28.9291
48660	Wichita Falls, TX	31.9682	28.9050

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
48700	Williamsport, PA	26.4450	25.6635
48864	Wilmington, DE-MD-NJ	36.0749	34.4544
48900	Wilmington, NC	30.4695	29.5269
49020	Winchester, VA-WV	32.7159	31.6193
49180	Winston-Salem, NC	30.0901	29.1122
49340	Worcester, MA	37.7854	36.1298
49420	Yakima, WA	33.2485	32.3514
49500	Yauco, PR	11.2311	10.6665
49620	York-Hanover, PA	31.2753	30.5426
49660	Youngstown-Warren-Boardman, OH-PA	29.1038	28.5962
49700	Yuba City, CA	36.8254	34.8196
49740	Yuma, AZ	31.1767	31.4583

[1] This area has no average hourly wage because there are no short-term, acute care hospitals in the area.
[2] This is a new CBSA for FY 2010. To calculate the 3-year average hourly wage for this new area, we included the hospitals' data from their previous geographic location for FY 2008 and FY 2009.

TABLE 3B.--FY 2010 AND 3-YEAR* AVERAGE HOURLY WAGE FOR ACUTE CARE HOSPITLAS IN RURAL AREAS BY CBSA

(*Based on the sum of the salaries and hours computed for Federal FYs 2008, 2009, and 2010.)

CBSA Code	Nonurban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
01	Alabama	24.8146	24.3148
02	Alaska	39.0741	38.2827
03	Arizona	29.5567	28.5201
04	Arkansas	25.2796	24.4167
05	California	39.6099	38.1443
06	Colorado	32.5160	30.6737
07	Connecticut	37.7488	36.2265
08	Delaware	33.5768	32.2647
10	Florida	28.8833	27.8162
11	Georgia	26.2591	25.3158
12	Hawaii	37.8872	35.8138
13	Idaho	25.6665	24.8063
14	Illinois	27.9488	27.0224
15	Indiana	28.5959	27.5222
16	Iowa	28.7798	27.7566
17	Kansas	27.3429	25.9646
18	Kentucky	26.5465	25.3692
19	Louisiana	26.2741	24.8704
20	Maine	28.7294	27.5621
21	Maryland	30.9997	29.0487
22	Massachusetts[1]	--	--
23	Michigan	29.5431	28.6035
24	Minnesota	30.7430	29.4257
25	Mississippi	25.9174	24.8664
26	Missouri	26.2592	25.9176
27	Montana	27.8600	27.1930
28	Nebraska	29.0887	28.1064
29	Nevada	32.4918	31.4500
30	New Hampshire	33.5377	33.1757
31	New Jersey[2]	--	--
32	New Mexico	30.1811	28.8822
33	New York	28.1563	26.8980
34	North Carolina	28.8580	27.8011
35	North Dakota	26.8044	24.0269
36	Ohio	28.6105	27.7919
37	Oklahoma	26.2175	25.2558
38	Oregon	34.2294	32.7387
39	Pennsylvania	28.0420	26.9589
40	Puerto Rico[2]	--	--
41	Rhode Island[2]	--	--
42	South Carolina	28.1897	27.6702
43	South Dakota	28.0750	27.0426
44	Tennessee	26.5320	25.5310
45	Texas	26.6774	26.1223
46	Utah	28.3500	26.9909
47	Vermont	32.2060	31.4939
49	Virginia	27.0866	26.0134
50	Washington	33.9950	32.7409
51	West Virginia	25.1138	24.4098
52	Wisconsin	30.9892	30.4981
53	Wyoming	31.5338	29.8815

[1]Massachusetts has area(s) designated as rural. However, no short term, acute care hospitals are located in the area(s) for FY 2010.
[2]All counties within the State or territory are classified as urban.

TABLE 4A.--WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS IN URBAN AREAS BY CBSA AND BY STATE--FY 2010
[Constituent counties are listed in Table 4E.]

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Urban Area	State	Wage Index	GAF
10180	Abilene, TX	TX	0.8336	0.8828
10380	Aguadilla-Isabela-San Sebastián, PR	PR	0.3364	0.4742
10420	Akron, OH	OH	0.8839	0.9190
10500	Albany, GA	GA	0.8931	0.9255
10580	Albany-Schenectady-Troy, NY	NY	0.8805	0.9165
10740	Albuquerque, NM	NM	0.9554	0.9692
10780	Alexandria, LA	LA	0.8152	0.8694
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1341	1.0900
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9811	0.9870
11020	Altoona, PA	PA	0.8821	0.9177
11100	Amarillo, TX	TX	0.8594	0.9014
11180	Ames, IA	IA	0.9533	0.9678
11260	Anchorage, AK	AK	1.1920	1.1278
11300	Anderson, IN	IN	0.9116	0.9386
11340	Anderson, SC	SC	0.9130	0.9396
11460	Ann Arbor, MI	MI	1.0243	1.0166
11500	Anniston-Oxford, AL	AL	0.7603	0.8289
11540	Appleton, WI	WI	0.9245	0.9477
11700	Asheville, NC	NC	0.9082	0.9362
12020	Athens-Clarke County, GA	GA	0.9205	0.9449
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9581	0.9711
12100	Atlantic City-Hammonton, NJ	NJ	1.1341	1.0900
12220	Auburn-Opelika, AL	AL	0.8432	0.8898
12260	Augusta-Richmond County, GA-SC	GA	0.9445	0.9617
12260	Augusta-Richmond County, GA-SC	SC	0.9440	0.9613
12420	Austin-Round Rock, TX	TX	0.9515	0.9665
12540	Bakersfield, CA	CA	1.1745	1.1164
12580	Baltimore-Towson, MD	MD	1.0148	1.0101
12620	Bangor, ME	ME	1.0025	1.0017
12700	Barnstable Town, MA	MA	1.2580	1.1702
12940	Baton Rouge, LA	LA	0.8239	0.8758
12980	Battle Creek, MI	MI	1.0074	1.0051
13020	Bay City, MI	MI	0.9446	0.9617
13140	Beaumont-Port Arthur, TX	TX	0.8325	0.8820
13380	Bellingham, WA	WA	1.1279	1.0859
13460	Bend, OR	OR	1.1268	1.0852
13644	Bethesda-Frederick-Rockville, MD	MD	1.0789	1.0534
13740	Billings, MT	MT	0.9021	0.9319
13780	Binghamton, NY	NY	0.8965	0.9279
13820	Birmingham-Hoover, AL	AL	0.8512	0.8955
13900	Bismarck, ND	ND	0.7968	0.8559
13980	Blacksburg-Christiansburg-Radford, VA	VA	0.8349	0.8838
14020	Bloomington, IN	IN	0.9311	0.9523
14060	Bloomington-Normal, IL	IL	0.9475	0.9637
14260	Boise City-Nampa, ID	ID	0.9324	0.9532
14484	Boston-Quincy, MA	MA	1.2293	1.1519
14500	Boulder, CO	CO	1.0244	1.0166
14540	Bowling Green, KY	KY	0.8499	0.8946
14600	Bradenton-Sarasota-Venice, FL	FL	0.9490	0.9648
14740	Bremerton-Silverdale, WA	WA	1.0642	1.0435
14860	Bridgeport-Stamford-Norwalk, CT	CT	1.2592	1.1710
15180	Brownsville-Harlingen, TX	TX	0.9301	0.9516
15260	Brunswick, GA	GA	0.9338	0.9542
15380	Buffalo-Niagara Falls, NY	NY	0.9800	0.9863
15500	Burlington, NC	NC	0.8647	0.9052
15540	Burlington-South Burlington, VT	VT	1.0456	1.0310
15764	Cambridge-Newton-Framingham, MA	MA	1.1286	1.0864
15804	Camden, NJ	NJ	1.1341	1.0900
15940	Canton-Massillon, OH	OH	0.8661	0.9062
15980	Cape Coral-Fort Myers, FL	FL	0.9047	0.9337
16020	Cape Girardeau-Jackson, MO-IL	IL	0.8940	0.9261
16020	Cape Girardeau-Jackson, MO-IL	MO	0.8940	0.9261
16180	Carson City, NV	NV	1.0315	1.0215
16220	Casper, WY	WY	0.9390	0.9578
16300	Cedar Rapids, IA	IA	0.8908	0.9239
16580	Champaign-Urbana, IL	IL	1.0003	1.0002
16620	Charleston, WV	WV	0.8297	0.8800
16700	Charleston-North Charleston-Summerville, SC	SC	0.9212	0.9453
16740	Charlotte-Gastonia-Concord, NC-SC	NC	0.9320	0.9529

CBSA Code	Urban Area	State	Wage Index	GAF
16740	Charlotte-Gastonia-Concord, NC-SC	SC	0.9315	0.9526
16820	Charlottesville, VA	VA	0.9245	0.9477
16860	Chattanooga, TN-GA	GA	0.8856	0.9202
16860	Chattanooga, TN-GA	TN	0.8844	0.9193
16940	Cheyenne, WY	WY	0.9390	0.9578
16974	Chicago-Naperville-Joliet, IL	IL	1.0385	1.0262
17020	Chico, CA	CA	1.1745	1.1164
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9397	0.9583
17140	Cincinnati-Middletown, OH-KY-IN	KY	0.9399	0.9584
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9395	0.9582
17300	Clarksville, TN-KY	KY	0.8143	0.8688
17300	Clarksville, TN-KY	TN	0.8131	0.8679
17420	Cleveland, TN	TN	0.7890	0.8502
17460	Cleveland-Elyria-Mentor, OH	OH	0.8934	0.9257
17660	Coeur d'Alene, ID	ID	0.9061	0.9347
17780	College Station-Bryan, TX	TX	0.9133	0.9398
17820	Colorado Springs, CO	CO	0.9642	0.9753
17860	Columbia, MO	MO	0.8571	0.8998
17900	Columbia, SC	SC	0.8850	0.9197
17980	Columbus, GA-AL	AL	0.8781	0.9148
17980	Columbus, GA-AL	GA	0.8781	0.9148
18020	Columbus, IN	IN	0.9546	0.9687
18140	Columbus, OH	OH	1.0105	1.0072
18580	Corpus Christi, TX	TX	0.8661	0.9062
18700	Corvallis, OR	OR	1.0836	1.0565
19060	Cumberland, MD-WV	MD	0.9246	0.9477
19060	Cumberland, MD-WV	WV	0.8062	0.8628
19124	Dallas-Plano-Irving, TX	TX	0.9731	0.9815
19140	Dalton, GA	GA	0.8526	0.8965
19180	Danville, IL	IL	0.8737	0.9117
19260	Danville, VA	VA	0.8298	0.8801
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8471	0.8926
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8564	0.8993
19380	Dayton, OH	OH	0.9220	0.9459
19460	Decatur, AL	AL	0.7694	0.8357
19500	Decatur, IL	IL	0.8322	0.8818
19660	Deltona-Daytona Beach-Ormond Beach, FL	FL	0.8869	0.9211
19740	Denver-Aurora-Broomfield, CO	CO	1.0563	1.0382
19780	Des Moines-West Des Moines, IA	IA	0.9521	0.9669
19804	Detroit-Livonia-Dearborn, MI	MI	0.9788	0.9854
20020	Dothan, AL	AL	0.7499	0.8211

CBSA Code	Urban Area	State	Wage Index	GAF
20100	Dover, DE	DE	1.0011	1.0008
20220	Dubuque, IA	IA	0.8626	0.9037
20260	Duluth, MN-WI	MN	1.0641	1.0435
20260	Duluth, MN-WI	WI	1.0639	1.0433
20500	Durham-Chapel Hill, NC	NC	0.9590	0.9717
20740	Eau Claire, WI	WI	0.9496	0.9652
20764	Edison-New Brunswick, NJ	NJ	1.1341	1.0900
20940	El Centro, CA	CA	1.1745	1.1164
21060	Elizabethtown, KY	KY	0.8289	0.8794
21140	Elkhart-Goshen, IN	IN	0.9463	0.9629
21300	Elmira, NY	NY	0.8474	0.8928
21340	El Paso, TX	TX	0.8641	0.9048
21500	Erie, PA	PA	0.8748	0.9125
21660	Eugene-Springfield, OR	OR	1.0974	1.0657
21780	Evansville, IN-KY	IN	0.8513	0.8956
21780	Evansville, IN-KY	KY	0.8456	0.8915
21820	Fairbanks, AK	AK	1.1636	1.1093
21940	Fajardo, PR	PR	0.3786	0.5142
22020	Fargo, ND-MN	MN	0.9266	0.9491
22020	Fargo, ND-MN	ND	0.8325	0.8820
22140	Farmington, NM	NM	0.8964	0.9278
22180	Fayetteville, NC	NC	0.9458	0.9626
22220	Fayetteville-Springdale-Rogers, AR-MO	AR	0.8787	0.9153
22220	Fayetteville-Springdale-Rogers, AR-MO	MO	0.8787	0.9153
22380	Flagstaff, AZ	AZ	1.2450	1.1619
22420	Flint, MI	MI	1.1087	1.0732
22500	Florence, SC	SC	0.8389	0.8867
22520	Florence-Muscle Shoals, AL	AL	0.7932	0.8533
22540	Fond du Lac, WI	WI	0.9797	0.9861
22660	Fort Collins-Loveland, CO	CO	0.9818	0.9875
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0378	1.0257
22900	Fort Smith, AR-OK	AR	0.7994	0.8579
22900	Fort Smith, AR-OK	OK	0.7994	0.8579
23020	Fort Walton Beach-Crestview-Destin, FL	FL	0.8653	0.9057
23060	Fort Wayne, IN	IN	0.8950	0.9268
23104	Fort Worth-Arlington, TX	TX	0.9434	0.9609
23420	Fresno, CA	CA	1.1745	1.1164
23460	Gadsden, AL	AL	0.8350	0.8838
23540	Gainesville, FL	FL	0.9196	0.9442
23580	Gainesville, GA	GA	0.9422	0.9600
23844	Gary, IN	IN	0.9196	0.9442

CBSA Code	Urban Area	State	Wage Index	GAF
24020	Glens Falls, NY	NY	0.8748	0.9125
24140	Goldsboro, NC	NC	0.9241	0.9474
24220	Grand Forks, ND-MN	MN	0.9266	0.9491
24220	Grand Forks, ND-MN	ND	0.8055	0.8623
24300	Grand Junction, CO	CO	0.9923	0.9947
24340	Grand Rapids-Wyoming, MI	MI	0.9294	0.9511
24500	Great Falls, MT	MT	0.8364	0.8848
24540	Greeley, CO	CO	0.9644	0.9755
24580	Green Bay, WI	WI	0.9447	0.9618
24660	Greensboro-High Point, NC	NC	0.9151	0.9411
24780	Greenville, NC	NC	0.9346	0.9547
24860	Greenville-Mauldin-Easley, SC	SC	0.9733	0.9816
25020	Guayama, PR	PR	0.3533	0.4904
25060	Gulfport-Biloxi, MS	MS	0.8723	0.9107
25180	Hagerstown-Martinsburg, MD-WV	MD	0.9246	0.9477
25180	Hagerstown-Martinsburg, MD-WV	WV	0.9167	0.9422
25260	Hanford-Corcoran, CA	CA	1.1745	1.1164
25420	Harrisburg-Carlisle, PA	PA	0.9186	0.9435
25500	Harrisonburg, VA	VA	0.9132	0.9397
25540	Hartford-West Hartford-East Hartford, CT	CT	1.2236	1.1482
25620	Hattiesburg, MS	MS	0.7877	0.8492
25860	Hickory-Lenoir-Morganton, NC	NC	0.8937	0.9259
26100	Holland-Grand Haven, MI	MI	0.8830	0.9183
26180	Honolulu, HI	HI	1.1467	1.0983
26300	Hot Springs, AR	AR	0.9115	0.9385
26380	Houma-Bayou Cane-Thibodaux, LA	LA	0.8006	0.8587
26420	Houston-Sugar Land-Baytown, TX	TX	0.9934	0.9955
26580	Huntington-Ashland, WV-KY-OH	KY	0.9036	0.9329
26580	Huntington-Ashland, WV-KY-OH	OH	0.9031	0.9326
26580	Huntington-Ashland, WV-KY-OH	WV	0.9025	0.9322
26620	Huntsville, AL	AL	0.8924	0.9250
26820	Idaho Falls, ID	ID	0.9418	0.9598
26900	Indianapolis-Carmel, IN	IN	0.9593	0.9719
26980	Iowa City, IA	IA	0.9407	0.9590
27060	Ithaca, NY	NY	1.0014	1.0010
27100	Jackson, MI	MI	0.8797	0.9160
27140	Jackson, MS	MS	0.8191	0.8723
27180	Jackson, TN	TN	0.8516	0.8958
27260	Jacksonville, FL	FL	0.9102	0.9376
27340	Jacksonville, NC	NC	0.8593	0.9014
27500	Janesville, WI	WI	0.9448	0.9619

CBSA Code	Urban Area	State	Wage Index	GAF
27620	Jefferson City, MO	MO	0.8868	0.9210
27740	Johnson City, TN	TN	0.7890	0.8502
27780	Johnstown, PA	PA	0.8466	0.8922
27860	Jonesboro, AR	AR	0.7796	0.8432
27900	Joplin, MO	MO	0.8486	0.8937
28020	Kalamazoo-Portage, MI	MI	1.0251	1.0171
28100	Kankakee-Bradley, IL	IL	1.0095	1.0065
28140	Kansas City, MO-KS	KS	0.9555	0.9693
28140	Kansas City, MO-KS	MO	0.9555	0.9693
28420	Kennewick-Pasco-Richland, WA	WA	1.0266	1.0181
28660	Killeen-Temple-Fort Hood, TX	TX	0.8757	0.9131
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.8111	0.8664
28700	Kingsport-Bristol-Bristol, TN-VA	VA	0.8123	0.8673
28740	Kingston, NY	NY	0.9414	0.9595
28940	Knoxville, TN	TN	0.7890	0.8502
29020	Kokomo, IN	IN	0.9710	0.9800
29100	La Crosse, WI-MN	MN	0.9945	0.9962
29100	La Crosse, WI-MN	WI	0.9943	0.9961
29140	Lafayette, IN	IN	0.9115	0.9385
29180	Lafayette, LA	LA	0.8569	0.8996
29340	Lake Charles, LA	LA	0.7971	0.8562
29404	Lake County-Kenosha County, IL-WI	IL	1.0394	1.0268
29404	Lake County-Kenosha County, IL-WI	WI	1.0392	1.0267
29420	Lake Havasu City-Kingman, AZ	AZ	1.0590	1.0400
29460	Lakeland-Winter Haven, FL	FL	0.8594	0.9014
29540	Lancaster, PA	PA	0.9612	0.9733
29620	Lansing-East Lansing, MI	MI	0.9719	0.9807
29700	Laredo, TX	TX	0.8378	0.8859
29740	Las Cruces, NM	NM	0.8964	0.9278
29820	Las Vegas-Paradise, NV	NV	1.1812	1.1208
29940	Lawrence, KS	KS	0.8532	0.8970
30020	Lawton, OK	OK	0.8153	0.8695
30140	Lebanon, PA	PA	0.8447	0.8909
30300	Lewiston, ID-WA	ID	0.9359	0.9556
30300	Lewiston, ID-WA	WA	1.0119	1.0081
30340	Lewiston-Auburn, ME	ME	0.9110	0.9382
30460	Lexington-Fayette, KY	KY	0.8842	0.9192
30620	Lima, OH	OH	0.9340	0.9543
30700	Lincoln, NE	NE	0.9405	0.9589
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8683	0.9078
30860	Logan, UT-ID	ID	0.9014	0.9314

CBSA Code	Urban Area	State	Wage Index	GAF
30860	Logan, UT-ID	UT	0.9014	0.9314
30980	Longview, TX	TX	0.8239	0.8758
31020	Longview, WA	WA	1.1065	1.0718
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.1890	1.1259
31140	Louisville-Jefferson County, KY-IN	IN	0.8900	0.9233
31140	Louisville-Jefferson County, KY-IN	KY	0.8902	0.9234
31180	Lubbock, TX	TX	0.8813	0.9171
31340	Lynchburg, VA	VA	0.8323	0.8819
31420	Macon, GA	GA	1.0175	1.0120
31460	Madera-Chowchilla, CA	CA	1.1745	1.1164
31540	Madison, WI	WI	1.1221	1.0821
31700	Manchester-Nashua, NH	NH	1.0525	1.0357
31740	Manhattan, KS	KS	0.8183	0.8717
31860	Mankato-North Mankato, MN	MN	0.9336	0.9540
31900	Mansfield, OH	OH	0.9073	0.9356
32420	Mayagüez, PR	PR	0.3664	0.5028
32580	McAllen-Edinburg-Mission, TX	TX	0.8883	0.9221
32780	Medford, OR	OR	1.0235	1.0160
32820	Memphis, TN-MS-AR	AR	0.9265	0.9491
32820	Memphis, TN-MS-AR	MS	0.9265	0.9491
32820	Memphis, TN-MS-AR	TN	0.9251	0.9481
32900	Merced, CA	CA	1.1853	1.1235
33124	Miami-Miami Beach-Kendall, FL	FL	1.0026	1.0018
33140	Michigan City-La Porte, IN	IN	0.9210	0.9452
33260	Midland, TX	TX	0.9348	0.9549
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0158	1.0108
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.0945	1.0638
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.0943	1.0637
33540	Missoula, MT	MT	0.9066	0.9351
33660	Mobile, AL	AL	0.7735	0.8387
33700	Modesto, CA	CA	1.2337	1.1547
33740	Monroe, LA	LA	0.7925	0.8528
33780	Monroe, MI	MI	0.9962	0.9974
33860	Montgomery, AL	AL	0.8459	0.8917
34060	Morgantown, WV	WV	0.8571	0.8998
34100	Morristown, TN	TN	0.7890	0.8502
34580	Mount Vernon-Anacortes, WA	WA	1.0127	1.0087
34620	Muncie, IN	IN	0.8513	0.8956
34740	Muskegon-Norton Shores, MI	MI	0.9830	0.9883
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	SC	0.8668	0.9067
34900	Napa, CA	CA	1.4240	1.2739

CBSA Code	Urban Area	State	Wage Index	GAF
34940	Naples-Marco Island, FL	FL	0.9751	0.9829
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9588	0.9716
35004	Nassau-Suffolk, NY	NY	1.2718	1.1790
35084	Newark-Union, NJ-PA	NJ	1.1341	1.0900
35084	Newark-Union, NJ-PA	PA	1.1235	1.0830
35300	New Haven-Milford, CT	CT	1.2236	1.1482
35380	New Orleans-Metairie-Kenner, LA	LA	0.9010	0.9311
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.3005	1.1971
35644	New York-White Plains-Wayne, NY-NJ	NY	1.3190	1.2088
35660	Niles-Benton Harbor, MI	MI	0.8992	0.9298
35980	Norwich-New London, CT	CT	1.2236	1.1482
36084	Oakland-Fremont-Hayward, CA	CA	1.5857	1.3712
36100	Ocala, FL	FL	0.8647	0.9052
36140	Ocean City, NJ	NJ	1.1341	1.0900
36220	Odessa, TX	TX	0.9837	0.9888
36260	Ogden-Clearfield, UT	UT	0.9414	0.9595
36420	Oklahoma City, OK	OK	0.8895	0.9229
36500	Olympia, WA	WA	1.1174	1.0790
36540	Omaha-Council Bluffs, NE-IA	IA	0.9541	0.9683
36540	Omaha-Council Bluffs, NE-IA	NE	0.9547	0.9688
36740	Orlando-Kissimmee, FL	FL	0.8961	0.9276
36780	Oshkosh-Neenah, WI	WI	0.9226	0.9463
36980	Owensboro, KY	KY	0.8493	0.8942
37100	Oxnard-Thousand Oaks-Ventura, CA	CA	1.2216	1.1469
37340	Palm Bay-Melbourne-Titusville, FL	FL	0.9156	0.9414
37380	Palm Coast, FL	FL	0.9338	0.9542
37460	Panama City-Lynn Haven-Panama City Beach, FL	FL	0.8594	0.9014
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8515	0.8958
37620	Parkersburg-Marietta-Vienna, WV-OH	WV	0.7656	0.8328
37700	Pascagoula, MS	MS	0.8284	0.8790
37764	Peabody, MA	MA	1.0882	1.0596
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8594	0.9014
37900	Peoria, IL	IL	0.9268	0.9493
37964	Philadelphia, PA	PA	1.0708	1.0480
38060	Phoenix-Mesa-Scottsdale, AZ	AZ	1.0472	1.0321
38220	Pine Bluff, AR	AR	0.7767	0.8411
38300	Pittsburgh, PA	PA	0.8592	0.9013
38340	Pittsfield, MA	MA	1.0735	1.0498
38540	Pocatello, ID	ID	0.9085	0.9364
38660	Ponce, PR	PR	0.4216	0.5535
38860	Portland-South Portland-Biddeford, ME	ME	1.0200	1.0137

CBSA Code	Urban Area	State	Wage Index	GAF
38900	Portland-Vancouver-Beaverton, OR-WA	OR	1.1195	1.0804
38900	Portland-Vancouver-Beaverton, OR-WA	WA	1.1205	1.0810
38940	Port St. Lucie, FL	FL	0.9899	0.9931
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.1266	1.0851
39140	Prescott, AZ	AZ	1.0169	1.0115
39300	Providence-New Bedford-Fall River, RI-MA	MA	1.0783	1.0530
39300	Providence-New Bedford-Fall River, RI-MA	RI	1.0783	1.0530
39340	Provo-Orem, UT	UT	0.9443	0.9615
39380	Pueblo, CO	CO	0.9642	0.9753
39460	Punta Gorda, FL	FL	0.9062	0.9348
39540	Racine, WI	WI	0.9406	0.9589
39580	Raleigh-Cary, NC	NC	0.9535	0.9679
39660	Rapid City, SD	SD	1.0279	1.0190
39740	Reading, PA	PA	0.9212	0.9453
39820	Redding, CA	CA	1.3428	1.2237
39900	Reno-Sparks, NV	NV	1.0270	1.0184
40060	Richmond, VA	VA	0.9369	0.9563
40140	Riverside-San Bernardino-Ontario, CA	CA	1.1745	1.1164
40220	Roanoke, VA	VA	0.8840	0.9190
40340	Rochester, MN	MN	1.0912	1.0616
40380	Rochester, NY	NY	0.8814	0.9172
40420	Rockford, IL	IL	1.0142	1.0097
40484	Rockingham County-Strafford County, NH	NH	1.0525	1.0357
40580	Rocky Mount, NC	NC	0.8910	0.9240
40660	Rome, GA	GA	0.8843	0.9192
40900	Sacramento--Arden-Arcade--Roseville, CA	CA	1.3594	1.2340
40980	Saginaw-Saginaw Township North, MI	MI	0.9594	0.9720
41060	St. Cloud, MN	MN	1.1685	1.1125
41100	St. George, UT	UT	0.9386	0.9575
41140	St. Joseph, MO-KS	KS	1.0229	1.0156
41140	St. Joseph, MO-KS	MO	1.0230	1.0157
41180	St. Louis, MO-IL	IL	0.9043	0.9334
41180	St. Louis, MO-IL	MO	0.9043	0.9334
41420	Salem, OR	OR	1.0915	1.0618
41500	Salinas, CA	CA	1.5301	1.3381
41540	Salisbury, MD	MD	0.9246	0.9477
41620	Salt Lake City, UT	UT	0.9450	0.9620
41660	San Angelo, TX	TX	0.8068	0.8633
41700	San Antonio, TX	TX	0.8913	0.9242
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.1745	1.1164
41780	Sandusky, OH	OH	0.8790	0.9155

CBSA Code	Urban Area	State	Wage Index	GAF
41884	San Francisco-San Mateo-Redwood City, CA	CA	1.5454	1.3473
41900	San Germán-Cabo Rojo, PR	PR	0.4735	0.5993
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.6059	1.3832
41980	San Juan-Caguas-Guaynabo, PR	PR	0.4355	0.5660
42020	San Luis Obispo-Paso Robles, CA	CA	1.1990	1.1323
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.1745	1.1164
42060	Santa Barbara-Santa Maria-Goleta, CA	CA	1.1972	1.1312
42100	Santa Cruz-Watsonville, CA	CA	1.6191	1.3909
42140	Santa Fe, NM	NM	1.0574	1.0390
42220	Santa Rosa-Petaluma, CA	CA	1.5483	1.3490
42340	Savannah, GA	GA	0.8967	0.9281
42540	Scranton--Wilkes-Barre, PA	PA	0.8363	0.8848
42644	Seattle-Bellevue-Everett, WA	WA	1.1384	1.0928
42680	Sebastian-Vero Beach, FL	FL	0.9524	0.9672
43100	Sheboygan, WI	WI	0.9258	0.9486
43300	Sherman-Denison, TX	TX	0.8299	0.8801
43340	Shreveport-Bossier City, LA	LA	0.8465	0.8922
43580	Sioux City, IA-NE-SD	IA	0.8937	0.9259
43580	Sioux City, IA-NE-SD	NE	0.8943	0.9264
43580	Sioux City, IA-NE-SD	SD	0.8943	0.9264
43620	Sioux Falls, SD	SD	0.9040	0.9332
43780	South Bend-Mishawaka, IN-MI	IN	0.9599	0.9724
43780	South Bend-Mishawaka, IN-MI	MI	0.9601	0.9725
43900	Spartanburg, SC	SC	0.9138	0.9401
44060	Spokane, WA	WA	1.0435	1.0296
44100	Springfield, IL	IL	0.9323	0.9531
44140	Springfield, MA	MA	1.0433	1.0295
44180	Springfield, MO	MO	0.8586	0.9009
44220	Springfield, OH	OH	0.8939	0.9261
44300	State College, PA	PA	0.8951	0.9269
44700	Stockton, CA	CA	1.2245	1.1488
44940	Sumter, SC	SC	0.8452	0.8912
45060	Syracuse, NY	NY	0.9854	0.9900
45104	Tacoma, WA	WA	1.1089	1.0734
45220	Tallahassee, FL	FL	0.8594	0.9014
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.9006	0.9308
45460	Terre Haute, IN	IN	0.9078	0.9359
45500	Texarkana, TX-Texarkana, AR	AR	0.8153	0.8695
45500	Texarkana, TX-Texarkana, AR	TX	0.8153	0.8695
45780	Toledo, OH	OH	0.9455	0.9623
45820	Topeka, KS	KS	0.9180	0.9431

CBSA Code	Urban Area	State	Wage Index	GAF
45940	Trenton-Ewing, NJ	NJ	1.1341	1.0900
46060	Tucson, AZ	AZ	0.9686	0.9784
46140	Tulsa, OK	OK	0.8758	0.9132
46220	Tuscaloosa, AL	AL	0.8942	0.9263
46340	Tyler, TX	TX	0.8449	0.8910
46540	Utica-Rome, NY	NY	0.8695	0.9087
46660	Valdosta, GA	GA	0.8126	0.8675
46700	Vallejo-Fairfield, CA	CA	1.4473	1.2881
47020	Victoria, TX	TX	0.7944	0.8542
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1341	1.0900
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8930	0.9254
47260	Virginia Beach-Norfolk-Newport News, VA	VA	0.8930	0.9254
47300	Visalia-Porterville, CA	CA	1.1745	1.1164
47380	Waco, TX	TX	0.8608	0.9024
47580	Warner Robins, GA	GA	0.9202	0.9446
47644	Warren-Troy-Farmington-Hills, MI	MI	0.9858	0.9903
47894	Washington-Arlington-Alexandria, DC-VA	DC	1.0700	1.0474
47894	Washington-Arlington-Alexandria, DC-VA	MD	1.0718	1.0486
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0700	1.0474
47894	Washington-Arlington-Alexandria, DC-VA	WV	1.0687	1.0466
47940	Waterloo-Cedar Falls, IA	IA	0.8564	0.8993
48140	Wausau, WI	WI	0.9644	0.9755
48260	Weirton-Steubenville, WV-OH	OH	0.8515	0.8958
48260	Weirton-Steubenville, WV-OH	WV	0.7470	0.8189
48300	Wenatchee-East Wenatchee, WA	WA	1.0119	1.0081
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	FL	0.9746	0.9825
48540	Wheeling, WV-OH	OH	0.8515	0.8958
48540	Wheeling, WV-OH	WV	0.7470	0.8189
48620	Wichita, KS	KS	0.8962	0.9277
48660	Wichita Falls, TX	TX	0.9519	0.9668
48700	Williamsport, PA	PA	0.8363	0.8848
48864	Wilmington, DE-MD-NJ	DE	1.0742	1.0502
48864	Wilmington, DE-MD-NJ	MD	1.0760	1.0514
48864	Wilmington, DE-MD-NJ	NJ	1.1341	1.0900
48900	Wilmington, NC	NC	0.9125	0.9392
49020	Winchester, VA-WV	VA	0.9742	0.9823
49020	Winchester, VA-WV	WV	0.9730	0.9814
49180	Winston-Salem, NC	NC	0.8960	0.9276
49340	Worcester, MA	MA	1.1251	1.0841
49420	Yakima, WA	WA	1.0119	1.0081
49500	Yauco, PR	PR	0.3344	0.4723
49620	York-Hanover, PA	PA	0.9310	0.9522
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8662	0.9063
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8665	0.9065
49700	Yuba City, CA	CA	1.1745	1.1164
49740	Yuma, AZ	AZ	0.9284	0.9504

TABLE 4B.--WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS IN RURAL AREAS BY CBSA AND BY STATE--FY 2010

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Rural Area	State	Wage Index	GAF
01	Alabama	AL	0.7389	0.8128
02	Alaska	AK	1.1636	1.1093
03	Arizona	AZ	0.8801	0.9163
04	Arkansas	AR	0.7559	0.8256
05	California	CA	1.1745	1.1164
06	Colorado	CO	0.9642	0.9753
07	Connecticut	CT	1.2236	1.1482
08	Delaware	DE	0.9998	0.9999
10	Florida	FL	0.8594	0.9014
11	Georgia	GA	0.7819	0.8449
12	Hawaii	HI	1.1282	1.0861
13	Idaho	ID	0.7643	0.8319
14	Illinois	IL	0.8322	0.8818
15	Indiana	IN	0.8513	0.8956
16	Iowa	IA	0.8564	0.8993
17	Kansas	KS	0.8183	0.8717
18	Kentucky	KY	0.7961	0.8554
19	Louisiana	LA	0.7824	0.8453
20	Maine	ME	0.8555	0.8986
21	Maryland	MD	0.9246	0.9477
22	Massachusetts	MA	1.0358	1.0244
23	Michigan	MI	0.8797	0.9160
24	Minnesota	MN	0.9266	0.9491
25	Mississippi	MS	0.7717	0.8374
26	Missouri	MO	0.8164	0.8703
27	Montana	MT	0.8296	0.8799
28	Nebraska	NE	0.8662	0.9063
29	Nevada	NV	1.0026	1.0018
30	New Hampshire	NH	1.0525	1.0357
31	New Jersey[1]	NJ	1.1341	1.0900
32	New Mexico	NM	0.8964	0.9278
33	New York	NY	0.8474	0.8928
34	North Carolina	NC	0.8593	0.9014
35	North Dakota	ND	0.7968	0.8559
36	Ohio	OH	0.8515	0.8958
37	Oklahoma	OK	0.7807	0.8441
38	Oregon	OR	1.0235	1.0160
39	Pennsylvania	PA	0.8363	0.8848
40	Puerto Rico[1]	PR	-----	-----
41	Rhode Island[1]	RI	-----	-----
42	South Carolina	SC	0.8389	0.8867
43	South Dakota	SD	0.8360	0.8846
44	Tennessee	TN	0.7890	0.8502
45	Texas	TX	0.7944	0.8542
46	Utah	UT	0.8442	0.8905
47	Vermont	VT	0.9590	0.9717
49	Virginia	VA	0.8101	0.8657
50	Washington	WA	1.0119	1.0081
51	West Virginia	WV	0.7470	0.8189
52	Wisconsin	WI	0.9226	0.9463
53	Wyoming	WY	0.9390	0.9578

[1] All counties in the State or Territory are classified as urban. The New Jersey floor is imputed as specified in §412.64 (h)(4) and discussed in the FY 2005 IPPS final rule (69 FR 49109) and in section III.B.2. of the preamble of the FY 2009 IPPS final rule (73 FR 48567).

TABLE 4C.--WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS THAT ARE RECLASSIFIED BY CBSA AND BY STATE--FY 2010

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Area	State	Wage Index	GAF
04	Arkansas	AR	0.7559	0.8256
05	California	CA	1.1745	1.1164
07	Connecticut	CT	1.2236	1.1482
10	Florida	FL	0.8594	0.9014
14	Illinois	IL	0.8322	0.8818
14	Illinois	MO	0.8322	0.8818
16	Iowa	MO	0.8570	0.8997
17	Kansas	KS	0.8183	0.8717
18	Kentucky	KY	0.7961	0.8554
22	Massachusetts	MA	1.0358	1.0244
23	Michigan	MI	0.8797	0.9160
24	Minnesota	IA	0.9259	0.9486

CBSA Code	Area	State	Wage Index	GAF
25	Mississippi	MS	0.7717	0.8374
26	Missouri	AR	0.8164	0.8703
26	Missouri	MO	0.8164	0.8703
30	New Hampshire	VT	1.0004	1.0003
33	New York	NH	1.0525	1.0357
33	New York	NY	0.8474	0.8928
34	North Carolina	TN	0.8580	0.9004
36	Ohio	OH	0.8515	0.8958
37	Oklahoma	OK	0.7807	0.8441
38	Oregon	OR	1.0235	1.0160
39	Pennsylvania	PA	0.8363	0.8848
44	Tennessee	KY	0.7961	0.8554
45	Texas	TX	0.7944	0.8542
47	Vermont	NY	0.9404	0.9588
49	Virginia	KY	0.8101	0.8657
49	Virginia	VA	0.8101	0.8657
50	Washington	WA	1.0119	1.0081
53	Wyoming	NE	0.9209	0.9451
10420	Akron, OH	OH	0.8839	0.9190
10500	Albany, GA	AL	0.8387	0.8865
10500	Albany, GA	GA	0.8387	0.8865
10580	Albany-Schenectady-Troy, NY	NY	0.8805	0.9165
10740	Albuquerque, NM	NM	0.9371	0.9565
10780	Alexandria, LA	LA	0.8152	0.8694
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9636	0.9749
11100	Amarillo, TX	KS	0.8468	0.8924
11100	Amarillo, TX	TX	0.8469	0.8924
11180	Ames, IA	IA	0.9274	0.9497
11260	Anchorage, AK	AK	1.1920	1.1278
11300	Anderson, IN	IN	0.8709	0.9097
11460	Ann Arbor, MI	MI	0.9871	0.9911
12060	Atlanta-Sandy Springs-Marietta, GA	AL	0.9581	0.9711
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9581	0.9711
12260	Augusta-Richmond County, GA-SC	SC	0.9332	0.9538
12420	Austin-Round Rock, TX	TX	0.9515	0.9665
12620	Bangor, ME	ME	1.0025	1.0017
12940	Baton Rouge, LA	MS	0.8239	0.8758
13020	Bay City, MI	MI	0.9176	0.9428
13644	Bethesda-Frederick-Rockville, MD	DC	1.0771	1.0522
13644	Bethesda-Frederick-Rockville, MD	PA	1.0769	1.0520
13644	Bethesda-Frederick-Rockville, MD	VA	1.0771	1.0522

CBSA Code	Area	State	Wage Index	GAF
13780	Binghamton, NY	PA	0.8746	0.9123
13820	Birmingham-Hoover, AL	AL	0.8512	0.8955
13980	Blacksburg-Christiansburg-Radford, VA	WV	0.7522	0.8228
14020	Bloomington, IN	IN	0.8637	0.9045
14260	Boise City-Nampa, ID	ID	0.9140	0.9403
14484	Boston-Quincy, MA	MA	1.1577	1.1055
14484	Boston-Quincy, MA	RI	1.1577	1.1055
14600	Bradenton-Sarasota-Venice, FL	FL	0.9490	0.9648
14740	Bremerton-Silverdale, WA	WA	1.0482	1.0328
14860	Bridgeport-Stamford-Norwalk, CT	NY	1.2515	1.1661
15260	Brunswick, GA	GA	0.9338	0.9542
15380	Buffalo-Niagara Falls, NY	NY	0.9800	0.9863
15540	Burlington-South Burlington, VT	NY	1.0206	1.0141
15764	Cambridge-Newton-Framingham, MA	NH	1.0961	1.0649
16020	Cape Girardeau-Jackson, MO-IL	MO	0.8684	0.9079
16180	Carson City, NV	NV	1.0145	1.0099
16580	Champaign-Urbana, IL	IL	0.9055	0.9343
16620	Charleston, WV	WV	0.8184	0.8718
16700	Charleston-North Charleston-Summerville, SC	SC	0.9212	0.9453
16740	Charlotte-Gastonia-Concord, NC-SC	NC	0.9320	0.9529
16740	Charlotte-Gastonia-Concord, NC-SC	SC	0.9315	0.9526
16820	Charlottesville, VA	VA	0.9141	0.9403
16860	Chattanooga, TN-GA	AL	0.8676	0.9073
16860	Chattanooga, TN-GA	GA	0.8676	0.9073
16860	Chattanooga, TN-GA	TN	0.8663	0.9064
16974	Chicago-Naperville-Joliet, IL	IL	1.0385	1.0262
16974	Chicago-Naperville-Joliet, IL	IN	1.0383	1.0261
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9397	0.9583
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9395	0.9582
17300	Clarksville, TN-KY	KY	0.8143	0.8688
17460	Cleveland-Elyria-Mentor, OH	OH	0.8934	0.9257
17820	Colorado Springs, CO	CO	0.9642	0.9753
17860	Columbia, MO	MO	0.8444	0.8906
17900	Columbia, SC	SC	0.8850	0.9197
17980	Columbus, GA-AL	AL	0.8454	0.8914
17980	Columbus, GA-AL	GA	0.8454	0.8914
18140	Columbus, OH	OH	0.9837	0.9888
18580	Corpus Christi, TX	TX	0.8661	0.9062
18700	Corvallis, OR	OR	1.0460	1.0313
19124	Dallas-Plano-Irving, TX	TX	0.9578	0.9709
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8471	0.8926

CBSA Code	Area	State	Wage Index	GAF
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8564	0.8993
19380	Dayton, OH	OH	0.9220	0.9459
19740	Denver-Aurora-Broomfield, CO	CO	1.0394	1.0268
19780	Des Moines-West Des Moines, IA	IA	0.9521	0.9669
19804	Detroit-Livonia-Dearborn, MI	MI	0.9788	0.9854
20100	Dover, DE	DE	0.9998	0.9999
20260	Duluth, MN-WI	MN	1.0641	1.0435
20500	Durham-Chapel Hill, NC	NC	0.9590	0.9717
20500	Durham-Chapel Hill, NC	VA	0.9590	0.9717
20764	Edison-New Brunswick, NJ	NJ	1.1341	1.0900
21060	Elizabethtown, KY	KY	0.8080	0.8642
21140	Elkhart-Goshen, IN	IN	0.9463	0.9629
21500	Erie, PA	NY	0.8474	0.8928
21660	Eugene-Springfield, OR	OR	1.0974	1.0657
21780	Evansville, IN-KY	IN	0.8513	0.8956
21780	Evansville, IN-KY	KY	0.8152	0.8694
22020	Fargo, ND-MN	SD	0.8360	0.8846
22180	Fayetteville, NC	NC	0.9310	0.9522
22220	Fayetteville-Springdale-Rogers, AR-MO	OK	0.8787	0.9153
22380	Flagstaff, AZ	AZ	1.1887	1.1257
22420	Flint, MI	MI	1.0139	1.0095
22520	Florence-Muscle Shoals, AL	AL	0.7932	0.8533
22540	Fond du Lac, WI	WI	0.9641	0.9753
22660	Fort Collins-Loveland, CO	CO	0.9818	0.9875
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0378	1.0257
23020	Fort Walton Beach-Crestview-Destin, FL	FL	0.8594	0.9014
23060	Fort Wayne, IN	IN	0.8950	0.9268
23104	Fort Worth-Arlington, TX	TX	0.9434	0.9609
23540	Gainesville, FL	FL	0.9196	0.9442
23844	Gary, IN	IN	0.9196	0.9442
24300	Grand Junction, CO	CO	0.9923	0.9947
24340	Grand Rapids-Wyoming, MI	MI	0.9294	0.9511
24500	Great Falls, MT	MT	0.8364	0.8848
24540	Greeley, CO	NE	0.9439	0.9612
24540	Greeley, CO	WY	0.9439	0.9612
24580	Green Bay, WI	MI	0.9327	0.9534
24580	Green Bay, WI	WI	0.9325	0.9533
24660	Greensboro-High Point, NC	NC	0.9151	0.9411
24780	Greenville, NC	NC	0.9242	0.9475
24860	Greenville-Mauldin-Easley, SC	NC	0.9308	0.9521
24860	Greenville-Mauldin-Easley, SC	SC	0.9303	0.9517
25060	Gulfport-Biloxi, MS	MS	0.8300	0.8802
25180	Hagerstown-Martinsburg, MD-WV	PA	0.9176	0.9428
25420	Harrisburg-Carlisle, PA	PA	0.9186	0.9435
25540	Hartford-West Hartford-East Hartford, CT	CT	1.2236	1.1482
25540	Hartford-West Hartford-East Hartford, CT	MA	1.1179	1.0793
25860	Hickory-Lenoir-Morganton, NC	NC	0.8741	0.9120
26300	Hot Springs, AR	AR	0.8972	0.9284
26420	Houston-Sugar Land-Baytown, TX	TX	0.9934	0.9955
26580	Huntington-Ashland, WV-KY-OH	KY	0.8725	0.9108
26580	Huntington-Ashland, WV-KY-OH	OH	0.8720	0.9105
26580	Huntington-Ashland, WV-KY-OH	WV	0.8714	0.9100
26620	Huntsville, AL	AL	0.8558	0.8989
26620	Huntsville, AL	TN	0.8546	0.8980
26820	Idaho Falls, ID	ID	0.9418	0.9598
26900	Indianapolis-Carmel, IN	IN	0.9593	0.9719
26980	Iowa City, IA	IA	0.9152	0.9411
27060	Ithaca, NY	NY	0.9261	0.9488
27140	Jackson, MS	MS	0.8191	0.8723
27180	Jackson, TN	MS	0.8410	0.8882
27260	Jacksonville, FL	FL	0.9102	0.9376
27620	Jefferson City, MO	MO	0.8868	0.9210
27860	Jonesboro, AR	AR	0.7796	0.8432
27900	Joplin, MO	KS	0.8485	0.8936
27900	Joplin, MO	OK	0.8486	0.8937
28020	Kalamazoo-Portage, MI	MI	0.9900	0.9931
28140	Kansas City, MO-KS	MO	0.9555	0.9693
28420	Kennewick-Pasco-Richland, WA	ID	0.9989	0.9992
28420	Kennewick-Pasco-Richland, WA	WA	1.0119	1.0081
28700	Kingsport-Bristol-Bristol, TN-VA	KY	0.8123	0.8673
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.8111	0.8664
28940	Knoxville, TN	KY	0.7961	0.8554
28940	Knoxville, TN	TN	0.7890	0.8502
29180	Lafayette, LA	LA	0.8569	0.8996
29404	Lake County-Kenosha County, IL-WI	IL	1.0394	1.0268
29460	Lakeland-Winter Haven, FL	FL	0.8594	0.9014
29540	Lancaster, PA	PA	0.9466	0.9631
29620	Lansing-East Lansing, MI	MI	0.9564	0.9699
29740	Las Cruces, NM	NM	0.8964	0.9278
29820	Las Vegas-Paradise, NV	AZ	1.1523	1.1019
29820	Las Vegas-Paradise, NV	UT	1.1523	1.1019
30020	Lawton, OK	OK	0.7926	0.8528

CBSA Code	Area	State	Wage Index	GAF
30460	Lexington-Fayette, KY	KY	0.8732	0.9113
30620	Lima, OH	OH	0.9340	0.9543
30700	Lincoln, NE	NE	0.9257	0.9485
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8455	0.8914
30980	Longview, TX	TX	0.8239	0.8758
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.1766	1.1178
31140	Louisville-Jefferson County, KY-IN	KY	0.8902	0.9234
31420	Macon, GA	GA	0.9873	0.9913
31540	Madison, WI	WI	1.0990	1.0668
31700	Manchester-Nashua, NH	NH	1.0525	1.0357
31900	Mansfield, OH	OH	0.9073	0.9356
32780	Medford, OR	OR	1.0235	1.0160
32820	Memphis, TN-MS-AR	AR	0.8936	0.9259
32820	Memphis, TN-MS-AR	MS	0.8936	0.9259
32820	Memphis, TN-MS-AR	TN	0.8923	0.9249
33124	Miami-Miami Beach-Kendall, FL	FL	1.0026	1.0018
33260	Midland, TX	TX	0.9348	0.9549
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0031	1.0021
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.0945	1.0638
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.0943	1.0637
33540	Missoula, MT	MT	0.8916	0.9244
33700	Modesto, CA	CA	1.2337	1.1547
33740	Monroe, LA	AR	0.7925	0.8528
33740	Monroe, LA	LA	0.7925	0.8528
33780	Monroe, MI	OH	0.9956	0.9970
33860	Montgomery, AL	AL	0.8459	0.8917
34060	Morgantown, WV	WV	0.8571	0.8998
34740	Muskegon-Norton Shores, MI	MI	0.9370	0.9564
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	SC	0.8668	0.9067
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	KY	0.9351	0.9551
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9337	0.9541
35004	Nassau-Suffolk, NY	CT	1.2236	1.1482
35084	Newark-Union, NJ-PA	NJ	1.1341	1.0900
35084	Newark-Union, NJ-PA	NY	1.1238	1.0832
35084	Newark-Union, NJ-PA	PA	1.1235	1.0830
35380	New Orleans-Metairie-Kenner, LA	LA	0.9010	0.9311
35644	New York-White Plains-Wayne, NY-NJ	CT	1.2624	1.1730
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.2694	1.1775
35644	New York-White Plains-Wayne, NY-NJ	NY	1.2875	1.1889
35980	Norwich-New London, CT	RI	1.1562	1.1045
36084	Oakland-Fremont-Hayward, CA	CA	1.5857	1.3712

CBSA Code	Area	State	Wage Index	GAF
36140	Ocean City, NJ	DE	1.0402	1.0274
36220	Odessa, TX	NM	0.9458	0.9626
36220	Odessa, TX	TX	0.9482	0.9642
36260	Ogden-Clearfield, UT	UT	0.9414	0.9595
36420	Oklahoma City, OK	OK	0.8734	0.9115
36500	Olympia, WA	WA	1.1174	1.0790
36740	Orlando-Kissimmee, FL	FL	0.8961	0.9276
37460	Panama City-Lynn Haven-Panama City Beach, FL	AL	0.8320	0.8817
37700	Pascagoula, MS	AL	0.8156	0.8697
37764	Peabody, MA	NH	1.0867	1.0586
37860	Pensacola-Ferry Pass-Brent, FL	AL	0.8068	0.8633
37900	Peoria, IL	IL	0.9268	0.9493
37964	Philadelphia, PA	NJ	1.1341	1.0900
37964	Philadelphia, PA	PA	1.0545	1.0370
38220	Pine Bluff, AR	MS	0.7767	0.8411
38300	Pittsburgh, PA	OH	0.8589	0.9011
38300	Pittsburgh, PA	PA	0.8592	0.9013
38300	Pittsburgh, PA	WV	0.8583	0.9007
38340	Pittsfield, MA	NY	1.0260	1.0177
38340	Pittsfield, MA	VT	1.0260	1.0177
38860	Portland-South Portland-Biddeford, ME	ME	0.9743	0.9823
38900	Portland-Vancouver-Beaverton, OR-WA	OR	1.1195	1.0804
38900	Portland-Vancouver-Beaverton, OR-WA	WA	1.1205	1.0810
38940	Port St. Lucie, FL	FL	0.9761	0.9836
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.0983	1.0663
39340	Provo-Orem, UT	UT	0.9443	0.9615
39580	Raleigh-Cary, NC	NC	0.9535	0.9679
39740	Reading, PA	PA	0.8984	0.9293
39820	Redding, CA	CA	1.3428	1.2237
39900	Reno-Sparks, NV	NV	1.0270	1.0184
40060	Richmond, VA	VA	0.9369	0.9563
40140	Riverside-San Bernardino-Ontario, CA	AZ	1.1147	1.0772
40220	Roanoke, VA	VA	0.8721	0.9105
40220	Roanoke, VA	WV	0.8710	0.9098
40380	Rochester, NY	NY	0.8814	0.9172
40420	Rockford, IL	IL	1.0000	1.0000
40484	Rockingham County-Strafford County, NH	ME	1.0206	1.0141
40660	Rome, GA	AL	0.8665	0.9065
40900	Sacramento--Arden-Arcade--Roseville, CA	CA	1.3354	1.2190
40980	Saginaw-Saginaw Township North, MI	MI	0.9407	0.9590
41060	St. Cloud, MN	MN	1.0773	1.0523

CBSA Code	Area	State	Wage Index	GAF
41100	St. George, UT	UT	0.9386	0.9575
41180	St. Louis, MO-IL	IL	0.8924	0.9250
41180	St. Louis, MO-IL	MO	0.8924	0.9250
41620	Salt Lake City, UT	UT	0.9450	0.9620
41700	San Antonio, TX	TX	0.8913	0.9242
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.6059	1.3832
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.1745	1.1164
42140	Santa Fe, NM	NM	1.0144	1.0098
42220	Santa Rosa-Petaluma, CA	CA	1.5033	1.3220
42340	Savannah, GA	GA	0.8967	0.9281
42340	Savannah, GA	SC	0.8962	0.9277
42644	Seattle-Bellevue-Everett, WA	WA	1.1236	1.0831
43300	Sherman-Denison, TX	OK	0.8299	0.8801
43340	Shreveport-Bossier City, LA	LA	0.8465	0.8922
43580	Sioux City, IA-NE-SD	NE	0.8662	0.9063
43620	Sioux Falls, SD	SD	0.9040	0.9332
43780	South Bend-Mishawaka, IN-MI	IN	0.9269	0.9493
43900	Spartanburg, SC	SC	0.8985	0.9293
44060	Spokane, WA	ID	1.0242	1.0165
44100	Springfield, IL	IL	0.9323	0.9531
44180	Springfield, MO	AR	0.8586	0.9009
44180	Springfield, MO	MO	0.8586	0.9009
44300	State College, PA	PA	0.8363	0.8848
44940	Sumter, SC	SC	0.8389	0.8867
45060	Syracuse, NY	NY	0.9492	0.9649
45220	Tallahassee, FL	GA	0.8205	0.8733
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.9006	0.9308
45500	Texarkana, TX-Texarkana, AR	AR	0.8153	0.8695
45780	Toledo, OH	OH	0.9281	0.9502
45820	Topeka, KS	KS	0.8963	0.9278
46140	Tulsa, OK	OK	0.8758	0.9132
46220	Tuscaloosa, AL	MS	0.8402	0.8876
46340	Tyler, TX	TX	0.8449	0.8910
46700	Vallejo-Fairfield, CA	CA	1.4473	1.2881
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8930	0.9254
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0700	1.0474
48140	Wausau, WI	WI	0.9467	0.9632
48620	Wichita, KS	KS	0.8743	0.9121
48620	Wichita, KS	OK	0.8744	0.9122
48700	Williamsport, PA	PA	0.8363	0.8848
48864	Wilmington, DE-MD-NJ	DE	1.0636	1.0431
48864	Wilmington, DE-MD-NJ	NJ	1.1341	1.0900
48900	Wilmington, NC	SC	0.9120	0.9389
49180	Winston-Salem, NC	NC	0.8960	0.9276
49180	Winston-Salem, NC	VA	0.8960	0.9276
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8515	0.8958
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8404	0.8877

TABLE 4D-1.—RURAL FLOOR BUDGET NEUTRALITY FACTORS FOR ACUTE CARE HOSPITALS—FY 2010

[The rural floor budget neutrality adjustment factor reflects a blend of a State factor (weighted at 50 percent) and a nationwide factor (50 percent).]

State	Rural Floor Budget Neutrality Adjustment Factor
Alabama	0.99835
Alaska	0.99835
Arizona	0.99835
Arkansas	0.99835
California	0.99415
Colorado	0.99413
Connecticut	0.97887
Delaware	0.99835
Washington, D.C.	0.99835
Florida	0.99755
Georgia	0.99835
Hawaii	0.99835
Idaho	0.99835
Illinois	0.99835
Indiana	0.99813
Iowa	0.99767
Kansas	0.99829
Kentucky	0.99835
Louisiana	0.99835
Maine	0.99835
Maryland*	------
Massachusetts	0.99835
Michigan	0.99835
Minnesota	0.99835
Mississippi	0.99835
Missouri	0.99835
Montana	0.99835
Nebraska	0.99835
Nevada	0.99835
New Hampshire	0.99698
New Jersey **	0.98437
New Mexico	0.99576
New York	0.99836
North Carolina	0.99833
North Dakota	0.99668
Ohio	0.99783
Oklahoma	0.99835
Oregon	0.99705
Pennsylvania	0.99812
Puerto Rico	0.99835
Rhode Island	0.99835
South Carolina	0.99778
South Dakota	0.99835
Tennessee	0.99691
Texas	0.99835
Utah	0.99835
Vermont	0.99835
Virginia	0.99835
Washington	0.99792
West Virginia	0.99714
Wisconsin	0.99816
Wyoming	0.99835

* Maryland hospitals, under section 1814(b)(3) of the Act, are waived from the IPPS ratesetting. Therefore, the rural floor budget neutrality adjustment does not apply.
** The rural floor budget neutrality factor for New Jersey is based on an imputed floor (see TABLE 4B).

TABLE 4D-2.--URBAN AREAS WITH ACUTE CARE HOSPITALS RECEIVING THE STATEWIDE RURAL FLOOR OR IMPUTED FLOOR WAGE INDEX--FY 2010

[*Only hospitals that are geographically located in the specified State receive the State's rural or imputed floor wage index.]

(Wage Index Includes Rural Floor Budget Neutrality Adjustment)

CBSA Code	Urban Area	State*	Rural or Imputed Floor Wage Index
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1341
12100	Atlantic City-Hammonton, NJ	NJ	1.1341
12540	Bakersfield, CA	CA	1.1745
13900	Bismarck, ND	ND	0.7968
15804	Camden, NJ	NJ	1.1341

CBSA Code	Urban Area	State*	Rural or Imputed Floor Wage Index
16220	Casper, WY	WY	0.9390
16940	Cheyenne, WY	WY	0.9390
17020	Chico, CA	CA	1.1745
17420	Cleveland, TN	TN	0.7890
17820	Colorado Springs, CO	CO	0.9642
19060	Cumberland, MD-WV	MD	0.9246
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8564
19500	Decatur, IL	IL	0.8322
20764	Edison-New Brunswick, NJ	NJ	1.1341
20940	El Centro, CA	CA	1.1745
21300	Elmira, NY	NY	0.8474
21780	Evansville, IN-KY	IN	0.8513
21820	Fairbanks, AK	AK	1.1636
22020	Fargo, ND-MN	MN	0.9266
22140	Farmington, NM	NM	0.8964
22500	Florence, SC	SC	0.8389
23420	Fresno, CA	CA	1.1745
24220	Grand Forks, ND-MN	MN	0.9266
25180	Hagerstown-Martinsburg, MD-WV	MD	0.9246
25260	Hanford-Corcoran, CA	CA	1.1745
25540	Hartford-West Hartford-East Hartford, CT	CT	1.2236
27100	Jackson, MI	MI	0.8797
27340	Jacksonville, NC	NC	0.8593
27740	Johnson City, TN	TN	0.7890
28940	Knoxville, TN	TN	0.7890
29460	Lakeland-Winter Haven, FL	FL	0.8594
29740	Las Cruces, NM	NM	0.8964
30300	Lewiston, ID-WA	WA	1.0119
31460	Madera-Chowchilla, CA	CA	1.1745
31700	Manchester-Nashua, NH	NH	1.0525
31740	Manhattan, KS	KS	0.8183
32780	Medford, OR	OR	1.0235
34100	Morristown, TN	TN	0.7890
34620	Muncie, IN	IN	0.8513
35084	Newark-Union, NJ-PA	NJ	1.1341
35300	New Haven-Milford, CT	CT	1.2236
35980	Norwich-New London, CT	CT	1.2236
36140	Ocean City, NJ	NJ	1.1341
36780	Oshkosh-Neenah, WI	WI	0.9226
37460	Panama City-Lynn Haven-Panama City Beach, FL	FL	0.8594
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8515
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8594
39380	Pueblo, CO	CO	0.9642
40140	Riverside-San Bernardino-Ontario, CA	CA	1.1745
40484	Rockingham County-Strafford County, NH	NH	1.0525
41540	Salisbury, MD	MD	0.9246
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.1745
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.1745
42540	Scranton--Wilkes-Barre, PA	PA	0.8363
45220	Tallahassee, FL	FL	0.8594
45940	Trenton-Ewing, NJ	NJ	1.1341
47020	Victoria, TX	TX	0.7944
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1341
47300	Visalia-Porterville, CA	CA	1.1745
47940	Waterloo-Cedar Falls, IA	IA	0.8564
48260	Weirton-Steubenville, WV-OH	OH	0.8515
48260	Weirton-Steubenville, WV-OH	WV	0.7470
48300	Wenatchee-East Wenatchee, WA	WA	1.0119
48540	Wheeling, WV-OH	OH	0.8515
48540	Wheeling, WV-OH	WV	0.7470
48700	Williamsport, PA	PA	0.8363
48864	Wilmington, DE-MD-NJ	NJ	1.1341
49420	Yakima, WA	WA	1.0119
49700	Yuba City, CA	CA	1.1745

TABLE 4E.—URBAN CBSAs AND CONSTITUENT COUNTIES FOR ACUTE CARE HOSPITALS—FY 2010

CBSA Code	Urban Area (Constituent Counties)
10180	Abilene, TX
	Callahan County, TX
	Jones County, TX
	Taylor County, TX
10380	Aguadilla-Isabela-San Sebastián, PR
	Aguada Municipio, PR
	Aguadilla Municipio, PR
	Añasco Municipio, PR
	Isabela Municipio, PR
	Lares Municipio, PR
	Moca Municipio, PR
	Rincón Municipio, PR
	San Sebastián Municipio, PR
10420	Akron, OH
	Portage County, OH
	Summit County, OH
10500	Albany, GA
	Baker County, GA
	Dougherty County, GA
	Lee County, GA
	Terrell County, GA
	Worth County, GA
10580	Albany-Schenectady-Troy, NY
	Albany County, NY
	Rensselaer County, NY
	Saratoga County, NY
	Schenectady County, NY
	Schoharie County, NY
10740	Albuquerque, NM
	Bernalillo County, NM
	Sandoval County, NM
	Torrance County, NM
	Valencia County, NM
10780	Alexandria, LA
	Grant Parish, LA
	Rapides Parish, LA
10900	Allentown-Bethlehem-Easton, PA-NJ
	Warren County, NJ
	Carbon County, PA
	Lehigh County, PA
	Northampton County, PA
11020	Altoona, PA
	Blair County, PA
11100	Amarillo, TX
	Armstrong County, TX
	Carson County, TX
	Potter County, TX
	Randall County, TX
11180	Ames, IA
	Story County, IA
11260	Anchorage, AK
	Anchorage Municipality, AK
	Matanuska-Susitna Borough, AK
11300	Anderson, IN
	Madison County, IN
11340	Anderson, SC
	Anderson County, SC
11460	Ann Arbor, MI
	Washtenaw County, MI
11500	Anniston-Oxford, AL
	Calhoun County, AL
11540	Appleton, WI
	Calumet County, WI
	Outagamie County, WI
11700	Asheville, NC
	Buncombe County, NC
	Haywood County, NC
	Henderson County, NC
	Madison County, NC
12020	Athens-Clarke County, GA
	Clarke County, GA
	Madison County, GA
	Oconee County, GA
	Oglethorpe County, GA

CBSA Code	Urban Area (Constituent Counties)
12060	[1]Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ Hammonton County, NJ
12220	Auburn-Opelika, AL Lee County, AL
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC

CBSA Code	Urban Area (Constituent Counties)
12420	[1]Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX
12540	Bakersfield, CA Kern County, CA
12580	[1]Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD
12620	Bangor, ME Penobscot County, ME
12700	Barnstable Town, MA Barnstable County, MA
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA
12980	Battle Creek, MI Calhoun County, MI
13020	Bay City, MI Bay County, MI
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX
13380	Bellingham, WA Whatcom County, WA
13460	Bend, OR Deschutes County, OR

CBSA Code	Urban Area (Constituent Counties)
13644	[1]Bethesda-Frederick-Rockville, MD Frederick County, MD Montgomery County, MD
13740	Billings, MT Carbon County, MT Yellowstone County, MT
13780	Binghamton, NY Broome County, NY Tioga County, NY
13820	[1]Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL
13900	Bismarck, ND Burleigh County, ND Morton County, ND
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN
14060	Bloomington-Normal, IL McLean County, IL
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID
14484	[1]Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA

CBSA Code	Urban Area (Constituent Counties)
14500	Boulder, CO Boulder County, CO
14540	Bowling Green, KY Edmonson County, KY Warren County, KY
14600	Bradenton-Sarasota-Venice, FL Bradenton County, FL Manatee County, FL Sarasota County, FL
14740	Bremerton-Silverdale, WA Kitsap County, WA
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT
15180	Brownsville-Harlingen, TX Cameron County, TX
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA
15380	[1]Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY
15500	Burlington, NC Alamance County, NC
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT
15764	[1]Cambridge-Newton-Framingham, MA Middlesex County, MA
15804	[1]Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH
15980	Cape Coral-Fort Myers, FL Lee County, FL

CBSA Code	Urban Area (Constituent Counties)
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO
16180	Carson City, NV Carson City, NV
16220	Casper, WY Natrona County, WY
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC Summerville County, SC
16740	[1]Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA

CBSA Code	Urban Area (Constituent Counties)
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN
16940	Cheyenne, WY Laramie County, WY
16974	[1]Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL
17020	Chico, CA Butte County, CA
17140	[1]Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN

CBSA Code	Urban Area (Constituent Counties)
17420	Cleveland, TN Bradley County, TN Polk County, TN
17460	[1]Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH
17660	Coeur d'Alene, ID Kootenai County, ID
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX
17820	Colorado Springs, CO El Paso County, CO Teller County, CO
17860	Columbia, MO Boone County, MO Howard County, MO
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA
18020	Columbus, IN Bartholomew County, IN

CBSA Code	Urban Area (Constituent Counties)
18140	[1]Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX
18700	Corvallis, OR Benton County, OR
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV
19124	[1]Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX
19140	Dalton, GA Murray County, GA Whitfield County, GA
19180	Danville, IL Vermilion County, IL
19260	Danville, VA Pittsylvania County, VA Danville City, VA
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA

CBSA Code	Urban Area (Constituent Counties)
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH
19460	Decatur, AL Lawrence County, AL Morgan County, AL
19500	Decatur, IL Macon County, IL
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL
19740	[1]Denver-Aurora-Broomfield, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA
19804	[1]Detroit-Livonia-Dearborn, MI Wayne County, MI
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL
20100	Dover, DE Kent County, DE
20220	Dubuque, IA Dubuque County, IA

CBSA Code	Urban Area (Constituent Counties)
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI
20764	[1]Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ New Brunswick County, NJ Ocean County, NJ Somerset County, NJ
20940	El Centro, CA Imperial County, CA
21060	Elizabethtown, KY Hardin County, KY Larue County, KY
21140	Elkhart-Goshen, IN Elkhart County, IN
21300	Elmira, NY Chemung County, NY
21340	El Paso, TX El Paso County, TX
21500	Erie, PA Erie County, PA
21660	Eugene-Springfield, OR Lane County, OR
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY
21820	Fairbanks, AK Fairbanks North Star Borough, AK

CBSA Code	Urban Area (Constituent Counties)
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR
22020	Fargo, ND-MN Clay County, MN Cass County, ND
22140	Farmington, NM San Juan County, NM
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO
22380	Flagstaff, AZ Coconino County, AZ
22420	Flint, MI Genesee County, MI
22500	Florence, SC Darlington County, SC Florence County, SC
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL
22540	Fond du Lac, WI Fond du Lac County, WI
22660	Fort Collins-Loveland, CO Larimer County, CO
22744	[1]Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL

CBSA Code	Urban Area (Constituent Counties)
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN
23104	[1]Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX
23420	Fresno, CA Fresno County, CA
23460	Gadsden, AL Etowah County, AL
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL
23580	Gainesville, GA Hall County, GA
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN
24020	Glens Falls, NY Warren County, NY Washington County, NY
24140	Goldsboro, NC Wayne County, NC
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND
24300	Grand Junction, CO Mesa County, CO
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI
24500	Great Falls, MT Cascade County, MT
24540	Greeley, CO Weld County, CO

CBSA Code	Urban Area (Constituent Counties)
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC
24780	Greenville, NC Greene County, NC Pitt County, NC
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV
25260	Hanford-Corcoran, CA Kings County, CA
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA
25540	[1]Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT

CBSA Code	Urban Area (Constituent Counties)
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA
26100	Holland-Grand Haven, MI Ottawa County, MI
26180	Honolulu, HI Honolulu County, HI
26300	Hot Springs, AR Garland County, AR
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA
26420	[1]Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV
26620	Huntsville, AL Limestone County, AL Madison County, AL

CBSA Code	Urban Area (Constituent Counties)
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID
26900	[1]Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN
26980	Iowa City, IA Johnson County, IA Washington County, IA
27060	Ithaca, NY Tompkins County, NY
27100	Jackson, MI Jackson County, MI
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS
27180	Jackson, TN Chester County, TN Madison County, TN
27260	[1]Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL
27340	Jacksonville, NC Onslow County, NC
27500	Janesville, WI Rock County, WI

CBSA Code	Urban Area (Constituent Counties)
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN
27780	Johnstown, PA Cambria County, PA
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR
27900	Joplin, MO Jasper County, MO Newton County, MO
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI
28100	Kankakee-Bradley, IL Kankakee County, IL
28140	[1]Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA

CBSA Code	Urban Area (Constituent Counties)
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA
28740	Kingston, NY Ulster County, NY
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN
29020	Kokomo, IN Howard County, IN Tipton County, IN
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ
29460	Lakeland-Winter Haven, FL Polk County, FL Winter Haven County, FL

CBSA Code	Urban Area (Constituent Counties)
29540	Lancaster, PA Lancaster County, PA
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI
29700	Laredo, TX Webb County, TX
29740	Las Cruces, NM Dona Ana County, NM
29820	[1]Las Vegas-Paradise, NV Clark County, NV
29940	Lawrence, KS Douglas County, KS
30020	Lawton, OK Comanche County, OK
30140	Lebanon, PA Lebanon County, PA
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA
30340	Lewiston-Auburn, ME Androscoggin County, ME
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY
30620	Lima, OH Allen County, OH
30700	Lincoln, NE Lancaster County, NE Seward County, NE
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR

CBSA Code	Urban Area (Constituent Counties)
30860	Logan, UT-ID Franklin County, ID Cache County, UT
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX
31020	Longview, WA Cowlitz County, WA
31084	[1]Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA
31140	[1]Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Jefferson County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY
31180	Lubbock, TX Crosby County, TX Lubbock County, TX
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA

CBSA Code	Urban Area (Constituent Counties)
31460	Madera-Chowchilla, CA Madera County, CA
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI
31700	Manchester-Nashua, NH Hillsborough County, NH
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN
31900	Mansfield, OH Richland County, OH
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX
32780	Medford, OR Jackson County, OR
32820	[1]Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN
32900	Merced, CA Merced County, CA
33124	[1]Miami-Miami Beach-Kendall, FL Miami-Dade County, FL
33140	Michigan City-La Porte, IN LaPorte County, IN
33260	Midland, TX Midland County, TX

CBSA Code	Urban Area (Constituent Counties)
33340	[1]Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI
33460	[1]Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI
33540	Missoula, MT Missoula County, MT
33660	Mobile, AL Mobile County, AL
33700	Modesto, CA Stanislaus County, CA
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA
33780	Monroe, MI Monroe County, MI
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL
34060	Morgantown, WV Monongalia County, WV Preston County, WV
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN

CBSA Code	Urban Area (Constituent Counties)
34580	Mount Vernon-Anacortes, WA Skagit County, WA
34620	Muncie, IN Delaware County, IN
34740	Muskegon-Norton Shores, MI Muskegon County, MI
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC
34900	Napa, CA Napa County, CA
34940	Naples-Marco Island, FL Collier County, FL
34980	[1]Nashville-Davidson-Murfreesboro-Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN
35004	[1]Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY
35084	[1]Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA
35300	New Haven-Milford, CT New Haven County, CT

CBSA Code	Urban Area (Constituent Counties)
35380	[1]New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA
35644	[1]New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY
35660	Niles-Benton Harbor, MI Berrien County, MI
35980	Norwich-New London, CT New London County, CT
36084	[1]Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA
36100	Ocala, FL Marion County, FL
36140	Ocean City, NJ Cape May County, NJ
36220	Odessa, TX Ector County, TX
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT

CBSA Code	Urban Area (Constituent Counties)
36420	[1]Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK
36500	Olympia, WA Thurston County, WA
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE
36740	[1]Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL
36780	Oshkosh-Neenah, WI Winnebago County, WI
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL
37380	Palm Coast, FL Flager County, FL
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL

CBSA Code	Urban Area (Constituent Counties)
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV
37700	Pascagoula, MS George County, MS Jackson County, MS
37764	Peabody, MA Essex County, MA
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL
37964	[1]Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA
38060	[1]Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR
38300	[1]Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA
38340	Pittsfield, MA Berkshire County, MA

CBSA Code	Urban Area (Constituent Counties)
38540	Pocatello, ID Bannock County, ID Power County, ID
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME
38900	[1]Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY
39140	Prescott, AZ Yavapai County, AZ
39300	[1]Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI
39340	Provo-Orem, UT Juab County, UT Utah County, UT
39380	Pueblo, CO Pueblo County, CO
39460	Punta Gorda, FL Charlotte County, FL

CBSA Code	Urban Area (Constituent Counties)
39540	Racine, WI Racine County, WI
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC
39660	Rapid City, SD Meade County, SD Pennington County, SD
39740	Reading, PA Berks County, PA
39820	Redding, CA Shasta County, CA
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV
40060	[1]Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA
40140	[1]Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA

CBSA Code	Urban Area (Constituent Counties)
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN
40380	[1]Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY
40420	Rockford, IL Boone County, IL Winnebago County, IL
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC
40660	Rome, GA Floyd County, GA
40900	[1]Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI
41060	St. Cloud, MN Benton County, MN Stearns County, MN
41100	St. George, UT Washington County, UT

CBSA Code	Urban Area (Constituent Counties)
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO
41180	[1]St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO
41420	Salem, OR Marion County, OR Polk County, OR
41500	Salinas, CA Monterey County, CA
41540	Salisbury, MD Somerset County, MD Wicomico County, MD
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT
41660	San Angelo, TX Irion County, TX Tom Green County, TX

CBSA Code	Urban Area (Constituent Counties)
41700	[1]San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX
41740	[1]San Diego-Carlsbad-San Marcos, CA San Diego County, CA
41780	Sandusky, OH Erie County, OH
41884	[1]San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR
41940	[1]San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA

CBSA Code	Urban Area (Constituent Counties)
41980	[1]San Juan-Caguas-Guaynabo, PR
	Aguas Buenas Municipio, PR
	Aibonito Municipio, PR
	Arecibo Municipio, PR
	Barceloneta Municipio, PR
	Barranquitas Municipio, PR
	Bayamón Municipio, PR
	Caguas Municipio, PR
	Camuy Municipio, PR
	Canóvanas Municipio, PR
	Carolina Municipio, PR
	Cataño Municipio, PR
	Cayey Municipio, PR
	Ciales Municipio, PR
	Cidra Municipio, PR
	Comerío Municipio, PR
	Corozal Municipio, PR
	Dorado Municipio, PR
	Florida Municipio, PR
	Guaynabo Municipio, PR
	Gurabo Municipio, PR
	Hatillo Municipio, PR
	Humacao Municipio, PR
	Juncos Municipio, PR
	Las Piedras Municipio, PR
	Loíza Municipio, PR
	Manatí Municipio, PR
	Maunabo Municipio, PR
	Morovis Municipio, PR
	Naguabo Municipio, PR
	Naranjito Municipio, PR
	Orocovis Municipio, PR
	Quebradillas Municipio, PR
	Río Grande Municipio, PR
	San Juan Municipio, PR
	San Lorenzo Municipio, PR
	Toa Alta Municipio, PR
	Toa Baja Municipio, PR
	Trujillo Alto Municipio, PR
	Vega Alta Municipio, PR
	Vega Baja Municipio, PR
	Yabucoa Municipio, PR

CBSA Code	Urban Area (Constituent Counties)
42020	San Luis Obispo-Paso Robles, CA
	San Luis Obispo County, CA
42044	[1]Santa Ana-Anaheim-Irvine, CA
	Orange County, CA
42060	Santa Barbara-Santa Maria-Goleta, CA
	Santa Barbara County, CA
42100	Santa Cruz-Watsonville, CA
	Santa Cruz County, CA
42140	Santa Fe, NM
	Santa Fe County, NM
42220	Santa Rosa-Petaluma, CA
	Sonoma County, CA
42340	Savannah, GA
	Bryan County, GA
	Chatham County, GA
	Effingham County, GA
42540	Scranton--Wilkes-Barre, PA
	Lackawanna County, PA
	Luzerne County, PA
	Wyoming County, PA
42644	[1]Seattle-Bellevue-Everett, WA
	King County, WA
	Snohomish County, WA
42680	Sebastian-Vero Beach, FL
	Indian River County, FL
43100	Sheboygan, WI
	Sheboygan County, WI
43300	Sherman-Denison, TX
	Grayson County, TX
43340	Shreveport-Bossier City, LA
	Bossier Parish, LA
	Caddo Parish, LA
	De Soto Parish, LA
43580	Sioux City, IA-NE-SD
	Woodbury County, IA
	Dakota County, NE
	Dixon County, NE
	Union County, SD

CBSA Code	Urban Area (Constituent Counties)
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI
43900	Spartanburg, SC Spartanburg County, SC
44060	Spokane, WA Spokane County, WA
44100	Springfield, IL Menard County, IL Sangamon County, IL
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO
44220	Springfield, OH Clark County, OH
44300	State College, PA Centre County, PA
44700	Stockton, CA San Joaquin County, CA
44940	Sumter, SC Sumter County, SC
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY
45104	Tacoma, WA Pierce County, WA

CBSA Code	Urban Area (Constituent Counties)
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL
45300	[1]Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS
45940	Trenton-Ewing, NJ Mercer County, NJ
46060	Tucson, AZ Pima County, AZ
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK

CBSA Code	Urban Area (Constituent Counties)
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL
46340	Tyler, TX Smith County, TX
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA
46700	Vallejo-Fairfield, CA Solano County, CA
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ
47260	[1]Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA
47300	Visalia-Porterville, CA Tulare County, CA

CBSA Code	Urban Area (Constituent Counties)
47380	Waco, TX McLennan County, TX
47580	Warner Robins, GA Houston County, GA
47644	[1]Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI
47894	[1]Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA
48140	Wausau, WI Marathon County, WI
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV

CBSA Code	Urban Area (Constituent Counties)
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA
48424	[1]West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX
48700	Williamsport, PA Lycoming County, PA
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC
49340	Worcester, MA Worcester County, MA
49420	Yakima, WA Yakima County, WA
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR
49620	York-Hanover, PA York County, PA
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA
49700	Yuba City, CA Sutter County, CA Yuba County, CA
49740	Yuma, AZ Yuma County, AZ

TABLE 4F.--PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS BY CBSA--FY 2010

(Note: The rural floor budget neutrality adjustment is not applicable to the Puerto Rico specific wage index.)

CBSA Code	Area	Wage Index	GAF	Wage Index – Reclassified Hospitals	GAF – Reclassified Hospitals
10380	Aguadilla-Isabela-San Sebastián, PR	0.8012	0.8592	------	------
21940	Fajardo, PR	0.8919	0.9246	------	------
25020	Guayama, PR	0.8324	0.8819	------	------
32420	Mayagüez, PR	0.8667	0.9067	------	------
38660	Ponce, PR	0.9931	0.9953	------	------
41900	San Germán-Cabo Rojo, PR	1.1156	1.0778	------	------
41980	San Juan-Caguas-Guaynabo, PR	1.0286	1.0195	------	------
49500	Yauco, PR	0.7878	0.8493	------	------

TABLE 4J.--OUT-MIGRATION ADJUSTMENT FOR ACUTE CARE HOSPITALS--FY 2010

The following list represents all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act. Hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act are designated with an asterisk. We automatically assumed that hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act wished to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Section 1886(d)(10) hospitals that wished to receive the out-migration adjustment, rather than their reclassification, had to follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this final rule. Otherwise, they were deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8)(B) of the Act were deemed to have waived the out-migration adjustment, unless they explicitly notified CMS that they elected to receive the out-migration adjustment instead within 45 days from the publication of the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule.

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
010005	*	0.0296	MARSHALL	01470
010008		0.0174	CRENSHAW	01200
010010	*	0.0296	MARSHALL	01470
010012	*	0.0186	DE KALB	01240
010015		0.0046	CLARKE	01120
010021		0.0052	DALE	01220
010022	*	0.1128	CHEROKEE	01090
010025	*	0.0389	CHAMBERS	01080
010027		0.0026	COFFEE	01150
010029	*	0.0289	LEE	01400
010032		0.0325	RANDOLPH	01550
010035	*	0.0254	CULLMAN	01210
010038		0.0047	CALHOUN	01070
010040		0.0061	ETOWAH	01270
010045		0.0222	FAYETTE	01280
010046		0.0061	ETOWAH	01270
010047		0.0127	BUTLER	01060
010049		0.0026	COFFEE	01150
010052	*	0.0245	TALLAPOOSA	01610
010059	*	0.0071	LAWRENCE	01390
010061	*	0.0542	JACKSON	01350
010065	*	0.0245	TALLAPOOSA	01610
010078		0.0047	CALHOUN	01070
010083	*	0.0134	BALDWIN	01010
010091		0.0046	CLARKE	01120
010100	*	0.0134	BALDWIN	01010
010101	*	0.0211	TALLADEGA	01600
010109		0.0405	PICKENS	01530
010110		0.0215	BULLOCK	01050
010125		0.0476	WINSTON	01660
010128		0.0046	CLARKE	01120
010129		0.0134	BALDWIN	01010
010138		0.0066	SUMTER	01590
010143	*	0.0254	CULLMAN	01210
010146		0.0047	CALHOUN	01070
010150		0.0127	BUTLER	01060
010158	*	0.0023	FRANKLIN	01290
010164	*	0.0211	TALLADEGA	01600
030067		0.0298	LAPAZ	03055
040014	*	0.0199	WHITE	04720
040019	*	0.0258	ST. FRANCIS	04610
040039	*	0.0172	GREENE	04270
040047		0.0117	RANDOLPH	04600
040067		0.0007	COLUMBIA	04130
040071	*	0.0149	JEFFERSON	04340
040076	*	0.1	HOT SPRING	04290
040081		0.0357	PIKE	04540
040149		0.0199	WHITE	04720
050002	*	0.001	ALAMEDA	05000
050007		0.0146	SAN MATEO	05510
050009	*	0.018	NAPA	05380
050013	*	0.018	NAPA	05380
050014	*	0.0139	AMADOR	05020
050042	*	0.0162	TEHAMA	05620
050043	*	0.001	ALAMEDA	05000
050069	*	0.0013	ORANGE	05400
050070		0.0146	SAN MATEO	05510
050073	*	0.0171	SOLANO	05580
050075	*	0.001	ALAMEDA	05000
050084	*	0.0132	SAN JOAQUIN	05490
050089	*	0.0011	SAN BERNARDINO	05460
050090		0.0058	SONOMA	05590
050099	*	0.0011	SAN BERNARDINO	05460
050101	*	0.0171	SOLANO	05580

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
050113		0.0146	SAN MATEO	05510
050118		0.0132	SAN JOAQUIN	05490
050122		0.0132	SAN JOAQUIN	05490
050129	*	0.0011	SAN BERNARDINO	05460
050133	*	0.0178	YUBA	05680
050136		0.0058	SONOMA	05590
050140	*	0.0011	SAN BERNARDINO	05460
050150	*	0.0342	NEVADA	05390
050167		0.0132	SAN JOAQUIN	05490
050168	*	0.0013	ORANGE	05400
050173	*	0.0013	ORANGE	05400
050174		0.0058	SONOMA	05590
050193	*	0.0013	ORANGE	05400
050195	*	0.001	ALAMEDA	05000
050197	*	0.0146	SAN MATEO	05510
050211	*	0.001	ALAMEDA	05000
050224	*	0.0013	ORANGE	05400
050226	*	0.0013	ORANGE	05400
050230	*	0.0013	ORANGE	05400
050245	*	0.0011	SAN BERNARDINO	05460
050264	*	0.001	ALAMEDA	05000
050272	*	0.0011	SAN BERNARDINO	05460
050279	*	0.0011	SAN BERNARDINO	05460
050283	*	0.001	ALAMEDA	05000
050289		0.0146	SAN MATEO	05510
050291		0.0058	SONOMA	05590
050298		0.0011	SAN BERNARDINO	05460
050300	*	0.0011	SAN BERNARDINO	05460
050305	*	0.001	ALAMEDA	05000
050313		0.0132	SAN JOAQUIN	05490
050320	*	0.001	ALAMEDA	05000
050325		0.0033	TUOLUMNE	05650
050327	*	0.0011	SAN BERNARDINO	05460
050335	*	0.0033	TUOLUMNE	05650
050336		0.0132	SAN JOAQUIN	05490
050348	*	0.0013	ORANGE	05400
050366		0.0015	CALAVERAS	05040
050367	*	0.0171	SOLANO	05580
050385		0.0058	SONOMA	05590
050426	*	0.0013	ORANGE	05400
050444		0.0233	MERCED	05340
050488	*	0.001	ALAMEDA	05000
050512	*	0.001	ALAMEDA	05000

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
050517	*	0.0011	SAN BERNARDINO	05460
050526	*	0.0013	ORANGE	05400
050528	*	0.0233	MERCED	05340
050541	*	0.0146	SAN MATEO	05510
050543	*	0.0013	ORANGE	05400
050547		0.0058	SONOMA	05590
050548	*	0.0013	ORANGE	05400
050551	*	0.0013	ORANGE	05400
050567	*	0.0013	ORANGE	05400
050570	*	0.0013	ORANGE	05400
050580	*	0.0013	ORANGE	05400
050586	*	0.0011	SAN BERNARDINO	05460
050589	*	0.0013	ORANGE	05400
050603	*	0.0013	ORANGE	05400
050609	*	0.0013	ORANGE	05400
050618	*	0.0011	SAN BERNARDINO	05460
050667	*	0.018	NAPA	05380
050678	*	0.0013	ORANGE	05400
050680	*	0.0171	SOLANO	05580
050690		0.0058	SONOMA	05590
050693	*	0.0013	ORANGE	05400
050720	*	0.0013	ORANGE	05400
050744	*	0.0013	ORANGE	05400
050745	*	0.0013	ORANGE	05400
050746	*	0.0013	ORANGE	05400
050747	*	0.0013	ORANGE	05400
050748		0.0132	SAN JOAQUIN	05490
050754		0.0146	SAN MATEO	05510
050758	*	0.0011	SAN BERNARDINO	05460
060001	*	0.0042	WELD	06610
060003	*	0.0069	BOULDER	06060
060027	*	0.0069	BOULDER	06060
060103	*	0.0069	BOULDER	06060
060116	*	0.0069	BOULDER	06060
060121	*	0.0042	WELD	06610
070006	*	0.0045	FAIRFIELD	07000
070010	*	0.0045	FAIRFIELD	07000
070018	*	0.0045	FAIRFIELD	07000
070028	*	0.0045	FAIRFIELD	07000
070033	*	0.0045	FAIRFIELD	07000
070034	*	0.0045	FAIRFIELD	07000
080001		0.0044	NEW CASTLE	08010
080003		0.0044	NEW CASTLE	08010

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
090001		0.0033	THE DISTRICT	09000
090003		0.0033	THE DISTRICT	09000
090004	*	0.0033	THE DISTRICT	09000
090005		0.0033	THE DISTRICT	09000
090006		0.0033	THE DISTRICT	09000
090008		0.0033	THE DISTRICT	09000
090011	*	0.0033	THE DISTRICT	09000
100014	*	0.0047	VOLUSIA	10630
100017	*	0.0047	VOLUSIA	10630
100023	*	0.0031	CITRUS	10080
100045	*	0.0047	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0047	VOLUSIA	10630
100072	*	0.0047	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070
100081	*	0.0022	WALTON	10650
100118	*	0.0177	FLAGLER	10170
100139	*	0.0006	LEVY	10370
100232	*	0.0054	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100249	*	0.0031	CITRUS	10080
100252	*	0.0151	OKEECHOBEE	10460
100290		0.0338	SUMTER	10590
100292	*	0.0022	WALTON	10650
110023	*	0.0416	GORDON	11500
110029	*	0.0052	HALL	11550
110040	*	0.1455	JACKSON	11610
110041	*	0.0623	HABERSHAM	11540
110100		0.079	JEFFERSON	11620
110101		0.0067	COOK	11311
110142		0.0185	EVANS	11441
110146	*	0.0364	CAMDEN	11170
110150	*	0.0227	BALDWIN	11030
110187	*	0.0643	LUMPKIN	11701
110189	*	0.0066	FANNIN	11450
110190		0.0241	MACON	11710
110205		0.0507	GILMER	11471
130003	*	0.0235	NEZ PERCE	13340
130024		0.0675	BONNER	13080
130049	*	0.0319	KOOTENAI	13270
130066		0.0319	KOOTENAI	13270
130067	*	0.0725	BINGHAM	13050
140001		0.0369	FULTON	14370

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
140026		0.0315	LA SALLE	14580
140043	*	0.0056	WHITESIDE	14988
140058	*	0.0126	MORGAN	14770
140110	*	0.0315	LA SALLE	14580
140116		0.0014	MC HENRY	14640
140160	*	0.0332	STEPHENSON	14970
140161	*	0.0168	LIVINGSTON	14610
140167	*	0.0632	IROQUOIS	14460
140176		0.0014	MC HENRY	14640
140234		0.0315	LA SALLE	14580
150022		0.0158	MONTGOMERY	15530
150030	*	0.0192	HENRY	15320
150072		0.0105	CASS	15080
150076	*	0.0215	MARSHALL	15490
150088	*	0.0111	MADISON	15470
150091	*	0.005	HUNTINGTON	15340
150102	*	0.0108	STARKE	15740
150113	*	0.0111	MADISON	15470
150133	*	0.0193	KOSCIUSKO	15420
150146	*	0.0087	NOBLE	15560
160013		0.0179	MUSCATINE	16690
160030		0.0013	STORY	16840
160032		0.0235	JASPER	16490
160080	*	0.0066	CLINTON	16220
170137	*	0.0421	DOUGLAS	17220
170150		0.0166	COWLEY	17170
180012	*	0.008	HARDIN	18460
180017	*	0.0035	BARREN	18040
180049	*	0.0488	MADISON	18750
180064		0.0314	MONTGOMERY	18860
180066	*	0.0439	LOGAN	18700
180070		0.024	GRAYSON	18420
180079		0.0259	HARRISON	18480
190003	*	0.0085	IBERIA	19220
190015	*	0.0243	TANGIPAHOA	19520
190017	*	0.0187	ST. LANDRY	19480
190034		0.0189	VERMILION	19560
190044		0.0261	ACADIA	19000
190050		0.0044	BEAUREGARD	19050
190053		0.0101	JEFFRSON DAVIS	19260
190054		0.0085	IBERIA	19220
190078		0.0187	ST. LANDRY	19480
190086	*	0.0061	LINCOLN	19300

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
190088	*	0.0387	WEBSTER	19590
190099		0.0189	AVOYELLES	19040
190106	*	0.0102	ALLEN	19010
190116		0.0085	MOREHOUSE	19330
190133		0.0102	ALLEN	19010
190140		0.0035	FRANKLIN	19200
190144	*	0.0387	WEBSTER	19590
190145		0.009	LA SALLE	19290
190184	*	0.0075	CALDWELL	19100
190190	*	0.0075	CALDWELL	19100
190191	*	0.0187	ST. LANDRY	19480
190246		0.0075	CALDWELL	19100
190257	*	0.0061	LINCOLN	19300
200024	*	0.0094	ANDROSCOGGIN	20000
200032		0.0367	OXFORD	20080
200034	*	0.0094	ANDROSCOGGIN	20000
200050	*	0.0227	HANCOCK	20040
210001		0.0187	WASHINGTON	21210
210023		0.0079	ANNE ARUNDEL	21010
210028		0.0383	ST. MARYS	21180
210043		0.0079	ANNE ARUNDEL	21010
210061		0.0188	WORCESTER	21230
220001	*	0.0072	WORCESTER	22170
220002	*	0.0271	MIDDLESEX	22090
220010	*	0.0355	ESSEX	22040
220011	*	0.0271	MIDDLESEX	22090
220019	*	0.0072	WORCESTER	22170
220025	*	0.0072	WORCESTER	22170
220029	*	0.0355	ESSEX	22040
220033	*	0.0355	ESSEX	22040
220035	*	0.0355	ESSEX	22040
220049	*	0.0271	MIDDLESEX	22090
220058	*	0.0072	WORCESTER	22170
220062	*	0.0072	WORCESTER	22170
220063	*	0.0271	MIDDLESEX	22090
220070	*	0.0271	MIDDLESEX	22090
220080	*	0.0355	ESSEX	22040
220082	*	0.0271	MIDDLESEX	22090
220084	*	0.0271	MIDDLESEX	22090
220090	*	0.0072	WORCESTER	22170
220095	*	0.0072	WORCESTER	22170
220098	*	0.0271	MIDDLESEX	22090
220101	*	0.0271	MIDDLESEX	22090
220105	*	0.0271	MIDDLESEX	22090
220163	*	0.0072	WORCESTER	22170
220171	*	0.0271	MIDDLESEX	22090
220174	*	0.0355	ESSEX	22040
220175	*	0.0271	MIDDLESEX	22090
220176	*	0.0072	WORCESTER	22170
230002	*	0.0041	WAYNE	23810
230003	*	0.022	OTTAWA	23690
230005		0.0473	LENAWEE	23450
230013	*	0.0025	OAKLAND	23620
230015		0.0295	ST. JOSEPH	23740
230019	*	0.0025	OAKLAND	23620
230020	*	0.0041	WAYNE	23810
230021	*	0.0101	BERRIEN	23100
230022	*	0.0212	BRANCH	23110
230024	*	0.0041	WAYNE	23810
230029	*	0.0025	OAKLAND	23620
230035	*	0.0095	MONTCALM	23580
230037	*	0.021	HILLSDALE	23290
230041		0.0052	BAY	23080
230047		0.0021	MACOMB	23490
230053	*	0.0041	WAYNE	23810
230069	*	0.021	LIVINGSTON	23460
230071	*	0.0025	OAKLAND	23620
230072	*	0.022	OTTAWA	23690
230075		0.0047	CALHOUN	23120
230078	*	0.0101	BERRIEN	23100
230089	*	0.0041	WAYNE	23810
230092	*	0.0223	JACKSON	23370
230093		0.0058	MECOSTA	23530
230096	*	0.0295	ST. JOSEPH	23740
230099		0.0231	MONROE	23570
230104	*	0.0041	WAYNE	23810
230121	*	0.0678	SHIAWASSEE	23770
230130	*	0.0025	OAKLAND	23620
230135	*	0.0041	WAYNE	23810
230142	*	0.0041	WAYNE	23810
230146	*	0.0041	WAYNE	23810
230151	*	0.0025	OAKLAND	23620
230165	*	0.0041	WAYNE	23810
230174	*	0.022	OTTAWA	23690
230176	*	0.0041	WAYNE	23810
230195	*	0.0021	MACOMB	23490

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
230204		0.0021	MACOMB	23490
230207	*	0.0025	OAKLAND	23620
230208	*	0.0095	MONTCALM	23580
230217		0.0047	CALHOUN	23120
230222	*	0.0035	MIDLAND	23550
230227		0.0021	MACOMB	23490
230244	*	0.0041	WAYNE	23810
230254	*	0.0025	OAKLAND	23620
230257		0.0021	MACOMB	23490
230264		0.0021	MACOMB	23490
230269	*	0.0025	OAKLAND	23620
230270	*	0.0041	WAYNE	23810
230273	*	0.0041	WAYNE	23810
230277	*	0.0025	OAKLAND	23620
230279	*	0.021	LIVINGSTON	23460
230297	*	0.0041	WAYNE	23810
230301		0.0025	OAKLAND	23620
240018		0.0805	GOODHUE	24240
240044		0.0625	WINONA	24840
240064	*	0.0134	ITASCA	24300
240069	*	0.0267	STEELE	24730
240071	*	0.0385	RICE	24650
240117		0.0527	MOWER	24490
240211		0.0812	PINE	24570
250023	*	0.0541	PEARL RIVER	25540
250040	*	0.0021	JACKSON	25290
250117	*	0.0541	PEARL RIVER	25540
250128		0.0446	PANOLA	25530
250162		0.0014	HANCOCK	25220
260059		0.0077	LACLEDE	26520
260064	*	0.0089	AUDRAIN	26030
260097		0.03	JOHNSON	26500
260116	*	0.0087	ST. FRANCOIS	26930
260160		0.0144	STODDARD	26985
260163		0.0087	ST. FRANCOIS	26930
280077	*	0.008	DODGE	28260
290002	*	0.0277	LYON	29090
300011	*	0.0049	HILLSBOROUGH	30050
300012	*	0.0049	HILLSBOROUGH	30050
300017	*	0.0075	ROCKINGHAM	30070
300020	*	0.0049	HILLSBOROUGH	30050
300023	*	0.0075	ROCKINGHAM	30070
300029	*	0.0075	ROCKINGHAM	30070

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
300034	*	0.0049	HILLSBOROUGH	30050
310002	*	0.0268	ESSEX	31200
310009	*	0.0268	ESSEX	31200
310015	*	0.0199	MORRIS	31300
310017	*	0.0199	MORRIS	31300
310018	*	0.0268	ESSEX	31200
310038	*	0.0209	MIDDLESEX	31270
310039	*	0.0209	MIDDLESEX	31270
310050	*	0.0199	MORRIS	31300
310054	*	0.0268	ESSEX	31200
310070	*	0.0209	MIDDLESEX	31270
310076	*	0.0268	ESSEX	31200
310083	*	0.0268	ESSEX	31200
310093	*	0.0268	ESSEX	31200
310096	*	0.0268	ESSEX	31200
310108	*	0.0209	MIDDLESEX	31270
310119	*	0.0268	ESSEX	31200
320003	*	0.048	SAN MIGUEL	32230
320011		0.0337	RIO ARRIBA	32190
320018		0.0024	DONA ANA	32060
320085		0.0024	DONA ANA	32060
320088		0.0024	DONA ANA	32060
330004	*	0.0633	ULSTER	33740
330008	*	0.0126	WYOMING	33900
330010		0.0067	MONTGOMERY	33380
330027	*	0.0123	NASSAU	33400
330033		0.0223	CHENANGO	33080
330047		0.0067	MONTGOMERY	33380
330073	*	0.0151	GENESEE	33290
330094	*	0.0503	COLUMBIA	33200
330103		0.0131	CATTARAUGUS	33040
330106		0.0123	NASSAU	33400
330126	*	0.0642	ORANGE	33540
330132		0.0131	CATTARAUGUS	33040
330135		0.0642	ORANGE	33540
330144		0.0056	STEUBEN	33690
330151		0.0056	STEUBEN	33690
330167	*	0.0123	NASSAU	33400
330175		0.026	CORTLAND	33210
330181	*	0.0123	NASSAU	33400
330182	*	0.0123	NASSAU	33400
330191	*	0.0017	WARREN	33750
330198	*	0.0123	NASSAU	33400

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
330205		0.0642	ORANGE	33540
330224	*	0.0633	ULSTER	33740
330225	*	0.0123	NASSAU	33400
330235	*	0.0306	CAYUGA	33050
330259	*	0.0123	NASSAU	33400
330264		0.0642	ORANGE	33540
330276		0.0036	FULTON	33280
330277	*	0.0056	STEUBEN	33690
330331	*	0.0123	NASSAU	33400
330332	*	0.0123	NASSAU	33400
330372	*	0.0123	NASSAU	33400
330386	*	0.0745	SULLIVAN	33710
340020		0.0156	LEE	34520
340021	*	0.0162	CLEVELAND	34220
340024		0.0177	SAMPSON	34810
340027	*	0.0128	LENOIR	34530
340037		0.0162	CLEVELAND	34220
340038		0.0253	BEAUFORT	34060
340039	*	0.0101	IREDELL	34480
340068		0.0087	COLUMBUS	34230
340069	*	0.0015	WAKE	34910
340070		0.0395	ALAMANCE	34000
340071	*	0.0226	HARNETT	34420
340073	*	0.0015	WAKE	34910
340085	*	0.025	DAVIDSON	34280
340096	*	0.025	DAVIDSON	34280
340104		0.0162	CLEVELAND	34220
340114	*	0.0015	WAKE	34910
340126	*	0.01	WILSON	34970
340129	*	0.0101	IREDELL	34480
340133		0.026	MARTIN	34580
340138	*	0.0015	WAKE	34910
340144	*	0.0101	IREDELL	34480
340145	*	0.0336	LINCOLN	34540
340151		0.0052	HALIFAX	34410
340173	*	0.0015	WAKE	34910
360002		0.0141	ASHLAND	36020
360010	*	0.0074	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0077	ERIE	36220
360036	*	0.0126	WAYNE	36860
360040		0.0387	KNOX	36430
360044		0.0127	DARKE	36190

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
360055	*	0.0011	TRUMBULL	36790
360065	*	0.0075	HURON	36400
360070		0.0005	STARK	36770
360071		0.0035	VAN WERT	36820
360084		0.0005	STARK	36770
360086	*	0.0186	CLARK	36110
360096		0.0071	COLUMBIANA	36140
360107		0.0119	SANDUSKY	36730
360125	*	0.0133	ASHTABULA	36030
360131		0.0005	STARK	36770
360151		0.0005	STARK	36770
360156		0.0119	SANDUSKY	36730
360161		0.0011	TRUMBULL	36790
360175	*	0.0183	CLINTON	36130
360185	*	0.0071	COLUMBIANA	36140
360187	*	0.0186	CLARK	36110
360245	*	0.0133	ASHTABULA	36030
370014	*	0.0361	BRYAN	37060
370015	*	0.0366	MAYES	37480
370023		0.009	STEPHENS	37680
370065		0.0096	CRAIG	37170
370072		0.0258	LATIMER	37380
370083		0.0051	PUSHMATAHA	37630
370100		0.01	CHOCTAW	37110
370149	*	0.0302	POTTAWATOMIE	37620
370156		0.0121	GARVIN	37240
370169		0.0163	MCINTOSH	37450
370172		0.0258	LATIMER	37380
370214		0.0121	GARVIN	37240
380022	*	0.0067	LINN	38210
390008		0.006	LAWRENCE	39450
390016	*	0.006	LAWRENCE	39450
390030	*	0.0147	SCHUYLKILL	39650
390031	*	0.0147	SCHUYLKILL	39650
390039		0.0037	SOMERSET	39680
390044	*	0.0191	BERKS	39110
390052		0.0047	CLEARFIELD	39230
390056		0.0036	HUNTINGDON	39380
390065	*	0.0532	ADAMS	39000
390066	*	0.0372	LEBANON	39460
390079	*	0.0003	BRADFORD	39130
390086	*	0.0047	CLEARFIELD	39230
390096	*	0.0191	BERKS	39110

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
390110	*	0.0003	CAMBRIA	39160
390112		0.0037	SOMERSET	39680
390113	*	0.0053	CRAWFORD	39260
390117		0.0002	BEDFORD	39100
390122		0.0053	CRAWFORD	39260
390125		0.0022	WAYNE	39760
390130	*	0.0003	CAMBRIA	39160
390138	*	0.0218	FRANKLIN	39350
390146		0.0022	WARREN	39740
390150		0.0031	GREENE	39370
390151	*	0.0218	FRANKLIN	39350
390162	*	0.0217	NORTHAMPTON	39590
390173		0.0037	INDIANA	39390
390183	*	0.0147	SCHUYLKILL	39650
390201	*	0.117	MONROE	39550
390236		0.0003	BRADFORD	39130
390313	*	0.0147	SCHUYLKILL	39650
390316		0.0191	BERKS	39110
420002		0.0001	YORK	42450
420007	*	0.0027	SPARTANBURG	42410
420019		0.0158	CHESTER	42110
420020	*	0.0008	GEORGETOWN	42210
420027	*	0.0108	ANDERSON	42030
420030	*	0.0069	COLLETON	42140
420036	*	0.0064	LANCASTER	42280
420039	*	0.011	UNION	42430
420043		0.0157	CHEROKEE	42100
420053		0.0035	NEWBERRY	42350
420054		0.0002	MARLBORO	42340
420062	*	0.0125	CHESTERFIELD	42120
420068	*	0.0027	ORANGEBURG	42370
420069	*	0.0052	CLARENDON	42130
420070	*	0.0051	SUMTER	42420
420082		0.0002	AIKEN	42010
420083	*	0.0027	SPARTANBURG	42410
420098	*	0.0008	GEORGETOWN	42210
430008		0.0535	BROOKINGS	43050
430048		0.0129	LAWRENCE	43400
430094		0.0129	LAWRENCE	43400
440007		0.0219	COFFEE	44150
440008		0.0449	HENDERSON	44380
440012		0.0009	SULLIVAN	44810
440016		0.0144	CARROLL	44080

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
440017		0.0009	SULLIVAN	44810
440025	*	0.0009	GREENE	44290
440031		0.0019	ROANE	44720
440033		0.0027	CAMPBELL	44060
440035	*	0.0301	MONTGOMERY	44620
440047		0.0338	GIBSON	44260
440050		0.0009	GREENE	44290
440051		0.0082	MC NAIRY	44540
440057		0.0021	CLAIBORNE	44120
440060		0.0338	GIBSON	44260
440063		0.0033	WASHINGTON	44890
440070		0.0109	DECATUR	44190
440081		0.0052	SEVIER	44770
440084		0.0025	MONROE	44610
440105		0.0033	WASHINGTON	44890
440109		0.007	HARDIN	44350
440115		0.0338	GIBSON	44260
440137		0.0738	BEDFORD	44010
440144	*	0.0219	COFFEE	44150
440148	*	0.0296	DE KALB	44200
440174	*	0.0312	HAYWOOD	44370
440176		0.0009	SULLIVAN	44810
440180		0.0027	CAMPBELL	44060
440181		0.0365	HARDEMAN	44340
440182		0.0144	CARROLL	44080
440184		0.0033	WASHINGTON	44890
440185	*	0.023	BRADLEY	44050
450032	*	0.0254	HARRISON	45620
450039	*	0.0024	TARRANT	45910
450052	*	0.0276	BOSQUE	45160
450059		0.0075	COMAL	45320
450064	*	0.0024	TARRANT	45910
450087	*	0.0024	TARRANT	45910
450090		0.065	COOKE	45340
450099	*	0.0145	GRAY	45563
450135	*	0.0024	TARRANT	45910
450137	*	0.0024	TARRANT	45910
450144	*	0.0559	ANDREWS	45010
450163		0.0054	KLEBERG	45743
450192		0.0271	HILL	45651
450194		0.0213	CHEROKEE	45281
450210		0.0151	PANOLA	45842
450224	*	0.0195	WOOD	45974

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
450236		0.0389	HOPKINS	45654
450270		0.0271	HILL	45651
450283	*	0.0653	VAN ZANDT	45947
450347	*	0.037	WALKER	45949
450348	*	0.0059	FALLS	45500
450370	*	0.0235	COLORADO	45312
450389	*	0.0618	HENDERSON	45640
450395		0.0441	POLK	45850
450419	*	0.0024	TARRANT	45910
450438	*	0.0235	COLORADO	45312
450451		0.0536	SOMERVELL	45893
450460		0.0053	TYLER	45942
450497		0.0375	MONTAGUE	45800
450539		0.0067	HALE	45582
450547	*	0.0195	WOOD	45974
450563	*	0.0024	TARRANT	45910
450565	*	0.0509	PALO PINTO	45841
450573		0.0126	JASPER	45690
450596	*	0.0743	HOOD	45653
450615		0.0033	CASS	45260
450639	*	0.0024	TARRANT	45910
450641		0.0375	MONTAGUE	45800
450672	*	0.0024	TARRANT	45910
450675	*	0.0024	TARRANT	45910
450677	*	0.0024	TARRANT	45910
450698		0.0127	LAMB	45751
450747	*	0.0126	ANDERSON	45000
450755		0.0276	HOCKLEY	45652
450770	*	0.0182	MILAM	45795
450779	*	0.0024	TARRANT	45910
450813		0.0126	ANDERSON	45000
450838		0.0126	JASPER	45690
450872	*	0.0024	TARRANT	45910
450880	*	0.0024	TARRANT	45910
450884		0.0049	UPSHUR	45943
450886	*	0.0024	TARRANT	45910
450888		0.0024	TARRANT	45910
460001		0.0001	UTAH	46240
460013		0.0001	UTAH	46240
460017		0.0383	BOX ELDER	46010
460023		0.0001	UTAH	46240
460039	*	0.0383	BOX ELDER	46010
460043		0.0001	UTAH	46240

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
460052		0.0001	UTAH	46240
490002		0.0003	RUSSELL	49830
490019	*	0.1088	CULPEPER	49230
490038		0.0003	SMYTH	49860
490084		0.0187	ESSEX	49280
490105		0.0003	SMYTH	49860
490110		0.0185	MONTGOMERY	49600
500003	*	0.0166	SKAGIT	50280
500007	*	0.0166	SKAGIT	50280
500019		0.0131	LEWIS	50200
500039	*	0.0094	KITSAP	50170
500041	*	0.002	COWLITZ	50070
510012		0.0124	MASON	51260
510018	*	0.0188	JACKSON	51170
510047	*	0.0269	MARION	51240
520028	*	0.0286	GREEN	52220
520035		0.0076	SHEBOYGAN	52580
520044		0.0076	SHEBOYGAN	52580
520045		0.0022	WINNEBAGO	52690
520048		0.0022	WINNEBAGO	52690
520057		0.0193	SAUK	52550
520059	*	0.0195	RACINE	52500
520071	*	0.0161	JEFFERSON	52270
520076	*	0.0146	DODGE	52130
520095	*	0.0193	SAUK	52550
520096	*	0.0195	RACINE	52500
520102	*	0.0242	WALWORTH	52630
520116	*	0.0161	JEFFERSON	52270
520198		0.0022	WINNEBAGO	52690

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGs), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

MS-DRG	FY 2010 Final Rule Post-Acute DRG	FY 2010 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
001	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	24.8548	31.5	43.9
002	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	11.7540	16.4	21.2
003	Yes	No	PRE	SURG	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.2667	31.6	38.5
004	Yes	No	PRE	SURG	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.1941	22.9	28.2
005	No	No	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.1358	14.9	20.3
006	No	No	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.7569	8.3	9.2
007	No	No	PRE	SURG	LUNG TRANSPLANT	9.4543	15.6	18.6
008	No	No	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.0615	10.4	12.3
009	No	No	PRE	SURG	BONE MARROW TRANSPLANT	6.5419	17.7	21.3
010	No	No	PRE	SURG	PANCREAS TRANSPLANT	4.2752	8.9	10.0
011	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.7341	12.7	16.3
012	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.0306	8.8	10.5
013	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	1.8643	5.7	6.9
020	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	8.4392	14.8	18.3
021	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	6.2068	12.2	14.4
022	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	4.3765	7.4	8.9
023	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	4.9401	8.5	12.1
024	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.2566	5.7	8.0
025	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.8236	9.4	12.1
026	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	2.9421	6.1	7.7
027	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.0902	3.1	4.1
028	Yes	Yes	01	SURG	SPINAL PROCEDURES W MCC	5.1090	10.2	13.4
029	Yes	Yes	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	2.7768	4.8	6.7
030	Yes	Yes	01	SURG	SPINAL PROCEDURES W/O CC/MCC	1.6019	2.7	3.5
031	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.5341	9.0	13.2
032	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	1.9186	3.7	5.5
033	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.3331	2.2	2.8
034	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.1900	4.4	6.9
035	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.0165	2.0	2.9
036	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.5744	1.3	1.6
037	No	No	01	SURG	EXTRACRANIAL PROCEDURES W MCC	2.9190	5.7	8.3
038	No	No	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.4783	2.4	3.4
039	No	No	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.0033	1.4	1.7
040	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.9518	9.4	12.9
041	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.1249	5.2	7.0
042	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.6448	2.4	3.3
052	No	No	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.4836	4.5	6.3
053	No	No	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.8382	3.1	4.0
054	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.5637	5.0	6.8
055	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0613	3.6	4.9
056	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1.6952	5.7	7.7
057	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	0.9028	3.9	5.0
058	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.5512	5.8	7.8
059	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	0.9581	4.2	5.1
060	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.7083	3.2	3.8
061	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	2.9168	6.5	8.7
062	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	1.9290	5.0	5.9
063	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	1.5187	3.6	4.2
064	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8258	5.3	7.2
065	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	1.1580	4.1	5.0
066	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.8223	2.9	3.5
067	No	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.3335	4.3	5.5
068	No	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8593	2.7	3.4
069	No	No	01	MED	TRANSIENT ISCHEMIA	0.7289	2.4	2.9
070	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.7919	5.7	7.4
071	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.1027	4.1	5.2
072	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7616	2.6	3.3
073	No	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.2939	4.5	6.0
074	No	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.8380	3.3	4.1
075	No	No	01	MED	VIRAL MENINGITIS W CC/MCC	1.6670	5.7	7.3
076	No	No	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.8336	3.3	3.9
077	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.6245	5.3	6.6
078	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	0.9822	3.6	4.3
079	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7359	2.7	3.2
080	No	No	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.1461	3.7	5.0
081	No	No	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.7113	2.7	3.4
082	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.0130	3.7	6.3
083	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.3031	3.6	4.9

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084	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.8532	2.2	2.9
085	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.0572	5.3	7.4
086	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.2098	3.8	4.9
087	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.7815	2.4	3.1
088	No	No	01	MED	CONCUSSION W MCC	1.4741	4.2	5.5
089	No	No	01	MED	CONCUSSION W CC	0.9298	2.9	3.7
090	No	No	01	MED	CONCUSSION W/O CC/MCC	0.6818	1.9	2.4
091	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.5465	4.5	6.2
092	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9167	3.4	4.3
093	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.6691	2.4	3.0
094	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.4161	9.0	11.7
095	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.2416	6.4	8.1
096	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	1.7927	4.7	5.9
097	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.0233	9.1	11.5
098	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.7985	6.3	8.0
099	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2084	4.6	5.5
100	Yes	No	01	MED	SEIZURES W MCC	1.4778	4.5	6.1
101	Yes	No	01	MED	SEIZURES W/O MCC	0.7577	2.8	3.6
102	No	No	01	MED	HEADACHES W MCC	0.9772	3.2	4.4
103	No	No	01	MED	HEADACHES W/O MCC	0.6355	2.4	3.0
113	No	No	02	SURG	ORBITAL PROCEDURES W CC/MCC	1.7702	4.0	5.7
114	No	No	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	0.8825	2.0	2.6
115	No	No	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.1589	3.2	4.4
116	No	No	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.1418	2.7	4.0
117	No	No	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	0.6914	1.6	2.1
121	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	1.0006	4.4	5.6
122	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.6713	3.4	4.2
123	No	No	02	MED	NEUROLOGICAL EYE DISORDERS	0.7153	2.3	2.8
124	No	No	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.1843	4.1	5.6
125	No	No	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.6627	2.6	3.3
129	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.0661	3.6	5.2
130	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.2054	2.4	3.0
131	No	No	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.0146	3.9	5.7
132	No	No	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.1355	2.1	2.7
133	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	1.5884	3.7	5.5
134	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	0.8166	1.7	2.2
135	No	No	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	1.8520	4.3	6.5
136	No	No	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	0.9615	1.7	2.1
137	No	No	03	SURG	MOUTH PROCEDURES W CC/MCC	1.4004	4.0	5.4
138	No	No	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.7458	1.9	2.4
139	No	No	03	SURG	SALIVARY GLAND PROCEDURES	0.8080	1.4	1.7
146	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	2.1291	6.7	9.5
147	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2345	4.0	5.8
148	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.6995	2.3	3.2
149	No	No	03	MED	DYSEQUILIBRIUM	0.6293	2.2	2.7
150	No	No	03	MED	EPISTAXIS W MCC	1.3363	4.0	5.4
151	No	No	03	MED	EPISTAXIS W/O MCC	0.6194	2.3	2.9
152	No	No	03	MED	OTITIS MEDIA & URI W MCC	0.9396	3.6	4.6
153	No	No	03	MED	OTITIS MEDIA & URI W/O MCC	0.6084	2.7	3.3
154	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.3872	4.5	6.1
155	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.8823	3.4	4.3
156	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6201	2.4	3.0
157	No	No	03	MED	DENTAL & ORAL DISEASES W MCC	1.4763	4.8	6.6
158	No	No	03	MED	DENTAL & ORAL DISEASES W CC	0.9235	3.5	4.6
159	No	No	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.5949	2.3	3.0
163	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W MCC	4.9549	11.7	14.3
164	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W CC	2.5164	6.3	7.5
165	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.7662	4.0	4.7
166	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.7227	9.8	12.5
167	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.0068	6.0	7.6
168	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3026	3.4	4.6
175	Yes	No	04	MED	PULMONARY EMBOLISM W MCC	1.6121	5.9	7.1
176	Yes	No	04	MED	PULMONARY EMBOLISM W/O MCC	1.0685	4.3	5.1
177	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	2.0483	7.1	8.9
178	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.4860	5.8	7.1
179	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	1.0088	4.3	5.2
180	No	No	04	MED	RESPIRATORY NEOPLASMS W MCC	1.7263	5.9	7.7
181	No	No	04	MED	RESPIRATORY NEOPLASMS W CC	1.2062	4.3	5.6
182	No	No	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.8159	3.0	3.8
183	No	No	04	MED	MAJOR CHEST TRAUMA W MCC	1.4432	5.2	6.6
184	No	No	04	MED	MAJOR CHEST TRAUMA W CC	0.9483	3.7	4.5
185	No	No	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.6665	2.6	3.2
186	Yes	No	04	MED	PLEURAL EFFUSION W MCC	1.5917	5.5	7.1
187	Yes	No	04	MED	PLEURAL EFFUSION W CC	1.0620	3.9	5.0
188	Yes	No	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7612	2.9	3.6
189	No	No	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3455	4.7	6.0
190	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.2076	4.7	5.8

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191	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9622	4.0	4.8
192	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7175	3.2	3.8
193	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4378	5.3	6.6
194	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9976	4.3	5.1
195	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7095	3.3	3.9
196	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.5396	5.6	7.0
197	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.0647	4.2	5.1
198	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.8137	3.2	3.9
199	No	No	04	MED	PNEUMOTHORAX W MCC	1.8266	6.4	8.3
200	No	No	04	MED	PNEUMOTHORAX W CC	0.9745	3.7	4.8
201	No	No	04	MED	PNEUMOTHORAX W/O CC/MCC	0.7144	2.9	3.8
202	No	No	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.8374	3.5	4.3
203	No	No	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6055	2.7	3.3
204	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.6472	2.1	2.8
205	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.2566	4.0	5.4
206	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.7294	2.6	3.3
207	Yes	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	5.1780	12.8	15.1
208	No	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	2.2358	5.1	7.2
215	No	No	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.8304	7.0	14.4
216	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	10.1967	15.5	18.1
217	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.5932	10.1	11.2
218	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.2809	7.6	8.3
219	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	7.9336	11.1	13.6
220	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.1767	7.3	8.0
221	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.3926	5.7	6.1
222	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.4829	9.8	12.4
223	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.2229	3.8	5.4
224	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.5477	7.8	9.9
225	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	5.8321	3.9	5.0
226	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.5457	5.7	8.5
227	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.0519	1.8	2.8
228	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	7.5401	11.8	14.2
229	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W CC	4.8428	7.5	8.5
230	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	3.7989	5.0	5.9
231	No	No	05	SURG	CORONARY BYPASS W PTCA W MCC	7.6784	10.8	12.9
232	No	No	05	SURG	CORONARY BYPASS W PTCA W/O MCC	5.5589	8.3	9.2
233	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	6.9240	12.0	13.7
234	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	4.6212	8.1	8.7
235	Yes	No	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.6898	9.5	11.1
236	Yes	No	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.6128	6.0	6.5
237	No	No	05	SURG	MAJOR CARDIOVASC PROCEDURES W MCC OR THORACIC AORTIC ANEURYSM REPAIR	5.0355	7.3	10.5
238	No	No	05	SURG	MAJOR CARDIOVASC PROCEDURES W/O MCC	2.9366	3.0	4.3
239	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.7275	12.2	15.5
240	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.5377	7.9	9.7
241	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.4922	5.3	6.3
242	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.5878	6.3	8.1
243	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.5737	3.6	4.8
244	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	1.9888	2.1	2.7
245	No	No	05	SURG	AICD GENERATOR PROCEDURES	4.0534	2.2	3.4
246	No	No	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	3.0955	3.5	5.0
247	No	No	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	1.9121	1.7	2.1
248	No	No	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	2.8419	4.3	6.0
249	No	No	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.6840	2.0	2.5
250	No	No	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.7546	5.0	7.0
251	No	No	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.6455	2.0	2.7
252	No	No	05	SURG	OTHER VASCULAR PROCEDURES W MCC	2.9443	5.3	8.2
253	No	No	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.2817	4.2	5.9
254	No	No	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.5713	1.9	2.6
255	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.5388	7.4	9.9
256	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.5518	5.6	7.1
257	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	0.9529	3.4	4.5
258	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	2.8006	5.0	6.8
259	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	1.7191	2.0	2.8
260	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.2956	7.4	10.7
261	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.4677	2.9	4.1
262	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.0412	1.9	2.5
263	No	No	05	SURG	VEIN LIGATION & STRIPPING	1.6163	3.3	5.4
264	Yes	No	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.5087	5.6	8.5
265	No	No	05	SURG	AICD LEAD PROCEDURES	2.2407	2.3	3.4

MS-DRG	FY 2010 Final Rule Post-Acute DRG	FY 2010 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
280	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.8313	5.4	6.8
281	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	1.1620	3.6	4.5
282	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.8177	2.3	2.9
283	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.6717	3.3	5.3
284	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.8024	1.9	2.7
285	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5602	1.5	1.9
286	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	1.9634	5.0	6.7
287	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.0321	2.4	3.1
288	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	3.0888	9.2	11.8
289	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.8496	6.6	8.0
290	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.2313	4.5	5.5
291	Yes	No	05	MED	HEART FAILURE & SHOCK W MCC	1.4609	5.0	6.4
292	Yes	No	05	MED	HEART FAILURE & SHOCK W CC	0.9740	3.9	4.7
293	Yes	No	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6940	2.9	3.4
294	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	1.0104	4.6	5.7
295	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.6504	3.6	4.2
296	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC	1.1665	1.9	3.0
297	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6704	1.4	1.8
298	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4469	1.1	1.2
299	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4045	5.0	6.4
300	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9378	4.0	5.0
301	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.6522	2.9	3.6
302	No	No	05	MED	ATHEROSCLEROSIS W MCC	0.9999	3.1	4.2
303	No	No	05	MED	ATHEROSCLEROSIS W/O MCC	0.5681	2.0	2.4
304	No	No	05	MED	HYPERTENSION W MCC	1.0242	3.7	4.8
305	No	No	05	MED	HYPERTENSION W/O MCC	0.5959	2.2	2.8
306	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.3076	4.1	5.6
307	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.7624	2.6	3.3
308	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2188	4.0	5.3
309	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8207	3.0	3.8
310	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5710	2.1	2.6
311	No	No	05	MED	ANGINA PECTORIS	0.5128	1.9	2.3
312	No	No	05	MED	SYNCOPE & COLLAPSE	0.7215	2.5	3.1
313	No	No	05	MED	CHEST PAIN	0.5404	1.7	2.1
314	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1.7589	5.0	6.9
315	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9598	3.4	4.4
316	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.6211	2.2	2.7
326	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	5.6845	12.9	16.6
327	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.7062	7.2	9.2
328	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.3950	3.0	4.0

MS-DRG	FY 2010 Final Rule Post-Acute DRG	FY 2010 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
329	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	5.1396	12.7	15.7
330	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.4981	7.9	9.2
331	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.5952	4.9	5.5
332	Yes	No	06	SURG	RECTAL RESECTION W MCC	4.7762	12.1	14.5
333	Yes	No	06	SURG	RECTAL RESECTION W CC	2.4150	7.3	8.4
334	Yes	No	06	SURG	RECTAL RESECTION W/O CC/MCC	1.6208	4.5	5.2
335	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.1422	11.5	14.0
336	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.2458	7.3	8.8
337	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.4441	4.2	5.2
338	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	3.0677	8.6	10.3
339	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.7979	5.7	6.6
340	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.2197	3.4	3.9
341	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.2109	5.1	6.8
342	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.3112	3.1	3.9
343	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0.9360	1.7	2.1
344	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	3.0345	9.1	11.3
345	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6179	5.9	7.0
346	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.1755	4.3	4.8
347	No	No	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.2657	6.4	8.7
348	No	No	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3237	4.2	5.5
349	No	No	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.7665	2.3	2.9
350	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.2798	5.7	7.8
351	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.2628	3.4	4.4
352	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	0.8210	1.9	2.4
353	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.5349	6.4	8.4
354	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.4337	3.9	4.9
355	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	0.9878	2.3	2.8
356	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	3.9597	9.5	13.0
357	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1160	5.9	7.7
358	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3008	3.3	4.3
368	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.6584	5.0	6.6
369	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.0480	3.8	4.6
370	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.7501	2.7	3.2
371	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	1.9214	6.7	8.7
372	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.2865	5.4	6.6
373	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.8619	4.1	4.8
374	Yes	No	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0149	6.4	8.6
375	Yes	No	06	MED	DIGESTIVE MALIGNANCY W CC	1.2631	4.5	5.9

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376	Yes	No	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.8883	3.0	3.9
377	Yes	No	06	MED	G.I. HEMORRHAGE W MCC	1.6149	4.9	6.3
378	Yes	No	06	MED	G.I. HEMORRHAGE W CC	0.9873	3.6	4.3
379	Yes	No	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.7179	2.7	3.2
380	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.7333	5.5	7.0
381	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W CC	1.0853	3.9	4.8
382	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.7785	2.9	3.5
383	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.2399	4.4	5.5
384	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8146	3.1	3.7
385	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.7089	6.1	8.0
386	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W CC	1.0423	4.3	5.4
387	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.7871	3.4	4.1
388	Yes	No	06	MED	G.I. OBSTRUCTION W MCC	1.5060	5.3	7.0
389	Yes	No	06	MED	G.I. OBSTRUCTION W CC	0.9268	3.9	4.9
390	Yes	No	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.6341	2.9	3.5
391	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.0958	3.9	5.1
392	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.6921	2.8	3.5
393	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.5632	4.9	6.8
394	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9572	3.7	4.7
395	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6666	2.6	3.2
405	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.5911	12.5	16.6
406	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.6729	6.7	8.5
407	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	1.8068	4.1	5.2
408	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	4.0844	11.3	14.0
409	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.3103	7.5	8.8
410	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.6134	5.2	6.1
411	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.9655	10.3	12.4
412	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.3982	7.3	8.4
413	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.6222	4.5	5.4
414	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.6023	9.6	11.7
415	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	1.9824	6.2	7.3
416	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.2904	3.9	4.5
417	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.4050	6.4	8.0
418	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6354	4.3	5.3
419	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.1334	2.4	3.0
420	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	4.1182	10.2	14.0
421	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.6987	4.9	6.8
422	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.1791	3.2	4.4

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423	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	4.2255	11.2	14.9
424	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.2105	6.9	9.0
425	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.4477	3.9	5.2
432	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.6369	5.1	6.8
433	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	0.9076	3.6	4.6
434	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6489	2.7	3.4
435	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.7293	5.7	7.4
436	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.1831	4.3	5.6
437	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.8780	3.0	3.9
438	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.6993	5.5	7.4
439	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	0.9960	4.0	5.1
440	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6865	3.0	3.6
441	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.7290	5.2	7.2
442	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9407	3.7	4.8
443	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6631	2.8	3.5
444	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.5055	4.9	6.4
445	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0386	3.7	4.6
446	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7239	2.5	3.1
453	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	10.0108	11.2	14.4
454	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	6.9533	5.8	7.2
455	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.0197	3.3	4.0
456	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	8.7412	11.2	14.0
457	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC	5.9617	6.1	7.2
458	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W/O CC/MCC	4.8966	3.8	4.3
459	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.1506	7.5	9.3
460	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	3.7097	3.5	4.0
461	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.5614	6.5	8.1
462	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.2056	3.8	4.2
463	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.3025	12.2	16.8
464	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.8384	7.3	9.5
465	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.7896	4.4	5.7
466	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	4.6698	7.4	9.2
467	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.1207	4.5	5.2
468	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.5167	3.4	3.7
469	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	3.3282	6.6	7.9

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470	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0613	3.5	3.8
471	No	No	08	SURG	CERVICAL SPINAL FUSION W MCC	4.6182	7.2	10.1
472	No	No	08	SURG	CERVICAL SPINAL FUSION W CC	2.7547	2.8	4.1
473	No	No	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.0033	1.5	1.9
474	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.5040	9.7	12.5
475	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	1.9230	6.2	8.0
476	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	1.0650	3.5	4.6
477	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.1343	8.7	11.1
478	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.1321	4.7	6.5
479	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.5121	1.9	2.8
480	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	2.8752	7.6	8.9
481	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	1.8373	5.2	5.7
482	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.5071	4.3	4.7
483	Yes	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W CC/MCC	2.3024	3.2	3.9
484	Yes	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W/O CC/MCC	1.8358	2.0	2.3
485	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.0871	9.3	11.4
486	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.0558	6.4	7.6
487	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.4338	4.5	5.2
488	Yes	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	1.6774	3.9	5.0
489	Yes	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.1830	2.5	2.9
490	No	No	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	1.7718	3.0	4.3
491	No	No	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	0.9522	1.7	2.1
492	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	2.8500	6.8	8.5
493	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	1.7806	4.2	5.1
494	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.2619	2.7	3.2
495	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	2.8743	7.4	10.1
496	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.6254	4.2	5.7
497	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.0344	2.0	2.6
498	No	No	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	1.9228	5.4	7.4
499	No	No	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	0.8975	2.2	2.8
500	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W MCC	3.0244	8.1	11.0
501	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5169	4.6	6.0
502	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	0.9834	2.3	2.9

MS-DRG	FY 2010 Final Rule Post-Acute DRG	FY 2010 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
503	No	No	08	SURG	FOOT PROCEDURES W MCC	2.1835	6.7	8.8
504	No	No	08	SURG	FOOT PROCEDURES W CC	1.5082	5.1	6.4
505	No	No	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.0282	2.5	3.3
506	No	No	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.1381	2.5	3.6
507	No	No	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.8188	3.5	4.8
508	No	No	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.2568	1.7	2.0
509	No	No	08	SURG	ARTHROSCOPY	1.2065	2.2	3.1
510	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.1482	5.0	6.4
511	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.3747	3.2	3.9
512	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.0033	1.8	2.2
513	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.2327	3.5	4.7
514	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.7712	2.0	2.5
515	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.0414	7.8	10.1
516	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.8355	4.5	5.8
517	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.3640	2.2	3.0
533	Yes	No	08	MED	FRACTURES OF FEMUR W MCC	1.5632	5.0	6.9
534	Yes	No	08	MED	FRACTURES OF FEMUR W/O MCC	0.7386	3.2	3.9
535	Yes	No	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.2914	4.5	5.9
536	Yes	No	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7127	3.3	3.9
537	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.8831	3.7	4.3
538	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.5863	2.5	3.0
539	Yes	No	08	MED	OSTEOMYELITIS W MCC	2.2839	7.9	10.5
540	Yes	No	08	MED	OSTEOMYELITIS W CC	1.3839	5.7	7.2
541	Yes	No	08	MED	OSTEOMYELITIS W/O CC/MCC	0.9422	4.1	5.2
542	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.9540	6.6	8.6
543	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.1211	4.6	5.8
544	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7717	3.6	4.2
545	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.2783	6.3	8.7
546	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.0758	4.3	5.3
547	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.7475	3.0	3.7
548	No	No	08	MED	SEPTIC ARTHRITIS W MCC	1.9281	6.7	9.0
549	No	No	08	MED	SEPTIC ARTHRITIS W CC	1.1758	5.0	6.3
550	No	No	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.7082	3.3	4.1
551	Yes	No	08	MED	MEDICAL BACK PROBLEMS W MCC	1.5442	5.4	6.9
552	Yes	No	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.7937	3.3	4.1
553	No	No	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.1057	4.5	5.7

MS-DRG	FY 2010 Final Rule Post-Acute DRG	FY 2010 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
554	No	No	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.6478	2.9	3.6
555	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	0.9698	3.4	4.7
556	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.6027	2.5	3.1
557	Yes	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.4685	5.4	6.6
558	Yes	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8387	3.6	4.3
559	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.7514	5.2	7.2
560	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	0.9852	3.7	4.8
561	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.5959	2.1	2.7
562	Yes	No	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.3793	4.8	6.1
563	Yes	No	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.6927	3.1	3.6
564	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.5068	5.3	7.0
565	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9070	3.9	4.8
566	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.6498	2.8	3.5
573	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W MCC	3.5286	10.0	13.9
574	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.9090	6.8	8.9
575	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC/MCC	1.1260	4.5	5.6
576	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W MCC	3.3598	8.2	12.6
577	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W CC	1.7235	4.1	6.2
578	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	0.9925	2.4	3.2
579	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.8556	8.0	10.7
580	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.3997	3.6	5.3
581	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	0.8589	1.8	2.4
582	No	No	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.0226	2.1	2.8
583	No	No	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	0.7889	1.5	1.8
584	No	No	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.4877	3.6	5.5
585	No	No	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	0.8593	1.7	2.1
592	Yes	No	09	MED	SKIN ULCERS W MCC	1.8499	6.6	8.8
593	Yes	No	09	MED	SKIN ULCERS W CC	1.0807	4.9	6.3
594	Yes	No	09	MED	SKIN ULCERS W/O CC/MCC	0.7523	3.7	4.7
595	No	No	09	MED	MAJOR SKIN DISORDERS W MCC	1.7691	6.0	8.2
596	No	No	09	MED	MAJOR SKIN DISORDERS W/O MCC	0.8285	3.7	4.7
597	No	No	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.6302	5.6	8.0
598	No	No	09	MED	MALIGNANT BREAST DISORDERS W CC	1.0650	4.2	5.7

MS-DRG	FY 2010 Final Rule Post-Acute DRG	FY 2010 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
599	No	No	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6102	2.6	3.5
600	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9801	4.2	5.4
601	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.5941	3.0	3.6
602	Yes	No	09	MED	CELLULITIS W MCC	1.4300	5.5	6.9
603	Yes	No	09	MED	CELLULITIS W/O MCC	0.8178	3.8	4.6
604	No	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.1719	4.1	5.5
605	No	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.6824	2.7	3.4
606	No	No	09	MED	MINOR SKIN DISORDERS W MCC	1.1964	4.3	5.9
607	No	No	09	MED	MINOR SKIN DISORDERS W/O MCC	0.6403	2.8	3.6
614	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.6525	5.0	7.1
615	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.3859	2.6	3.1
616	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.8537	13.2	16.8
617	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0316	6.9	8.5
618	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.2713	5.0	6.1
619	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	3.5839	5.0	7.9
620	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8258	2.6	3.4
621	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.4500	1.7	1.9
622	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	4.2285	11.3	16.0
623	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	2.0271	6.9	8.9
624	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.1304	4.5	5.6
625	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.2380	4.7	7.1
626	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.1339	2.0	3.0
627	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	0.7545	1.3	1.4
628	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.3978	7.4	11.1
629	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.3003	6.8	8.5
630	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.4359	3.5	4.8
637	Yes	No	10	MED	DIABETES W MCC	1.3303	4.4	5.8
638	Yes	No	10	MED	DIABETES W CC	0.8263	3.3	4.2
639	Yes	No	10	MED	DIABETES W/O CC/MCC	0.5547	2.4	2.9
640	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS W MCC	1.0896	3.7	5.1
641	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS W/O MCC	0.6843	3.0	3.7
642	No	No	10	MED	INBORN ERRORS OF METABOLISM	1.0463	3.6	4.9
643	Yes	No	10	MED	ENDOCRINE DISORDERS W MCC	1.6325	5.8	7.3
644	Yes	No	10	MED	ENDOCRINE DISORDERS W CC	1.0453	4.2	5.3
645	Yes	No	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7187	3.0	3.7
652	No	No	11	SURG	KIDNEY TRANSPLANT	2.9736	6.5	7.5
653	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W MCC	5.8189	13.3	16.5

MS-DRG	FY 2010 Final Rule Post-Acute DRG	FY 2010 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
654	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W CC	2.8942	8.3	9.4
655	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	1.9180	5.0	5.9
656	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.2592	7.7	9.9
657	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	1.8523	4.8	5.6
658	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.3668	3.0	3.4
659	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	3.2812	7.8	10.7
660	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.8136	4.4	6.0
661	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.2817	2.4	3.0
662	No	No	11	SURG	MINOR BLADDER PROCEDURES W MCC	2.7753	7.4	10.2
663	No	No	11	SURG	MINOR BLADDER PROCEDURES W CC	1.3713	3.4	4.9
664	No	No	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.0193	1.5	1.9
665	No	No	11	SURG	PROSTATECTOMY W MCC	2.8052	9.0	11.4
666	No	No	11	SURG	PROSTATECTOMY W CC	1.5506	4.1	6.1
667	No	No	11	SURG	PROSTATECTOMY W/O CC/MCC	0.7615	1.8	2.3
668	No	No	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.2481	6.1	8.4
669	No	No	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1938	3.0	4.2
670	No	No	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.7573	1.8	2.3
671	No	No	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.4698	4.0	6.0
672	No	No	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	0.7699	1.9	2.4
673	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	2.9192	5.7	9.7
674	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.0576	4.5	6.8
675	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.3129	1.5	2.1
682	Yes	No	11	MED	RENAL FAILURE W MCC	1.6422	5.1	7.0
683	Yes	No	11	MED	RENAL FAILURE W CC	1.0523	4.2	5.2
684	Yes	No	11	MED	RENAL FAILURE W/O CC/MCC	0.6746	2.9	3.5
685	No	No	11	MED	ADMIT FOR RENAL DIALYSIS	0.8994	2.5	3.4
686	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.5362	5.5	7.3
687	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0260	3.9	5.1
688	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.6852	2.3	3.0
689	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.2122	4.8	6.0
690	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7708	3.5	4.2
691	No	No	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.4711	3.1	4.1
692	No	No	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1044	1.9	2.3
693	No	No	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.1496	3.5	4.6
694	No	No	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.6539	2.0	2.5
695	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.2396	4.2	5.7
696	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.6453	2.6	3.2
697	No	No	11	MED	URETHRAL STRICTURE	0.8140	2.5	3.5
698	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.4877	5.0	6.6
699	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	0.9518	3.7	4.7

MS-DRG	FY 2010 Final Rule Post-Acute DRG	FY 2010 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
700	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.6533	2.6	3.3
707	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.6691	3.2	4.2
708	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.2024	1.7	2.0
709	No	No	12	SURG	PENIS PROCEDURES W CC/MCC	1.8350	3.6	6.0
710	No	No	12	SURG	PENIS PROCEDURES W/Q CC/MCC	1.3227	1.3	1.6
711	No	No	12	SURG	TESTES PROCEDURES W CC/MCC	1.7128	5.0	7.4
712	No	No	12	SURG	TESTES PROCEDURES W/O CC/MCC	0.7666	1.9	2.6
713	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.1285	2.9	4.1
714	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.6364	1.6	1.9
715	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	1.7460	4.1	6.3
716	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	1.0053	1.3	1.5
717	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.6782	4.8	6.8
718	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	0.7921	2.0	2.7
722	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.4962	5.4	7.0
723	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	0.9732	3.9	5.1
724	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6288	2.1	2.8
725	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.0685	3.9	5.1
726	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.6979	2.8	3.5
727	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.3162	5.0	6.4
728	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.7331	3.3	4.1
729	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	0.9642	3.7	4.9
730	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.5786	2.3	2.8
734	No	No	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.5091	5.6	7.7
735	No	No	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.1370	2.5	3.0
736	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.3490	11.4	14.0
737	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	1.9651	5.8	6.8
738	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.1766	3.3	3.7
739	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.0553	7.7	10.0
740	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.5028	4.1	4.9
741	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.0568	2.4	2.8
742	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.3481	3.3	4.3
743	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	0.8787	1.9	2.2
744	No	No	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.4699	4.1	5.7
745	No	No	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	0.7721	2.0	2.5
746	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.2251	2.9	4.0

MS-DRG	FY 2010 Final Rule Post-Acute DRG	FY 2010 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
747	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.8471	1.6	1.8
748	No	No	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.8784	1.5	1.7
749	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.4378	6.6	9.1
750	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.0159	2.3	3.0
754	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	1.8829	6.2	8.5
755	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1184	4.1	5.5
756	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.5883	2.2	2.9
757	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.7189	6.5	8.4
758	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0980	4.8	5.9
759	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7719	3.6	4.4
760	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.7992	3.0	3.9
761	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.4952	1.9	2.4
765	No	No	14	SURG	CESAREAN SECTION W CC/MCC	1.1083	4.0	5.2
766	No	No	14	SURG	CESAREAN SECTION W/O CC/MCC	0.7526	2.9	3.0
767	No	No	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.8389	2.5	3.0
768	No	No	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.7754	0.0	0.0
769	No	No	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.8900	3.9	6.9
770	No	No	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5367	1.5	1.9
774	No	No	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.6873	2.6	3.3
775	No	No	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4971	2.1	2.3
776	No	No	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6808	2.6	3.5
777	No	No	14	MED	ECTOPIC PREGNANCY	0.7786	1.9	2.3
778	No	No	14	MED	THREATENED ABORTION	0.4229	1.9	3.0
779	No	No	14	MED	ABORTION W/O D&C	0.4386	1.6	2.1
780	No	No	14	MED	FALSE LABOR	0.2023	1.2	1.3
781	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.6357	2.7	3.8
782	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4504	1.7	2.4
789	No	No	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.4583	0.0	0.0
790	No	No	15	MED	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.8090	0.0	0.0
791	No	No	15	MED	PREMATURITY W MAJOR PROBLEMS	3.2844	0.0	0.0
792	No	No	15	MED	PREMATURITY W/O MAJOR PROBLEMS	1.9817	0.0	0.0
793	No	No	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.3738	0.0	0.0
794	No	No	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1941	0.0	0.0
795	No	No	15	MED	NORMAL NEWBORN	0.1617	0.0	0.0
799	No	No	16	SURG	SPLENECTOMY W MCC	5.1087	10.5	13.7
800	No	No	16	SURG	SPLENECTOMY W CC	2.5315	5.7	7.4
801	No	No	16	SURG	SPLENECTOMY W/O CC/MCC	1.5865	3.2	4.0

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802	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.4788	8.8	11.9
803	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.7680	4.9	6.9
804	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.0388	2.4	3.2
808	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.0487	6.3	8.2
809	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.1725	4.1	5.2
810	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.8689	3.1	3.9
811	No	No	16	MED	RED BLOOD CELL DISORDERS W MCC	1.2431	3.9	5.4
812	No	No	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.7751	2.8	3.7
813	No	No	16	MED	COAGULATION DISORDERS	1.3846	3.7	5.2
814	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.5144	5.1	6.8
815	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9596	3.6	4.6
816	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.6953	2.7	3.4
820	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.3673	12.8	16.8
821	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.2672	5.2	7.5
822	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.1632	2.4	3.3
823	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	3.9010	11.5	14.8
824	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.1520	6.3	8.6
825	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	1.2003	2.9	4.1
826	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	4.5104	11.7	14.9
827	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.0111	5.2	6.9
828	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.2384	2.8	3.5
829	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC	2.6088	6.4	9.6
830	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	0.9784	2.3	3.1
834	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	4.3709	9.3	15.1
835	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.4817	5.9	9.7
836	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.2595	3.2	4.9
837	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	6.3616	18.1	23.4
838	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	3.0949	8.5	12.9
839	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.2496	4.8	5.9
840	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	2.7258	7.7	10.5
841	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.5071	5.0	6.7
842	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	0.9803	3.2	4.3
843	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	1.6852	5.9	7.9
844	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.1997	4.5	6.0

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845	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8043	3.1	4.1
846	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.1717	6.0	8.5
847	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	0.9451	2.7	3.4
848	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.8235	2.5	3.2
849	No	No	17	MED	RADIOTHERAPY	1.2837	4.4	6.2
853	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.4946	12.5	16.3
854	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.7290	8.8	10.8
855	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.7040	5.5	7.3
856	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	4.9249	11.4	15.5
857	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.0439	6.3	8.1
858	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3521	4.4	5.5
862	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.9008	6.0	8.0
863	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.9702	4.1	5.1
864	No	No	18	MED	FEVER	0.8153	3.1	3.9
865	No	No	18	MED	VIRAL ILLNESS W MCC	1.3601	4.4	6.2
866	No	No	18	MED	VIRAL ILLNESS W/O MCC	0.6736	2.8	3.5
867	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.3705	6.9	9.4
868	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	1.0680	4.2	5.4
869	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7419	3.3	4.1
870	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	5.8007	12.9	15.5
871	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.8437	5.4	7.3
872	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.1155	4.6	5.6
876	No	No	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.5892	8.0	13.1
880	No	No	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6191	2.4	3.2
881	No	No	19	MED	DEPRESSIVE NEUROSES	0.6048	3.1	4.3
882	No	No	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.6676	3.1	4.4
883	No	No	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.1188	4.9	8.2
884	Yes	No	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.9452	4.2	5.6
885	No	No	19	MED	PSYCHOSES	0.8899	5.5	7.5
886	No	No	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.7895	3.7	6.0
887	No	No	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.8336	3.1	4.7
894	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4021	2.1	2.9
895	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	0.9742	8.2	10.6
896	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.4155	4.9	6.8
897	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.6288	3.2	4.0

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901	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	4.0545	10.0	15.0
902	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.7850	5.7	8.0
903	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.0137	3.3	4.5
904	No	No	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	2.8601	7.3	11.3
905	No	No	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.0901	3.4	4.6
906	No	No	21	SURG	HAND PROCEDURES FOR INJURIES	0.9991	2.1	3.1
907	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	3.8072	8.1	11.6
908	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.8736	4.7	6.5
909	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.1135	2.6	3.4
913	No	No	21	MED	TRAUMATIC INJURY W MCC	1.3473	4.2	6.0
914	No	No	21	MED	TRAUMATIC INJURY W/O MCC	0.6789	2.6	3.4
915	No	No	21	MED	ALLERGIC REACTIONS W MCC	1.2545	3.3	4.6
916	No	No	21	MED	ALLERGIC REACTIONS W/O MCC	0.4513	1.7	2.1
917	Yes	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4449	3.7	5.2
918	Yes	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.5839	2.0	2.7
919	No	No	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.5883	4.4	6.3
920	No	No	21	MED	COMPLICATIONS OF TREATMENT W CC	0.9405	3.2	4.3
921	No	No	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.6121	2.3	2.8
922	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.3114	3.8	5.5
923	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.6556	2.3	3.2
927	No	No	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	13.7351	24.4	32.7
928	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	5.3052	11.7	16.4
929	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.0086	5.0	7.4
933	No	No	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	2.3081	2.4	5.7
934	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	1.3403	4.2	6.2
935	No	No	22	MED	NON-EXTENSIVE BURNS	1.2507	3.5	5.3
939	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	2.8593	7.2	10.9
940	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	1.6821	3.5	5.7
941	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.1298	2.0	2.6
945	Yes	No	23	MED	REHABILITATION W CC/MCC	1.2388	8.2	10.0
946	Yes	No	23	MED	REHABILITATION W/O CC/MCC	1.1159	6.7	7.7
947	Yes	No	23	MED	SIGNS & SYMPTOMS W MCC	1.0922	3.8	5.1
948	Yes	No	23	MED	SIGNS & SYMPTOMS W/O MCC	0.6689	2.8	3.5
949	No	No	23	MED	AFTERCARE W CC/MCC	0.9758	2.7	4.8
950	No	No	23	MED	AFTERCARE W/O CC/MCC	0.5459	2.5	3.4
951	No	No	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.7239	2.1	4.2
955	No	No	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.6781	8.9	12.8
956	Yes	No	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.4364	7.3	9.1

MS-DRG	FY 2010 Final Rule Post-Acute DRG	FY 2010 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
957	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	6.2993	10.5	15.1
958	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	3.6544	7.3	9.5
959	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.2000	4.5	5.8
963	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.7687	6.2	9.2
964	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.5026	4.6	5.8
965	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9781	3.1	3.8
969	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.5074	13.2	18.8
970	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.5627	6.1	8.9
974	No	No	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.4810	7.1	10.0
975	No	No	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.3597	5.2	6.8
976	No	No	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.8967	3.7	4.7
977	No	No	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0538	3.7	5.0
981	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	5.0389	11.3	14.6
982	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.8954	7.0	9.0
983	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.8072	3.4	4.6
984	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3443	11.7	14.6
985	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.9481	6.2	8.7
986	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.1079	2.9	4.3
987	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.4020	9.4	12.6
988	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.7836	5.4	7.3
989	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.0358	2.6	3.7
998	No	No		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
999	No	No		**	UNGROUPABLE	0.0000	0.0	0.0

TABLE 6A.--NEW DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
209.31	Merkel cell carcinoma of the face	N	09	595, 596
209.32	Merkel cell carcinoma of the scalp and neck	N	09	595, 596
209.33	Merkel cell carcinoma of the upper limb	N	09	595, 596
209.34	Merkel cell carcinoma of the lower limb	N	09	595, 596
209.35	Merkel cell carcinoma of the trunk	N	09	595, 596
209.36	Merkel cell carcinoma of other sites	N	09	595, 596
209.70	Secondary neuroendocrine tumor, unspecified site	N	17	826, 827, 828, 829, 830, 843, 844, 845
209.71	Secondary neuroendocrine tumor of distant lymph nodes	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
209.72	Secondary neuroendocrine tumor of liver	CC	07	435, 436, 437
209.73	Secondary neuroendocrine tumor of bone	CC	08	456, 457, 458, 542, 543, 544
209.74	Secondary neuroendocrine tumor of peritoneum	CC	06	374, 375, 376
209.75*	Secondary Merkel cell carcinoma	N	17	826, 827, 828, 829, 830, 843, 844, 845
209.79	Secondary neuroendocrine tumor of other sites	CC	17	826, 827, 828, 829, 830, 843, 844, 845
239.81	Neoplasms of unspecified nature, retina and choroid	N	17	826, 827, 828, 829, 830, 843, 844, 845
239.89	Neoplasms of unspecified nature, other specified sites	N	17	826, 827, 828, 829, 830, 843, 844, 845
274.00	Gouty arthropathy, unspecified	N	08	553, 554
274.01	Acute gouty arthropathy	N	08	553, 554
274.02	Chronic gouty arthropathy without mention of tophus (tophi)	N	08	553, 554
274.03	Chronic gouty arthropathy with tophus (tophi)	N	08	553, 554
277.88	Tumor lysis syndrome	MCC	11 15	673, 674, 675, 682, 683, 684 791[1], 793[1]
279.41	Autoimmune lymphoproliferative syndrome	N	08 25	545, 546, 547 977
279.49	Autoimmune disease, not elsewhere classified	N	08 25	545, 546, 547 977
285.3	Antineoplastic chemotherapy induced anemia	N	16	811, 812
348.81	Temporal sclerosis	N	01	070, 071, 072
348.89	Other conditions of brain	N	01	070, 071, 072
359.71	Inclusion body myositis	N	08	545, 546, 547
359.79	Other inflammatory and immune myopathies, NEC	N	08	545, 546, 547
372.06	Acute chemical conjunctivitis	N	02	124, 125
416.2	Chronic pulmonary embolism	CC	04 15	175, 176 791[1], 793[1]
438.13	Late effects of cerebrovascular disease, dysarthria	N	01	056, 057

Diagnosis Code	Description	CC	MDC	MS-DRG
438.14	Late effects of cerebrovascular disease, fluency disorder	N	01	056, 057
453.50	Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity	CC	05	299, 300, 301
453.51	Chronic venous embolism and thrombosis of deep vessels of proximal lower extremity	CC	05	299, 300, 301
453.52	Chronic venous embolism and thrombosis of deep vessels of distal lower extremity	CC	05	299, 300, 301
453.6	Venous embolism and thrombosis of superficial vessels of lower extremity	CC	05	299, 300, 301
453.71	Chronic venous embolism and thrombosis of superficial veins of upper extremity	CC	05	299, 300, 301
453.72	Chronic venous embolism and thrombosis of deep veins of upper extremity	CC	05	299, 300, 301
453.73	Chronic venous embolism and thrombosis of upper extremity, unspecified	CC	05	299, 300, 301
453.74**	Chronic venous embolism and thrombosis of axillary veins	CC	05	299, 300, 301
453.75	Chronic venous embolism and thrombosis of subclavian veins	CC	05	299, 300, 301
453.76	Chronic venous embolism and thrombosis of internal jugular veins	CC	05	299, 300, 301
453.77	Chronic venous embolism and thrombosis of other thoracic veins	CC	05	299, 300, 301
453.79	Chronic venous embolism and thrombosis of other specified veins	CC	05	299, 300, 301
453.81	Acute venous embolism and thrombosis of superficial veins of upper extremity	CC	05	299, 300, 301
453.82	Acute venous embolism and thrombosis of deep veins of upper extremity	CC	05	299, 300, 301
453.83	Acute venous embolism and thrombosis of upper extremity, unspecified	CC	05	299, 300, 301
453.84	Acute venous embolism and thrombosis of axillary veins	CC	05	299, 300, 301
453.85	Acute venous embolism and thrombosis of subclavian veins	CC	05	299, 300, 301
453.86	Acute venous embolism and thrombosis of internal jugular veins	CC	05	299, 300, 301
453.87	Acute venous embolism and thrombosis of other thoracic veins	CC	05	299, 300, 301
453.89	Acute venous embolism and thrombosis of other specified veins	CC	05	299, 300, 301
488.0***	Influenza due to identified avian influenza virus	N	03	152, 153
488.1***	Influenza due to identified novel H1N1 influenza virus	N	03	152, 153
569.71	Pouchitis	CC	06 15	393, 394, 395 791[1], 793[1]
569.79	Other complications of intestinal pouch	CC	06 15	393, 394, 395 791[1], 793[1]
569.87	Vomiting of fecal matter	N	06	393, 394, 395

Diagnosis Code	Description	CC	MDC	MS-DRG
621.34	Benign endometrial hyperplasia	N	13	742, 743, 760,761
621.35	Endometrial intraepithelial neoplasia [EIN]	N	13	742,743, 760, 761
670.10	Puerperal endometritis, unspecified as to episode of care or not applicable	CC	14	998
670.12	Puerperal endometritis, delivered, with mention of postpartum complication	CC	14	765, 766, 767, 768, 774
670.14	Puerperal endometritis, postpartum condition or complication	CC	14	769, 776
670.20	Puerperal sepsis, unspecified as to episode of care or not applicable	CC	14	998
670.22	Puerperal sepsis, delivered, with mention of postpartum complication	MCC	14	765, 766, 767, 768, 774
670.24	Puerperal sepsis, postpartum condition or complication	MCC	14	769, 776
670.30	Puerperal septic thrombophlebitis, unspecified as to episode of care or not applicable	CC	14	998
670.32	Puerperal septic thrombophlebitis, delivered, with mention of postpartum complication	MCC	14	765, 766, 767, 768, 774
670.34	Puerperal septic thrombophlebitis, postpartum condition or complication	MCC	14	769, 776
670.80	Other major puerperal infection, unspecified as to episode of care or not applicable	MCC	14	998
670.82	Other major puerperal infection, delivered, with mention of postpartum complication	MCC	14	765, 766, 767, 768, 774
670.84	Other major puerperal infection, postpartum condition or complication	MCC	14	769, 776
756.72	Omphalocele	MCC	06 15	393, 394, 395 791[1], 793[1]
756.73	Gastroschisis	MCC	06 15	393, 394, 395 791[1], 793[1]
768.70	Hypoxic-ischemic encephalopathy, unspecified	CC	15	794
768.71	Mild hypoxic-ischemic encephalopathy	CC	15	794
768.72	Moderate hypoxic-ischemic encephalopathy	CC	15	791[2], 793[2]
768.73	Severe hypoxic-ischemic encephalopathy	MCC	15	791[2], 793[2]
779.31	Feeding problems in newborn	N	15	795[3]
779.32	Bilious vomiting in newborn	MCC	15	791[2], 793[2]
779.33	Other vomiting in newborn	N	15	795[3]
779.34	Failure to thrive in newborn	N	10 25	640, 641 977
784.42	Dysphonia	N	03	154, 155, 156
784.43	Hypernasality	N	03	154, 155, 156
784.44	Hyponasality	N	03	154, 155, 156
784.51	Dysarthria	N	01	091, 092, 093
784.59	Other speech disturbance	N	01	091, 092, 093
787.04	Bilious emesis	N	06	391, 392
789.7	Colic	N	06	391, 392
793.82	Inconclusive mammogram	N	09	600, 601
799.21	Nervousness	N	19	880
799.22	Irritability	N	19	880
799.23	Impulsiveness	N	19	882

Diagnosis Code	Description	CC	MDC	MS-DRG
799.24	Emotional lability	N	19	883
799.25	Demoralization and apathy	N	19	880
799.29	Other signs and symptoms involving emotional state	N	19	880
799.82	Apparent life threatening event in infant	N	23	951
813.46	Torus fracture of ulna (alone)	CC	08 24	562, 563 963, 964, 965
813.47	Torus fracture of radius and ulna	CC	08 24	562, 563 963, 964, 965
832.2	Nursemaid's elbow	N	08 24	562, 563 963, 964, 965
969.00	Poisoning by antidepressant, unspecified	N	21	917, 918
969.01	Poisoning by monoamine oxidase inhibitors	N	21	917, 918
969.02	Poisoning by selective serotonin and norepinephrine reuptake inhibitors	N	21	917, 918
969.03	Poisoning by selective serotonin reuptake inhibitors	N	21	917, 918
969.04	Poisoning by tetracyclic antidepressants	N	21	917, 918
969.05	Poisoning by tricyclic antidepressants	N	21	917, 918
969.09	Poisoning by other antidepressants	N	21	917, 918
969.70	Poisoning by psychostimulant, unspecified	N	21	917, 918
969.71	Poisoning by caffeine	N	21	917, 918
969.72	Poisoning by amphetamines	N	21	917, 918
969.73	Poisoning by methylphenidate	N	21	917, 918
969.79	Poisoning by other psychostimulants	N	21	917, 918
995.24	Failed moderate sedation during procedure	N	21	917, 918
V10.90*	Personal history of unspecified malignant neoplasm	N	17	826, 827, 828, 829, 830, 843, 844, 845
V10.91	Personal history of malignant neuroendocrine tumor	N	17	826, 827, 828, 829, 830, 843, 844, 845
V15.52	Personal history of traumatic brain injury	N	23	951
V15.80	Personal history of failed moderate sedation	N	23	951
V15.83	Personal history of underimmunization status	N	23	951
V20.31**	Health supervision for newborn under 8 days old	N	15 23	795[4] 951
V20.32	Health supervision for newborn 8 to 28 days old	N	15 23	795[4] 951
V26.42	Encounter for fertility preservation counseling	N	23	951
V26.82	Encounter for fertility preservation procedure	N	23	951
V53.50	Fitting and adjustment of intestinal appliance and device	N	06	393, 394, 395
V53.51	Fitting and adjustment of gastric lap band	N	06	393, 394, 395
V53.59	Fitting and adjustment of other gastrointestinal appliance and device	N	06	393, 394, 395
V60.81	Foster care (status)	N	23	951
V60.89	Other specified housing or economic circumstances	N	23	951
V61.07	Family disruption due to death of family member	N	23	951
V61.08	Family disruption due to other extended absence of family member	N	23	951
V61.23	Counseling for parent-biological child problem	N	23	951
V61.24	Counseling for parent-adopted child problem	N	23	951
V61.25	Counseling for parent (guardian)-foster child problem	N	23	951
V61.42	Substance abuse in family	N	23	951
V72.60	Laboratory examination, unspecified	N	23	951
V72.61	Antibody response examination	N	23	951
V72.62	Laboratory examination ordered as part of a routine general medical examination	N	23	951
V72.63	Pre-procedural laboratory examination	N	23	951
V72.69	Other laboratory examination	N	23	951
V80.01	Special screening for traumatic brain injury	N	23	951
V80.09	Special screening for other neurological conditions	N	23	951
V87.32	Contact with and (suspected) exposure to algae bloom	N	23	951
V87.43	Personal history of estrogen therapy	N	23	949, 950
V87.44	Personal history of inhaled steroid therapy	N	23	949, 950
V87.45	Personal history of systemic steroid therapy	N	23	949, 950
V87.46	Personal history of immunosuppressive therapy	N	23	949, 950

Notes:

*These diagnosis codes were discussed at the March 11-12, 2009 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. They will be implemented on October 1, 2009. Please note that the code title for 209.75 has changed from the proposed rule to the final rule and as a result of this change, the MS-DRG assignments also changed.

**The code title has changed from the proposed rule.

***CDC created new flu codes to better capture H1N1 flu cases in response to the recent flu outbreak.

[1]Secondary diagnosis of major problem.

[2]Principal or secondary diagnosis of major problem.

[3]On "Principal Diagnosis" list.

[4]On "Only Secondary Diagnosis" list.

TABLE 6B.--NEW PROCEDURE CODES

Procedure Code	Description	O.R.	MDC	MS-DRG
17.51	Implantation of rechargeable cardiac contractility modulation [CCM], total system	Y	05	222, 223, 224, 225, 226, 227
17.52	Implantation or replacement of cardiac contractility modulation [CCM] rechargeable pulse generator only	Y	05	245
17.61	Laser interstitial thermal therapy [LITT] of lesion or tissue of brain under guidance	Y	01	023, 024, 025, 026, 027

Procedure Code	Description	O.R.	MDC	MS-DRG
17.62	Laser interstitial thermal therapy [LITT] of lesion or tissue of head and neck under guidance	Y	10 17	625, 626, 627 820, 821, 822, 826, 827, 828
17.63	Laser interstitial thermal therapy [LITT] of lesion or tissue of liver under guidance	Y	06 07	356, 357, 358 405, 406, 407
17.69	Laser interstitial thermal therapy [LITT] of lesion or tissue of other and unspecified site under guidance	Y	04 09 12 17	163, 164, 165 584, 585 715, 716, 717, 718 820, 821, 822, 826, 827,828
17.70*	Intravenous infusion of clofarabine	N		
33.73	Endoscopic insertion or replacement of bronchial valve(s), multiple lobes	N		
38.24*	Intravascular imaging of coronary vessel(s) by optical coherence tomography [OCT]	N		
38.25*	Intravascular imaging of non-coronary vessel(s) by optical coherence tomography [OCT]	N		
39.75	Endovascular embolization or occlusion of vessel(s) of head or neck using bare coils	Y	01 05 11 21 24	020, 021, 022, 023, 024, 025, 026, 027 237, 238 673, 674, 675 907, 908, 909 957, 958, 959
39.76	Endovascular embolization or occlusion of vessel(s) of head or neck using bioactive coils	Y	01 05 11 21 24	020, 021, 022, 023, 024, 025, 026, 027 237, 238 673, 674, 675 907, 908, 909 957, 958, 959
46.86	Endoscopic insertion of colonic stent(s)	N		
46.87	Other insertion of colonic stent(s)	N		

Notes:

*These procedure codes were discussed at the March 11-12, 2009 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2009.

TABLE 6C.--INVALID DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
239.8	Neoplasm of unspecified nature of other specified sites	N	17	826, 827, 828, 829, 830, 843, 844, 845
274.0	Gouty arthropathy	N	08	553, 554
279.4	Autoimmune disease, not elsewhere classified	N	08 25	545, 546, 547 977
348.8	Other conditions of brain	N	01	070, 071, 072
453.8	Other venous embolism and thrombosis of other specified veins	CC	05	299, 300, 301
488*	Influenza due to identified avian influenza virus	N	03	152, 153
768.7	Hypoxic-ischemic encephalopathy (HIE)	MCC	15	794
779.3	Feeding problems in newborn	N	15	795[1]
784.5	Other speech disturbance	N	01	091, 092, 093
799.2	Nervousness	N	19	880
969.0	Poisoning by antidepressants	N	21	917, 918
969.7	Poisoning by psychostimulants	N	21	917, 918
V10.9	Unspecified personal history of malignant neoplasm	N	17	826, 827, 828, 829, 830, 843, 844, 845
V53.5	Fitting and adjustment of other intestinal appliance	N	06	393, 394, 395
V60.8	Other specified housing or economic circumstances	N	23	951
V72.6	Laboratory examination	N	23	951
V80.0	Special screening for neurological conditions	N	23	951

Notes:

[1]On "Principal Diagnosis" list.

*CDC created new flu codes to better capture H1N1 flu cases in response to the recent flu outbreak. As a result, code 488 was deleted.

TABLE 6D.--INVALID PROCEDURE CODES

There were no invalid procedure codes.

TABLE 6E.--REVISED DIAGNOSIS CODE TITLES

Diagnosis Code	Description	CC	MDC	MS-DRG
008.65	Enteritis due to calicivirus	CC	06	391, 392
041.3	Klebsiella pneumoniae	N	18	867, 868, 869
041.86	Helicobacter pylori [H. pylori]	N	18	867, 868, 869
453.2*	Other venous embolism and thrombosis of inferior vena cava	MCC	05 15	294, 295 791[1], 793[1]
453.40	Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity	CC	05	299, 300, 301
453.41	Acute venous embolism and thrombosis of deep vessels of proximal lower extremity	CC	05	299, 300, 301
453.42	Acute venous embolism and thrombosis of deep vessels	CC	05	299, 300, 301

Diagnosis Code	Description	CC	MDC	MS-DRG
	of distal lower extremity			
572.2	Hepatic encephalopathy	MCC	07 15	441, 442, 443 791[1], 793[1]
584.5	Acute kidney failure with lesion of tubular necrosis	MCC	11 15	673, 674, 675, 682, 683, 684 791[1], 793[1]
584.6	Acute kidney failure with lesion of renal cortical necrosis	MCC	11 15	673, 674, 675, 682, 683, 684 791[1], 793[1]
584.7**	Acute kidney failure with lesion of renal medullary [papillary] necrosis	MCC	11 15	673, 674, 675, 682, 683, 684 791[1], 793[1]
584.8	Acute kidney failure with other specified pathological lesion in kidney	MCC	11 15	673, 674, 675, 682, 683, 684 791[1], 793[1]
584.9	Acute kidney failure, unspecified	MCC	11 15	673, 674, 675, 682, 683, 684 791[1], 793[1]
639.3	Kidney failure following abortion and ectopic and molar pregnancies	MCC	14	769, 776
669.30	Acute kidney failure following labor and delivery, unspecified as to episode of care or not applicable	N	14	765, 766, 767, 768, 774, 775
669.32	Acute kidney failure following labor and delivery, delivered, with mention of postpartum complication	MCC	14	765, 766, 767, 768, 774
669.34	Acute kidney failure following labor and delivery, postpartum condition or complication	MCC	14	769, 776
670.00	Major puerperal infection, unspecified, unspecified as to episode of care or not applicable	N	14	998
670.02	Major puerperal infection, unspecified, delivered, with mention of postpartum complication	MCC	14	765, 766, 767, 768, 774
670.04	Major puerperal infection, unspecified, postpartum condition or complication	MCC	14	769, 776
757.6	Specified congenital anomalies of breast	N	09	600, 601
772.0	Fetal blood loss affecting newborn	N	15	791, 793
776.9	Unspecified hematological disorder specific to newborn	N	15	794
784.40	Voice and resonance disorder, unspecified	N	03	154, 155, 156
784.49	Other voice and resonance disorders	N	03	154, 155, 156
793.0	Nonspecific (abnormal) findings on radiological and other examination of skull and head	N	01	091, 092, 093
793.1	Nonspecific (abnormal) findings on radiological and other examination of lung field	N	04	204
793.2	Nonspecific (abnormal) findings on radiological and other examination of other intrathoracic organs	N	05	302, 303
793.3	Nonspecific (abnormal) findings on radiological and other examination of biliary tract	N	07	444, 445, 446
793.4	Nonspecific (abnormal) findings on radiological and other examination of gastrointestinal tract	N	06	391, 392
793.5	Nonspecific (abnormal) findings on radiological and other examination of genitourinary organs	N	11	695, 696
793.6	Nonspecific (abnormal) findings on radiological and other examination of abdominal area, including retroperitoneum	N	06	391, 392
793.7	Nonspecific (abnormal) findings on radiological and other examination of musculoskeletal system	N	08	564, 565, 566
793.89	Other (abnormal) findings on radiological examination of breast	N	09	600, 601
793.99	Other nonspecific (abnormal) findings on radiological and other examination of body structure	N	23	947, 948
813.45	Torus fracture of radius (alone)	CC	08 24	562, 563 963, 964, 965
996.43	Broken prosthetic joint implant	CC	08	559, 560, 561
V15.06	Allergy to insects and arachnids	N	23	951
V15.84	Personal history of contact with and (suspected) exposure to asbestos	N	23	951
V15.85	Personal history of contact with and (suspected) exposure to potentially hazardous body fluids	N	23	951
V15.86	Personal history of contact with and (suspected) exposure to lead	N	23	951
V57.3	Care involving speech-language therapy	N	23	945, 946
V61.29	Other parent-child problems	N	23	951
V65.11	Pediatric pre-birth visit for expectant parent(s)	N	23	951

Notes:

*This diagnosis code was discussed at the March 11-12, 2009 ICD-9-CM Coordination and Maintenance Committee meeting and was not finalized in time to include in the proposed rule. However, it will be implemented on October 1, 2009.

**The code title has changed from the proposed rule.

[1]Secondary diagnosis of major problem

TABLE 6F.--REVISED PROCEDURE CODE TITLES

Procedure Code	Description	O.R.	MDC	MS-DRG
00.56	Insertion or replacement of implantable pressure sensor (lead) for intracardiac or great vessel hemodynamic monitoring	Y	05	260, 261, 262, 264[1]
00.57*	Implantation or replacement of subcutaneous device for intracardiac or great vessel hemodynamic monitoring	Y	05	258, 259, 264[1]
33.71	Endoscopic insertion or replacement of bronchial valve(s), single lobe	N		
39.72	Endovascular embolization or occlusion of head and neck vessels	Y	01 05 11 21 24	020, 021, 022, 023, 024, 025, 026, 027 237, 238 673, 674, 675 907, 908, 909 957, 958, 959
39.79	Other endovascular procedures on other vessels	Y	01 05 11 21 24	020, 021, 022, 023, 024, 025, 026, 027 237, 238 673, 674, 675 907, 908, 909 957, 958,959
39.90*	Insertion of non-drug-eluting peripheral (non-coronary) vessel stent(s)	N		
80.00	Arthrotomy for removal of prosthesis without replacement, unspecified site	Y	08 21 24	495, 496, 497 907, 908, 909 957, 958, 959
80.01	Arthrotomy for removal of prosthesis without replacement, shoulder	Y	08 21 24	495, 496, 497 907, 908, 909 957, 958, 959
80.02	Arthrotomy for removal of prosthesis without replacement, elbow	Y	08 21 24	495, 496, 497 907, 908, 909 957, 958, 959
80.03	Arthrotomy for removal of prosthesis without replacement, wrist	Y	08 21 24	495, 496, 497 906 957, 958, 959
80.04	Arthrotomy for removal of prosthesis without replacement, hand and finger	Y	08 21 24	495, 496, 497 906 957, 958, 959
80.05	Arthrotomy for removal of prosthesis without replacement, hip	Y	08 21 24	463[2], 464[2], 465[2] 907, 908, 909 956
80.06	Arthrotomy for removal of prosthesis without replacement, knee	Y	08 21 24	463[2], 464[2], 465[2] 907, 908, 909 957, 958, 959
80.07	Arthrotomy for removal of prosthesis without replacement, ankle	Y	08 21 24	495, 496, 497 907, 908, 909 957, 958, 959
80.08	Arthrotomy for removal of prosthesis without replacement, foot and toe	Y	08 21 24	495, 496, 497 907, 908, 909 957, 958, 959
80.09	Arthrotomy for removal of prosthesis without replacement, other specified sites	Y	08 21 24	495, 496, 497 907, 908, 909 957, 958, 959

Notes:

*These procedure codes were discussed at the March 11-12, 2009 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. However, they will be implemented on October 1, 2009.

[1]Assigned to DRG 264 when both 0056 and 0057 are reported.

[2]Note MS-DRG change.

TABLE 7A.--MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY; FY 2008 MedPAR UPDATE--MARCH 2009 GROUPER V26.0 MS-DRGs

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
001	865	43.8590	12	19	31	56	91
002	233	21.1803	8	10	15	25	42
003	23,135	38.4860	15	22	32	46	66
004	21,879	28.2321	11	16	23	34	48
005	934	20.3704	7	9	14	24	42
006	380	9.1658	5	6	8	10	14
007	406	18.5616	8	10	15	21	34
008	511	12.2896	6	7	9	13	22
009	1,568	21.2736	8	16	20	24	34
010	141	9.9929	5	6	8	11	17
011	1,384	16.3129	6	8	12	20	29
012	1,992	10.5216	4	6	9	13	19
013	1,063	6.8993	3	4	6	8	11
020	1,047	18.2722	6	11	17	23	31
021	487	14.4004	5	9	14	18	23
022	156	8.9295	3	6	9	12	14
023	4,273	12.1311	2	5	10	16	24
024	2,066	8.0445	1	3	7	11	16
025	10,198	12.1480	4	6	10	16	23
026	11,489	7.7418	2	4	7	10	14
027	12,455	4.1104	1	2	3	5	8
028	1,737	13.4220	4	7	11	17	26
029	3,431	6.6706	1	3	5	9	14
030	3,394	3.5457	1	1	3	5	7
031	1,089	13.1938	3	5	10	17	28
032	2,750	5.5265	1	2	4	7	12
033	3,266	2.8472	1	1	2	3	5
034	847	6.9008	1	2	5	9	15
035	2,396	2.9253	1	1	2	4	7
036	5,909	1.5727	1	1	1	1	3
037	5,357	8.2938	2	3	6	11	17
038	14,291	3.4481	1	1	2	4	8
039	46,457	1.7237	1	1	1	2	3
040	4,981	12.8735	3	6	10	16	25
041	7,598	7.0091	1	3	6	9	13
042	4,111	3.3162	1	1	2	4	7
052	1,391	6.2646	1	3	5	8	12
053	571	4.0298	1	2	3	5	7
054	6,586	6.7686	2	3	5	8	14
055	14,336	4.8634	1	2	4	6	9
056	10,314	7.6732	2	3	6	9	14
057	45,687	4.9702	2	3	4	6	9
058	869	7.7733	2	4	6	9	14
059	3,215	5.0572	2	3	4	6	9
060	3,706	3.7957	1	2	3	5	6
061	2,001	8.6842	2	4	7	11	17
062	2,946	5.9175	3	3	5	7	10
063	1,175	4.1779	2	3	4	5	7
064	63,679	7.1957	2	3	6	9	14
065	108,646	5.0083	2	3	4	6	9
066	71,843	3.4640	1	2	3	4	6
067	1,928	5.5327	2	3	4	7	10
068	11,705	3.4132	1	2	3	4	6
069	96,454	2.9324	1	2	2	4	5
070	10,194	7.4269	2	4	6	9	14
071	11,522	5.2332	2	3	4	6	9
072	5,235	3.2959	1	2	3	4	6
073	10,686	5.9992	2	3	4	7	12
074	31,077	4.1325	1	2	3	5	8
075	1,288	7.3517	2	4	6	9	14
076	694	3.9179	2	2	3	5	7
077	1,635	6.6355	2	3	5	8	12
078	1,689	4.3387	2	2	3	5	8
079	864	3.2211	1	2	3	4	6
080	1,706	5.0193	1	2	4	6	10
081	5,755	3.4271	1	2	3	4	6
082	2,249	6.3330	1	1	4	9	14
083	2,381	4.8963	1	2	4	6	9
084	2,569	2.9116	1	1	2	4	6
085	7,110	7.3951	2	3	6	9	15
086	12,836	4.8695	1	2	4	6	9
087	12,307	3.0498	1	1	2	4	6
088	1,002	5.5160	1	3	4	7	10
089	2,950	3.7163	1	2	3	5	7
090	2,823	2.3999	1	1	2	3	4
091	9,863	6.2081	2	3	5	8	12
092	18,530	4.3387	1	2	3	5	8
093	14,833	3.0216	1	2	3	4	5
094	1,517	11.6862	4	6	10	15	21
095	1,165	8.0987	2	4	7	10	15
096	603	5.9154	1	3	5	7	10
097	1,317	11.5452	4	6	9	15	21
098	1,019	7.9833	3	4	6	10	15
099	508	5.4882	2	3	5	7	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
100	19,097	6.0820	2	3	4	7	12
101	55,572	3.5559	1	2	3	4	6
102	1,278	4.4280	1	2	3	5	9
103	12,799	3.0447	1	1	2	4	6
113	641	5.6755	1	2	4	7	11
114	462	2.6277	1	1	2	3	5
115	1,020	4.3892	1	2	4	5	7
116	532	3.9643	1	1	2	4	6
117	827	2.0617	1	1	1	2	3
121	752	5.5598	2	3	4	7	10
122	502	4.1932	2	2	3	5	7
123	2,798	2.8388	1	2	2	3	5
124	860	5.5756	1	2	4	7	10
125	4,052	3.2989	1	2	3	4	6
129	1,521	5.1999	1	2	4	6	10
130	940	2.9670	1	1	2	4	6
131	991	5.6741	1	2	4	7	12
132	828	2.6787	1	1	2	3	5
133	2,162	5.4894	1	2	4	7	12
134	2,862	2.1771	1	1	1	2	4
135	385	6.5039	1	2	5	8	14
136	415	2.1398	1	1	1	2	5
137	840	5.4202	1	2	4	7	10
138	800	2.4263	1	1	2	3	5
139	1,445	1.6990	1	1	1	2	3
146	826	9.4419	2	4	7	12	18
147	1,475	5.7939	1	2	4	7	11
148	704	3.1804	1	1	2	4	7
149	35,087	2.7079	1	1	2	3	5
150	1,272	5.3616	1	2	4	7	11
151	6,136	2.8763	1	1	2	4	5
152	3,462	4.6355	1	2	4	6	9
153	16,902	3.3151	1	2	3	4	6
154	2,435	6.0628	2	3	5	8	12
155	5,507	4.3343	1	2	4	5	8
156	4,144	3.0347	1	1	2	4	6
157	1,415	6.5943	2	3	5	8	13
158	3,635	4.5497	1	2	3	6	9
159	1,885	2.9618	1	1	2	4	5
163	13,940	14.3499	5	8	12	18	26
164	18,528	7.5327	3	4	6	9	13
165	10,717	4.7466	2	3	4	6	8
166	24,146	12.5405	4	7	10	15	23
167	19,915	7.6047	2	4	6	10	14

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
168	4,949	4.5999	1	2	4	6	9
175	15,006	7.1116	3	4	6	9	12
176	36,307	5.0909	2	3	5	6	8
177	71,347	8.8710	3	5	7	11	16
178	72,885	7.0750	3	4	6	9	13
179	19,704	5.2288	2	3	4	7	9
180	22,826	7.6566	2	4	6	10	15
181	28,136	5.6392	2	3	4	7	11
182	3,629	3.8247	1	2	3	5	7
183	2,647	6.6011	2	3	5	8	12
184	4,847	4.5135	2	3	4	6	8
185	2,217	3.1556	1	2	3	4	5
186	10,556	7.0704	2	3	6	9	14
187	10,195	4.9724	2	2	4	6	9
188	3,660	3.6052	1	2	3	5	7
189	129,261	5.9805	2	3	5	8	11
190	125,834	5.7988	2	3	5	7	10
191	138,634	4.8100	2	3	4	6	9
192	153,027	3.8040	1	2	3	5	7
193	103,143	6.6082	2	4	5	8	12
194	217,831	5.0971	2	3	4	6	9
195	105,680	3.8566	2	2	3	5	7
196	6,669	7.0088	2	4	6	9	13
197	6,891	5.1383	2	3	4	6	9
198	3,485	3.9297	1	2	3	5	7
199	3,759	8.2626	2	4	7	11	16
200	8,433	4.8069	1	2	4	6	9
201	2,980	3.7668	1	2	3	5	7
202	37,480	4.2973	2	2	4	5	8
203	34,631	3.2957	1	2	3	4	6
204	24,701	2.7757	1	1	2	3	5
205	6,812	5.4284	1	2	4	7	11
206	20,750	3.3217	1	2	3	4	6
207	38,198	15.1069	6	9	13	18	25
208	77,135	7.1870	1	3	6	10	14
215	138	14.4493	1	3	7	17	31
216	9,882	18.1298	8	11	16	22	31
217	6,449	11.2253	6	7	10	14	18
218	1,402	8.3302	5	6	7	10	13
219	12,505	13.5662	6	7	11	17	25
220	14,399	8.0178	5	6	7	9	13
221	4,933	6.1024	4	5	6	7	9
222	3,274	12.3952	4	7	10	15	23
223	4,421	5.4252	1	2	5	8	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
224	2,936	9.9220	3	5	8	13	18
225	4,767	5.0480	1	2	4	7	9
226	8,040	8.5116	1	3	7	11	17
227	33,271	2.7731	1	1	1	3	7
228	3,210	14.2100	6	8	12	17	24
229	3,330	8.4616	4	6	7	10	14
230	1,171	5.8779	2	4	6	7	10
231	1,566	12.8678	6	8	11	15	23
232	1,256	9.1513	5	7	9	11	14
233	17,630	13.6569	7	9	12	16	23
234	27,949	8.7444	5	6	8	10	13
235	10,519	11.1489	5	7	9	13	20
236	25,910	6.5372	4	5	6	8	10
237	23,979	10.4636	2	5	8	14	21
238	39,321	4.2773	1	1	3	6	9
239	11,673	15.4965	5	8	12	20	29
240	10,724	9.7112	3	5	8	12	18
241	1,917	6.2780	3	3	5	8	11
242	20,901	8.0780	2	4	7	10	15
243	38,084	4.7817	1	2	4	6	9
244	50,970	2.7335	1	1	2	4	6
245	4,085	3.3792	1	1	2	4	7
246	30,432	5.0278	1	2	4	7	11
247	148,268	2.0891	1	1	1	3	4
248	19,743	6.0479	1	3	5	8	12
249	68,042	2.5103	1	1	2	3	5
250	8,191	6.9894	2	3	5	9	14
251	38,152	2.7254	1	1	2	4	6
252	44,207	8.1998	1	3	6	11	17
253	43,050	5.9051	1	2	5	8	12
254	44,529	2.6148	1	1	2	3	6
255	2,524	9.8649	3	5	8	12	18
256	3,032	7.0604	2	4	6	9	13
257	493	4.5314	1	2	3	6	9
258	829	6.7949	2	3	5	8	13
259	6,194	2.7830	1	1	2	4	6
260	1,763	10.6568	2	4	8	14	21
261	3,846	4.0910	1	1	3	6	8
262	2,825	2.4935	1	1	2	3	5
263	564	5.3617	1	1	3	7	11
264	24,726	8.5244	1	3	6	11	18
265	2,094	3.4351	1	1	2	4	7
280	78,351	6.8317	2	4	6	9	12
281	50,942	4.4588	1	2	4	6	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
282	40,807	2.9018	1	1	2	4	5
283	15,370	5.3118	1	1	3	7	12
284	3,211	2.7203	1	1	2	3	6
285	1,788	1.9144	1	1	1	2	4
286	29,363	6.7091	2	3	5	8	13
287	141,009	3.0596	1	1	2	4	6
288	3,011	11.7629	4	6	9	14	21
289	1,166	7.9777	3	5	7	10	13
290	299	5.5117	2	3	5	7	9
291	202,158	6.3841	2	3	5	8	12
292	207,645	4.7393	2	3	4	6	8
293	138,517	3.4422	1	2	3	4	6
294	1,558	5.6611	2	3	5	7	10
295	1,012	4.2243	2	3	4	5	7
296	2,163	2.9903	1	1	1	3	7
297	724	1.7762	1	1	1	1	3
298	478	1.2406	1	1	1	1	1
299	23,060	6.3813	2	3	5	8	12
300	45,573	4.9678	2	3	4	6	9
301	31,315	3.5671	1	2	3	5	6
302	8,583	4.1572	1	2	3	5	8
303	59,020	2.4491	1	1	2	3	4
304	2,706	4.8293	1	2	4	6	9
305	31,637	2.7870	1	1	2	3	5
306	2,534	5.5675	1	3	4	7	10
307	5,822	3.3332	1	2	3	4	6
308	56,391	5.2621	2	3	4	7	10
309	92,496	3.7691	1	2	3	5	7
310	136,447	2.5895	1	1	2	3	5
311	18,515	2.2921	1	1	2	3	4
312	163,570	3.0723	1	2	2	4	6
313	187,990	2.1067	1	1	2	3	4
314	65,753	6.9196	2	3	5	9	14
315	30,267	4.3603	1	2	3	6	8
316	15,107	2.7482	1	1	2	3	5
326	11,460	16.5634	6	8	13	21	31
327	10,130	9.2364	3	5	8	12	17
328	8,000	3.9521	1	2	3	5	8
329	49,850	15.6873	6	8	13	19	28
330	60,069	9.2330	4	6	8	11	16
331	25,406	5.4784	3	4	5	7	8
332	1,999	14.4522	6	8	12	18	26
333	5,641	8.4028	4	5	7	10	14
334	3,308	5.1814	2	3	5	7	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
335	7,888	14.0033	5	8	12	18	25
336	12,358	8.7999	3	5	8	11	15
337	7,791	5.2450	1	3	5	7	10
338	1,611	10.2657	4	6	9	13	18
339	3,079	6.6297	3	4	6	8	11
340	3,330	3.9357	2	2	4	5	7
341	991	6.7598	2	3	5	9	13
342	2,724	3.9391	1	2	3	5	7
343	6,689	2.0599	1	1	2	3	4
344	1,004	11.3058	4	6	9	14	21
345	2,956	6.9513	3	4	6	8	12
346	2,782	4.7606	2	3	4	6	7
347	1,628	8.7193	2	4	7	11	18
348	4,223	5.5153	1	3	4	7	11
349	4,419	2.9007	1	1	2	4	6
350	1,895	7.8332	2	3	6	10	16
351	4,429	4.4373	1	2	4	6	9
352	7,056	2.3740	1	1	2	3	5
353	3,648	8.4246	2	4	7	11	16
354	8,800	4.9335	1	3	4	6	9
355	13,664	2.8119	1	1	2	4	5
356	8,507	13.0000	3	6	10	16	25
357	7,508	7.6501	2	4	6	9	14
358	2,086	4.3365	1	2	4	6	8
368	3,739	6.5633	2	3	5	8	13
369	5,523	4.5712	2	3	4	6	8
370	2,222	3.2457	1	2	3	4	6
371	27,801	8.6732	3	4	7	11	17
372	28,866	6.6097	2	4	5	8	12
373	12,526	4.7864	2	3	4	6	8
374	9,735	8.5674	2	4	7	11	16
375	17,369	5.8817	2	3	5	7	11
376	3,111	3.9029	1	2	3	5	7
377	60,392	6.2786	2	3	5	8	12
378	123,174	4.2530	2	2	4	5	7
379	61,710	3.1651	1	2	3	4	5
380	3,318	7.0401	2	3	6	9	13
381	5,857	4.8212	2	3	4	6	9
382	3,186	3.4761	1	2	3	4	6
383	1,573	5.5067	2	3	4	7	10
384	7,281	3.7624	1	2	3	5	7
385	2,874	7.9809	2	4	6	10	16
386	7,836	5.3798	2	3	4	7	10
387	4,287	4.1185	1	2	3	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
388	22,264	7.0349	2	3	5	9	14
389	48,564	4.8684	2	3	4	6	9
390	43,011	3.4504	1	2	3	4	6
391	49,229	5.1491	1	2	4	6	10
392	243,145	3.4552	1	2	3	4	6
393	24,689	6.8145	2	3	5	8	14
394	48,064	4.7075	1	2	4	6	9
395	21,110	3.1799	1	2	3	4	6
405	4,265	16.5944	5	8	13	21	32
406	5,200	8.4777	2	5	7	10	15
407	1,942	5.1807	1	3	5	7	9
408	1,579	14.0247	5	7	12	17	26
409	1,386	8.7496	4	5	8	11	15
410	495	6.0808	2	4	6	8	10
411	897	12.4448	5	7	10	15	22
412	866	8.3880	4	5	7	10	14
413	607	5.3608	2	3	5	7	9
414	5,226	11.7086	4	7	9	14	20
415	5,621	7.2539	3	4	6	9	12
416	4,531	4.4827	2	3	4	6	7
417	19,310	8.0109	3	4	6	10	15
418	25,684	5.3125	2	3	5	7	10
419	31,142	3.0398	1	1	2	4	6
420	797	13.9787	3	6	11	18	29
421	1,009	6.7463	1	3	5	8	14
422	247	4.3725	1	2	4	5	8
423	1,574	14.9333	4	7	11	19	29
424	790	8.9557	3	4	7	11	17
425	88	5.1818	1	2	5	7	9
432	14,500	6.7798	2	3	5	8	13
433	8,910	4.5626	1	2	4	6	8
434	582	3.3969	1	2	3	4	6
435	13,645	7.4026	2	3	6	9	14
436	12,101	5.6191	2	3	4	7	11
437	2,757	3.9198	1	2	3	5	8
438	17,103	7.4398	2	3	5	9	15
439	24,734	5.0556	2	3	4	6	9
440	20,943	3.6212	1	2	3	4	6
441	14,296	7.1668	2	3	5	9	14
442	15,246	4.7657	2	2	4	6	9
443	5,398	3.4750	1	2	3	4	6
444	13,755	6.3650	2	3	5	8	12
445	17,239	4.5635	1	2	4	6	8
446	13,815	3.1243	1	2	3	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
453	1,103	14.3717	5	7	11	18	28
454	2,379	7.2161	3	4	6	8	13
455	2,022	4.0257	1	2	4	5	7
456	1,111	13.9613	5	7	11	17	26
457	2,829	7.2471	3	4	6	8	13
458	1,449	4.3037	2	3	4	5	7
459	4,134	9.2830	4	5	7	11	17
460	55,514	4.0475	2	3	4	5	6
461	990	8.1081	3	4	6	9	15
462	12,295	4.1563	3	3	4	5	6
463	3,831	17.9702	5	8	13	21	35
464	6,251	10.4115	3	5	8	13	20
465	1,943	5.7535	1	3	4	7	11
466	4,246	9.3401	3	5	7	11	17
467	17,613	5.2034	3	3	4	6	9
468	17,276	3.7510	2	3	3	4	6
469	33,485	7.9023	3	4	6	9	14
470	406,523	3.7951	3	3	3	4	6
471	2,762	10.0724	2	4	8	14	20
472	7,775	4.0710	1	1	3	5	9
473	23,413	1.8888	1	1	1	2	3
474	2,743	12.5822	4	6	10	16	23
475	3,470	8.1066	3	4	6	10	15
476	1,302	4.5899	1	2	3	6	9
477	2,919	11.1069	4	6	9	14	21
478	9,204	6.4860	1	3	5	9	13
479	9,276	2.8381	1	1	1	4	7
480	29,388	9.0366	4	5	7	11	16
481	77,042	5.7530	3	4	5	7	9
482	38,920	4.6775	3	3	4	5	7
483	9,167	3.9369	2	2	3	5	7
484	17,038	2.3062	1	2	2	3	3
485	1,269	11.6879	4	6	9	14	22
486	2,323	7.6832	3	4	6	9	13
487	1,214	5.2669	3	3	5	7	9
488	2,993	4.9843	2	3	4	6	9
489	5,354	2.8823	1	2	3	3	5
490	23,834	4.2756	1	1	3	5	9
491	48,456	2.1270	1	1	2	3	4
492	5,871	8.4761	3	4	7	10	15
493	18,572	5.0703	2	3	4	6	9
494	26,864	3.2305	1	2	3	4	6
495	1,904	10.4653	3	5	8	13	20
496	6,103	5.9564	2	3	5	7	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
497	6,216	2.9011	1	1	2	4	6
498	1,332	7.3986	2	3	6	9	15
499	976	2.8207	1	1	2	3	6
500	1,791	11.0491	3	5	9	14	21
501	4,417	5.9989	2	3	5	8	11
502	5,867	2.8515	1	1	2	3	5
503	863	8.7764	2	4	7	11	16
504	2,365	6.3662	2	3	5	8	12
505	2,503	3.2713	1	1	3	4	6
506	725	3.5848	1	1	2	4	7
507	966	4.8385	1	2	3	6	9
508	2,045	1.9980	1	1	2	2	3
509	435	3.1494	1	1	2	4	7
510	1,185	6.4059	2	3	5	8	12
511	4,263	3.9336	1	2	3	5	7
512	9,362	2.1714	1	1	2	3	4
513	1,253	4.7223	1	2	4	6	9
514	1,015	2.5094	1	1	2	3	5
515	4,257	10.1266	3	5	8	13	18
516	11,691	5.8394	1	3	5	8	11
517	14,162	3.0462	1	1	2	4	7
533	863	6.8992	2	3	5	8	13
534	3,274	3.9356	1	2	3	5	7
535	8,153	5.8694	2	3	4	7	11
536	32,810	3.8604	1	3	3	5	6
537	838	4.3473	2	3	4	5	7
538	889	3.0146	1	2	3	4	5
539	2,725	10.5134	3	5	8	13	19
540	5,014	7.2146	2	4	6	8	12
541	1,457	5.2450	2	3	4	6	9
542	6,326	8.6012	3	4	7	11	16
543	16,651	5.7774	2	3	5	7	11
544	8,412	4.2045	2	3	4	5	7
545	4,399	8.7497	2	4	6	11	18
546	5,595	5.3324	2	3	4	7	10
547	3,912	3.7393	1	2	3	5	7
548	641	8.9922	2	4	7	11	17
549	1,145	6.2856	2	3	5	7	11
550	601	4.0749	1	2	4	5	7
551	12,231	6.9214	2	3	5	9	13
552	78,742	4.0758	1	2	3	5	7
553	3,393	5.7121	2	3	5	7	11
554	17,391	3.5988	1	2	3	4	6
555	2,163	4.6528	1	2	3	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
556	16,214	3.1221	1	1	3	4	6
557	6,154	6.6081	2	4	5	8	12
558	16,369	4.2992	2	3	4	5	7
559	2,006	7.2458	2	3	6	9	14
560	5,084	4.8179	1	2	4	6	9
561	6,251	2.6922	1	1	2	3	5
562	6,667	6.1359	2	3	5	7	11
563	33,700	3.6434	1	2	3	4	6
564	1,862	7.0156	2	3	5	9	13
565	3,813	4.8298	2	3	4	6	9
566	2,159	3.4924	1	2	3	4	6
573	5,129	13.9199	4	6	10	16	27
574	10,013	8.9254	3	4	7	10	16
575	4,156	5.5683	2	3	5	7	10
576	604	12.6242	2	5	8	15	27
577	2,323	6.1632	1	2	4	7	13
578	2,809	3.2471	1	1	2	4	7
579	3,896	10.7189	3	5	8	13	20
580	10,379	5.3295	1	2	4	7	11
581	11,077	2.4236	1	1	2	3	5
582	5,403	2.8058	1	1	2	3	5
583	8,132	1.7522	1	1	1	2	3
584	777	5.5393	1	2	4	7	12
585	1,265	2.1194	1	1	1	2	4
592	5,008	8.8107	3	4	7	10	16
593	11,631	6.2605	2	3	5	7	11
594	1,980	4.7030	1	3	4	6	8
595	1,379	8.1914	2	4	6	10	15
596	4,988	4.6776	1	2	4	6	8
597	586	7.9693	2	3	6	9	15
598	1,329	5.6697	1	3	4	7	10
599	246	3.5488	1	1	3	4	6
600	955	5.3895	2	3	4	6	10
601	844	3.6220	1	2	3	5	6
602	24,673	6.8901	2	4	6	8	13
603	129,590	4.6086	2	3	4	6	8
604	3,170	5.4584	1	3	4	7	10
605	20,027	3.3698	1	2	3	4	6
606	1,546	5.9288	1	3	4	7	11
607	6,553	3.6078	1	2	3	4	7
614	1,576	7.1383	2	3	5	8	14
615	1,446	3.0622	1	2	3	4	5
616	989	16.7826	6	9	13	20	30
617	6,848	8.4620	3	5	7	11	15

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
618	172	6.1453	2	3	6	8	10
619	799	7.8761	2	3	5	8	17
620	2,600	3.4219	1	2	3	4	6
621	9,739	1.9043	1	1	2	2	3
622	809	15.9938	4	7	11	19	32
623	3,192	8.9283	3	4	7	11	16
624	344	5.6192	2	3	5	7	9
625	1,342	7.0827	1	2	5	9	16
626	2,820	2.9589	1	1	2	3	6
627	13,050	1.4415	1	1	1	2	2
628	3,326	11.0613	2	4	8	14	22
629	4,422	8.4806	3	5	7	10	15
630	456	4.7807	1	2	4	7	10
637	21,127	5.7746	2	3	4	7	11
638	47,897	4.1819	1	2	3	5	8
639	29,361	2.9403	1	2	2	4	5
640	61,855	5.0977	1	2	4	6	10
641	187,587	3.6896	1	2	3	5	7
642	1,564	4.9175	1	2	4	6	8
643	6,570	7.3364	2	4	6	9	13
644	12,262	5.2553	2	3	4	7	9
645	7,108	3.6877	1	2	3	5	7
652	10,052	7.5197	4	5	6	8	13
653	1,843	16.4829	7	8	13	20	30
654	3,672	9.3540	5	6	8	11	15
655	1,336	5.9184	2	4	6	8	9
656	4,447	9.8927	3	5	8	12	19
657	7,563	5.6107	2	3	5	7	9
658	7,250	3.4479	1	2	3	4	5
659	4,956	10.7470	3	5	8	13	21
660	7,089	5.9958	2	3	4	7	12
661	3,955	3.0334	1	2	2	4	5
662	954	10.1813	2	5	8	13	20
663	1,934	4.9018	1	2	3	7	10
664	3,713	1.9305	1	1	1	2	4
665	772	11.4093	3	6	10	15	20
666	2,122	6.1056	1	2	4	8	13
667	3,123	2.2911	1	1	2	2	4
668	4,636	8.3611	2	4	6	11	16
669	12,519	4.2319	1	2	3	6	9
670	10,028	2.3269	1	1	2	3	5
671	871	5.9747	1	2	4	8	11
672	766	2.4386	1	1	2	3	5
673	12,545	9.6609	1	3	7	13	20

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
674	10,172	6.7921	1	2	5	9	14
675	5,159	2.0562	1	1	1	2	4
682	97,663	7.0104	2	3	5	9	14
683	135,146	5.2352	2	3	4	7	9
684	33,608	3.5327	1	2	3	4	6
685	2,367	3.4347	1	1	2	4	7
686	1,953	7.2570	2	3	6	9	14
687	3,061	5.1009	1	2	4	7	9
688	925	2.9697	1	1	2	4	6
689	60,381	5.9701	2	3	5	7	11
690	201,282	4.1617	2	2	3	5	7
691	979	4.1481	1	2	3	5	8
692	417	2.3453	1	1	2	3	4
693	3,192	4.5868	1	2	3	6	9
694	16,051	2.4604	1	1	2	3	5
695	1,011	5.7389	1	2	4	7	11
696	9,931	3.2007	1	2	3	4	6
697	562	3.4573	1	1	3	4	7
698	26,277	6.5765	2	3	5	8	13
699	25,729	4.6718	1	2	4	6	9
700	10,200	3.3118	1	2	3	4	6
707	5,792	4.2360	1	2	3	5	8
708	17,798	1.9734	1	1	2	2	3
709	787	5.9720	1	2	4	7	13
710	1,715	1.6251	1	1	1	2	3
711	757	7.4135	1	3	6	10	15
712	508	2.5610	1	1	2	3	5
713	10,506	4.0974	1	2	3	5	9
714	25,428	1.8654	1	1	2	2	3
715	523	6.2906	1	2	4	9	14
716	1,033	1.4666	1	1	1	2	2
717	790	6.8494	1	3	5	9	14
718	538	2.6970	1	1	2	3	5
722	847	6.9929	2	3	5	9	14
723	1,792	5.0603	1	2	4	6	9
724	386	2.8109	1	1	2	3	5
725	947	5.1426	2	2	4	6	10
726	3,288	3.5018	1	2	3	4	7
727	1,467	6.3729	2	3	5	8	12
728	5,687	4.0855	1	2	3	5	7
729	741	4.8880	1	2	4	6	9
730	344	2.7907	1	1	2	4	5
734	1,597	7.6662	2	3	5	9	15
735	1,032	3.0058	1	2	3	4	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
736	950	14.0337	5	8	11	18	25
737	3,235	6.8284	3	4	6	8	12
738	744	3.7151	2	3	3	4	6
739	1,075	9.9544	3	5	7	13	20
740	4,422	4.9245	2	3	4	6	8
741	5,524	2.7500	1	2	3	3	4
742	10,837	4.2701	2	2	3	5	8
743	29,354	2.1670	1	1	2	3	3
744	1,674	5.7133	1	2	4	7	12
745	1,395	2.5176	1	1	2	3	5
746	2,661	4.0218	1	2	3	5	8
747	8,083	1.8237	1	1	2	2	3
748	19,051	1.7136	1	1	1	2	3
749	1,019	9.1079	2	4	7	11	18
750	396	3.0076	1	1	2	4	6
754	1,267	8.5438	2	4	6	10	16
755	3,127	5.4883	1	2	4	7	11
756	530	2.9151	1	1	2	4	6
757	1,533	8.3686	3	4	6	10	16
758	1,916	5.9149	2	3	5	7	11
759	1,238	4.4120	2	2	4	5	8
760	1,813	3.8941	1	2	3	5	8
761	1,317	2.4229	1	1	2	3	4
765	3,132	5.1928	2	3	4	5	7
766	2,807	3.0363	2	2	3	3	4
767	142	2.9859	2	2	2	3	4
768	9	5.5556	2	3	5	6	8
769	86	6.8953	1	2	4	7	14
770	225	1.8933	1	1	1	2	4
774	1,636	3.3136	2	2	2	3	4
775	5,864	2.2877	1	2	2	3	3
776	561	3.5258	1	2	2	4	6
777	232	2.2500	1	1	2	3	4
778	445	2.9798	1	1	2	3	5
779	130	2.1000	1	1	1	2	3
780	44	1.2955	1	1	1	1	3
781	3,131	3.8116	1	1	2	4	7
782	180	2.3667	1	1	1	3	4
799	613	13.7210	4	7	11	17	26
800	674	7.4214	2	4	6	9	14
801	399	4.0426	1	2	3	5	7
802	886	11.8544	3	5	9	15	23
803	1,136	6.8627	2	3	5	9	14
804	816	3.1863	1	1	2	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
808	7,559	8.2232	3	4	6	10	16
809	13,401	5.1782	2	3	4	6	9
810	2,475	3.8642	1	2	3	5	7
811	27,129	5.4328	1	2	4	7	11
812	90,209	3.6824	1	2	3	5	7
813	13,144	5.2039	1	2	4	6	10
814	1,862	6.7653	2	3	5	8	13
815	3,669	4.6443	1	2	4	6	9
816	1,823	3.3922	1	2	3	4	6
820	1,353	16.7613	5	8	13	21	31
821	2,171	7.4929	1	3	6	10	15
822	1,837	3.2542	1	1	2	4	6
823	2,355	14.7737	5	7	12	18	27
824	2,895	8.5948	2	4	7	11	16
825	1,579	4.1374	1	1	3	6	9
826	638	14.8793	5	7	12	19	27
827	1,287	6.9169	2	3	6	9	13
828	785	3.5159	1	2	3	5	7
829	1,326	9.5973	2	3	7	12	21
830	400	3.0750	1	1	2	4	6
834	4,130	15.0545	2	4	9	23	34
835	2,722	9.7303	2	3	6	11	27
836	1,336	4.8510	1	2	3	5	10
837	1,196	23.4490	5	10	23	31	43
838	1,441	12.8952	3	4	6	22	30
839	1,415	5.9110	3	4	5	6	8
840	9,732	10.5227	3	5	8	13	21
841	9,727	6.6585	2	3	5	8	13
842	4,347	4.2501	1	2	3	6	8
843	1,795	7.9426	2	4	6	10	15
844	2,642	5.9682	2	3	5	8	11
845	586	4.0802	1	2	3	5	7
846	2,586	8.4954	2	4	6	10	18
847	22,623	3.3684	1	2	3	4	6
848	1,386	3.2258	1	1	3	4	5
849	1,080	6.2083	1	3	5	6	13
853	38,103	16.3380	5	8	13	20	30
854	8,088	10.7591	4	6	9	13	19
855	432	7.2523	2	4	6	9	14
856	5,808	15.4695	4	7	12	19	29
857	9,308	8.1476	3	4	6	10	15
858	2,623	5.4979	2	3	5	7	10
862	9,162	7.9843	2	4	6	10	15
863	21,329	5.0708	2	3	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
864	17,580	3.8699	1	2	3	5	7
865	2,846	6.1514	2	3	4	7	12
866	9,136	3.4499	1	2	3	4	6
867	5,370	9.3821	3	4	7	12	19
868	2,764	5.3694	2	3	4	7	10
869	954	4.0671	1	2	3	5	7
870	24,792	15.4721	6	9	13	19	26
871	256,135	7.3324	2	3	6	9	14
872	90,189	5.5727	2	3	5	7	10
876	685	13.0934	2	4	8	15	26
880	8,535	3.1589	1	1	2	4	6
881	4,578	4.2977	1	2	3	5	8
882	1,691	4.4370	1	2	3	5	8
883	896	8.2310	1	3	5	8	16
884	19,081	5.6479	2	3	4	6	10
885	84,194	7.4573	2	3	6	9	14
886	500	6.0360	1	2	4	7	12
887	571	4.6690	1	2	3	5	10
894	4,260	2.9462	1	1	2	3	4
895	6,545	10.5668	3	4	6	8	9
896	6,713	6.7846	2	3	5	8	13
897	35,203	4.0295	1	2	3	5	6
901	917	15.0196	3	6	10	19	30
902	1,944	8.0077	2	3	6	10	16
903	1,109	4.4869	1	2	3	6	9
904	1,474	11.2551	2	4	7	13	21
905	824	4.5922	1	2	4	6	8
906	692	3.1243	1	1	2	3	6
907	8,703	11.6446	3	5	8	14	23
908	8,622	6.4505	2	3	5	8	12
909	4,987	3.3619	1	1	3	4	6
913	1,041	6.0058	2	3	4	7	11
914	5,775	3.3614	1	2	3	4	6
915	1,334	4.6207	1	2	3	6	10
916	5,210	2.1094	1	1	2	3	4
917	19,659	5.1948	1	2	4	6	10
918	34,890	2.6673	1	1	2	3	5
919	11,279	6.3163	1	3	4	8	12
920	14,560	4.2532	1	2	3	5	8
921	8,237	2.8428	1	1	2	3	5
922	1,258	5.4889	1	2	4	7	11
923	3,271	3.1556	1	1	2	4	6
927	167	32.7365	8	16	26	42	64
928	857	16.4119	3	7	13	21	31

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
929	416	7.3798	1	2	6	10	15
933	153	5.7451	1	1	1	5	14
934	691	6.1679	1	2	5	8	13
935	2,055	5.3182	1	2	3	6	11
939	764	10.9018	2	4	8	14	22
940	1,675	5.7200	1	2	3	7	12
941	1,720	2.5512	1	1	2	3	5
945	6,572	10.0490	4	6	8	11	14
946	3,008	7.6599	3	5	6	7	8
947	12,025	5.0913	1	2	4	6	10
948	52,821	3.4687	1	2	3	4	6
949	704	4.7827	1	1	2	5	8
950	296	3.3581	1	1	2	4	6
951	904	4.1936	1	1	2	3	6
955	485	12.8062	2	6	10	17	24
956	4,238	9.1182	4	5	7	11	17
957	1,520	15.0559	3	7	12	20	28
958	1,177	9.5115	3	5	8	12	17
959	230	5.8000	1	3	5	7	11
963	1,892	9.1781	1	4	7	12	19
964	2,803	5.7827	2	3	5	7	10
965	961	3.8398	1	2	3	5	7
969	633	18.8278	5	8	13	22	35
970	122	8.9262	2	3	6	11	15
974	6,062	9.9919	2	4	7	13	20
975	4,376	6.8441	2	3	5	8	13
976	1,933	4.6762	1	2	4	6	8
977	3,970	5.0305	1	2	4	6	9
981	29,324	14.6229	5	7	12	18	27
982	19,564	8.9636	3	5	7	11	16
983	5,628	4.6105	1	2	4	6	9
984	753	14.6135	5	8	12	18	26
985	909	8.7228	2	3	7	12	17
986	539	4.2505	1	1	3	6	9
987	8,732	12.5849	3	6	10	16	23
988	10,787	7.2991	2	3	6	9	14
989	4,641	3.6572	1	1	3	5	8
Total	11,237,072						

TABLE 7B.--MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY; FY 2008 MedPAR UPDATE--MARCH 2009 GROUPER V27.0 MS-DRGs

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
001	865	43.8590	12	19	31	56	91
002	233	21.1803	8	10	15	25	42
003	23,135	38.4860	15	22	32	46	66
004	21,879	28.2321	11	16	23	34	48
005	934	20.3704	7	9	14	24	42
006	380	9.1658	5	6	8	10	14
007	406	18.5616	8	10	15	21	34
008	511	12.2896	6	7	9	13	22
009	1,568	21.2736	8	16	20	24	34
010	141	9.9929	5	6	8	11	17
011	1,384	16.3129	6	8	12	20	29
012	1,992	10.5216	4	6	9	13	19
013	1,063	6.8993	3	4	6	8	11
020	1,047	18.2722	6	11	17	23	31
021	487	14.4004	5	9	14	18	23
022	156	8.9295	3	6	9	12	14
023	4,273	12.1311	2	5	10	16	24
024	2,066	8.0445	1	3	7	11	16
025	10,198	12.1480	4	6	10	16	23
026	11,489	7.7418	2	4	7	10	14
027	12,455	4.1104	1	2	3	5	8
028	1,737	13.4220	4	7	11	17	26
029	3,431	6.6706	1	3	5	9	14
030	3,394	3.5457	1	1	3	5	7
031	1,089	13.1938	3	5	10	17	28
032	2,750	5.5265	1	2	4	7	12
033	3,266	2.8472	1	1	2	3	5
034	847	6.9008	1	2	5	9	15
035	2,396	2.9253	1	1	2	4	7
036	5,909	1.5727	1	1	1	1	3
037	5,357	8.2938	2	3	6	11	17
038	14,291	3.4481	1	1	2	4	8
039	46,457	1.7237	1	1	1	2	3
040	4,981	12.8735	3	6	10	16	25
041	7,598	7.0091	1	3	6	9	13
042	4,111	3.3162	1	1	2	4	7
052	1,391	6.2646	1	3	5	8	12
053	571	4.0298	1	2	3	5	7
054	6,586	6.7686	2	3	5	8	14
055	14,336	4.8634	1	2	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
056	10,314	7.6732	2	3	6	9	14
057	45,687	4.9702	2	3	4	6	9
058	869	7.7733	2	4	6	9	14
059	3,215	5.0572	2	3	4	6	9
060	3,706	3.7957	1	2	3	5	6
061	2,001	8.6842	2	4	7	11	17
062	2,946	5.9175	3	3	5	7	10
063	1,175	4.1779	2	3	4	5	7
064	63,679	7.1957	2	3	6	9	14
065	108,646	5.0083	2	3	4	6	9
066	71,843	3.4640	1	2	3	4	6
067	1,928	5.5327	2	3	4	7	10
068	11,705	3.4132	1	2	3	4	6
069	96,454	2.9324	1	2	2	4	5
070	10,194	7.4269	2	4	6	9	14
071	11,522	5.2332	2	3	4	6	9
072	5,235	3.2959	1	2	3	4	6
073	10,686	5.9992	2	3	4	7	12
074	31,077	4.1325	1	2	3	5	8
075	1,288	7.3517	2	4	6	9	14
076	694	3.9179	2	2	3	5	7
077	1,635	6.6355	2	3	5	8	12
078	1,689	4.3387	2	2	3	5	8
079	864	3.2211	1	2	3	4	6
080	1,706	5.0193	1	2	4	6	10
081	5,755	3.4271	1	2	3	4	6
082	2,249	6.3330	1	1	4	9	14
083	2,381	4.8963	1	2	4	6	9
084	2,569	2.9116	1	1	2	4	6
085	7,110	7.3951	2	3	6	9	15
086	12,836	4.8695	1	2	4	6	9
087	12,307	3.0498	1	1	2	4	6
088	1,002	5.5160	1	3	4	7	10
089	2,950	3.7163	1	2	3	5	7
090	2,823	2.3999	1	1	2	3	4
091	9,863	6.2081	2	3	5	8	12
092	18,530	4.3387	1	2	3	5	8
093	14,833	3.0216	1	2	3	4	5
094	1,517	11.6862	4	6	10	15	21
095	1,165	8.0987	2	4	7	10	15
096	603	5.9154	1	3	5	7	10
097	1,317	11.5452	4	6	9	15	21
098	1,019	7.9833	3	4	6	10	15
099	508	5.4882	2	3	5	7	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
100	19,097	6.0820	2	3	4	7	12
101	55,572	3.5559	1	2	3	4	6
102	1,278	4.4280	1	2	3	5	9
103	12,799	3.0447	1	1	2	4	6
113	641	5.6755	1	2	4	7	11
114	462	2.6277	1	1	2	3	5
115	1,020	4.3892	1	2	4	5	7
116	532	3.9643	1	1	2	4	6
117	827	2.0617	1	1	1	2	3
121	752	5.5598	2	3	4	7	10
122	502	4.1932	2	2	3	5	7
123	2,798	2.8388	1	2	2	3	5
124	860	5.5756	1	2	4	7	10
125	4,052	3.2989	1	2	3	4	6
129	1,521	5.1999	1	2	4	6	10
130	940	2.9670	1	1	2	4	6
131	991	5.6741	1	2	4	7	12
132	828	2.6787	1	1	2	3	5
133	2,162	5.4894	1	2	4	7	12
134	2,862	2.1771	1	1	1	2	4
135	385	6.5039	1	2	5	8	14
136	415	2.1398	1	1	1	2	5
137	840	5.4202	1	2	4	7	10
138	800	2.4263	1	1	2	3	5
139	1,445	1.6990	1	1	1	2	3
146	826	9.4419	2	4	7	12	18
147	1,475	5.7939	1	2	4	7	11
148	704	3.1804	1	1	2	4	7
149	35,087	2.7079	1	1	2	3	5
150	1,272	5.3616	1	2	4	7	11
151	6,136	2.8763	1	1	2	4	5
152	3,462	4.6355	1	2	4	6	9
153	16,902	3.3151	1	2	3	4	6
154	2,435	6.0628	2	3	5	8	12
155	5,507	4.3343	1	2	4	5	8
156	4,144	3.0347	1	1	2	4	6
157	1,415	6.5943	2	3	5	8	13
158	3,635	4.5497	1	2	3	6	9
159	1,885	2.9618	1	1	2	4	5
163	13,940	14.3499	5	8	12	18	26
164	18,528	7.5327	3	4	6	9	13
165	10,717	4.7466	2	3	4	6	8
166	24,146	12.5405	4	7	10	15	23
167	19,915	7.6047	2	4	6	10	14

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
168	4,949	4.5999	1	2	4	6	9
175	15,006	7.1116	3	4	6	9	12
176	36,307	5.0909	2	3	5	6	8
177	71,347	8.8710	3	5	7	11	16
178	72,885	7.0750	3	4	6	9	13
179	19,704	5.2288	2	3	4	7	9
180	22,826	7.6566	2	4	6	10	15
181	28,136	5.6392	2	3	4	7	11
182	3,629	3.8247	1	2	3	5	7
183	2,647	6.6011	2	3	5	8	12
184	4,847	4.5135	2	3	4	6	8
185	2,217	3.1556	1	2	3	4	5
186	10,556	7.0704	2	3	6	9	14
187	10,195	4.9724	2	2	4	6	9
188	3,660	3.6052	1	2	3	5	7
189	129,261	5.9805	2	3	5	8	11
190	125,834	5.7988	2	3	5	7	10
191	138,634	4.8100	2	3	4	6	9
192	153,027	3.8040	1	2	3	5	7
193	103,143	6.6082	2	4	5	8	12
194	217,831	5.0971	2	3	4	6	9
195	105,680	3.8566	2	2	3	5	7
196	6,669	7.0088	2	4	6	9	13
197	6,891	5.1383	2	3	4	6	9
198	3,485	3.9297	1	2	3	5	7
199	3,759	8.2626	2	4	7	11	16
200	8,433	4.8069	1	2	4	6	9
201	2,980	3.7668	1	2	3	5	7
202	37,480	4.2973	2	2	4	5	8
203	34,631	3.2957	1	2	3	4	6
204	24,701	2.7757	1	1	2	3	5
205	6,812	5.4284	1	2	4	7	11
206	20,750	3.3217	1	2	3	4	6
207	38,198	15.1069	6	9	13	18	25
208	77,135	7.1870	1	3	6	10	14
215	138	14.4493	1	3	7	17	31
216	9,882	18.1298	8	11	16	22	31
217	6,449	11.2253	6	7	10	14	18
218	1,402	8.3302	5	6	7	10	13
219	12,505	13.5662	6	7	11	17	25
220	14,399	8.0178	5	6	7	9	13
221	4,933	6.1024	4	5	6	7	9
222	3,274	12.3952	4	7	10	15	23
223	4,421	5.4252	1	2	5	8	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
224	2,936	9.9220	3	5	8	13	18
225	4,767	5.0480	1	2	4	7	9
226	8,040	8.5116	1	3	7	11	17
227	33,271	2.7731	1	1	1	3	7
228	3,210	14.2100	6	8	12	17	24
229	3,330	8.4616	4	6	7	10	14
230	1,171	5.8779	2	4	6	7	10
231	1,566	12.8678	6	8	11	15	23
232	1,256	9.1513	5	7	9	11	14
233	17,630	13.6569	7	9	12	16	23
234	27,949	8.7444	5	6	8	10	13
235	10,519	11.1489	5	7	9	13	20
236	25,910	6.5372	4	5	6	8	10
237	23,979	10.4636	2	5	8	14	21
238	39,321	4.2773	1	1	3	6	9
239	11,673	15.4965	5	8	12	20	29
240	10,724	9.7112	3	5	8	12	18
241	1,917	6.2780	3	3	5	8	11
242	20,901	8.0780	2	4	7	10	15
243	38,084	4.7817	1	2	4	6	9
244	50,970	2.7335	1	1	2	4	6
245	4,085	3.3792	1	1	2	4	7
246	30,432	5.0278	1	2	4	7	11
247	148,268	2.0891	1	1	1	3	4
248	19,743	6.0479	1	3	5	8	12
249	68,042	2.5103	1	1	2	3	5
250	8,191	6.9894	2	3	5	9	14
251	38,152	2.7254	1	1	2	4	6
252	44,207	8.1998	1	3	6	11	17
253	43,050	5.9051	1	2	5	8	12
254	44,529	2.6148	1	1	2	3	6
255	2,524	9.8649	3	5	8	12	18
256	3,032	7.0604	2	4	6	9	13
257	493	4.5314	1	2	3	6	9
258	829	6.7949	2	3	5	8	13
259	6,194	2.7830	1	1	2	4	6
260	1,763	10.6568	2	4	8	14	21
261	3,846	4.0910	1	1	3	6	8
262	2,825	2.4935	1	1	2	3	5
263	564	5.3617	1	1	3	7	11
264	24,726	8.5244	1	3	6	11	18
265	2,094	3.4351	1	1	2	4	7
280	78,351	6.8317	2	4	6	9	12
281	50,942	4.4588	1	2	4	6	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
282	40,807	2.9018	1	1	2	4	5
283	15,370	5.3118	1	1	3	7	12
284	3,211	2.7203	1	1	2	3	6
285	1,788	1.9144	1	1	1	2	4
286	29,363	6.7091	2	3	5	8	13
287	141,009	3.0596	1	1	2	4	6
288	3,011	11.7629	4	6	9	14	21
289	1,166	7.9777	3	5	7	10	13
290	299	5.5117	2	3	5	7	9
291	202,158	6.3841	2	3	5	8	12
292	207,645	4.7393	2	3	4	6	8
293	138,517	3.4422	1	2	3	4	6
294	1,558	5.6611	2	3	5	7	10
295	1,012	4.2243	2	3	4	5	7
296	2,163	2.9903	1	1	1	3	7
297	724	1.7762	1	1	1	1	3
298	478	1.2406	1	1	1	1	1
299	23,060	6.3813	2	3	5	8	12
300	45,573	4.9678	2	3	4	6	9
301	31,315	3.5671	1	2	3	5	6
302	8,583	4.1572	1	2	3	5	8
303	59,020	2.4491	1	1	2	3	4
304	2,706	4.8293	1	2	4	6	9
305	31,637	2.7870	1	1	2	3	5
306	2,534	5.5675	1	3	4	7	10
307	5,822	3.3332	1	2	3	4	6
308	56,391	5.2621	2	3	4	7	10
309	92,496	3.7691	1	2	3	5	7
310	136,447	2.5895	1	1	2	3	5
311	18,515	2.2921	1	1	2	3	4
312	163,570	3.0723	1	2	2	4	6
313	187,990	2.1067	1	1	2	3	4
314	65,753	6.9196	2	3	5	9	14
315	30,267	4.3603	1	2	3	6	8
316	15,107	2.7482	1	1	2	3	5
326	11,460	16.5634	6	8	13	21	31
327	10,130	9.2364	3	5	8	12	17
328	8,000	3.9521	1	2	3	5	8
329	49,850	15.6873	6	8	13	19	28
330	60,069	9.2330	4	6	8	11	16
331	25,406	5.4784	3	4	5	7	8
332	1,999	14.4522	6	8	12	18	26
333	5,641	8.4028	4	5	7	10	14
334	3,308	5.1814	2	3	5	7	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
335	7,888	14.0033	5	8	12	18	25
336	12,358	8.7999	3	5	8	11	15
337	7,791	5.2450	1	3	5	7	10
338	1,611	10.2657	4	6	9	13	18
339	3,079	6.6297	3	4	6	8	11
340	3,330	3.9357	2	2	4	5	7
341	991	6.7598	2	3	5	9	13
342	2,724	3.9391	1	2	3	5	7
343	6,689	2.0599	1	1	2	3	4
344	1,004	11.3058	4	6	9	14	21
345	2,956	6.9513	3	4	6	8	12
346	2,782	4.7606	2	3	4	6	7
347	1,628	8.7193	2	4	7	11	18
348	4,223	5.5153	1	3	4	7	11
349	4,419	2.9007	1	1	2	4	6
350	1,895	7.8332	2	3	6	10	16
351	4,429	4.4373	1	2	4	6	9
352	7,056	2.3740	1	1	2	3	5
353	3,648	8.4246	2	4	7	11	16
354	8,800	4.9335	1	3	4	6	9
355	13,664	2.8119	1	1	2	4	5
356	8,507	13.0000	3	6	10	16	25
357	7,508	7.6501	2	4	6	9	14
358	2,086	4.3365	1	2	4	6	8
368	3,739	6.5633	2	3	5	8	13
369	5,523	4.5712	2	3	4	6	8
370	2,222	3.2457	1	2	3	4	6
371	27,801	8.6732	3	4	7	11	17
372	28,866	6.6097	2	4	5	8	12
373	12,526	4.7864	2	3	4	6	8
374	9,735	8.5674	2	4	7	11	16
375	17,369	5.8817	2	3	5	7	11
376	3,111	3.9029	1	2	3	5	7
377	60,392	6.2786	2	3	5	8	12
378	123,174	4.2530	2	2	4	5	7
379	61,710	3.1651	1	2	3	4	5
380	3,318	7.0401	2	3	6	9	13
381	5,857	4.8212	2	3	4	6	9
382	3,186	3.4761	1	2	3	4	6
383	1,573	5.5067	2	3	4	7	10
384	7,281	3.7624	1	2	3	5	7
385	2,874	7.9809	2	4	6	10	16
386	7,836	5.3798	2	3	4	7	10
387	4,287	4.1185	1	2	3	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
388	22,264	7.0349	2	3	5	9	14
389	48,564	4.8684	2	3	4	6	9
390	43,011	3.4504	1	2	3	4	6
391	49,229	5.1491	1	2	4	6	10
392	243,145	3.4552	1	2	3	4	6
393	24,689	6.8145	2	3	5	8	14
394	48,064	4.7075	1	2	4	6	9
395	21,110	3.1799	1	2	3	4	6
405	4,265	16.5944	5	8	13	21	32
406	5,200	8.4777	2	5	7	10	15
407	1,942	5.1807	1	3	5	7	9
408	1,579	14.0247	5	7	12	17	26
409	1,386	8.7496	4	5	8	11	15
410	495	6.0808	2	4	6	8	10
411	897	12.4448	5	7	10	15	22
412	866	8.3880	4	5	7	10	14
413	607	5.3608	2	3	5	7	9
414	5,226	11.7086	4	7	9	14	20
415	5,621	7.2539	3	4	6	9	12
416	4,531	4.4827	2	3	4	6	7
417	19,310	8.0109	3	4	6	10	15
418	25,684	5.3125	2	3	5	7	10
419	31,142	3.0398	1	1	2	4	6
420	797	13.9787	3	6	11	18	29
421	1,009	6.7463	1	3	5	8	14
422	247	4.3725	1	2	4	5	8
423	1,574	14.9333	4	7	11	19	29
424	790	8.9557	3	4	7	11	17
425	88	5.1818	1	2	5	7	9
432	14,500	6.7798	2	3	5	8	13
433	8,910	4.5626	1	2	4	6	8
434	582	3.3969	1	2	3	4	6
435	13,645	7.4026	2	3	6	9	14
436	12,101	5.6191	2	3	4	7	11
437	2,757	3.9198	1	2	3	5	8
438	17,103	7.4398	2	3	5	9	15
439	24,734	5.0556	2	3	4	6	9
440	20,943	3.6212	1	2	3	4	6
441	14,296	7.1668	2	3	5	9	14
442	15,246	4.7657	2	2	4	6	9
443	5,398	3.4750	1	2	3	4	6
444	13,755	6.3650	2	3	5	8	12
445	17,239	4.5635	1	2	4	6	8
446	13,815	3.1243	1	2	3	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
453	1,103	14.3717	5	7	11	18	28
454	2,379	7.2161	3	4	6	8	13
455	2,022	4.0257	1	2	4	5	7
456	1,111	13.9613	5	7	11	17	26
457	2,829	7.2471	3	4	6	8	13
458	1,449	4.3037	2	3	4	5	7
459	4,134	9.2830	4	5	7	11	17
460	55,514	4.0475	2	3	4	5	6
461	990	8.1081	3	4	6	9	15
462	12,295	4.1563	3	3	4	5	6
463	5,242	16.7963	5	7	12	20	33
464	9,397	9.5325	3	5	7	11	18
465	3,251	5.7192	2	3	5	7	10
466	4,166	9.1906	3	5	7	11	16
467	17,459	5.1585	3	3	4	6	8
468	17,206	3.7358	2	3	3	4	6
469	33,462	7.8944	3	4	6	9	14
470	406,435	3.7947	3	3	3	4	6
471	2,762	10.0724	2	4	8	14	20
472	7,775	4.0710	1	1	3	5	9
473	23,413	1.8888	1	1	1	2	3
474	2,726	12.5213	4	6	10	16	23
475	3,451	8.0194	3	4	6	10	15
476	1,300	4.5931	1	2	3	6	9
477	2,909	11.0846	4	6	9	14	20
478	9,193	6.4808	1	3	5	9	13
479	9,273	2.8366	1	1	1	4	7
480	28,792	8.9235	4	5	7	11	15
481	76,001	5.7158	3	4	5	7	9
482	38,607	4.6610	3	3	4	5	7
483	9,167	3.9369	2	2	3	5	7
484	17,038	2.3062	1	2	2	3	3
485	1,107	11.4056	4	6	9	14	21
486	1,982	7.5499	3	4	6	9	13
487	1,096	5.1743	2	3	5	6	9
488	2,928	4.9508	2	3	4	6	9
489	5,319	2.8791	1	2	3	3	5
490	23,832	4.2753	1	1	3	5	9
491	48,456	2.1270	1	1	2	3	4
492	5,869	8.4769	3	4	7	10	15
493	18,551	5.0689	2	3	4	6	9
494	26,856	3.2306	1	2	3	4	6
495	1,396	10.0874	3	5	8	12	19
496	4,663	5.6953	1	3	4	7	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
497	5,480	2.5995	1	1	2	3	5
498	1,332	7.3986	2	3	6	9	15
499	976	2.8207	1	1	2	3	6
500	1,791	11.0491	3	5	9	14	21
501	4,417	5.9989	2	3	5	8	11
502	5,867	2.8515	1	1	2	3	5
503	863	8.7764	2	4	7	11	16
504	2,365	6.3662	2	3	5	8	12
505	2,503	3.2713	1	1	3	4	6
506	725	3.5848	1	1	2	4	7
507	966	4.8385	1	2	3	6	9
508	2,045	1.9980	1	1	2	2	3
509	435	3.1494	1	1	2	4	7
510	1,185	6.4059	2	3	5	8	12
511	4,263	3.9336	1	2	3	5	7
512	9,362	2.1714	1	1	2	3	4
513	1,253	4.7223	1	2	4	6	9
514	1,015	2.5094	1	1	2	3	5
515	4,257	10.1266	3	5	8	13	18
516	11,691	5.8394	1	3	5	8	11
517	14,162	3.0462	1	1	2	4	7
533	863	6.8992	2	3	5	8	13
534	3,274	3.9356	1	2	3	5	7
535	8,153	5.8694	2	3	4	7	11
536	32,810	3.8604	1	3	3	5	6
537	838	4.3473	2	3	4	5	7
538	889	3.0146	1	2	3	4	5
539	2,725	10.5134	3	5	8	13	19
540	5,014	7.2146	2	4	6	8	12
541	1,457	5.2450	2	3	4	6	9
542	6,326	8.6012	3	4	7	11	16
543	16,651	5.7774	2	3	5	7	11
544	8,412	4.2045	2	3	4	5	7
545	4,399	8.7497	2	4	6	11	18
546	5,595	5.3324	2	3	4	7	10
547	3,912	3.7393	1	2	3	5	7
548	641	8.9922	2	4	7	11	17
549	1,145	6.2856	2	3	5	7	11
550	601	4.0749	1	2	4	5	7
551	12,231	6.9214	2	3	5	9	13
552	78,742	4.0758	1	2	3	5	7
553	3,393	5.7121	2	3	5	7	11
554	17,391	3.5988	1	2	3	4	6
555	2,163	4.6528	1	2	3	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
556	16,214	3.1221	1	1	3	4	6
557	6,154	6.6081	2	4	5	8	12
558	16,369	4.2992	2	3	4	5	7
559	2,006	7.2458	2	3	6	9	14
560	5,084	4.8179	1	2	4	6	9
561	6,251	2.6922	1	1	2	3	5
562	6,667	6.1359	2	3	5	7	11
563	33,700	3.6434	1	2	3	4	6
564	1,862	7.0156	2	3	5	9	13
565	3,813	4.8298	2	3	4	6	9
566	2,159	3.4924	1	2	3	4	6
573	5,129	13.9199	4	6	10	16	27
574	10,013	8.9254	3	4	7	10	16
575	4,156	5.5683	2	3	5	7	10
576	604	12.6242	2	5	8	15	27
577	2,323	6.1632	1	2	4	7	13
578	2,809	3.2471	1	1	2	4	7
579	3,896	10.7189	3	5	8	13	20
580	10,379	5.3295	1	2	4	7	11
581	11,077	2.4236	1	1	2	3	5
582	5,403	2.8058	1	1	2	3	5
583	8,132	1.7522	1	1	1	2	3
584	777	5.5393	1	2	4	7	12
585	1,265	2.1194	1	1	1	2	4
592	5,008	8.8107	3	4	7	10	16
593	11,631	6.2605	2	3	5	7	11
594	1,980	4.7030	1	3	4	6	8
595	1,379	8.1914	2	4	6	10	15
596	4,988	4.6776	1	2	4	6	8
597	586	7.9693	2	3	6	9	15
598	1,329	5.6697	1	3	4	7	10
599	246	3.5488	1	1	3	4	6
600	955	5.3895	2	3	4	6	10
601	844	3.6220	1	2	3	5	6
602	24,673	6.8901	2	4	6	8	13
603	129,590	4.6086	2	3	4	6	8
604	3,170	5.4584	1	3	4	7	10
605	20,027	3.3698	1	2	3	4	6
606	1,546	5.9288	1	3	4	7	11
607	6,553	3.6078	1	2	3	4	7
614	1,576	7.1383	2	3	5	8	14
615	1,446	3.0622	1	2	3	4	5
616	989	16.7826	6	9	13	20	30
617	6,848	8.4620	3	5	7	11	15

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
618	172	6.1453	2	3	6	8	10
619	799	7.8761	2	3	5	8	17
620	2,600	3.4219	1	2	3	4	6
621	9,739	1.9043	1	1	2	2	3
622	809	15.9938	4	7	11	19	32
623	3,192	8.9283	3	4	7	11	16
624	344	5.6192	2	3	5	7	9
625	1,342	7.0827	1	2	5	9	16
626	2,820	2.9589	1	1	2	3	6
627	13,050	1.4415	1	1	1	2	2
628	3,326	11.0613	2	4	8	14	22
629	4,422	8.4806	3	5	7	10	15
630	456	4.7807	1	2	4	7	10
637	21,127	5.7746	2	3	4	7	11
638	47,897	4.1819	1	2	3	5	8
639	29,361	2.9403	1	2	2	4	5
640	61,855	5.0977	1	2	4	6	10
641	187,587	3.6896	1	2	3	5	7
642	1,564	4.9175	1	2	4	6	8
643	6,570	7.3364	2	4	6	9	13
644	12,262	5.2553	2	3	4	7	9
645	7,108	3.6877	1	2	3	5	7
652	10,052	7.5197	4	5	6	8	13
653	1,843	16.4829	7	8	13	20	30
654	3,672	9.3540	5	6	8	11	15
655	1,336	5.9184	2	4	6	8	9
656	4,447	9.8927	3	5	8	12	19
657	7,563	5.6107	2	3	5	7	9
658	7,250	3.4479	1	2	3	4	5
659	4,956	10.7470	3	5	8	13	21
660	7,089	5.9958	2	3	4	7	12
661	3,955	3.0334	1	2	2	4	5
662	954	10.1813	2	5	8	13	20
663	1,934	4.9018	1	2	3	7	10
664	3,713	1.9305	1	1	1	2	4
665	772	11.4093	3	6	10	15	20
666	2,122	6.1056	1	2	4	8	13
667	3,123	2.2911	1	1	2	2	4
668	4,636	8.3611	2	4	6	11	16
669	12,519	4.2319	1	2	3	6	9
670	10,028	2.3269	1	1	2	3	5
671	871	5.9747	1	2	4	8	11
672	766	2.4386	1	1	2	3	5
673	12,545	9.6609	1	3	7	13	20

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
674	10,172	6.7921	1	2	5	9	14
675	5,159	2.0562	1	1	1	2	4
682	97,663	7.0104	2	3	5	9	14
683	135,146	5.2352	2	3	4	7	9
684	33,608	3.5327	1	2	3	4	6
685	2,367	3.4347	1	1	2	4	7
686	1,953	7.2570	2	3	6	9	14
687	3,061	5.1009	1	2	4	7	9
688	925	2.9697	1	1	2	4	6
689	60,381	5.9701	2	3	5	7	11
690	201,282	4.1617	2	2	3	5	7
691	979	4.1481	1	2	3	5	8
692	417	2.3453	1	1	2	3	4
693	3,192	4.5868	1	2	3	6	9
694	16,051	2.4604	1	1	2	3	5
695	1,011	5.7389	1	2	4	7	11
696	9,931	3.2007	1	2	3	4	6
697	562	3.4573	1	1	3	4	7
698	26,277	6.5765	2	3	5	8	13
699	25,729	4.6718	1	2	4	6	9
700	10,200	3.3118	1	2	3	4	6
707	5,792	4.2360	1	2	3	5	8
708	17,798	1.9734	1	1	2	2	3
709	787	5.9720	1	2	4	7	13
710	1,715	1.6251	1	1	1	2	3
711	757	7.4135	1	3	6	10	15
712	508	2.5610	1	1	2	3	5
713	10,506	4.0974	1	2	3	5	9
714	25,428	1.8654	1	1	2	2	3
715	523	6.2906	1	2	4	9	14
716	1,033	1.4666	1	1	1	2	2
717	790	6.8494	1	3	5	9	14
718	538	2.6970	1	1	2	3	5
722	847	6.9929	2	3	5	9	14
723	1,792	5.0603	1	2	4	6	9
724	386	2.8109	1	1	2	3	5
725	947	5.1426	2	2	4	6	10
726	3,288	3.5018	1	2	3	4	7
727	1,467	6.3729	2	3	5	8	12
728	5,687	4.0855	1	2	3	5	7
729	741	4.8880	1	2	4	6	9
730	344	2.7907	1	1	2	4	5
734	1,597	7.6662	2	3	5	9	15
735	1,032	3.0058	1	2	3	4	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
736	950	14.0337	5	8	11	18	25
737	3,235	6.8284	3	4	6	8	12
738	744	3.7151	2	3	3	4	6
739	1,075	9.9544	3	5	7	13	20
740	4,422	4.9245	2	3	4	6	8
741	5,524	2.7500	1	2	3	3	4
742	10,837	4.2701	2	2	3	5	8
743	29,354	2.1670	1	1	2	3	3
744	1,674	5.7133	1	2	4	7	12
745	1,395	2.5176	1	1	2	3	5
746	2,661	4.0218	1	2	3	5	8
747	8,083	1.8237	1	1	2	2	3
748	19,051	1.7136	1	1	1	2	3
749	1,019	9.1079	2	4	7	11	18
750	396	3.0076	1	1	2	4	6
754	1,267	8.5438	2	4	6	10	16
755	3,127	5.4883	1	2	4	7	11
756	530	2.9151	1	1	2	4	6
757	1,533	8.3686	3	4	6	10	16
758	1,916	5.9149	2	3	5	7	11
759	1,238	4.4120	2	2	4	5	8
760	1,813	3.8941	1	2	3	5	8
761	1,317	2.4229	1	1	2	3	4
765	3,132	5.1928	2	3	4	5	7
766	2,807	3.0363	2	2	3	3	4
767	142	2.9859	2	2	2	3	4
768	9	5.5556	2	3	5	6	8
769	86	6.8953	1	2	4	7	14
770	225	1.8933	1	1	1	2	4
774	1,636	3.3136	2	2	2	3	4
775	5,864	2.2877	1	2	2	3	3
776	561	3.5258	1	2	2	4	6
777	232	2.2500	1	1	2	3	4
778	445	2.9798	1	1	2	3	5
779	130	2.1000	1	1	1	2	3
780	44	1.2955	1	1	1	1	3
781	3,131	3.8116	1	1	2	4	7
782	180	2.3667	1	1	1	3	4
799	613	13.7210	4	7	11	17	26
800	674	7.4214	2	4	6	9	14
801	399	4.0426	1	2	3	5	7
802	886	11.8544	3	5	9	15	23
803	1,136	6.8627	2	3	5	9	14
804	816	3.1863	1	1	2	4	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
808	7,559	8.2232	3	4	6	10	16
809	13,401	5.1782	2	3	4	6	9
810	2,475	3.8642	1	2	3	5	7
811	27,129	5.4328	1	2	4	7	11
812	90,209	3.6824	1	2	3	5	7
813	13,144	5.2039	1	2	4	6	10
814	1,862	6.7653	2	3	5	8	13
815	3,669	4.6443	1	2	4	6	9
816	1,823	3.3922	1	2	3	4	6
820	1,353	16.7613	5	8	13	21	31
821	2,171	7.4929	1	3	6	10	15
822	1,837	3.2542	1	1	2	4	6
823	2,355	14.7737	5	7	12	18	27
824	2,895	8.5948	2	4	7	11	16
825	1,579	4.1374	1	1	3	6	9
826	638	14.8793	5	7	12	19	27
827	1,287	6.9169	2	3	6	9	13
828	785	3.5159	1	2	3	5	7
829	1,326	9.5973	2	3	7	12	21
830	400	3.0750	1	1	2	4	6
834	4,130	15.0545	2	4	9	23	34
835	2,722	9.7303	2	3	6	11	27
836	1,336	4.8510	1	2	3	5	10
837	1,196	23.4490	5	10	23	31	43
838	1,441	12.8952	3	4	6	22	30
839	1,415	5.9110	3	4	5	6	8
840	9,732	10.5227	3	5	8	13	21
841	9,727	6.6585	2	3	5	8	13
842	4,347	4.2501	1	2	3	6	8
843	1,795	7.9426	2	4	6	10	15
844	2,642	5.9682	2	3	5	8	11
845	586	4.0802	1	2	3	5	7
846	2,586	8.4954	2	4	6	10	18
847	22,623	3.3684	1	2	3	4	6
848	1,386	3.2258	1	1	3	4	5
849	1,080	6.2083	1	3	5	6	13
853	38,103	16.3380	5	8	13	20	30
854	8,088	10.7591	4	6	9	13	19
855	432	7.2523	2	4	6	9	14
856	5,808	15.4695	4	7	12	19	29
857	9,308	8.1476	3	4	6	10	15
858	2,623	5.4979	2	3	5	7	10
862	9,162	7.9843	2	4	6	10	15
863	21,329	5.0708	2	3	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
864	17,580	3.8699	1	2	3	5	7
865	2,846	6.1514	2	3	4	7	12
866	9,136	3.4499	1	2	3	4	6
867	5,370	9.3821	3	4	7	12	19
868	2,764	5.3694	2	3	4	7	10
869	954	4.0671	1	2	3	5	7
870	24,792	15.4721	6	9	13	19	26
871	256,135	7.3324	2	3	6	9	14
872	90,189	5.5727	2	3	5	7	10
876	685	13.0934	2	4	8	15	26
880	8,535	3.1589	1	1	2	4	6
881	4,578	4.2977	1	2	3	5	8
882	1,691	4.4370	1	2	3	5	8
883	896	8.2310	1	3	5	8	16
884	19,081	5.6479	2	3	4	6	10
885	84,194	7.4573	2	3	6	9	14
886	500	6.0360	1	2	4	7	12
887	571	4.6690	1	2	3	5	10
894	4,260	2.9462	1	1	2	3	4
895	6,545	10.5668	3	4	6	8	9
896	6,713	6.7846	2	3	5	8	13
897	35,203	4.0295	1	2	3	5	6
901	917	15.0196	3	6	10	19	30
902	1,944	8.0077	2	3	6	10	16
903	1,109	4.4869	1	2	3	6	9
904	1,474	11.2551	2	4	7	13	21
905	824	4.5922	1	2	4	6	8
906	692	3.1243	1	1	2	3	6
907	8,703	11.6446	3	5	8	14	23
908	8,622	6.4505	2	3	5	8	12
909	4,987	3.3619	1	1	3	4	6
913	1,041	6.0058	2	3	4	7	11
914	5,775	3.3614	1	2	3	4	6
915	1,334	4.6207	1	2	3	6	10
916	5,210	2.1094	1	1	2	3	4
917	19,659	5.1948	1	2	4	6	10
918	34,890	2.6673	1	1	2	3	5
919	11,279	6.3163	1	3	4	8	12
920	14,560	4.2532	1	2	3	5	8
921	8,237	2.8428	1	1	2	3	5
922	1,258	5.4889	1	2	4	7	11
923	3,271	3.1556	1	1	2	4	6
927	167	32.7365	8	16	26	42	64
928	857	16.4119	3	7	13	21	31

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
929	416	7.3798	1	2	6	10	15
933	153	5.7451	1	1	1	5	14
934	691	6.1679	1	2	5	8	13
935	2,055	5.3182	1	2	3	6	11
939	764	10.9018	2	4	8	14	22
940	1,675	5.7200	1	2	3	7	12
941	1,720	2.5512	1	1	2	3	5
945	6,572	10.0490	4	6	8	11	14
946	3,008	7.6599	3	5	6	7	8
947	12,025	5.0913	1	2	4	6	10
948	52,821	3.4687	1	2	3	4	6
949	704	4.7827	1	1	2	5	8
950	296	3.3581	1	1	2	4	6
951	904	4.1936	1	1	2	3	6
955	485	12.8062	2	6	10	17	24
956	4,238	9.1182	4	5	7	11	17
957	1,520	15.0559	3	7	12	20	28
958	1,177	9.5115	3	5	8	12	17
959	230	5.8000	1	3	5	7	11
963	1,892	9.1781	1	4	7	12	19
964	2,803	5.7827	2	3	5	7	10
965	961	3.8398	1	2	3	5	7
969	633	18.8278	5	8	13	22	35
970	122	8.9262	2	3	6	11	15
974	6,062	9.9919	2	4	7	13	20
975	4,376	6.8441	2	3	5	8	13
976	1,933	4.6762	1	2	4	6	8
977	3,970	5.0305	1	2	4	6	9
981	29,324	14.6229	5	7	12	18	27
982	19,564	8.9636	3	5	7	11	16
983	5,628	4.6105	1	2	4	6	9
984	753	14.6135	5	8	12	18	26
985	909	8.7228	2	3	7	12	17
986	539	4.2505	1	1	3	6	9
987	8,732	12.5849	3	6	10	16	23
988	10,787	7.2991	2	3	6	9	14
989	4,641	3.6572	1	1	3	5	8
Total	11,237,072						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS (CCRs) FOR ACUTE CARE HOSPITALS—JULY 2009

State	Urban	Rural
Alabama	0.25	0.318
Alaska	0.365	0.66
Arizona	0.277	0.381
Arkansas	0.314	0.336
California	0.22	0.3
Colorado	0.274	0.422
Connecticut	0.39	0.51
Delaware	0.498	0.45
District of Columbia*	0.337	---
Florida	0.233	0.265
Georgia	0.313	0.376
Hawaii	0.375	0.474
Idaho	0.467	0.595
Illinois	0.3	0.371
Indiana	0.376	0.437
Iowa	0.342	0.427
Kansas	0.298	0.409
Kentucky	0.366	0.363
Louisiana	0.3	0.34
Maine	0.494	0.471
Maryland	0.718	0.767
Massachusetts*	0.462	1.12
Michigan	0.365	0.446
Minnesota	0.385	0.506
Mississippi	0.29	0.354
Missouri	0.334	0.354
Montana	0.419	0.463
Nebraska	0.329	0.449
Nevada	0.207	0.453
New Hampshire	0.418	0.407
New Jersey*	0.175	---
New Mexico	0.354	0.361
New York	0.347	0.522
North Carolina	0.385	0.384
North Dakota	0.441	0.385
Ohio	0.324	0.5
Oklahoma	0.292	0.376
Oregon	0.443	0.409
Pennsylvania	0.257	0.408
Puerto Rico*	0.477	---
Rhode Island*	0.391	---
South Carolina	0.284	0.307
South Dakota	0.323	0.398
Tennessee	0.283	0.355
Texas	0.25	0.328
Utah	0.415	0.541
Vermont	0.557	0.622
Virginia	0.348	0.346
Washington	0.362	0.437
West Virginia	0.461	0.456
Wisconsin	0.402	0.445
Wyoming	0.394	0.539

*All counties in the State or Territory are classified as urban, with the exception of Massachusetts, which has areas designated as rural. However, no short-term acute care IPPS hospitals are located in those areas as of July 2009.

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CCRs) FOR ACUTE CARE HOSPITALS—JULY 2009

State	Ratio
Alabama	0.024
Alaska	0.04
Arizona	0.025
Arkansas	0.024
California	0.015
Colorado	0.029
Connecticut	0.027
Delaware	0.035
District of Columbia	0.019
Florida	0.022
Georgia	0.028
Hawaii	0.03
Idaho	0.038
Illinois	0.025
Indiana	0.037
Iowa	0.026
Kansas	0.03
Kentucky	0.029
Louisiana	0.026
Maine	0.03
Maryland	0.057
Massachusetts	0.031
Michigan	0.03
Minnesota	0.028
Mississippi	0.027
Missouri	0.028
Montana	0.036
Nebraska	0.035
Nevada	0.02
New Hampshire	0.032
New Jersey	0.013
New Mexico	0.035
New York	0.026
North Carolina	0.032
North Dakota	0.031
Ohio	0.029
Oklahoma	0.026
Oregon	0.032
Pennsylvania	0.021
Puerto Rico	0.042
Rhode Island	0.02
South Carolina	0.025
South Dakota	0.027
Tennessee	0.027
Texas	0.026
Utah	0.032
Vermont	0.046
Virginia	0.033
Washington	0.028
West Virginia	0.034
Wisconsin	0.036
Wyoming	0.04

TABLE 8C.—STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS (CCRs) FOR LTCHs—JULY 2009

State	Urban	Rural
Alabama	0.273	0.349
Alaska	0.397	0.748
Arizona	0.302	0.409
Arkansas	0.336	0.366
California	0.234	0.319
Colorado	0.302	0.466
Connecticut	0.415	0.556
Delaware	0.533	0.487
District of Columbia*	0.356	---
Florida	0.255	0.293
Georgia	0.34	0.41
Hawaii	0.404	0.504
Idaho	0.505	0.633
Illinois	0.324	0.403
Indiana	0.412	0.478
Iowa	0.365	0.464
Kansas	0.326	0.445

State	Urban	Rural
Kentucky	0.394	0.393
Louisiana	0.326	0.365
Maine	0.525	0.497
Maryland**	0.332	0.423
Massachusetts*	0.493	1.208
Michigan	0.395	0.479
Minnesota	0.411	0.548
Mississippi	0.317	0.381
Missouri	0.36	0.387
Montana	0.452	0.504
Nebraska	0.362	0.489
Nevada	0.226	0.516
New Hampshire	0.451	0.438
New Jersey*	0.188	---
New Mexico	0.387	0.399
New York	0.372	0.557
North Carolina	0.417	0.417
North Dakota	0.473	0.408
Ohio	0.351	0.543
Oklahoma	0.317	0.405
Oregon	0.476	0.438
Pennsylvania	0.277	0.441
Puerto Rico*	0.518	---
Rhode Island*	0.411	---
South Carolina	0.309	0.332
South Dakota	0.348	0.431
Tennessee	0.309	0.39
Texas	0.275	0.362
Utah	0.445	0.592
Vermont	0.611	0.659
Virginia	0.381	0.381
Washington	0.39	0.467
West Virginia	0.496	0.49
Wisconsin	0.438	0.482
Wyoming	0.428	0.587

*All counties in the State or Territory are classified as urban, with the exception of Massachusetts, which has areas designated as rural. However, no short-term acute care IPPS hospitals or LTCHs are located in those areas as of July 2009.

**National average IPPS total CCRs, as discussed in section V.C.2. of this Addendum.

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS–FY 2010

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
010001	20020	10500	
010005	01	26620	
010009	19460	26620	
010010	01	13820	
010012	01	40660	
010022	01	12060	
010025	01	17980	
010029	12220	17980	
010035	01	13820	
010052	01	33860	
010054	19460	26620	
010055	20020	37460	
010059	19460	26620	
010061	01	16860	
010065	01	13820	
010083	01	37860	
010085	19460	26620	
010090	33660	37700	
010100	01	37860	
010101	01	13820	
010102	01	33860	
010118	01	13820	
010126	01	33860	
010143	01	26620	
010158	01	22520	
010164	01	13820	
020008	02	11260	
030007	39140	22380	
030033	03	22380	
030069	29420	40140	
030101	29420	29820	
040014	04	30780	
040017	04	26	
040019	04	32820	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
040020	27860	32820	
040027	04	44180	
040039	04	26	
040041	04	30780	
040069	04	32820	
040071	38220	30780	
040076	04	26300	LUGAR
040080	04	27860	
040085	04	32820	
040088	04	33740	
040091	04	45500	
040119	04	30780	
050002	36084	41940	
050006	05	39820	
050009	34900	46700	
050013	34900	46700	
050014	05	40900	
050022	40140	42044	
050042	05	39820	
050043	36084	41940	
050054	40140	42044	
050069	42044	31084	
050073	46700	36084	
050075	36084	41940	
050076	41884	36084	
050084	44700	40900	
050089	40140	31084	
050095	36084	41940	
050099	40140	31084	
050101	46700	36084	
050102	40140	42044	
050129	40140	31084	
050131	41884	36084	
050133	49700	40900	
050140	40140	31084	
050150	05	40900	
050152	41884	36084	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050168	42044	31084	
050173	42044	31084	
050193	42044	31084	
050195	36084	41940	
050197	41884	41940	
050211	36084	41940	
050224	42044	31084	
050226	42044	31084	
050230	42044	31084	
050243	40140	42044	
050245	40140	31084	
050264	36084	41940	
050272	40140	31084	
050279	40140	31084	
050283	36084	41940	
050292	40140	42044	
050300	40140	31084	
050301	05	42220	
050305	36084	41940	
050320	36084	41940	
050327	40140	31084	
050329	40140	42044	
050334	41500	41940	
050335	05	33700	
050348	42044	31084	
050360	41884	36084	
050367	46700	36084	
050390	40140	42044	
050423	40140	42044	
050426	42044	31084	
050488	36084	41940	
050510	41884	36084	
050512	36084	41940	
050517	40140	31084	
050526	42044	31084	
050534	40140	42044	
050541	41884	41940	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050543	42044	31084	
050548	42044	31084	
050551	42044	31084	
050567	42044	31084	
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050586	40140	31084	
050589	42044	31084	
050603	42044	31084	
050609	42044	31084	
050667	34900	46700	
050668	41884	36084	
050678	42044	31084	
050680	46700	36084	
050684	40140	42044	
050686	40140	42044	
050693	42044	31084	
050694	40140	42044	
050701	40140	42044	
050709	40140	31084	
050720	42044	31084	
050744	42044	31084	
050745	42044	31084	
050746	42044	31084	
050747	42044	31084	
050758	40140	31084	
060001	24540	19740	
060003	14500	19740	
060012	39380	17820	
060023	24300	19740	
060027	14500	19740	
060031	17820	19740	
060049	06	22660	
060075	06	24300	
060096	06	19740	
060103	14500	19740	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
060116	14500	19740	
060121	24540	19740	
070001	35300	35004	
070003	07	25540	LUGAR
070005	35300	35004	
070006	14860	35644	
070010	14860	35644	
070011	07	25540	LUGAR
070015	07	35644	
070016	35300	35004	
070017	35300	35004	
070018	14860	35644	
070019	35300	35004	
070022	35300	35004	
070028	14860	35644	
070031	35300	35004	
070033	14860	35644	
070034	14860	35644	
070038	35300	35004	
070039	35300	35004	
080004	20100	48864	
080006	08	20100	
080007	08	36140	
090004	47894	13644	
090011	47894	13644	
100002	48424	22744	
100014	19660	36740	
100017	19660	36740	
100022	33124	22744	
100023	10	36740	
100024	10	33124	
100045	19660	36740	
100047	39460	14600	
100049	10	29460	
100068	19660	36740	
100072	19660	36740	
100077	39460	14600	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
100080	48424	22744	
100081	10	23020	LUGAR
100105	42680	38940	
100109	10	36740	
100130	48424	22744	
100139	10	23540	LUGAR
100150	10	33124	
100156	10	23540	
100157	29460	45300	
100160	10	33124	
100168	48424	22744	
100176	48424	22744	
100217	42680	38940	
100232	10	27260	
100234	48424	22744	
100236	39460	14600	
100249	10	45300	
100252	10	38940	
100253	48424	22744	
100258	48424	22744	
100268	48424	22744	
100269	48424	22744	
100275	48424	22744	
100287	48424	22744	
100288	48424	22744	
100292	10	23020	LUGAR
110001	19140	16860	
110002	11	12060	
110016	11	17980	
110023	11	12060	
110029	23580	12060	
110038	11	45220	
110040	11	12060	LUGAR
110041	11	12060	
110054	40660	12060	
110069	47580	31420	
110075	11	42340	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
110095	11	10500	
110105	11	10500	
110112	11	10500	
110121	11	45220	
110122	46660	45220	
110125	11	31420	
110128	11	42340	
110146	11	15260	
110150	11	12060	
110153	47580	31420	
110168	40660	12060	
110187	11	12060	LUGAR
110189	11	12060	
110230	11	16860	LUGAR
130002	13	14260	
130003	30300	28420	
130049	17660	44060	
130067	13	26820	LUGAR
140008	16974	29404	
140010	16974	29404	
140012	14	16974	
140015	14	41180	
140018	16974	29404	
140032	14	41180	
140034	14	41180	
140040	14	37900	
140043	14	19340	
140046	14	41180	
140048	16974	29404	
140049	16974	29404	
140051	16974	29404	
140054	16974	29404	
140058	14	44100	
140062	16974	29404	
140063	16974	29404	
140064	14	37900	
140065	16974	29404	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
140068	16974	29404	
140075	16974	29404	
140080	16974	29404	
140082	16974	29404	
140083	16974	29404	
140088	16974	29404	
140094	16974	29404	
140095	16974	29404	
140103	16974	29404	
140110	14	16974	
140114	16974	29404	
140115	16974	29404	
140117	16974	29404	
140118	16974	29404	
140119	16974	29404	
140124	16974	29404	
140133	16974	29404	
140135	19500	16580	
140143	14	16974	
140150	16974	29404	
140151	16974	29404	
140155	28100	16974	
140158	16974	29404	
140160	14	40420	
140161	14	16974	
140164	14	41180	
140166	19500	16580	
140172	16974	29404	
140177	16974	29404	
140179	16974	29404	
140180	16974	29404	
140181	16974	29404	
140182	16974	29404	
140186	28100	16974	
140191	16974	29404	
140197	16974	29404	
140206	16974	29404	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
140207	16974	29404	
140208	16974	29404	
140223	16974	29404	
140224	16974	29404	
140240	16974	29404	
140250	16974	29404	
140251	16974	29404	
140252	16974	29404	
140258	16974	29404	
140276	16974	29404	
140281	16974	29404	
140290	16974	29404	
140300	16974	29404	
140301	16974	29404	
140303	16974	29404	
150002	23844	16974	
150004	23844	16974	
150006	33140	43780	
150008	23844	16974	
150011	15	26900	
150015	33140	23844	
150023	45460	26900	
150030	15	26900	LUGAR
150034	23844	16974	
150042	15	14020	
150045	15	23060	
150048	15	17140	
150051	14020	26900	
150065	15	26900	
150069	15	17140	
150076	15	43780	
150088	11300	26900	
150089	34620	11300	
150090	23844	16974	
150091	15	23060	
150102	15	23844	LUGAR
150113	11300	26900	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
150115	15	21780	
150125	23844	16974	
150126	23844	16974	
150133	15	43780	
150146	15	21140	
150165	23844	16974	
150166	23844	16974	
150170	23844	16974	
160001	16	19780	
160016	16	11180	
160057	16	26980	
160064	16	24	
160080	16	19340	
160089	16	26980	
160147	16	11180	
170006	17	27900	
170012	17	48620	
170013	17	48620	
170020	17	48620	
170023	17	48620	
170033	17	48620	
170068	17	11100	
170120	17	27900	
170142	31740	45820	
170175	17	48620	
180002	18	49	
180005	18	26580	
180011	18	30460	
180012	21060	31140	
180013	14540	34980	
180017	18	21060	
180020	18	49	
180024	18	31140	
180027	18	17300	
180029	18	30460	
180043	18	44	
180044	18	26580	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
180048	18	31140	
180049	18	30460	
180050	18	28700	
180066	18	34980	
180069	18	26580	
180078	18	26580	
180080	18	28940	
180093	18	21780	
180102	18	17300	
180104	18	17300	
180116	18	17300	
180124	14540	34980	
180127	18	31140	
180132	18	30460	
190003	19	29180	
190015	19	35380	
190017	19	29180	
190086	19	33740	
190088	19	43340	
190106	19	10780	
190144	19	43340	
190164	19	10780	
190167	19	29180	
190184	19	33740	
190190	19	33740	
190191	19	29180	
190218	19	43340	
190257	19	33740	
200002	20	38860	
200020	38860	40484	
200024	30340	38860	
200034	30340	38860	
200039	20	38860	
200050	20	12620	
220001	49340	14484	
220002	15764	14484	
220008	39300	14484	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
220010	37764	14484	
220011	15764	14484	
220019	49340	14484	
220020	39300	14484	
220025	49340	14484	
220029	37764	14484	
220033	37764	14484	
220035	37764	14484	
220049	15764	14484	
220058	49340	14484	
220062	49340	14484	
220063	15764	14484	
220070	15764	14484	
220073	39300	14484	
220074	39300	14484	
220077	44140	25540	
220080	37764	14484	
220082	15764	14484	
220084	15764	14484	
220090	49340	14484	
220095	49340	14484	
220098	15764	14484	
220101	15764	14484	
220105	15764	14484	
220163	49340	14484	
220171	15764	14484	
220174	37764	14484	
220175	15764	14484	
220176	49340	14484	
230002	19804	11460	
230003	26100	34740	
230013	47644	22420	
230019	47644	22420	
230020	19804	11460	
230021	35660	28020	
230022	23	29620	
230024	19804	11460	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
230029	47644	22420	
230030	23	40980	
230035	23	24340	LUGAR
230036	23	13020	
230037	23	11460	
230038	24340	34740	
230053	19804	11460	
230054	23	24580	
230059	24340	34740	
230069	47644	22420	
230071	47644	22420	
230072	26100	34740	
230077	40980	22420	
230080	23	13020	
230089	19804	11460	
230092	27100	11460	
230095	23	13020	
230096	23	28020	
230097	23	24340	
230104	19804	11460	
230105	23	13020	
230106	24340	34740	
230121	23	29620	LUGAR
230130	47644	22420	
230135	19804	11460	
230142	19804	11460	
230146	19804	11460	
230151	47644	22420	
230165	19804	11460	
230174	26100	34740	
230176	19804	11460	
230195	47644	19804	
230207	47644	22420	
230208	23	24340	LUGAR
230222	23	13020	
230236	24340	34740	
230244	19804	11460	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
230254	47644	22420	
230269	47644	22420	
230270	19804	11460	
230273	19804	11460	
230277	47644	22420	
230279	47644	22420	
230297	19804	11460	
230B95	19804	11460	
240030	24	41060	
240064	24	20260	
240069	24	33460	
240071	24	33460	
240075	24	41060	
240088	24	41060	
240093	31860	33460	
250004	25	32820	
250006	25	32820	
250009	25	27180	
250023	25	25060	LUGAR
250031	25	27140	
250034	25	32820	
250040	37700	25060	
250042	25	32820	
250069	25	46220	
250078	25620	25060	
250079	25	27140	
250081	25	46220	
250082	25	38220	
250094	25620	25060	
250097	25	12940	
250099	25	27140	
250100	25	46220	
250104	25	46220	
250117	25	25060	LUGAR
260009	26	28140	
260017	26	27620	
260022	26	16	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
260025	26	41180	
260064	26	17860	
260074	26	17860	
260094	26	44180	
260113	26	14	
260116	26	14	
260119	26	16020	
260175	26	28140	
260186	26	27620	
270003	27	24500	
270017	27	33540	
270051	27	33540	
280009	28	30700	
280023	28	30700	
280032	28	30700	
280061	28	53	
280065	28	24540	
280077	28	30700	
280125	28	43580	
290002	29	16180	LUGAR
290006	29	39900	
300001	30	31700	
300011	31700	15764	
300012	31700	15764	
300017	40484	37764	
300019	30	15764	
300020	31700	15764	
300029	40484	37764	
300034	31700	15764	
310002	35084	35644	
310009	35084	35644	
310014	15804	37964	
310015	35084	35644	
310017	35084	35644	
310018	35084	35644	
310022	15804	37964	
310029	15804	37964	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
310031	15804	20764	
310032	47220	48864	
310038	20764	35644	
310039	20764	35644	
310048	20764	35084	
310050	35084	35644	
310054	35084	35644	
310070	20764	35644	
310076	35084	35644	
310081	15804	37964	
310083	35084	35644	
310086	15804	37964	
310093	35084	35644	
310096	35084	35644	
310108	20764	35644	
310119	35084	35644	
320003	32	42140	
320005	22140	10740	
320006	32	10740	
320013	32	42140	
320014	32	29740	
320033	32	42140	LUGAR
320063	32	36220	
320065	32	36220	
330004	28740	39100	
330008	33	15380	LUGAR
330023	39100	35644	
330027	35004	35644	
330049	39100	14860	
330067	39100	14860	
330073	33	40380	LUGAR
330079	33	47	
330085	33	45060	
330090	21300	27060	
330094	33	38340	
330126	39100	35644	
330136	33	45060	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
330157	33	45060	
330167	35004	35644	
330181	35004	35644	
330182	35004	35644	
330191	24020	10580	
330198	35004	35644	
330224	28740	39100	
330225	35004	35644	
330229	33	21500	
330239	33	21500	
330250	33	15540	
330259	35004	35644	
330277	33	27060	
330331	35004	35644	
330332	35004	35644	
330372	35004	35644	
330386	33	35084	
340008	34	22180	
340013	34	16740	
340015	34	16740	
340021	34	16740	
340023	11700	24860	
340027	34	24780	
340039	34	49180	
340050	34	22180	
340051	34	25860	
340069	39580	20500	
340071	34	39580	LUGAR
340073	39580	20500	
340085	34	24660	LUGAR
340096	34	24660	LUGAR
340109	34	47260	
340114	39580	20500	
340115	34	20500	
340126	34	39580	
340127	34	20500	LUGAR
340129	34	16740	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
340131	34	24780	
340138	39580	20500	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
340173	39580	20500	
360008	36	26580	
360010	36	10420	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	45780	
360027	10420	17460	
360036	36	31900	
360039	36	18140	
360054	36	26580	
360055	49660	17460	
360065	36	45780	
360078	10420	17460	
360086	44220	19380	
360095	36	30620	
360109	36	18140	
360112	45780	33780	
360121	36	45780	
360133	19380	17140	
360150	10420	17460	
360159	36	18140	
360175	36	18140	
360185	36	49660	LUGAR
360187	44220	19380	
360197	36	18140	
360211	48260	38300	
360241	10420	17460	
360245	36	17460	LUGAR
370004	37	27900	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
370006	37	48620	
370014	37	43300	
370015	37	46140	
370016	37	36420	
370018	37	46140	
370020	37	36420	
370022	37	30020	
370025	37	46140	
370026	37	36420	
370030	37	46140	
370047	37	36420	
370049	37	36420	
370099	37	36420	
370113	37	22220	
370149	37	36420	
380001	38	38900	
380022	38	18700	LUGAR
380027	38	21660	
380050	38	32780	
380051	41420	38900	
380090	38	21660	
390006	39	25420	
390013	39	25420	
390016	39	38300	
390030	39	39740	LUGAR
390031	39	39740	LUGAR
390044	39740	37964	
390046	49620	29540	
390048	39	25420	
390065	39	13644	
390066	30140	25420	
390067	25420	29540	
390071	39	48700	LUGAR
390079	39	13780	
390086	39	44300	
390091	39	49660	
390093	39	49660	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
390096	39740	37964	
390110	27780	38300	
390113	39	49660	
390133	10900	37964	
390138	39	25180	
390151	39	13644	
390162	10900	35084	
390185	42540	10900	
390201	39	10900	LUGAR
390313	39	39740	LUGAR
410001	39300	14484	
410004	39300	14484	
410005	39300	14484	
410007	39300	14484	
410010	39300	14484	
410011	39300	14484	
410012	39300	14484	
410013	39300	35980	
420007	43900	24860	
420009	42	24860	LUGAR
420020	42	16700	
420027	11340	24860	
420030	42	16700	
420036	42	16740	
420039	42	43900	LUGAR
420062	42	16740	
420067	42	42340	
420068	42	12260	
420069	42	44940	LUGAR
420070	44940	17900	
420071	42	24860	
420080	42	42340	
420083	43900	24860	
420085	34820	48900	
420098	42	34820	
420101	42	42340	
430012	43	43620	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
430013	43	43620	
430014	43	22020	
440002	27180	32820	
440020	44	26620	
440025	44	34	
440035	17300	34980	
440056	34100	28940	
440058	44	16860	
440059	44	34980	
440067	34100	28700	
440068	44	16860	
440073	44	34980	
440144	44	34980	
440148	44	34980	
440151	44	34980	
440174	44	32820	
440185	17420	16860	
440192	44	34980	
450007	45	41700	
450032	45	30980	LUGAR
450039	23104	19124	
450064	23104	19124	
450080	45	19124	
450087	23104	19124	
450099	45	11100	
450135	23104	19124	
450137	23104	19124	
450144	45	33260	
450147	47020	18580	
450148	23104	19124	
450178	45	36220	
450187	45	26420	
450211	45	30980	
450214	45	26420	
450224	45	46340	
450283	45	19124	LUGAR
450324	43300	19124	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
450347	45	26420	
450351	45	23104	
450370	45	26420	
450389	45	19124	LUGAR
450419	23104	19124	
450438	45	26420	
450447	45	19124	
450465	45	26420	
450469	43300	19124	
450484	45	30980	
450508	45	30980	
450547	45	19124	
450563	23104	19124	
450565	45	23104	
450596	45	23104	
450639	23104	19124	
450656	45	30980	
450672	23104	19124	
450675	23104	19124	
450677	23104	19124	
450747	45	46340	
450770	45	12420	LUGAR
450779	23104	19124	
450872	23104	19124	
450880	23104	19124	
450886	23104	19124	
460004	36260	41620	
460005	36260	41620	
460007	46	41100	
460021	41100	29820	
460026	46	39340	
460039	46	36260	
460041	36260	41620	
460042	36260	41620	
470001	47	30	
470012	47	38340	
490004	25500	16820	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
490005	49020	47894	
490013	49	20500	
490018	49	16820	
490019	49	47894	
490042	13980	40220	
490043	47894	13644	
490063	47894	13644	
490066	47260	40060	
490079	49	49180	
490097	49	40060	
490101	47894	13644	
490107	47894	13644	
490122	47894	13644	
500002	50	28420	
500003	34580	42644	
500007	34580	42644	
500016	48300	42644	
500021	45104	42644	
500031	50	36500	
500039	14740	42644	
500041	31020	38900	
500072	50	14740	
500079	45104	42644	
500108	45104	42644	
500129	45104	42644	
510001	34060	38300	
510002	51	40220	
510006	51	34060	
510018	51	16620	LUGAR
510024	34060	38300	
510046	51	13980	
510047	51	38300	
510050	48540	38300	
510070	51	16620	
510071	51	13980	
510077	51	26580	
520002	52	48140	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
520013	20740	33460	
520028	52	31540	LUGAR
520037	52	48140	
520059	39540	33340	
520071	52	33340	LUGAR
520076	52	33340	
520095	52	31540	
520096	39540	33340	
520102	52	33340	LUGAR
520107	52	22540	
520113	52	24580	
520116	52	33340	LUGAR
530014	16940	24540	

TABLE 9C.--HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT--FY 2010

Provider No.	Geographic CBSA	Redesignated Rural Area
040118	27860	04
050192	23420	05
050528	32900	05
050618	40140	05
070004	07	07
100048	37860	10
100118	37380	10
100134	27260	10
140167	14	14
170137	29940	17
180038	36980	18
220051	38340	22
230078	35660	23
250017	25	25
260006	41140	26
260034	28140	26
260047	27620	26
260195	44180	26
300023	40484	33
330235	33	33
330268	10580	33
360125	36	36
370054	36420	37
380040	13460	38
390130	27780	39
390183	39	39
390233	49620	39
450052	45	45
450078	10180	45
450243	10180	45
450348	45	45
490116	13980	49
500148	48300	50

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG)—JULY 2009[1]

MS-DRG	Number of Cases	Threshold
1	865	$389,023
2	233	$195,076
3	23,101	$271,605
4	21,861	$164,672
5	933	$173,605
6	380	$103,578
7	406	$170,050
8	511	$105,177
9	1,567	$109,508
10	141	$90,896
11	1,384	$80,163
12	1,989	$58,993
13	1,062	$40,510
20	1,047	$157,844
21	487	$119,149

MS-DRG	Number of Cases	Threshold
22	156	$85,653
23	4,272	$91,602
24	2,066	$63,388
25	10,196	$84,185
26	11,484	$58,612
27	12,446	$47,053
28	1,737	$83,562
29	3,431	$52,845
30	3,394	$34,653
31	1,089	$70,007
32	2,750	$40,258
33	3,263	$32,975
34	847	$63,533
35	2,388	$46,958
36	5,878	$40,732
37	5,356	$57,256
38	14,284	$36,845
39	46,412	$27,494
40	4,979	$65,484
41	7,598	$43,534
42	4,110	$37,791
52	1,391	$33,050
53	571	$22,196
54	6,584	$33,308
55	14,332	$28,187
56	10,308	$32,330
57	45,636	$21,051
58	869	$32,696
59	3,214	$24,364
60	3,702	$18,278
61	2,000	$59,701
62	2,944	$46,686
63	1,171	$41,282
64	63,659	$37,316
65	108,572	$29,516
66	71,747	$22,397
67	1,926	$32,924
68	11,692	$24,825
69	96,409	$20,405
70	10,189	$36,477
71	11,517	$28,259

MS-DRG	Number of Cases	Threshold
72	5,232	$21,046
73	10,681	$29,823
74	31,053	$22,361
75	1,287	$37,897
76	694	$23,662
77	1,632	$36,722
78	1,688	$26,558
79	862	$20,557
80	1,706	$28,226
81	5,753	$18,865
82	2,249	$38,342
83	2,381	$31,195
84	2,569	$23,039
85	7,108	$38,831
86	12,830	$29,408
87	12,297	$20,266
88	1,000	$33,319
89	2,949	$25,227
90	2,821	$19,387
91	9,861	$32,631
92	18,526	$23,203
93	14,820	$17,999
94	1,517	$60,986
95	1,163	$44,865
96	603	$39,791
97	1,317	$57,367
98	1,019	$39,130
99	508	$31,018
100	19,094	$31,854
101	55,560	$20,167
102	1,277	$26,479
103	12,792	$18,026
113	640	$38,414
114	462	$23,767
115	1,019	$29,742
116	532	$29,270
117	826	$18,459
121	752	$24,718
122	502	$16,035
123	2,794	$20,642
124	860	$27,900

MS-DRG	Number of Cases	Threshold
125	4,051	$17,572
129	1,521	$44,680
130	939	$32,961
131	989	$42,046
132	826	$30,729
133	2,161	$34,758
134	2,857	$22,176
135	385	$40,116
136	414	$25,091
137	839	$32,444
138	798	$20,224
139	1,441	$22,174
146	825	$39,709
147	1,474	$28,118
148	704	$18,711
149	35,070	$17,386
150	1,272	$28,093
151	6,133	$14,750
152	3,460	$24,044
153	16,897	$16,059
154	2,435	$31,085
155	5,504	$23,142
156	4,142	$16,627
157	1,414	$31,550
158	3,633	$23,578
159	1,885	$15,750
163	13,934	$86,870
164	18,517	$52,998
165	10,712	$42,119
166	24,135	$65,404
167	19,905	$43,689
168	4,947	$33,184
175	15,001	$36,991
176	36,290	$27,485
177	71,329	$40,618
178	72,866	$33,102
179	19,697	$25,265
180	22,810	$36,959
181	28,116	$29,894
182	3,624	$22,658
183	2,647	$33,467

MS-DRG	Number of Cases	Threshold
184	4,846	$24,630
185	2,217	$17,427
186	10,555	$35,013
187	10,193	$27,682
188	3,657	$20,141
189	129,179	$32,253
190	125,804	$29,849
191	138,603	$24,810
192	152,980	$18,644
193	103,110	$32,581
194	217,767	$25,507
195	105,641	$18,329
196	6,665	$34,135
197	6,890	$27,608
198	3,484	$21,389
199	3,757	$38,104
200	8,432	$25,132
201	2,979	$18,052
202	37,472	$21,725
203	34,621	$15,784
204	24,686	$18,264
205	6,810	$29,176
206	20,742	$19,694
207	38,118	$92,712
208	77,115	$46,552
215	138	$192,907
216	9,880	$176,157
217	6,447	$124,942
218	1,401	$107,207
219	12,500	$141,447
220	14,385	$102,694
221	4,929	$91,209
222	3,272	$160,712
223	4,418	$122,934
224	2,933	$145,134
225	4,763	$116,704
226	8,032	$120,892
227	33,159	$97,877
228	3,210	$137,181
229	3,325	$98,383
230	1,169	$80,454

MS-DRG	Number of Cases	Threshold
231	1,566	$156,429
232	1,256	$122,253
233	17,622	$130,953
234	27,918	$98,229
235	10,517	$104,999
236	25,885	$77,842
237	23,974	$92,344
238	39,313	$61,453
239	11,664	$69,066
240	10,718	$44,526
241	1,917	$32,866
242	20,888	$68,454
243	38,043	$55,198
244	50,838	$46,312
245	4,079	$78,560
246	30,411	$69,998
247	147,952	$51,473
248	19,736	$64,861
249	67,964	$47,447
250	8,184	$59,976
251	38,091	$45,167
252	44,196	$54,889
253	43,034	$49,408
254	44,467	$39,842
255	2,524	$44,271
256	3,032	$33,290
257	493	$23,340
258	829	$55,695
259	6,169	$40,167
260	1,763	$56,927
261	3,844	$33,633
262	2,818	$27,572
263	563	$32,216
264	24,723	$43,871
265	2,093	$44,355
280	78,326	$37,838
281	50,932	$30,400
282	40,796	$23,085
283	15,365	$34,194
284	3,208	$22,535
285	1,782	$16,046

MS-DRG	Number of Cases	Threshold
286	29,351	$44,742
287	140,845	$31,560
288	3,008	$52,708
289	1,165	$38,612
290	299	$29,384
291	202,108	$32,028
292	207,580	$24,223
293	138,456	$17,654
294	1,558	$24,579
295	1,012	$14,868
296	2,158	$29,818
297	721	$19,111
298	476	$12,936
299	23,052	$30,920
300	45,558	$22,596
301	31,295	$15,992
302	8,576	$25,387
303	58,979	$15,820
304	2,704	$27,043
305	31,624	$16,270
306	2,531	$29,116
307	5,817	$19,647
308	56,369	$29,349
309	92,446	$21,355
310	136,366	$15,302
311	18,509	$14,403
312	163,512	$19,476
313	187,903	$15,879
314	65,724	$34,119
315	30,253	$24,606
316	15,094	$16,812
326	11,455	$94,114
327	10,124	$53,367
328	7,997	$35,159
329	49,835	$87,733
330	60,038	$51,510
331	25,381	$38,799
332	1,999	$82,264
333	5,637	$50,557
334	3,306	$38,022
335	7,885	$75,101

MS-DRG	Number of Cases	Threshold
336	12,356	$48,223
337	7,787	$36,323
338	1,610	$62,625
339	3,077	$43,726
340	3,324	$32,810
341	991	$47,761
342	2,722	$35,907
343	6,674	$26,294
344	1,004	$57,431
345	2,955	$37,397
346	2,780	$29,277
347	1,626	$42,444
348	4,221	$31,962
349	4,416	$20,331
350	1,895	$46,267
351	4,428	$32,715
352	7,044	$21,873
353	3,646	$50,460
354	8,794	$35,594
355	13,646	$25,587
356	8,505	$67,098
357	7,508	$44,611
358	2,085	$33,806
368	3,735	$36,196
369	5,521	$27,556
370	2,222	$20,185
371	27,790	$36,408
372	28,853	$29,894
373	12,523	$21,164
374	9,731	$39,169
375	17,353	$30,149
376	3,102	$23,904
377	60,356	$34,408
378	123,093	$24,985
379	61,670	$18,619
380	3,316	$36,983
381	5,855	$28,390
382	3,184	$21,165
383	1,573	$31,871
384	7,276	$23,263
385	2,870	$35,753

MS-DRG	Number of Cases	Threshold
386	7,834	$27,516
387	4,285	$21,199
388	22,261	$32,903
389	48,548	$24,225
390	42,991	$17,129
391	49,223	$27,780
392	243,035	$19,259
393	24,676	$33,204
394	48,045	$25,167
395	21,085	$18,104
405	4,264	$90,749
406	5,198	$54,139
407	1,940	$40,819
408	1,579	$73,022
409	1,385	$49,923
410	494	$38,918
411	897	$75,504
412	865	$53,830
413	607	$40,610
414	5,219	$65,709
415	5,620	$44,582
416	4,525	$33,823
417	19,305	$51,952
418	25,675	$41,138
419	31,110	$31,502
420	797	$70,242
421	1,008	$39,161
422	247	$31,294
423	1,573	$72,609
424	790	$47,362
425	88	$37,290
432	14,494	$34,550
433	8,905	$24,409
434	582	$18,029
435	13,630	$37,223
436	12,090	$29,821
437	2,756	$25,102
438	17,093	$35,426
439	24,725	$27,440
440	20,936	$19,391
441	14,282	$34,067

MS-DRG	Number of Cases	Threshold
442	15,240	$24,134
443	5,392	$17,965
444	13,747	$34,506
445	17,233	$28,729
446	13,796	$20,917
453	1,103	$174,720
454	2,376	$123,877
455	2,020	$93,635
456	1,111	$152,525
457	2,826	$106,917
458	1,446	$89,234
459	4,130	$104,735
460	55,432	$71,412
461	990	$86,592
462	12,260	$66,400
463	5,234	$73,871
464	9,387	$49,927
465	3,238	$38,082
466	4,164	$80,215
467	17,434	$61,492
468	17,171	$52,579
469	33,437	$62,553
470	405,607	$47,203
471	2,762	$84,005
472	7,773	$56,855
473	23,363	$46,361
474	2,725	$56,688
475	3,450	$38,209
476	1,299	$26,054
477	2,908	$60,946
478	9,193	$47,475
479	9,268	$38,261
480	28,778	$56,402
481	75,926	$42,772
482	38,532	$36,612
483	9,156	$50,984
484	16,998	$44,108
485	1,106	$59,381
486	1,981	$45,620
487	1,096	$36,056
488	2,927	$37,795

MS-DRG	Number of Cases	Threshold
489	5,313	$29,696
490	23,821	$39,933
491	48,360	$25,460
492	5,867	$55,254
493	18,534	$41,217
494	26,815	$32,105
495	1,394	$52,081
496	4,662	$36,928
497	5,476	$27,045
498	1,330	$40,091
499	976	$22,908
500	1,791	$53,106
501	4,415	$35,126
502	5,864	$25,212
503	863	$43,157
504	2,363	$34,942
505	2,503	$26,368
506	725	$29,487
507	966	$40,261
508	2,043	$32,420
509	435	$30,513
510	1,183	$45,317
511	4,260	$35,259
512	9,343	$26,439
513	1,252	$31,417
514	1,014	$20,554
515	4,257	$56,763
516	11,688	$42,032
517	14,158	$34,610
533	863	$30,825
534	3,272	$16,944
535	8,149	$28,785
536	32,791	$16,530
537	838	$21,960
538	889	$14,522
539	2,724	$40,327
540	5,011	$30,416
541	1,457	$22,494
542	6,322	$37,556
543	16,638	$27,734
544	8,409	$18,768

MS-DRG	Number of Cases	Threshold
545	4,398	$38,721
546	5,591	$27,346
547	3,906	$19,238
548	639	$37,127
549	1,145	$28,303
550	600	$18,033
551	12,224	$33,103
552	78,714	$20,306
553	3,387	$26,682
554	17,367	$15,998
555	2,163	$24,276
556	16,208	$15,807
557	6,151	$32,965
558	16,353	$21,183
559	2,005	$32,838
560	5,078	$22,973
561	6,250	$14,590
562	6,665	$29,795
563	33,686	$16,574
564	1,861	$31,649
565	3,813	$22,875
566	2,157	$16,134
573	5,129	$50,184
574	10,013	$35,500
575	4,156	$26,619
576	604	$53,496
577	2,322	$36,047
578	2,806	$25,986
579	3,893	$48,755
580	10,376	$32,931
581	11,069	$23,619
582	5,398	$27,405
583	8,117	$21,470
584	777	$33,506
585	1,260	$23,632
592	5,008	$33,322
593	11,623	$24,271
594	1,978	$16,813
595	1,376	$33,018
596	4,982	$20,187
597	586	$33,426

MS-DRG	Number of Cases	Threshold
598	1,329	$26,732
599	246	$16,205
600	955	$23,588
601	844	$14,665
602	24,663	$30,530
603	129,540	$19,396
604	3,167	$28,239
605	20,019	$17,476
606	1,545	$26,540
607	6,551	$15,695
614	1,575	$51,060
615	1,442	$37,013
616	989	$72,737
617	6,847	$40,310
618	172	$30,517
619	799	$61,197
620	2,599	$42,735
621	9,718	$37,202
622	809	$56,713
623	3,190	$36,970
624	344	$24,840
625	1,341	$44,959
626	2,820	$30,681
627	13,010	$20,965
628	3,326	$58,361
629	4,419	$44,534
630	455	$34,328
637	21,119	$29,666
638	47,885	$20,408
639	29,351	$14,074
640	61,837	$26,179
641	187,535	$17,306
642	1,563	$25,190
643	6,566	$34,076
644	12,257	$26,452
645	7,099	$18,903
652	10,051	$65,257
653	1,843	$94,173
654	3,671	$58,871
655	1,336	$43,749

MS-DRG	Number of Cases	Threshold
656	4,444	$62,479
657	7,561	$43,379
658	7,243	$35,012
659	4,953	$55,968
660	7,085	$40,180
661	3,952	$34,109
662	954	$49,176
663	1,933	$32,638
664	3,709	$26,578
665	771	$52,802
666	2,122	$34,297
667	3,117	$19,813
668	4,635	$44,611
669	12,516	$31,520
670	10,021	$20,142
671	871	$33,060
672	765	$20,538
673	12,544	$49,469
674	10,170	$42,827
675	5,147	$35,939
682	97,609	$33,378
683	135,093	$26,095
684	33,583	$17,342
685	2,366	$21,566
686	1,953	$33,443
687	3,060	$27,399
688	921	$19,138
689	60,360	$28,647
690	201,231	$19,233
691	977	$36,073
692	416	$27,497
693	3,192	$29,801
694	16,029	$18,924
695	1,010	$27,728
696	9,929	$16,041
697	562	$21,291
698	26,265	$31,488
699	25,718	$23,792
700	10,193	$16,867

MS-DRG	Number of Cases	Threshold
707	5,784	$40,153
708	17,747	$32,659
709	787	$37,986
710	1,711	$32,491
711	757	$37,263
712	507	$20,275
713	10,501	$28,617
714	25,392	$16,607
715	523	$39,087
716	1,033	$31,967
717	790	$34,905
718	537	$20,367
722	846	$32,628
723	1,792	$25,510
724	386	$17,126
725	947	$25,634
726	3,285	$17,762
727	1,466	$29,739
728	5,687	$18,770
729	741	$24,092
730	343	$15,065
734	1,596	$47,632
735	1,032	$30,387
736	950	$78,786
737	3,230	$44,054
738	743	$30,874
739	1,074	$57,053
740	4,420	$36,863
741	5,510	$27,799
742	10,825	$33,800
743	29,288	$23,322
744	1,673	$33,461
745	1,389	$22,208
746	2,659	$31,510
747	8,067	$22,591
748	19,014	$23,182
749	1,018	$46,614
750	395	$27,294
754	1,267	$35,960

MS-DRG	Number of Cases	Threshold
755	3,125	$27,637
756	528	$15,945
757	1,533	$36,004
758	1,915	$28,040
759	1,238	$19,930
760	1,811	$20,574
761	1,317	$13,597
765	3,126	$21,732
766	2,802	$14,572
767	142	$17,038
768	9	$11,891
769	86	$33,943
770	225	$14,870
774	1,636	$13,499
775	5,854	$9,411
776	561	$16,686
777	232	$21,795
778	445	$8,995
779	130	$10,883
780	44	$4,578
781	3,131	$14,290
782	180	$10,164
799	613	$90,562
800	674	$52,275
801	399	$38,606
802	886	$59,164
803	1,136	$39,217
804	814	$28,065
808	7,551	$40,023
809	13,393	$29,014
810	2,471	$22,975
811	27,117	$28,383
812	90,161	$19,562
813	13,097	$29,175
814	1,861	$33,142
815	3,668	$26,057
816	1,821	$19,224
820	1,353	$94,053
821	2,170	$46,505

MS-DRG	Number of Cases	Threshold
822	1,836	$31,412
823	2,354	$70,989
824	2,894	$45,992
825	1,579	$32,091
826	637	$80,619
827	1,286	$43,898
828	785	$32,651
829	1,325	$48,035
830	399	$27,124
834	4,125	$61,184
835	2,720	$38,912
836	1,333	$26,699
837	1,196	$102,805
838	1,441	$51,422
839	1,413	$30,415
840	9,724	$47,089
841	9,715	$33,464
842	4,341	$26,430
843	1,795	$36,142
844	2,642	$29,323
845	586	$22,306
846	2,586	$41,124
847	22,609	$27,930
848	1,385	$23,861
849	1,077	$31,053
853	38,089	$87,932
854	8,081	$51,353
855	432	$38,209
856	5,807	$70,681
857	9,306	$39,504
858	2,623	$31,585
862	9,159	$36,211
863	21,321	$23,361
864	17,572	$21,559
865	2,846	$29,474
866	9,130	$17,839
867	5,370	$41,496
868	2,762	$26,618
869	953	$19,248

MS-DRG	Number of Cases	Threshold
870	24,761	$101,861
871	256,093	$37,529
872	90,163	$27,946
876	684	$44,843
880	8,529	$16,598
881	4,578	$12,659
882	1,690	$13,471
883	896	$20,508
884	19,075	$20,749
885	84,180	$16,352
886	500	$15,664
887	571	$19,686
894	4,259	$8,723
895	6,544	$17,041
896	6,711	$29,416
897	35,191	$14,348
901	916	$59,444
902	1,944	$35,555
903	1,109	$25,200
904	1,474	$46,836
905	824	$26,780
906	691	$25,655
907	8,699	$61,361
908	8,619	$38,872
909	4,982	$29,005
913	1,041	$29,499
914	5,773	$17,668
915	1,334	$27,623
916	5,203	$11,317
917	19,652	$31,737
918	34,844	$15,140
919	11,273	$32,248
920	14,556	$23,797
921	8,230	$15,851
922	1,257	$29,370
923	3,269	$16,721
927	167	$198,481
928	857	$70,289
929	416	$37,421

MS-DRG	Number of Cases	Threshold
933	153	$34,106
934	690	$26,303
935	2,055	$24,364
939	764	$49,642
940	1,674	$35,978
941	1,719	$30,016
945	6,545	$20,406
946	3,005	$18,303
947	12,021	$26,925
948	52,796	$17,145
949	704	$22,198
950	296	$12,931
951	903	$16,292
955	485	$99,368
956	4,236	$61,532
957	1,519	$109,966
958	1,177	$70,154
959	230	$48,186
963	1,892	$51,667
964	2,803	$34,923
965	961	$25,958
969	633	$85,466
970	122	$49,879
974	6,060	$43,046
975	4,375	$30,641
976	1,933	$23,242
977	3,968	$26,193
981	29,313	$83,522
982	19,558	$55,385
983	5,621	$39,862
984	752	$62,197
985	909	$41,143
986	539	$28,495
987	8,729	$57,948
988	10,785	$38,696
989	4,639	$27,294
999	26	$21,513

[1]Cases taken from the FY 2008 MedPAR file; MS-DRGs are from GROUPER Version 27.0.

TABLE 11.—MS-LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND SHORT-STAY OUTLIER (SSO) THRESHOLD FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2010 UNDER THE LTCH PPS

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
1	1	Heart transplant or implant of heart assist system w MCC	0	0.0000	0.0	0.0
2	1	Heart transplant or implant of heart assist system w/o MCC	0	0.0000	0.0	0.0
3	3	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	290	4.5834	65.2	54.3
4	4	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	1,401	3.1040	45.3	37.8
5	5	Liver transplant w MCC or intestinal transplant	0	0.0000	0.0	0.0
6	5	Liver transplant w/o MCC	0	0.0000	0.0	0.0
7	7	Lung transplant	0	0.0000	0.0	0.0
8	8	Simultaneous pancreas/kidney transplant	0	0.0000	0.0	0.0
9	9	Bone marrow transplant	0	1.6608	37.7	31.4
10	10	Pancreas transplant	0	0.0000	0.0	0.0
11	11	Tracheostomy for face,mouth & neck diagnoses w MCC*	2	1.6608	37.7	31.4
12	11	Tracheostomy for face,mouth & neck diagnoses w CC*	0	1.1636	24.1	20.1
13	11	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC*	0	1.1636	24.1	20.1
20	20	Intracranial vascular procedures w PDX hemorrhage w MCC	0	1.6608	37.7	31.4
21	20	Intracranial vascular procedures w PDX hemorrhage w CC	0	0.6392	21.6	18.0
22	20	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	0	0.6392	21.6	18.0
23	23	Craniotomy w major device implant or acute complex CNS PDX w MCC*	1	0.7552	24.0	20.0
24	23	Craniotomy w major device implant or acute complex CNS PDX w/o MCC*	0	0.7552	24.0	20.0
25	25	Craniotomy & endovascular intracranial procedures w MCC*	3	1.6608	37.7	31.4
26	25	Craniotomy & endovascular intracranial procedures w CC*	1	0.4766	19.2	16.0
27	25	Craniotomy & endovascular intracranial procedures w/o CC/MCC*	0	0.4766	19.2	16.0
28	28	Spinal procedures w MCC	16	1.0933	26.6	22.2
29	28	Spinal procedures w CC	12	0.7552	24.0	20.0
30	28	Spinal procedures w/o CC/MCC	1	0.7552	24.0	20.0
31	31	Ventricular shunt procedures w MCC	4	1.6608	37.7	31.4
32	31	Ventricular shunt procedures w CC	2	0.6392	21.6	18.0
33	31	Ventricular shunt procedures w/o CC/MCC	1	0.6392	21.6	18.0
34	34	Carotid artery stent procedure w MCC	0	1.6608	37.7	31.4
35	34	Carotid artery stent procedurew CC	0	1.6608	37.7	31.4
36	34	Carotid artery stent procedure w/o CC/MCC	0	1.6608	37.7	31.4
37	37	Extracranial procedures w MCC	17	1.6608	37.7	31.4
38	37	Extracranial procedures w CC	4	1.6608	37.7	31.4
39	37	Extracranial procedures w/o CC/MCC	0	1.6608	37.7	31.4
40	40	Periph & cranial nerve & other nerv syst proc w MCC	122	1.4187	35.4	29.5
41	40	Periph & cranial nerve & other nerv syst proc w CC	91	0.9739	30.4	25.3
42	40	Periph & cranial nerve & other nerv syst proc w/o CC/MCC	6	0.6392	21.6	18.0
52	52	Spinal disorders & injuries w CC/MCC	88	1.0309	33.9	28.3
53	52	Spinal disorders & injuries w/o CC/MCC	8	0.4766	19.2	16.0
54	54	Nervous system neoplasms w MCC	38	0.9120	23.0	19.2
55	54	Nervous system neoplasms w/o MCC	37	0.7390	23.0	19.2
56	56	Degenerative nervous system disorders w MCC	1,136	0.7871	25.8	21.5
57	56	Degenerative nervous system disorders w/o MCC	1,443	0.5845	24.0	20.0
58	58	Multiple sclerosis & cerebellar ataxia w MCC	14	0.7552	24.0	20.0
59	58	Multiple sclerosis & cerebellar ataxia w CC	31	0.5813	21.5	17.9
60	58	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	4	0.4766	19.2	16.0
61	61	Acute ischemic stroke w use of thrombolytic agent w MCC	0	0.8439	25.4	21.2
62	61	Acute ischemic stroke w use of thrombolytic agent w CC	0	0.6614	24.1	20.1
63	61	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	0	0.4766	19.2	16.0
64	64	Intracranial hemorrhage or cerebral infarction w MCC	152	0.8839	24.6	20.5
65	64	Intracranial hemorrhage or cerebral infarction w CC	63	0.5549	23.6	19.7
66	64	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	8	0.4766	19.2	16.0
67	67	Nonspecific cva & precerebral occlusion w/o infarct w MCC	3	0.6392	21.6	18.0
68	67	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC	2	0.4766	19.2	16.0
69	69	Transient ischemia	7	0.4766	19.2	16.0
70	70	Nonspecific cerebrovascular disorders w MCC	140	0.8439	25.4	21.2
71	70	Nonspecific cerebrovascular disorders w CC	76	0.6614	24.1	20.1
72	70	Nonspecific cerebrovascular disorders w/o CC/MCC	8	0.4766	19.2	16.0
73	73	Cranial & peripheral nerve disorders w MCC	102	0.9626	26.8	22.3
74	73	Cranial & peripheral nerve disorders w/o MCC	129	0.5916	23.8	19.8
75	75	Viral meningitis w CC/MCC	19	0.7552	24.0	20.0
76	75	Viral meningitis w/o CC/MCC	0	0.7552	24.0	20.0
77	77	Hypertensive encephalopathy w MCC	2	1.0933	26.6	22.2
78	77	Hypertensive encephalopathy w CC	1	0.4766	19.2	16.0
79	77	Hypertensive encephalopathy w/o CC/MCC	0	0.4536	18.9	15.8
80	80	Nontraumatic stupor & coma w MCC	23	0.6392	21.6	18.0
81	80	Nontraumatic stupor & coma w/o MCC	11	0.4766	19.2	16.0
82	82	Traumatic stupor & coma, coma >1 hr w MCC	11	1.0933	26.6	22.2
83	82	Traumatic stupor & coma, coma >1 hr w CC	8	0.7552	24.0	20.0
84	82	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	2	0.7552	24.0	20.0
85	85	Traumatic stupor & coma, coma <1 hr w MCC	99	0.8570	24.6	20.5
86	85	Traumatic stupor & coma, coma <1 hr w CC	79	0.6217	23.8	19.8
87	85	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	18	0.6217	23.8	19.8
88	88	Concussion w MCC	2	0.6392	21.6	18.0
89	88	Concussion w CC	2	0.4766	19.2	16.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
90	88	Concussion w/o CC/MCC	1	0.4766	19.2	16.0
91	91	Other disorders of nervous system w MCC	230	0.8424	23.8	19.8
92	91	Other disorders of nervous system w CC	101	0.6400	22.8	19.0
93	91	Other disorders of nervous system w/o CC/MCC	12	0.4766	19.2	16.0
94	94	Bacterial & tuberculous infections of nervous system w MCC	256	1.0229	27.7	23.1
95	94	Bacterial & tuberculous infections of nervous system w CC	99	0.8058	27.1	22.6
96	94	Bacterial & tuberculous infections of nervous system w/o CC/MCC	16	0.6392	21.6	18.0
97	97	Non-bacterial infect of nervous sys exc viral meningitis w MCC	51	0.8945	22.1	18.4
98	97	Non-bacterial infect of nervous sys exc viral meningitis w CC	29	0.7561	21.6	18.0
99	97	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC	3	0.7561	21.6	18.0
100	100	Seizures w MCC	52	0.9450	25.9	21.6
101	100	Seizures w/o MCC	28	0.6297	23.8	19.8
102	102	Headaches w MCC	5	0.6392	21.6	18.0
103	102	Headaches w/o MCC	4	0.4766	19.2	16.0
113	113	Orbital procedures w CC/MCC	0	1.1636	24.1	20.1
114	113	Orbital procedures w/o CC/MCC	0	0.9756	25.5	21.3
115	115	Extraocular procedures except orbit	1	0.4766	19.2	16.0
116	116	Intraocular procedures w CC/MCC	0	0.6392	21.6	18.0
117	116	Intraocular procedures w/o CC/MCC	0	0.6392	21.6	18.0
121	121	Acute major eye infections w CC/MCC	5	0.7552	24.0	20.0
122	121	Acute major eye infections w/o CC/MCC	0	0.6392	21.6	18.0
123	123	Neurological eye disorders	0	0.6392	21.6	18.0
124	124	Other disorders of the eye w MCC	4	0.7552	24.0	20.0
125	124	Other disorders of the eye w/o MCC	11	0.6392	21.6	18.0
129	129	Major head & neck procedures w CC/MCC or major device	0	1.1636	24.1	20.1
130	129	Major head & neck procedures w/o CC/MCC	0	0.9756	25.5	21.3
131	131	Cranial/facial procedures w CC/MCC	1	1.0933	26.6	22.2
132	131	Cranial/facial procedures w/o CC/MCC	0	1.0933	26.6	22.2
133	133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC	9	1.0933	26.6	22.2
134	133	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	0	1.0933	26.6	22.2
135	135	Sinus & mastoid procedures w CC/MCC	3	1.6608	37.7	31.4
136	135	Sinus & mastoid procedures w/o CC/MCC	0	1.0933	26.6	22.2
137	137	Mouth procedures w CC/MCC	0	1.0933	26.6	22.2
138	137	Mouth procedures w/o CC/MCC	0	1.0933	26.6	22.2
139	139	Salivary gland procedures	1	0.4766	19.2	16.0
146	146	Ear, nose, mouth & throat malignancy w MCC	50	1.1636	24.1	20.1
147	146	Ear, nose, mouth & throat malignancy w CC	29	0.9756	25.5	21.3
148	146	Ear, nose, mouth & throat malignancy w/o CC/MCC	3	0.9756	25.5	21.3
149	149	Dysequilibrium	8	0.4766	19.2	16.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
150	150	Epistaxis w MCC	0	0.7298	21.3	17.8
151	150	Epistaxis w/o MCC	0	0.6312	20.5	17.1
152	152	Otitis media & URI w MCC	29	0.7298	21.3	17.8
153	152	Otitis media & URI w/o MCC	30	0.6312	20.5	17.1
154	154	Nasal trauma & deformity w MCC	53	0.9197	23.9	19.9
155	154	Nasal trauma & deformity w CC	33	0.6209	20.6	17.2
156	154	Nasal trauma & deformity w/o CC/MCC	9	0.6209	20.6	17.2
157	157	Dental & Oral Diseases w MCC	15	1.0933	26.6	22.2
158	157	Dental & Oral Diseases w CC	17	0.7552	24.0	20.0
159	157	Dental & Oral Diseases w/o CC/MCC	6	0.6392	21.6	18.0
163	163	Major chest procedures w MCC	33	2.4859	40.7	33.9
164	163	Major chest procedures w CC	6	1.6608	37.7	31.4
165	163	Major chest procedures w/o CC/MCC	0	1.0759	29.5	24.6
166	166	Other resp system O.R. procedures w MCC	1,514	2.4805	42.5	35.4
167	166	Other resp system O.R. procedures w CC	295	1.9175	38.6	32.2
168	166	Other resp system O.R. procedures w/o CC/MCC	9	1.0933	26.6	22.2
175	175	Pulmonary embolism w MCC	149	0.7868	23.5	19.6
176	175	Pulmonary embolism w/o MCC	112	0.5673	20.4	17.0
177	177	Respiratory infections & inflammations w MCC	3,546	0.8920	23.4	19.5
178	177	Respiratory infections & inflammations w CC	2,219	0.7253	21.7	18.1
179	177	Respiratory infections & inflammations w/o CC/MCC	232	0.5766	18.7	15.6
180	180	Respiratory neoplasms w MCC	126	0.7830	19.8	16.5
181	180	Respiratory neoplasms w CC	82	0.6242	19.0	15.8
182	180	Respiratory neoplasms w/o CC/MCC	10	0.6242	19.0	15.8
183	183	Major chest trauma w MCC*	3	0.6392	21.6	18.0
184	183	Major chest trauma w CC*	1	0.4766	19.2	16.0
185	183	Major chest trauma w/o CC/MCC*	0	0.4766	19.2	16.0
186	186	Pleural effusion w MCC	167	0.7925	21.8	18.2
187	186	Pleural effusion w CC	46	0.6618	21.6	18.0
188	186	Pleural effusion w/o CC/MCC	7	0.6392	24.0	20.0
189	189	Pulmonary edema & respiratory failure	7,670	0.9707	23.9	19.9
190	190	Chronic obstructive pulmonary disease w MCC	2,220	0.7228	20.4	17.0
191	190	Chronic obstructive pulmonary disease w CC	1,309	0.6086	18.9	15.8
192	190	Chronic obstructive pulmonary disease w/o CC/MCC	431	0.4782	16.3	13.6
193	193	Simple pneumonia & pleurisy w MCC	2,124	0.7654	21.2	17.7
194	193	Simple pneumonia & pleurisy w CC	1,787	0.5977	19.5	16.3
195	193	Simple pneumonia & pleurisy w/o CC/MCC	258	0.5038	16.9	14.1
196	196	Interstitial lung disease w MCC	105	0.7417	21.7	18.1
197	196	Interstitial lung disease w CC	70	0.5648	17.7	14.8
198	196	Interstitial lung disease w/o CC/MCC	13	0.4766	19.2	16.0
199	199	Pneumothorax w MCC	57	0.7829	20.7	17.3
200	199	Pneumothorax w CC	29	0.6045	18.5	15.4
201	199	Pneumothorax w/o CC/MCC	5	0.4766	19.2	16.0
202	202	Bronchitis & asthma w CC/MCC	125	0.6467	20.6	17.2
203	202	Bronchitis & asthma w/o CC/MCC	16	0.4766	19.2	16.0
204	204	Respiratory signs & symptoms	159	0.8262	22.9	19.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
205	205	Other respiratory system diagnoses w MCC	397	0.8527	22.5	18.8
206	205	Other respiratory system diagnoses w/o MCC	151	0.6627	20.8	17.3
207	207	Respiratory system diagnosis w ventilator support 96+ hours	14,440	2.0288	33.8	28.2
208	208	Respiratory system diagnosis w ventilator support <96 hours	1,647	1.1475	22.9	19.1
215	215	Other heart assist system implant	0	1.0759	29.5	24.6
216	216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC*	0	1.0933	26.6	22.2
217	216	Cardiac valve & oth maj cardiothoracic proc w card cath w CC*	0	1.0759	29.5	24.6
218	216	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC*	0	1.0759	29.5	24.6
219	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC*	0	1.0933	26.6	22.2
220	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC*	0	1.0759	29.5	24.6
221	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC*	0	1.0759	29.5	24.6
222	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	1	1.6608	37.7	31.4
223	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	0	1.0933	26.6	22.2
224	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	0	1.6608	37.7	31.4
225	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	0	1.0933	26.6	22.2
226	226	Cardiac defibrillator implant w/o cardiac cath w MCC	11	1.6608	37.7	31.4
227	226	Cardiac defibrillator implant w/o cardiac cath w/o MCC	2	1.6608	37.7	31.4
228	228	Other cardiothoracic procedures w MCC	0	1.4677	31.6	26.3
229	228	Other cardiothoracic procedures w CC	0	1.0759	29.5	24.6
230	228	Other cardiothoracic procedures w/o CC/MCC	0	1.0759	29.5	24.6
231	231	Coronary bypass w PTCA w MCC	0	1.0933	26.6	22.2
232	231	Coronary bypass w PTCA w/o MCC	0	1.0759	29.5	24.6
233	233	Coronary bypass w cardiac cath w MCC	0	1.0933	26.6	22.2
234	233	Coronary bypass w cardiac cath w/o MCC	0	1.0759	29.5	24.6
235	235	Coronary bypass w/o cardiac cath w MCC	0	1.0933	26.6	22.2
236	235	Coronary bypass w/o cardiac cath w/o MCC	0	1.0759	29.5	24.6
237	237	Major cardiovascular procedures w MCC	2	1.0933	26.6	22.2
238	237	Major cardiovascular procedures w/o MCC	0	1.0759	29.5	24.6
239	239	Amputation for circ sys disorders exc upper limb & toe w MCC	137	1.5489	39.1	32.6
240	239	Amputation for circ sys disorders exc upper limb & toe w CC	59	1.1037	34.3	28.6
241	239	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	3	0.7552	24.0	20.0
242	242	Permanent cardiac pacemaker implant w MCC	6	1.6608	37.7	31.4
243	242	Permanent cardiac pacemaker implant w CC	7	1.0933	26.6	22.2
244	242	Permanent cardiac pacemaker implant w/o CC/MCC	3	1.0933	26.6	22.2
245	245	AICD generator procedures	1	1.6608	37.7	31.4
246	246	Percutaneous cardiovascular proc w drug-eluting stent w MCC	0	1.4677	31.6	26.3
247	246	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC	0	1.0759	29.5	24.6
248	248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC	0	1.4677	31.6	26.3
249	248	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC	0	1.0759	29.5	24.6
250	250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	4	1.6608	37.7	31.4
251	250	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	0	1.6608	37.7	31.4
252	252	Other vascular procedures w MCC	132	1.4677	31.6	26.3
253	252	Other vascular procedures w CC	57	1.0759	29.5	24.6
254	252	Other vascular procedures w/o CC/MCC	1	1.0759	29.5	24.6
255	255	Upper limb & toe amputation for circ system disorders w MCC	46	1.2906	34.3	28.6
256	255	Upper limb & toe amputation for circ system disorders w CC	29	0.9007	28.1	23.4
257	255	Upper limb & toe amputation for circ system disorders w/o CC/MCC	2	0.6392	21.6	18.0
258	258	Cardiac pacemaker device replacement w MCC	0	0.6392	21.6	18.0
259	258	Cardiac pacemaker device replacement w/o MCC	1	0.6392	21.6	18.0
260	260	Cardiac pacemaker revision except device replacement w MCC	6	1.6608	37.7	31.4
261	260	Cardiac pacemaker revision except device replacement w CC	0	0.6392	21.6	18.0
262	260	Cardiac pacemaker revision except device replacement w/o CC/MCC	0	0.6392	21.6	18.0
263	263	Vein ligation & stripping	0	0.4497	19.2	16.0
264	264	Other circulatory system O.R. procedures	542	1.0418	30.9	25.8
265	265	AICD lead procedures	0	0.6392	21.6	18.0
280	280	Circulatory disorders w AMI, discharged alive w MCC	264	0.7487	22.3	18.6
281	280	Circulatory disorders w AMI, discharged alive w CC	114	0.5579	19.7	16.4
282	280	Circulatory disorders w AMI, discharged alive w/o CC/MCC	24	0.5579	19.7	16.4
283	283	Circulatory disorders w AMI, expired w MCC	40	0.9575	19.6	16.3
284	283	Circulatory disorders w AMI, expired w CC	9	0.6392	21.6	18.0
285	283	Circulatory disorders w AMI, expired w/o CC/MCC	2	0.6392	21.6	18.0
286	286	Circulatory disorders except AMI, w card cath w MCC	10	1.0933	26.6	22.2
287	286	Circulatory disorders except AMI, w card cath w/o MCC	5	1.0933	26.6	22.2
288	288	Acute & subacute endocarditis w MCC	638	0.9920	26.2	21.8
289	288	Acute & subacute endocarditis w CC	206	0.8048	26.8	22.3
290	288	Acute & subacute endocarditis w/o CC/MCC	21	0.7552	24.0	20.0
291	291	Heart failure & shock w MCC	1,430	0.7390	21.5	17.9
292	291	Heart failure & shock w CC	734	0.5980	20.1	16.8
293	291	Heart failure & shock w/o CC/MCC	153	0.5294	18.8	15.7
294	294	Deep vein thrombophlebitis w CC/MCC	5	0.6392	21.6	18.0
295	294	Deep vein thrombophlebitis w/o CC/MCC	0	0.6392	21.6	18.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
296	296	Cardiac arrest, unexplained w MCC	0	0.9575	19.6	16.3
297	296	Cardiac arrest, unexplained w CC	0	0.6392	21.6	18.0
298	296	Cardiac arrest, unexplained w/o CC/MCC	0	0.6392	21.6	18.0
299	299	Peripheral vascular disorders w MCC	672	0.7874	23.6	19.7
300	299	Peripheral vascular disorders w CC	774	0.5919	22.3	18.6
301	299	Peripheral vascular disorders w/o CC/MCC	61	0.4497	19.2	16.0
302	302	Atherosclerosis w MCC	30	0.7104	22.8	19.0
303	302	Atherosclerosis w/o MCC	25	0.4330	17.3	14.4
304	304	Hypertension w MCC	9	1.0933	26.6	22.2
305	304	Hypertension w/o MCC	27	0.4536	18.9	15.8
306	306	Cardiac congenital & valvular disorders w MCC	73	0.7982	21.7	18.1
307	306	Cardiac congenital & valvular disorders w/o MCC	36	0.7500	25.6	21.3
308	308	Cardiac arrhythmia & conduction disorders w MCC	115	0.7349	22.8	19.0
309	308	Cardiac arrhythmia & conduction disorders w CC	85	0.5777	20.6	17.2
310	308	Cardiac arrhythmia & conduction disorders w/o CC/MCC	23	0.4766	19.2	16.0
311	311	Angina pectoris	4	0.6392	21.6	18.0
312	312	Syncope & collapse	38	0.4661	19.1	15.9
313	313	Chest pain	2	0.4766	19.2	16.0
314	314	Other circulatory system diagnoses w MCC	1,366	0.8918	23.5	19.6
315	314	Other circulatory system diagnoses w CC	278	0.6180	21.3	17.8
316	314	Other circulatory system diagnoses w/o CC/MCC	45	0.5117	18.5	15.4
326	326	Stomach, esophageal & duodenal proc w MCC	24	1.6608	37.7	31.4
327	326	Stomach, esophageal & duodenal proc w CC	6	0.7552	24.0	20.0
328	326	Stomach, esophageal & duodenal proc w/o CC/MCC	0	0.7552	24.0	20.0
329	329	Major small & large bowel procedures w MCC	35	2.2203	39.6	33.0
330	329	Major small & large bowel procedures w CC	14	1.6608	37.7	31.4
331	329	Major small & large bowel procedures w/o CC/MCC	1	0.7552	24.0	20.0
332	332	Rectal resection w MCC	0	1.6999	37.1	30.9
333	332	Rectal resection w CC	0	1.2902	33.5	27.9
334	332	Rectal resection w/o CC/MCC	0	1.2902	33.5	27.9
335	335	Peritoneal adhesiolysis w MCC	6	1.6608	37.7	31.4
336	335	Peritoneal adhesiolysis w CC	0	1.6608	37.7	31.4
337	335	Peritoneal adhesiolysis w/o CC/MCC	0	1.6608	37.7	31.4
338	338	Appendectomy w complicated principal diag w MCC	1	1.0933	26.6	22.2
339	338	Appendectomy w complicated principal diag w CC	0	0.7081	22.5	18.8
340	338	Appendectomy w complicated principal diag w/o CC/MCC	0	0.5434	19.1	15.9
341	341	Appendectomy w/o complicated principal diag w MCC	0	0.9458	24.5	20.4
342	341	Appendectomy w/o complicated principal diag w CC	0	0.7081	22.5	18.8
343	341	Appendectomy w/o complicated principal diag w/o CC/MCC	0	0.5434	19.1	15.9
344	344	Minor small & large bowel procedures w MCC	1	1.0933	26.6	22.2
345	344	Minor small & large bowel procedures w CC	0	1.0933	26.6	22.2
346	344	Minor small & large bowel procedures w/o CC/MCC	0	1.0933	26.6	22.2
347	347	Anal & stomal procedures w MCC	5	1.0933	26.6	22.2
348	347	Anal & stomal procedures w CC	2	0.7552	24.0	20.0
349	347	Anal & stomal procedures w/o CC/MCC	0	0.7552	24.0	20.0
350	350	Inguinal & femoral hernia procedures w MCC*	1	0.4766	19.2	16.0
351	350	Inguinal & femoral hernia procedures w CC*	0	0.4766	19.2	16.0
352	350	Inguinal & femoral hernia procedures w/o CC/MCC*	0	0.4766	19.2	16.0
353	353	Hernia procedures except inguinal & femoral w MCC	1	1.0933	26.6	22.2
354	353	Hernia procedures except inguinal & femoral w CC	1	1.0933	26.6	22.2
355	353	Hernia procedures except inguinal & femoral w/o CC/MCC	0	1.0933	26.6	22.2
356	356	Other digestive system O.R. procedures w MCC	118	1.6999	37.1	30.9
357	356	Other digestive system O.R. procedures w CC	46	1.2902	33.5	27.9
358	356	Other digestive system O.R. procedures w/o CC/MCC	0	1.2902	33.5	27.9
368	368	Major esophageal disorders w MCC	34	0.9890	26.3	21.9
369	368	Major esophageal disorders w CC	13	0.9890	26.3	21.9
370	368	Major esophageal disorders w/o CC/MCC	1	0.4766	19.2	16.0
371	371	Major gastrointestinal disorders & peritoneal infections w MCC	840	0.9458	24.5	20.4
372	371	Major gastrointestinal disorders & peritoneal infections w CC	365	0.7081	22.5	18.8
373	371	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	37	0.5434	19.1	15.9
374	374	Digestive malignancy w MCC	109	1.0220	25.0	20.8
375	374	Digestive malignancy w CC	61	0.6836	21.9	18.3
376	374	Digestive malignancy w/o CC/MCC	4	0.4766	19.2	16.0
377	377	G.I. hemorrhage w MCC	76	0.9713	24.3	20.3
378	377	G.I. hemorrhage w CC	41	0.5877	20.1	16.8
379	377	G.I. hemorrhage w/o CC/MCC	8	0.5877	20.1	16.8
380	380	Complicated peptic ulcer w MCC	16	1.0933	26.6	22.2
381	380	Complicated peptic ulcer w CC	17	0.7552	24.0	20.0
382	380	Complicated peptic ulcer w/o CC/MCC	1	0.7552	24.0	20.0
383	383	Uncomplicated peptic ulcer w MCC	8	0.7552	24.0	20.0
384	383	Uncomplicated peptic ulcer w/o MCC	5	0.6392	21.6	18.0
385	385	Inflammatory bowel disease w MCC	31	1.2583	26.8	22.3
386	385	Inflammatory bowel disease w CC	19	0.6392	21.6	18.0
387	385	Inflammatory bowel disease w/o CC/MCC	2	0.4766	19.2	16.0
388	388	G.I. obstruction w MCC	181	1.0107	23.9	19.9
389	388	G.I. obstruction w CC	96	0.7201	21.1	17.6
390	388	G.I. obstruction w/o CC/MCC	14	0.6392	21.6	18.0
391	391	Esophagitis, gastroent & misc digest disorders w MCC	369	0.8782	23.4	19.5
392	391	Esophagitis, gastroent & misc digest disorders w/o MCC	239	0.6273	21.1	17.6
393	393	Other digestive system diagnoses w MCC	840	1.0940	27.1	22.6
394	393	Other digestive system diagnoses w CC	446	0.7549	23.0	19.2
395	393	Other digestive system diagnoses w/o CC/MCC	39	0.6000	19.8	16.5
405	405	Pancreas, liver & shunt procedures w MCC	10	1.6608	37.7	31.4
406	405	Pancreas, liver & shunt procedures w CC	4	1.6608	37.7	31.4
407	405	Pancreas, liver & shunt procedures w/o CC/MCC	0	1.6608	37.7	31.4
408	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	0	0.7552	24.0	20.0
409	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	0	0.7552	24.0	20.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
410	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	0	0.7552	24.0	20.0
411	411	Cholecystectomy w c.d.e. w MCC	0	0.6392	21.6	18.0
412	411	Cholecystectomy w c.d.e. w CC	0	0.6392	21.6	18.0
413	411	Cholecystectomy w c.d.e. w/o CC/MCC	0	0.6392	21.6	18.0
414	414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	6	1.6608	37.7	31.4
415	414	Cholecystectomy except by laparoscope w/o c.d.e. w CC	0	0.6392	21.6	18.0
416	414	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	0	0.6392	21.6	18.0
417	417	Laparoscopic cholecystectomy w/o c.d.e. w MCC	9	1.6608	37.7	31.4
418	417	Laparoscopic cholecystectomy w/o c.d.e. w CC	2	0.6392	21.6	18.0
419	417	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	0	0.6392	21.6	18.0
420	420	Hepatobiliary diagnostic procedures w MCC	2	1.6608	37.7	31.4
421	420	Hepatobiliary diagnostic procedures w CC	0	0.7552	24.0	20.0
422	420	Hepatobiliary diagnostic procedures w/o CC/MCC	0	0.7552	24.0	20.0
423	423	Other hepatobiliary or pancreas O.R. procedures w MCC	18	1.0933	26.6	22.2
424	423	Other hepatobiliary or pancreas O.R. procedures w CC	4	0.7552	24.0	20.0
425	423	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	0	0.7552	24.0	20.0
432	432	Cirrhosis & alcoholic hepatitis w MCC	66	0.6883	19.9	16.6
433	432	Cirrhosis & alcoholic hepatitis w CC	22	0.6392	21.6	18.0
434	432	Cirrhosis & alcoholic hepatitis w/o CC/MCC	0	0.6392	21.6	18.0
435	435	Malignancy of hepatobiliary system or pancreas w MCC	33	0.7643	21.2	17.7
436	435	Malignancy of hepatobiliary system or pancreas w CC	22	0.6392	21.6	18.0
437	435	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	2	0.4766	19.2	16.0
438	438	Disorders of pancreas except malignancy w MCC	315	1.0684	24.5	20.4
439	438	Disorders of pancreas except malignancy w CC	126	0.8237	20.7	17.3
440	438	Disorders of pancreas except malignancy w/o CC/MCC	12	0.4766	19.2	16.0
441	441	Disorders of liver except malig,cirr,alc hepa w MCC	168	0.8154	22.0	18.3
442	441	Disorders of liver except malig,cirr,alc hepa w CC	69	0.6446	22.1	18.4
443	441	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC	8	0.4766	19.2	16.0
444	444	Disorders of the biliary tract w MCC	117	0.8346	22.6	18.8
445	444	Disorders of the biliary tract w CC	47	0.5926	21.0	17.5
446	444	Disorders of the biliary tract w/o CC/MCC	9	0.4766	19.2	16.0
453	453	Combined anterior/posterior spinal fusion w MCC	2	1.6608	37.7	31.4
454	453	Combined anterior/posterior spinal fusion w CC	1	1.6608	37.7	31.4
455	453	Combined anterior/posterior spinal fusion w/o CC/MCC	0	1.6608	37.7	31.4
456	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC	1	1.6608	37.7	31.4
457	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC	1	1.6608	37.7	31.4
458	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC	0	1.6608	37.7	31.4
459	459	Spinal fusion except cervical w MCC	3	1.6608	37.7	31.4
460	459	Spinal fusion except cervical w/o MCC	0	1.6608	37.7	31.4
461	461	Bilateral or multiple major joint procs of lower extremity w MCC	0	1.6608	37.7	31.4
462	461	Bilateral or multiple major joint procs of lower extremity w/o MCC	0	1.6608	37.7	31.4
463	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	582	1.4511	38.7	32.3
464	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	556	1.1279	36.3	30.3
465	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	61	0.9286	32.7	27.3
466	466	Revision of hip or knee replacement w MCC	5	1.6608	37.7	31.4
467	466	Revision of hip or knee replacement w CC	6	1.6608	37.7	31.4
468	466	Revision of hip or knee replacement w/o CC/MCC	0	1.6608	37.7	31.4
469	469	Major joint replacement or reattachment of lower extremity w MCC	1	1.6608	37.7	31.4
470	469	Major joint replacement or reattachment of lower extremity w/o MCC	3	1.6608	37.7	31.4
471	471	Cervical spinal fusion w MCC	3	1.0933	26.6	22.2
472	471	Cervical spinal fusion w CC	2	0.7552	24.0	20.0
473	471	Cervical spinal fusion w/o CC/MCC	0	0.7552	24.0	20.0
474	474	Amputation for musculoskeletal sys & conn tissue dis w MCC	88	1.3506	35.8	29.8
475	474	Amputation for musculoskeletal sys & conn tissue dis w CC	70	1.0702	32.4	27.0
476	474	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	4	0.7552	24.0	20.0
477	477	Biopsies of musculoskeletal system & connective tissue w MCC	34	1.3553	35.4	29.5
478	477	Biopsies of musculoskeletal system & connective tissue w CC	27	1.3040	39.1	32.6
479	477	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	3	0.6392	21.6	18.0
480	480	Hip & femur procedures except major joint w MCC	13	1.6608	37.7	31.4
481	480	Hip & femur procedures except major joint w CC	8	1.6608	37.7	31.4
482	480	Hip & femur procedures except major joint w/o CC/MCC	0	1.6608	37.7	31.4
483	483	Major joint & limb reattachment proc of upper extremity w CC/MCC	0	1.6608	37.7	31.4
484	483	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	0	1.6608	37.7	31.4
485	485	Knee procedures w pdx of infection w MCC	8	1.6608	37.7	31.4
486	485	Knee procedures w pdx of infection w CC	4	1.6608	37.7	31.4
487	485	Knee procedures w pdx of infection w/o CC/MCC	1	1.0933	26.6	22.2
488	488	Knee procedures w/o pdx of infection w CC/MCC*	4	1.0933	26.6	22.2
489	488	Knee procedures w/o pdx of infection w/o CC/MCC*	0	1.0933	26.6	22.2
490	490	Back & neck procedures except spinal fusion w CC/MCC or disc devices	4	1.0933	26.6	22.2
491	490	Back & neck procedures except spinal fusion w/o CC/MCC	0	1.0933	26.6	22.2
492	492	Lower extrem & humer proc except hip,foot,femur w MCC*	4	1.6608	37.7	31.4
493	492	Lower extrem & humer proc except hip,foot,femur w CC*	9	0.7552	24.0	20.0
494	492	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC*	0	0.7552	24.0	20.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
495	495	Local excision & removal int fix devices exc hip & femur w MCC	30	1.2956	37.8	31.5
496	495	Local excision & removal int fix devices exc hip & femur w CC	39	1.0692	34.0	28.3
497	495	Local excision & removal int fix devices exc hip & femur w/o CC/MCC	6	0.6392	21.6	18.0
498	498	Local excision & removal int fix devices of hip & femur w CC/MCC	19	1.6608	37.7	31.4
499	498	Local excision & removal int fix devices of hip & femur w/o CC/MCC	1	0.7552	24.0	20.0
500	500	Soft tissue procedures w MCC	106	1.3940	36.8	30.7
501	500	Soft tissue procedures w CC	66	1.0254	32.8	27.3
502	500	Soft tissue procedures w/o CC/MCC	7	1.0254	32.8	27.3
503	503	Foot procedures w MCC	24	1.0933	26.6	22.2
504	503	Foot procedures w CC	28	1.0376	31.2	26.0
505	503	Foot procedures w/o CC/MCC	4	1.0376	31.2	26.0
506	506	Major thumb or joint procedures	0	1.0933	26.6	22.2
507	507	Major shoulder or elbow joint procedures w CC/MCC	2	1.6608	37.7	31.4
508	507	Major shoulder or elbow joint procedures w/o CC/MCC	0	1.6608	37.7	31.4
509	509	Arthroscopy	0	1.0376	31.2	26.0
510	510	Shoulder,elbow or forearm proc,exc major joint proc w MCC	3	1.0933	26.6	22.2
511	510	Shoulder,elbow or forearm proc,exc major joint proc w CC	2	0.7552	24.0	20.0
512	510	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	0	0.7552	24.0	20.0
513	513	Hand or wrist proc, except major thumb or joint proc w CC/MCC	9	1.0933	26.6	22.2
514	513	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	1	1.0933	26.6	22.2
515	515	Other musculoskelet sys & conn tiss O.R. proc w MCC	45	1.1914	30.1	25.1
516	515	Other musculoskelet sys & conn tiss O.R. proc w CC	21	1.0933	26.6	22.2
517	515	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	3	0.6392	21.6	18.0
533	533	Fractures of femur w MCC	0	1.6608	37.7	31.4
534	533	Fractures of femur w/o MCC	1	0.4766	19.2	16.0
535	535	Fractures of hip & pelvis w MCC	15	0.6392	21.6	18.0
536	535	Fractures of hip & pelvis w/o MCC	11	0.4766	19.2	16.0
537	537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	1	1.0933	26.6	22.2
538	537	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	0	1.0933	26.6	22.2
539	539	Osteomyelitis w MCC	1,279	1.0283	30.0	25.0
540	539	Osteomyelitis w CC	1,264	0.8004	28.7	23.9
541	539	Osteomyelitis w/o CC/MCC	201	0.6962	26.7	22.3
542	542	Pathological fractures & musculoskelet & conn tiss malig w MCC	40	0.7953	23.6	19.7
543	542	Pathological fractures & musculoskelet & conn tiss malig w CC	34	0.6149	21.6	18.0
544	542	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC	2	0.4766	19.2	16.0
545	545	Connective tissue disorders w MCC	55	0.8053	21.8	18.2
546	545	Connective tissue disorders w CC	31	0.5615	21.2	17.7
547	545	Connective tissue disorders w/o CC/MCC	4	0.4766	19.2	16.0
548	548	Septic arthritis w MCC	225	0.8577	26.9	22.4
549	548	Septic arthritis w CC	173	0.7354	25.6	21.3
550	548	Septic arthritis w/o CC/MCC	62	0.5233	23.5	19.6
551	551	Medical back problems w MCC	104	0.8996	27.3	22.8
552	551	Medical back problems w/o MCC	128	0.5894	23.0	19.2
553	553	Bone diseases & arthropathies w MCC	16	0.6392	21.6	18.0
554	553	Bone diseases & arthropathies w/o MCC	35	0.4674	20.0	16.7
555	555	Signs & symptoms of musculoskeletal system & conn tissue w MCC	7	0.7552	24.0	20.0
556	555	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC	18	0.4766	19.2	16.0
557	557	Tendonitis, myositis & bursitis w MCC	112	0.8769	24.5	20.4
558	557	Tendonitis, myositis & bursitis w/o MCC	126	0.7061	23.2	19.3
559	559	Aftercare, musculoskeletal system & connective tissue w MCC	1,558	0.8153	25.8	21.5
560	559	Aftercare, musculoskeletal system & connective tissue w CC	1,578	0.6780	25.4	21.2
561	559	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	429	0.5327	22.1	18.4
562	562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC	22	0.7552	24.0	20.0
563	562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC	8	0.7552	24.0	20.0
564	564	Other musculoskeletal sys & connective tissue diagnoses w MCC	335	0.8934	24.6	20.5
565	564	Other musculoskeletal sys & connective tissue diagnoses w CC	266	0.6839	24.1	20.1
566	564	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC	31	0.5185	21.4	17.8
573	573	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	1,842	1.3740	37.9	31.6
574	573	Skin graft &/or debrid for skn ulcer or cellulitis w CC	1,371	1.0133	35.1	29.3
575	573	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	97	0.8023	28.7	23.9
576	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	43	1.2370	32.3	26.9
577	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	26	0.9539	31.7	26.4
578	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC	6	0.4766	19.2	16.0
579	579	Other skin, subcut tiss & breast proc w MCC	555	1.3281	35.9	29.9
580	579	Other skin, subcut tiss & breast proc w CC	295	0.9368	32.0	26.7
581	579	Other skin, subcut tiss & breast proc w/o CC/MCC	23	0.7552	24.0	20.0
582	582	Mastectomy for malignancy w CC/MCC	4	0.7552	24.0	20.0
583	582	Mastectomy for malignancy w/o CC/MCC	0	0.7552	24.0	20.0
584	584	Breast biopsy, local excision & other breast procedures w CC/MCC	3	0.7552	24.0	20.0
585	584	Breast biopsy, local excision & other breast procedures w/o CC/MCC	0	0.7552	24.0	20.0

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592	592	Skin ulcers w MCC	3,621	0.9291	26.7	22.3
593	592	Skin ulcers w CC	2,483	0.6876	25.5	21.3
594	592	Skin ulcers w/o CC/MCC	222	0.5712	22.2	18.5
595	595	Major skin disorders w MCC	35	0.6821	22.9	19.1
596	595	Major skin disorders w/o MCC	34	0.4965	19.9	16.6
597	597	Malignant breast disorders w MCC*	10	0.7552	24.0	20.0
598	597	Malignant breast disorders w CC*	8	0.6392	21.6	18.0
599	597	Malignant breast disorders w/o CC/MCC*	0	0.6392	21.6	18.0
600	600	Non-malignant breast disorders w CC/MCC	18	0.6392	21.6	18.0
601	600	Non-malignant breast disorders w/o CC/MCC	3	0.4766	19.2	16.0
602	602	Cellulitis w MCC	943	0.7077	22.6	18.8
603	602	Cellulitis w/o MCC	1,429	0.5157	19.3	16.1
604	604	Trauma to the skin, subcut tiss & breast w MCC	44	0.8435	25.6	21.3
605	604	Trauma to the skin, subcut tiss & breast w/o MCC	45	0.5798	21.0	17.5
606	606	Minor skin disorders w MCC	88	1.1918	27.0	22.5
607	606	Minor skin disorders w/o MCC	103	0.5715	21.6	18.0
614	614	Adrenal & pituitary procedures w CC/MCC	0	1.0434	32.0	26.7
615	614	Adrenal & pituitary procedures w/o CC/MCC	0	1.0434	32.0	26.7
616	616	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC	61	1.5849	38.4	32.0
617	616	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC	151	1.1006	31.3	26.1
618	616	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	0	1.1006	31.3	26.1
619	619	O.R. procedures for obesity w MCC*	1	1.6608	37.7	31.4
620	619	O.R. procedures for obesity w CC*	2	0.7552	24.0	20.0
621	619	O.R. procedures for obesity w/o CC/MCC*	0	0.7552	24.0	20.0
622	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	119	1.2575	33.7	28.1
623	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	342	0.9963	30.9	25.8
624	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC	12	0.9963	30.9	25.8
625	625	Thyroid, parathyroid & thyroglossal procedures w MCC	0	1.3071	33.6	28.0
626	625	Thyroid, parathyroid & thyroglossal procedures w CC	0	1.0434	32.0	26.7
627	625	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	0	1.0434	32.0	26.7
628	628	Other endocrine, nutrit & metab O.R. proc w MCC	58	1.3071	33.6	28.0
629	628	Other endocrine, nutrit & metab O.R. proc w CC	122	1.0434	32.0	26.7
630	628	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	0	1.0434	32.0	26.7
637	637	Diabetes w MCC	423	0.8786	25.9	21.6
638	637	Diabetes w CC	1,176	0.6952	24.3	20.3
639	637	Diabetes w/o CC/MCC	38	0.4056	18.0	15.0
640	640	Nutritional & misc metabolic disorders w MCC	670	0.8153	22.3	18.6
641	640	Nutritional & misc metabolic disorders w/o MCC	515	0.6443	21.2	17.7
642	642	Inborn errors of metabolism	7	1.0933	26.6	22.2
643	643	Endocrine disorders w MCC	19	0.7552	24.0	20.0
644	643	Endocrine disorders w CC	19	0.6392	21.6	18.0
645	643	Endocrine disorders w/o CC/MCC	4	0.4766	19.2	16.0
652	652	Kidney transplant	0	0.0000	0.0	0.0
653	653	Major bladder procedures w MCC	0	0.7552	24.0	20.0
654	653	Major bladder procedures w CC	0	0.7552	24.0	20.0
655	653	Major bladder procedures w/o CC/MCC	0	0.7552	24.0	20.0
656	656	Kidney & ureter procedures for neoplasm w MCC	2	0.7552	24.0	20.0
657	656	Kidney & ureter procedures forneoplasm w CC	0	0.7552	24.0	20.0
658	656	Kidney & ureter procedures for neoplasm w/o CC/MCC	0	0.7552	24.0	20.0
659	659	Kidney & ureter procedures for non-neoplasm w MCC*	4	1.6608	37.7	31.4
660	659	Kidney & ureter procedures for non-neoplasm w CC*	9	0.7552	24.0	20.0
661	659	Kidney & ureter procedures for non-neoplasm w/o CC/MCC*	0	0.7552	24.0	20.0
662	662	Minor bladder procedures w MCC	2	1.6608	37.7	31.4
663	662	Minor bladder procedures w CC	3	0.6392	21.6	18.0
664	662	Minor bladder procedures w/o CC/MCC	0	0.6392	21.6	18.0
665	665	Prostatectomy w MCC	0	0.7552	24.0	20.0
666	665	Prostatectomy w CC	1	0.7552	24.0	20.0
667	665	Prostatectomy w/o CC/MCC	1	0.4766	19.2	16.0
668	668	Transurethral procedures w MCC	4	0.7552	24.0	20.0
669	668	Transurethral procedures w CC	7	0.7552	24.0	20.0
670	668	Transurethral procedures w/o CC/MCC	0	0.7552	24.0	20.0
671	671	Urethral procedures w CC/MCC	2	1.0933	26.6	22.2
672	671	Urethral procedures w/o CC/MCC	0	1.0933	26.6	22.2
673	673	Other kidney & urinary tract procedures w MCC	151	1.3257	32.1	26.8
674	673	Other kidney & urinary tract procedures w CC	56	0.9676	29.0	24.2
675	673	Other kidney & urinary tract procedures w/o CC/MCC	5	0.6392	21.6	18.0
682	682	Renal failure w MCC	1,470	0.9030	23.4	19.5
683	682	Renal failure w CC	578	0.7180	22.1	18.4
684	682	Renal failure w/o CC/MCC	35	0.5141	17.7	14.8
685	685	Admit for renal dialysis	10	0.6392	21.6	18.0
686	686	Kidney & urinary tract neoplasms w MCC*	31	0.7953	23.5	19.6
687	686	Kidney & urinary tract neoplasms w CC*	19	0.7552	24.0	20.0
688	686	Kidney & urinary tract neoplasms w/o CC/MCC*	0	0.7552	24.0	20.0
689	689	Kidney & urinary tract infections w MCC	888	0.6733	22.6	18.8
690	689	Kidney & urinary tract infections w/o MCC	702	0.5296	19.9	16.6
691	691	Urinary stones w esw lithotripsy w CC/MCC	1	1.0933	26.6	22.2
692	691	Urinary stones w esw lithotripsy w/o CC/MCC	0	0.4766	19.2	16.0
693	693	Urinary stones w/o esw lithotripsy w MCC	5	0.7552	24.0	20.0
694	693	Urinary stones w/ot esw lithotripsy w/o MCC	2	0.4766	19.2	16.0
695	695	Kidney & urinary tract signs & symptoms w MCC	3	0.7552	24.0	20.0
696	695	Kidney & urinary tract signs & symptoms w/o MCC	2	0.4766	19.2	16.0
697	697	Urethral stricture	1	0.6392	21.6	18.0
698	698	Other kidney & urinary tract diagnoses w MCC	235	0.8760	23.4	19.5
699	698	Other kidney & urinary tract diagnoses w CC	145	0.7211	22.4	18.7
700	698	Other kidney & urinary tract diagnoses w/o CC/MCC	14	0.6392	21.6	18.0
707	707	Major male pelvic procedures w CC/MCC	0	0.7552	24.0	20.0
708	707	Major male pelvic procedures w/o CC/MCC	0	0.7552	24.0	20.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
709	709	Penis procedures w CC/MCC	2	1.6608	37.7	31.4
710	709	Penis procedures w/o CC/MCC	0	1.6608	37.7	31.4
711	711	Testes procedures w CC/MCC	8	1.0933	26.6	22.2
712	711	Testes procedures w/o CC/MCC	0	1.0933	26.6	22.2
713	713	Transurethral prostatectomy w CC/MCC	1	1.6608	37.7	31.4
714	713	Transurethral prostatectomy w/o CC/MCC	0	0.7552	24.0	20.0
715	715	Other male reproductive system O.R. proc for malignancy w CC/MCC	0	1.6608	37.7	31.4
716	715	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	0	1.6608	37.7	31.4
717	717	Other male reproductive system O.R. proc exc malignancy w CC/MCC	12	1.6608	37.7	31.4
718	717	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	0	1.6608	37.7	31.4
722	722	Malignancy, male reproductive system w MCC	8	0.6392	21.6	18.0
723	722	Malignancy, male reproductive system w CC	10	0.6392	21.6	18.0
724	722	Malignancy, male reproductive system w/o CC/MCC	0	0.6392	21.6	18.0
725	725	Benign prostatic hypertrophy w MCC	4	0.4766	19.2	16.0
726	725	Benign prostatic hypertrophy w/o MCC	1	0.4766	19.2	16.0
727	727	Inflammation of the male reproductive system w MCC	66	0.7689	24.0	20.0
728	727	Inflammation of the male reproductive system w/o MCC	66	0.4964	20.9	17.4
729	729	Other male reproductive system diagnoses w CC/MCC	72	0.8669	24.0	20.0
730	729	Other male reproductive system diagnoses w/o CC/MCC	1	0.4766	19.2	16.0
734	734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	0	1.6608	37.7	31.4
735	734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	0	1.6608	37.7	31.4
736	736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC*	0	0.9345	22.3	18.6
737	736	Uterine & adnexa proc for ovarian or adnexal malignancy w CC*	0	0.7552	24.0	20.0
738	736	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC*	0	0.7552	24.0	20.0
739	739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC*	0	1.3071	33.6	28.0
740	739	Uterine,adnexa proc for non-ovarian/adnexal malig w CC*	0	0.7552	24.0	20.0
741	739	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC*	0	0.7552	24.0	20.0
742	742	Uterine & adnexa proc for non-malignancy w CC/MCC*	0	0.7552	24.0	20.0
743	742	Uterine & adnexa proc for non-malignancy w/o CC/MCC*	0	0.7552	24.0	20.0
744	744	D&C, conization, laparascopy & tubal interruption w CC/MCC	0	0.7552	24.0	20.0
745	744	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	0	0.7552	24.0	20.0
746	746	Vagina, cervix & vulva procedures w CC/MCC	1	0.6392	21.6	18.0
747	746	Vagina, cervix & vulva procedures w/o CC/MCC	1	0.6392	21.6	18.0
748	748	Female reproductive system reconstructive procedures	0	0.7552	24.0	20.0
749	749	Other female reproductive system O.R. procedures w CC/MCC	4	0.7552	24.0	20.0
750	749	Other female reproductive system O.R. procedures w/o CC/MCC	0	0.7552	24.0	20.0
754	754	Malignancy, female reproductive system w MCC	25	0.9345	22.3	18.6
755	754	Malignancy, female reproductive system w CC	17	0.7552	24.0	20.0
756	754	Malignancy, female reproductive system w/o CC/MCC	0	0.7552	24.0	20.0
757	757	Infections, female reproductive system w MCC	78	0.8737	24.2	20.2
758	757	Infections, female reproductive system w CC	35	0.7902	21.3	17.8
759	757	Infections, female reproductive system w/o CC/MCC	2	0.6392	21.6	18.0
760	760	Menstrual & other female reproductive system disorders w CC/MCC*	11	0.7552	24.0	20.0
761	760	Menstrual & other female reproductive system disorders w/o CC/MCC*	0	0.7552	24.0	20.0
765	765	Cesarean section w CC/MCC	0	1.0434	32.0	26.7
766	765	Cesarean section w/o CC/MCC	0	1.0434	32.0	26.7
767	767	Vaginal delivery w sterilization &/or D&C	0	1.0434	32.0	26.7
768	768	Vaginal delivery w O.R. proc except steril &/or D&C	0	1.0434	32.0	26.7
769	769	Postpartum & post abortion diagnoses w O.R. procedure	0	1.0434	32.0	26.7
770	770	Abortion w D&C, aspiration curettage or hysterotomy	0	1.0434	32.0	26.7
774	774	Vaginal delivery w complicating diagnoses	0	1.0434	32.0	26.7
775	775	Vaginal delivery w/o complicating diagnoses	0	1.0434	32.0	26.7
776	776	Postpartum & post abortion diagnoses w/o O.R. procedure	1	1.6608	37.7	31.4
777	777	Ectopic pregnancy	0	1.0434	32.0	26.7
778	778	Threatened abortion	0	0.6392	21.6	18.0
779	779	Abortion w/o D&C	0	0.6392	21.6	18.0
780	780	False labor	0	0.6392	21.6	18.0
781	781	Other antepartum diagnoses w medical complications	3	0.7552	24.0	20.0
782	782	Other antepartum diagnoses w/o medical complications	0	0.7552	24.0	20.0
789	789	Neonates, died or transferred to another acute care facility	0	0.7552	24.0	20.0
790	790	Extreme immaturity or respiratory distress syndrome, neonate	0	0.7552	24.0	20.0
791	791	Prematurity w major problems	0	0.7552	24.0	20.0
792	792	Prematurity w/o major problems	0	0.7552	24.0	20.0
793	793	Full term neonate w major problems	0	0.7552	24.0	20.0
794	794	Neonate w other significant problems	0	0.7552	24.0	20.0
795	795	Normal newborn	0	0.7552	24.0	20.0
799	799	Splenectomy w MCC	0	1.0933	26.6	22.2
800	799	Splenectomy w CC	1	1.0933	26.6	22.2
801	799	Splenectomy w/o CC/MCC	0	1.0933	26.6	22.2
802	802	Other O.R. proc of the blood & blood forming organs w MCC*	3	1.6608	37.7	31.4
803	802	Other O.R. proc of the blood & blood forming organs w CC*	3	0.6392	21.6	18.0
804	802	Other O.R. proc of the blood & blood forming organs w/o CC/MCC*	0	0.6392	21.6	18.0
808	808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC	13	0.6904	19.7	16.4
809	808	Major hematol/immun diag exc sickle cell crisis & coagul w CC	16	0.6904	19.7	16.4

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Relative Weight	Geometric Average Length of Stay	Short-Stay Outlier (SSO) Threshold[1]
810	808	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	0	0.5548	19.7	16.4
811	811	Red blood cell disorders w MCC	39	0.8250	22.1	18.4
812	811	Red blood cell disorders w/o MCC	38	0.5548	19.7	16.4
813	813	Coagulation disorders	42	0.8179	22.1	18.4
814	814	Reticuloendothelial & immunity disorders w MCC	10	1.0933	26.6	22.2
815	814	Reticuloendothelial & immunity disorders w CC	9	0.6392	21.6	18.0
816	814	Reticuloendothelial & immunity disorders w/o CC/MCC	3	0.4766	19.2	16.0
820	820	Lymphoma & leukemia w major O.R. procedure w MCC*	0	1.6608	37.7	31.4
821	820	Lymphoma & leukemia w major O.R. procedure w CC*	1	0.7552	24.0	20.0
822	820	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC*	0	0.7552	24.0	20.0
823	823	Lymphoma & non-acute leukemia w other O.R. proc w MCC	2	1.6608	37.7	31.4
824	823	Lymphoma & non-acute leukemia w other O.R. proc w CC	2	1.6608	37.7	31.4
825	823	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	0	1.6608	37.7	31.4
826	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	0	1.6608	37.7	31.4
827	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	1	1.6608	37.7	31.4
828	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	0	1.6608	37.7	31.4
829	829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC	14	1.0933	26.6	22.2
830	829	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	0	1.0933	26.6	22.2
834	834	Acute leukemia w/o major O.R. procedure w MCC*	20	1.0933	26.6	22.2
835	834	Acute leukemia w/o major O.R. procedure w CC*	9	0.7552	24.0	20.0
836	834	Acute leukemia w/o major O.R. procedure w/o CC/MCC*	0	0.7552	24.0	20.0
837	837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC*	1	0.6392	21.6	18.0
838	837	Chemo w acute leukemia as sdx or w high dose chemo agent w CC*	0	0.6392	21.6	18.0
839	837	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC*	0	0.6392	21.6	18.0
840	840	Lymphoma & non-acute leukemia w MCC	82	0.9776	23.8	19.8
841	840	Lymphoma & non-acute leukemia w CC	56	0.8884	22.1	18.4
842	840	Lymphoma & non-acute leukemia w/o CC/MCC	10	0.6392	21.6	18.0
843	843	Other myeloprolif dis or poorly diff neopl diag w MCC*	14	0.8219	22.9	19.1
844	843	Other myeloprolif dis or poorly diff neopl diag w CC*	13	0.8219	22.9	19.1
845	843	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC*	0	0.8219	22.9	19.1
846	846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	59	1.5248	30.4	25.3
847	846	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	41	1.1207	25.1	20.9
848	846	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	1	1.1207	25.1	20.9
849	849	Radiotherapy	139	0.8004	22.4	18.7
853	853	Infectious & parasitic diseases w O.R. procedure w MCC	749	1.7562	38.1	31.8
854	853	Infectious & parasitic diseases w O.R. procedure w CC	180	1.2120	34.8	29.0
855	853	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC	13	1.0933	26.6	22.2
856	856	Postoperative or post-traumatic infections w O.R. proc w MCC	314	1.3718	35.0	29.2
857	856	Postoperative or post-traumatic infections w O.R. proc w CC	173	1.0359	31.0	25.8
858	856	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	24	0.7552	24.0	20.0
862	862	Postoperative & post-traumatic infections w MCC	1,450	0.9496	25.3	21.1
863	862	Postoperative & post-traumatic infections w/o MCC	1,097	0.6778	23.2	19.3
864	864	Fever of unknown origin	6	0.6392	21.6	18.0
865	865	Viral illness w MCC	33	0.7641	23.5	19.6
866	865	Viral illness w/o MCC	18	0.7552	24.0	20.0
867	867	Other infectious & parasitic diseases diagnoses w MCC	374	1.1325	23.9	19.9
868	867	Other infectious & parasitic diseases diagnoses w CC	70	0.6705	21.8	18.2
869	867	Other infectious & parasitic diseases diagnoses w/o CC/MCC	6	0.4766	19.2	16.0
870	870	Septicemia w MV 96+ hours	1,017	2.1306	32.2	26.8
871	871	Septicemia w/o MV 96+ hours w MCC	5,381	0.8650	23.5	19.6
872	871	Septicemia w/o MV 96+ hours w/o MCC	1,434	0.6409	21.7	18.1
876	876	O.R. procedure w principal diagnoses of mental illness	3	1.6608	37.7	31.4
880	880	Acute adjustment reaction & psychosocial dysfunction	7	0.4766	19.2	16.0
881	881	Depressive neuroses	24	0.4766	19.2	16.0
882	882	Neuroses except depressive	11	0.6392	21.6	18.0
883	883	Disorders of personality & impulse control	5	0.4766	19.2	16.0
884	884	Organic disturbances & mental retardation	83	0.5382	28.0	23.3
885	885	Psychoses	1,149	0.4049	23.0	19.2
886	886	Behavioral & developmental disorders	62	0.3976	22.5	18.8
887	887	Other mental disorder diagnoses	0	0.4766	19.2	16.0
894	894	Alcohol/drug abuse or dependence, left ama	1	0.6392	21.6	18.0
895	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1	0.4766	19.2	16.0
896	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	15	0.7552	24.0	20.0
897	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	11	0.4766	19.2	16.0
901	901	Wound debridements for injuries w MCC	215	1.3120	34.1	28.4
902	901	Wound debridements for injuries w CC	150	1.1853	33.2	27.7
903	901	Wound debridements for injuries w/o CC/MCC	14	0.7552	24.0	20.0
904	904	Skin grafts for injuries w CC/MCC	79	1.4057	39.2	32.7
905	904	Skin grafts for injuries w/o CC/MCC	4	0.7552	24.0	20.0
906	906	Hand procedures for injuries	2	0.7552	24.0	20.0
907	907	Other O.R. procedures for injuries w MCC	128	1.6734	37.9	31.6
908	907	Other O.R. procedures for injuries w CC	79	1.1627	33.4	27.8
909	907	Other O.R. procedures for injuries w/o CC/MCC	2	1.0933	26.6	22.2
913	913	Traumatic injury w MCC	65	0.8202	24.3	20.3
914	913	Traumatic injury w/o MCC	64	0.5688	21.6	18.0

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915	915	Allergic reactions w MCC	0	0.4766	19.2	16.0
916	915	Allergic reactions w/o MCC	0	0.4766	19.2	16.0
917	917	Poisoning & toxic effects of drugs w MCC	15	1.0933	26.6	22.2
918	917	Poisoning & toxic effects of drugs w/o MCC	9	0.4766	19.2	16.0
919	919	Complications of treatment w MCC	1,395	1.1109	26.8	22.3
920	919	Complications of treatment w CC	897	0.7889	25.1	20.9
921	919	Complications of treatment w/o CC/MCC	80	0.6069	20.2	16.8
922	922	Other injury, poisoning & toxic effect diag w MCC	2	1.6608	37.7	31.4
923	922	Other injury, poisoning & toxic effect diag w/o MCC	2	1.6608	37.7	31.4
927	927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	1	1.0933	26.6	22.2
928	928	Full thickness burn w skin graft or inhal inj w CC/MCC	9	1.0933	26.6	22.2
929	928	Full thickness burn w skin graft or inhal inj w/o CC/MCC	0	0.8231	26.6	22.2
933	933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	7	0.7552	24.0	20.0
934	934	Full thickness burn w/o skin grft or inhal inj	36	0.8231	26.6	22.2
935	935	Non-extensive burns	41	0.9214	25.3	21.1
939	939	O.R. proc w diagnoses of other contact w health services w MCC	236	1.4017	34.4	28.7
940	939	O.R. proc w diagnoses of other contact w health services w CC	105	0.9985	32.1	26.8
941	939	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	12	0.7552	24.0	20.0
945	945	Rehabilitation w CC/MCC	2,069	0.6439	21.9	18.3
946	945	Rehabilitation w/o CC/MCC	201	0.4164	18.7	15.6
947	947	Signs & symptoms w MCC	51	0.7667	23.0	19.2
948	947	Signs & symptoms w/o MCC	56	0.4992	19.9	16.6
949	949	Aftercare w CC/MCC	3,411	0.6836	22.2	18.5
950	949	Aftercare w/o CC/MCC	263	0.4421	17.1	14.3
951	951	Other factors influencing health status	76	1.5107	32.0	26.7
955	955	Craniotomy for multiple significant trauma	0	0.4766	19.2	16.0
956	956	Limb reattachment, hip & femur proc for multiple significant trauma	0	1.6608	37.7	31.4
957	957	Other O.R. procedures for multiple significant trauma w MCC	3	1.6608	37.7	31.4
958	957	Other O.R. procedures for multiple significant trauma w CC	2	1.0933	26.6	22.2
959	957	Other O.R. procedures for multiple significant trauma w/o CC/MCC	0	1.0933	26.6	22.2
963	963	Other multiple significant trauma w MCC	17	1.0933	26.6	22.2
964	963	Other multiple significant trauma w CC	6	0.4766	19.2	16.0
965	963	Other multiple significant trauma w/o CC/MCC	2	0.4766	19.2	16.0
969	969	HIV w extensive O.R. procedure w MCC	19	1.6608	37.7	31.4
970	969	HIV w extensive O.R. procedure w/o MCC	3	1.6608	37.7	31.4
974	974	HIV w major related condition w MCC	220	1.0349	22.6	18.8
975	974	HIV w major related condition w CC	65	0.7605	20.2	16.8
976	974	HIV w major related condition w/o CC/MCC	8	0.4766	19.2	16.0
977	977	HIV w or w/o other related condition	54	0.5768	18.8	15.7
981	981	Extensive O.R. procedure unrelated to principal diagnosis w MCC	1,143	2.3236	42.9	35.8
982	981	Extensive O.R. procedure unrelated to principal diagnosis w CC	307	1.3447	34.8	29.0
983	981	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC	15	1.0933	26.6	22.2
984	984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	13	1.6608	37.7	31.4
985	984	Prostatic O.R. procedure unrelated to principal diagnosis w CC	5	1.6608	37.7	31.4
986	984	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1	0.6392	21.6	18.0
987	987	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	431	1.7366	37.6	31.3
988	987	Non-extensive O.R. proc unrelated to principal diagnosis w CC	181	1.0874	31.7	26.4
989	987	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC	8	1.0874	31.7	26.4
998	998	Principal diagnosis invalid as discharge diagnosis	0	0.0000	0.0	0.0
999	999	Ungroupable	0	0.0000	0.0	0.0

[1] The SSO Threshold is calculated as 5/6th of the geometric average length of stay of the MS-LTC-DRG (as specified in §412.529(a) in conjunction with §412.503).

* In determining the MS-LTC-DRG relative weights for FY 2010, these MS-LTC-DRGs were adjusted for nonmonotonicity as discussed in section VIII.B.3.g. (step 6) of the preamble of this final rule.

TABLE 12A.--LTCH PPS WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2010

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.7946
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.3462

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
10420	Akron, OH Portage County, OH Summit County, OH	0.8850
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8899
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8777
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9399
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8012
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9611
11020	Altoona, PA Blair County, PA	0.8863
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8689
11180	Ames, IA Story County, IA	0.9493
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2013
11300	Anderson, IN Madison County, IN	0.9052
11340	Anderson, SC Anderson County, SC	0.9023
11460	Ann Arbor, MI Washtenaw County, MI	1.0293
11500	Anniston-Oxford, AL Calhoun County, AL	0.7643
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9289
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9057
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9492

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
12060	Atlanta-Sandy Springs-Marietta, GA	0.9591
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City, NJ	1.1554
	Atlantic County, NJ	
12220	Auburn-Opelika, AL	0.8138
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	0.9409
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
12420	Austin-Round Rock, TX	0.9518
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	
12540	Bakersfield, CA	1.1232
	Kern County, CA	
12580	Baltimore-Towson, MD	1.0214
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
	Baltimore City, MD	
12620	Bangor, ME	1.0154
	Penobscot County, ME	
12700	Barnstable Town, MA	1.2618
	Barnstable County, MA	
12940	Baton Rouge, LA	0.8180
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	
12980	Battle Creek, MI	1.0000
	Calhoun County, MI	
13020	Bay City, MI	0.9267
	Bay County, MI	
13140	Beaumont-Port Arthur, TX	0.8383
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	
13380	Bellingham, WA	1.1395
	Whatcom County, WA	
13460	Bend, OR	1.1446
	Deschutes County, OR	

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
13644	Bethesda-Gaithersburg-Frederick, MD Frederick County, MD Montgomery County, MD	1.0298
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8781
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8780
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.8554
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7637
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8394
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9043
14060	Bloomington-Normal, IL McLean County, IL	0.9378
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9318
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2186

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
14500	Boulder, CO Boulder County, CO	1.0266
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8469
14600	Bradenton-Sarasota Venice, FL Manatee County, FL Sarasota County, FL	0.9735
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0755
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2792
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9020
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9178
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9731
15500	Burlington, NC Alamance County, NC	0.8749
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0106
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1278
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0374
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8813
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9076
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9047

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
16180	Carson City, NV Carson City, NV	1.0531
16220	Casper, WY Natrona County, WY	0.9520
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8984
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0108
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8141
16700	Charleston-North Charleston, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9279
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9474
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9372
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8831

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
16940	Cheyenne, WY Laramie County, WY	0.9344
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0471
17020	Chico, CA Butte County, CA	1.1198
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	0.9483
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.7980
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.7564

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.8914
17660	Coeur d'Alene, ID Kootenai County, ID	0.9235
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9498
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9821
17860	Columbia, MO Boone County, MO Howard County, MO	0.8618
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8789
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8724
18020	Columbus, IN Bartholomew County, IN	0.9536
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	1.0101

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8693
18700	Corvallis, OR Benton County, OR	1.1002
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8045
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	0.9853
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8666
19180	Danville, IL Vermilion County, IL	0.8738
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8323
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8284
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9211
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7799
19500	Decatur, IL Macon County, IL	0.7995

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8865
19740	Denver-Aurora, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.0731
19780	Des Moines,-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9649
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9729
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7406
20100	Dover, DE Kent County, DE	0.9931
20220	Dubuque, IA Dubuque County, IA	0.8869
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0448
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9618
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9567
20764	Edison, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1061
20940	El Centro, CA Imperial County, CA	0.8766
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8388
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9489
21300	Elmira, NY Chemung County, NY	0.8341
21340	El Paso, TX El Paso County, TX	0.8541
21500	Erie, PA Erie County, PA	0.8779
21660	Eugene-Springfield, OR Lane County, OR	1.1034
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8522
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1114
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3790
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8172
22140	Farmington, NM San Juan County, NM	0.7889
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9358

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8775
22380	Flagstaff, AZ Coconino County, AZ	1.2475
22420	Flint, MI Genesee County, MI	1.1234
22500	Florence, SC Darlington County, SC Florence County, SC	0.8114
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7998
22540	Fond du Lac, WI Fond du Lac County, WI	0.9660
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0175
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0383
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7861
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8758
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9012
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9499
23420	Fresno, CA Fresno County, CA	1.1267
23460	Gadsden, AL Etowah County, AL	0.8266
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.8978
23580	Gainesville, GA Hall County, GA	0.9123
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9288
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8456
24140	Goldsboro, NC Wayne County, NC	0.9056
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7775
24300	Grand Junction, CO Mesa County, CO	0.9721
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9178
24500	Great Falls, MT Cascade County, MT	0.8354
24540	Greeley, CO Weld County, CO	0.9578
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9621
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9062
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9401

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9980
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3537
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8783
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.8965
25260	Hanford-Corcoran, CA Kings County, CA	1.1010
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9286
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9025
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1194
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7664
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9000
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.9028
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8696
26180	Honolulu, HI Honolulu County, HI	1.1662
26300	Hot Springs, AR Garland County, AR	0.9004
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7875
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	0.9841
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9097
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9064
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9436

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	0.9742
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9548
27060	Ithaca, NY Tompkins County, NY	1.0112
27100	Jackson, MI Jackson County, MI	0.8720
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8186
27180	Jackson, TN Chester County, TN Madison County, TN	0.8581
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9105
27340	Jacksonville, NC Onslow County, NC	0.8026
27500	Janesville, WI Rock County, WI	0.9201
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8709
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7722
27780	Johnstown, PA Cambria County, PA	0.8233
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7722
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8285
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0264
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0174
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	0.9679
28420	Kennewick-Richland-Pasco, WA Benton County, WA Franklin County, WA	1.0448
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8702

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7999
28740	Kingston, NY Ulster County, NY	0.9367
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7881
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9862
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9915
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9181
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8516
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7985
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0475
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0567
29460	Lakeland, FL Polk County, FL	0.8390
29540	Lancaster, PA Lancaster County, PA	0.9204
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9770
29700	Laredo, TX Webb County, TX	0.8078
29740	Las Cruces, NM Dona Ana County, NM	0.8939
29820	Las Vegas-Paradise, NV Clark County, NV	1.2130
29940	Lawrence, KS Douglas County, KS	0.8580
30020	Lawton, OK Comanche County, OK	0.7847
30140	Lebanon, PA Lebanon County, PA	0.8119
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9570
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9085
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.8889
30620	Lima, OH Allen County, OH	0.9379
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9563
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8559

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8993
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8049
31020	Longview, WA Cowlitz County, WA	1.0707
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2039
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Jefferson County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.8964
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8751
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8521
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9826
31460	Madera, CA Madera County, CA	0.7958
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1234
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0171
31740	Mahattan, KS Geary County, KS Pottawatomie County, KS Riley County; KS	0.7878
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9177
31900	Mansfield, OH Richland County, OH	0.9100
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3704
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.8852
32780	Medford, OR Jackson County, OR	1.0070
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9268
32900	Merced, CA Merced County, CA	1.2123
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	0.9954
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9311
33260	Midland, TX Midland County, TX	0.9546

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0151
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1095
33540	Missoula, MT Missoula County, MT	0.9206
33660	Mobile, AL Mobile County, AL	0.7785
33700	Modesto, CA Stanislaus County, CA	1.2502
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7752
33780	Monroe, MI Monroe County, MI	0.8885
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8304
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8459
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7201
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0452
34620	Muncie, IN Delaware County, IN	0.8386
34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.9823
34820	Myrtle Beach-Conway-North Myrtle Beach, SC Horry County, SC	0.8730
34900	Napa, CA Napa County, CA	1.4453
34940	Naples-Marco Island, FL Collier County, FL	0.9662
34980	Nashville-Davidson-Murfreesboro-Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	0.9689
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2477
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1419
35300	New Haven-Milford, CT New Haven County, CT	1.1545

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9092
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.3005
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8903
35980	Norwich-New London, CT New London County, CT	1.1399
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6404
36100	Ocala, FL Marion County, FL	0.8556
36140	Ocean City, NJ Cape May County, NJ	1.0160
36220	Odessa, TX Ector County, TX	0.9862
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9361
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.8900
36500	Olympia, WA Thurston County, WA	1.1531
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	0.9608
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.8951
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9152
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8357
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2301
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9060
37380	Palm Coast, FL Flager County, FL	0.9603
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8324

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7716
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8433
37764	Peabody, MA Essex County, MA	1.0871
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8312
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9155
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0739
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0630
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7281
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8625
38340	Pittsfield, MA Berkshire County, MA	1.0658
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9239
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4220
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0187
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1498
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9896
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1216
39140	Prescott, AZ Yavapai County, AZ	1.0121
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.0782
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9548
39380	Pueblo, CO Pueblo County, CO	0.8570
39460	Punta Gorda, FL Charlotte County, FL	0.8774

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
39540	Racine, WI Racine County, WI	0.9373
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9663
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0046
39740	Reading, PA Berks County, PA	0.9263
39820	Redding, CA Shasta County, CA	1.4039
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0285
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	0.9521
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1285
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8671
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1136
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8724
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0152
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0125
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.8845
40660	Rome, GA Floyd County, GA	0.8915
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4073
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9122
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1107
41100	St. George, UT Washington County, UT	0.9236

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0189
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9102
41420	Salem, OR Marion County, OR Polk County, OR	1.0974
41500	Salinas, CA Monterey County, CA	1.5207
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9110
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9378
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.7914
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.8857
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1752
41780	Sandusky, OH Erie County, OH	0.8888
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5874
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4740
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6404

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
41980	San Juan-Caguas-Guaynabo, PR	0.4363
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
42020	San Luis Obispo-Paso Robles, CA	1.2550
	San Luis Obispo County, CA	
42044	Santa Ana-Anaheim-Irvine, CA	1.1972
	Orange County, CA	
42060	Santa Barbara-Santa Maria-Goleta, CA	1.2213
	Santa Barbara County, CA	
42100	Santa Cruz-Watsonville, CA	1.6735
	Santa Cruz County, CA	
42140	Santa Fe, NM	1.0694
	Santa Fe County, NM	
42220	Santa Rosa-Petaluma, CA	1.5891
	Sonoma County, CA	
42340	Savannah, GA	0.9043
	Bryan County, GA	
	Chatham County, GA	
	Effingham County, GA	
42540	Scranton--Wilkes-Barre, PA	0.8375
	Lackawanna County, PA	
	Luzerne County, PA	
	Wyoming County, PA	
42644	Seattle-Bellevue-Everett, WA	1.1577
	King County, WA	
	Snohomish County, WA	
42680	Sebastian-Vero Beach, FL	0.9362
	Indian River County, FL	
43100	Sheboygan, WI	0.9166
	Sheboygan County, WI	
43300	Sherman-Denison, TX	0.8064
	Grayson County, TX	
43340	Shreveport-Bossier City, LA	0.8383
	Bossier Parish, LA	
	Caddo Parish, LA	
	De Soto Parish, LA	
43580	Sioux City, IA-NE-SD	0.9094
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.8983
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9690
43900	Spartanburg, SC Spartanburg County, SC	0.9341
44060	Spokane, WA Spokane County, WA	1.0444
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9545
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0373
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8453
44220	Springfield, OH Clark County, OH	0.9195
44300	State College, PA Centre County, PA	0.9096
44700	Stockton, CA San Joaquin County, CA	1.2331
44940	Sumter, SC Sumter County, SC	0.8152
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9785
45104	Tacoma, WA Pierce County, WA	1.1195

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8406
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.8982
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9061
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8113
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9541
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.9026
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0552
46060	Tucson, AZ Pima County, AZ	0.9505
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8662

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8698
46340	Tyler, TX Smith County, TX	0.8312
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8460
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.7944
46700	Vallejo-Fairfield, CA Solano County, CA	1.4934
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8054
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0207
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.8960
47300	Visalia-Porterville, CA Tulare County, CA	1.0221
47380	Waco, TX McLennan County, TX	0.8377
47580	Warner Robins, GA Houston County, GA	0.8754
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9806
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.0882
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8518
48140	Wausau, WI Marathon County, WI	0.9440
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.7368

CBSA Code	Urban Area (Constituent Counties)	LTCH PPS Wage Index
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	0.9719
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9879
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6869
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9018
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9197
48700	Williamsport, PA Lycoming County, PA	0.7877
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0555
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.8986
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9777
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8953
49340	Worcester, MA Worcester County, MA	1.1089
49420	Yakima, WA Yakima County, WA	0.9949
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3348
49620	York-Hanover, PA York County, PA	0.9299
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8679
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1265
49740	Yuma, AZ Yuma County, AZ	0.9143

TABLE 12B.--LTCH PPS WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2010

CBSA Code	Nonurban Area	LTCH PPS Wage Index
01	Alabama	0.7327
02	Alaska	1.1669
03	Arizona	0.8790
04	Arkansas	0.7332
05	California	1.2001
06	Colorado	0.9929
07	Connecticut	1.1093
08	Delaware	0.9910
10	Florida	0.8566
11	Georgia	0.7623
12	Hawaii	1.1113
13	Idaho	0.7733
14	Illinois	0.8312
15	Indiana	0.8529
16	Iowa	0.8624
17	Kansas	0.8167
18	Kentucky	0.7813

CBSA Code	Nonurban Area	LTCH PPS Wage Index
19	Louisiana	0.7611
20	Maine	0.8579
21	Maryland	0.9131
22	Massachusetts	1.1700
23	Michigan	0.8778
24	Minnesota	0.9160
25	Mississippi	0.7638
26	Missouri	0.7671
27	Montana	0.8399
28	Nebraska	0.8705
29	Nevada	0.9674
30	New Hampshire	0.9957
31	New Jersey*	----------
32	New Mexico	0.8938
33	New York	0.8269
34	North Carolina	0.8535
35	North Dakota	0.7813
36	Ohio	0.8506
37	Oklahoma	0.7654
38	Oregon	1.0236
39	Pennsylvania	0.8306
41	Rhode Island*	----------
42	South Carolina	0.8394
43	South Dakota	0.8510
44	Tennessee	0.7808
45	Texas	0.7759
46	Utah	0.8363
47	Vermont	0.9763
49	Virginia	0.7869
50	Washington	1.0224
51	West Virginia	0.7396
52	Wisconsin	0.9206
53	Wyoming	0.9535

* All counties within the State are classified as urban.

Appendix A: Regulatory Impact Analysis

I. Overall Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this final rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the changes for FY 2010 acute care hospital operating and capital payments will redistribute in excess of $100 million among different types of inpatient cases. The changes to rebase and revise the market basket for purposes of the market basket update to the IPPS rates required by the statute, in conjunction with other payment changes in this final rule, will result in an estimated $1.73 billion increase in FY 2010 operating payments (or 1.6 percent increase), and $171 million increase in FY 2010 capital payments (or 1.9 percent increase). The impacts analysis of the capital payments can be found in section VIII. of this Appendix. In addition, as described in section IX. of this Appendix, LTCHs are expected to experience an increase in payments by $153 million (or 3.3 percent).

Our operating impact estimate includes the 2.1 percent market basket update to the standardized amount. Though we had proposed a −2.5 percent documentation and coding adjustment applied to the hospital-specific rates, the −1.1 percent documentation and coding adjustment applied to the Puerto Rico-specific rates and the −1.9 percent adjustment for documentation and coding changes to the IPPS standardized amounts, we are not applying any documentation and coding adjustments to any of the rates in this final rule. The estimates of IPPS operating payments to acute care hospitals do not reflect any changes in hospital admissions or real case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most hospitals and most other providers and suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration definition of a small business (having revenues of $34.5 million or less in any 1 year). (For details on the latest standards for heath care providers, we refer readers to the Table of Small Business Size Standards for NAIC 622 found on the Small Business Administration Office of Size Standards Web site at: *http://www.sba.gov/contractingopportunities/officials/size/GC-SMALL-BUS-SIZE-STANDARDS.html*.) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that the provisions of this final rule relating to acute care hospitals would have a significant impact on small entities as explained in this Appendix. Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary LTCHs. Therefore, we are assuming that all LTCHs are considered small entities for the purpose of the analysis in section IX. of this Appendix. Medicare fiscal intermediaries and MACs are not considered to be small entities. Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this final rule constitutes our final regulatory flexibility analysis. We address any public comments that we received on the impact of these changes we are finalizing in the applicable sections of this Appendix.

The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Public Law 104–121, as amended by section 8302 of Public Law 110–28, requires an agency to provide compliance guides for each rule or group of related rules for which an agency is required to prepare a final regulatory flexibility analysis. The compliance guides associated with this final rule are available on the CMS IPPS Web page at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp*. We also note that the Hospital Center Web page at *http://www.cms.hhs.gov/center/hospital.asp* was developed to assist hospitals in understanding and adapting to changes in Medicare regulations and in billing and payment procedures. This Web page provides hospitals with substantial downloadable explanatory materials.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed or final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS and the LTCH PPS, we continue to classify these hospitals as urban hospitals. (We refer readers to Table 1 and section VI. of this Appendix for the quantitative effects of the policy changes under the IPPS for operating costs.)

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $133 million. This

final rule will not mandate any requirements for State, local, or tribal governments, nor would it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this final rule will not have a substantial effect on State and local governments.

The following analysis, in conjunction with the remainder of this document, demonstrates that this final rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The final rule will affect payments to a substantial number of small rural hospitals, as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives of the IPPS

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Hospital Insurance Trust Fund.

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

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 2010, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but, generally, we do not attempt to make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. However, in the FY 2008 IPPS final rule with comment period, we indicated that we believe that implementation of the MS–DRGs would lead to increases in case-mix that do not reflect actual increases in patients' severity of illness as a result of more comprehensive documentation and coding. As explained in section II.D. of the preamble of this final rule, the FY 2008 IPPS final rule with comment period established a documentation and coding adjustment of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 to maintain budget neutrality for the transition to the MS–DRGs. Subsequently, Congress enacted Public Law 110–90. Section 7 of Public Law 110–90 reduced the IPPS documentation and coding adjustment from −1.2 percent to −0.6 percent for FY 2008 and from −1.8 percent to −0.9 percent for FY 2009. For FY 2010, we had proposed to reduce the national standardized amount. However, we have decided to postpone the documentation and coding adjustment to the national standardized amount until FY 2011 and will not apply the adjustment to the national standardized amount for FY 2010.

Furthermore, we believe that hospitals that are paid under the hospital-specific payment rate, specifically SCHs and MDHs, experience similar increases in case-mix due to documentation and coding changes that do not reflect real changes in case-mix. Our actuarial office estimates that hospitals paid under the hospital-specific rate experienced a 4.8 percent increase in payments due to documentation and coding changes in FY 2008 and FY 2009. We did not apply a documentation and coding adjustment to the hospital-specific rates when we first implemented the MS–DRG system. For FY 2010, we had proposed to reduce the hospital-specific rate by −2.5 percent in FY 2010 to account for the case-mix increase that occurred in FY 2008 due to changes in documentation and coding under the adoption of MS–DRGs that do not reflect real changes in case-mix. However, we have decided to postpone the documentation and coding adjustment to the hospital-specific rate until FY 2011 and will not apply an adjustment to the hospital-specific rate for FY 2010.

Our analysis, as described in II.D. of the preamble, shows that Puerto Rico hospitals experienced an increase in case-mix by 1.1 percent in FY 2008 due to changes in documentation and coding. We did not apply a documentation and coding adjustment to the Puerto Rico-specific rate when we first implemented the MS–DRG system. Consistent with our decision to postpone documentation and coding adjustments for the hospital-specific rate and the Federal standardized amount, we also are postponing the documentation and coding adjustment to the Puerto-Rico specific rate until FY 2011.

The impacts shown below illustrate the impact of the FY 2010 IPPS changes on acute care hospital operating payments. As we have done in the previous rules, we solicited comments and information about the anticipated effects of the proposed changes on hospitals and our methodology for estimating them.

Comment: Several comments questioned whether Medicare Advantage claims were used in the impacts analysis. The commenters suggested that CMS reevaluate its calculations and data to ensure that Medicare Advantage claims are not used in the impacts analysis.

Response: The three primary data sources for the impacts analyses are the MedPAR claims file, the Medicare hospital cost report, and the Provider-Specific File. Historically, we have excluded data from Medicare Advantage claims from the impacts analysis. However, for the FY 2010 IPPS proposed rule, the December 31, 2008 update of the FY 2008 MedPAR data that was used as the source for the impact analysis contained a significant number of Medicare Advantage claims. Under Change Request 5647, Transmittal 1311, hospitals were required to submit informational only claims for all Medicare Advantage patients they treated for discharges occurring on or after October 1, 2006. As a result, we inadvertently included claims from discharges enrolled in Medicare Advantage plans in the impact analysis in the proposed rule.

We generally have excluded Medicare Advantage claims from the impact analysis. However, as described in section II.A.4. of the Addendum to this final rule, we have used the Medicare Advantage claims information to determine the IME payment made on Medicare Advantage claims. Because IME Medicare Advantage payments are made to IPPS hospitals under section 1886(d) of the Act, we believe these payments must be part of these budget neutrality calculations and in the operating impact analysis.

The methodology for calculating the IME payment made on Medicare Advantage claims is described in section II.A.4. of the Addendum to this final rule.

IV. Hospitals Included in and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs of acute care hospitals encompass most general short-term, acute care hospitals that participate in the Medicare program. There were 33 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment methodology for these hospitals. Among other short-term, acute care hospitals, only the 46 such hospitals in Maryland remain excluded from the IPPS pursuant to the waiver under section 1814(b)(3) of the Act.

As of July 2009, there are 3,517 IPPS acute care hospitals to be included in our analysis. This represents about 58 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 1,330 CAHs. These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. (We refer readers to section VII. of this Appendix for a further description of the impact of CAH-related policy changes.) There are also 1,251 IPPS-excluded hospitals and 2,188 IPPS-excluded hospital units. These IPPS-excluded hospitals and units include IPFs, IRFs, LTCHs, RNHCIs, children's hospitals, and cancer hospitals, which are paid under separate payment systems. Changes in the prospective payment systems for IPFs and IRFs are made through separate rulemaking. Payment impacts for these IPPS-excluded hospitals and units are not included in this final rule. The impact of the update and policy changes to the LTCH PPS for RY 2010 are discussed in section IX. of this Appendix.

V. Effects on Hospitals Excluded From the IPPS

As of July 2009, there were 1,251 hospitals excluded from the IPPS. Of these 1,251 hospitals, 78 children's hospitals, 11 cancer hospitals, and 16 RNHCIs are being paid on a reasonable cost basis subject to the rate-of-

increase ceiling under § 413.40. The remaining providers, 225 IRFs and 421 LTCHs, are paid the Federal prospective per discharge rate under the IRF PPS and the LTCH PPS, respectively, and 1,224 IPFs are paid the Federal per diem amount under the IPF PPS. As stated above, IRFs and IPFs are not affected by rate updates in this final rule. The impacts of the changes to LTCHs are discussed in section IX. of this Appendix. In addition, there are 1,224 IPF units located in hospitals otherwise subject to the IPPS. There are 964 IRFs (paid under the IRF PPS) located in hospitals otherwise subject to the IPPS.

In the past, certain hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Cancer and children's hospitals continue to be paid on a reasonable cost basis subject to TEFRA limits for FY 2010. For these hospitals (cancer and children's hospitals), consistent with the authority provided in section 1886(b)(3)(B)(ii) of the Act, the update is the percentage increase in the FY 2010 IPPS operating market basket. In compliance with section 404 of the MMA, in this final rule, we are replacing the FY 2002-based IPPS operating and capital market baskets with the revised and rebased FY 2006-based IPPS operating and capital market baskets for FY 2010. Therefore, consistent with current law, based on IHS Global Insight, Inc.'s 2009 second quarter forecast, with historical data through the 2009 first quarter, we are estimating that the FY 2010 update to the IPPS operating market basket will be 2.1 percent (that is, the current estimate of the market basket rate-of-increase). In addition, in accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update target amounts by the rate-of-increase percentage. For RNHCIs, the update is the percentage increase in the FY 2010 IPPS operating market basket increase, which is estimated to be 2.1 percent, based on IHS Global Insight, Inc.'s 2009 second quarter forecast of the IPPS operating market basket increase, with historical data through the 2009 first quarter.

The impact of the update in the rate-of-increase limit on those excluded hospitals depends on the cumulative cost increases experienced by each excluded hospital since its applicable base period. For excluded hospitals that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect is on the level of incentive payments these excluded hospitals receive. Conversely, for excluded hospitals with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect is the amount of excess costs that will not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital that continues to be paid under the TEFRA system, whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, cancer and children's hospitals can obtain payment adjustments for justifiable increases in operating costs that exceed the limit.

VI. Quantitative Effects of the Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the IPPS for operating costs of acute care hospitals. Updates to the capital payments to acute care hospitals are discussed in section VIII. of this Appendix.

Based on the overall percentage change in payments per case estimated using our payment simulation model, we estimate that total FY 2010 operating payments will increase by 1.6 percent compared to FY 2009, largely due to the statutorily mandated update to the IPPS rates. The impacts do not illustrate changes in hospital admissions or real case-mix intensity, which will also affect overall payment changes.

We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system for acute care hospitals. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes in this final rule. However, there are other changes for which we do not have data available that would allow us to estimate the payment impacts using this model. For those changes, we have attempted to predict the payment impacts based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2008 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, in this analysis, we do not make adjustments for future changes in such variables as admissions, lengths of stay, or underlying growth in real case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each change. Third, we use various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the FY 2008 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPS (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of the capital IPPS for FY 2010 are discussed in section VIII. of this Appendix.

The changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures, full implementation of the MS–DRG system and 100 percent cost-based MS–DRG relative weights.
- The effects of the changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2006, compared to the FY 2005 wage data.
- The effects of the changes to the hospital labor-related share, where the hospital labor-related share for hospitals with a wage index greater than 1 has been rebased from 69.7 percent to 68.8 percent. Hospitals with a wage index less than or equal to 1 will continue to have a hospital labor-related share of 62 percent.
- The effects of the recalibration of the DRG relative weights as required by section 1886(d)(4)(C) of the Act, including the wage and recalibration budget neutrality factors.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2010.
- The effects of the second year of the 3-year transition to apply rural floor budget neutrality adjustment at the State level. In FY 2010, hospitals will receive a blended wage index that is 50 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 50 percent of a wage index with the national budget neutrality adjustment.
- The effects of section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.
- The total estimated change in payments based on the FY 2010 policies relative to payments based on FY 2009 policies that include the market basket update of 2.1 percent.

To illustrate the impacts of the FY 2010 changes, our analysis begins with a FY 2009 baseline simulation model using: the FY 2010 market basket update of 2.1 percent; the FY 2009 MS–DRG GROUPER (Version 26.0); the most current CBSA designations for hospitals based on OMB's MSA definitions; the FY 2009 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a) of Public Law 109–171, provides that, for FY 2007 and subsequent years, the update factor will be reduced by 2.0 percentage points for any hospital that does not submit quality data in a form and manner and at a time specified by the Secretary. At the time this impact was prepared, 94 hospitals did not receive the full market basket rate-of-increase for FY 2009 because they failed the quality data submission process. For purposes of the simulations shown below, we modeled the

payment changes for FY 2010 using a reduced update for these 94 hospitals. However, we do not have enough information at this time to determine which hospitals will not receive the full market basket rate-of-increase for FY 2010.

Each policy change, statutorily or otherwise, is then added incrementally to this baseline, finally arriving at an FY 2010 model incorporating all of the changes. This simulation allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 2009 to FY 2010. Three factors not discussed separately have significant impacts here. The first factor is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we are updating the standardized amounts for FY 2010 using the most recently forecasted hospital market basket increase for FY 2010 of 2.1 percent. (Hospitals that fail to comply with the quality data submission requirements to receive the full update will receive an update reduced by 2.0 percentage points from 2.1 percent to 0.1 percent.) Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for SCHs and for MDHs are also equal to the market basket percentage increase, or 2.1 percent.

A second significant factor that affects the changes in hospitals' payments per case from FY 2010 to FY 2010 is the change in a hospital's geographic reclassification status from one year to the next. That is, payments may be reduced for hospitals reclassified in FY 2009 that are no longer reclassified in FY 2010. Conversely, payments may increase for hospitals not reclassified in FY 2009 that are reclassified in FY 2010. In addition, section 508 of Public Law 108–173, the special reclassification provision, is set to expire in FY 2010. The section 508 reclassification is a nonbudget neutral provision, so overall payments will be reduced as a result of the expiration of this provision. In the impact analysis for this final rule, the expiration of certain special exceptions as well as section 508 of Public Law 108–173 resulted in substantial impacts for a relatively small number of hospitals in a particular category because those providers have lost their reclassification status resulting in a percentage change in payments for the category to be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 2009 will be 5.4 percent of total DRG payments. When the FY 2008 final rule was published, we projected FY 2009 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2009 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2009 payments per case to estimated FY 2010 payments per case (with outlier payments projected to equal 5.1 percent of total DRG payments).

B. Analysis of Table I

Table I displays the results of our analysis of the changes for FY 2010. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,517 acute care hospitals included in the analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location: all urban, which is further divided into large urban and other urban; and rural. There are 2,525 hospitals located in urban areas included in our analysis. Among these, there are 1,377 hospitals located in large urban areas (populations over 1 million), and 1,148 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 992 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2010 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the numbers of hospitals paid based on these categorizations after consideration of geographic reclassifications (including reclassifications under section 1886(d)(8)(B) and section 1886(d)(8)(E) of the Act that have implications for capital payments) are 2,593, 1,422, 1,171 and 924, respectively.

The next three groupings examine the impacts of the changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,475 nonteaching hospitals in our analysis, 804 teaching hospitals with fewer than 100 residents, and 238 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural for DSH purposes. The next category groups together hospitals considered urban or rural, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the changes on rural hospitals by special payment groups (SCHs, RRCs, and MDHs). There were 187 RRCs, 337 SCHs, 186 MDHs, and 106 hospitals that are both SCHs and RRCs, and 15 hospitals that are both an MDH and an RRC.

The next series of groupings are based on the type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data were taken from the FY 2007 or FY 2006 Medicare cost reports.

The next two groupings concern the geographic reclassification status of hospitals. The first grouping displays all urban hospitals that were reclassified by the MGCRB for FY 2010. The second grouping shows the MGCRB rural reclassifications. The final category shows the impact of the policy changes on the 20 cardiac hospitals in our analysis.

TABLE I—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2010

	Number of hospitals	FY 2010 Weights & DRG changes (1)	Application of re-calibration budget neutrality (2)	FY 2010 Wage data and labor-related share (3)	Application of wage budget neutrality (4)	FY 2010 DRG, rel. wts., wage index changes, labor-related share with wage and re-calibration budget neutrality (5)	FY 2010 MGCRB reclassifications (6)	Transitional ½ within state rural floor budget neutrality and ½ national rural floor budget neutrality (7)	FY 2010 Out-migration adjustment (8)	All FY 2010 changes (9)
All Hospitals	3,517	0.2	0	0	0	0	0	0	0	1.6
By Geographic Location:										
Urban hospitals	2,525	0.2	0	0	0	0	−0.2	0	0	1.6
Large urban areas	1,377	0.2	0	0	0	0	−0.3	0	0	1.7
Other urban areas	1,148	0.2	0	−0.1	0	−0.1	0	0.1	0	1.5
Rural hospitals	992	0	−0.2	−0.2	−0.1	−0.3	1.8	−0.1	0.1	1.6
Bed Size (Urban):										
0–99 beds	634	0.4	0.1	0.1	0.2	0.2	−0.5	0	0	1.8
100–199 beds	808	0.2	0	0	0	0	−0.1	0.1	0	1.6
200–299 beds	466	0.2	0	0	0	0	−0.1	0	0	1.7
300–499 beds	426	0.2	0	−0.1	−0.1	−0.1	−0.2	0	0	1.5

TABLE I—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2010—Continued

	Number of hospitals	FY 2010 Weights & DRG changes (1)	Application of re-calibration budget neutrality (2)	FY 2010 Wage data and labor-related share (3)	Application of wage budget neutrality (4)	FY 2010 DRG, rel. wts., wage index changes, labor-related share with wage and re-calibration budget neutrality (5)	FY 2010 MGCRB reclassifications (6)	Transitional ½ within state rural floor budget neutrality and ½ national rural floor budget neutrality (7)	FY 2010 Out-migration adjustment (8)	All FY 2010 changes (9)
500 or more beds	191	0.2	0	0	0.1	0.1	−0.3	−0.1	0	1.7
Bed Size (Rural):										
0–49 beds	349	−0.1	−0.3	−0.2	−0.1	−0.5	0.5	−0.1	0.2	2.2
50–99 beds	370	0	−0.2	−0.2	−0.1	−0.4	0.9	−0.1	0.1	1.5
100–149 beds	164	0	−0.2	−0.3	−0.2	−0.4	2.3	−0.1	0	1.5
150–199 beds	62	0.1	−0.2	−0.2	−0.1	−0.3	2.4	−0.1	0.1	1.6
200 or more beds	42	0.1	−0.1	−0.1	−0	−0.2	2.6	−0.1	0	1.5
Urban by Region:										
New England	120	0.2	0	1	0.8	0.8	0.7	0.3	0	2.2
Middle Atlantic	344	0.1	0	0	−0.1	−0.1	0.2	0.1	0	1.5
South Atlantic	388	0.2	0	−0.3	−0.2	−0.2	−0.4	−0.1	0	1.5
East North Central	397	0.2	0	−0.4	−0.3	−0.2	−0.3	−0.1	0	1.3
East South Central	160	0.2	0	−0.3	−0.1	−0.1	−0.3	0	0	1.6
West North Central	165	0.3	0	0.3	0.2	0.2	−0.6	−0.1	0	1.8
West South Central	346	0.2	0	−0.3	−0.2	−0.2	−0.6	−0.1	0	1.7
Mountain	163	0.3	0.1	0.9	0.8	0.8	−0.4	0	0	2.9
Pacific	391	0.3	0	0.3	0.2	0.1	−0.2	0.1	0	1.4
Puerto Rico	51	0	−0.2	−0.1	0.2	−0.2	−0.8	−0.1	0	1.6
Rural by Region:										
New England	24	0.1	−0.2	−0.5	−0.5	−0.7	2	−0.2	0	0.2
Middle Atlantic	70	−0.1	−0.3	0.2	0.2	−0.1	1.7	0	0	0.9
South Atlantic	171	0	−0.2	−0.3	−0.2	−0.4	1.7	−0.1	0.1	2.1
East North Central	122	0	−0.2	−0.2	−0.2	−0.4	1.5	−0.1	0	1
East South Central	176	0	−0.2	−0	0.1	−0.2	2.8	−0.1	0.1	1.9
West North Central	101	0	−0.2	−0.2	−0.2	−0.4	0.6	0	0	1.3
West South Central	224	0	−0.2	−0.4	−0.3	−0.5	2.1	−0.1	0.1	1.3
Mountain	72	0.2	0	0.2	0.2	0.2	0.2	0	0	3.7
Pacific	32	0.1	−0.2	−0.3	−0.2	−0.5	1.8	−0.1	0	2.8
By Payment Classification:										
Urban hospitals	2,593	0.2	0	0	0	0	−0.2	0	0	1.6
Large urban areas	1,422	0.2	0	0	0	0	−0.3	0	0	1.7
Other urban areas	1,171	0.2	0	−0.1	0	−0.1	0	0.1	0	1.5
Rural areas	924	−0	−0.2	−0.2	−0.1	−0.3	1.6	0	0.1	1.6
Teaching Status:										
Nonteaching	2,475	0.2	0	−0.1	−0.1	−0.1	0.3	0	0	1.6
Fewer than 100 residents	804	0.2	0	−0.1	0	0	−0.2	0	0	1.6
100 or more residents	238	0.2	0	0.1	0.1	0.1	−0.2	0	0	1.7
Urban DSH:										
Non-DSH	845	0.2	0	−0.1	−0.1	−0.2	0.1	0	0	1.3
100 or more beds	1,538	0.2	0	0	0	0	−0.2	0	0	1.7
Less than 100 beds	346	0.1	−0.1	0.1	0.1	0	−0.2	0	0	1.9
Rural DSH:										
SCH	397	−0.2	−0.3	−0.1	−0.1	−0.4	0.3	0	0.1	2.1
RRC	207	0.1	−0.1	−0.2	−0.1	−0.3	2.7	−0.1	0	1.5
100 or more beds	34	0.1	−0.2	0.3	0.3	0.1	0.9	0.4	0.2	1.5
Less than 100 beds	150	0.1	−0.1	−0.4	−0.2	−0.4	1.4	−0.1	0.3	1.2
Urban teaching and DSH:										
Both teaching and DSH	802	0.2	0	0	0.1	0.1	−0.3	0	0	1.7
Teaching and no DSH	178	0.2	0	−0.2	−0.2	−0.3	0.2	0.1	0	1.3
No teaching and DSH	1,082	0.2	0	−0.1	−0.1	−0.1	0	0.1	0	1.6
No teaching and no DSH	531	0.3	0	0	0	−0.1	−0.2	0	0	1.4
Special Hospital Types:										
RRC	187	0.1	0	0	0.1	−0	3.3	−0.1	0	1.6
SCH	337	−0.1	−0.3	−0.1	−0	−0.4	0.2	0	0	2.1
MDH	186	−0.2	−0.4	−0.2	−0.1	−0.5	0.5	−0.1	0.2	2.2
SCH and RRC	106	0	−0.2	0	0	−0.2	0.7	0	0	1.7
MDH and RRC	15	−0.2	−0.4	−0.2	−0.2	−0.6	0.4	0	0	0.2
Type of Ownership:										
Voluntary	2,014	0.2	0	0	0	−0.1	0	0	0	1.6
Proprietary	860	0.3	0.1	−0.1	0	0	0	−0.1	0	1.7
Government	583	0.1	0	0.1	0.1	0	0	0.1	0	1.9
Medicare Utilization as a Percent of Inpatient Days:										
0–25	317	0.2	0.1	0.4	0.4	0.4	−0.4	−0.1	0	2.2
25–50	1,433	0.2	0	0	0	0	−0.3	0	0	1.7
50–65	1,331	0.1	−0.1	−0.2	−0.1	−0.2	0.6	0	0	1.4
Over 65	308	0	−0.1	−0.3	−0.2	−0.4	0.2	0.1	0.1	1.4
FY 2010 Reclassifications by the Medicare Geographic Classification Review Board:										

TABLE I—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2010—Continued

	Number of hospitals	FY 2010 Weights & DRG changes (1)	Application of re-calibration budget neutrality (2)	FY 2010 Wage data and labor-related share (3)	Application of wage budget neutrality (4)	FY 2010 DRG, rel. wts., wage index changes, labor-re-lated share with wage and re-calibration budget neutrality (5)	FY 2010 MGCRB reclassi-fications (6)	Transi-tional ½ within state rural floor budget neutrality and ½ na-tional rural floor budget neutrality (7)	FY 2010 Out-migration adjustment (8)	All FY 2010 changes (9)
All Reclassified Hospitals	807	0.2	0	−0.2	−0.1	−0.2	2	−0.1	0	1.6
Non-Reclassified Hos-pitals	2,710	0.2	0	0	0	0	−0.7	0	0	1.6
Urban Hospitals Reclassi-fied	456	0.2	0	−0.2	−0.1	−0.2	1.7	−0.1	0	1.6
Urban Nonreclassified Hospitals, FY 2010:	2,045	0.2	0	0	0	0	−0.7	0	0	1.6
All Rural Hospitals Re-classified FY 2010:	351	0.1	−0.1	−0.2	−0.1	−0.3	2.8	−0.1	0	1.7
Rural Nonreclassified Hospitals FY 2010:	579	−0.1	−0.3	−0.2	−0.1	−0.4	−0.3	−0.1	0.2	1.6
All Section 401 Reclassi-fied Hospitals:	32	−0.1	−0.3	0.2	0.2	−0.2	−0.4	0.4	0	0.3
Other Reclassified Hos-pitals (Section 1886(d)(8)(B))	62	−0.1	−0.3	−0.2	−0.1	−0.5	3.1	−0.2	0	0.9
Specialty Hospitals:										
Cardiac specialty Hos-pitals	20	−0.1	−0.2	0	0.1	−0.2	−0.8	0	0	1.6

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2008, and hospital cost report data are from reporting periods beginning in FY 2007 and FY 2006.

[2] This column displays the payment impact of the changes to the Version 27 GROUPER and the recalibration of the DRG weights based on FY 2008 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act.

[3] This column displays the application of the recalibration budget neutrality factor of 0.997941, in accordance with section 1886(d)(4)(C)(iii) of the Act.

[4] This column displays the payment impact of the update to wage index data using FY 2006 cost report data and the update to the labor-related share for providers with a wage index greater than 1. Based on FY 2006 data, the labor related share, or the proportion of the standardized amount that the wage index is applied to, is being reduced from 69.7 percent to 68.8 percent.

[5] This column displays the payment impact of the application of the wage budget neutrality factor, which from now on will be calculated separately from the recalibration budget neutrality factor, and will be calculated in accordance with section 1886(d)(3)(E)(i) of the Act. The wage budget neutrality factor is 1.000407.

[6] This column displays the combined payment impact of the changes in Columns 2 through 5 and the cumulative budget neutrality factor for DRG and wage changes in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act. The cumulative wage and recalibration budget neutrality factor of 0.998347 is the product of the wage budget neutrality factor and the recalibration budget neutrality factor.

[7] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2010 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2009. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.991297.

[8] This column displays the effects of the rural floor and the imputed floor, including the transition to the rural floor budget neutrality adjustment at the State level. Under the transition, hospitals will receive a blended wage index that is 50 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 50 percent of a wage index with the national budget neutrality adjustment.

[9] This column displays the impact of section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

[10] This column shows the changes in payments from FY 2009 to FY 2010. It incorporates all of the changes displayed in Columns 5, 6, 7, and 8 (the changes displayed in Columns 2, 4 are included in Column 5). It also reflects the impact of the FY 2010 market basket update, and changes in hospitals' reclassification status in FY 2010 compared to FY 2009. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effects.

C. Effects of the Changes to the MS–DRG Reclassifications and Relative Cost-Based Weights (Column 1)

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

As discussed in the preamble of this final rule, the FY 2010 DRG relative weights will be 100 percent cost-based and 100 percent MS–DRGs. For FY 2010, the MS–DRGs are calculated using the FY 2008 MedPAR data grouped to the Version 27.0 (FY 2010) DRGs. The methods of calculating the relative weights and the reclassification changes to the GROUPER are described in more detail in section II.H. of the preamble to this final rule. The changes to the relative weights and MS–DRGs shown in Column 2 are prior to any offset for budget neutrality. Overall, hospitals will experience a 0.2 percent increase in payments due to the changes in the MS–DRGs and relative weights prior to budget neutrality. Urban hospitals will experience a 0.2 percent increase in payments under the updates to the relative weights and DRGs, while rural hospitals will not experience a change in payments. Under the MS–DRG system, rural hospitals generally will not experience an increase in payments from recalibration due to the lower acuity of services provided.

D. Effects of the Application of Recalibration Budget Neutrality (Column 2)

Column 2 shows the effects of the changes to the MS–DRGs and relative weights with the application of the recalibration budget neutrality factor to the standardized amounts. Consistent with section 1886(d)(4)(C)(iii) of the Act, we are calculating a recalibration budget neutrality factor to account for the changes in MS–DRGs and relative weights to ensure that the overall payment impact is budget neutral. Beginning in FY 2010, we are calculating a budget neutrality factor to account for changes in MS–DRGs and relative weights separately from the budget neutrality factor to account for changes in wage data. In addition, as described in section II.A.4. of the Addendum to this final rule, we are including IME payments made on Medicare Advantage claims to IPPS hospitals in order to calculate budget neutrality.

The ''All Hospitals'' line in Column 1 indicates that changes due to MS–DRGs and relative weights will increase payments by 0.2 percent before application of the budget neutrality factor. The recalibration budget neutrality factor is 0.997941, which is applied to the standardized amount. Thus, the impact after accounting only for budget neutrality for changes to the MS–DRG relative weights and classification is

somewhat lower than the figures shown in Column 1 (approximately 0.2 percent). Consequentially, urban hospitals will not experience a change in payments when recalibration budget neutrality is applied, while rural hospitals will experience a 0.2 percent decrease in payments due to the lower acuity of services provided.

E. Effects of Wage Index Changes (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for acute care hospitals for FY 2010 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006. The estimated impact of the updated wage data and labor share on hospital payments is isolated in Column 3 by holding the other payment parameters constant in this simulation. That is, Column 3 shows the percentage change in payments when going from a model using the FY 2009 wage index, based on FY 2005 wage data, the current labor-related share and having a 100-percent occupational mix adjustment applied, to a model using the FY 2010 pre-reclassification wage index with the labor-related share, also having a 100-percent occupational mix adjustment applied, based on FY 2006 wage data (while holding other payment parameters such as use of the Version 26.0 DRG GROUPER constant). The occupational mix adjustment is based on the FY 2007/2008 occupational mix survey. The wage data collected on the FY 2006 cost report include overhead costs for contract labor that were not collected on FY 2005 and earlier cost reports. The impacts below incorporate the effects of the FY 2006 wage data collected on hospital cost reports, including additional overhead costs for contract labor compared to the wage data from FY 2005 cost reports that were used to calculate the FY 2009 wage index.

As discussed in section III. of this final rule, under section 1886(d)(3)(E) of the Act, the Secretary estimates from time to time the proportion of payments that are labor-related. ''The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *.'' We refer to the proportion of hospitals' costs that are attributable to wages and wage-related costs as the ''labor-related share.''

The labor-related share is used to determine the proportion of the national IPPS base payment rate to which the area wage index is applied. In this final rule, we describe our updated methodology and data sources to calculate the national labor-related share. In the proposed rule, using the cost category weights from the FY 2006-based IPPS market basket, we proposed a labor-related share of 67.1 percent. In this final rule, based on updated data, we have determined a labor-related share of 68.8 percent, approximately 0.9 percentage points lower than the current labor-related share of 69.7 percent. Accordingly, in this final rule, we are implementing a national labor-related share of 68.8 percent for discharges occurring on or after October 1, 2009. This updated calculation only affects hospitals with a wage index greater than 1. According to section 1886(d)(3)(E)(ii) of the Act, hospitals with a wage index less than or equal to 1 have their wage index adjusted to 62 percent of the national standardized amount; therefore, these hospitals remain unaffected by the updated labor-related share. In addition, we are updating the labor-related share for Puerto Rico. Using FY 2006-based Puerto Rico cost category weights, we calculated a labor-related share of 62.1 percent, approximately 3 percentage points higher than the current Puerto Rico specific labor-related share of 58.721. Accordingly, for FY 2010, we are adopting an updated Puerto Rico labor-related share of 62.1 percent for hospitals with a wage index greater than 1.

Column 3 shows the impacts of updating the wage data using FY 2006 cost reports and the updated labor-related share. The payment changes simulated in this column are used to calculate the wage budget neutrality. Beginning in FY 2010, we are calculating separate wage budget neutrality and recalibration budget neutrality factors, in accordance with section 1886(d)(3)(E) of the Act, which specifies that budget neutrality to account for wage changes or updates made under that subparagraph must be made without regard to the 62 percent labor-related share guaranteed under section 1886(d)(3)(E)(ii) of the Act. Therefore, for FY 2010, we are calculating the wage budget neutrality factor to ensure that payments under updated wage data and the labor-related share are budget neutral without regard to the lower labor-related share of 62 percent applied to hospitals with a wage index less than or equal to 1. In other words, the wage budget neutrality is calculated under the assumption that all hospitals receive the higher labor-related share of the standardized amount. Column 3 shows the effects of the new wage data and new labor share before budget neutrality under the assumption that all providers have their wage index adjusted by the same labor-related share. Overall, the new wage data will lead to a 0.0 percent change for all hospitals before being combined with the wage budget neutrality adjustment shown in Column 5. Thus, the figures in this column are estimated to be the same as what they otherwise would be if they also illustrated a budget neutrality adjustment solely for changes to the wage index and labor-related share. Among the regions, the largest increase is in the urban New England region, which experiences a 1.0 percent increase before applying an adjustment for budget neutrality. The largest decline from updating the wage data is seen in rural New England (−0.5 percent decrease).

In looking at the wage data itself, the national average hourly wage increased 4.0 percent compared to FY 2009. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match or exceed the national 4.0 percent increase in average hourly wage. Of the 3,467 hospitals with wage data for both FYs 2009 and 2010, 1,662, or 47.9 percent, experienced an average hourly wage increase of 4.0 percent or more.

The following chart compares the shifts in wage index values for hospitals for FY 2010 relative to FY 2009. Among urban hospitals, 36 will experience an increase of more than 5 percent and less than 10 percent and 8 will experience an increase of more than 10 percent. Among rural hospitals, 7 will experience an increase of more than 5 percent and less than 10 percent, and none will experience an increase of more than 10 percent. However, 952 rural hospitals will experience increases or decreases of less than 5 percent, while 2,421 urban hospitals will experience increases or decreases of less than 5 percent. Thirty-seven urban hospitals will experience decreases in their wage index values of more than 5 percent and less than 10 percent. Six urban hospitals will experience decreases in their wage index values of greater than 10 percent. No rural hospitals will experience decreases of more than 5 percent. These figures reflect changes in the wage index which is an adjustment to either 68.8 percent or 62 percent of a hospital's standardized amount, depending upon whether its wage index is greater than 1.0 or less than or equal to 1.0. Therefore, these figures are illustrating a somewhat larger change in the wage index than will occur to the hospital's total payment.

The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	8	0
Increase more than 5 percent and less than 10 percent	36	7
Increase or decrease less than 5 percent	2,421	952
Decrease more than 5 percent and less than 10 percent	37	0
Decrease more than 10 percent	6	0

F. Application of the Wage Budget Neutrality Factor (Column 4)

Column 4 shows the impact of the new wage data, new labor share with the application of the wage budget neutrality factor. For FY 2010, we will calculate the wage budget neutrality factor without regard to the lower labor share of 62 percent for hospitals with a wage index less than or equal to 1, in accordance with section 1886(d)(3)(E)(i) of the Act. In other words, the wage budget neutrality is calculated under the assumption that all hospitals receive the labor-related share of 68.8 percent of the standardized amount compared to the current labor-related share of 69.7 percent of the standardized amount. In addition, as described in section II.A.4. of the Addendum to this final rule, we are including IME payments made on Medicare Advantage claims to IPPS hospitals in order to calculate budget neutrality. Because the wage data changes did not change overall payments (displayed in Column 3), the wage budget neutrality factor is minimal at 1.000407, and the overall payment change is 0.0 percent.

G. Combined Effects of MS–DRG and Wage Index Changes (Column 5)

Section 1886(d)(4)(C)(iii) of the Act requires that changes to MS–DRG reclassifications and the relative weights cannot increase or decrease aggregate payments. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. We computed a wage budget neutrality factor of 1.000411, and a recalibration budget neutrality factor of 0.997926 (which is applied to the Puerto Rico specific standardized amount and the hospital-specific rates). The product of the two budget neutrality factors is the cumulative wage and recalibration budget neutrality factor. The cumulative wage and recalibration budget neutrality adjustment is 0.998347 or approximately −0.2 percent which is applied to the national standardized amounts. Because the wage budget neutrality and the recalibration budget neutrality are calculated under different methodologies according to the statute, when the two budget neutralities are combined and applied to the standardized amount, the overall payment impact is not necessarily budget neutral. However, in this final rule, we are estimating that the changes in the DRG, relative weights and updated wage data and rebased labor-related share with wage and budget neutrality applied will result in a 0.0 change in payments. The estimated changes shown in this column reflect the combined effects of the changes in Columns 2, 3, and 4 and the budget neutrality factors discussed previously.

We estimate that the combined impact of the changes to the relative weights and DRGs, the updated wage data and changes to the labor share with budget neutrality applied will result in no change in payments for urban hospitals. Rural hospitals will generally experience a decrease in payments (−0.3 percent) primarily due to payment decreases under the MS–DRGs and wage data. Among the rural hospital categories, rural New England hospitals will experience the greatest decline in payment (−0.7 percent) primarily due to the changes to MS–DRGs and the relative cost weights.

H. Effects of MGCRB Reclassifications (Column 6)

Our impact analysis to this point has assumed acute care hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on other bases than where they are geographically located). The changes in Column 6 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2010 which affect hospitals' wage index area assignments. By Spring of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's wage index value. Hospitals may appeal denials of MGCRB decisions to the CMS Administrator. Further, hospitals have 45 days from publication of the IPPS rule in the **Federal Register** to decide whether to withdraw or terminate an approved geographic reclassification for the following year. This column reflects all MGCRB decisions, Administrator appeals and decisions of hospitals for FY 2010 geographic reclassifications. The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, for the purposes of this impact analysis, we are applying an adjustment of 0.991297 to ensure that the effects of the section 1886(d)(10) reclassifications are budget neutral. (See section II.A. of the Addendum to this final rule.) Geographic reclassification generally benefits hospitals in rural areas. We estimate that geographic reclassification will increase payments to rural hospitals by an average of 1.8 percent.

Table 9A of the Addendum to this final rule reflects the approved reclassifications for FY 2010.

I. Effects of the Rural Floor and Imputed Floor, Including the Transition To Apply Budget Neutrality at the State Level (Column 7)

As discussed in section III.B. of the preamble of the FY 2009 IPPS final rule and this final rule, section 4410 of Public Law 105–33 established the rural floor by requiring that the wage index for a hospital in any urban area cannot be less than the wage index received by rural hospitals in the same State. In FY 2008, we changed how we applied budget neutrality to the rural floor. Rather than applying a budget neutrality adjustment to the standardized amount, a uniform budget neutrality adjustment is applied to the wage index. In the FY 2009 final rule, we finalized the policy to apply the rural floor budget neutrality at the State level with a 3-year transition. In FY 2009, hospitals received a blended wage index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. As described in FY 2009 IPPS final rule (73 FR 48570), in FY 2010, hospitals will receive a blended wage index that is 50 percent of a wage index with the State level rural and imputed floor budget neutrality and 50 percent of a wage index with the national budget neutrality adjustment. The national rural floor budget neutrality applied to the wage index is 0.996705. The blended rural floor budget neutrality factors applied to the wage index are shown in Table 4D–1 in the Addendum to this final rule. After the wage index is blended, an additional adjustment of 0.999995 is applied to the wage index to ensure that payments before the application of the rural floor are equivalent to the payments under the blended budget neutral rural floor wage index.

Furthermore, the FY 2005 IPPS final rule (69 FR 49109) established a temporary imputed floor for all urban States from FY 2005 to FY 2007. The rural floor requires that an urban wage index cannot be lower than the wage index for any rural hospital in that State. Therefore, an imputed floor was established for States that do not have rural areas or rural IPPS hospitals. In the FY 2008 IPPS final rule with comment period (72 FR 47321), we finalized our proposal to extend the imputed floor for 1 additional year. In the FY 2009 IPPS final rule (73 FR 48573), we extended the imputed floor for an additional 3 years through FY 2011. Furthermore, in that final rule, we provided for a 3-year transition to the rural floor budget neutrality adjustment at the State level. Therefore, we also apply the imputed floor budget neutrality adjustment at the State level through a 3-year transition, so that wage indices adjusted for the imputed floor will be blended where 50 percent of the wage index will have the national rural and imputed floor budget neutrality factor applied and 50 percent of the wage index will have the within-State rural and imputed budget neutrality factor applied. The national rural floor budget neutrality factor listed also incorporates the imputed floor in its adjustment to the wage index.

Column 7 shows the projected impact of the rural floor and the imputed floor, including the application of the transition to within-State rural and imputed floor budget neutrality. The column compares the post-reclassification FY 2010 wage index of providers before the rural floor adjustment and the post-reclassification FY 2010 wage index of providers with the rural floor and imputed floor adjustment. Only urban hospitals can benefit from the rural floor provision. Because the provision is budget neutral, in prior years, all other hospitals (that is, all rural hospitals and those urban hospitals to which the adjustment is not made) had experienced a decrease in payments due to the budget neutrality adjustment applied nationally. However, because, for FY 2010, the rural floor adjusted wage index is based on a blend where 50 percent of the wage index will have a within-State budget neutrality factor applied and 50 percent of the wage index will have a national rural floor budget neutrality factor applied, rural hospitals and urban hospitals that do not benefit from the rural floor will

continue to see decreases in payments, to a lesser extent. Conversely, all hospitals in States with hospitals receiving a rural floor will have their wage indices only partly downwardly adjusted to achieve budget neutrality within the State.

We project that, in aggregate, rural hospitals will experience a 0.1 percent decrease in payments as a result of the application of rural floor budget neutrality because these hospitals do not benefit from the rural floor, but have their wage indexes downwardly adjusted to ensure that the application of the rural floor is budget neutral overall. We project hospitals located in other urban areas (populations of 1 million or fewer) will experience a 0.1 percent increase in payments because those providers benefit from the rural floor. The rural floor in Connecticut has increased significantly resulting in increased payments to urban hospitals in Connecticut that qualify for the rural floor. Because the rural floor is a budget neutral provision, rural hospitals located in Connecticut and non-rural floor urban providers will have their wage index downwardly adjusted by a rural floor budget neutrality factor of 0.978887 (or −2.1 percent). As a result, rural New England hospitals can expect decreases in payments by 0.2 percent while urban New England hospitals can expect increases in payments of 0.3 percent. Urban Middle Atlantic hospitals can expect a payment increase of 0.1 percent primarily due to payment increases among urban hospitals in New Jersey, which is the only State that benefits from the imputed floor.

J. Effects of the Wage Index Adjustment for Out-Migration (Column 8)

Section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county, post-reclassification and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index. With the out-migration adjustment, small rural providers DSH providers with less than 100 beds will experience a 0.3 percent increase in payments in FY 2010 relative to no adjustment at all. We included these additional payments to providers in the impact table shown above, and we estimate the impact of these providers receiving the out-migration increase to be approximately $20 million.

K. Effects of All Changes (Column 9)

Column 9 shows our estimate of the changes in payments per discharge from FY 2009 and FY 2010, resulting from all changes reflected in this final rule for FY 2010 (including statutory changes). In the IPPS proposed rule, we had proposed to apply FY 2010 documentation and coding adjustment of −1.9 percent on the national standardized amount, −2.5 percent on the hospital-specific amount and −1.1 percent on the Puerto Rico-specific rate. However in this final rule, we have decided to postpone the application of the documentation and coding adjustments. Because the hospital payment projections are based on FY 2008 Medicare claims data and we believe that case-mix was expected to increase an additional 1.54 percent in FY 2009 and in FY 2010, the payment models reflect a case-mix growth of 1.54 percent in FY 2009 and in FY 2010.

Column 9 reflects the impact of all FY 2010 changes relative to FY 2009, including those shown in Columns 1 through 8. The average increase in payments under the IPPS for all hospitals is approximately 1.6 percent. This average increase includes the effects of the 2.1 percent market basket update, the −0.3 percentage point difference between the projected outlier payments in FY 2009 (5.1 percent of total DRG payments), the current estimate of the percentage of actual outlier payments in FY 2009 (5.4 percent), and a 0.2 percent decrease in payments due to the expiration of section 508 reclassification.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in Column 9 may not equal the sum of the percentage changes described above.

The overall change in payments per discharge for hospitals paid under the IPPS in FY 2010 is estimated to increase by 1.6 percent. The payment increases among the hospital categories are largely due to the market basket update. Hospitals in urban areas will experience an estimated 1.6 percent increase in payments per discharge in FY 2010 compared to FY 2009. Hospitals in large urban areas will experience an estimated 1.7 percent increase and hospitals in other urban areas will experience an estimated 1.5 percent increase in payments per discharge in FY 2010 as compared to FY 2009. Hospital payments per discharge in rural areas are estimated to increase by 1.6 percent in FY 2010 as compared to FY 2009.

Among urban census divisions, the largest estimated payment increases will be 2.2 percent in the New England region and 2.9 percent in the Mountain region. Among the rural regions, the providers in the Mountain region will experience the largest increase in payments (3.7 percent) because several rural SCHs located in this region will benefit from rebasing to the 2006 hospital-specific rate under section 112 of Public Law 110–275 (MIPPA). The rural providers in the New England region will have the smallest increase among rural regions at 0.2 percent due to decreases associated with the application of the rural floor budget neutrality on their wage index.

Among special categories of rural hospitals, MDHs will receive an estimated payment increase of 2.2 percent. MDHs are paid the higher of the IPPS rate based on the national standardized amount, that is, the Federal rate, or, if the hospital-specific rate exceeds the Federal rate, the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate. This payment impact accounts for the corrected wage and recalibration budget neutrality factor, described in section V.B.2. of the preamble of this final rule, applied to the hospital-specific rates for MDHs that are paid based on their FY 2002 hospital-specific rate. Overall, SCHs will experience an estimated increase in payments by 2.1 percent. The increase in payments to SCHs can be largely attributed to the implementation of section 112 of Pub. L. 110–275 (MIPPA), which allowed for SCHs to be paid based on a FY 2006 hospital-specific rate (that is, based on their updated costs per discharge from their 12-month cost reporting period beginning during Federal FY 2006), if this results in the greatest payment to the SCH, effective for cost reporting periods beginning on or after January 1, 2009. We estimated the FY 2006 hospital-specific rate for SCHs that we believed will benefit from the rebased rate and included those rates in our analysis.

Rural hospitals reclassified for FY 2010 are anticipated to receive a 1.7 percent payment increase, and rural hospitals that are not reclassifying are estimated to receive a payment increase of 1.6 percent.

Cardiac hospitals are expected to experience a payment increase of 1.6 percent in FY 2010 relative to FY 2009.

L. Effects of Policy on Payment Adjustments for Low-Volume Hospitals

For FY 2010, we are proposing to continue to apply the volume adjustment criteria we specified in the FY 2005 IPPS final rule (69 FR 49099). We expect that two providers will receive the low-volume adjustment for FY 2010. We estimate that low-volume hospitals will experience an increase of $82,000 in payments due to the low volume payment adjustment.

M. Impact Analysis of Table II

Table II presents the projected impact of the changes for FY 2010 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated average payments per discharge for FY 2009 with the payments per discharge for FY 2010, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The estimated percentage changes shown in the last column of Table II equal the estimated percentage changes in average payments per discharge from Column 9 of Table I.

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2010 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per discharge]

	Number of hospitals	Average FY 2009 payment per discharge [1] (2)	Average FY 2010 payment per discharge [1] (3)	All FY 2010 changes (4)
All hospitals	3,517	$9,996	$10,158	1.6
By Geographic Location:				
Urban hospitals	2,525	10,435	10,605	1.6
Large urban areas (populations over 1 million)	1,377	11,003	11,192	1.7
Other urban areas (populations of 1 million or fewer)	1,148	9,749	9,895	1.5
Rural hospitals	992	7,397	7,516	1.6
Bed Size (Urban):				
0–99 beds	634	7,867	8,008	1.8
100–199 beds	808	8,798	8,935	1.6
200–299 beds	466	9,660	9,825	1.7
300–499 beds	426	10,886	11,048	1.5
500 or more beds	191	12,925	13,149	1.7
Bed Size (Rural):				
0–49 beds	349	5,996	6,128	2.2
50–99 beds	370	6,900	7,005	1.5
100–149 beds	164	7,333	7,445	1.5
150–199 beds	62	8,116	8,246	1.6
200 or more beds	42	9,225	9,363	1.5
Urban by Region:				
New England	120	10,821	11,055	2.2
Middle Atlantic	344	11,479	11,651	1.5
South Atlantic	388	9,769	9,920	1.5
East North Central	397	9,825	9,954	1.3
East South Central	160	9,337	9,491	1.6
West North Central	165	10,016	10,198	1.8
West South Central	346	9,697	9,863	1.7
Mountain	163	10,539	10,846	2.9
Pacific	391	12,821	13,004	1.4
Puerto Rico	51	5,044	5,126	1.6
Rural by Region:				
New England	24	9,791	9,810	0.2
Middle Atlantic	70	7,802	7,872	0.9
South Atlantic	171	7,197	7,349	2.1
East North Central	122	7,601	7,677	1
East South Central	176	6,704	6,831	1.9
West North Central	101	7,836	7,939	1.3
West South Central	224	6,663	6,747	1.3
Mountain	72	8,038	8,337	3.7
Pacific	32	9,815	10,088	2.8
By Payment Classification:				
Urban hospitals	2,593	10,408	10,578	1.6
Large urban areas (populations over 1 million)	1,422	10,977	11,165	1.7
Other urban areas (populations of 1 million or fewer)	1,171	9,719	9,865	1.5
Rural areas	924	7,465	7,583	1.6
Teaching Status:				
Non-teaching	2,475	8,402	8,536	1.6
Fewer than 100 Residents	804	9,952	10,112	1.6
100 or more Residents	238	14,838	15,091	1.7
Urban DSH:				
Non-DSH	845	8,811	8,930	1.3
100 or more beds	1,538	10,962	11,146	1.7
Less than 100 beds	346	7,393	7,532	1.9
Rural DSH:				
SCH	397	6,777	6,922	2.1
RRC	207	8,203	8,326	1.5
100 or more beds	34	7,022	7,124	1.5
Less than 100 beds	150	5,772	5,841	1.2
Urban teaching and DSH:				
Both teaching and DSH	802	12,012	12,217	1.7
Teaching and no DSH	178	9,663	9,788	1.3
No teaching and DSH	1,082	8,976	9,122	1.6
No teaching and no DSH	531	8,383	8,503	1.4
Rural Hospital Types:				
RRC	187	8,320	8,458	1.6

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2010 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per discharge]

	Number of hospitals	Average FY 2009 payment per discharge [1] (2)	Average FY 2010 payment per discharge [1] (3)	All FY 2010 changes (4)
SCH	337	7,680	7,842	2.1
MDH	186	6,144	6,279	2.2
SCH and RRC	106	9,298	9,459	1.7
MDH and RRC	15	8,292	8,310	0.2
Type of Ownership:				
Voluntary	2,014	10,151	10,308	1.6
Proprietary	860	9,004	9,158	1.7
Government	583	10,402	10,601	1.9
Medicare Utilization as a Percent of Inpatient Days:				
0–25	317	14,046	14,358	2.2
25–50	1,433	11,102	11,293	1.7
50–65	1,331	8,476	8,593	1.4
Over 65	308	7,442	7,549	1.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY 2010 Reclassifications:				
All Reclassified Hospitals FY 2010	807	9,612	9,765	1.6
All Non-Reclassified Hospitals FY 2010	2,710	10,137	10,302	1.6
Urban Reclassified Hospitals FY 2010	456	10,314	10,476	1.6
Urban Non-reclassified Hospitals FY 2010	2,045	10,474	10,646	1.6
Rural Reclassified Hospitals FY 2010	351	7,989	8,122	1.7
Rural Nonreclassified Hospitals FY 2010	579	6,559	6,665	1.6
All Section 401 Reclassified Hospitals	32	9,306	9,335	0.3
Other Reclassified Hospitals (Section 1886(d)(8)(B))	62	7,267	7,333	0.9
Specialty Hospitals:				
Cardiac Hospitals	20	11,461	11,645	1.6

[1]These payment amounts per discharge reflect estimates of case-mix increase of 1.54 percent in FY 2009 and FY 2010. Using FY 2008 claims data to model payments for FY 2009 and FY 2010, we estimate case-mix will increase an additional 1.54 percent from FY 2008 to FY 2009 and from FY 2008 to FY 2010 due to the adoption of MS–DRGs.

VII. Effects of Other Policy Changes

In addition to those policy changes discussed above that we are able to model using our IPPS payment simulation model, we are making various other changes in this final rule. Generally, we have limited or no specific data available with which to estimate the impacts of these changes. Our estimates of the likely impacts associated with these other changes are discussed below.

A. Effects of Policy on HACs, Including Infections

In section II.F. of the preamble of this final rule, we discuss our implementation of section 1886(d)(4)(D) of the Act, which requires the Secretary to identify conditions that are: (1) High cost, high volume, or both; (2) result in the assignment of a case to an MS–DRG that has a higher payment when present as a secondary diagnosis; and (3) could reasonably have been prevented through application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission, unless based on data and clinical judgment, it cannot be determined at the time of admission whether a condition is present. That is, the case will be paid as though the secondary diagnosis were not present. However, the statute also requires the Secretary to continue counting the condition as a secondary diagnosis that results in a higher IPPS payment when doing the budget neutrality calculations for MS–DRG reclassifications and recalibration. Therefore, we will perform our budget neutrality calculations as though the payment provision did not apply, but Medicare will make a lower payment to the hospital for the specific case that includes the secondary diagnosis. Thus, the provision results in cost savings to the Medicare program.

We note that the provision will only apply when one or more of the selected conditions are the only secondary diagnosis or diagnoses present on the claim that will lead to higher payment. Medicare beneficiaries will generally have multiple secondary diagnoses during a hospital stay, such that beneficiaries having one MCC or CC will frequently have additional conditions that also will generate higher payment. Only a small percentage of the cases will have only one secondary diagnosis that would lead to a higher payment. Therefore, if at least one nonselected secondary diagnosis that leads to higher payment is on the claim, the case will continue to be assigned to the higher paying MS–DRG and there will be no Medicare savings from that case.

The HAC payment provision went into effect on October 1, 2008. Our savings estimates for the next 5 fiscal years are shown below:

Year	Savings (in millions)
FY 2010	$21
FY 2011	21
FY 2012	22
FY 2013	22
FY 2014	22

B. Effects of Policy Change Relating to New Medical Service and Technology Add-On Payments

In the proposed rule, we discussed the five applications for add-on payments for new medical services and technologies for FY 2010. After the publication of the proposed rule and prior to publication of this final rule, three of the applicants withdrew their application for consideration of new technology add-on payments in FY 2010. In section II.I. of the preamble to this final rule, we discuss the remaining two applications (LipiScan™ Coronary Imaging System and the Spiration® IBV® Valve System) for add-on payments for new medical services and technologies for FY 2010, as well as the status of the new technology that was approved to receive new technology add-on payments in FY 2009. As explained in that section, add-on payments for new technology

under section 1886(d)(5)(K) of the Act are not required to be budget neutral. However, we are providing an estimate of additional payments for new technology add-on payments because such payments will have an impact on total operating IPPS payments in FY 2010. For FY 2010 we are continuing to make new technology add-on payments for the Cardiowest™ Temporary Total Artificial Heart System (TAH-t). In addition, we are approving the Spiration® IBV® Valve System for new technology add-on payments in FY 2010. We note that new technology add-on payments per case are limited to the lesser of (1) 50 percent of the costs of the new technology or (2) 50 percent of the amount by which the costs of the case exceed the standard MS–DRG payment for the case. Because it is difficult to predict the actual new technology add-on payment for each case, our estimate below is based on the increase in add-on payments for FY 2010 as if every claim that would qualify for a new technology add-on payments would receive the maximum add-on payment. Therefore, we currently estimate that payments for the TAH-t will increase overall FY 2010 payments by $9.54 million. For the Spiration® IBV® Valve System, the applicant estimates that approximately 2,286 Medicare beneficiaries will be eligible for the Spiration® IBV® Valve System. Therefore, we currently estimate that payments for the Spiration® IBV® Valve System will increase overall FY 2010 payments by $7.80 million.

C. Effects of Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In section V.A. of the preamble of this final rule, we discuss our requirements for hospitals to report quality data under the RHQDAPU program in order to receive the full payment update for FY 2010 and FY 2011. We estimate that 96 hospitals may not receive the full payment update for FY 2010 and that 96 hospitals may not receive the full payment update for FY 2011. Most of these hospitals are either small rural or small urban hospitals. However, at this time, information is not available to determine how many hospitals will not meet the requirements to receive the full hospital market basket increase for services furnished in FY 2010 and FY 2011.

For the FY 2010 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability based upon our chart-audit validation process. For all but two measures (SCIP–Infection-4 and SCIP–Infection-6), this process uses four quarters of data from FY 2008. These data were due to the QIO Clinical Warehouse by May 15, 2008 (fourth quarter CY 2007 discharges), August 15, 2008 (first quarter CY 2008 discharges), November 15, 2008 (second quarter CY 2008 discharges), and February 15, 2009 (third quarter CY 2008 discharges). For the SCIP–Infection-4 and SCIP–Infection-6 measures, the validation process will be based on two quarters of data from FY 2008. These data were due to the QIO Clinical Warehouse by November 15, 2008 (second quarter CY 2008 discharges) and February 15, 2009 (third quarter CY 2008 discharges).

In section V.A.9. of the preamble of this final rule, we state that if we determine that a hospital is not entitled to receive the full FY 2010 payment update because it failed to satisfy the validation requirement, and the hospital asks for a reconsideration of that decision, the hospital must submit complete copies of the medical records that it submitted to the CDAC contractor for purposes of the validation. We estimate that no more than 20 hospitals will fail the validation requirement for the FY 2010 payment update. We estimate that this policy will cost hospitals approximately 12 cents per page for copying and approximately $4.00 per chart for postage. We have found, based on experience, that an average sized medical chart is approximately 150 pages. Hospitals will be required to return all 20 sampled medical records for the four quarters of data from FY 2008. We estimate that the total cost to the 20 impacted hospitals will be approximately $8,800, or $440 per hospital. We believe that this cost is minimal, compared with the 2.0 percentage point RHQDAPU program component of the annual payment update at risk. This requirement is necessary so that CMS has all the information it needs to fairly and timely make a decision on the hospital's reconsideration request. We also anticipate that this requirement will benefit hospitals seeking reconsiderations because it will enable us to resolve potential issues earlier in the appeals process, obviating the need for a hearing before the Provider Reimbursement Review Board (PRRB). We believe that this benefit will greatly outweigh the burden of copying and mailing the requested records.

For the FY 2011 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability based upon our chart-audit validation process. For all but one measure (SCIP–Cardiovascular-2), this process will use four quarters of data from FY 2009. These data are due to the QIO Clinical Warehouse by May 15, 2009 (fourth quarter CY 2008 discharges), August 15, 2009 (first quarter CY 2009 discharges), November 15, 2009 (second quarter CY 2009 discharges), and February 15, 2010 (third quarter CY 2009 discharges). For the SCIP–Cardiovascular-2 measure, the validation process will be based on two quarters of data from FY 2009. SCIP–Cardiovascular-2 data are due to the QIO Clinical Warehouse by November 15, 2009 (second quarter CY 2009 discharges) and February 15, 2010 (third quarter CY 2009 discharges).

We have continued our efforts to ensure that QIOs provide assistance to all hospitals that wish to participate in the RHQDAPU program. The requirement of 5 charts per hospital will result in approximately 21,500 charts per quarter being submitted to CMS for the FY 2010 payment update and for the FY 2011 payment update. We reimburse hospitals for the cost of sending charts to the CDAC contractor at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received by the CDAC contractor is approximately 150 pages. Thus, CMS will have expenditures of approximately $597,600 per quarter to collect the charts. Because we reimburse hospitals for the data collection effort, we believe that a requirement for five charts per hospital per quarter represents a minimal burden to the participating hospital.

We are modifying our validation process for the FY 2012 payment update. We believe that our decision to validate data submitted by 800 hospitals for the FY 2012 RHQDAPU payment determination will not change the number of hospitals that fail the validation requirement for the FY 2012 payment update. We have changed the way we calculate the validation matches (that is, all relevant data elements submitted by the hospital must match the independently re-abstracted data elements to count as a match), which will make it more difficult for hospitals to satisfy the validation requirement. However, we will also validate data for a much smaller number of hospitals each year and we have reduced the validation score needed to satisfy the validation requirement. In combination, we believe that these revisions will counterbalance each other and result in no change to the number of hospitals failing our validation requirement for the FY 2012 payment update.

D. Effects of Correcting the FY 2002-Based Hospital-Specific Rates for MDHs

In section V.B. of the preamble of this final rule, we are correcting the calculation of the FY 2002 hospital-specific rates for MDHs and applying a cumulative budget neutrality adjustment factor for DRG changes for FYs 1993 through 2002, in addition to the cumulative budget neutrality adjustment factors for FYs 2003 forward (which have already been applied). The cumulative budget neutrality adjustment factor of 0.982557 is calculated as the product of the following budget neutrality adjustment factors for FYs 1993 through 2002: 0.999851 for FY 1993; 0.999003 for FY 1994; 0.998050 for FY 1995; 0.999306 for FY 1996; 0.998703 for FY 1997; 0.997731 for FY 1998; 0.998978 for FY 1999; 0.997808 for FY 2000; 0.997174 for FY 2001; and 0.995821 for FY 2002. We estimate that there are currently about 195 MDHs. We estimate that approximately 60 percent of MDHs qualified for the rebasing to a FY 2002 hospital-specific rate (that is, their FY 2002 hospital-specific rate was higher than the other hospital-specific rates (FY 1982 or FY 1987)), of which about 46 percent of those MDHs were paid based on their FY 2002 hospital-specific rate because it was higher than the Federal rate. The remaining 54 percent of those MDHs are estimated to have been paid based solely on the Federal rate because the Federal rate was higher than their FY 2002 hospital-specific rate. We estimate that correcting the FY 2002 hospital-specific rate to ensure cumulative budget neutrality for FY 1993 though FY 2002 will result in a decrease in operating IPPS payments in FY 2010 of approximately $5 million. However, this figure may be lower because application of the cumulative budget neutrality adjustment factor will, in some cases, lower the FY 2002 hospital-specific rate to below the Federal rate, thus creating a floor to the potential reduction.

E. Effect of Policy Changes Relating to the Payment Adjustments to Disproportionate Share Hospitals

1. Change Relating to Inclusion of Labor and Delivery Days in DSH Calculation

In section V.E.2. of the preamble of this final rule, we discuss our decision to amend the regulations so that patient days associated with labor and delivery services furnished in an ancillary labor and delivery bed will always be included in both the Medicaid and Medicare fractions of the DPP used for calculating the DSH payment adjustment regardless of whether the patient previously occupied a routine bed. We believe that the impact of the inclusion of these days in the Medicare fraction of the DPP will be negligible because, generally, there are not many labor and delivery patient days among the Medicare population. With respect to the Medicaid fraction, we do not believe the impact will be substantial, since it will only recategorize ancillary labor and delivery bed days that did not follow a routine bed day, and will affect both the numerator and the denominator of the Medicaid fraction. We are not able to provide a detailed analysis of the potential of this policy change because the impact will depend on both the number of days associated with Medicaid-eligible patients who occupied an ancillary labor and delivery bed at some point after being admitted as an inpatient, but prior to occupying a routine bed, and the number of such days associated with similarly situated non-Medicaid-eligible patients. We do not have data on either of these numbers either in the aggregate or for individual hospitals. Furthermore, the impact would depend on the proportion of Medicaid to the total of such days for each hospital. We expect that the Medicaid fraction for some hospitals will increase while it will decrease for other hospitals. Therefore, we estimate that the overall impact of this policy change will be negligible.

Comment: One comment stated that ''nearly all hospital will see there [sic] DSH payment go up and by a substantial amount.'' The commenter stated that overall utilization is ''substantially higher'' than overall hospital utilization as the result of a Medicaid law that requires Medicaid coverage for labor and delivery services for patients who would not normally have full-scope Medicaid. The commenter stated that it is important that the financial impact of this policy is not understated and that hospitals need to be able to budget for the increase in Medicare DSH funding from this policy. Finally, the commenter stated that if the proposed policy was applied retroactively, it would result in large payment increases for thousands of cost reports for many years as well as the administrative costs to reopen and revise the cost reports. The commenter stated that there are many appeals and requests for cost report reopenings based on the proposed policy and that the costs and potential payments should be identified and quantified in the final rule.

Response: It appears that the commenter is concerned with the potential financial impact of the proposed policy because the commenter believed that the policy will necessarily increase the Medicaid fraction of the Medicare DSH calculation for all hospitals and thereby increase overall DSH payment adjustments. The commenter appeared particularly concerned with the ''Emergency Medicaid'' laws under section 1903(v) of the Act that requires that an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United states under the color of the law be covered under Medicaid for the treatment of an ''emergency medical condition'' as defined by the statute. We disagree with the commenter that the adoption of the proposed policy will necessarily increase overall Medicare DSH payments for the reasons discussed below.

First, we reiterate that this policy change relates only to labor and delivery days when a patient was (1) admitted as an inpatient to the hospital and (2) occupied an ancillary labor and delivery bed prior to occupying a routine bed. Patients who occupied a routine bed upon admission or prior to occupying an ancillary labor and delivery bed were already counted in the DPP. In most cases, there would only be one day (*i.e.,* the day that the patient occupied the ancillary labor and delivery bed prior to occupying the routine bed) that would be added to the DPP under the new policy that was not already included under the previous policy. Under both the previous and new policy all days that a patient occupied a routine bed are already included in the DPP. Therefore, the new policy would potentially only add one day in most cases to the DPP per maternity patient to the extent the hospital placed such patients in an ancillary labor and delivery bed after admission as an inpatient to the hospital, but prior to placing the patient in a routine bed. To the extent that the maternity patient was a Medicaid-eligible patient, the day would be added to both the numerator and denominator of the Medicaid fraction of the DPP; to the extent that the patient was not eligible for Medicaid, one day would be added just to the denominator of the Medicaid fraction of the DPP (thereby lowering the Medicaid ratio).

Second, we note that the population of aliens, as defined under section 1903(v) of the Act, varies from State to State and that, even in an area with a relatively high proportion of aliens, the potential effect on the Medicaid fractions is limited to the number of aliens who are (1) female, (2) pregnant and in the hospital for labor and delivery services, and (3) admitted as an inpatient, but do not occupy a routine bed prior to occupying a labor and delivery bed. Therefore, we do not expect that, even for areas with a large population of aliens, there will be a material impact on a hospital's Medicare DSH payment adjustments as a result of this policy.

Third, we note that an increase in the Medicaid fraction does not necessarily correlate to a proportional increase in the actual Medicare DSH adjustment (that is, payment). Rather, the actual amount of the adjustment will depend on a number of factors, including the Medicare fraction, the hospital's geographic designation, the hospital's number of available beds, and, ultimately, the hospital's number of Medicare discharges because, by definition, the Medicare DSH adjustment is a percentage add-on to the hospital's Medicare payments.

In addition, as we stated in the proposed FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, with regard to the Medicaid fraction, we are not able to provide a detailed analysis of the potential of this policy change because the impact will depend on the proportion of days associated with Medicaid-eligible patients who occupied an ancillary labor and delivery bed at some point after being admitted as an inpatient, but prior to occupying a routine bed, to days associated with similarly situated non-Medicaid-eligible patients relative to a hospital's current Medicaid-to-total-days ratio (which would not have included the types of days we proposed to include in this policy). We expect that the Medicaid fraction for some hospitals will increase while it will decrease for other hospitals. Therefore, we estimate that the overall impact of this policy change will be negligible.

In response to the comment concerning the potential impact that this policy would have if applied retroactively, we note that the change in policy is only effective prospectively, for cost reporting periods beginning on or after October 1, 2009. Therefore, it is not necessary to estimate payments for prior periods.

2. Change Relating to Calculation of Inpatient Days in Medicaid Fraction

In section V.E.3. of the preamble of this final rule, we discuss our decision to allow a hospital to change its methodology of reporting days in the numerator of the Medicaid fraction of the DPP used in the DSH payment adjustment calculation. Under the change, we will allow a hospital to report the Medicaid days in the numerator of the Medicaid fraction of the DPP based on one of the following: date of discharge; date of admission; or dates of service. Hospitals will be permitted to use only one basis for all of the Medicaid days for the entire cost reporting period. In addition, under the policy, CMS, or its fiscal intermediaries or MACs, has the authority to make adjustments to the number of Medicaid days reported to avoid counting Medicaid days in one cost reporting period of a hospital that may have been reported in a hospital's previous cost reporting period. We do not believe that the change in the methodology of counting days in the numerator of the Medicaid fraction of the DPP will result in any increase in aggregate DSH payments.

3. Change Relating to Exclusion of Observation Beds and Patient Days From DSH Calculation

In section V.E.4. of the preamble of this final rule, we discuss our decision to amend the regulations so that patient days associated with beds used for observation services for patients who are subsequently admitted as an inpatient are no longer included in the DPP for calculating the DSH payment adjustment or in the available bed day count for calculating the DSH payment adjustment and IME payments. Some hospitals may receive increased DSH payment adjustments and other hospitals may expect to receive lower DSH payment

adjustments, depending on how the exclusion of observation patient days affects the hospital's overall DPP. Overall, we estimate the DSH savings associated with this policy will be $10 million for FY 2010. For IME payment purposes, a decrease in a hospital's number of available beds results in an increase in the resident-to-bed ratio. The exclusion of observation bed days from the available bed count for IME will reduce the available beds, increase the resident-to-bed ratio, and, consequently, increase IME payments to teaching hospitals. We estimate that Medicare spending for IME will increase by approximately $7 million as a result of this policy. As a result, we believe that any savings associated with changes in DSH payment adjustments will be offset by additional spending for IME payments. Therefore, we anticipate the impact of these policy changes will be negligible.

F. Effects of Policy Revisions Related to Payment to Hospitals for Direct GME

In section V.G. of the preamble of this final rule, we discuss our decision to clarify the definition of a new medical residency training program in the regulations by specifying that a new medical residency program is one that receives initial accreditation for the first time, as opposed to a reaccreditation of a program that existed previously at the same or another hospital. When considering whether a particular program is a new medical residency training program and whether an accreditation is an initial one, we identify several supporting factors (such as whether the program director, teaching staff, and residents are the same). We will also consider whether there previously was a program in the same specialty at a hospital that closed and, more generally, whether that program is part of the FTE caps of any existing hospital. With respect to GME policy regarding Medicare GME affiliation agreements, we discuss our addition of a provision to the regulations relating to Medicare GME affiliation agreements to specify that a hospital that is new after July 1 and that begins training residents for the first time after the July 1start date of that academic year will be permitted to submit a Medicare GME affiliation agreement prior to the end of its cost reporting period in order to participate in an existing Medicare GME affiliated group for the remainder of the academic year.

With respect to the first policy regarding a new medical residency training program, there is no financial impact on the Medicare program because this is a clarification of existing policy and is not a policy revision or addition of a new policy. In the clarification, we identify and explain the characteristics of a medical residency training program that would be indicative of a new program rather than one that has been merely relocated from another hospital. We also explain that there would be no net increase in the national aggregate FTE caps, and therefore, no financial impact, if a hospital received a new program adjustment to its FTE cap for a program in the same specialty as one that was located at another hospital that closed. Further, there is no financial impact related to the second policy concerning Medicare GME affiliated groups because it does not provide for an increase in the aggregate number of resident FTEs. Rather, it merely provides increased flexibility for a hospital that is new after July 1 and that begins training residents for the first time after the start date of that academic year to enter into an existing Medicare GME affiliation agreement after July 1, so that, in that academic year, it may train and receive IME and direct GME payments relating to FTE for residents that will otherwise be counted for IME and direct GME at another hospital.

G. Effects of Policy Changes Relating to Hospital Emergency Services Under EMTALA

In section V.H. of the preamble of this final rule, we discuss our decision to amend the regulations pertaining to the waiver of EMTALA sanctions in an emergency area during an emergency period to make the regulations consistent with the statutory language of section 1135 of the Act. Specifically, we are revising the existing regulations to reflect the Secretary's authority under section 1135 of the Act to waive or modify requirements for a single health care provider, a class of health care providers, or a geographic subset of health care providers located within an emergency area during an emergency period or portion of an emergency period. We are amending the regulations to clarify that, in cases where the Secretary has delegated implementation of a waiver of EMTALA sanctions to CMS, CMS is also authorized to apply a section 1135 waiver to a subset of the emergency area and some or all of the emergency period, as necessary. We also are making the regulations consistent with section 1135 of the Act by stating in the regulations that a waiver of EMTALA sanctions pursuant to an inappropriate transfer only applies if the transfer is necessitated by the circumstances of the declared emergency. Finally, we are making the regulation text consistent with section 1135 of the Act to provide that the sanctions waived for an inappropriate transfer or for the relocation or redirection of an individual to receive a medical screening examination at an alternate location are only in effect if the hospital to which the waiver applies does not discriminate on the source of an individual's payment or ability to pay. We estimate that these changes will have no impact on Medicare expenditures and no significant impact on hospitals with emergency departments.

H. Effects of Implementation of Rural Community Hospital Demonstration Program

In section V.I. of the preamble to this final rule, we discuss our implementation of section 410A of Public Law 108–173 that required the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that ''[i]n conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' There are currently 11 hospitals participating in the demonstration; 4 of these hospitals were selected to participate in the demonstration as of July 1, 2008, as a result of our February 6, 2008 solicitation (73 FR 6971).

As discussed in section V.I. of the preamble to this final rule, we will satisfy this budget neutrality requirement by adjusting the national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. For this final rule, based on more recent data than we had for the proposed rule, we are estimating the cost of the demonstration program for FY 2010 for the 11 currently participating hospitals. (Two hospitals recently withdrew from the demonstration, and we are adjusting the estimation of the cost of the demonstration for FY 2010 for this final rule to reflect this.) The estimated cost of the demonstration for FY 2010 for 7 of the 11 currently participating hospitals (specifically, the 7 hospitals that have participated in the demonstration since its inception and that still are participating in the demonstration) is based on data from their second year cost reports—that is, cost reporting periods beginning in CY 2006. We used these cost reports because they are the most recent complete cost reports and, thus, we believe they enable us to estimate FY 2010 costs for this final rule as accurately as possible. In addition, we estimated the cost of the demonstration for FY 2010 for the 4 hospitals that joined the demonstration in 2008. For 3 of the 4 hospitals that joined the demonstration in 2008, we estimate the cost of the demonstration for FY 2010 based on data from their cost reports for cost reporting periods beginning January 1, 2007 through July 1, 2007. Similarly, we used these cost reports because they are the most recent cost reports and, thus, we believe they enable us to estimate FY 2010 costs for these 3 hospitals as accurately as possible. The remaining hospital of the 4 that began in 2008 is an Indian Health Service provider. Historically, the hospital has not filed standard Medicare cost reports. In order to estimate its costs, we used an analysis of Medicare inpatient costs and payments submitted by the hospital for the cost reporting period of October 1, 2005, through September 30, 2006. The Medicare cost amount from this analysis for the IHS provider is identical to that used in the proposed rule. When we add together the estimated costs of the demonstration for FY 2010 for the 7 hospitals that have participated in the demonstration since its inception and the 4 new hospitals selected in 2008 based on the more recent data, the total estimated cost is $15,081,251. This estimated amount reflects the difference between the participating hospitals' estimated costs under the methodology set forth in Public Law 108–173 and the estimated amount the hospitals would have been paid under the IPPS.

Second, because the FY 2005 and FY 2006 cost reports of all hospitals participating in the demonstration in its first and second years have been finalized, we are able to determine how much the cost of the demonstration program exceeded the amount that was offset by the budget neutrality

adjustment for FY 2005 and FY 2006. We note that, for this final rule, we had updated data that enabled us to now include the amount by which the cost of the demonstration exceeded the amount that was offset by the FY 2006 budget neutrality adjustment. For all 13 hospitals that participated in the demonstration in FY 2005, the amount is $7,856,617. For the 10 hospitals with cost reporting periods that began in FY 2006, the amount is $4,203,947. The sum of these amounts, or the amount by which the cost of the demonstration program exceeded the offset of the budget neutrality adjustment for FY 2005 and FY 2006, is $12,060,564.

The budget neutrality adjustment factor applied to the IPPS Federal rate to account for the total $27,141,815 in costs for the demonstration is 0.999739.

I. Effects of Policy Changes Relating to Payments to Satellite Facilities

In section VII.B. of the preamble of this final rule, we discuss our policy change that requires, effective for cost reporting periods beginning on or after October 1, 2009, in addition to meeting the other criteria in the regulations, that in order to be excluded from the IPPS, the governing body of the hospital of which the satellite facility is a part cannot be under the control of any third entity that controls both the hospital of which the satellite facility is a part and the hospital with which the satellite facility is co-located. We also are adopting a policy that if a hospital and its satellite facility were excluded from the IPPS under § 412.22(h) for the most recent cost reporting period beginning prior to October 1, 2009, the hospital does not have to meet the requirements of § 412.22(h)(2)(iii)(A)(*1*) with respect to that satellite facility in order to retain its IPPS-excluded status. However, the creation of any satellite facility that will trigger the hospital of which it is a part to comply with the additional policies will occur at some point in the future. Therefore, we are unable to quantify the impact of the policy changes.

J. Effects of Policy Changes Relating to Payments to CAHs

In section VII.C.2. of the preamble of this final rule, we discuss our implementation of section 148 of Public Law 110–275 (MIPPA). Under our policy, a CAH may receive payment based on reasonable cost for outpatient clinical diagnostic laboratory tests furnished to an individual who is an outpatient of the CAH (that is, receiving outpatient services directly from the CAH) even if the individual with respect to whom the laboratory services are furnished is not physically present in the CAH at the time the specimen is collected. In order for an individual who is not physically present in the CAH at the time the specimen is collected to be determined to be receiving services directly from the CAH, we are requiring that the individual must either receive an outpatient service in the CAH or a provider-based facility of the CAH on the same day the specimen is collected or the specimen collection must be performed by an employee of the CAH. We anticipate that, for FY 2009 through FY 2016, the cost of implementing section 148 of Public Law 110–275 will be less than $50 million per year.

In section VII.C.3. of the preamble of this final rule, we discuss our decision to amend the regulations to make them consistent with the plain reading of section 1834(g)(2)(A) of the Act. Section 1834(g)(2)(A) of the Act requires that CAHs that select the optional method of payment receive payment at 100 percent of reasonable cost instead of 101 percent of reasonable cost for outpatient facility services. It is difficult for us to quantify the payment impact of these changes because we cannot estimate the number of CAHs that will be affected by this provision because election of the optional method is not permanent; CAHs are only required to make the election 30 days prior to the cost reporting period for which it is effective. Therefore, we cannot estimate how many CAHs will choose to retain the optional method of payment once the provision is finalized. Furthermore, the optional method of payment is physician-specific. If the physician has not reassigned his or her billing rights, the CAH will be paid for that outpatient service under the traditional method. We believe we cannot accurately estimate the number of physicians who will decide to continue to reassign their billing rights to the CAH once the provision is finalized. We note that one commenter estimated that the CMS proposal will cut payments to CAHs by $22 million in FY 2010.

In section VII.C.4. of the preamble of this final rule, we discuss the effect CBSA changes made by OMB on CAHs located in areas that have been reclassified from rural to urban in FY 2010. We are revising the regulations (in the same manner as the revisions that were made in FY 2005) to allow CAHs that are located in areas that were designated rural in FY 2009 but as a result of implementation of the new MSA definitions announced by OMB on November 20, 2008, will be located in an MSA effective for FY 2010, 2 years to obtain a rural redesignation under § 412.103 in order to retain their CAH status. We believe that because virtually all of these facilities will be granted rural status by the State, they will retain their CAH status. We estimate that these changes will have little or no impact on Medicare expenditures.

K. Effects of Policy Changes Relating to Provider-Based Status of Entities and Organizations

In section VII.D. of the preamble of this final rule, we discuss our decision to amend the regulations to require facilities that furnish only clinical diagnostic laboratory tests and operate as part of a CAH to meet the provider-based status rules currently in the regulations at § 413.65. If a facility that is part of a CAH and furnishes only clinical diagnostic laboratory tests meets the provider-based status rules, the CAH will be paid for services furnished by the laboratory facility on a reasonable cost basis. If a facility that furnishes only clinical diagnostic laboratory tests does not meet the provider-based status rules, the services furnished in the facility will be paid under the CLFS, unless the laboratory specimen is collected from an outpatient of the CAH as described in VII.C.2. of the preamble of this final rule. It is difficult for us to quantify the payment impact of these changes because we cannot estimate the number of CAHs that will be affected by this policy. In the FY 2010 IPPS proposed rule, we solicited public comments on the impact of this proposed change to our provider-based status rules. We did not receive any public comments as to how to quantify the payment impact of this policy. We are finalizing our policy as proposed, with one modification. In response to public comments, we are delaying the effective date of the policy until October 1, 2010.

VIII. Effects of Changes in the Capital IPPS

A. General Considerations

Fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the capital Federal rate (see § 412.344). As we state in section VI. of the preamble of this final rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

The basic methodology for determining a capital IPPS payment is set forth at § 412.312. The basic methodology for calculating capital IPPS payments in FY 2010 is as follows:

(Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME adjustment factor, if applicable).

As discussed in section VI.E.2. of the preamble of this final rule, we are deleting § 412.322(d) of the regulations that eliminated the IME adjustment factor for FY 2010, the third year of a 3-year transition period. Therefore, the IME adjustment factor has been restored for FY 2010. We also note that the 50-percent reduction to capital IME adjustments for FY 2009 was repealed by section 4301(b)(1) of the ARRA. Thus, the full IME adjustment was restored for FY 2009, as well. In addition to the other adjustments, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the

March 2009 update of the FY 2008 MedPAR file and the March 2009 update of the Provider-Specific File (PSF) that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the March 2009 update of the most recently available hospital cost report data (FYs 2006 and 2007) to categorize hospitals. Our analysis has several qualifications. We use the best data available and make assumptions about case-mix and beneficiary enrollment as described below. In addition, as discussed in section III. of the Addendum to this final rule, we established for FY 2008 (−0.6 percent) and for FY 2009 (−0.9 percent) a cumulative permanent adjustment of −1.5 percent to the national capital rate to account for improvements in documentation and coding under the MS–DRGs in FY 2010. Furthermore, due to the interdependent nature of the IPPS, it is very difficult to precisely quantify the impact associated with each change. In addition, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the March 2009 update of the FY 2008 MedPAR file, we simulated payments under the capital PPS for FY 2009 and FY 2010 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. The final capital rates and factors for FY 2009 were published in a subsequent notice in the **Federal Register** (73 FR 57891).

As we explain in section III.A.4. of the Addendum to this final rule, payments are no longer made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we no longer use the actuarial capital cost model (described in Appendix B of the August 1, 2001 proposed rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index will increase by 1.0 percent in both FYs 2009 and 2010.
- We estimate that the Medicare discharges will be approximately 13 million in both FY 2009 and FY 2010.
- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. As discussed in section III.1.a. of the Addendum to this final rule, the FY 2010 update is 1.4 percent.
- In addition to the FY 2010 update factor, the FY 2010 capital Federal rate was calculated based on a GAF/DRG budget neutrality factor of 0.9990, an outlier adjustment factor of 0.9477, and a (special) exceptions adjustment factor of 0.9998.
- For FY 2010, as discussed in section VI.E.1.of the preamble of this final rule, we are not applying an additional adjustment to the FY 2010 national capital rate for changes in documentation and coding that are expected to increase case-mix under the MS–DRGs. In the FY 2008 IPPS final rule with comment period (72 FR 47186), we established adjustments to the IPPS rates based on the Office of the Actuary projected case-mix growth resulting from improved documentation and coding of 1.2 percent for FY 2008, 1.8 percent for FY 2009, and 1.8 percent for FY 2010. However, we reduced the documentation and coding adjustment to −0.6 percent for FY 2008. For FY 2009, we applied an adjustment of 0.9 percent, consistent with section 7 of Public Law 110–90, for a permanent cumulative adjustment of −1.5 percent (that is, a factor of 0.985).

B. Results

We used the actuarial model described above to estimate the potential impact of our changes for FY 2010 on total capital payments per case, using a universe of 3517 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the March 2009 update of the FY 2008 MedPAR file, the March 2009 update to the PSF, and the most recent cost report data from the March 2009 update of HCRIS. In Table III, we present a comparison of estimated total payments per case for FY 2009 compared to FY 2010 based on the FY 2010 payment policies. Column 2 shows estimates of payments per case under our model for FY 2009. Column 3 shows estimates of payments per case under our model for FY 2010. Column 4 shows the total percentage change in payments from FY 2009 to FY 2010. The change represented in Column 4 includes the proposed 1.4 percent update to the capital Federal rate, other changes in the adjustments to the capital Federal rate (for example, the restoration of the teaching adjustment for FY 2010). The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case in FY 2010 are expected to increase as compared to capital payments per case in FY 2009. The capital rate for FY 2010 will increase 1.4 percent as compared to the FY 2009 capital rate. The changes to the GAFs are expected to result in a slight decrease in capital payments largely due to the expiration of section 508 of Public Law 108–173. We also are estimating a decrease in outlier payments from FY 2009 to FY 2010 due primarily to an increase in the fixed-loss amount. Our impact analysis includes actuarial assumptions of growth from FY 2009 to FY 2010 resulting in an increase in aggregate capital payments. The net result of these changes is an estimated 1.9 percent change in capital payments per discharge from FY 2009 to FY 2010 for all hospitals (as shown below in Table III).

The geographic comparison shows that, on average, all urban hospitals are expected to experience a 2.0 percent increase in capital IPPS payments per case in FY 2010 as compared to FY 2009, while hospitals in large urban areas are expected to experience a 2.1 percent increase in capital IPPS payments per case in FY 2010 as compared to FY 2009. Capital IPPS payments per case for rural hospitals are expected to increase 1.5 percent.

All regions are estimated to experience an increase in total capital payments per case from FY 2009 to FY 2010. These increases vary by region and range from a 0.7 percent increase in the New England rural region to a 2.8 percent increase in the Mountain urban region.

By type of ownership, voluntary and proprietary hospitals each are estimated to experience an increase of 1.9 percent. Government hospitals are projected to have a slightly larger increase of 2.0 percent in capital payments per case.

Section 1886(d)(10) of the Act established the MGCRB. Before FY 2005, hospitals could apply to the MGCRB for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of Public Law 108–173 equalized the standardized amounts under the operating IPPS. Therefore, beginning in FY 2005, there is no longer reclassification for the purposes of the standardized amounts; however, hospitals still may apply for reclassification for purposes of the wage index for FY 2010. Reclassification for wage index purposes also affects the GAFs because that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2010, we show the average capital payments per case for reclassified hospitals for FY 2009. All classifications of reclassified hospitals are expected to experience an increase in capital payments in FY 2010 as compared to FY 2009. Both urban reclassified and urban non-reclassified hospitals are expected to have an increase in capital payments of 2.0 percent, while capital payments for rural reclassified and rural non-reclassified hospitals are estimated to increase 1.7 percent and 1.1 percent, respectively. Other reclassified hospitals (that is, hospitals reclassified under section 1886(d)(8)(B) of the Act) are expected to experience an increase of 1.9 percent in capital payment from FY 2009 to FY 2010.

TABLE III—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2009 Payments Compared to FY 2010 Payments]

	Number of hospitals	Average FY 2009 payments/ case	Average FY 2010 payments/ case	Change
By Geographic Location:				
All hospitals	3,517	788	803	1.9
Large urban areas (populations over 1 million)	1,377	869	887	2.1
Other urban areas (populations of 1 million or fewer)	1,148	780	794	1.8
Rural areas	992	546	554	1.5
Urban hospitals	2,525	829	845	2.0
0–99 beds	634	654	665	1.7
100–199 beds	808	712	724	1.8
200–299 beds	466	779	794	2.0
300–499 beds	426	858	874	1.9
500 or more beds	191	1,003	1,024	2.1
Rural hospitals	992	546	554	1.5
0–49 beds	349	437	444	1.6
50–99 beds	370	507	514	1.5
100–149 beds	164	552	561	1.5
150–199 beds	62	600	610	1.6
200 or more beds	42	671	680	1.3
By Region:				
Urban by Region	2,525	829	845	2.0
New England	120	857	879	2.6
Middle Atlantic	344	885	902	1.9
South Atlantic	388	787	801	1.8
East North Central	397	807	820	1.6
East South Central	160	742	756	1.9
West North Central	165	815	833	2.2
West South Central	346	772	787	1.9
Mountain	163	842	866	2.8
Pacific	391	978	998	2.1
Puerto Rico	51	370	377	2.0
Rural by Region	992	546	554	1.5
New England	24	728	733	0.7
Middle Atlantic	70	558	572	2.5
South Atlantic	171	539	547	1.5
East North Central	122	568	576	1.4
East South Central	176	496	505	1.8
West North Central	101	567	574	1.1
West South Central	224	508	512	0.8
Mountain	72	547	559	2.3
Pacific	32	693	701	1.2
By Payment Classification:				
All hospitals	3,517	788	803	1.9
Large urban areas (populations over 1 million)	1,422	867	885	2.1
Other urban areas (populations of 1 million of fewer)	1,171	779	793	1.8
Rural areas	924	545	553	1.4
Teaching Status:				
Non-teaching	2,475	672	684	1.8
Fewer than 100 Residents	804	793	808	1.9
100 or more Residents	238	1,123	1,147	2.1
Urban DSH:				
100 or more beds	1,538	856	873	2.0
Less than 100 beds	346	585	596	1.8
Rural DSH:				
Sole Community (SCH/EACH)	397	476	484	1.6
Referral Center (RRC/EACH)	207	602	611	1.5
Other Rural:				
100 or more beds	34	540	548	1.5
Less than 100 beds	150	450	457	1.4
Urban teaching and DSH:				
Both teaching and DSH	802	929	948	2.1
Teaching and no DSH	178	810	823	1.6
No teaching and DSH	1,082	715	729	2.0
No teaching and no DSH	531	733	745	1.7
Rural Hospital Types:				
Non special status hospitals	2,467	832	848	1.9
RRC/EACH	62	725	743	2.5
SCH/EACH	38	682	693	1.6
Medicare-dependent hospitals (MDH)	10	481	488	1.4
SCH, RRC and EACH	16	792	809	2.2

TABLE III—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2009 Payments Compared to FY 2010 Payments]

	Number of hospitals	Average FY 2009 payments/ case	Average FY 2010 payments/ case	Change
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2010 Reclassifications:				
All Urban Reclassified	456	825	841	2.0
All Urban Non-Reclassified	2,045	831	847	2.0
All Rural Reclassified	351	591	601	1.7
All Rural Non-Reclassified	579	479	485	1.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	54	559	569	1.9
Type of Ownership:				
Voluntary	2,014	804	819	1.9
Proprietary	860	722	736	1.9
Government	583	784	800	2.0
Medicare Utilization as a Percent of Inpatient Days:				
0–25	317	1,005	1,032	2.6
25–50	1,433	869	886	2.0
50–65	1,331	686	697	1.6
Over 65	308	598	608	1.7

IX. Effects of Payment Rate Changes and Policy Changes Under the LTCH PPS

A. Introduction and General Considerations

In section VIII. of the preamble of this final rule, we are setting forth the annual update to the payment rates for the LTCH PPS for RY 2010. In the preamble, we specify the statutory authority for the provisions that are presented, identify those policies where discretion has been exercised, and present rationale for our decisions as well as alternatives that were considered. In this section of Appendix A to this final rule, we discuss the impact of the changes to the payment rates, factors, and other payment rate policies related to the LTCH PPS that are presented in the preamble of this final rule in terms of their estimated fiscal impact on the Medicare budget and on LTCHs.

Currently, our database of 399 LTCHs includes the data for 81 nonprofit (voluntary ownership control) LTCHs and 267 proprietary LTCHs. Of the remaining 51 LTCHs, 12 LTCHs are government-owned and operated and the ownership type of the other 39 LTCHs is unknown. In the impact analysis, we are using the rates, factors, and policies presented in this final rule, including updated wage index values and the labor-related share, and the best available claims and CCR data to estimate the change in payments for the 2010 LTCH PPS rate year. The standard Federal rate for RY 2009 is $39,114.36. As discussed in section V.A.2. of the Addendum to this final rule, consistent with our historical practice, we are updating the standard Federal rate for RY 2009 by 2.0 percent in order to establish the RY 2010 standard Federal rate at $39,896.65. Based on the best available data for the 399 LTCHs in our database, we estimate that the update to the standard Federal rate for RY 2010 (discussed in section VIII. of the preamble of this final rule) and the changes to the area wage adjustment (discussed in section V.A. of the Addendum to this final rule) for the 2010 LTCH PPS rate year, in addition to an estimated increase in HCO payments and an estimated increase in SSO payments, will result in an increase in estimated payments from the 2009 LTCH PPS rate year of approximately $153 million (or about 3.3 percent). Based on the 399 LTCHs in our database, we estimate RY 2009 LTCH PPS payments to be approximately $4.609 billion and RY 2010 LTCH PPS payments to be approximately $4.762 billion. Because the combined distributional effects and estimated changes to the Medicare program payments would be greater than $100 million, this final rule is considered a major economic rule, as defined in this section. We note the approximately $153 million for the projected increase in estimated aggregate LTCH PPS payments from RY 2009 to RY 2010 does not reflect changes in LTCH admissions or case-mix intensity in estimated LTCH PPS payments, which also would affect overall payment changes.

The projected 3.3 percent increase in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year is attributable to several factors, including the 2.0 percent increase to the standard Federal rate and projected increases in estimated HCO and SSO payments. As Table IV shows, the change attributable solely to the standard Federal rate is projected to result in an increase of 1.8 percent in estimated payments per discharge from RY 2009 to RY 2010, on average, for all LTCHs, while the changes to the area wage adjustment are projected to result in a slight decrease in estimated payments, on average, for all LTCHs (Columns 6 and 7 of Table IV, respectively). We note that because payments for cost-based SSO cases and a portion of payments for SSO cases that are paid based on the ''blend'' option (that is, SSO cases paid under § 412.529(c)(2)(iv)) are not affected by the update to the standard Federal rate, we estimate that the effect of the 2.0 percent update to the standard Federal rate will result in a 1.8 percent increase (as shown in Column 6 of Table IV) on estimated aggregate LTCH PPS payments for all LTCH PPS cases, including SSO cases.

While the effects of the estimated increase in SSO and HCO payments and the change to the standard Federal rate are projected to increase estimated payments from RY 2009 to RY 2010, the changes to the area wage adjustment from RY 2009 to RY 2010 are expected to result in a slight decrease in estimated aggregate LTCH PPS payments from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year (Column 7 of Table IV). As discussed in section V.B. of the Addendum to this final rule, we are updating the wage index values for FY 2010 based on the most recent available data. In addition, we are increasing the labor-related share slightly from 75.662 percent to 75.779 percent under the LTCH PPS for RY 2010 based on the most recent available data on the relative importance of the labor-related share of operating and capital costs of the RPL market basket (also discussed in section VIII.C.2. of this final rule).

We note that the overall percent change in estimated LTCH payments from RY 2009 to RY 2010 for all changes (shown in Column 8) cannot be determined by adding the incremental effect of the standard Federal rate (Column 6) and the area wage adjustment changes (Column 7) on estimated aggregate LTCH PPS payments because each of those two columns are intended to show the isolated impact of the respective change (that is, the change to the standard Federal rate or the change to the area wage adjustment) on estimated payments for RY 2010 as compared to RY 2009, but the interactive effects resulting from both the change to the standard Federal rate and the change to the area wage adjustment, as well as estimated changes to HCO and SSO payments, are not reflected in each of these columns. However, the interactive effects of all changes, including the change in estimated HCO and SSO payments, are reflected in the estimated change in payments for all changes for RY 2010 as compared to RY 2009 (shown in Column 8 of Table IV).

Notwithstanding this limitation, the projected increase in payments per discharge from RY 2009 to RY 2010 is 3.3 percent

(shown in Column 8). This projected increase in payments is attributable to the impacts of the change to the standard Federal rate (1.8 percent in Column 6) and the change due to the area wage adjustment (−0.1 percent in Column 7), and is also due to the effect of the estimated increase in payments for HCO cases and SSO cases in RY 2010 as compared to RY 2009. That is, estimated total HCO payments are projected to increase from RY 2009 to RY 2010 in order to ensure that estimated HCO payments will be 8 percent of total estimated LTCH PPS payments in RY 2010. As discussed in detail in section V. of the Addendum to this final rule, an analysis of the most recent available LTCH PPS claims data (that is, FY 2008 claims from the March 2009 update of the MedPAR files) indicates that the RY 2009 HCO threshold of $22,960 may result in HCO payments in RY 2009 that fall below the estimated 8 percent. Specifically, we currently estimate that HCO payments will be approximately 6.8 percent of estimated total LTCH PPS payments in RY 2009. Consequently, it is necessary to decrease the HCO threshold for RY 2010 in order to ensure that estimated HCO payments will be 8 percent of total estimated LTCH PPS payments in RY 2010. We estimate that the impact of the increase in HCO payments would result in approximately a 1.2 percent increase in estimated payments from RY 2009 to RY 2010 on average for all LTCHs. Furthermore, in calculating the estimated increase in payments from RY 2009 to RY 2010 for HCO and SSO cases, we increased estimated costs by the applicable market basket percentage increase as projected by our actuaries. We note that estimated payments for all SSO cases comprise approximately 15 percent of estimated total LTCH PPS payments, and estimated payments for HCO cases comprise approximately 8 percent of estimated total LTCH PPS payments. Payments for HCO cases are based on 80 percent of the estimated cost above the HCO threshold, while the majority of the payments for SSO cases (over 67 percent) are based on the estimated cost of the SSO case. A thorough discussion of the regulatory impact analysis for the changes presented in this final rule can be found below in section V. of the Addendum to this final rule.

As we discuss in detail throughout this final rule, based on the most recent available data, we believe that the provisions of this final rule relating to the LTCH PPS will result in an increase in estimated aggregate LTCH PPS payments and that the resulting LTCH PPS payment amounts result in appropriate Medicare payments.

B. Impact on Rural Hospitals

For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table IV, we are projecting a 4.2 percent increase in estimated payments per discharge for the 2010 LTCH PPS rate year as compared to the 2009 LTCH PPS rate year for rural LTCHs that will result from the changes presented in this final rule (that is, the update to the standard Federal rate discussed in section V.A. of the Addendum to this final rule and the changes to the area wage adjustment as discussed in section V.B. of the Addendum to this final rule) as well as the effect of estimated changes to HCO and SSO payments. This estimated impact is based on the data for the 26 rural LTCHs in our database of 399 LTCHs, for which complete data were available.

The estimated increase in LTCH PPS payments from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year for rural LTCHs is primarily due to the higher than average impacts from the change to the standard Federal rate (1.9 percent) and changes to the area wage adjustment (0.4 percent). We believe that the changes to the area wage adjustment presented in this final rule (that is, the use of updated wage data and the change in the labor-related share) would result in accurate and appropriate LTCH PPS payments in RY 2010 because they are based on the most recent available data. Such updated data appropriately reflect national differences in area wage levels and appropriately identifies the portion of the standard Federal rate that should be adjusted to account for such differences in area wages, thereby resulting in accurate and appropriate LTCH PPS payments. Furthermore, rural LTCHs are projected to experience a higher than average increase in estimated HCO payments in RY 2010, which also contributes to the estimated higher than average percent change in payments per discharge from RY 2009 to RY 2010. That is, our current estimate shows that, for rural LTCHs, the increase in HCO payments in RY 2010 will be higher than the average increase when compared to all hospitals.

C. Anticipated Effects of LTCH PPS Payment Rate Change and Policy Changes

We discuss the impact of the changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for RY 2010 (in terms of their estimated fiscal impact on the Medicare budget and on LTCHs) in section VIII. of the preamble of this final rule.

1. Budgetary Impact

Section 123(a)(1) of the BBRA requires that the PPS developed for LTCHs ''maintain budget neutrality.'' We believe that the statute's mandate for budget neutrality applies only to the first year of the implementation of the LTCH PPS (that is, FY 2003). Therefore, in calculating the FY 2003 standard Federal rate under § 412.523(d)(2), we set total estimated payments for FY 2003 under the LTCH PPS so that estimated aggregate payments under the LTCH PPS were estimated to equal the amount that would have been paid if the LTCH PPS had not been implemented.

As discussed in section IX.A. of this Appendix A, we project an increase in aggregate LTCH PPS payments in RY 2010 of approximately $153 million (or 3.3 percent) based on the 399 LTCHs in our database.

2. Impact on Providers

The basic methodology for determining a per discharge LTCH PPS payment is set forth in § 412.515 through § 412.536. In addition to the basic MS–LTC–DRG payment (standard Federal rate multiplied by the MS–LTC–DRG relative weight), we make adjustments for differences in area wage levels, COLA for Alaska and Hawaii, and SSOs. Furthermore, LTCHs may also receive HCO payments for those cases that qualify based on the threshold established each rate year.

To understand the impact of the changes to the LTCH PPS payments presented in this final rule on different categories of LTCHs for the 2010 LTCH PPS rate year, it is necessary to estimate payments per discharge for the 2009 LTCH PPS rate year using the rates, factors and policies established in the RY 2009 LTCH PPS final rule (73 FR 26788 through 26874) and the FY 2009 GROUPER (Version 26.0) and relative weights established in the FY 2009 IPPS final rule (73 FR 23537 through 23617). It is also necessary to estimate the payments per discharge that would be made under the LTCH PPS rates, factors, policies, and GROUPER for the 2010 LTCH PPS rate year (as discussed in VIII. of the preamble and section V. of the Addendum to this final rule). These estimates of RY 2009 and RY 2010 LTCH PPS payments are based on the best available LTCH claims data and other factors, such as the application of inflation factors to estimate costs for SSO and HCO cases in each year. We also evaluated the change in estimated 2009 LTCH PPS rate year payments to estimated 2010 LTCH PPS rate year payments (on a per discharge basis) for each category of LTCHs.

Hospital groups were based on characteristics provided in the OSCAR data, FY 2004 through FY 2006 cost report data in HCRIS, and PSF data. Hospitals with incomplete characteristics were grouped into the ''unknown'' category. Hospital groups include the following:

- Location: large urban/other urban/rural.
- Participation date.
- Ownership control.
- Census region.
- Bed size.

To estimate the impacts of the payment rates and policy changes among the various categories of existing providers, we used LTCH cases from the FY 2008 MedPAR file to estimate payments for RY 2009 and to estimate payments for RY 2010 for 399 LTCHs. While currently there are just under 400 LTCHs, the most recent growth is predominantly in for-profit LTCHs that primarily provide respiratory and ventilator-dependent patient care. We believe that the discharges based on the FY 2008 MedPAR data for the 399 LTCHs in our database, which includes 267 proprietary LTCHs, provide sufficient representation in the MS–LTC–DRGs containing discharges for patients who received LTCH care for the most commonly treated LTCH patients' diagnoses.

3. Calculation of Prospective Payments

For purposes of this impact analysis, to estimate per discharge payments under the LTCH PPS, we simulated payments on a case-by-case basis using LTCH claims from the FY 2008 MedPAR files. For modeling estimated LTCH PPS payments for RY 2009, we applied the RY 2009 standard Federal rate (that is, $39,114.36, which is effective for LTCH discharges occurring on or after July 1, 2008, and through September 30, 2009). For modeling estimated LTCH PPS payments for

RY 2010, we applied the RY 2010 standard Federal rate of $39,896.65, which will be effective for LTCH discharges occurring on or after October 1, 2009, and through September 30, 2010).

Furthermore, in modeling estimated LTCH PPS payments for both RY 2009 and RY 2010 in this impact analysis, we applied the RY 2009 and RY 2010 adjustments for area wage differences and the COLA for Alaska and Hawaii. Specifically, we adjusted for area wage differences for estimated 2009 LTCH PPS rate year payments using the current LTCH PPS labor-related share of 75.662 percent (73 FR 26815), the wage index values established in the Tables 1 and 2 of the Addendum to the RY 2009 final rule (73 FR 26840 through 26863) and the COLA factors established in Table III of the preamble of the RY 2009 final rule (73 FR 26819). Similarly, we adjusted for area wage differences for estimated 2010 LTCH PPS rate year payments using the LTCH PPS RY 2010 labor-related share of 75.779 percent (section VIII.C.2. of the preamble of this final rule), the RY 2010 wage index values presented in Tables 12A and 12B of the Addendum to this final rule, and the RY 2010 COLA factors shown in the table in section V. of the Addendum to this final rule.

As discussed above, our impact analysis reflects an estimated change in payments for SSO cases as well as an estimated increase in payments for HCO cases (as described in section V.C. of the Addendum to this final rule). In modeling payments for SSO and HCO cases in RY 2009, we applied an inflation factor of 1.025 percent (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2008 MedPAR files and the best available CCRs from the March 2009 update of the PSF. In modeling payments for SSO and HCO cases in RY 2010, we applied an inflation factor of 1.051 (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2008 MedPAR files and the best available CCRs from the March 2009 update of the PSF.

These impacts reflect the estimated ''losses'' or ''gains'' among the various classifications of LTCHs from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year based on the payment rates and policy changes presented in this final rule. Table IV illustrates the estimated aggregate impact of the LTCH PPS among various classifications of LTCHs.

- The first column, LTCH Classification, identifies the type of LTCH.
- The second column lists the number of LTCHs of each classification type.
- The third column identifies the number of LTCH cases.
- The fourth column shows the estimated payment per discharge for the 2009 LTCH PPS rate year (as described above).
- The fifth column shows the estimated payment per discharge for the 2010 LTCH PPS rate year (as described above).
- The sixth column shows the percentage change in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year for changes to the standard Federal rate (as discussed in section V. of the Addendum to this final rule).
- The seventh column shows the percentage change in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year for changes to the area wage adjustment at § 412.525(c) (as discussed in section V.B.4. of the Addendum to this final rule).
- The eighth column shows the percentage change in estimated payments per discharge from the 2009 LTCH PPS rate year (Column 4) to the 2010 LTCH PPS rate year (Column 5) for all changes (and includes the effect of estimated changes to HCO and SSO payments).

TABLE IV—IMPACT OF PAYMENT RATE AND PAYMENT RATE POLICY CHANGES TO LTCH PPS PAYMENTS FOR RY 2010

[Estimated 2009 LTCH PPS Rate Year Payments Compared to Estimated 2010 LTCH PPS Rate Year Payments*]

LTCH classification	Number of LTCHs	Number of LTCH PPS cases	Average RY 2009 LTCH PPS rate year payment per case [1]	Average RY 2010 LTCH PPS rate year payment per case [2]	Percent change in estimated payments per discharge from RY 2009 to RY 2010 for changes to the federal rate [3]	Percent change in estimated payments per discharge from RY 2009 to RY 2010 for changes to the area wage adjustment [4]	Percent change in payments per discharge from RY 2009 to RY 2010 for all changes [5]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
ALL PROVIDERS	399	131,214	$35,127	$36,293	1.8	−0.1	3.3
BY LOCATION:							
RURAL	26	5,844	30,336	31,597	1.9	0.4	4.2
URBAN	373	125,370	35,350	36,512	1.7	−0.1	3.3
LARGE	191	75,370	36,748	37,979	1.7	0	3.4
OTHER	182	50,000	33,244	34,301	1.8	−0.2	3.2
BY PARTICIPATION DATE:							
BEFORE OCT. 1983	17	6,666	31,248	32,535	1.7	0.6	4.1
OCT. 1983—SEPT. 1993	44	18,426	35,496	36,829	1.7	0.2	3.8
OCT. 1993—SEPT. 2002	191	66,503	34,699	35,791	1.8	−0.1	3.1
AFTER OCTOBER 2002	140	38,506	36,290	37,474	1.8	−0.2	3.3
UNKNOWN PARTICIPATION DATE	7	1,113	37,590	39,155	1.7	0.4	4.2
BY OWNERSHIP TYPE:							
VOLUNTARY	81	21,655	35,546	36,810	1.7	−0.2	3.6
PROPRIETARY	267	99,479	34,738	35,839	1.8	0	3.2
GOVERNMENT	12	1,904	41,093	42,674	1.6	−0.3	3.9
UNKNOWN OWNERSHIP TYPE	39	8,176	37,364	38,969	1.8	0.2	4.3
BY REGION:							
NEW ENGLAND	15	7,916	30,685	32,030	1.7	0.8	4.4
MIDDLE ATLANTIC	29	8,180	36,267	37,172	1.7	−0.4	2.5
SOUTH ATLANTIC	49	13,555	39,848	41,175	1.7	−0.3	3.3
EAST NORTH CENTRAL	67	19,630	38,943	39,870	1.7	−0.8	2.4
EAST SOUTH CENTRAL	31	8,345	35,513	36,739	1.8	−0.2	3.5
WEST NORTH CENTRAL	21	5,199	36,847	38,094	1.7	0.2	3.4
WEST SOUTH CENTRAL	138	50,413	30,454	31,420	1.8	−0.3	3.2
MOUNTAIN	25	5,988	37,769	39,415	1.7	0.8	4.4

TABLE IV—IMPACT OF PAYMENT RATE AND PAYMENT RATE POLICY CHANGES TO LTCH PPS PAYMENTS FOR RY 2010—Continued

[Estimated 2009 LTCH PPS Rate Year Payments Compared to Estimated 2010 LTCH PPS Rate Year Payments*]

LTCH classification	Number of LTCHs	Number of LTCH PPS cases	Average RY 2009 LTCH PPS rate year payment per case [1]	Average RY 2010 LTCH PPS rate year payment per case [2]	Percent change in estimated payments per discharge from RY 2009 to RY 2010 for changes to the federal rate [3]	Percent change in estimated payments per discharge from RY 2009 to RY 2010 for changes to the area wage adjustment [4]	Percent change in payments per discharge from RY 2009 to RY 2010 for all changes [5]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
PACIFIC	24	11,988	43,014	44,977	1.7	1.3	4.6
BY BED SIZE:							
BEDS: 0–24	41	5,455	31,273	32,442	1.8	−0.1	3.7
BEDS: 25–49	191	44,459	35,502	36,581	1.8	−0.2	3
BEDS: 50–74	82	27,914	34,978	36,160	1.8	0	3.4
BEDS: 75–124	49	24,540	37,266	38,562	1.7	0.1	3.5
BEDS: 125–199	23	16,598	33,752	34,892	1.7	−0.1	3.4
BEDS: 200 +	13	12,248	33,400	34,622	1.7	0.4	3.7

[1] Estimated 2009 LTCH PPS rate year payments based on the rates, factors and policies established in the RY 2009 LTCH PPS final rule (73 FR 26788) and the FY 2009 GROUPER (Version 26.0) and relative weights established in the FY 2009 IPPS final rule (73 FR 23537 through 23617).

[2] Estimated 2010 LTCH PPS rate year payments based on the payment rates and policy changes presented in the preamble and the Addendum of this final rule.

[3] Percent change in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year for the changes to the standard Federal rate, as discussed in section V.A. of the Addendum to this final rule.

[4] Percent change in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year for changes to the area wage adjustment at § 412.525(c) (as discussed in section V.B.4. of the Addendum to this final rule).

[5] Percent change in estimated payments per discharge from the 2009 LTCH PPS rate year (shown in Column 4) to the 2010 LTCH PPS rate year (shown in Column 5), including all of the changes presented in the preamble of this final rule. Note, this column, which shows the percent change in estimated payments per discharge for all changes, does not equal the sum of the percent changes in estimated payments per discharge for changes to the standard Federal rate (column 6) and the changes to the area wage adjustment (Column 7) due to the effect of estimated changes in both payments to SSO cases that are paid based on estimated costs and aggregate HCO payments (as discussed in this impact analysis), as well as other interactive effects that cannot be isolated.

4. Results

Based on the most recent available data (as described previously for 399 LTCHs), we have prepared the following summary of the impact (as shown in Table IV) of the LTCH PPS payment rate and policy changes presented in this final rule. The impact analysis in Table IV shows that estimated payments per discharge are expected to increase approximately 3.3 percent, on average, for all LTCHs from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year as a result of the payment rate and policy changes presented in this final rule as well as estimated increases in HCO and SSO payments. We note that we are adopting a 2.0 percent increase to the standard Federal rate for RY 2010, based on the latest market basket estimate (2.5 percent) and the adjustment for documentation and coding in 2007 (−0.5 percent). We noted earlier in this section that for most categories of LTCHs, as shown in Table IV (Column 6), the impact of the increase of 2.0 percent to the standard Federal rate is projected to result in approximately a 1.8 percent increase in estimated payments per discharge for all LTCHs from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year. In addition to the 2.0 percent increase to the standard Federal rate for RY 2010, the projected percent increase in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year of 3.3 percent shown in Table IV (Column 8) reflects the effect of estimated increases in HCO and SSO payments, as discussed previously. Furthermore, as discussed previously in this regulatory impact analysis, the average increase in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year for all LTCHs of approximately 3.3 percent (as shown in Table IV) was determined by comparing estimated RY 2010 LTCH PPS payments (using the rates and policies discussed in this final rule) to estimated RY 2009 LTCH PPS payments (as described above in section IX.C. of this regulatory impact analysis).

a. Location

Based on the most recent available data, the vast majority of LTCHs are located in urban areas. Only approximately 7 percent of the LTCHs are identified as being located in a rural area, and approximately 4 percent of all LTCH cases are treated in these rural hospitals. The impact analysis presented in Table IV shows that the average percent increase in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year for all hospitals is 3.3 percent for all changes. For rural LTCHs, the percent change for all changes is estimated to be 4.16 percent, while for urban LTCHs, we estimate the increase to be 3.3 percent. Large urban LTCHs are projected to experience an average increase, 3.4 percent, in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year, while other urban LTCHs are projected to experience a nearly average increase (3.2 percent) in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year, as shown in Table IV.

b. Participation Date

LTCHs are grouped by participation date into four categories: (1) Before October 1983; (2) between October 1983 and September 1993; (3) between October 1993 and September 2002; and (4) after October 2002. Based on the most recent available data, the majority (approximately 51 percent) of the LTCH cases are in hospitals that began participating between October 1993 and September 2002, and are projected to experience nearly the average increase (3.1 percent) in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year, as shown in Table IV.

In the participation category where LTCHs began participating in Medicare before October 1983, LTCHs are projected to experience a higher than average percent increase (4.1) in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year, as shown in Table IV, due to changes in the wage index

and an estimated increase in HCO payments. Approximately 4 percent of LTCHs began participating in Medicare before October 1983. The LTCHs in this category are projected to experience a higher than average increase in estimated payments because 65 percent of these LTCHs are located in areas where the RY 2010 wage index value is greater than the RY 2009 wage index value, and also because the majority of these LTCHs have a wage index value of greater than 1.0. Approximately 11 percent of LTCHs began participating in Medicare between October 1983 and September 1993. These LTCHs are projected to experience a slightly higher than average increase (3.8 percent) in estimated payments. The majority of LTCHs, that is, those that began participating in Medicare since October 1993, are projected to experience near average increases in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year, as shown in Table IV.

c. Ownership Control

Other than LTCHs whose ownership control type is unknown, LTCHs are grouped into three categories based on ownership control type: voluntary, proprietary, and government. Based on the most recent available data, approximately 20 percent of LTCHs are identified as voluntary (Table IV). We expect that, for these LTCHs in the voluntary category, estimated 2010 LTCH PPS rate year payments per discharge will increase slightly higher than the average (3.6 percent) in comparison to estimated payments in the 2009 LTCH PPS rate year, as shown in Table IV, primarily because the change in estimated HCO payments is projected to be higher than the average for these LTCHs. The majority (67 percent) of LTCHs are identified as proprietary and these LTCHs are projected to experience a near average increase (3.2 percent) in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year. Finally, government-owned and operated LTCHs (3 percent) are expected to experience a slightly higher than the average increase (3.9 percent) in estimated payments primarily due to larger than the average increase in estimated HCO payments.

d. Census Region

Estimated payments per discharge for the 2010 LTCH PPS rate year are projected to increase for LTCHs located in all regions in comparison to the 2009 LTCH PPS rate year. Of the 9 census regions, we project that the increase in estimated payments per discharge will have the largest positive impact on LTCHs in the New England, Mountain, and Pacific regions (4.4 percent, 4.4 percent, and 4.6 percent, respectively, as shown in Table IV). As explained in greater detail above in section XV.B.4. of this Appendix, the estimated percent increase in payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year for these regions is largely attributable to the projected increase in estimated HCO and SSO payments, in addition to the increase in the standard Federal rate and the changes to the area wage adjustment. Specifically, for the New England region, all the LTCHs located in this region have a wage index value of greater than 1.0; and the majority (87 percent) of these LTCHs are located in areas where the RY 2010 wage index value is greater than the RY 2009 wage index value. The projected increase in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year for LTCHs in the Mountain and Pacific regions is 4.4 percent and 4.6 percent respectively. These projected increases in payments are due to both the estimated increase in HCO payments and the significantly higher than average estimated impact from the changes to the area wage adjustment. That is, the majority (60 percent) of the LTCHs located in the Mountain region have a wage index value of greater than 1.0, and in addition, most of these LTCHs (76 percent) are located in areas where the RY 2010 wage index value is greater than the RY 2009 wage index value. Furthermore, all the LTCHs located in the Pacific region have a wage index value of greater than 1.0 and they are all located in areas where the RY 2010 wage index value is greater than the RY 2009 wage index value.

In contrast, LTCHs located in the Middle Atlantic and East North Central regions are projected to experience a lower than average increase in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year. The projected increase in payments of 2.5 percent for LTCHs in the Middle Atlantic region is primarily due to the 55 percent of LTCHs located in areas where the RY 2010 wage index value would be less than the RY 2009 wage index value. In addition, 62 percent of the LTCHs in this category are projected to have a RY 2010 wage index value of greater than 1.0. Similarly, the lower than average increase in payments per discharge for LTCHs in the East North Central region is largely due to the majority of LTCHs in this region that are expected to experience a decrease in estimated payments per discharge due to the changes in the area wage adjustment. However, we note that the projected increase in estimated HCO payments for LTCHs in this region in addition to the increase in the standard Federal rate results in an overall estimated increase, albeit less than the average increase, in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year. The remaining regions, South Atlantic, East South Central, West North Central, and West South Central, are expected to experience near the average increases in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year.

e. Bed Size

LTCHs were grouped into six categories based on bed size: 0–24 beds; 25–49 beds; 50–74 beds; 75–124 beds; 125–199 beds; and greater than 200 beds.

We are projecting an average or near average increase in estimated 2010 LTCH PPS rate year payments per discharge in comparison to the 2009 LTCH PPS rate year for all bed size categories.

D. Effect on the Medicare Program

As noted previously, we project that the provisions of this final rule will result in an increase in estimated aggregate LTCH PPS payments in RY 2010 of approximately $153 million (or about 3.3 percent) for the 399 LTCHs in our database.

E. Effect on Medicare Beneficiaries

Under the LTCH PPS, hospitals receive payment based on the average resources consumed by patients for each diagnosis. We do not expect any changes in the quality of care or access to services for Medicare beneficiaries under the LTCH PPS, but we expect that paying prospectively for LTCH services would enhance the efficiency of the Medicare program.

X. Alternatives Considered

This final rule contains a range of policies. The preamble of this final rule provides descriptions of the statutory provisions that are addressed, identifies implementing policies where discretion has been exercised, and presents rationales for our decisions and, where relevant, alternatives that were considered.

XI. Overall Conclusion

A. Acute Care Hospitals

Table I of section VI. of this Appendix demonstrates the estimated distributional impact of the IPPS budget neutrality requirements for the MS–DRG and wage index changes, and for the wage index reclassifications under the MGCRB. Table I also shows an overall increase of 1.6 percent in operating payments. We estimate that operating payments will increase by approximately $1.73 billion in FY 2010. This accounts for the projected savings associated with the HACs policy, which has an estimated savings of $21 million, and the additional spending of $17.4 million due to new technology add-on payments. In addition, this estimate includes the reporting of hospital quality data program costs of $2.4 million, and all operating payment policies as described in section VII. of this Appendix. We estimate that capital payments will increase by 2.1 percent per case, as shown in Table III of section VIII. of this Appendix. Therefore, we project that the increase in capital payments in FY 2010 compared to FY 2009 will be approximately $171 million. The cumulative operating and capital payments should result in a net increase of $1.899 billion to IPPS providers. The discussions presented in the previous pages, in combination with the rest of this final rule, constitute a regulatory impact analysis.

B. LTCHs

Overall, LTCHs are projected to experience an increase in estimated payments per discharge in RY 2010. In the impact analysis, we are using the rates, factors, and policies presented in this final rule, including updated wage index values, and the best available claims and CCR data to estimate the change in payments for the 2010 LTCH PPS rate year. Accordingly, based on the best available data for the 399 LTCHs in our database, we estimate that RY 2010 LTCH PPS payments will increase approximately $153 million (or about 3.3 percent).

XII. Accounting Statements

A. Acute Care Hospitals

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table V below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule as they relate to acute care hospitals. This table provides our best estimate of the change in Medicare payments to providers as a result of the changes to the IPPS presented in this final rule. All expenditures are classified as transfers to Medicare providers.

TABLE V—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM FY 2009 TO FY 2010

Category	Transfers
Annualized Monetized Transfers.	$1.899 billion.
From Whom to Whom.	Federal Government to IPPS Medicare Providers.
Total	$1.899 billion.

B. LTCHs

As discussed in section IX. of this Appendix, the impact analysis for the changes under the LTCH PPS for this final rule projects an increase in estimated aggregate payments of approximately $153 million (or about 3.3 percent) for the 399 LTCHs in our database that are subject to payment under the LTCH PPS. Therefore, as required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf),* in Table VI below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule as they relate to changes to the LTCH PPS. Table VI provides our best estimate of the increase in Medicare payments under the LTCH PPS as a result of the provisions presented in this final rule based on the data for the 399 LTCHs in our database. All expenditures are classified as transfers to Medicare providers (that is, LTCHs).

TABLE VI—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM THE 2009 LTCH PPS RATE YEAR TO THE 2010 LTCH PPS RATE YEAR

Category	Transfers
Annualized Monetized Transfers.	Positive transfer—Estimated increase in expenditures: $153 million.
From Whom to Whom.	Federal Government to LTCH PPS Medicare Providers.
Total	$153 million.

XIII. Executive Order 12866

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

Appendix B: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the MedPAC, recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish update factors recommended by the Secretary in the proposed and final IPPS rules, respectively. Accordingly, this Appendix provides the recommendations for the update factors for the IPPS national standardized amount, the Puerto Rico-specific standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for certain hospitals excluded from the IPPS, as well as LTCHs, IPFs, and IRFs. We also discuss our response to MedPAC's recommended update factors for inpatient hospital services.

II. Inpatient Hospital Update for FY 2010

Section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Public Law 109–171, sets the FY 2010 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to the hospital submitting quality information under rules established by the Secretary in accordance with section 1886(b)(3)(B)(viii) of the Act. For hospitals that do not provide these data, the update is equal to the market basket percentage increase less 2.0 percentage points.

In compliance with section 404 of the MMA, as we proposed in the FY 2010 IPPS/LTCH PPS proposed rule (74 FR 24685), in section IV. of the preamble of this final rule, we are replacing the FY 2002-based IPPS operating and capital market baskets with the revised and rebased FY 2006-based IPPS operating and capital market baskets for FY 2010. In addition to updating the base year to reflect more recent data, we also are making several changes to the structure of the market basket, including three new expense categories and revising several price proxies.

As we proposed, we also are rebasing the labor-related share to reflect the more recent base year. The current labor-related share, which is based on the FY 2002-based IPPS market basket, is 69.7. We are adopting a labor-related share of 68.8, which is based on the rebased and revised FY 2006-based IPPS market basket. For a complete discussion on the rebasing of the market basket and labor share, we refer readers to section IV. of the preamble to this final rule.

Consistent with current law, based on IHS Global Insight, Inc.'s first quarter 2009 forecast of the FY 2010 market basket increase, we stated in the proposed rule that we are estimating that the FY 2010 update to the standardized amount will be 2.1 percent (that is, the then current estimate of the market basket rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, we stated in the proposed rule that we are estimating that the update to the standardized amount will be 0.1 percent (that is, the then current estimate of the market basket rate-of-increase minus 2.0 percentage points). Therefore, we are adopting in this final rule, based on IHS Global Insight, Inc.'s second quarter 2009 forecast of the FY 2010 market basket increase, a FY 2010 update to the standardized amount of 2.1 percent (that is, the current estimate of the market basket rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, the update to the standardized amount will be 0.1 percent (that is, the current estimate of the market basket rate-of-increase minus 2.0 percentage points).

Section 1886(d)(9)(C)(1) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. In the proposed rule, we proposed to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Because we did not receive any public comments on this proposal, for FY 2010, we are applying the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is 2.1 percent.

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2010 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS, or the rate-of-increase in the market basket). Therefore, the update to the hospital-specific rates applicable to SCHs and MDHs is 2.1 or 0.1 percent, depending upon whether the hospital submits quality data.

Section 1886(b)(3)(B)(ii) of the Act is used for purposes of determining the percentage increase in the rate-of-increase limits for children's and cancer hospitals. Section 1886(b)(3)(B)(ii) of the Act sets the percentage increase in the rate-of-increase limits equal to the market basket percentage increase. In accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. Section 1886(j)(3)(C) of the Act addresses the increase factor for the Federal prospective payment rate of IRFs. Section 123 of Public Law 106–113, as amended by section 307(b) of Public Law 106–554, provides the statutory authority for updating payment rates under the LTCH PPS. In addition, section 124 of Public Law 106–113 provides the statutory authority for updating all aspects of the payment rates for IPFs.

Currently, children's hospitals, cancer hospitals, and RNHCIs are the remaining three types of hospitals still reimbursed under the reasonable cost methodology. We are providing our current estimate of the FY 2010 IPPS operating market basket percentage increase (2.1 percent) to update the target limits for children's hospitals, cancer hospitals, and RNHCIs.

For RY 2010, as discussed in section VIII. of the preamble to this final rule, we are establishing an update of 2.0 percent to the LTCH PPS Federal rate, which is based on a market basket increase of 2.5 percent (based on IHS Global Insight, Inc.'s second quarter 2009 forecast of the FY 2002-based RPL market basket increase for RY 2010) and an adjustment of −0.5 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity.

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS. IPF PPS payments are based on a Federal per diem rate that is derived from the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality.

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), and thereafter, the Federal prospective payments to IRFs are based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (69 FR 45721).

We refer readers to section IV. of the preamble to this final rule for a summary of the public comments we received on the rebasing and revising of the market basket and labor-related share.

III. Secretary's Final Recommendations

MedPAC is recommending an inpatient hospital update equal to the market basket rate of increase for FY 2010. MedPAC's rationale for this update recommendation is described in more detail below. Based on IHS Global Insight, Inc.'s 2009 second quarter forecast, with historical data through the 2009 first quarter, of the rebased and revised FY 2006-based IPPS market basket, we are recommending an update to the standardized amount of 2.1 percent. We are recommending that this same update factor apply to SCHs and MDHs.

Section 1886(d)(9)(C)(i) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. For FY 2010, we are applying the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is 2.1 percent.

In addition to making a recommendation for IPPS hospitals, in accordance with section 1886(e)(4)(A) of the Act, we also are recommending update factors for all other types of hospitals. Using IHS Global Insight, Inc.'s 2009 second quarter forecast, with historical data through the 2009 first quarter, of the rebased and revised FY 2006-based IPPS market basket, we are recommending an update based on the IPPS market basket increase for children's hospitals, cancer hospitals, and RNHCIs of 2.1 percent.

In the IPF PPS RY 2010 notice (74 FR 20365), we implemented an update to the IPF PPS Federal rate for RY 2010 of 2.1 percent for the Federal per diem payment amount. Similar to the update we implemented in the IPF PPS RY 2010 notice, we are recommending an update to the IPF PPS Federal rate for RY 2010 of 2.1 percent for the Federal per diem payment amount.

For RY 2010, similar to our approach in section VIII. of the preamble of this final rule, we are recommending an update of 2.0 percent to the LTCH PPS Federal rate, which is based on a market basket increase of 2.5 percent (based on IHS Global Insight, Inc.'s second quarter 2009 forecast of the FY 2002-based RPL market basket increase for RY 2010) and an adjustment of −0.5 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity.

Finally, in the FY 2010 IRF PPS final rule scheduled to publish in the August 7, 2009, issue of the **Federal Register**, we are recommending the update factor that will be applied to the FY 2010 IRF PPS Federal rate.

IV. MedPAC Recommendation for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In its March 2009 Report to Congress, MedPAC assessed the adequacy of current payments and costs, and the relationship between payments and an appropriate cost base, utilizing an established methodology used by MedPAC in the past several years.

MedPAC recommended an update to the hospital inpatient rates equal to the increase in the hospital market basket in FY 2010, concurrent with implementation of a quality incentive program. Similar to last year, MedPAC also recommended that CMS put pressure on hospitals to control their costs rather than accommodate the current rate of cost growth, which is, in part, caused by a lack of pressure from private payers.

MedPAC noted that indicators of payment adequacy are almost uniformly positive. MedPAC expects Medicare margins to remain low in 2010. At the same time though, MedPAC's analysis finds that hospitals with low non-Medicare profit margins have below average standardized costs and most of these facilities have positive overall Medicare margins.

Response: Similar to our response last year, we agree with MedPAC that hospitals should control costs rather than accommodate the current rate of growth. An update equal to less than the market basket will motivate hospitals to control their costs, consistent with MedPAC's recommendation. As MedPAC noted, the lack of financial pressure at certain hospitals can lead to higher costs and in turn bring down the overall Medicare margin for the industry.

As discussed in section II. of the preamble of this final rule, CMS implemented the MS–DRGs in FY 2008 to better account for severity of illness under the IPPS and is basing the DRG weights on costs rather than charges. We continue to believe that these refinements will better match Medicare payment of the cost of care and provide incentives for hospitals to be more efficient in controlling costs.

We note that, because the operating and capital prospective payment systems remain separate, we are continuing to use separate updates for operating and capital payments. The update to the capital rate is discussed in section III. of the Addendum to this final rule.

Comment: One commenter reiterated that MedPAC reported that Medicare margins are growing increasingly negative and that MedPAC recommended that hospitals be given a positive update of 2.7 percent in FY 2010 concurrent with implementation of a quality incentive program. The commenter supported MedPAC's recommendation of a full update to the market basket concurrent with implementation of a quality incentive program.

Response: We thank the commenter for their comments. As discussed above, section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Public Law 109–171, sets the FY 2010 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas. Under section 1886(b)(3)(B)(viii) of the Act, for hospitals that do not provide quality data, the update is equal to the market basket percentage increase less 2.0 percentage points. In this final rule, based on IHS Global Insight, Inc.'s second quarter 2009 forecast of the FY 2010 market basket increase, we are adopting a FY 2010 update to the standardized amount of 2.1 percent.

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