Federal Register

Friday,
May 22, 2009

Book 2 of 2 Books
Pages 24079–24694

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 415 et al.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 415, and 489

[CMS–1406–P]

RIN 0938–AP39

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

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems, and to implement certain provisions made by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Pub. L. 110–275) and the American Recovery and Reinvestment Act of 2009 (ARRA, Pub. L. 111–5). In addition, in the Addendum to this proposed rule, we describe the proposed changes to the amounts and factors used to determine the rates for Medicare acute care hospital inpatient services for operating costs and capital-related costs. These proposed changes would be applicable to discharges occurring on or after October 1, 2009. We also are setting forth the proposed update to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The proposed updated rate-of-increase limits would be effective for cost reporting periods beginning on or after October 1, 2009.

In addition, we are proposing to update the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). In the Addendum to this proposed rule, we also set forth the proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for rate year 2010. These proposed changes would be applicable to discharges occurring on or after October 1, 2009. In this proposed rule, we also note those provisions of the ARRA that amended provisions of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, Pub. L. 110–173) relating to payments to LTCHs and new LTCHs and LTCH satellite facilities, and increases in beds in existing LTCHs and LTCH satellite facilities under the LTCH PPS that will be implemented in the final rule issued for this proposed rule.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. E.S.T. on June 30, 2009.

ADDRESSES: When commenting on issues presented in this proposed rule, please refer to file code CMS–1406–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

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

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

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

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201

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

b. 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the ''Collection of Information Requirements'' section in this document.

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

FOR FURTHER INFORMATION, CONTACT: Tzvi Hefter, (410) 786–4487, 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, EMTALA, Hospital Emergency Services, and Hospital-Within-Hospital Issues.

Michele Hudson, (410) 786–4487, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRGs Issues.

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

Sheila Blackstock, (410) 786–3502, Quality Data for Annual Payment Update Issues.

Thomas Valuck, (410) 786–7479, 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.

Electronic Access

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access*, a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web, (the Superintendent of Documents' home Web page address is *http://www.gpoaccess.gov/*), by using local WAIS client software, or by telnet to *swais.access.gpo.gov*, then log in as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then log in as guest (no password required).

Acronyms

3M 3M Health Information System
AAHKS American Association of Hip and Knee Surgeons
AAMC Association of American Medical Colleges
ACGME Accreditation Council for Graduate Medical Education
AHA American Hospital Association
AHIC American Health Information Community
AHIMA American Health Information Management Association
AHRQ Agency for Healthcare Research and Quality
ALOS Average length of stay
ALTHA Acute Long Term Hospital Association
AMA American Medical Association
AMGA American Medical Group Association
AOA American Osteopathic Association
APR DRG All Patient Refined Diagnosis Related Group System
ARRA American Recovery and Reinvestment Act of 2009, Public Law 111–5
ASC Ambulatory surgical center
ASCA Administrative Simplification Compliance Act of 2002, Public Law 107–105
ASITN American Society of Interventional and Therapeutic Neuroradiology
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
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
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
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
VAP Ventilator-associated pneumonia

Table of Contents

I. Background
A. Summary
1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)
2. Hospitals and Hospital Units Excluded from the IPPS
3. Long-Term Care Hospital Prospective Payment System (LTCH PPS)
4. Critical Access Hospitals (CAHs)
5. Payments for Graduate Medical Education (GME)
B. Provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
C. Provisions of the American Recovery and Reinvestment Act of 2009 (ARRA)
D. Major Contents of This Proposed Rule
1. Proposed Changes to MS–DRG Classifications and Recalibrations of Relative Weights
2. Proposed Changes to the Hospital Wage Index for Acute Care Hospitals
3. Proposed Rebasing and Revision of the Hospital Market Basket for Acute Care Hospitals
4. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs
5. FY 2010 Policy Governing the IPPS for Capital-Related Costs
6. Proposed Changes to the Payment Rates for Certain Excluded Hospitals: Rate-of-Increase Percentages
7. Proposed Changes to the LTCH PPS
8. Determining Proposed Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits for Acute Care Hospitals
9. Determining Proposed Prospective Payments Rates for LTCHs
10. Impact Analysis
11. Recommendation of Update Factors for Operating Cost Rates of Payment for Hospital Inpatient Services
12. Discussion of Medicare Payment Advisory Commission Recommendations
E. Public Comments Received on Two LTCH PPS Interim Final Rules with Comment Period Issued in 2008
II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS–DRG) Classifications and Relative Weights
A. Background
B. MS–DRG Reclassifications
1. General
2. Yearly Review for Making MS–DRG Changes
C. Adoption of the MS–DRGs in FY 2008
D. Proposed 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
2. Prospective Adjustment to the Average Standardized Amounts Required by Section 7(b)(1)(A) of Public Law 110–90
3. Recoupment or Repayment Adjustments in FYs 2010 through 2012 Required by Public Law 110–90
4. Retrospective Evaluation of FY 2008 Claims Data
5. Proposed 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
6. Additional Adjustment for FY 2010 Authorized by Section 7(b)(1)(B) of Public Law 110–90
7. Background on the Application of the Documentation and Coding Adjustment to the Hospital-Specific Rates
8. Proposed Documentation and Coding Adjustment to the Hospital-Specific Rates for FY 2010 and Subsequent Years
9. Background on the Application of the Documentation and Coding Adjustment to the Puerto Rico-Specific Standardized Amount
10. Proposed Documentation and Coding Adjustment to the Puerto Rico-Specific Standardized Amount
E. Refinement of the MS–DRG Relative Weight Calculation
1. Background
a. Summary of the RTI Study of Charge Compression and CCR Refinement
b. Summary of the Rand Corporation Study of Alternative Relative Weight Methodologies
2. Summary of FY 2009 Changes and Discussion for FY 2010
3. Timeline for Revising the Medicare Cost Report
F. Preventable Hospital-Acquired Conditions (HACs), Including Infections
1. Statutory Authority
2. HAC Selection Process
3. Collaborative Process
4. Selected HAC Categories
5. Public Input Regarding Selected and Potential Candidate HACs
6. POA Indicator Reporting
G. Proposed Changes to Specific MS–DRG Classifications
1. MDC 5 (Diseases and Disorders of the Circulatory System): Intraoperative Fluorescence Vascular Angiography (IFVA)
2. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Infected Hip and Knee Replacements
3. Proposed Medicare Code Editor (MCE) Changes
a. Diagnoses Allowed for Males Only Edit
b. Manifestation Codes as Principal Diagnosis Edit
c. Invalid Diagnosis or Procedure Code
d. Unacceptable Principal Diagnosis
e. Proposed Creation of New Edit Titled ''Wrong Surgeries''
f. Procedures Allowed for Females Only Edit
4. Surgical Hierarchies
5. Complication or Comorbidity (CC) Exclusions List
a. Background
b. CC Exclusions List for FY 2010
6. Review of Procedure Codes in MS–DRGs 981 through 983, 984 through 986, and 987 through 989
a. Moving Procedure Codes from MS–DRGs 981 through 983 or MS–DRGs 987 through 989 to MDCs
b. Reassignment of Procedures among MS–DRGs 981 through 983, 984 through 986, and 987 through 989
c. Adding Diagnosis or Procedure Codes to MDCs
7. Changes to the ICD–9–CM Coding System
H. Recalibration of MS–DRG Weights
I. Proposed Add-On Payments for New Services and Technologies
1. Background
2. Public Input Before Publication of a Notice of Proposed Rulemaking on Add-On Payments
3. FY 2010 Status of Technologies Approved for FY 2009 Add-On Payments
4. FY 2010 Applications for New Technology Add-On Payments
a. The AutoLITT™ System
b. CLOLAR® (clofarabine) Injection
c. LipiScan™ Coronary Imaging System
d. Spiration® IBV® Valve System
e. TherOx Downstream® System
5. Technical Correction
III. Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

A. Background
B. Requirements of Section 106 of the MIEA–TRHCA
1. Wage Index Study Required Under the MIEA–TRHCA
a. Legislative Requirement
b. Interim and Final Reports on Results of Acumen's Study
2. FY 2009 Policy Changes in Response to Requirements Under Section 106(b) of the MIEA–TRHCA
a. Reclassification Average Hourly Wage Comparison Criteria
b. Within-State Budget Neutrality Adjustment for the Rural and Imputed Floors
C. Core-Based Statistical Areas for the Hospital Wage Index
D. Proposed Occupational Mix Adjustment to the Proposed FY 2010 Wage Index
1. Development of Data for the Proposed FY 2010 Occupational Mix Adjustment Based on the 2007–2008 Occupational Mix Survey
2. Calculation of the Proposed Occupational Mix Adjustment for FY 2010
E. Worksheet S–3 Wage Data for the Proposed FY 2010 Wage Index
1. Included Categories of Costs
2. Excluded Categories of Costs
3. Use of Wage Index Data by Providers Other Than Acute Care Hospitals Under the IPPS
F. Verification of Worksheet S–3 Wage Data
G. Method for Computing the Proposed FY 2010 Unadjusted Wage Index
H. Analysis and Implementation of the Proposed Occupational Mix Adjustment and the Proposed FY 2010 Occupational Mix Adjusted Wage Index
I. Revisions to the Wage Index Based on Hospital Redesignations
1. General
2. Effects of Reclassification/Redesignation
3. FY 2010 MGCRB Reclassifications
4. Redesignations of Hospitals Under Section 1886(d)(8)(B) of the Act
5. Reclassifications Under Section 1886(d)(8)(B) of the Act
6. Reclassifications Under Section 508 of Public Law 108–173
J. Proposed FY 2010 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees
K. Process for Requests for Wage Index Data Corrections
IV. Proposed Rebasing and Revision of the Hospital Market Baskets for Acute Care Hospitals
A. Background
B. Rebasing and Revising the IPPS Market Basket
1. Development of Cost Categories and Weights
a. Medicare Cost Reports
b. Other Data Sources
2. Final Cost Category Computation
3. Selection of Price Proxies
a. Wages and Salaries
b. Employment Benefits
c. Fuel, Oil, and Gasoline
d. Electricity
e. Water and Sewage
f. Professional Liability Insurance
g. Pharmaceuticals
h. Food: Direct Purchase
i. Food: Contract Services
j. Chemicals
k. Blood and Blood Products
l. Medical Instruments
m. Photographic Supplies
n. Rubber and Plastics
o. Paper and Printing Products
p. Apparel
q. Machinery and Equipment
r. Miscellaneous Products
s. Professional Fees: Labor-Related
t. Administrative and Business Support Services
u. All Other: Labor-Related Services
v. Professional Fees: Nonlabor-Related
w. Financial Services
x. Telephone Services
y. Postage
z. All Other: Nonlabor-Related Services
4. Labor-Related Share
C. Separate Market Basket for Certain Hospitals Presently Excluded From the IPPS
D. Rebasing and Revising the Capital Input Price Index (CIPI)
V. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs
A. Reporting of Hospital Quality Data for Annual Hospital Payment Update
1. Background
a. Overview
b. Hospital Quality Data Reporting Under Section 501(b) of Public Law 108–173
c. Hospital Quality Data Reporting Under Section 5001(a) of Public Law 109–171
2. Retirement of RHQDAPU Program Measures
3. Quality Measures for the FY 2011 Payment Determination and Subsequent Years
a. Considerations in Expanding and Updating Quality Measures Under the RHQDAPU Program
b. Proposed RHQDAPU Program Quality Measures for the FY 2011 Payment Determination
3. Possible New Quality Measures for the FY 2012 Payment Determination and Subsequent Years
4. Possible New Quality Measures for the FY 2012 Payment Determination and Subsequent Years
5. Form, Manner, and Timing of Quality Data Submission
a. Proposed RHQDAPU Program Procedures for the FY 2011 Payment Determination
b. RHQDAPU Program Disaster Extensions and Waivers
c. HACHPS Requirements for the FY 2011 Payment Determination
6. Proposed Chart Validation Requirements
a. Proposed Chart Validation Requirements and Methods for the FY 2011 Payment Determination
b. Proposed 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
7. Data Accuracy and Completeness Acknowledgement Requirements for the FY 2011 Payment Determination and Subsequent Years
8. Public Display Requirements for the FY 2011 Payment Determination and Subsequent Years
9. Proposed Reconsideration and Appeal Procedures for the FY 2010 Payment Determination
10. RHQDAPU Program Withdrawal Deadlines
11. Electronic Health Records
a. Background
b. EHR Testing of Quality Measures Submission
c. HITECH Act EHR Provisions
B. Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs): Budget Neutrality Adjustment Factors for FY 2002-Based Hospital-Specific Rate for MDHs
1. Background
2. FY 2002-Based Hospital-Specific Rate
C. Rural Referral Centers (RRCs)
1. Case-Mix Index
2. Discharges
D. Indirect Medical Education (IME) Adjustment
1. Background
2. IME Adjustment Factor for FY 2010
3. IME-Related Proposed Changes in Other Sections of this Proposed Rule
E. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs)
1. Background
2. Proposed Policy Change Relating to the Inclusion of Labor and Delivery Patient Days in the Medicare DSH Calculation
a. Background
b. Proposed Policy Change
3. Proposed Policy Change Relating to Calculation of Inpatient Days in the Medicaid Fraction in the Medicare DSH Calculation
a. Background
b. Proposed Policy Change
4. Proposed Policy Change Relating to the Exclusion of Observation Beds and Patient Days From the Medicare DSH Calculation
a. Background
b. Proposed Policy Change
F. Technical Correction to Regulations on Payments for Anesthesia Services Furnished by Hospital or CAH Employed Nonphysician Anesthetists or Obtained Under Arrangements
G. Payments for Direct Graduate Medical Education (GME) Costs
1. Background
2. Clarification of Definition of New Medical Residency Training Program
3. Participation of New Teaching Hospitals in Medicare GME Affiliated Groups
4. Technical Corrections to Regulations
H. Hospital Emergency Services Under EMTALA
1. Background
2. Proposed Changes Relating to Applicability of Sanctions Under EMTALA
I. Rural Community Hospital Demonstration Program
J. Technical Correction to Regulations Relating to Calculation of the Federal Rate Under the IPPS
VI. Proposed Changes to the IPPS for Capital-Related Costs

A. Overview
B. Exception Payments
C. New Hospitals
D. Hospitals Located in Puerto Rico
E. Proposed Changes
1. Proposed 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
b. Proposed Prospective MS–DRG Documentation and Coding Adjustment to the National Capital Federal Rate for FY 2010 and Subsequent Years
c. Proposed Documentation and Coding Adjustment to the Puerto Rico-Specific Capital Rate
2. Revision to the FY 2009 IME Adjustment Factor
3. Other Proposed Changes for FY 2010
VII. Proposed Changes for Hospitals Excluded From the IPPS
A. Excluded Hospitals
B. Criteria for Satellite Facilities of Hospitals
C. Critical Access Hospitals (CAHs)
1. Background
2. Payment for Clinical Diagnostic Laboratory Tests Furnished by CAHs
3. CAH Optional Method of Payment for Outpatient Services
D. Provider-Based Status of Facilities and Organizations: Proposed Policy Changes
1. Background
2. Proposed Changes to the Scope of the Provider-Based Status Regulations for CAHs
a. CAH-Based Clinical Diagnostic Laboratory Facilities
b. CAH-Based Ambulance Services
3. Technical Correction to Regulations
VIII. Proposed 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
2. Criteria for Classification as a LTCH
a. Classification as a LTCH
b. Hospitals Excluded from the LTCH PPS
3. Limitation on Charges to Beneficiaries
4. Administrative Simplification Compliance Act (ASCA) and Health Insurance Portability and Accountability Act (HIPAA) Compliance
B. Proposed Medicare Severity Long-Term Care Diagnosis-Related Group (MS–LTC–DRG) Classifications and Relative Weights
1. Background
2. Patient Classifications Into MS–LTC–DRGs
a. Background
b. Proposed Changes to the MS–LTC–DRGs for RY 2010
3. Development of the Proposed RY 2010 MS–LTC–DRG Relative Weights
a. General Overview of the Development of the MS–LTC–DRG Relative Weights
b. Data
c. Hospital-Specific Relative Value (HSRV) Methodology
d. Treatment of Severity Levels in Developing the Proposed MS–LTC–DRG Relative Weights
e. Low-Volume MS–LTC–DRGs
f. Steps for Determining the Proposed RY 2010 MS–LTC–DRG Relative Weights
C. Proposed Changes to the LTCH Payment Rates and Other Changes to the RY 2010 LTCH PPS
1. Overview of Development of the LTCH Payment Rates
2. Market Basket for LTCHs Reimbursed under the LTCH PPS
a. Overview
b. Proposed Market Basket under the LTCH PPS for RY 2010
c. Proposed Market Basket Update for LTCHs for RY 2010
d. Proposed Labor-Related Share under the LTCH PPS for RY 2010
3. Proposed Adjustment for Changes in LTCHs' Case-Mix Due to Changes in Documentation and Coding Practices That Occurred in a Prior Period
a. Background
b. Evaluation of FY 2007 Claims Data
c. Evaluation of FY 2008 Claims Data
d. Proposed RY 2010 Documentation and Coding Adjustment
D. Monitoring
E. Research Conducted by the Research Triangle Institute, International (RTI)
F. Proposed Technical Corrections of LTCH PPS Regulations
IX. MedPAC Recommendations
X. Other Required Information
A. Requests for Data from the Public
B. Collection of Information Requirements
C. Additional Information Collection Requirements
1. Present on Admission (POA) Indicator Reporting
2. Proposed Add-On Payments for New Services and Technologies
3. Reporting of Hospital Quality Data for Annual Hospital Payment Update
4. Occupational Mix Adjustment to the FY 2010 Index (Hospital Wage Index Occupational Mix Survey)
5. Hospital Applications for Geographic Reclassifications by the MGCRB
C. Response to Public Comments

Regulation Text

Addendum—Proposed 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
II. Proposed Changes to the Prospective Payment Rates for Hospital Inpatient Operating Costs for Acute Care Hospitals for FY 2010
A. Calculation of the Adjusted Standardized Amount
B. Proposed Adjustments for Area Wage Levels and Cost-of-Living
C. Proposed MS–DRG Relative Weights
D. Calculation of the Proposed Prospective Payment Rates
III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2010
A. Determination of Proposed Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update
B. Calculation of the Proposed Inpatient Capital-Related Prospective Payments for FY 2010
C. Capital Input Price Index
IV. Proposed Changes to Payment Rates for Certain Excluded Hospitals: Rate-of-Increase Percentages
V. Proposed Changes to the Payment Rates for the LTCH PPS for RY 2010
A. Proposed LTCH PPS Standard Federal Rate for RY 2010
B. Proposed Adjustment for Area Wage Levels under the LTCH PPS for RY 2010
C. Proposed Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases
D. Computing the Proposed Adjusted LTCH PPS Federal Prospective Payments for RY 2010
VI. Tables
Table 1A.—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (67.1 Percent Labor Share/32.9 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—FY 2010
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 6G.—Additions to the CC Exclusions List (Available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/*)
Table 6H.—Deletions from the CC Exclusions List (Available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/*)
Table 6I.—Complete List of Complication and Comorbidity (CC) Exclusions (Available only through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/*)
Table 6J.—Major Complication and Comorbidity (MCC) List (Available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/*)
Table 6K.—Complication and Comorbidity (CC) List (Available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/*)
Table 7A.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2008 MedPAR Update—December 2008 GROUPER V26.0 MS–DRGs
Table 7B.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2008 MedPAR Update—December 2008 GROUPER V27.0 MS–DRGs
Table 8A.—Proposed Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—March 2009
Table 8B.—Proposed Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—March 2009
Table 8C.—Proposed Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs—March 2009
Table 9A.—Hospital Reclassifications and Redesignations—FY 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 Groups (MS–DRGs)—March 2009
Table 11.—Proposed MS–LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier 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 Ares for Discharges Occurring from October 1, 2009 through September 30, 2010

Appendix A—Regulatory Impact Analysis

I. Overall Impact
II. Objectives of the IPPS
III. Limitations of Our Analysis
IV. Hospitals Included in and Excluded From the IPPS
V. Effects on Hospitals Excluded from the IPPS
VI. Quantitative Effects of the Policy Changes under the IPPS for Operating Costs
A. Basis and Methodology of Estimates
B. Analysis of Table I
C. Effects of the Proposed Changes to the MS–DRG Reclassifications and Relative Cost-Based Weights (Column 1)
D. Effects of the Application of Recalibration Budget Neutrality (Column 2)
E. Effects of Proposed Wage Index Changes (Column 3)
F. Application of the Wage Budget Neutrality Factor (Column 4)
G. Combined Effects of Proposed MS–DRG and Wage Index Changes (Column 5)
H. Effects of MGCRB Reclassifications (Column 6)
I. Effects of the Proposed Rural Floor and Imputed Floor, Including the Transition To Apply Budget Neutrality at the State Level (Column 7)
J. Effects of the Proposed Wage Index Adjustment for Out-Migration (Column 8)
K. Effects of All Proposed Changes Prior to Documentation and Coding (or CMI) Adjustment (Column 9)
L. Effects of All Proposed Changes With Documentation and Coding (or CMI) Adjustment (Column 10)
M. Effects of Policy on Payment Adjustments for Low-Volume Hospitals
N. Impact Analysis of Table II
VII. Effects of Other Proposed Policy Changes
A. Effects of Proposed Policy on HACs, Including Infections
B. Effects of Proposed Policy Change Relating to New Medical Service and Technology Add-On Payments
C. Effects of Proposed Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update
D. Effects of Correcting the FY 2002-Based Hospital-Specific Rates for MDHs
E. Effects of Proposed Policy Changes Relating to DSH Payment Adjustment
F. Effects of Proposed Policy Changes Related to Direct GME
G. Effects of Proposed Policy Changes Relating to Hospital Emergency Services under EMTALA
H. Effects of Proposed Policy Changes Relating to Payments to CAHs
I. Effects of Proposed Policy Changes Relating to Provider-Based Status of Facilities and Organizations
J. Effects of Proposed Policy Changes Relating to Criteria for Satellite Facilities of Hospitals
K. Effects of Implementation of Rural Community Hospital Demonstration Program
VIII. Effects of Proposed Changes in the Capital IPPS
A. General Considerations
B. Results
IX. Effects of Proposed Payment Rate Changes and Policy Changes Under the LTCH PPS
A. Introduction and General Considerations
B. Impact on Rural Hospitals
C. Anticipated Effects of Proposed LTCH PPS Payment Rate Change and Policy Changes
D. Effect on the Medicare Program
E. Effect on Medicare Beneficiaries
X. Alternatives Considered
XI. Overall Conclusion
A. Acute Care Hospitals
B. LTCHs
XII. Accounting Statements
A. Acute Care Hospitals
B. LTCHs
XIII. Executive Order 12866

Appendix B—Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background
II. Inpatient Hospital Update for FY 2010
III. Secretary's Recommendation
IV. MedPAC Recommendation for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

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 no 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. We began phasing out the capital IPPS IME adjustment in FY 2008, as discussed in section VI.B.2. of this preamble. However, section 4301(b)(1) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5), enacted on February 17, 2009, requires that the 50-percent reduction in the capital IPPS teaching adjustment for FY 2009 specified in the regulations at § 412.322(c) shall not be applied. Section 4301(b)(2) of Public Law 111–5 specifies that, for subsequent years, the change made by section 4301(b)(1) has no effect on the capital teaching adjustment. Therefore, beginning in FY 2010, there will no longer be a capital teaching adjustment under the capital IPPS. The provisions of section 4301(b) of Public Law 111–5 are discussed in sections VI.A. and E. of this preamble. 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 proposed annual updates to the LTCH PPS are now included as part of the IPPS annual update document (for RY 2010, in this proposed 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 VI.C.2. of the preamble of this proposed rule, we discuss our proposal to codify 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), Public 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. Section 4301(b) of Public Law 111–5 also specifies that there will be no effect on the phase-out of the capital teaching adjustment for subsequent years, such that, for discharges occurring during FY 2010 and thereafter, there will no longer be a teaching adjustment under the capital IPPS as is currently specified at § 412.322(d). We discuss the proposed implementation of these provisions in section VI.A. and E. of the preamble of this proposed rule.

Section 4302 of Public Law 111–5 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 proposed implementation of these provisions in sections I.E. and VIII. of the preamble of this proposed rule.

D. Major Contents of this Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs of acute care hospitals in FY 2010. We also are setting forth proposed changes relating to payments for IME costs and payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis. In addition, we are setting forth proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for RY 2010.

The following is a summary of the major changes that we are proposing to make:

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

In section II. of the preamble of this proposed rule, we are including—

- 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 are also presenting 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 are presenting 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 this proposed rule, we are proposing revisions to the wage index for acute care hospitals and the annual update of the wage data. Specific issues addressed include the following:

- 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 Basket for Acute Care Hospitals

In section IV. of the preamble of this proposed rule, we are proposing 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 are setting 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 this proposed rule, we discuss 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 this proposed rule, we discuss the payment policy requirements for capital-related costs and capital payments to hospitals for FY 2010. We also are proposing 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 American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5).

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

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

- 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 this 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 this proposed rule, we discuss our ongoing monitoring protocols under the LTCH PPS. In section VIII.E., we discuss 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.

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

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

9. Determining Proposed Prospective Payment Rates for LTCHs

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the proposed RY 2010 prospective standard Federal rate. We also establish 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 this 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 this proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provide our recommendations of the appropriate percentage changes for FY 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 address these recommendations in Appendix B of this proposed rule. For further information relating specifically to the MedPAC March 2008 report or to obtain a copy of the report, contact MedPAC at (202) 220–3700 or visit MedPAC's Web site at: *http://www.medpac.gov*.

E. Public Comments Received on Two LTCH PPS Interim Final Rules With Comment Period Issued in 2008

On May 6, 2008 and May 22, 2008, we issued in the **Federal Register** two interim final rules with comment periods 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.

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. We have issued instructions to the fiscal intermediaries and Medicare administrative contractors (MACs) to interpret these amendments (Change Request 6444). We intend to implement the provisions of section 4302 of Public Law 111–5 by issuing an interim final rule with comment period along with the FY 2010 IPPS and RY 2010 LTCH PPS final rule that is scheduled for publication in August 2009. In the FY 2010 IPPS and RY 2010 LTCH PPS final rule, we also intend to respond to the public comments that we received on the two interim final rules with comment period noted above and finalize those provisions, as appropriate.

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

A. Background

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

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

B. MS–DRG Reclassifications

1. General

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

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

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.

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.
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.

PRE-MAJOR DIAGNOSTIC CATEGORIES (PRE-MDCS)—Continued

MS–DRG 006.	Liver Transplant without MCC.
MS–DRG 007.	Lung Transplant.
MS–DRG 008.	Simultaneous Pancreas/Kidney Transplant.
MS–DRG 009.	Bone Marrow Transplant.
MS–DRG 010.	Pancreas Transplant.
MS–DRG 011.	Tracheostomy for Face, Mouth, and Neck Diagnoses with MCC.
MS–DRG 012.	Tracheostomy for Face, Mouth, and Neck Diagnoses with CC.
MS–DRG 013.	Tracheostomy for Face, Mouth, and Neck Diagnoses without CC/MCC.

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

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

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

A patient's diagnosis, procedure, discharge status, and demographic information is entered into the Medicare claims processing systems and subjected to a series of automated screens called the Medicare Code Editor (MCE). The MCE screens are designed to identify cases that require further review before classification into an MS–DRG.

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

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

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible MS–DRG classification changes and to recalibrate the MS–DRG weights. However, in the FY 2000 IPPS final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for us to consider using particular non-MedPAR data, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the

nature and quality of the non-MedPAR data submitted. Generally, however, a significant sample of the non-MedPAR data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule. This date allows us time to test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

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

In the FY 2007 IPPS proposed rule, we discussed MedPAC's recommendations to move to a cost-based HSRV weighting methodology using HSRVs beginning with the FY 2007 IPPS proposed rule for determining the DRG relative weights. Although we proposed to adopt the HSRV weighting methodology for FY 2007, we decided not to adopt the proposed methodology in the final rule after considering the public comments we received on the proposal. Instead, in the FY 2007 IPPS final rule, we adopted a cost-based weighting methodology without the HSRV portion of the proposed methodology. The cost-based weights were adopted over a 3-year transition period in 1/3 increments between FY 2007 and FY 2009. In addition, in the FY 2007 IPPS final rule, we indicated our intent to further study the HSRV-based methodology as well as other issues brought to our attention related to the cost-based weighting methodology adopted in the FY 2007 final rule. There was significant concern in the public comments that our cost-based weighting methodology does not adequately account for charge compression—the practice of applying a higher percentage charge markup over costs to lower cost items and services and a lower percentage charge markup over costs to higher cost items and services. Further, public commenters expressed concern about potential inconsistencies between how costs and charges are reported on the Medicare cost reports and charges on the Medicare claims. In the FY 2007 IPPS final rule, we used costs and charges from the cost report to determine departmental level cost-to-charge ratios (CCRs) which we then applied to charges on the Medicare claims to determine the cost-based weights. The commenters were concerned about potential distortions to the cost-based weights that would result from inconsistent reporting between the cost reports and the Medicare claims. After publication of the FY 2007 IPPS final rule, we entered into a contract with RTI International (RTI) to study both charge compression and to what extent our methodology for calculating DRG relative weights is affected by inconsistencies between how hospitals report costs and charges on the cost reports and how hospitals report charges on individual claims. Further, as part of its study of alternative DRG systems, the RAND Corporation analyzed the HSRV cost-weighting methodology. We refer readers to section II.E. of the preamble of this proposed rule for discussion of the issue of charge compression and the HSRV 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 proposing to make in this proposed 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. Proposed 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 encourages 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.

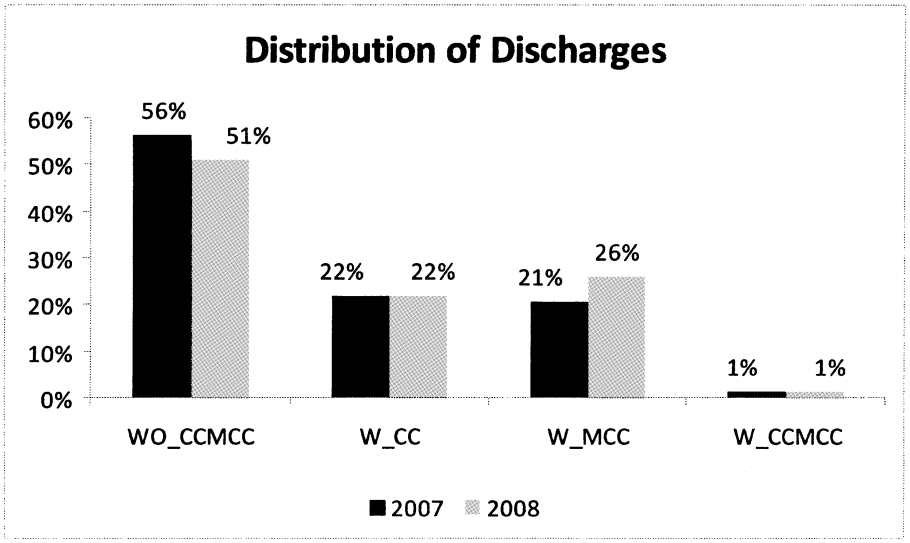
We took these comments into consideration as we developed our proposed analysis plan (described in greater detail below) and in this proposed rule are seeking comment on our methodology. We performed a retrospective evaluation of the FY 2008 data for claims paid through December 2008. Based on this evaluation, our actuaries have 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 performing this analysis, 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 the 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 is 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.

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. In Figure 1 below, we show that, between FY 2007 and FY 2008, there was a 5 percentage point increase in the discharges with an MCC from 21 percent to 26 percent and a corresponding decrease of 5 percentage points from 56 percent to 51 percent in discharges without a CC or an MCC.

FIGURE 1: Comparison of IPPS Discharge Severity in FY 2007 and FY 2008



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 are classified as non-CCs, while others 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 this analysis provides additional support for our conclusion that the 2.5 percent estimate accurately reflects 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 estimate that the use of the FY 2009 relative weights will 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 current estimate of the FY 2009 MS–DRG documentation and coding effect is 2.3 percent.

As in prior years, the FY 2008 MedPAR files are available to the public to allow independent analysis of the FY 2008 documentation and coding effect. Interested individuals may 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 will describe the file and provide 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.

We are seeking public comment on our methodology and analysis. We intend to update our analysis with FY 2008 data on claims paid through March 2008 in the FY 2010 IPPS final rule.

5. Proposed 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

The estimated 2.5 percent change in FY 2008 case-mix due to changes in documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 exceeded the −0.6 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 by 1.9 percentage points. Under section 7(B)(1)(a) of Public Law 119–90, the Secretary is required to make an appropriate adjustment under section 1886(d)(3)(A)(vi) of the Act to the average standardized amounts for subsequent fiscal years in order to eliminate the full effect of the documentation and coding changes. 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.

Therefore, we are proposing to change the average standardized amounts under section 1886(d) of the Act in FY 2010 by −1.9 percent, the difference between the 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 section 7 of Public Law 110–90. We are proposing 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 not reflective of an increase in real case-mix.

We also estimate that the 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 believe 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 will not receive all FY 2009 claims data prior to publication of the final rule, we will 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 are seeking 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 are seeking 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.

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

As indicated above, the 2.5 percent change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008 exceeded the −0.6 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 by 1.9 percentage points. 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 are not proposing to make an adjustment to FY 2010 to offset, in whole or in part, the estimated increase in aggregate payments for discharges occurring in FY 2008, but intend to address this issue in future rulemaking for FYs 2011 and 2012. That is, we will 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. While we have the statutory authority to make this −1.9 percent recoupment adjustment entirely in FY 2010, we are proposing to delay 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. For this reason, we are proposing 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 the final 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 estimated 4.8 percent cumulative actual documentation and coding changes for FY 2009 includes the impact of the changes in documentation and coping 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 proposed −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 occurring in FY 2008 expenditures and FY 2009 expenditures, if any.

We are seeking 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.

To assist the public in commenting on this issue, the following table shows our estimate of the adjustments required under section 7(b)(1) of Public Law 110–90. Column (A) and Column (C) show the prospective adjustments discussed above in section II.D.5. of this preamble. Column (B) and Column (D) show the retrospective adjustments discussed above in section II.D.6. of this preamble. Column (E) shows the −1.9 percent adjustment from Column (A) that we are proposing for FY 2010. The estimated −6.6 percent adjustment in Column (F) reflects the cumulative effect of the remaining −1.9 adjustment from Column (B), the remaining −1.4 percent adjustment from Column (C), and the remaining −3.3 adjustment from

Column (D) that are required by statute, but that we are not proposing for FY 2010. Column (G) shows the combined effect of the −1.9 percent adjustment in Column (E) that we are proposing for FY 2010 and the −6.6 percent adjustment in Column (F) that we currently estimate we will need to propose in future years. As noted above, we are unable to provide our final estimate of the documentation and coding changes in FY 2009 that do not reflect real changes in case-mix, as we do not have all FY 2009 claims data. The table instead reflects our current estimate of the difference between changes in documentation and coding in FY 2009 that do not reflect real changes in case-mix and the prospective adjustment applied in FY 2009 under section 7(a) of Public Law 110–90. If documentation and coding increases were to exceed current projections for FY 2009, future adjustments would be greater than those shown here. If documentation and coding adjustments were to be less than current projections for FY 2009, future adjustments would be less than those shown here.

FY 2010 MS–DRG DOCUMENTATION AND CODING ADJUSTMENT RANGE

	Prospective adjustment for FY 2008 (A)	Recoupment adjustment for FY 2008 (B)	Prospective adjustment for FY 2009* (C)	Recoupment adjustment for FY 2009* (D)	Adjustment proposed for FY 2010 (E)	Estimated remaining adjustment* (F)	Total adjustment FY 2010–FY 2012* (G)
FY 2010 Proposal	Proposed for FY 2010.	Not Proposed for FY 2010.	Not Proposed for FY 2010.	Not Proposed for FY 2010.			
Amount of Adjustment	−1.9	−1.9	−1.4	−3.3	−1.9	−6.6	−8.5

*Estimated. The actual percentage adjustment to the national standardized amounts for the purpose of offsetting the estimated $2.2 billion in increased payments under IPPS in FY 2008 will depend on when we apply the adjustment. However, we believe this adjustment will be approximately −1.9 percent, or the difference between the actual changes in documentation and coding that do not reflect real changes in case-mix in FY 2008 and the documentation and coding adjustment applied under section 7(a) of Public Law 110–90. Similarly, we based our estimate of the percentage adjustment to the national standardized amounts for the purpose of offsetting the expected increase in payments in FY 2009 on the estimated difference between the cumulative actual changes in documentation and coding that do not reflect real changes in case-mix in FY 2009 and the documentation and coding adjustments applied under section 7(a) of Public Law 110–90, or 3.3 percent. As discussed earlier, we are not permitted to apply a retroactive FY 2009 adjustment until we have performed an analysis of the FY 2009 data.

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

We performed 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 2.5 percent result discussed earlier, but did not significantly differ from that result.

Again, we found that the within-base DRG increases were almost entirely responsible for the case-mix change. In Figure 2 below, we show that, for SCHs, there was a 5 percentage point increase in the discharges with an MCC from 17 percent to 22 percent and a corresponding decrease of 5 percentage points from 59 percent to 54 percent in discharges without a CC or an MCC. In Figure 3 below, we show that, for MDHs, there was a 5 percentage point increase in the discharges with an MCC from 15 percent to 20 percent and a decrease of 6 percentage points from 60 percent to 54 percent in discharges without a CC or an MCC.

BILLING CODE 4120–01–P

FIGURE 2.--Comparison of SCH Discharge Severity in FY 2007 and FY 2008

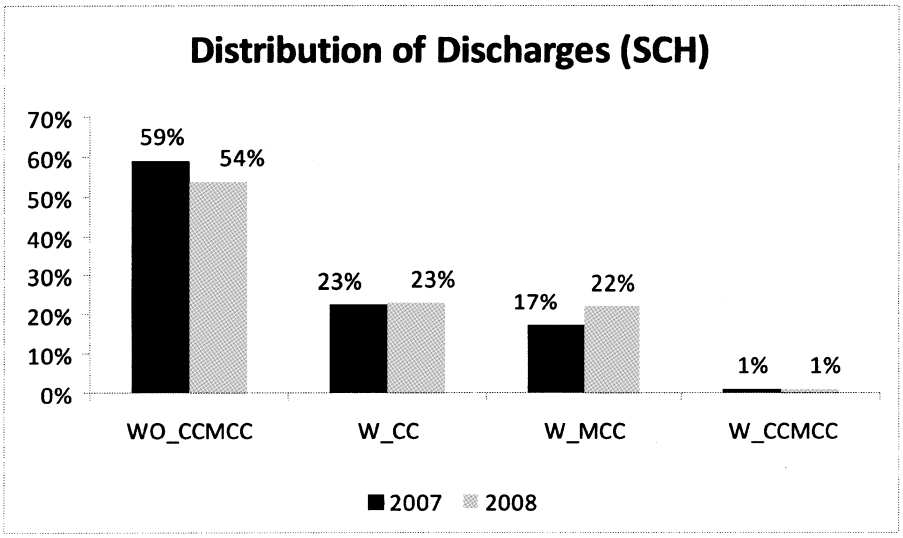
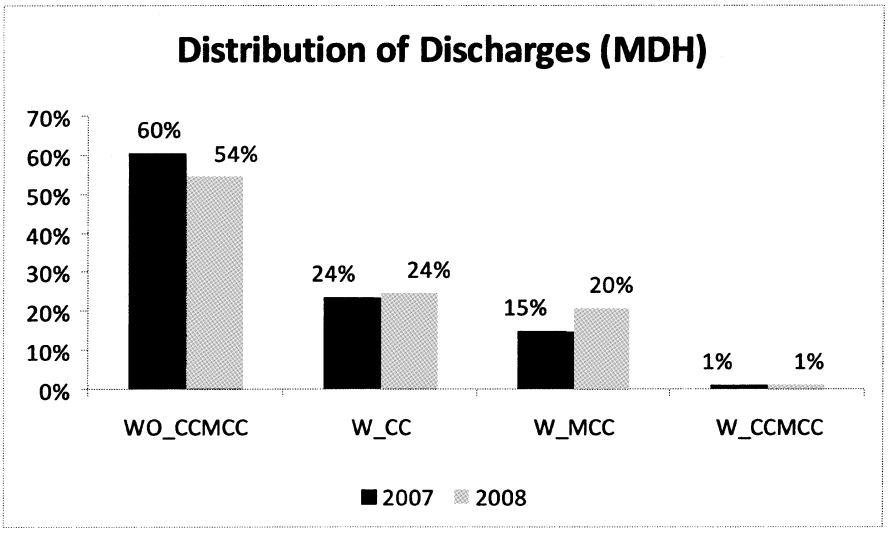


FIGURE 3.--Comparison of MDH Discharge Severity in FY 2007 and FY 2008



BILLING CODE 4120–01–C

The largest within-base DRG contributors for both types of hospitals are heart failure and shock, chronic obstructive pulmonary disease, and simple pneumonia and pleurisy. For each of these conditions, a significant decrease in the percentage of discharges without a CC or an MCC was observed.

Therefore, consistent with our statements in prior IPPS rules, we are proposing 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 to account for our estimated documentation and coding effect in FY 2008 that does not reflect real changes in case-mix. We are proposing 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. This proposed −2.5 percent adjustment to the hospital-specific rates exceeds the proposed −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.

Consistent with our proposed approach for IPPS hospitals discussed earlier, we will address in the FY 2011 rulemaking cycle any changes in documentation and coding that do 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.

We are seeking 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 addressing 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 intend to update our analysis with FY 2008 data on claims paid through March 2008 for the FY 2010 IPPS final rule.

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

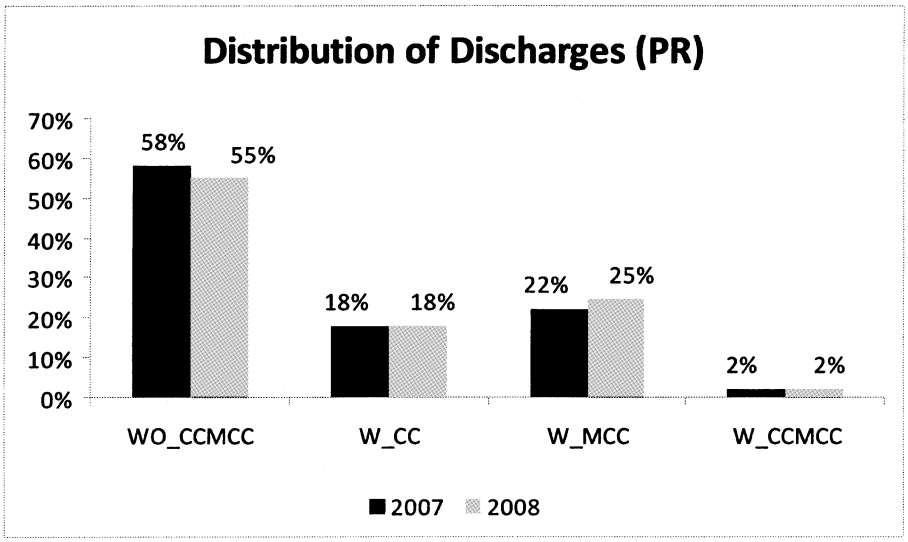
Puerto Rico hospitals are paid based on 75 percent of the national standardized amount and 25 percent of the Puerto Rico-specific standardized amount. As noted previously, the documentation and coding adjustment we adopted in the FY 2008 IPPS final rule with comment period relied upon our authority under 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. Proposed Documentation and Coding Adjustment to the Puerto Rico-Specific Standardized Amount

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 calculate the within-base DRG changes and the across-base DRG changes for Puerto Rico hospitals, we find that responsibility for the case-mix change between FY 2007 and FY 2008 is much more evenly shared. Across-base DRG shifts account for 44 percent of the changes, and within-base DRG shifts account for 56 percent. Thus, the change in the percentage of discharges with an MCC is not as large as that for other IPPS hospitals. In Figure 4 below, we show 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.

FIGURE 4.--Comparison of Puerto Rico Discharge Severity in FY 2007 and FY 2008



The top contributing base DRGs to the case-mix change due to the within-base DRG changes differ partially from those of other hospitals. The top three are acute myocardial infarction, major small and large bowel procedures, and chronic obstructive pulmonary disease.

Given these documentation and coding increases, consistent with our statements in prior IPPS rules, we are proposing 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 increase not due to changes in real case-mix and to leave that adjustment in place for subsequent fiscal years. The proposed −1.1 percent adjustment will 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, which we are proposing to adjust as described above. 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.

Consistent with our proposed 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.

We are seeking 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 addressing 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 intend to update our analysis with FY 2008 data on claims paid through March 2008 for the FY 2010 IPPS final rule.

E. Refinement of the MS–DRG Relative Weight Calculation

1. Background

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

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

In FY 2009, the third and final year of the transition from charge-based weights to cost-based weights, we calculated the MS–DRG relative weights based on 100 percent of hospital costs. We refer readers to the FY 2007 IPPS final rule (71 FR 47882) for a more

detailed discussion of our final policy for calculating the cost-based DRG relative weights and to the FY 2008 IPPS final rule with comment period (72 FR 47199) for information on how we blended relative weights based on the CMS DRGs and MS–DRGs.

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

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

In its interim draft report, RTI offered a number of recommendations to mitigate the effects of charge compression, including estimating regression-based CCRs to disaggregate the Medical Supplies Charged to Patients, Drugs Charged to Patients, and Radiology cost centers, and adding new cost centers to the Medicare cost report, such as adding a ''Devices, Implants and Prosthetics'' line under ''Medical Supplies Charged to Patients'' and a ''CT Scanning and MRI'' subscripted line under ''Radiology-Diagnostics''. (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 are not proposing to adopt regression-based CCRs for the calculation of the FY 2010 IPPS relative weights.

However, we are concerned 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 cautions 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 note 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.

We understand that MedPAC has 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 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, 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, 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. 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 are not proposing changes for FY 2010, in light of the previous discussion of the current IME and DSH adjustments in the standardization process, we are interested in receiving 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.

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 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, 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 within the guidelines of GAAP, 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 this time, we anticipate that the transmittal to create this new cost center will 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 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, 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.

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 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 from time to time, again in consultation with CDC, 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 condition 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. That is, if there is a HAC, 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 IPPS hospitals.

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 and proposed 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 the CDC to identify the candidate preventable HACs, review comments, and select HACs. CMS and CDC staff 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 and CDC again hosted a jointly sponsored HAC and POA Listening Session to receive input from interested organizations and individuals. Experts from AHRQ also participated in the event. 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_Educational Resources.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: 800–829, 830–839, 850–854, 925–929, 940–949, 991–994.
—Fracture	
—Dislocation	
—Intracranial Injury	
—Crushing Injury	
—Burn	
—Electric Shock	
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 (MCC).
	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 with comment period (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. We refer readers to Table 6A in the Addendum to this proposed rule for proposed changes. In Table 6A, we are proposing the following changes that reflect the new diagnosis codes that are within the fracture code range for the falls/trauma HAC category:

ICD–9–CM code	Code descriptor	Proposed CC/MCC designations
813.46	Torus fracture of ulna.	CC
813.47	Torus fracture of radius and ulna.	CC

If these proposed CC designations for ICD–9–CM codes 813.46 and 813.47 are finalized, these codes will be adopted within the fracture code range for the falls/trauma HAC category.

5. Public Input Regarding Selected and Potential Candidate HACs

We are not proposing to add or remove categories of HACs at this time. However, 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.

Some stakeholders commented on previously selected HACs. For example, one commenter requested a coding change to the Stages III and IV Pressure Ulcer HAC. The commenter recommended that CMS include the following ICD–9–CM codes to further define pressure ulcers as a HAC: (1) 707.20 (Pressure ulcer, unspecified stage); and (2) 707.25 (Pressure ulcer, unstageable). However, these codes are not classified as CCs or MCCs and, therefore, do not meet the statutory requirement of causing a higher paying MS–DRG.

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. Now that we have early program data, we are focused on evaluating the impact of the HAC payment provision through a joint program evaluation with CDC and AHRQ. That evaluation process will provide valuable information for future policymaking aimed at preventing HACs. Commenters emphasized during the IPPS FY 2009 rulemaking and during and after the December 18, 2008 Listening Session the need for a robust program evaluation prior to changing the HAC list.

As an early aspect of the program evaluation, we plan to analyze the available POA data. This early analysis may be useful for future HAC policymaking and for other purposes like identifying priorities for the development of HAC prevention guidelines.

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 provider 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 48487), we adopted our proposal to: (1) Pay the CC/MCC MS–DRGs for those HACs coded with ''Y'' and ''W'' indicators; and (2) not pay the CC/MCC MS–DRGs for those HACs coded with ''N'' and ''U'' indicators. We are not proposing changes to the payment implications of the POA indicator reporting options at this time.

As we have noted in previous IPPS rulemaking documents, most recently in the FY 2009 IPPS final rule (73 FR 48487), the American Health Information Management Association (AHIMA) has promulgated Standards of Ethical Coding that require accurate coding regardless of the payment implications of the diagnoses. Further, Medicare program integrity initiatives closely monitor for inaccurate coding and coding inconsistent with medical record documentation.

G. Proposed Changes to Specific MS–DRG Classifications

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

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 (Intraoperative 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 1/3 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. We invite 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.

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

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.

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 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 1/3 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, we are proposing 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 are proposing 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 is shown in Table

6F of the Addendum to this proposed rule.

3. Proposed 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. For FY 2010, we are proposing 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 this FY 2010 IPPS proposed rule, we are acknowledging this omission and are again proposing to make the changes.

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, we are proposing to remove codes 365.41, 365.42, and 365.43 from the Manifestation Code as Principal Diagnosis Edit.

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, we are proposing to add code 00.01 to the table of valid codes.

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 this proposed rule, we are proposing 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 interim 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.

e. Proposed Creation of New Edit Titled ''Wrong Surgeries''

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 this proposed rule, we are proposing 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)

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 are proposing 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 Surgery'' edit. Any claim with this edit will be denied and returned to the provider.

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, we are proposing to add codes 75.37 and 75.38 and to the edit for procedures allowed for females only.

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 are not proposing any revisions to the surgical hierarchy.

5. Complications or Comorbidity (CC) Exclusions List

a. Background

As indicated earlier in the preamble of this proposed 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]

For FY 2010, we are proposing to make limited revisions to the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2009. (*See* section II.G.7. of the preamble of this proposed rule for a discussion of ICD–9–CM changes.) We are proposing to make these changes in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6G and 6H, Additions to and Deletions from the CC Exclusion List, respectively, which would be effective for discharges occurring on or after October 1, 2009, are not being published in this proposed rule because of the length of the two tables. Instead, we are making them available through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS*. Each of these principal diagnoses for which there is a CC exclusion is shown in Tables 6G and 6H 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 the review of changes to the MCC and CC lists that occurred as a result of updates to the ICD–9–CM codes, as described in Tables 6A, 6C, and 6E of the Addendum to this proposed rule, we are providing the following summaries of those MCC and CC changes.

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.

[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.

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 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.

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

Code	Description
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.
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.

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]

For FY 2010, we are not proposing to change the procedures assigned among these MS–DRGs.

a. Moving Procedure Codes from MS–DRGs 981 Through 983 or MS–DRGs 987 Through 989 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 are not proposing to remove any procedures from MS–DRGs 981 through 983 or MS–DRGs 987 through 989.

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 are not proposing to move any procedure codes among these MS-DRGs.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on our review this year, we are not proposing to add any diagnosis codes to MDCs for FY 2010.

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

As described in section II.B.1. of the preamble of this proposed rule, the ICD–9–CM is a coding system 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 proposed rule. The Committee held its 2009 meeting on March 11–12, 2009. New codes for which there was a

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

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 this proposed rule are not included in Tables 6A through 6F. These additional codes will be included in Tables 6A through 6F of the final rule and will be marked with an asterisk (*).

Copies of the minutes of the procedure codes discussions at the Committee's September 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 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 DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In this FY 2010 IPPS proposed rule, we are only soliciting comments on the proposed classification of these new codes.

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

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

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

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

A discussion of this timeline and the need for changes are included in the December 4–5, 2005 ICD–9–CM Coordination and Maintenance Committee minutes. The public agreed that there was a need to hold the fall meetings earlier, in September or October, in order to meet the new implementation dates. The public provided comment that additional time would be needed to update hospital

systems and obtain new code books and coding software. There was considerable concern expressed about the impact this new April update would have on providers.

In the FY 2005 IPPS final rule, we implemented section 1886(d)(5)(K)(vii) of the Act, as added by section 503(a) of Public Law 108–173, by developing a mechanism for approving, in time for the April update, diagnosis and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We also established the following process for making these determinations. Topics considered during the Fall ICD–9–CM Coordination and Maintenance Committee meeting are considered for an April 1 update if a strong and convincing case is made by the requester at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at the meeting and those reviewing the Committee meeting summary report are provided the opportunity to comment on this expedited request. All other topics are considered for the October 1 update. Participants at the Committee meeting are encouraged to comment on all such requests. There were no requests approved for an expedited April 1, 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.

H. Recalibration of MS–DRG Weights

In section II.E. of the preamble of this proposed 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.

In developing the FY 2010 proposed 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 proposed rule include discharges occurring on October 1, 2007, through September 30, 2008, based on bills received by CMS through December 31, 2008, 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 11,648,471 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 December 31, 2008 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 proposed FY 2010 MS–DRG classifications discussed in sections II.B. and G. of the preamble of this proposed rule.
- The transplant cases that were used to establish the relative weights for heart and heart-lung, liver and/or intestinal, and lung transplants (MS–DRGs 001, 002, 005, 006, and 007, respectively) were limited to those Medicare-approved transplant centers that have cases in the FY 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 length 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, 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, 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, we are proposing 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.

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.

BILLING CODE 4120–01–P

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)
			Drugs Charged To Patient	C_1_C5_56	C_1_C7_48 C_1_C6_56 C_1_C7_56	D4_HOS_C2_56
Supplies and Equipment	Medical/Surgical Supply Charges	027X and 062X	Medical Supplies Charged to Patients	C_1_C5_55	C_1_C6_55 C_1_C7_55	D4_HOS_C2_55
	Durable Medical Equipment Charges	0290, 0291, 0292 and 0294-0299	DME-Rented	C_1_C5_66	C_1_C6_66 C_1_C7_66	D4_HOS_C2_66
	Used Durable Medical Charges	0293	DME-Sold	C_1_C5_67	C_1_C6_67 C_1_C7_67	D4_HOS_C2_67
Therapy Services	Physical Therapy Charges	042X	Physical Therapy	C_1_C5_50	C_1_C6_50 C_1_C7_50	D4_HOS_C2_50
	Occupational Therapy Charges	043X	Occupational Therapy	C_1_C5_51	C_1_C6_51 C_1_C7_51	D4_HOS_C2_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 C_1_C7_53	D4_HOS_C2_53
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X	Laboratory	C_1_C5_44	C_1_C6_44 C_1_C7_44	D4_HOS_C2_44
			PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45 C_1_C7_45	D4_HOS_C2_45
			Electro-encep halography	C_1_C5_54	C_1_C6_54 C_1_C7_54	D4_HOS_C2_54
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X	Radiology - Diagnostic	C_1_C5_41	C_1_C6_41 C_1_C7_41	D4_HOS_C2_41
	MRI Charges	061X	Radiology - Therapeutic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42
			Radioisotope	C_1_C5_43	C_1_C6_43	D4_HOS_C2_43

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

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

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

BILLING CODE 4120–01–C

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 1.54005 so that the average case weight after recalibration was equal to the average case weight before recalibration. The normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS, as required by section 1886(d)(4)(C)(iii) of the Act.

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

Group	CCR
Routine Days	0.534
Intensive Days	0.469
Drugs	0.199
Supplies & Equipment	0.344
Therapy Services	0.408
Laboratory	0.160
Operating Room	0.281
Cardiology	0.178
Radiology	0.161
Emergency Room	0.276
Blood and Blood Products	0.426
Other Services	0.418
Labor & Delivery	0.460
Inhalation Therapy	0.199
Anesthesia	0.134

As we explained in section II.E. of the preamble of this proposed 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. We are proposing 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 are proposing 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).

I. Proposed Add-On Payments for New Services and Technologies

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as ''new technologies'') under the IPPS. Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered new if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that 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 proposed rule. Section 412.87(b)(2) of the regulations therefore provides that ''a medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the 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 proposed 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 Public Law 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 affects 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 are being used to determine if an applicant for new technology add-on payments discussed in this FY 2010 proposed rule meets 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 of 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 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/*).

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 this 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 this proposed 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 have summarized these comments or, if applicable, indicated that there were no comments received, at the end of each discussion of the individual applications. 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's 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. Therefore, for FY 2010, we are proposing to continue 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 withdrew its application. Emphasys Medical submitted an application for new technology add-on payments for FY 2010 for the Emphasys Medical Zephyr® Endobronchial Valve (Zephyr® EBV). However, Emphasys Medical withdrew its application from further review in December 2008. Since the Zephyr® EBV application was withdrawn prior to the town hall meeting and publication of the FY 2010 IPPS proposed rule, we are not discussing the application in this proposed rule.

A discussion of the remaining five applications is presented below. At the time this proposed rule was developed, some of the technologies had not yet received FDA approval. Consequently, our discussion below of these cases may be limited.

a. The AutoLITT ™ System

Monteris Medical submitted an application for new technology add-on payments for FY 2010 for the AutoLITT ™. AutoLITT ™ is a minimally invasive, MRI-guided catheter tipped laser designed to destroy malignant brain tumors with interstitial thermal energy and is designed to cause immediate coagulation and necrosis of diseased tissue. The applicant asserts that the AutoLITT ™ delivers laser energy to the lesion with a proprietary 3mm diameter probe that directs the energy radially (that is, at right angle to the axis of the probe) toward the targeted tumor tissue in a narrow beam profile and at the same time, a proprietary probe cooling system removes heat from tissue not directly in the path of the laser beam, ostensibly protecting it from thermal damage and enabling the physician to selectively coagulate only targeted tissue. The applicant expects that AutoLITT ™ will receive a 510K FDA clearance in early 2009, and the FDA approval will be for use in patients with glioblastoma multiforme brain tumors. Because the technology is not yet approved by the FDA, we will limit our discussion of this technology to data and information that the applicant submitted, rather than make specific proposals with respect to whether the device would meet the new technology add-on payment criteria.

With regard to the newness criterion, we are concerned that the AutoLITT ™ may be substantially similar to the device that it listed as its predicate device in its application to the FDA for approval. The applicant identified Visual-ase as its predicate device, which is also used to treat tumors of the brain. Visual-ase was approved by the FDA in 2006. The applicant maintains that AutoLITT ™ can be distinguished from the Visual-ase by its mechanism of action (that is, side-firing laser versus elliptical firing).

A new ICD–9–CM procedure code, 17.61 (Laser interstitial thermal therapy [LITT] of lesion or tissue of brain under guidance), was recommended for approval at the September 2008 ICD–9–CM Coordination and Maintenance Committee meeting. If approved, the new code would become effective on October 1, 2009. We welcome comments from the public regarding whether or not the AutoLITT ™ is substantially similar to the Visual-ase.

In an effort to demonstrate that AutoLITT ™ meets the cost criterion, the applicant used 2006 Medicare data from the Healthcare Cost and Utilization Project (HCUP). We first note that the applicant believes that cases eligible for the AutoLITT ™ will map to MS–DRGs 25 (Craniotomy and Endovascular Intracranial Procedures with MCC), 26 (Craniotomy and Endovascular Intracranial Procedures with CC), and 27 (Craniotomy and Endovascular Intracranial Procedures without CC or MCC). The applicant searched HCUP hospital data for cases potentially eligible for the AutoLITT ™ that was assigned one of the following ICD–9–CM diagnosis codes: a diagnosis code that begins with a prefix of 191 (Malignant neoplasm of brain); diagnosis code 225.0 (Benign neoplasm of brain and other parts of nervous system); or diagnosis code 239.6 (Neoplasm of the brain of unspecified nature). The applicant found 39,295 cases and weighted the standardized charge per case based on the amount of cases found within each of the diagnosis codes listed above rather than the percentage of cases that would group to different MS–DRGs. Based on this analysis, the average standardized charge per case was $46,754. While the applicant's analysis established a case-weighted average charge per case, it did not determine a case-weighted average standardized charge per case by MS–DRG (as required by the application). Therefore, in order to determine a case-weighted average standardized charge per case by MS–DRG, the applicant used data from a Rand health report [4] to first determine the percentage of cases that would map to MS–DRGs 25, 26, and 27 and combined this analysis with the analysis above to determine a case-weighted average standardized charge per case by MS–DRG. According to its report, Rand used 2006 MedPAR claims data and found 63,876 cases in CMS–DRG 1 (Craniotomy Age Greater Than 17 with CC) and 39,878 cases in CMS–DRG 2 (Craniotomy Age Greater Than 17 without CC) for a total of 103,754 cases. Based on ICD–9–CM procedure and diagnosis codes, Rand converted these cases from CMS–DRGs 1 and 2 to MS–DRGs 25, 26, and 27. Rand determined that, of the 63,876 cases in CMS–DRG 1, 24,116 of these cases would map to MS–DRG 25 (or 23.2 percent of all cases) and 39,760 cases would map to MS–DRG 26 (or 38.4 percent of all cases). All 39,878 cases from CMS–DRG 2 would map to MS–DRG 27 (or 38.4 percent of all cases in CMS–DRGs 1 and 2). Using the percentages from Rand's analysis, the case-weighted average standardized charge per case by MS–DRG was $46,754. We note that, combining the Rand analysis with the HCUP analysis did not change the case-weighted average standardized charge per case from the results from the HCUP analysis (both analyses produced a case-weighted average standardized charge per case of $46,754). The applicant did identify the average standardized charge per case in the aggregate but has yet to identify cases within the MS–DRGs themselves and, therefore, the applicant has not determined the case-weighted average standardized charge per case by MS–DRG.

The applicant also noted that the case-weighted average standardized charge per case of $46,754 did not include charges related to the AutoLITT ™. Therefore, it is necessary to add the charges related to the device to the case-weighted average standardized charge per case in evaluating the cost threshold criterion. Although the applicant submitted data related to the estimated cost of the AutoLITT ™ per case, the applicant stated that the cost of the device was proprietary information. Based on a study of charge compression data by RTI [5] and charge master data from Stanford University and University of California, San Francisco, the applicant estimates $24,389 in charges related to the AutoLITT ™ (we note that some of the data used a markup of 294 percent of the costs). Adding the estimated charges related to the device to the case-weighted average standardized charge

[4] Rand Corporation: *Rand Health—Understanding Medicare Severity-DRGs*. A presentation given by Barbara Wynn at the Florida Hospital Association Meeting on November 1, 2007.

[5] RTI International, *A Study of Charge Compression in Calculating DRG Relative Weights*, RTI Project No. 0207964.012.008; January 2007.

per case resulted in a case-weighted average standardized charge per case of $71,143 ($46,754 plus $24,389). Using the FY 2010 thresholds published in Table 10 (73 FR 58008), the case-weighted threshold for MS–DRGs 25, 26, and 27 was $58,069 (all calculations above were performed using unrounded numbers). Because the case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount, the applicant maintains that the AutoLITT ™ would meet the cost criterion.

We invite public comment on whether or not the AutoLITT ™ meets the cost criterion for a new technology add-on payment, particularly in light of the fact that the applicant did not determine a case-weighted average standardized charge per case by MS–DRG (as discussed above).

With respect to the substantial clinical improvement criterion, the applicant maintains that it meets this criterion in its application. Specifically, the applicant stated that several non-AutoLITT ™ clinical trials have demonstrated that nonfocused LITT (and more recently, the use of LITT plus MRI) improved survival, quality of life, and recovery in patients with advanced glioblastoma multiforme tumors and advanced metastatic brain tumors that cannot be effectively treated with surgery, radiosurgery, radiation, chemotherapy, or any currently available clinical procedure. In a number of these patients, nonfocused LITT was the treatment of last resort, due to either the unresponsiveness or inability of these therapies to treat the brain tumor (due to tumor location, type, or size, among others). The applicant also maintains that improved clinical outcomes using nonfocused LITT have included reduced recovery time and a reduced rate of complications (that is, infection, brain edema). The applicant stated that these factors, as discussed in the FY 2001 final rule (66 FR 46914 through 46915) demonstrate that the AutoLITT ™ meets the new technology criterion for substantial clinical improvement.

The applicant further asserts that AutoLITT ™ would represent a substantial clinical improvement over existing standards of care for a number of reasons and should build upon less sophisticated, nonfocused LITT therapies. These clinical improvements cited by the applicant include: a less invasive method of tumor ablation, potentially leading to lower complication rates post procedure (infection, edema); an ability to employ multiple interventions over shorter periods of time and an ability to be used as a treatment of last resort (radiosurgery is limited due to radiation dosing and craniotomy is limited to 1 to 2 procedures); an ability to be used in hard-to-reach brain tumors (the AutoLITT ™ may be used as a treatment of last resort); and a shorter recovery time (the possibility for same day surgery, which has been demonstrated above with non-focused LITT).

We appreciate the applicant's summary of why this technology represents a substantial clinical improvement. While we recognize the future potential of this interesting therapy, we have concerns that, besides lacking FDA approval at this time, to date the AutoLITT ™ has been used for the treatment of only a few patients as part of a safety evaluation with no comparative efficacy data and, therefore, there may not be sufficient objective clinical evidence to determine if the AutoLITT ™ meets the substantial clinical improvement criteria. We invite public comment on whether or not the AutoLITT ™ meets the substantial clinical improvement criterion.

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

b. CLOLAR ® (clofarabine) Injection

Genzyme Oncology submitted an application for new technology add-on payments for FY 2010 for CLOLAR ® (clofarabine) injection. CLOLAR ® is a chemotherapeutic agent that is administered intravenously and is currently being evaluated for the treatment of patients with acute myeloid leukemia (AML). CLOLAR ® was first granted FDA approval in December 2004 for the treatment of pediatric patients (ages 1–21 years), a population not typically eligible for Medicare, with acute lymphoblastic leukemia (ALL) who did not respond to at least two prior treatment attempts. Genzyme Oncology submitted a supplement to its pediatric application (sNDA) to the FDA in November 2008, in which it requested approval for CLOLAR® use in previously untreated adult patients with AML with at least one unfavorable baseline prognostic factor. Unfavorable prognostic factors include: Age greater than or equal to 70 years; antecedent hematologic disorder (AHD); Easter Cooperative Oncology Group (ECOG) performance status (PS) of 2; or intermediate/unfavorable risk karyotype. CLOLAR ® is expecting to receive sNDA approval from the FDA by May 2009. Because the technology is not yet approved by the FDA, we are limiting our discussion of this technology to data that the applicant submitted, rather than making specific proposals with respect to whether the device would meet the new technology add-on payment criteria.

With regard to the newness criterion, we note that, although the applicant has submitted an application to the FDA for an sNDA for the treatment of patients with AML, the FDA approval for the new indication alone does not necessarily demonstrate that CLOLAR ® would meet the newness criterion for purposes of new technology add-on payments. 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. Unlike the typical applicant for the new technology add-on payment, however, CLOLAR ® is not new to the market but has been available since it was first granted FDA approval in December 2004 for the treatment of pediatric patients with acute lymphoblastic leukemia (ALL). Therefore, we first must determine whether CLOLAR ® nevertheless should be considered a new technology if approved by the FDA for a new indication, specifically for use in adult patients age 70 and above with AML.

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. 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 similiarity, 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 are relevant for determining substantial similarity. 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 criteria or factors in some contexts, but not others.

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 believe 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 would determine that the new use of an existing technology is substantially similar to one or more existing uses of the technology if (1) the new and existing uses of the technology use the same or a similar mechanism of action to achieve a therapeutic outcome, (2) the new use of the product is assigned to the same MS–DRG(s) as the existing uses, and (3) the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population. If all three criteria are met 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. We note 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, 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.

We note 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 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, 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. 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. We welcome comments on our proposed modification to analyzing whether a technology is substantially similar to another.

With respect to CLOLAR®, it is relevant to consider whether there is a clear distinction between the types of disease that CLOLAR® is intended to treat and the patient populations described in the indications in assessing whether the indication for which a supplemental FDA approval is pending is substantially similar to the indication related to the existing FDA approval for CLOLAR. Accordingly, we have analyzed both the current and pending FDA approvals and indications in order to determine whether or not CLOLAR® for the treatment of ALL in patients ages 1–21 should be deemed substantially similar to CLOLAR® when used for the treatment of AML in patients ages 70 and above. In this case, we compared the two indications against the substantial similarity factors that we outlined in the FY 2006 IPPS final rule (referenced above). We determined that CLOLAR® meets both factors of the substantial similarity criteria that we outlined in the FY 2006 IPPS final rule (that is, the use of CLOLAR® for either indication utilizes the same or a similar mechanism of effect to achieve a therapeutic outcome, and both indications map to the same MS–DRGs). We also analyzed both the current and pending FDA approvals and indications against the two additional factors we described above (that is, whether the new indication as compared to the old indication would involve the use of CLOLAR to treat the same or similar disease and the same or similar patient population). In the course of our analysis, we determined that, although ALL and AML are both types of leukemia, they are separate and distinct hematologic malignancies that typically affect different patient populations. Furthermore, patients ages 1–21 with ALL differ significantly from older patients ages 70 and above with AMI in terms of clinical factors, such as the presence of comorbid conditions, and expected prognosis. Accordingly, because the two indications do not meet the additional factors we included under substantial similarity, we do not

believe that CLOLAR® for the indication of treatment of ALL in patients ages 1–21 should be considered substantially similar to CLOLAR® for the indication of treatment of AML in older patients.

With respect to application of the newness criterion under § 412.87(b)(2), our evaluation also considers whether the data for the relevant MS–DRGs reflect use of the new technology for one or more purposes outside the previously approved indication(s). To the extent that the data suggest that the technology has been used outside the previously approved indication for more than 2 or 3 years (for example, the technology has been used for a purpose that is the basis of the newly approved indication), we believe that the costs of the technology for the new use are reflected in the weights assigned to the relevant MS–DRGs. In this case, we will conclude that the technology does not meet the newness criterion under § 412.87(b)(2) because its costs are already reflected within the relevant MS–DRGs. Therefore, even if we determine that the new use of CLOLAR® is not substantially similar to the existing use of CLOLAR®, we believe it is relevant to assess whether the likelihood that the costs of this drug are included in the data that goes into determining the MS–DRG relative weights because CLOLAR® has not been FDA approved to treat the types of patients that are commonly found in the Medicare population. Regarding this point, the applicant maintains that because of the age group for which CLOLAR® is currently used to treat patients with ALL (that is, pediatric patients who are ages 1–21 years), ''it is statistically improbable that claims paid under the relevant MS–DRGs include CLOLAR® costs.'' Currently, ICD–9–CM procedure code 99.25 (Injection or infusion of cancer chemotherapeutic substance) would be used to identify the administration of CLOLAR® for the treatment of both ALL and AML. We note that the applicant submitted an application for a unique ICD–9–CM procedure code that was discussed at the March 11, 2009 ICD–9–CM Coordination and Maintenance Committee meeting. In addition, cases involving the use of CLOLAR® for either indication would be expected to routinely map to MS–DRGs 837, 838, and 839 (Chemotherapy with Acute Leukemia as Secondary Diagnosis or High Dose Chemotherapy Agent with MCC, Chemotherapy with Acute Leukemia as Secondary Diagnosis with CC or High Dose Chemotherapy Agent, and Chemotherapy with Acute Leukemia as Secondary Diagnosis without CC/MCC, respectively). Although we generally agree with the applicant's statement that it is statistically improbable that any Medicare patients received CLOLAR® under the currently approved indication for younger patients with ALL, the applicant has not, to date, demonstrated that none of the inpatients who received CLOLAR® for the treatment of patients with ALL were Medicare patients. The applicant maintains that no data are available to identify the exact number of Medicare beneficiaries who are age 21 years or less (that is, those patients whose age identically matches that of the group for whom CLOLAR® is an approved treatment). However, the applicant conducted an analysis of the FY 2007 MedPAR claims data for the MS–DRGs associated with chemotherapy treatment for ALL (CMS–DRG 492 and MS–DRGs 837, 838, and 839) and found that less than 1 percent of all claims that map to those DRGs were for patients who are age 25 years or less. Therefore, the applicant asserts that, given the small number of patients eligible to receive CLOLAR® for its FDA approved indication, it is statistically improbable that claims paid under the relevant DRGs include or adequately reflect the costs of CLOLAR®.

We welcome comments from the public on whether the costs of CLOLAR® are already included in the data used to determine the relative weights for the MS–DRGs to which cases involving CLOLAR® map and on whether the current FDA-approved indication of CLOLAR® is substantially similar to that of the pending one.

In an effort to demonstrate that CLOLAR® meets the cost criterion, the applicant searched the FY 2007 MedPAR file for cases potentially eligible for CLOLAR® that were assigned a combination of the following codes: any principal diagnosis code with a prefix of V58.1 (Encounter for antineoplastic chemotherapy and immunotherapy), or a principal diagnosis code of V67.2 (Chemotherapy follow up examination), or any diagnosis code that begins with a prefix of 205 (Acute promyelocytic leukemia). The applicant found 874 cases (or 30.3 percent of all cases) in MS–DRG 837 (Chemotherapy with Acute Leukemia as Secondary Diagnosis or with High Dose Chemotherapy Agent with MCC), 863 cases (or 29.9 percent of all cases) in MS–DRG 838 (Chemotherapy with Acute Leukemia as Secondary Diagnosis with CC or with High Dose Chemotherapy Agent), and 1,148 cases (or 39.8 percent of all cases) in MS–DRG 839 (Chemotherapy with Acute Leukemia as Secondary Diagnosis without CC/MCC). The average standardized charge per case was $133,428 for MS–DRG 837, $66,997 for MS–DRG 838, and $28,453 for MS–DRG 839, which result in a case-weighted average standardized charge per case of $71,785.

The average standardized charge per case does not include charges related to CLOLAR®; therefore, it is necessary to add the charges related to CLOLAR® to the average standardized charge per case in evaluating the cost threshold criterion. Although the applicant submitted data related to the estimated cost of CLOLAR® per case, the applicant noted that the cost of the drug was proprietary information. The applicant estimates $63,364 in charges related to CLOLAR® (based on a 100-percent charge markup of the cost of the drug). Adding the charges related to the drug 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 $135,149 ($71,785 plus $63,364). Using the FY 2010 thresholds published in Table 10 (73 FR 58008), the case-weighted threshold for MS–DRGs 837, 838, and 839 was $55,802 (all calculations above were performed using unrounded numbers). Because the case-weighted average standardized charge per case for the applicable MS–DRGs exceeds the case-weighted threshold amount, the applicant maintains that CLOLAR® would meet the cost criterion. We invite public comment on whether or not CLOLAR® meets the cost criterion.

With regard to the substantial clinical improvement criterion, the applicant asserts that despite significant advances that have been made in the management of AML in younger adults (that is, persons under the age of 60 years), including the benefit of intensive remission induction therapy [often comprised of an anthracycline combined with intermediate or highdose cytarabine (''7 + 3'')] to either achieve or maintain a complete remission (CR) or CR with incomplete platelet recovery (CRp) that has been progressively demonstrated over the past several years, such success has not been achieved in persons over the age of 60 years. The applicant stated that for the older patient population, conventional induction therapy with ''7 + 3'' is poorly tolerated and often does not benefit older patients with unfavorable baseline prognostic factors. In addition, the applicant stated that older adult patients are also at high risk for early induction mortality. According to the applicant, depending on comorbidity factors, the rate of

induction mortality can be as high as 65 percent within 8 weeks following conventional intensive chemotherapy.

The applicant also presented an analysis of some recent data that has emerged in connection with CLOLAR® use in older patients with AML. A Phase II study comparing single agent CLOLAR® to CLOLAR® combined with low-dose cytarabine (LDAC) in patients age 60 years and older, found that 42 percent of the patients treated with CLOLAR® alone achieved a CR or CR with incomplete peripheral blood count recovery, and found that 59 percent of the patients treated with the combination therapy achieved a CR or CR with incomplete peripheral blood count recovery. Both treatment regimens were tolerated in this patient population without a distinction in terms of toxicity. The safety and efficacy of CLOLAR® was recently reported in another Phase II study of 66 older adult patients (over age 65 years) with untreated AML. All patients were considered unfit for conventional induction therapy due to the presence of one or more unfavorable prognostic factors. In the group of patients with adverse cytogenetic profiles, the overall response rate was 53 percent with a CR rate of 42 percent. In addition, this group had a significantly prolonged median survival (more than 6 months) when compared to a similar group that had received LDAC.

The applicant conducted a pivotal, multicenter clinical trial which serves as the basis for an sNDA to the FDA for approval of CLOLAR® as a treatment for adult AML. According to the applicant, the primary objective of this study was to assess the efficacy of CLOLAR® in previously untreated adults who were at least 60 years old with AML for whom standard induction chemotherapy was unlikely to be of benefit due to at least one unfavorable baseline prognostic factor. The results of this pivotal trial indicate that single agent CLOLAR® is active and well-tolerated when administered to previously untreated adults with AML and at least one adverse prognostic factor. The overall remission rate (CR + CRp = 45 percent) with CLOLAR® compared favorably to historical studies with ''7 + 3'' regimens. Responses in patients receiving CLOLAR® were consistent regardless of the number or the type of unfavorable prognostic factor including a CR of 43 percent in patients with unfavorable cytogenetics, 50 percent in patients with AHD, 40 percent in patients more than the age of 70, and 38 percent in patients with an Eastern Cooperative Oncology Group (ECOG) PS of 2. In addition, it did not appear that response rates were affected by the presence of multiple adverse prognostic factors (50 percent, 48 percent, and 42 percent in patients with one, two and three risk factors, respectively). The overall response rate was even higher in patients who were less than age 70 years (56 percent), and in patients with an ECOG PS of 0 (64 percent). Thirty-day mortality (for all causes) was 9.6 percent. Drug-related adverse events were consistent with prior reports with single agent CLOLAR®, and were manageable in the patient population studied. Five patients (4 percent) had to discontinue treatment due to toxicity, but many patients were able to receive subsequent consolidation CLOLAR® treatments. The applicant maintains that there is no standard treatment in older adult patients with comorbid conditions or adverse disease characteristics for whom conventional induction therapy is not considered an appropriate option. The applicant further asserts that the absence of treatment options, especially in a disease with onset at a median age of 67, clearly represents a significant unmet medical need.

We are concerned that this drug may offer little to no increased survival benefit in a patient population whose overall prognosis is exceedingly poor. Therefore, it is not clear that the drug represents a substantial clinical improvement over existing therapies, such as increased benefit survival or reduced need for hospitalization or physician visits. (We refer readers to 66 FR 46941 for a more detailed discussion relating to the substantial clinical improvement criterion.) We welcome public comment about whether or not CLOLAR® represents a substantial clinical improvement.

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

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 an invasive coronary catheterization to scan the artery wall in order to determine coronary plaque composition. The purpose of the device is to identify lipid-rich areas in the artery because such areas have been shown to be more prone to rupture. The procedure does not require flushing or occlusion of the artery. INIRS identifies the chemical content of plaque by focusing near infrared light at the vessel wall and measuring reflected light at different wavelengths (that is, spectroscopy). The LipiScan™ system collects approximately 1,000 measurements per 12.5 mm of pullback, with each measurement interrogating an area of 1 to 2 mm^2 of lumen surface perpendicular to the longitudinal axis of the catheter. When the catheter is in position, the physician activates the pullback and rotation device and the scan is initiated providing 360 degree images of the length of the artery. The rapid acquisition speed for the image freezes the motion of the heart and permits scanning of the artery in less than 2 minutes. When the catheter pullback is completed, the console displays the scan results, which is 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.''

We have 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 the CLOLAR® application in section II.I.4.b. of this proposed 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 Lipican™ 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, we have concerns as to whether or not the two intended uses are substantially similar, especially considering that the technologies appear essentially identical. We welcome 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.

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 have concerns as to whether or not the estimate of $5,280 in charges related to the device is a valid estimate. 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 exceeds the case-weighted threshold amount, the applicant maintains that Lipiscan™ would meet the cost criterion. We invite public comment on whether or not Lipiscan™ meets the cost criterion.

With regard to substantial clinical improvement, 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 of interest and to assess of coronary artery lipid core burden. The applicant further noted that FDA, in its approval documentation, has indicated that ''This is the first device that can help assess the chemical makeup of coronary artery plaques and help doctors identify those of particular concern.''

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

The applicant also noted that the device has the ability to make a diagnosis that better affects the management of the patient. Specifically, the applicant 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. Physicians have reported changes in therapy based on LipiScan™ findings in 20 to 50 percent of patients. 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.

While we recognize that the identification of lipid-rich plaques in the coronary vasculature holds promise in the management of coronary artery disease, we are concerned that statements in the FDA approval documents, as well as statements made by investigators in the literature, suggest that the clinical implications of identifying these lipid-rich plaques are not yet certain and that further studies need to be done to understand the clinical implications of obtaining this information. We are also concerned that there are no outcome data regarding the use of the LipiScan™ technology.

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.

We welcome public comment regarding whether or not the LipiScan™ technology represents a substantial clinical improvement in the Medicare population.

Below we summarize the written comments we received in response to the town hall meeting.

Comment: The manufacturer of LipiScan™ stated that, prior to the availability of LipiScan™, current methods of diagnosis could not detect that a patient has a lipid-core plaque prior to the occurrence of a myocardial infarction. In April 2008, the FDA approved the LipiScan™ Coronary Imaging System for identification of these lipid-core plaques in patients undergoing coronary angiography, thereby allowing the detection of this condition in patients prior to the occurrence of a myocardial infarction.

The manufacturer stated that, since its FDA approval, LipiScan™ has been used in over 110 patients and has identified lipid-core plaques that were previously undetectable, thereby revealing earlier stages of the disease. The manufacturer noted that physicians have used this diagnostic information to provide clinical benefits to their patients, including improved identification of the length of the artery to be stented and selection of the appropriate intensity of pharmacologic therapy designed to alter plasma lipids.

In addition to these early diagnostic uses, the manufacturer believes that LipiScan™ opens the possibility of eventual detection and treatment of lipid-core plaques before they cause a stenosis and/or a clinical event. The manufacturer added that the use of this technology could lead to prevention of myocardial infarction, which in turn would reduce the occurrence of heart failure and arrhythmias—two conditions responsible for severe morbidity and massive health care expenditures.

In addition, the manufacturer reiterated its assertion that LipiScan™ meets the newness criterion. The manufacturer explained 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.'' The manufacturer further noted that, while LipiScan™ is equivalent to the predicate intravascular ultrasound (IVUS) device, the features of the LipiScan™ system produce different information because it permits the physician to detect lipid-core plaques of interest and the lipid burden index.

The manufacturer also noted that the case-weighted average standardized charge per case exceeds the case-weighted threshold (as discussed above) and, therefore, the manufacturer believes that the technology meets the cost criterion. In addition, the manufacturer reasserted that it meets the substantial clinical improvement criterion by the arguments it put forth in its application regarding substantial clinical improvement (which are presented above in this section of the preamble).

Finally, in its comment, the manufacturer concluded that LipiScan™ is a novel diagnostic method that meets the three criteria for a new technology add-on payment and that more frequent utilization of LipiScan™ would occur with additional reimbursement resulting in possible improved outcomes for patients undergoing stenting. The manufacturer stated that LipiScan™ has the added potential of contributing to the prevention of acute coronary syndromes.

Response: We thank the manufacturer for its comments that were submitted concerning the town hall meeting. We have considered these comments in our evaluation of the technology in this proposed rule. As stated above, we invite additional public comment relating to objective data regarding the assertions presented by the manufacturer.

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. We welcome 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. We note 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 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 have concerns 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 made 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 have 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 exceeds the case-weighted threshold amount, the applicant maintains that the Spiration® IBV® would meet the cost criterion. We invite public comment on whether or not the Spiration® IBV® meets the cost criterion.

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. 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 have concerns that the outcome data presented is from a sample set of only seven patients, and the FDA HDE did not require demonstration of either safety or effectiveness. Therefore, we welcome 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.

e. TherOx Downstream® System

TherOx, Inc. submitted an application for new technology add-on payments for FY 2010 for the TherOx Downstream® System. The TherOx Downstream® System uses SuperSaturatedOxygen Therapy (SSO2) that is designed to limit myocardial necrosis by minimizing microvascular damage in acute myocardial infarction (AMI) patients following intervention with percutaneous transluminal coronary angioplasty (PTCA), and coronary stent placement by perfusing the affected myocardium with blood that has been supersaturated with oxygen. SSO2 therapy refers to the delivery of superoxygenated arterial blood directly to areas of myocardial tissue that have been reperfused using PTCA and stent placement, but which may still be at risk. The desired effect of SSO2 therapy is to reduce infarct size and, thus, preserve heart muscle and function. The TherOx DownStream® System is the console portion of a disposable cartridge-based system that withdraws a small amount of the patient's arterial blood, mixes it with a small amount of saline, and supersaturates it with oxygen to create highly oxygen-enriched blood. The superoxygenated blood is delivered directly to the infarct-related artery via the TherOx infusion catheter. SSO2 therapy is a catheter laboratory-based procedure. Additional time in the catheter laboratory area averages 100 minutes. The applicant claimed that the SSO2 therapy duration lasts 90 minutes and requires an additional 10 minutes post-procedure preparation for transfer time. We note that the TherOx DownStream® System is currently identified by ICD–9–CM procedure code 00.49 (Supersaturated oxygen therapy). TherOx, Inc. submitted an application for new technology add-on payments for FY 2009 for this technology. However, although FDA approval was expected in the second quarter of 2008, it had not received FDA approval at the time the proposed rule for FY 2009 was published. Because the technology was

not approved by the FDA during the development of the proposed rule, we limited our discussion of this technology to data that the applicant submitted, rather than make specific proposals with respect to whether the device would meet the new technology add-on payment criteria.

For its FY 2010 new technology add on payment application, the applicant has indicated to CMS that it expects to receive FDA approval in the second quarter of 2009. However, because the technology has not yet received approval by the FDA, we are limiting our discussion of this technology to data that the applicant submitted rather than making specific proposals with respect to whether the device would meet the new technology add-on payment criteria in this proposed rule.

In an effort to demonstrate that TherOx Downstream® System would meet the cost criterion, the applicant submitted two analyses. The applicant stated that it believed that the cases that would be eligible for the TherOx Downstream® System would most frequently group to MS–DRGs 246 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with MCC or 4+ Vessels/Stents), 247 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without MCC), 248 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent with MCC or 4+ Vessels/Stents), and 249 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent without MCC). The first analysis used data based on 83 clinical trial patients from 10 clinical sites. Of the 83 cases, 78 were assigned to MS–DRGs 246, 247, 248, or 249. (The remaining five cases grouped to MS–DRGs that the technology would not frequently group to and, therefore, are not included in this analysis.) The data showed that 32 of these patients were 65 years old or older. There were 12 cases (or 15.4 percent of the 78 cases) in MS–DRG 246, 56 cases (or 71.8 percent of the 78 cases) in MS–DRG 247, 2 cases (or 2.6 percent of the 78 cases) in MS–DRG 248, and 8 cases (or 10.3 percent of the 78 cases) in MS–DRG 249. The average standardized charge per case for MS–DRGs 246, 247, 248, and 249 was $71,955, $60,790, $55,238, and $42,723, respectively, equating to a case-weighted average standardized charge per case of $60,512. The average standardized charge per case does not include charges related to the TherOx Downstream® System. 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 TherOx Downstream® System per case, the applicant noted that the cost of the device was proprietary information. The applicant estimates $22,739.40 in charges related to the TherOx Downstream® System (based on a 100-percent charge markup of the cost of the drug). Adding the charges related to the device to the average standardized charge per case resulted in a case-weighted average standardized charge per case of $83,251 ($60,512 plus $22,739). Based on the FY 2010 threshold from Table 10 (73 FR 58008), the case-weighted threshold for the four MS–DRGs listed above was $51,564 (all calculations above were performed using unrounded numbers).

The applicant also searched the FY 2007 MedPAR file to identify cases that would be eligible for the TherOx Downstream® System. The applicant specifically searched for cases with primary ICD–9–CM diagnosis code 410.00 (Acute myocardial infarction of anterolateral wall with episode of care unspecified), 410.01 (Acute myocardial infarction of anterolateral wall with initial episode of care), 410.10 (Acute myocardial infarction of other anterior wall with episode of care unspecified), or 410.11 (Acute myocardial infarction of other anterior wall with initial episode of care) in combination with ICD–9–CM procedure code 36.06 (Insertion of non-drug-eluting coronary artery stent(s)) or 36.07 (Insertion of drug-eluting coronary artery stent(s)). The applicant's search found 12,345 cases within MS–DRGs 246, 247, 248, and 249 distributed as follows: 1,591 cases (or 12.9 percent of cases) in MS–DRG 246; 6,203 cases (or 50.2 percent of cases) in MS–DRG 247; 1,132 cases (or 9.2 percent of cases) in MS–DRG 248; and 3,419 cases (or 27.7 percent of cases) in MS–DRG 249. Not including the charges associated with the technology, the average standardized charge per case for MS–DRGs 246, 247, 248, and 249 was $65,967, $46,828, $56,807 and $40,107, respectively, equating to a case-weighted average standardized charge per case of $48,348. The applicant estimated that it was necessary to add an additional $22,739 in charges to the total case-weighted average standardized charge per case (as described above). In the additional charge amount, the applicant included charges for supplies and tests related to the technology, charges for 100 minutes of additional procedure time in the catheter laboratory, and charges for the technology itself. The inclusion of these charges would result in a total case-weighted average standardized charge per case of $71,087. The case-weighted threshold for MS–DRGs 246, 247, 248, and 249 (from Table 10 (73 FR 58008)) was $51,073 (all calculations above were performed using unrounded numbers). Because the total case-weighted average standardized charge per case from the first analysis of clinical trial patients and the case-weighted standardized charge per case from the second analysis of the FY 2006 MedPAR claims data exceeds the applicable case-weighted thresholds, the applicant maintained the TherOx Downstream® System would meet the cost criterion.

We invite public comment on whether or not the TherOx Downstream® System meets the cost criterion.

With respect to the substantial clinical improvement criterion, the applicant asserts that their technology represents a substantial clinical improvement in the treatment of acute anterior myocardial infarction in conjunction with percutaneous coronary intervention (PCI) with stent placement within 6 hours of onset of symptoms compared to PCI and stent placement alone. Specifically, the applicant asserts that there is a 6.5 percent absolute reduction in infarct size using the TherOx Downstream® System as assessed using Tc–99m Sestamibi SPECT nuclear imaging in the Acute Myocardial Infarction Hyperbaric Oxygen Treatment (AMIHOT) II clinical trial, and such a reduction has been correlated with both short-term (less than 30 day) and long-term (greater than 30 day) mortality reductions.

Although the TherOx Downstream® System remains investigational and has not yet received approval from the FDA at this time, we do recognize that a clear reduction of infarct size in acute anterior myocardial infarction may represent a substantial clinical improvement. However, we have concerns that the data presented by the applicant in the application are derived from a Bayesian methodology, which includes data from a subgroup of an earlier trial (AMIHOT I), that showed no overall benefit of using the technology, and that the AMIHOT II trial has yet to be published in any peer reviewed literature. We also are concerned that there were a higher number of adverse bleeding events in patients who had been treated in the group of AMIHOT II clinical trial, and the study did not demonstrate any specific improved clinical outcomes.

We invite public comment on whether or not the TherOx Downstream® System meets the

substantial clinical improvement criterion.

Below we summarize the written comments we received concerning the town hall meeting.

Comment: The physician who presented information at the town hall meeting on behalf of the applicant also submitted additional written comments in response to questions raised during the town hall meeting. Specifically, the physician addressed questions relating to the study of additional functional endpoints, such as ejection fraction a year after a patient received therapy using the TherOx Downstream® System or New York Heart Association (NYHA) functional class, and why the AMIHOT I study design included patients who presented up to 24 hours after infarction (instead of up to 6 hours). With regard to studying ejection fraction out to one year, the physician acknowledged that such an endpoint was considered during the design of the AMIHOT II trial, but that it was ultimately rejected because it was not required by the FDA.

The physician further acknowledged that the AMIHOT I trial failed to meet its overall primary efficacy endpoint, but asserted that when analyzing the subset of 105 patients from the trial who had an anterior myocardial infarction and were reperfused within 6 hours, ''substantial clinical benefit'' was observed. The physician noted that, although some people may have considered the subset of the anterior myocardial infarction patients a ''post hoc'' analysis, the subset was actually a ''pre-specified data set.'' In addition, the physician maintained that the analysis of the subset of data was the basis for the second randomized trial (AMIHOT II), and that the FDA ''was unambiguous in its contention that infarct size by single photon emission computed tomography (SPECT) imaging had been thoroughly validated as a surrogate endpoint* * *.''

Finally, the physician emphasized information regarding the technology's efficacy that was presented in its application. First, the physician stated that patients with an ejection fraction of less than 40 percent who received supersaturated oxygen therapy had an absolute difference in infarct size of 12.5 percent when compared to the control arm. The physician further asserted that such outcomes support that ''among the sickest acute MI patients* * * supersaturated oxygen is of the greatest benefit.'' Secondly, the physician noted that the pooled, adjusted data for AMIHOT II and the anterior MI patients from AMIHOT I show that there were nearly twice as many supersaturated oxygen patients with an imperceptible infarct compared to controls (18.2 percent versus 10.3 percent, respectively). The physician described an ''imperceptible'' infarct as that which is nearly undetectable upon SPECT imaging after an acute myocardial infarction patient undergoes primary coronary intervention at the hospital.

Response: In response to the physician's statements regarding the FDA rejecting the use of ejection fraction as a primary endpoint for the AMIHOT II trial, we note that the standards used in the determination of whether a new technology is ''safe and effective'' (FDA standards for approval) are not necessarily equivalent to the standards that are used to determine whether a new technology represents a substantial clinical improvement to the Medicare beneficiary patient population over existing technologies. While we welcome insight and data obtained during the FDA approval process, we are charged with going beyond the ''safe and effective'' standards of FDA for purposes of deeming that a new technology represents a substantial clinical improvement to the Medicare beneficiary patient population.

We have considered the comments concerning the town hall meeting and in response to questions raised at the town hall meeting in our evaluation of this technology in this proposed rule. As stated above, we invite additional public comment on objective data regarding the assertions presented by the physician.

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 are proposing to make this technical change to § 412.87(b)(1).

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

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the proposed FY 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 provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The proposed adjustment for FY 2010 is discussed in section II.B. of the Addendum to this proposed rule.

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

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we are proposing to apply beginning October 1, 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. This part of Acumen's study is complete and will be published immediately after the publication of this proposed rule. The second part, which is expected to be released after the publication of the FY 2010 IPPS 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. Both reports, when available, will be accessible at the Web site: *http://www.acumenllc.com/reports/cms*.

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.

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 of the publication date of this proposed rule, Acumen has not completed its analysis for the second part of its final report.

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 is not yet complete, we are not proposing any additional changes to the hospital wage index for acute care hospitals in this proposed rule.

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.

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 will reflect 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).

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, for FY 2010, we are proposing to provide that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, for each hospital, we are proposing to determine a wage index for FY 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.

D. Proposed Occupational Mix Adjustment to the Proposed 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 Proposed 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 end 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).

For the proposed FY 2010 hospital wage index, we are using occupational mix data collected on a revised 2007–2008 Medicare Wage Index Occupational Mix Survey (the 2007–2008 survey) to compute the proposed 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 was 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 Proposed Occupational Mix Adjustment for FY 2010

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

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

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

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

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

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

Step 6—For each hospital, compute the occupational mix adjustment factor for the total nursing category by dividing the national average hourly rate for the total nursing category (from

Step 5) by the hospital's adjusted average hourly rate for the total nursing category (from Step 4).

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

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

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

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

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

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

Step 10—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the Nation, then sum the total hours for all hospitals in the Nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours. The proposed FY 2010 occupational mix adjusted national average hourly wage is $33.4935.

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

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

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

BILLING CODE 4120–01–P

Example of Proposed 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 Occupa-tional 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.

BILLING CODE 4120–01–C

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 proposed 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 proposed 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 are proposing to assign 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 are proposing to assign 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 0.8452 (CBSA 17780, College Station-Bryan, TX), to a high of 1.0939 (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 8 CBSAs (that include 16 hospitals) for which we did not have occupational mix data for any of its hospitals. The CBSAs are:

- CBSA 16220—Casper, WY (one hospital)
- 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 89 percent for the 2007–2008 survey. In 43 areas, the response rate was only 66.7 percent or less. In addition, for 46 areas, including New York-White Plains-Wayne, New York-New Jersey (35644), Oklahoma City, Oklahoma (36420), Rural Georgia (11), and Rural Oklahoma (37), the area response rate decreased 20 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. While we are not proposing a penalty at this time, we will consider the public comments we previously received, as well as any public comments on this 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. We welcome public comments on this matter and look forward to addressing this issue in next year's IPPS proposed rule.

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

The proposed 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 proposed 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 includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching

physician Part A services, and certain contract indirect patient care services (as discussed in the FY 2008 final rule with comment period (72 FR 47315))

• Wage-related costs, including pensions and other deferred compensation costs. We note that, 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).

2. Excluded Categories of Costs

Consistent with the wage index methodology for FY 2009, the proposed wage index for FY 2010 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The proposed FY 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, 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 the FY 2010 IPPS 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 proposed 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 was too aberrant to include in the proposed wage index, although if data elements for some of these providers are corrected, we intend to include some of these providers in the FY 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. We believe all unresolved data elements will be resolved by the date the final rule is issued. The revised data will be reflected in the FY 2010 IPPS final rule.

In constructing the proposed 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 proposed rule, we removed 11 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 proposed FY 2010 wage index is calculated based on 3,521 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. The proposed FY 2010 wage index in this proposed 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 proposed rule.

G. Method for Computing the Proposed FY 2010 Unadjusted Wage Index

The method used to compute the proposed FY 2009 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we are basing the proposed 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 do not propose to make 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 proposed national average hourly wage (unadjusted for occupational mix) is $33.5184.

Step 9—For each urban or rural labor market area, we calculate the hospital wage index value, unadjusted for occupational mix, by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we develop a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We add the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divide the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall proposed average hourly wage (unadjusted for occupational mix) of $14.2462 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 proposed rule.

In the FY 2005 IPPS final rule (69 FR 49109), we adopted the ''imputed'' floor as a temporary 3-year measure to address a concern by some individuals that hospitals in all-urban States were disadvantaged by the absence of rural hospitals to set a wage index floor in those States. The imputed floor was originally set to expire in FY 2007, but we extended it an additional year in the FY 2008 IPPS final rule with comment period (72 FR 47321). In the FY 2009 IPPS final rule (73 FR 48570 through 48574 and 48584), we extended the imputed floor for an additional 3 years, through FY 2011.

H. Analysis and Implementation of the Proposed Occupational Mix Adjustment and the Proposed FY 2010 Occupational Mix Adjusted Wage Index

As discussed in section III.D. of this preamble, for FY 2010, we are proposing to apply the occupational mix adjustment to 100 percent of the FY 2010 wage index. We calculated the proposed occupational mix adjustment using data from the 2007–2008 occupational mix survey data, using the methodology described in section III.D.3. of this preamble.

Using the occupational mix survey data and applying the occupational mix adjustment to 100 percent of the proposed FY 2010 wage index results in a proposed national average hourly wage of $33.4935 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 proposed FY 2010 wage index, we calculated the proposed FY 2010 wage index using the occupational mix survey data from 3,135 hospitals. Using the Worksheet S–3 cost report data of 3,521 hospitals and occupational mix survey data from 3,135 hospitals represents an 89-percent survey response rate. The proposed 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	$36.067749019
National LPN and Surgical Technician	20.908955714
National Nurse Aide, Orderly, and Attendant	14.610222480
National Medical Assistant	16.358327509
National Nurse Category	30.484719916

The proposed national average hourly wage for the entire nurse category as computed in Step 5 of the occupational mix calculation is $30.484719916. 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 44.32 percent, and the national percentage of hospital employees in the all other occupations category is 55.68 percent. At the CBSA level, the percentage of hospital employees in the nurse category ranged from a low of 29.08 percent in one CBSA, to a high of 70.76 percent in another CBSA.

We compared the proposed FY 2010 occupational mix adjusted wage indices for each CBSA to the proposed unadjusted wage indices for each CBSA. As a result of applying the occupational mix adjustment to the wage data, the proposed wage index values for 205 (46.8 percent) urban areas and 33 (70.2 percent) rural areas would increase. One hundred and nine (24.9 percent) urban areas would increase by 1 percent or more, and 5 (1.1 percent) urban areas would increase by 5 percent or more. Nineteen (40.4 percent) rural areas would increase by 1 percent or more, and no rural areas would increase by 5 percent or more. However, the proposed wage index values for 185 (42.2 percent) urban areas and 14 (29.8 percent) rural areas would decrease. Eighty-nine (20.3 percent) urban areas would decrease by 1 percent or more, and 1 (0.23 percent) urban area would decrease by 5 percent or more. Six (12.8 percent) rural areas would decrease by 1 percent or more,

and no rural areas would decrease by 5 percent or more. The largest positive impacts are 7.86 percent for an urban area and 2.98 percent for a rural area. The largest negative impacts are 5.68 percent for an urban area and 2.07 percent for a rural area. One urban area would be unaffected. These results indicate that a larger percentage of rural areas (70.2 percent) benefit from the occupational mix adjustment than do urban areas (46.8 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 would still experience a decrease in their wage indices as a result of the occupational mix adjustment.

We also compared the proposed FY 2010 wage data adjusted for occupational mix from the 2007–2008 survey to the proposed 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 proposed wage index values for 186 (47.6 percent) urban areas and 18 (38.3 percent) rural areas would increase. Sixty-three (16.1 percent) urban areas would increase by 1 percent or more, and no urban areas would increase by 5 percent or more. One (2.1 percent) rural area would increase by 1 percent or more, and no rural areas would increase by 5 percent or more. However, the proposed wage index values for 201 (51.4 percent) urban areas and 28 (59.6 percent) rural areas would decrease using the 2007–2008 data. Fifty-six (14.3 percent) urban areas would decrease by 1 percent or more, and one (0.26 percent) urban area would decrease by 5 percent or more. Four (8.5 percent) rural areas would decrease by 1 percent or more, and no rural areas would decrease by 5 percent or more. The largest positive impacts using the 2007–2008 data compared to the 2006 data are 4.36 percent for an urban area and 2.39 percent for a rural area. The largest negative impacts are 6.46 percent for an urban area and 4.39 percent for a rural area. Four urban areas and one rural area would be unaffected. These results indicate that a larger percentage of urban areas (47.6 percent) would benefit from the 2007–2008 occupational mix survey as compared to the 2006 survey than would rural areas (38.3 percent). Further, the wage indices of more CBSAs overall (52.3 percent) would 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 (70.2 percent) would benefit from the application of the occupational mix adjustment than would urban areas.

The proposed 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 proposed rule include the proposed occupational mix adjustment.

Tables 3A and 3B in the Addendum to this proposed rule list the 3-year average hourly wage for each labor market area before the redesignation 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 proposed 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 proposed 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 proposed rule include the occupational mix adjustment. The proposed wage index values in Tables 4A, 4B, 4C, and 4D–1 also include the proposed State-specific rural floor and imputed floor budget neutrality adjustments.

I. Revisions to the Wage Index Based on Hospital Redesignations

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 proposed 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 the proposed rule, 876 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 must be received by the MGCRB within 45 days of the publication of the proposed rule. Hospitals may also cancel prior reclassification withdrawals or terminations in certain circumstances. For further information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer the reader to 42 CFR 412.273, as well as the FY 2002 IPPS final rule (66 FR 39887) and the FY 2003 IPPS final rule (67 FR 50065).

Changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in the FY 2010 IPPS 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/providers/prrb/mgcinfo.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.

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.
Macon, AL	Auburn-Opelika, AL.
Talladega, AL	Anniston-Oxford, AL.
Hot Springs, AR	Hot Springs, AR.
Windham, CT	Hartford-West Hartford-East Hartford, CT.
Bradford, FL	Gainesville, FL.
Hendry, FL	West Palm Beach-Boca Raton-Boynton, FL.
Levy, FL	Gainesville, FL.
Walton, FL	Fort Walton Beach-Crestview-Destin, FL.
Banks, GA	Gainesville, GA.
Chattooga, GA	Chattanooga, TN-GA.
Jackson, GA	Atlanta-Sandy Springs-Marietta, GA.
Lumpkin, GA	Atlanta-Sandy Springs-Marietta, GA.
Morgan, GA	Atlanta-Sandy Springs-Marietta, GA.
Peach, GA	Macon, GA.
Polk, GA	Atlanta-Sandy Springs-Marietta, GA.
Talbot, GA	Columbus, GA-AL.
Bingham, ID	Idaho Falls, ID.
Christian, IL	Springfield, IL.
DeWitt, IL	Bloomington-Normal, IL.
Iroquois, IL	Kankakee-Bradley, IL.
Logan, IL	Springfield, IL.
Mason, IL	Peoria, IL.
Ogle, IL	Rockford, IL.
Clinton, IN	Lafayette, IN.
Henry, IN	Indianapolis-Carmel, IN.
Spencer, IN	Evansville, IN-KY.
Starke, IN	Gary, IN.
Warren, IN	Lafayette, IN.
Boone, IA	Ames, IA.
Buchanan, IA	Waterloo-Cedar Falls, IA.
Cedar, IA	Iowa City, IA.
Allen, KY	Bowling Green, KY.
Assumption Parish, LA.	Baton Rouge, LA.
St. James Parish, LA	Baton Rouge, LA.
Allegan, MI	Holland-Grand Haven, MI.
Montcalm, MI	Grand Rapids-Wyoming, MI.

RURAL 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
Oceana, MI	Muskegon-Norton Shores, MI.
Shiawassee, MI	Lansing-East Lansing, MI.
Tuscola, MI	Saginaw-Saginaw Township North, MI.
Fillmore, MN	Rochester, MN.
Dade, MO	Springfield, MO.
Pearl River, MS	Gulfport-Biloxi, MS.
Caswell, NC	Burlington, NC.
Davidson, NC	Greensboro-High Point, NC.
Granville, NC	Durham, NC.
Harnett, NC	Raleigh-Cary, NC.
Lincoln, NC	Charlotte-Gastonia-Concord, NC-SC.
Polk, NC	Spartanburg, SC.
Los Alamos, NM	Santa Fe, NM.
Lyon, NV	Carson City, NV.
Cayuga, NY	Syracuse, NY.
Columbia, NY	Albany-Schenectady-Troy, NY.
Genesee, NY	Rochester, NY.
Greene, NY	Albany-Schenectady-Troy, NY.
Schuyler, NY	Ithaca, NY.
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY.
Wyoming, NY	Buffalo-Niagara Falls, NY.
Ashtabula, OH	Cleveland-Elyria-Mentor, OH.
Champaign, OH	Springfield, OH.
Columbiana, OH	Youngstown-Warren-Boardman, OH-PA.
Cotton, OK	Lawton, OK.
Linn, OR	Corvallis, OR.
Adams, PA	York-Hanover, PA.
Clinton, PA	Williamsport, PA.
Greene, PA	Pittsburgh, PA.
Monroe, PA	Allentown-Bethlehem-Easton, PA-NJ.
Schuylkill, PA	Reading, PA.
Susquehanna, PA	Binghamton, NY.
Clarendon, SC	Sumter, SC.
Lee, SC	Sumter, SC.
Oconee, SC	Greenville, SC.
Union, SC	Spartanburg, SC.
Meigs, TN	Cleveland, TN.
Bosque, TX	Waco, TX.
Falls, TX	Waco, TX.
Fannin, TX	Dallas-Plano-Irving, TX.
Grimes, TX	College Station-Bryan, TX.
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.

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
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 are permitted to compare the reclassified wage index for the labor market area in Table 4C in the Addendum to this proposed rule into which they have been reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals may withdraw from an MGCRB reclassification within 45 days of the publication of this proposed rule.

5. Reclassifications Under Section 1886(d)(8)(B) of the Act

As discussed in the FY 2009 IPPS final rule (73 FR 48588), Lugar hospitals are treated like reclassified hospitals for purposes of determining their applicable wage index and receive the reclassified wage index for the urban area to which they have been redesignated. Because Lugar hospitals are treated like reclassified hospitals, when they are seeking reclassification by the MGCRB, they are subject to the rural reclassification rules set forth at 42 CFR 412.230. The procedural rules set forth at § 412.230 list the criteria that a hospital must meet in order to reclassify as a rural hospital. Lugar hospitals are subject to the proximity criteria and payment thresholds that apply to rural hospitals. Specifically, the hospital must be no more than 35 miles from the area to which it seeks reclassification

(§ 412.230(b)(1)); and the hospital must show that its average hourly wage is at least 106 percent of the average hourly wage of all other hospitals in the area in which the hospital is located (§ 412.230(d)(1)(iii)(C)). In accordance with policy adopted in the FY 2009 IPPS final rule (73 FR 48568 and 48569), beginning with reclassifications for the FY 2010 wage index, a Lugar hospital must also demonstrate that its average hourly wage is equal to at least 84 percent (for FY 2010 reclassifications) and 86 percent (for reclassifications for FY 2011 and subsequent fiscal years) of the average hourly wage of hospitals in the area to which it seeks redesignation (§ 412.230(d)(1)(iv)(C)).

Hospitals not located in a Lugar county seeking reclassification to the urban area where the Lugar hospitals have been redesignated are not permitted to measure to the Lugar county to demonstrate proximity (no more than 15 miles for an urban hospital, and no more than 35 miles for a rural hospital or the closest urban or rural area for RRCs or SCHs) in order to be reclassified to such urban area. These hospitals must measure to the urban area exclusive of the Lugar County to meet the proximity or nearest urban or rural area requirement. We treat New England deemed counties in a manner consistent with how we treat Lugar counties. (We refer readers to FY 2008 IPPS final rule with comment period (72 FR 47337) for a discussion of this policy.)

6. Reclassifications Under Section 508 of Public Law 108–173

Section 508 of Public Law 108–173 allowed certain qualifying hospitals to receive wage index reclassifications and assignments that they otherwise would not have been eligible to receive under the law. Although section 508 originally was scheduled to expire after a 3-year period, Congress extended the provision several times, as well as certain special exceptions that would have otherwise expired. For a discussion of the original section 508 provision and its various extensions, we refer readers to the FY 2009 IPPS final rule (73 FR 48443). 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, in this proposed rule, we are not proposing to make any changes related to these provisions.

J. Proposed 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 are proposing to calculate the out-migration adjustment using the same formula described in the FY 2005 IPPS final rule (69 FR 49064), with the addition of using the post-reclassified wage indices, to calculate the out-migration adjustment. This adjustment is calculated as follows:

Step 1—Subtract the wage index for the qualifying county from the wage index of each of the higher wage area(s) to which hospital workers commute.

Step 2—Divide the number of hospital employees residing in the qualifying county who are employed in such higher wage index area by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area. For each of the higher wage index areas, multiply this result by the result obtained in Step 1.

Step 3—Sum the products resulting from Step 2 (if the qualifying county has workers commuting to more than one higher wage index area).

Step 4—Multiply the result from Step 3 by the percentage of hospital employees who are residing in the qualifying county and who are employed in any higher wage index area.

These adjustments will be effective for each county for a period of 3 fiscal years. For example, hospitals that received the adjustment for the first time in FY 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 wish to receive the out-migration adjustment, rather than their reclassification adjustment, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this proposed rule. Otherwise, they will be deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8) of the Act will be deemed to have waived the out-migration adjustment unless they explicitly notify CMS within 45 days from the publication of this proposed rule that they elect to receive the out-migration adjustment instead. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attention: Wage Index Adjustment Waivers, Division of

Acute Care, room C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Table 4J in the Addendum to this proposed rule lists the proposed out-migration wage index adjustments for FY 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 is otherwise notified within the necessary timeframe. In addition, hospitals eligible to receive the out-migration wage index adjustment and that withdraw their application for reclassification would automatically receive the wage index adjustment listed in the final Table 4J in the Addendum to this proposed rule.

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 encourage 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 are 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 is April 15, 2009.

Hospitals should also examine Table 2 in the Addendum to this proposed rule. Table 2 in the Addendum to this proposed rule contains each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 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 will release 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 will be 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 believes that its wage or occupational mix data are incorrect due to a fiscal intermediary/MAC or CMS error in the entry or tabulation of the final data, the hospital should send a letter to both its fiscal intermediary/MAC and CMS that outlines why the hospital believes an error existed and to provide all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries (or, if applicable, the MACs) must receive these requests no later than June 8, 2009.

Each request also must be sent to the fiscal intermediary/MAC. The fiscal intermediary/MAC will review requests upon receipt and contact CMS immediately to discuss any findings.

At this point in the process, that is, after the release of the May 2009 wage index data files, changes to the wage and occupational mix data will only be made in those very limited situations involving an error by the fiscal intermediary/MAC or CMS that the hospital could not have known about before its review of the final wage index data files. Specifically, neither the fiscal intermediary/MAC nor CMS will approve the following types of requests:

- Requests for wage index data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries or the MACs on or before April 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) will be incorporated into the final wage index in the FY 2010 IPPS 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 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 will have access to the final wage index data by early May 2009, they have the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or the MAC or CMS before the development and publication of the final FY 2010 wage index by August 1, 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. Proposed 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 proposed 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.

We are inviting 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 proposed market basket that would be applicable to LTCHs in section VIII.C.2. of the preamble of this proposed 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 proposed 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, we are proposing to rebase and revise 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 proposed 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	Proposed 2006-based market basket
Wages and salaries	45.590	45.156
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. We are proposing 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 this FY 2010 IPPS proposed rule, and in an effort to provide greater transparency, we will be posting 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 (that is, those not calculated using Medicare cost reports) are 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. The proposed 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. We are proposing to break 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 the section IV.B.3. of this proposed rule. Also, the proposed 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, we are proposing to include the photo supplies costs in the chemical cost category weight with other similar chemical products.

We are not proposing to change our definition of the labor-related share. However, we are proposing to rename our aggregate cost categories from ''labor-intensive'' and ''non-labor-intensive'' services to ''labor-related'' and ''nonlabor-related'' services. 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 proposed new labels more accurately reflect the concepts that they are intended to convey. We are not proposing to change to 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 proposed 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.

Chart 2 sets forth the proposed 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.—PROPOSED 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	Proposed rebased FY 2006-based hospital market basket cost weights	Proposed 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	7.435	
(1) Professional Fees: Labor-related (4)	5.510	3.616	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	9.625	
(1) Professional Fees: Nonlabor-Related (4)	n/a	5.814	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 are proposing to use 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 proposed 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 proposed 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 proposed 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 proposed FY 2006-based IPPS market basket.

a. Wages and Salaries

We are proposing to 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 are proposing to 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 proposed FY 2006-based market basket, we are proposing to 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 are proposing to use the PPI for petroleum refineries (series code #PCU324110) as the proxy for this cost category.

d. Electricity

We are proposing to use the PPI for commercial electric power (series code #WPU0542). This same proxy was used in the FY 2002-based IPPS market basket.

e. Water and Sewage

We are proposing to 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 are proposing to proxy price changes in hospital professional liability insurance premiums (PLI) using percentage changes as estimated by the CMS Hospital Professional Liability Index. To generate these estimates, we collect commercial insurance premiums for a fixed level of coverage while holding nonprice factors constant (such as a change in the level of coverage). This method is also used to proxy PLI price changes in the Medicare Economic Index (68 FR 63244). This same proxy was used in the FY 2002-based IPPS market basket.

g. Pharmaceuticals

We are proposing to 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 are proposing to 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 are proposing to 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 are proposing to 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 are proposing to 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 proposed FY 2006-based IPPS market basket, we are proposing to 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 are proposing to 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 proposing to change the price proxy for this cost category to the more aggregated PPI for medical, surgical, and personal aid devices.

m. Photographic Supplies

We are proposing to eliminate 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 are proposing to 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 are proposing to 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 are proposing to 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 are proposing to 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 are proposing to 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 are proposing to 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 are proposing to 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 are proposing to 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 are proposing to 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 are proposing to use for the professional fees: Labor-related cost category.

w. Financial Services

We are proposing to 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 are proposing to 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 are proposing to 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 are proposing to 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 proposed FY 2006-based IPPS market basket.

CHART 4—FY 2002-BASED AND PROPOSED 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	Proposed 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	2.0	2.5
FY 2010	2.3	2.1
FY 2011	2.9	2.8
FY 2012	3.1	3.0

CHART 4—FY 2002-BASED AND PROPOSED FY 2006-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING INDEX PERCENT CHANGE, FY 2004 THROUGH FY 2012—Continued

Fiscal year (FY)	FY 2002-based IPPS market basket operating index percent change	Proposed FY 2006-based IPPS market basket operating index percent change
Average FYs 2009–2012	2.6	2.6

Source: IHS Global Insight, Inc.1st Quarter 2009, USMACRO/CONTROL0209@CISSIM/TL0505.SIM.

The differences between the FY 2002-based and the proposed FY 2006-based IPPS market basket increases are mostly stemming from the proposal to revise the proxy used for the chemicals cost category. As stated earlier, we are proposing to adopt a blended chemical index that is comprised of four industry-based chemical price proxies that represent approximately 90 percent of the hospital's industry 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 proposed 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 proposed 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 proposed 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 continue to classify a cost category as labor-related if the costs are *labor-intensive and vary with the local labor market*. Given this, based on our definition of the labor-related share, we are proposing to include 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). 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 proposed FY 2006-based IPPS market basket rebasing, the proposed 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 proposing to establish 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.

Using data primarily from the Medicare cost reports and a CMS database of Home Office Medicare Records (HOMER) (a database that provides city and state information (addresses) for home offices), we were able to determine that 27 percent of hospitals that had home offices had those home offices located in their respective local labor markets—defined as being in the same MSA.

The Medicare cost report requires hospitals to report their home office provider numbers. Using the HOMER database to determine the home office location for each home office provider number, we compared the location of the 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 54 percent of the 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. Although there were a very limited number of exceptions (that is, hospitals located in different States but the same MSA as their home office), the 54 percent estimate was unchanged.

We found that 13 percent of all 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 33 percent of all 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 14 percent of all 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 27 percent of hospitals with home offices had home offices located within their local labor market (that is, 13 percent of hospitals with home offices had their home offices in the same State and city (and, thus, the same MSA), and 14 percent of hospitals with home offices had their home offices in the same State, a different city, but the same MSA). We are proposing to apportion the NAICS 55 expense data by this percentage. Thus, we are proposing to classify 27 percent of these costs into the professional fees: labor-related cost category and the remaining 73 percent into the professional fees: nonlabor-related cost category.

Below is a chart comparing the proposed FY 2006-based and the FY 2002-based labor-related share.

CHART 5—COMPARISON OF THE PROPOSED FY 2006-BASED LABOR-RELATED SHARE AND THE FY 2002-BASED LABOR-RELATED SHARES

	FY 2002–based market basket cost weights	Proposed 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	3.616
Administrative and Business Support Services		0.626
All Other: Labor-Related Services	4.228	3.193
Total Labor-Related Share	69.731	67.062

Using the proposed cost category weights from the proposed FY 2006-based IPPS market basket, we calculated a labor-related share of 67.062 percent, approximately 3 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 67.062 percent, using the proposed FY 2006-based IPPS market basket. Accordingly, we are proposing to implement a labor-related share of 67.1 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.''

We also are proposing to update 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 proposed 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 PROPOSED 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	Proposed 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	3.616
Administrative and Business Support Services		0.626
All Other: Labor-Related Services	4.228	3.193
Total Labor-Related Share	58.721	60.347

Using the proposed FY 2006-based Puerto Rico cost category weights, we calculated a labor-related share of 60.347 percent, approximately 2 percentage points higher than the current Puerto-Rico specific labor-related share of 58.721. Accordingly, we are proposing to adopt an updated Puerto Rico labor-related share of 60.3 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.

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 proposing to use the proposed 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 proposed 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.

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.

We are proposing to rebase and revise 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 have developed two sets of weights in order to calculate the proposed 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 proposed FY 2006-based CIPI cost weights and the FY 2002-based CIPI cost weights.

CHART 7—PROPOSED FY 2006-BASED CIPI COST CATEGORIES, WEIGHTS, AND PRICE PROXIES WITH FY 2002-BASED CIPI INCLUDED FOR COMPARISON

Cost categories	FY 2002 weights	Proposed 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 this FY 2010 IPPS proposed rule, and in order to provide greater transparency, we will be posting 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.

We are proposing to use 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. 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 proposed 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 proposed 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 proposed FY 2006-based CIPI. The vintage weights for the FY 2002-based CIPI and the proposed FY 2006-based CIPI are presented in Chart 8.

CHART 8—FY 2002 VINTAGE WEIGHTS AND PROPOSED FY 2006 VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Year	Building and fixed equipment		Movable equipment		Interest	
	FY 2002 23 years	Proposed FY 2006 25 years	FY 2002 11 years	Proposed FY 2006 12 years	FY 2002 23 years	Proposed 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

CHART 8—FY 2002 VINTAGE WEIGHTS AND PROPOSED FY 2006 VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES—Continued

Year	Building and fixed equipment		Movable equipment		Interest	
	FY 2002 23 years	Proposed FY 2006 25 years	FY 2002 11 years	Proposed FY 2006 12 years	FY 2002 23 years	Proposed FY 2006 25 years
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. We are proposing to use the same price proxies for the proposed FY 2006-based CIPI that were used in the FY 2002-based CIPI with the exception of the Boeckh Construction Index. We are proposing to replace 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 proposed FY 2006-based CIPI.

CHART 9—COMPARISON OF FY 2002-BASED AND PROPOSED FY 2006-BASED CAPITAL INPUT PRICE INDEX, PERCENT CHANGE, FY 2004 THROUGH FY 2012

Fiscal year	CIPI, FY 2002-based	CIPI, proposed 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	1.6	1.5
FY 2010	1.5	1.2
FY 2011	1.6	1.5
FY 2012	1.6	1.5
Average:		

CHART 9—COMPARISON OF FY 2002-BASED AND PROPOSED FY 2006-BASED CAPITAL INPUT PRICE INDEX, PERCENT CHANGE, FY 2004 THROUGH FY 2012—Continued

Fiscal year	CIPI, FY 2002-based	CIPI, proposed FY 2006-based
FYs 2004–2009	0.9	1.1
FYs 2010–2012	1.6	1.4

Source: IHS Global Insight, Inc, 1st Quarter 2009; USMACRO/CONTROL0209@CISSIM/TL0209.SIM.

IHS Global Insight, Inc. forecasts a 1.2 percent increase in the proposed 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	2.0	−1.8
FY 2010	1.2	1.7	−1.7
FY 2011	1.5	1.8	−0.3
FY 2012	1.5	1.7	−0.2

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 proposed 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 proposing to change 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 proposed change represents a technical improvement as the BEA price index is an index that is more representative of the hospital industry. For the proposed FY 2010 update, the result of this proposed change is a forecasted price change in total depreciation of 1.7 percent in the proposed FY 2006-based CIPI compared to 1.9 percent in the FY 2002-based CIPI. The other primary factor contributing to the difference is the proposed change in the vintage weights used to calculate the vintage-weighted price proxy for interest. The forecasted price change in total interest is −1.7

percent in the proposed FY 2006-based CIPI compared to −1.2 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.

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

A. Reporting of Hospital Quality Data for Annual Hospital Payment Update

1. Background

a. Overview

CMS is seeking to promote higher quality and more efficient health care for Medicare beneficiaries. This effort is supported by the adoption of an increasing number of widely-agreed upon quality measures. CMS has worked with relevant stakeholders to define measures of quality in almost every setting and currently measures some aspect of care for almost all Medicare beneficiaries. These measures assess structural aspects of care, clinical processes, patient experiences with care, and, increasingly, outcomes.

CMS has implemented quality measure reporting programs for multiple settings of care. 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) of 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.[6]

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.[7] 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.

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. NQF was established to standardize health care quality measurement and reporting through its consensus development process. We have generally adopted NQF-endorsed

[6] 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.

[7] 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 D.C. 1999.

measures. However, we believe that consensus among affected parties also can be reflected by other means, including, consensus achieved during the measure development process, consensus shown through broad acceptance and use of measures, and consensus through public comment.

Section 1886(b)(3)(B)(viii)(VI) of the Act authorizes the Secretary to replace any quality measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance with a measure, or the measures or indicators have been subsequently shown to not represent the best clinical practice. Thus, the Secretary is granted broad discretion to replace measures that are no longer appropriate for the RHQDAPU program.

In the FY 2007 IPPS final rule, we began to expand the RHQDAPU program measures by adding 11 quality measures to the 10-measure starter set to establish an expanded set of 21 quality measures for the FY 2007 payment determination (71 FR 48033 through 48037, 48045).

In the CY 2007 OPPS/ASC final rule (71 FR 68201), we adopted six additional quality measures for the FY 2008 payment determination, for a total of 27 measures. Two of these measures (30-Day Risk Standardized Mortality Rates for Heart Failure and 30-Day Risk Standardized Mortality Rates for AMI) were calculated using existing administrative Medicare claims data; thus, no additional data submission by hospitals was required for these two measures. The measures used for the FY 2008 payment determination included, for the first time, the HCAHPS patient experience of care survey.

In the FY 2008 IPPS final rule (72 FR 47348 through 47358) and the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875 through 66877), we added three additional process measures to the RHQDAPU program measure set. (These three measures are SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose, SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal, and Pneumonia 30-day mortality (Medicare patients).) The addition of these three 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 Infection Prevention (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. • 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.

Topic	RHQDAPU program quality measures for the FY 2010 payment determination
	• MORT–30–HF: Heart Failure 30-day mortality—Medicare patients. • MORT–30–PN: Pneumonia 30-day mortality—Medicare patients.
Patients' Experience of Care	• HCAHPS patient 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 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 final rule with comment period and the FY 2009 IPPS final rule, including the ''topping out'' of hospitals' performance under a measure (72 FR 47358–47359, and 73 FR 48603–48604). In this instance, however, 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 April 1, 2009 discharges. However, we are seeking public comment on the retirement of the AMI–6 measure.

(2) Maintenance of Technical Specifications for Quality Measures

The technical specifications for each RHQDAPU program measure are listed in the CMS/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. We are inviting 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 are inviting 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.

(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, *http://www.hospitalcompare.hhs.gov*. The RHQDAPU program 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.

2. Retirement of RHQDAPU Program Measures

As stated above, we retired AMI–6 from the RHQDAPU program measure set on December 1, 2008 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, we propose 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 propose 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 are inviting 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 are inviting 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, *http://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.

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 comments 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 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 [8] 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, 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.

[8] 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. We invite 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 continue to use these criteria to guide our decisions on what measures to propose for the RHQDAPU program measure set. Therefore, in commenting on the new quality measures we have proposed to include in future payment years and on measures to retire, we are inviting public comments on these criteria.

b. Proposed RHQDAPU Program Quality Measures for the FY 2011 Payment Determination

(1) Proposed Retention of Existing RHQDAPU Program Quality Measures

For the FY 2011 payment determination, we are proposing to retain the following RHQDAPU program quality measures that we are using for the FY 2010 payment determination:

Topic	RHQDAPU program quality measures for FY 2010 payment determination proposed for 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–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 patient survey.
Readmission Measure (Medicare Patients)	• READ–30–HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients). • READ–30–AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients). • READ–30–PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients).
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures.	• PSI 06: Iatrogenic pneumothorax, adult. • PSI 14: Postoperative wound dehiscence. • PSI 15: Accidental puncture or laceration. • IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume). • IQI 19: Hip fracture mortality rate. • Mortality for selected surgical procedures (composite). • Complication/patient safety for selected indicators (composite). • Mortality for selected medical conditions (composite).
Cardiac Surgery	

Topic	RHQDAPU program quality measures for FY 2010 payment determination proposed for FY 2011 payment determination
	• Participation in a Systematic Database for Cardiac Surgery.

As we discussed above, we retired AMI–6 Beta blocker at arrival from the RHQDAPU program measure set for the FY 2010 payment determination and subsequent years. In addition, as discussed below, we propose to harmonize two current RHQDAPU program measures for the FY 2011 payment determination: PSI 04: Death among surgical patients with treatable serious complications; and Nursing Sensitive—Failure to Rescue.

(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, we are proposing 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 may continue to publicly report the measure in two different topics areas on *Hospital Compare*—Nursing Sensitive Care and AHRQ PSIs, IQIs and Composite Measures. We are inviting public comment on this proposal.

(3) Proposed New Chart-Abstracted Measures

For the FY 2011 payment determination, we are proposing 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.[9]

Although these two measures require that hospitals abstract data from medical records, they add to the scope of the existing SCIP measurement 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 are inviting 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. 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.

(4) Proposed New Structural Measures

We also are proposing 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 are proposing 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 are soliciting public comment on these registry structural measures. Specifically, we are inviting public comment on whether ''systematic qualified clinical database registry'' is adequately defined and, if not, how it should be defined. In defining

[9] 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.

''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 welcome more precise data on what percentage of hospitals already participate in a stroke registry or a nursing sensitive registry.[10] Because we also retire measures when performance has reached a sufficiently high level, we are inviting 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 are inviting public comment on our proposal to adopt these two structural measures for the FY 2011 payment determination.

In summary, we are proposing for the FY 2011 payment determination to retain 41 of the measures we adopted for the FY 2010 payment determination. With respect to the other three measures we adopted for the FY 2010 payment determination, we retired AMI–6 Beta blocker at arrival measure and are proposing 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. Finally, we are proposing to add four measures (two SCIP Infection measures and two structural measures) to the RHQDAPU program measure set. Set out below are the 46 RHQDAPU program quality measures proposed for the FY 2011 payment determination:

Topic	Proposed 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 patient 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).

[10] 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).

Topic	Proposed RHQDAPU program quality measures for the FY 2011 payment determination
	• READ–30–PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients).
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures.	• PSI 06: Iatrogenic pneumothorax, adult. • PSI 14: Postoperative wound dehiscence. • PSI 15: Accidental puncture or laceration. • IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume). • IQI 19: Hip fracture mortality rate. • Mortality for selected surgical procedures (composite). • Complication/patient safety for selected indicators (composite). • Mortality for selected medical conditions (composite).
AHRQ PSI and Nursing Sensitive Care**	• Death among surgical inpatients with serious, treatable complications.
Cardiac Surgery	• Participation in a Systematic Database for Cardiac Surgery.
Stroke Care	• Participation in a Systematic Clinical Database Registry for Stroke Care.*
Nursing Sensitive Care	• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care.*

* Proposed new measure for FY 2011 payment determination.
** Proposed harmonized measure. This measure may be publicly reported under two topics—the AHRQ PSIs, IQIs, and Composite Measures topic and the Nursing Sensitive Care topic.

4. Possible New Quality Measures for the FY 2012 Payment Determination and Subsequent Years

We are inviting public comment on the following quality measures and topics that we might consider adopting beginning with the FY 2012 payment determination. We also are seeking 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.
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.

Measure topic	Measure description
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 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 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.
	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 are inviting 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.

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: *http://www.QualityNet.org*. CMS requires that hospitals submit data in accordance with the specifications for the appropriate discharge periods.

Hospitals submit quality data through the secure portion of the QualityNet Web site (formerly known as QualityNet Exchange) (*http://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. Proposed RHQDAPU Program Procedures for the FY 2011 Payment Determination

For the FY 2011 payment determination, we are proposing that the following procedures will 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 have 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 (*http://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 are proposing 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'' 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 are proposing that hospitals having an open 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 a completed Notice of Participation form 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 CMS Abstraction & Reporting Tool (CART), The Joint Commission ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that meets the measurement specification requirements for data transmission to QualityNet. All submissions will be executed through My QualityNet, the secure part of the QualityNet Web site. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR Part 480. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals.
- Submit complete data for each quality measure that requires chart abstraction in accordance with the joint CMS/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 4½ months following the last discharge date in the calendar quarter. CMS will post the quarterly submission deadline

schedule on the QualityNet Web site (*http://www.QualityNet.org*). The collection of new chart-abstracted measures for 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 (*http://www.QualityNet.org*).

CMS strongly recommends that hospitals review the QIO Clinical Warehouse Feedback Reports and the RHQDAPU Program Provider Participation Reports that are available after patient level data are submitted to the QIO Clinical Warehouse. CMS generally updates these reports on a daily basis to provide accurate information to hospitals about their submissions. These reports enable hospitals to ensure that their data were submitted on time and accepted into the QIO Clinical Warehouse.

Hospitals are encouraged to regularly check the QualityNet Web site, *http://www.QualityNet.org* for program updates and information.

• The following RHQDAPU program claims-based measures will 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. • 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 three 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 one year of claims from July 1, 2008 through June 30, 2009 to calculate these measures.

• We are proposing 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.

The following is the list of three structural measures proposed for the FY 2011 payment determination:

Topic	FY 2011 Payment determination: proposed structural measures
Cardiac Surgery	
	• Participation in a Systematic Database for Cardiac Surgery.

Topic	FY 2011 Payment determination: proposed structural measures
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 will add a link on the QualityNet Web site to the Web page(s) hospitals can use to report the proposed structural measures after we issue the FY 2010 IPPS final rule.

b. RHQDAPU Program Disaster Extensions and Waivers

We are soliciting 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 welcome 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, 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.

c. HCAHPS Requirements for the FY 2011 Payment Determination

We are proposing 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: *http://www.hcahpsonline.org*. A current list of approved HCAHPS survey vendors can be found on the HCAHPS Web site at: *http://www.hcahpsonline.org*.

Every hospital choosing to contract with a survey vendor should provide the sample frame of HCAHPS-eligible discharges to its survey vendor with sufficient time to allow the survey vendor to begin contacting each sampled patient within 6 weeks of discharge from the hospital. (We refer readers to the *Quality Assurance Guidelines* located at *http://www.hcahpsonline.org* for details about HCAHPS eligibility and sample frame creation.) In addition, the hospital must authorize the survey vendor to submit data via My QualityNet, the secure part of the QualityNet Web site, on the hospital's behalf.

After the survey vendor submits the data to the QIO Clinical Warehouse, we strongly recommend that hospitals employing a survey vendor promptly review the two HCAHPS Feedback Reports (the Provider Survey Status Summary Report and the Data Submission Detail Report) that are available. These reports enable a hospital to ensure that its survey vendor has submitted the data on time and the data has been accepted into the QIO Clinical Warehouse.

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 *http://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 *http://www.hcahpsonline.org*, for program updates and information.

6. Proposed Chart Validation Requirements

a. Proposed Chart Validation Requirements and Methods for the FY 2011 Payment Determination

For the FY 2011 payment determination, we are proposing to generally continue using the following existing requirements implemented in previous years. We note below where we are proposing 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 the FY 2010 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 are proposing the following timeline with respect to CDAC contractor requests for paper medical records for the purpose of validating RHQDAPU program data. Beginning with CDAC requests for second calendar quarter 2009 paper medical records, the CDAC 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. If the hospital does not comply within 30 days, the CDAC 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 medical record request. If the hospital still does not comply, then the CDAC will assign a ''zero'' score to each data element in each missing record.

We are proposing 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 reabstract 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 propose 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#
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.

b. Proposed 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, we are proposing the following modifications to the RHQDAPU program validation methodology beginning with the FY 2012 payment determination. Specifically, we propose 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 chart 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 chart threshold during CY 2009. We have proposed this 100-chart 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 are soliciting comments and suggestions on how we might be able to target the remaining 2 percent of hospitals for validation.

• Randomly validate for each of the 800 selected hospitals a stratified sample 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. We have proposed this 100-chart 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.

For the FY 2012 payment determination, we will validate 1st

calendar quarter 2010 through 3rd calendar quarter 2010 discharge data. We are proposing 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 propose validating 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 are proposing 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 are proposing 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 requests for second calendar quarter 2009 paper medical records, the CDAC 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. If the hospital does not comply within 30 days, the CDAC 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 medical record request. If the hospital still does not comply, then the CDAC 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 83–4 of the report (*http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf*). We believe that this approach is appropriate, as supported by many commenters' support in the FY 2009 IPPS final rule to our request for input about the RHQDAPU program validation process (73 FR 48622–3).
- 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 2012 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.

We believe that the proposed clustering approach is a statistically appropriate technique for calculating the annual validation confidence interval. Since 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. CMS has 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 are proposing to use a one-tail confidence interval to calculate the validation score because we strongly believe that a one-tail test most appropriately reflects the pass or fail dichotomous nature of the statistical test regarding whether the confidence interval includes or is completely above the 75 percent passing validation score.

We are also proposing 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 proposed rule.

c. Possible Supplements to the Chart Validation Process for the FY 2013 Payment Determination and Subsequent Years

We also are soliciting 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 number of cases in previous years resulting in hospital exclusion from RHQDAPU program validation sample;
- Failing multiple previous years' RHQDAPU program validations.

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, we are proposing 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 note 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 are proposing 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.

8. Public Display Requirements for the FY 2011 Payment Determination and Subsequent Years

For the FY 2011 payment determination, we are proposing 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 list of chart-abstracted measures and validate all available RHQDAPU program data.

We note below the circumstances under which we are proposing to modify a requirement. We are proposing 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 the FY 2010 IPPS 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 (*http://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 *Hospital Compare* 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 propose note on the Web site instances where publicly reported measures combine results from two or more hospitals.

9. Proposed 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, we are proposing that all hospitals submit a request for reconsideration and receive a decision on that request before they can file an appeal with the Provider Reimbursement Review Board (PRRB).

For the FY 2010 payment determination, we are proposing 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 are proposing 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 are proposing that if a hospital asks us to reconsider an adverse RHQDAPU program payment decision made because the hospital failed the validation requirement, the hospital must submit paper copies of all the medical records that it submitted to the CDAC contractor each quarter for purposes of the validation. Hospitals must submit this documentation to a CMS contractor, 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 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 preamble, 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 48621–2). Hospitals must provide a written justification for each appealed data element classified during the validation process as a mismatch. We will review the data elements that were labeled as mismatched, as well as the written justifications provided by the hospitals, and make a decision on the reconsideration request. As we mentioned above, we are proposing that all hospitals submit a reconsideration request to CMS and receive a decision on that request prior to submitting a PRRB appeal. We believe that the reconsideration process is less costly for both CMS and hospitals, and that this requirement will decrease the number of PRRB appeals by resolving issues earlier in the appeals process.

Following receipt of a request for reconsideration, we will—

• Provide an e-mail acknowledgement, using the contact information provided in the reconsideration request, to the CEO and the QualityNet Administrator that the request has been received.

• Provide written notification to the hospital CEO, using the contact information provided in the reconsideration request, regarding our decision. We expect the process to take approximately 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 are soliciting public comments on the extent to which these proposed procedures will be less costly for hospitals, and whether they will lead to fewer PRRB appeals.

10. RHQDAPU Program Withdrawal Deadlines

We are proposing to accept RHQDAPU program withdrawal forms for the FY 2011 payment determination from hospitals until August 15, 2010. We are proposing this deadline to provide CMS with 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 note 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.

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 for 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: *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.

We welcome comments on this discussion of EHR-based data submission testing.

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 proposed rule do not implicate or implement any HITECH statutory provisions. Those provisions will be implemented in a future rulemaking.

B. Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs): Budget Neutrality Adjustment Factors for FY 2002-Based Hospital-Specific Rate for MDHs (§ 412.79(j))

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 Pub. L. 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, 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 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, just like all other acute care hospitals paid under the IPPS. (We note that the MS–DRGs are currently used under the IPPS, effective beginning in FY 2008.) As discussed above, although the payment formulas for MDHs and SCHs differ slightly, 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). As we explained, if we were to remove the prior year adjustment(s), we would not satisfy this condition. 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 classification 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 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), we normalize DRG weights by an adjustment factor in order to 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 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 DRG reclassification changes and recalibration of the relative weights be budget neutral, we also compute a budget neutrality adjustment factor that applies to both the standardized amounts and the hospital-specific rates. This budget neutrality adjustment ensures that the recalibration process does not inadvertently increase total payments to hospitals. If we were to remove this budget neutrality adjustment factor for years prior to the base year, we believe the normalized DRG weights applied to the hospital-specific amounts would be artificially high, thus resulting in higher aggregate payments than permitted under the statute.

Section 1886(b)(3)(I) of the Act (as added by section 405 of Pub. L. 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 use their 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 Pub. L. 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. 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. Consequently, any MDH that has been paid based on its FY 2002 hospital-specific rate since FY 2007 was paid based on a hospital-specific rate that was computed inconsistent with CMS' stated policy of applying a cumulative budget neutrality adjustment factor to account for DRG changes as a result of annual updates. 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. 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 will 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 would 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 would lower the hospital-specific rate to the point that the Federal rate would result in higher payments.

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 occurring before October 1, 1994, RRCs received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount (as discussed in the FY 1993 IPPS final rule (59 FR 45404 through 45409). Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, RRCs continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Public Law 108–173 raised the DSH adjustment for RRCs such that they are not subject to the 12-percent cap on DSH payments that is applicable to other rural hospitals. RRCs are also not subject to the proximity criteria when applying for geographic reclassification. In addition, they do not have to meet the requirement that a hospital's average hourly wage must exceed the average hourly wage of the labor market area where the hospital is located by a certain percentage.

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. However, 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 used 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

Section 412.96(c)(1) provides that CMS establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining RRC status. The methodology we used to determine the national and regional CMI values is set forth in the regulations at § 412.96(c)(1)(ii). The proposed national median CMI value for FY 2010 includes data from all urban hospitals nationwide, and the proposed 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 proposed values are based on discharges occurring during FY 2008 (October 1, 2007 through September 30, 2008), and include bills posted to CMS' records through December 2008.

We are proposing that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 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.

The proposed 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)	1.2609
2. Middle Atlantic (PA, NJ, NY)	1.2993
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.4159
4. East North Central (IL, IN, MI, OH, WI)	1.4013
5. East South Central (AL, KY, MS, TN)	1.3377
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.4010
7. West South Central (AR, LA, OK, TX)	1.4667
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.5233

Region	Case-mix index value
9. Pacific (AK, CA, HI, OR, WA)	1.4390

The preceding numbers will be revised in the FY 2010 IPPS final rule to the extent required to reflect the updated FY 2008 MedPAR file, which will contain data from additional bills received through March 2009.

Hospitals seeking to qualify as RRCs or those wishing to know how their CMI value compares to the criteria should obtain hospital-specific CMI values (not transfer-adjusted) from their fiscal intermediary or MAC. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these CMI values are computed based on all Medicare patient discharges subject to the IPPS MS–DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2007 (that is, October 1, 2006 through September 30, 2007), which were the latest cost report data available at the time this proposed rule was developed.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 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, as indicated in the following table.

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	8,329
2. Middle Atlantic (PA, NJ, NY)	10,655
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,038
4. East North Central (IL, IN, MI, OH, WI)	9,262
5. East South Central (AL, KY, MS, TN)	6,311
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	8,764
7. West South Central (AR, LA, OK, TX)	6,222
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	10,452
9. Pacific (AK, CA, HI, OR, WA)	8,763

These numbers will be revised in the FY 2010 IPPS final rule based on the latest available cost report data.

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that, if an osteopathic hospital is to qualify for RRC status for cost reporting periods beginning on or after October 1, 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) modifies the formula multiplier beginning midway through FY 2004 and provides 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.

3. IME-Related Proposed Changes in Other Sections of This Proposed Rule

We refer readers to section V.E.2. and 4. of the preamble of this proposed rule for a discussion of proposed 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). 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, we are proposing to change

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 proposed rule for a discussion of our proposed clarification of the definition of a new medical residency training program for purposes of Medicare direct GME payment. This proposed clarification would also apply for purposes of IME payment and could affect IME FTE resident cap adjustments for new medical residency training programs.

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 proposed 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)(ii) because the underlying concepts are similar and we believe they should generally be interpreted in a consistent manner for both purposes. Specifically, we are proposing to change our policies with respect to counting patient days and bed days for patients receiving observation services.

2. Proposed 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 current 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 Policy Change

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 that 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, for cost reporting periods beginning on or after October 1, 2009, we are proposing 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. This proposed policy would be consistent with our existing policy under section 2205 of the PRM regarding counting patient days associated with other ancillary areas (such as surgery and postanesthesia).

We note that we are not proposing 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, this proposed policy does 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 for those purposes remain unchanged and unaffected by this proposed policy.

3. Proposed 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. 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 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, we are proposing 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 are proposing 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, 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. The written notification would have to 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. 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 note 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 are proposing 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.

4. Proposed 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 are proposing 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 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 within 3 days of an inpatient admission 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 that payment for these preadmission services, including observation services furnished to hospital outpatients who are later admitted as inpatients, is included within the per case inpatient payment if the services meet the statutory criteria described in section 1886(a)(4) of the Act, but they 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, we are proposing 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 all other preadmission diagnostic and nondiagnostic services are furnished, are not inpatient days and, therefore, we are proposing 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. 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, we are proposing 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 are proposing to exclude all observation patient days from the DPP of the Medicare DSH calculation. This proposal would be effective for cost reporting periods beginning on or after October 1, 2009.

For the same reasons, we also are proposing to eliminate from bed 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 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 are proposing 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 this 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 are proposing 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 days can be deducted from the bed day count for IME and DSH payment adjustment purposes.

In summary, we are proposing 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.

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 contain 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''. We are proposing to correct the cross-reference in § 412.113(c)(2)(i)(B) to refer to ''§ 410.69''.

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 between 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 statutory provision is also made 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. In accordance with the statute, 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 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 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 only permitted to receive an adjustment for new programs 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).

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(l) 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(l)] 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 and/or new teaching staff, and/or 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 and is accredited as a new program at the second entity. Such a program would 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 after 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, as long as 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, we are proposing 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 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 due to a new 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.

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.

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, after July 1 of an academic year. That is, the new hospital, since 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, we are proposing 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)). The proposed new paragraph (f)(6) would 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 prior to 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 proposing 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 are proposing 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.

4. Technical Corrections to Regulations

We have 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 are proposing to move paragraph (l) so that it appears as the last paragraph of the section after paragraph (k)(7).

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). 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 are proposing 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''.

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. Proposed 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 State 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 arises out of the circumstances of the emergency) 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.''

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 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 are further proposing 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 believe the regulations need to be clarified to include these provisions.

In addition, 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. We are proposing revisions to the regulation text to clarify this issue.

We also are proposing 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 are proposing 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 are proposing 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 are proposing 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. The proposed revised § 489.24(a)(2) reads as follows:

''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:

(i) If relating to an inappropriate transfer, the transfer arises out of the circumstances of the emergency.

(ii) If relating to the direction or relocation of an individual to receive medical screening at an alternate location, the direction or relocation 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.

(iii) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.

(iv) 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.

(v) There is a determination that a waiver of sanctions is necessary.

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*). Thirteen 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.

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 this proposed rule, we are proposing 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 are proposing to adjust the national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration program. We are proposing 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, we are estimating the cost of the demonstration program for FY 2010 for the 13 currently participating hospitals. 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 currently participating hospitals (that is, the 9 hospitals that have participated in the demonstration since its inception and that continue to participate in the demonstration) is based on data from their first and second year cost reports—that is, cost reporting periods beginning in CY 2005 and CY 2006. We are proposing to use these cost reports because they are the most recent complete cost reports and, thus, we believe they enable us to estimate FY 2010 costs as accurately as possible. In addition, we estimate 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). Cost reports for these periods were included along with the hospitals' applications for the demonstration program. When we add together the estimated costs of the demonstration for FY 2010 for the 9 hospitals that have participated in the demonstration since its inception and the 4 new hospitals selected in 2008, the total estimated cost is $14,613,632. 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 cost reports of all hospitals participating in the demonstration in its first year (that is FY 2005) 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. For all 13 hospitals that participated in the demonstration in FY 2005, the amount is $7,179,461.

The total proposed budget neutrality offset amount to be applied for the demonstration for FY 2010 is the sum of these two amounts, or $21,793,093. 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 proposed rule. We are proposing that the budget neutrality offset amount may be different in the FY 2010 IPPS final rule to the extent we have more recent data.

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, we are proposing 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.

VI. Proposed 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).

As discussed in the FY 2008 IPPS final rule with comment period (72 FR 47393 through 47401), based on our analysis of data on hospital inpatient Medicare capital margins that we obtained through our monitoring and comprehensive review of the adequacy of IPPS payments for capital-related costs, we made changes in the payment structure under the capital IPPS beginning with FY 2008. (We also provided an extended capital IPPS margin analysis discussion in the FY 2009 IPPS final rule (73 FR 48671 through 48675).) Specifically, in the FY 2008 IPPS final rule with comment period, we made two changes to the structure of payments under the capital IPPS: (1) We discontinued the 3.0 percent additional payment that had been provided to hospitals located in large urban areas at § 412.316(b) for FYs 2008 and beyond, (72 FR 47400 and 47412); and (2) we established a phase-out of the capital teaching adjustment (that is, the capital IME adjustment factor) at § 412.322 over a 3-year period beginning in FY 2008 (72 FR 47401 and 47412).

Under the established 3-year phase-out of the capital teaching adjustment, we maintained the adjustment for FY 2008 in order to give teaching hospitals an opportunity to plan and make adjustments in correlation to the change. For the second year of the transition (FY 2009), we revised the regulations at § 412.322 by adding paragraph (c), which currently specifies that, for discharges occurring during FY 2009, the formula for determining the amount of the capital IPPS teaching adjustment is half of the amount provided under the previous formula (at § 412.322(b)). Furthermore, for the last year of the transition (FY 2010) and subsequent years, we added paragraph (d) to § 412.322, which specifies that, for discharges occurring during FY 2010 and after, hospitals will no longer receive an adjustment for teaching activity under the capital IPPS.

Section 4301(b)(1) of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111–5, enacted on February 17, 2009, directed the Secretary to not apply the 50-percent reduction in the capital IPPS teaching adjustment for FY 2009, thereby restoring the full capital IME adjustment for FY 2009. However, section 4301(b)(2) of Public Law 111–5 specifies that the law will not affect the phase-out of the capital IPPS teaching adjustment for FY 2010 and subsequent fiscal years. The provisions of Public Law 111–5 related to the capital IPPS teaching adjustment are further discussed in section VI.E.2. of the preamble of this proposed rule.

B. Exception Payments

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the FY 2003 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). Additional information on the exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 49186).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of the hospital (§ 412.348(c)), but were available only during the 10-year transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, eligible hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period

beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital IPPS transition period. Hospitals eligible for special exceptions payments are required to submit documentation to the fiscal intermediary or MAC indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), we refer readers to the FY 2002 IPPS final rule (66 FR 39911 through 39914) and the FY 2003 IPPS final rule (67 FR 50102).)

C. New Hospitals

Under the IPPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years. For example, the following hospitals are not considered new hospitals: (1) A hospital that builds new or replacement facilities at the same or another location, even if coincidental with a change of ownership, a change in management, or a lease arrangement; (2) a hospital that closes and subsequently reopens; (3) a hospital that has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years; and (4) a hospital that changes its status from a hospital that is excluded from the IPPS to a hospital that is subject to the capital IPPS. For more detailed information, we refer readers to the FY 1992 IPPS final rule (56 FR 43418). During the 10-year transition period, a new hospital was exempt from the capital IPPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because, as discussed in the FY 2003 IPPS final rule (67 FR 50101), we believe that special protection to new hospitals is also appropriate even after the transition period, we revised the regulations at § 412.304(c)(2) to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its Medicare allowable capital-related costs through its first 2 years of operation, unless the new hospital elects to receive full prospective payment based on 100 percent of the Federal rate. (We refer readers to the FY 2003 IPPS final rule (67 FR 50101 through 50102) for a detailed discussion of the special payment provisions for new hospitals under the capital IPPS after the 10-year transition period.)

D. Hospitals Located in Puerto Rico

Section 412.374 of the regulations provides for the use of a blended payment amount for prospective payments for capital-related costs to hospitals located in Puerto Rico. Accordingly, under the capital IPPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In general, hospitals located in Puerto Rico are paid a blend of the applicable capital IPPS Puerto Rico rate and the applicable capital IPPS Federal rate.

Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital IPPS rate that consisted of 75 percent of the capital IPPS Puerto Rico specific rate and 25 percent of the capital IPPS Federal rate. However, effective October 1, 1997 (FY 1998), in conjunction with the change to the operating IPPS blend percentage for hospitals located in Puerto Rico required by section 4406 of Public Law 105–33, we revised the methodology for computing capital IPPS payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the capital IPPS Puerto Rico rate and 50 percent of the capital IPPS Federal rate. Similarly, in conjunction with the change in operating IPPS payments to hospitals located in Puerto Rico for FY 2005 required by section 504 of Public Law 108–173, we again revised the methodology for computing capital IPPS payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the capital IPPS Puerto Rico rate and 75 percent of the capital IPPS Federal rate effective for discharges occurring on or after October 1, 2004.

E. Proposed Changes

1. Proposed 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 Pub. L. 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. Proposed Prospective MS–DRG Documentation and Coding Adjustment to the National Capital Federal Rate for FY 2010 and Subsequent Years

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 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 proposed rule, we performed a retrospective evaluation of the FY 2008 claims data updated through December 2008. Based on this evaluation, 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. (As noted above, our analysis plan is described in greater detail in section II.D.4. of this preamble. As also noted in that section, the FY 2008 MedPAR files are available to the public to allow independent analysis of the documentation and coding effect, and we are seeking public comment on our methodology and analysis.)

The estimated 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 this proposed rule, under the Secretary's broad authority under section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, we are proposing to reduce the capital Federal rate in FY 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 are proposing 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.

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). 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 mitigated the FY 2008 documentation and coding effect on expenditures. Specifically, our analysis 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. Consistent with the proposal for the national operating standardized amounts presented in section II.D.4. of this preamble, we will address any differences between the increase 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 and the −0.9 percent prospective documentation and coding adjustment applied to the FY 2009 capital Federal rate (as established in the FY 2009 IPPS final rule (73 FR 48773 through 48774) in the FY 2011 rulemkaing cycle after an evaluation of the extent of the overall national average changes in case-mix for FY 2009 based on a retrospective evaluation of all FY 2009 claims data.

As we stated in section II.D. of this preamble, we are seeking 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 this proposed rule, we are seeking 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.

In summary, in this proposed rule, we are proposing to adjust the FY 2010 capital Federal rate by a cumulative prospective reduction of 3.4 percent to account for increased Medicare expenditures resulting from the changes

in documentation and coding practices with the adoption of the MS–DRGs. In addition, we are proposing to leave that adjustment in place for subsequent fiscal years to account for the effect in FY 2010 and subsequent years in order to ensure that changes in documentation and coding resulting from adoption of the MS–DRGs do not lead to an increase in aggregate payments not reflective of an increase in real case-mix. (In sections II.D.3. and 6. of this preamble, we discuss section 7(b)(1)(B) of Pub. L. 110–90 and the requirement to make an additional adjustment to the standardized amounts (referred to as recoupment or repayment adjustments in FYs 2010 through 2012 required by Pub. L. 110–90). We note that we are not proposing to apply section 7(b)(1)(B) of Pub. L. 110–90 to the capital Federal rate.) The application of this proposed MS–DRG documentation and coding adjustment in the determination of the proposed FY 2010 capital Federal rate is shown in section III.A.5. of the Addendum of this proposed rule.

c. Proposed Documentation and Coding Adjustment to the Puerto Rico-Specific Capital Rate

Under § 412.74, Puerto Rico hospitals are currently paid based on 75 percent of the national capital Federal rate and 25 percent of the Puerto Rico-specific capital rate. In the FY 2009 IPPS final rule (73 FR 48775), consistent with our development of the FY 2009 Puerto Rico-specific operating standardized amount, we did not apply the additional −0.9 percent documentation and coding adjustment (or the cumulative −1.5 percent adjustment) to the FY 2009 Puerto Rico-specific capital rate. However, 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 this preamble, 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 is 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 this preamble, in this proposed rule, under the Secretary's broad authority under section 1886(g) of the Act, we are proposing to adjust the Puerto Rico-specific capital rate by −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 this proposed rule, we are proposing 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. 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 are proposing 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.

Similar to the analysis performed for all IPPS hospitals noted above, we also examined FY 2008 claims data from hospitals located in Puerto Rico to help inform analysis of the potential for increase in the documentation and coding effect in FY 2009. As discussed in greater detail in section II.D.10. of this preamble, based on this analysis, our actuaries estimate that the cumulative overall effect of documentation and coding changes under the MS–DRG system in FY 2009 for hospitals located in Puerto Rico will be 1.3 percent (1.1 percent plus an additional 0.2 percent). Consistent with the proposal for the operating Puerto Rico-specific standardized amounts presented in section II.D.10. of this preamble, we will address any increase 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 in the FY 2011 rulemaking cycle.

As stated in section II.D.10. of this preamble, we are seeking 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 are seeking 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.

2. Revision to the FY 2009 IME Adjustment Factor

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 Pub. L. 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 this proposed rule, we are proposing 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). The elimination of the teaching adjustment for FY 2010, as currently specified at § 412.322(d) of the regulations, will remain, consistent with section 4301(b)(2) of Public Law 111–5. 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. As noted above, in this proposed rule, we are proposing to revise the existing regulations at § 412.322 by deleting the language of paragraph (c) and labeling the paragraph ''Repealed.'' We are soliciting public comments on our proposed implementation of section 4301(b) of Public Law 111–5 concerning capital IME payments.

3. Other Proposed Changes for FY 2010

The proposed 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 proposed rule.

VII. Proposed Changes for Hospitals Excluded From the IPPS

A. Excluded Hospitals

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. 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 this FY 2010 proposed rule, we are proposing 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 proposed FY 2010 IPPS operating market basket. In compliance with section 404 of the MMA, in this proposed rule, we are proposing 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 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).

Consistent with our historical approach, we calculate the proposed IPPS operating market basket for FY 2010 using the most recent data available. However, if more recent data become available for the final rule, we will use them to calculate the IPPS operating market basket for FY 2010. For cancer and children's hospitals and RNHCIs, the proposed FY 2010 rate-of-increase percentage that is applied to FY 2009 target amounts in order to calculate the proposed FY 2010 target amounts is estimated to be 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 proposed rule for the proposed 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.

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, we are proposing 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 are proposing that the revised criteria would be effective with cost reporting periods beginning on or after October 1, 2009.

In addition, we are proposing 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. 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, we are proposing 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 proposed 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*)).

However, because the proposed new separate governance criteria would be effective for cost reporting periods beginning on or after October 1, 2009, 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, we are proposing 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 priod beginning on or after October 1, 2009, the hospital would not 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 the hospital and the new additional satellite facility also would be required to meet the other applicable requirements in § 412.22(h), consistent with our longstanding policies.)

We give the following example of how the proposed 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 proposed 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.

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 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 proposed 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 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 this proposed rule, we are proposing 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 are proposing to implement section 148(a)(2) by revising the existing regulations to reflect our interpretation of the statutory change.

We are proposing 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 in order for a CAH to be paid 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, 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 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 are proposing, 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 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 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. 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 are proposing 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 are proposing that the individual must either 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 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. (We refer readers to section VII.D. of this preamble for further discussion of CAH provider-based facilities.)

Section 148 of Public Law 110–275 applies to all services furnished on or after July 1, 2009. Accordingly, we intend to issue guidance that will instruct Medicare contractors on the implementation of this statutory provision effective July 1, 2009. We expect the instructions in the guidance will parallel the proposed changes to the regulations described above. However, we will consider all public comments received in response to this proposal and make any necessary and appropriate modifications before finalizing revisions to our regulations. We also believe it will be important to develop a modifier that could assist CMS in tracking laboratory services paid to CAHs under this provision. When a modifier is developed, we will issue guidance regarding its use.

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 was 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, we are proposing 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. The proposed change would not affect payment for the professional component as set forth under § 413.70(b)(3)(ii)(B).

D. Provider-Based Status of Facilities and Organizations: Proposed 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. Proposed Changes to the Scope of the Provider-Based Status Regulations for CAHs

(a) CAH-Based Clinical Diagnostic Laboratory Facilities

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 in previously issued rules (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 excluded a facility that furnishes only clinical diagnostic laboratory services in § 413.65(a)(1)(ii)(G) from the list in § 413.65(a)(1)(ii) 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 at 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, we are proposing 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 are proposing to revise the regulations to require facilities furnishing only clinical diagnostic laboratory tests that operate as part of a CAH to meet the applicable provider-based criteria in § 413.65 in order for the CAH to receive payments for the services furnished at those facilities at 101 percent of reasonable cost. Specifically, we are proposing 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 would specify that ''Clinical diagnostic laboratories operating as parts of CAHs must meet the applicable provider-based requirements.''

In proposing this change to the provider-based status rules, we recognize that there may be confusion between this proposal that a clinical diagnostic laboratory facility that is part of a CAH must meet provider-based rules in order to receive the higher reasonable cost-based payment and the proposal 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 proposing 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. In the proposed revision of § 413.70, we are proposing that, in order for a CAH to bill 101 percent of reasonable costs for outpatient clinical diagnostic laboratory services furnished to an individual, the individual must be an outpatient of the CAH, as defined at § 410.2, and be receiving services directly from the CAH. That is, 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 proposed changes to the provider-based status rules under § 413.65 in this section of this proposed rule, if a CAH chooses to own or operate a 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 101 percent of reasonable cost for the clinical diagnostic laboratory services furnished by the laboratory facility. According to our proposal in section VII.C.2. of this preamble, a CAH would have the option to bill for outpatient clinical diagnostic laboratory services at 101 percent of reasonable cost for patients receiving services in nonprovider-based facilities or locations as long as the patients are outpatients of the CAH as defined above and 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 proposal, a CAH can also bill for clinical diagnostic laboratory services at 101 percent of reasonable costs 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, we 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 or when they are part of a hospital. Therefore, we are proposing that these facilities, which are currently exempt from provider-based determinations, must meet the applicable provider-based status requirements at § 413.65 when they are part of a CAH in order for the CAH to receive payment for their clinical diagnostic laboratory services based on reasonable cost. It is important to note that, in addition to meeting the provider-based status requirements at § 413.65, these provider-based facilities would also have to meet other requirements for provider-based facilities operated by CAHs, including distance requirements under § 485.610(e). Generally, the regulations at § 485.610(e) also provide that an off-campus provider-based department, remote location, or distinct part psychiatric or rehabilitation unit of a CAH that was created or acquired on or after January 1, 2008, cannot be within 35 miles of a hospital or another CAH if the CAH is to continue meeting the location requirements under § 485.610(e).

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. We are soliciting 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 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.

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.'' We are proposing two basic changes to the language of § 413.65(a)(1)(ii)(H). First, we are proposing to delete the phrase ''$1,500 annual cap'' and replace it with the generic phrase ''annual financial cap amount''. We are proposing 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 are proposing 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 are proposing 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 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.

VIII. Proposed 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 119–173 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 rulemaking documents (73 FR 24871 and 73 FR 29699).

Section 4302 of the American Recovery and Reinvestment Act of 2009 (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 (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). We intend to implement the provisions of section 4302 of Public Law 111–5 in an interim final rule with comment period as part of the FY 2010 IPPS and RY 2010 LTCH PPS final rule. In addition, we intend to finalize the regulatory provisions implementing section 114 of Public Law 110–173, as appropriate, in the same final rule.

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. Proposed Medicare Severity Long-Term Care Diagnosis-Related Group (MS–LTC–DRG) Classifications and Relative Weights

1. Background

Section 123 of the BBRA requires that the Secretary implement a PPS for LTCHs (that is, a per discharge system with a diagnosis-related group (DRG)-based patient classification system reflecting the differences in patient resources and costs). Section 307(b)(1) of the BIPA modified the requirements of section 123 of the BBRA by requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the long-term care hospital (LTCH) PPS] on the use of existing (or refined) hospital DRGs that have been modified to account for different resource use of LTCH patients, as well as the use of the most recently available hospital discharge data.''

When the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, we adopted the same DRG patient classification system (that is, the CMS DRGs) that was utilized at that time under the IPPS. As a component of the LTCH PPS, we refer to this patient classification system as the ''long-term care diagnosis-related groups (LTC–DRGs).'' 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 proposed methodology to adjust the proposed 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 a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). HIPAA Transactions and Code Sets Standards regulations at 45 CFR Parts 160 and 162 require that no later than October 16, 2003, all covered entities must comply with the applicable requirements of Subparts A and I through R of Part 162. Among other requirements, those provisions direct covered entities to use the ASC X12N 837 Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, and the applicable standard medical data code sets for the institutional health care claim or equivalent encounter information transaction (45 CFR 162.1002 and 45 CFR 162.1102). For additional information on the ICD–9–CM Coding System, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47241 through 47243 and 47277 through 47281). We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983). Additional coding instructions and examples are published in the *Coding Clinic for ICD–9–CM*, a product of the American Hospital Association.

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 is being done in this proposed 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 legislation 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 proposed rule), we will assign any new diagnosis or procedure codes to the same DRG in which its predecessor code was assigned, so that there will be 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 proposed 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 Pub. L. 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 proposed 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 are not included in this proposed rule because of the short turnaround time required for the publication of the proposed rule. However, new codes and any other revisions will appear in the final rule in Tables 6A through 6F of the Addendum to that final rule. Those codes appearing for the first time in the final rule will be 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 proposed rule.

b. Proposed Changes to the MS–LTC–DRGs for RY 2010

Consistent with our historical practice of using the same patient classification system under the LTCH PPS as is used under the IPPS, in this proposed rule, we are proposing to modify and revise the MS–LTC–DRG classifications effective October 1, 2009, through September 30, 2010 (RY 2010) consistent with the proposed changes to specific MS–DRG classifications presented above in section II.G. of this proposed rule (that is, proposed GROUPER Version 27.0). Therefore, the proposed MS–LTC–DRGs for RY 2010 presented in this proposed rule are the same as the proposed MS–DRGs that would 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 proposed rule). In addition, because the proposed MS–LTC–DRGs for RY 2010 are the same as the proposed MS–DRGs for FY 2010, the other proposed changes that would affect MS–DRG (and by extension MS–LTC–DRG) assignments under the proposed Version 27.0 of the GROUPER discussed in section II.G. of the preamble of this proposed rule, including the proposed changes to the

MCE software and changes to the ICD–9–CM coding system, would also be applicable under the LTCH PPS for RY 2010.

3. Development of the Proposed 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 proposed MS–LTC–DRG relative weights in this proposed rule continues to be determined in accordance with the general methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). Under the LTCH PPS, relative weights for each MS–LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each MS–LTC–DRG that represents the resources needed by an average inpatient LTCH case in that MS–LTC–DRG. For example, cases in an MS–LTC–DRG with a relative weight of 2 will, on average, cost twice as much to treat as cases in an MS–LTC–DRG with a weight of 1.

b. Data

In this proposed rule, to calculate the proposed MS–LTC–DRG relative weights for RY 2010, we are proposing to obtain total Medicare allowable charges from FY 2008 Medicare LTCH bill data from the December 2008 update of the MedPAR file, which are the best available data at this time, and to use the proposed Version 27.0 of the GROUPER to classify LTCH cases (as discussed above). We also are proposing that if more recent data become available, we would use those data and the finalized Version 27.0 of the GROUPER in establishing the RY 2010 MS–LTC–DRG relative weights in the final rule.

Consistent with our historical methodology, we have 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 proposed RY 2010 MS–LTC–DRG relative weights in this proposed rule, we have excluded the data of the 13 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. To account for the fact that cases may not be randomly distributed across LTCHs, in this proposed rule, we are proposing to use a hospital-specific relative value (HSRV) methodology to calculate the proposed 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 proposed rule. We believe this method will remove this hospital-specific source of bias in measuring LTCH average charges. Specifically, we are reducing the impact of the variation in charges across providers on any particular proposed MS–LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the HSRV methodology, we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, average 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

In accordance with 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 proposed rule) by the average adjusted charge for all cases at the LTCH in which the case was treated. SSO cases are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the MS–LTC–DRG (§ 412.529 and § 412.503). The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

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 Proposed MS–LTC–DRG Relative Weights

For purposes of determining the proposed 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 proposed relative weight; low-volume proposed MS–LTC–DRGs (that is, proposed MS–LTC–DRGs that contain between 1 and 24 cases based on a given year's claims data) are grouped into quintiles (as described below) and assigned the proposed relative weight of the quintile. No-volume proposed MS–LTC–DRGs (that is, no cases in the given year's claims data were assigned to those proposed MS–LTC–DRGs) are crosswalked to other proposed MS–LTC–DRGs based on the clinical similarities and assigned the relative weight of the crosswalked MS–LTC–DRG (as described in greater detail below). (We provide in-depth discussions of our policy regarding weight-setting for low-volume MS–LTC–DRGs in section VIII.B.3.e. of the preamble of this proposed rule and for no-volume MS–LTC–DRGs, under Step 5 in section VIII.B.3.f. of the preamble of this proposed 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 are proposing to determine the proposed RY 2010 relative weights for the proposed MS–LTC–DRGs using the following steps: (1) If a proposed MS–LTC–DRG has at least 25 cases, it is assigned its own proposed relative weight; (2) if a proposed MS–LTC–DRG has between 1 and 24 cases, it is assigned to a quintile for which we compute a proposed relative weight for all of the proposed MS–LTC–DRGs assigned to that quintile; and (3) if a proposed MS–LTC–DRG has no cases, it is crosswalked to another proposed MS–LTC–DRG based upon clinical similarities to assign an appropriate proposed relative weight (as described below in detail in Step 5 of section VIII.B.3.f. of this preamble). Furthermore, in determining the proposed RY 2010 MS–LTC–DRG relative weights, when necessary, we are proposing to make 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 proposed relative weight methodology outlined above, the proposed MS–LTC–DRG with MCC would have a lower relative weight than one with CC, or the proposed 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 proposed methodology for making adjustments because of nonmonotonicity in determining the proposed 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 proposed rule.

e. Low-Volume MS–LTC–DRGs

In order to account for proposed MS–LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), consistent with 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 proposed RY 2010 MS–LTC–DRG relative weights in this proposed 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 are proposing to continue to employ this quintile methodology for low-volume proposed MS–LTC–DRGs. In addition, in cases where the initial assignment of a low-volume proposed MS–LTC–DRG to quintiles results in nonmonotonicity within a base-DRG, in order to ensure appropriate Medicare payments, consistent with our historical methodology, we are proposing to make adjustments to the treatment of low-volume proposed MS–LTC–DRGs to preserve monotonicity, as discussed in detail below in section VIII.B.3.f. (Step 6) in this preamble.

In this proposed rule, using LTCH cases from the December 2008 update of the FY 2008 MedPAR file, we identified 282 MS–LTC–DRGs that contained between 1 and 24 cases. This list of proposed MS–LTC–DRGs was then

divided into one of the 5 low-volume quintiles, each containing a minimum of 56 proposed MS–LTC–DRGs (282/5 = 56 with 2 proposed MS–LTC–DRGs as the remainder). We are proposing to assign a low-volume proposed MS–LTC–DRG to a specific low-volume quintile by sorting the low-volume proposed MS–LTC–DRGs in ascending order by average charge in accordance with our established methodology. Furthermore, because the number of proposed MS–LTC–DRGs with less than 25 cases is not evenly divisible by 5, the average charge of the low-volume quintile was used to determine which of the low-volume quintiles contain the 2 additional low-volume proposed MS–LTC–DRGs. Specifically, after sorting the 282 low-volume proposed MS–LTC–DRGs by ascending order by average charge, we are proposing to assign the first fifth (1st through 56th) of low-volume proposed MS–LTC–DRGs (with the lowest average charge) into Quintile 1. The proposed MS–LTC–DRGs with the highest average charge cases would be assigned into Quintile 5. Because the average charge of the 57th low-volume proposed MS–LTC–DRG in the sorted list is closer to the average charge of the 56th low-volume proposed MS–LTC–DRG (assigned to Quintile 1) than to the average charge of the 58th low-volume proposed MS–LTC–DRG (assigned to Quintile 2), we are proposing to place it into Quintile 1 (such that Quintile 1 would contain 57 low-volume proposed MS–LTC–DRGs before any adjustments for nonmonotonicity, as discussed below). This process was repeated through the remaining low-volume proposed MS–LTC–DRGs so that 2 of the 5 low-volume quintiles contain 57 MS–LTC–DRGs (Quintiles 1 and 2) and 3 of the 5 low-volume quintiles contain 56 MS–LTC–DRGs (Quintiles 3, 4, and 5).

Accordingly, in order to determine the proposed RY 2010 relative weights for the proposed MS–LTC–DRGs with low volume, we are proposing to use 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 proposed RY 2010 MS–LTC–DRG relative weights (as shown in Table 11 of the Addendum to this proposed rule). We determined a proposed relative weight and (geometric) average length of stay for each of the 5 low-volume quintiles using the methodology that we applied to the proposed MS–LTC–DRGs (25 or more cases), as described in section VIII.B.3.f. of the preamble of this proposed rule. We are proposing to assign the same proposed relative weight and average length of stay to each of the low-volume proposed MS–LTC–DRGs that make up an individual low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of MS–LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume MS–LTC–DRGs and to calculate the proposed relative weights based on our methodology.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR RY 2010

MS–LTC–DRG (Version 27.0)	MS–LTC–DRG Description (Version 27.0)
Proposed Quintile 1	
026	Craniotomy & endovascular intracranial procedures w CC.
053	Spinal disorders & injuries w/o CC/MCC.
060	Multiple sclerosis & cerebellar ataxia w/o CC/MCC.
066	Intracranial hemorrhage or cerebral infarction w/o CC/MCC.
068	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC.
069	Transient ischemia.
072	Nonspecific cerebrovascular disorders w/o CC/MCC.
078	Hypertensive encephalopathy w CC.
081	Nontraumatic stupor & coma w/o MCC.
089	Concussion w CC.
090	Concussion w/o CC/MCC.
093	Other disorders of nervous system w/o CC/MCC.
103	Headaches w/o MCC.
115	Extraocular procedures except orbit.
139	Salivary gland procedures.
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.
358	Other digestive system O.R. procedures w/o CC/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.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR RY 2010—Continued

MS–LTC–DRG (Version 27.0)	MS–LTC–DRG Description (Version 27.0)
667	Prostatectomy w/o CC/MCC.
694	Urinary stones w/ot 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*.
803	Other O.R. proc of the blood & blood forming organs w CC.
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w 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.
Proposed 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.
183	Major chest trauma w MCC.
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC.
259	Cardiac pacemaker device replacement w/o 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.
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.
535	Fractures of hip & pelvis w MCC.
553	Bone diseases & arthropathies w MCC.
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC***.
598	Malignant breast disorders w CC.
600	Non-malignant breast disorders w CC/MCC.
644	Endocrine disorders w CC.
645	Endocrine disorders w/o CC/MCC.
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.
746	Vagina, cervix & vulva procedures w CC/MCC**.
747	Vagina, cervix & vulva procedures w/o CC/MCC.
755	Malignancy, female reproductive system w CC.
759	Infections, female reproductive system w/o CC/MCC.
802	Other O.R. proc of the blood & blood forming organs w MCC.
808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC***.
815	Reticuloendothelial & immunity disorders w CC.
816	Reticuloendothelial & immunity disorders w/o CC/MCC.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR RY 2010—Continued

MS–LTC–DRG (Version 27.0)	MS–LTC–DRG Description (Version 27.0)
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*.
976	HIV w major related condition w/o CC/MCC.
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC.
Proposed Quintile 3	
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.
182	Respiratory neoplasms w/o CC/MCC***.
188	Pleural effusion w/o CC/MCC***.
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.
487	Knee procedures w pdx of infection 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.
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC.
555	Signs & symptoms of musculoskeletal system & conn tissue 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.
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.
749	Other female reproductive system O.R. procedures w CC/MCC.
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.
844	Other myeloprolif dis or poorly diff neopl diag w CC**.
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.
941	O.R. proc w diagnoses of other contact w health services w/o CC/MCC.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR RY 2010—Continued

MS–LTC–DRG (Version 27.0)	MS–LTC–DRG Description (Version 27.0)
Proposed Quintile 4	
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.
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**.
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.
577	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC.
584	Breast biopsy, local excision & other breast procedures w CC/MCC.
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC***.
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.
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC**.
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC**.
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.
922	Other injury, poisoning & toxic effect diag w MCC**.
923	Other injury, poisoning & toxic effect diag w/o 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.
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft.
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.
Proposed Quintile 5	
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***.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR RY 2010—Continued

MS–LTC–DRG (Version 27.0)	MS–LTC–DRG Description (Version 27.0)
164	Major chest procedures w CC.
168	Other resp system O.R. procedures w/o CC/MCC.
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.
330	Major small & large bowel procedures w CC.
335	Peritoneal adhesiolysis w MCC.
336	Peritoneal adhesiolysis w CC.
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.
642	Inborn errors of metabolism.
659	Kidney & ureter procedures for non-neoplasm w MCC.
662	Minor bladder procedures w MCC.
709	Penis procedures 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.
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.
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 282 low-volume proposed MS–LTC–DRGs initially assigned to this low-volume quintile; removed from this low-volume quintile in addressing nonmonotonicity (refer to step 6 in section VIII.B.3.f.of the preamble of this proposed rule).

** One of the original 282 low-volume proposed 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 proposed rule).

*** One of the original 282 low-volume proposed 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 proposed 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 proposed MS–LTC–DRG relative weights result in appropriate payment for such cases and do not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

f. Steps for Determining the Proposed RY 2010 MS–LTC–DRG Relative Weights

In general, we are proposing to determine 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 proposed methodology for determining the proposed RY 2010 MS–LTC–DRG relative weights presented below.)

In summary, for RY 2010, we are proposing to group LTCH cases to the appropriate proposed MS–LTC–DRG, while taking into account the low-volume proposed MS–LTC–DRGs (as described above), in order to determine the proposed RY 2010 MS–LTC–DRG relative weights. After grouping the cases to the appropriate MS–LTC–DRG (or low-volume quintile), we calculate the proposed 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 adjust the number of cases in each proposed 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 proposed MS–LTC–DRG (or low-volume quintile) using the HSRV method (described above).

Below we discuss in detail the steps for calculating the proposed RY 2010 MS–LTC–DRG relative weights. We note that, as we stated above in section VIII.B.3.b. of the preamble of this proposed rule, we have 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 proposed RY 2010 MS–LTC–DRG relative weights is to remove statistical outlier cases. Consistent with our historical relative weight methodology, we are proposing to continue to define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each MS–LTC–DRG. These statistical outliers are removed prior to calculating the proposed relative weights because we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the proposed relative weights could result in an inaccurate proposed 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 proposed RY 2010 MS–LTC–DRG relative weights, the value of many proposed relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate. We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH by including data from these very short-stays. Therefore, consistent with our historical relative weight methodology, in determining the proposed RY 2010 MS–LTC–DRG relative weights, we are proposing to remove 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 proposed RY 2010 MS–LTC–DRG relative weights, consistent with our historical relative weight methodology, we are proposing to adjust each LTCH's charges per discharge for those remaining cases for the effects of SSOs (as defined in § 412.529(a) in conjunction with § 412.503).

We make this adjustment by counting an SSO case as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the MS–LTC–DRG for non-SSO cases. This has the effect of proportionately reducing the impact of the lower charges for the SSO cases in calculating the average charge for the MS–LTC–DRG. This process produces the same result as if the actual charges per discharge of an SSO case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the MS–LTC–DRG.

Counting SSO cases as full discharges with no adjustment in determining the proposed RY 2010 MS–LTC–DRG relative weights would lower the proposed 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 are proposing to adjust for SSO cases under § 412.529 in this manner because it results in more appropriate payments for all LTCH cases.

Step 4—Calculate the proposed RY 2010 MS–LTC–DRG relative weights on an iterative basis.

Consistent with our historical relative weight methodology, we are proposing to calculate the proposed 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 proposed MS–LTC–DRG, the proposed RY 2010 relative weight was calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the proposed MS–LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated proposed MS–LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (that is, its case-mix) is calculated by dividing the sum of all the LTCH's proposed MS–LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above is multiplied by these hospital-specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values are then used to calculate a new set of proposed MS–LTC–DRG relative weights across all LTCHs. This iterative process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5—Determine a proposed RY 2010 relative weight for MS–LTC–DRGs with no LTCH cases.

As we stated above, we are proposing to determine the proposed RY 2010 relative weight for each proposed MS–LTC–DRG using total Medicare allowable charges reported in the best available LTCH claims data (that is, the December 2008 update of the FY 2008 MedPAR file for this proposed rule). Of the proposed RY 2010 MS–LTC–DRGs, we identified a number of proposed 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 proposed rule, no patients who would have been classified to those proposed MS–LTC–DRGs were treated in LTCHs during FY 2008 and, therefore, no charge data were available for these proposed MS–LTC–DRGs. Thus, in the process of determining the proposed MS–LTC–DRG relative weights, we were unable to calculate proposed relative weights for the proposed MS–LTC–DRGs with no LTCH cases using the methodology described in Steps 1 through 4 above. However, because patients with a number of the diagnoses under these proposed MS–LTC–DRGs may be treated at LTCHs, consistent with our historical methodology, we are proposing to assign a proposed relative weight to each of the no-volume proposed MS–LTC–DRGs based on clinical similarity and relative costliness (with the exception of ''transplant'' proposed MS–LTC–DRGs and ''error'' proposed MS–LTC–DRGs, as discussed below). In general, we determine proposed RY 2010 relative weights for the proposed MS–LTC–DRGs with no LTCH cases in the FY 2008 MedPAR file used in this proposed rule (that is, ''no-volume'' proposed MS–LTC–DRGs) by crosswalking each no-volume proposed MS–LTC–DRG to another proposed MS–LTC–DRG with a calculated proposed relative weight (determined in accordance with the methodology described above). Then, the ''no-volume'' MS–LTC–DRG is assigned the same proposed relative weight of the MS–LTC–DRG to which it was crosswalked (as described in greater detail below).

Specifically, in this proposed rule, as stated above, we are proposing to determine the proposed relative weight for each proposed MS–LTC–DRG using total Medicare allowable charges reported in the December 2008 update of the FY 2008 MedPAR file. Of the 746 proposed MS–LTC–DRGs for RY 2010, we identified 216 proposed MS–LTC–DRGs for which there were no LTCH cases in the database (including the 8 ''transplant'' proposed MS–LTC–DRGs and 2 ''error'' proposed MS–LTC–DRGs). As stated above, we are proposing to assign proposed relative weights for each of the 216 no-volume proposed MS–LTC–DRGs (with the exception of the 8 ''transplant'' proposed MS–LTC–DRGs and the 2 ''error'' proposed MS–LTC–DRGs, which are discussed below) based on clinical similarity and relative costliness to one of the remaining 530 (746 − 216=530) proposed MS–LTC–DRGs for which we were able to determine proposed 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 530 proposed MS–LTC–DRGs for which we were able to determine a proposed relative weight as the ''crosswalked'' proposed MS–LTC–DRG.) Then, we are proposing to assign the no-volume proposed MS–LTC–DRG the proposed relative weight of the crosswalked proposed MS–LTC–DRG. (As explained below in Step 6, when necessary, we made adjustments to account for nonmonotonicity.)

In this proposed rule, we are proposing to use the following methodology for determining the proposed RY 2010 relative weights for the no-volume proposed MS–LTC–DRGs: We crosswalk the no-volume proposed MS–LTC–DRG to an proposed MS–LTC–DRG for which there are LTCH cases in the FY 2008 MedPAR file and to which it is similar clinically in intensity of use of resources and relative costliness as determined by criteria such as care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. As we explained in the FY 2009 IPPS final rule (73 FR 48543), we evaluate the relative costliness in determining the applicable proposed MS–LTC–DRG to which a no-volume proposed MS–LTC–DRG was crosswalked in order to assign an appropriate proposed relative weight for the no-volume proposed MS–LTC–DRGs in RY 2010. In general, most of the no-volume proposed 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 proposed 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 proposed MS–LTC–DRGs. Specifically, the relative costliness of each of the no-volume proposed 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 proposed 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 proposed MS–LTC–DRGs in RY 2010, the proposed relative weights assigned based on the crosswalked proposed MS–LTC–DRGs would result in an appropriate LTCH PPS payment because the proposed crosswalks, which are based on similar clinical similarity and relative costliness, generally require equivalent relative resource use. We then assign the proposed relative weight of the crosswalked proposed MS–LTC–DRG as the proposed relative weight for the no-volume proposed MS–LTC–DRG such that both of these proposed MS–LTC–DRGs (that is, the no-volume proposed MS–LTC–DRG and the crosswalked proposed MS–LTC–DRG) would have the same proposed relative weight for RY 2010. We note that if the crosswalked proposed MS–LTC–DRG has 25 cases or more, its proposed relative weight, which is calculated using the methodology described in steps 1 through 4 above, is assigned to the no-volume proposed MS–LTC–DRG as well. Similarly, if the MS–LTC–DRG to which the no-volume proposed MS–LTC–DRG is crosswalked has 24 or less cases and, therefore, is designated to one of the low-volume quintiles for purposes of determining the proposed relative weights, we assign the proposed relative weight of the applicable low-volume quintile to the no-volume proposed MS–LTC–DRG such that both of these proposed MS–LTC–DRGs (that is, the no-volume proposed MS–LTC–DRG and the crosswalked proposed MS–LTC–DRG) have the same proposed relative weight for RY 2010. (As we noted above, in the infrequent case where nonmonotonicity involving a no-volume proposed MS–LTC–DRG results, additional measures as described in Step 6 are required in order to maintain monotonically increasing proposed relative weights.)

For this proposed rule, a list of the no-volume MS–LTC–DRGs and the proposed MS–LTC–DRG to which it is crosswalked (that is, the crosswalked MS–LTC–DRG) for RY 2010 is shown in the chart below.

PROPOSED NO-VOLUME MS–LTC–DRG CROSSWALK FOR RY 2010

MS–LTC–DRG (V27.0)	MS–LTC–DRG description (version 27)	Proposed 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	358
332	Rectal resection w MCC	356

PROPOSED NO-VOLUME MS–LTC–DRG CROSSWALK FOR RY 2010—Continued

MS–LTC–DRG (V27.0)	MS–LTC–DRG description (version 27)	Proposed crosswalked MS–LTC–DRG
333	Rectal resection w CC	357
334	Rectal resection w/o CC/MCC	358
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
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 for neoplasm 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

PROPOSED NO-VOLUME MS–LTC–DRG CROSSWALK FOR RY 2010—Continued

MS–LTC–DRG (V27.0)	MS–LTC–DRG description (version 27)	Proposed 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
713	Transurethral prostatectomy w CC/MCC	669
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
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 proposed relative weights for the proposed RY 2010 MS–LTC–DRGs with no LTCH cases, we are providing the following example, which refers to the no-volume proposed MS–LTC–DRGs crosswalk information for RY 2010 provided in the chart above.

Example: There were no cases in the FY 2008 MedPAR file used for this proposed rule for proposed MS–LTC–DRG 61 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC). We determined that proposed MS–LTC–DRG 70 (Nonspecific Cebrovascular Disorders with MCC) was similar clinically and based on resource use to MS–LTC–DRG 61. Therefore, we assigned the same proposed relative weight of proposed MS–LTC–DRG 70 of 0.8612 for RY 2010 to proposed MS–LTC–DRG 61 (we refer readers to Table 11 of the Addendum to this proposed rule).

Furthermore, for RY 2010, consistent with our historical relative weight methodology, we are proposing to establish proposed MS–LTC–DRG relative weights of 0.0000 for the following transplant proposed MS–LTC–DRGs: Heart Transplant or Implant of Heart Assist System with MCC (proposed MS–LTC–DRG 1); Heart Transplant or Implant of Heart Assist System without MCC (proposed MS–LTC–DRG 2); Liver Transplant with MCC or Intestinal Transplant (proposed MS–LTC–DRG 5); Liver Transplant without MCC (proposed MS–LTC–DRG 6); Lung Transplant (proposed MS–LTC–DRG 7); Simultaneous Pancreas/Kidney Transplant (proposed MS–LTC–DRG 8); Pancreas Transplant (proposed MS–LTC–DRG 10); and Kidney Transplant (proposed MS–LTC–DRG 652). This is because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. 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 proposed relative weights in this proposed rule.

Step 6—Adjust the proposed 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 are proposing to combine proposed MS–LTC–DRG severity levels within a base MS–LTC–DRG for the purpose of computing a relative weight when necessary to ensure that monotonicity is maintained. Specifically, in determining the proposed RY 2010 MS–LTC–DRG relative weights in this proposed rule, we are proposing to use 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 proposed RY 2010 MS–LTC–DRG relative weights in this proposed rule, under each of the example scenarios provided below, we combine severity levels within a proposed base MS–LTC–DRG as follows:

The first example of nonmonotonically increasing relative weights for a proposed MS–LTC–DRG pertains to a proposed 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 proposed MS–LTC–DRGs is assigned to one of the five low-volume quintiles. In this proposed rule, if nonmonotonicity is detected in the proposed relative weights of the proposed MS–LTC–DRGs in adjacent severity levels (for example, the proposed relative weight of the ''with MCC'' (the highest severity level) is less than the ''with CC'' (the middle level), or the proposed relative weight ''with CC'' is less than the ''without CC/MCC'' (lowest severity level)), we combine the nonmonotonic adjacent proposed MS–LTC–DRGs and redetermine a proposed relative weight based on the case-weighted average of the combined LTCH cases of the nonmonotonic proposed MS–LTC–DRGs. The case-weighted average charge is calculated by dividing the total charges for all LTCH cases in both

severity levels by the total number of LTCH cases for both proposed MS–LTC–DRGs. The same proposed relative weight is assigned to both affected levels of the proposed base MS–LTC–DRG. If nonmonotonicity remains an issue because the above process results in a proposed relative weight that is still nonmonotonic to the proposed relative weight of the remaining proposed MS–LTC–DRG within the proposed base MS–LTC–DRG, we combine all three of the severity levels to redetermine the proposed relative weights based on the case-weighted average charge of the combined severity levels. This same proposed relative weight is then assigned to each of the proposed MS–LTC–DRGs in that proposed base MS–LTC–DRG.

A second example of nonmonotonically increasing relative weights for a proposed base MS–LTC–DRG pertains to the situation where there are three severity levels and one or more of the severity levels within a proposed base MS–LTC–DRG has less than 25 LTCH cases (that is, low volume). If nonmonotonicity occurs in the case where either the highest or lowest severity level (''with MCC'' or ''without CC/MCC'') has 25 LTCH cases or more and the other two severity levels are low volume (and, therefore, the other two severity levels are otherwise assigned the proposed relative weight of the applicable low-volume quintile(s)), we combine the data for the cases in the two adjacent low-volume proposed MS–LTC–DRGs for the purpose of determining a proposed relative weight. If the combination results in at least 25 cases, we redetermine one proposed relative weight based on the case-weighted average charge of the combined severity levels and assign this same proposed relative weight to each of the severity levels. If the combination results in less than 25 cases, based on the case-weighted average charge of the combined low-volume proposed MS–LTC–DRGs, both proposed MS–LTC–DRGs are 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 proposed MS–LTC–DRGs. Then the proposed relative weight of the affected low-volume quintile is redetermined and that proposed relative weight is assigned to each of the affected severity levels (and all of the proposed MS–LTC–DRGs in the affected low-volume quintile). If nonmonotonicity persists, we combine all three severity levels and redetermine one proposed relative weight based on the case-weighted average charge of the combined severity levels and this same proposed relative weight is assigned to each of the three levels within that proposed base MS–LTC–DRG.

Similarly, in nonmonotonic cases where the middle level has 25 cases or more but either or both of the lowest or highest severity level has less than 25 cases (that is, low volume), we combine the nonmonotonic low-volume proposed MS–LTC–DRG with the middle severity-level proposed MS–LTC–DRG (the ''with CC'') of the proposed base MS–LTC–DRG. We redetermine one proposed relative weight based on the case-weighted average charge of the combined severity levels, and assign this same proposed relative weight to each of the affected proposed MS–LTC–DRGs. If nonmonotonicity persists, we combine all three levels for the purpose of redetermining a proposed relative weight based on the case-weighted average charge of the combined severity levels, and assign that proposed relative weight to each of the three severity levels within the proposed base MS–LTC–DRG.

In the case where all three severity levels in the proposed base-MS–LTC–DRGs are low-volume proposed MS–LTC–DRGs and two of the severity levels are nonmonotonic in relation to each other, we combine the two adjacent nonmonotonic severity levels. If that combination resulted in less than 25 cases, both low-volume proposed MS–LTC–DRGs are 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 proposed MS–LTC–DRGs. Then the proposed relative weight of the affected low-volume quintile is redetermined, and that proposed relative weight is assigned to each of the affected severity levels (and all of the proposed MS–LTC–DRGs in the affected low-volume quintile). If the nonmonotonicity persists, we combine all three levels of that proposed base MS–LTC–DRG for the purpose of redetermining a proposed relative weight based on the case-weighted average charge of the combined severity levels, and assign that proposed relative weight to each of the three severity levels. If that combination of all three severity levels results in less than 25 cases, we assign that ''combined'' base MS–LTC–DRG to the appropriate low-volume quintile based on the case-weighted average charge of the combined low-volume proposed MS–LTC–DRGs. Then the proposed relative weight of the affected low-volume quintile is redetermined, and that proposed relative weight is 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 redetermine one proposed relative weight based on the case-weighted average charge of the combined severity levels, and assign this same proposed relative weight to all three of the severity levels within the proposed base MS–LTC–DRG.

Similarly, in the case where all three severity levels in the proposed base MS–LTC–DRGs are low-volume proposed MS–LTC–DRGs and two of the severity levels were nonmonotonic in relation to each other, we combine the two adjacent nonmonotonic severity levels. If the combination resulted in at least 25 cases, we then redetermine one proposed relative weight based on the case-weighted average charge of the combined severity levels, and assign this same proposed relative weight to both of the affected adjacent severity levels within the proposed base MS–LTC–DRG. If the nonmonotonicity persists, we combine all three levels of that proposed base MS–LTC–DRG for the purpose of redetermining a proposed relative weight based on the case-weighted average charge of the combined severity levels, and assign that proposed relative weight to each of the three severity levels within the proposed base MS–LTC–DRG.

Another example of nonmonotonicity involves a proposed base MS–LTC–DRG with three severity levels where at least one of the severity levels has no LTCH cases. As discussed above in Step 5, we are proposing to crosswalk a proposed no-volume MS–LTC–DRG to a proposed MS–LTC–DRG that has at least one case based on resource use intensity and clinical similarity. The no-volume proposed MS–LTC–DRG is assigned the same proposed relative weight as the proposed MS–LTC–DRG to which it is crosswalked. For many no-volume proposed MS–LTC–DRGs, as shown in the chart above in Step 5, the application of our methodology results in a crosswalked proposed MS–LTC–DRG that is the adjacent severity level in the same proposed base MS–LTC–DRG. Consequently, in most instances, the no-volume proposed MS–LTC–DRG and the adjacent proposed MS–LTC–DRG to which it is crosswalked do not result in nonmonotonicity because both of these severity levels would have the same proposed relative weight. (In this proposed rule, under our methodology for the treatment of no-volume proposed

MS–LTC–DRGs, in the case where the no-volume proposed MS–LTC–DRG was either the highest or lowest severity level, the crosswalked proposed MS–LTC–DRG is typically the middle level (''with CC'') within the same proposed base MS–LTC–DRG, and, therefore, the no-volume proposed MS–LTC–DRG (either the ''with MCC'' or the ''without CC/MCC'') and the crosswalked proposed MS–LTC–DRG (the ''with CC'') have the same proposed relative weight. Consequently, no adjustment for monotonicity is necessary.) However, if our methodology for determining proposed relative weights for no-volume proposed MS–LTC–DRGs results in nonmonotonicity with the third severity level in the base MS–LTC–DRG, all three severity levels are combined in order to redetermine one proposed relative weight based on the case-weighted average charge of the combined severity levels. This same proposed relative weight is 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 proposed base MS–LTC–DRG that has three severity levels. Under our methodology for the treatment of nonmonotonicity, we are proposing to apply the same process where the proposed base MS–LTC–DRG contains only two severity levels. For example, if nonmonotonicity occurs in a proposed base MS–LTC–DRG with two severity levels (that is, the relative weight of the higher severity level is less than the lower severity level), where both of the MS–LTC–DRGs have at least 25 cases or where one or both of the MS–LTC–DRGs are low volume (that is, less than 25 cases), we combine the two proposed MS–LTC–DRGs of that proposed base MS–LTC–DRG for the purpose of redetermining a proposed relative weight based on the combined case-weighted average charge for both severity levels. This same proposed relative weight is assigned to each of the two severity levels in the proposed base MS–LTC–DRG. Specifically, if the combination of the two severity levels results in at least 25 cases, we redetermine one proposed relative weight based on the case-weighted average charge, and assign that proposed relative weight to each of the two proposed MS–LTC–DRGs. If the combination results in less than 25 cases, we assign both proposed 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 proposed relative weight of the affected low-volume quintile is redetermined, and that proposed relative weight is assigned to each of the two severity levels within the proposed base MS–LTC–DRG (and all of the proposed 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 are proposing to update the proposed MS–LTC–DRG classifications and relative weights for RY 2010 based on the most recent available LTCH data, and to include a budget neutrality adjustment that is applied in determining the proposed RY 2010 MS–LTC–DRG relative weights.

To ensure budget neutrality in the proposed update to the MS–LTC–DRG classifications and relative weights under § 412.517(b), 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 proposed rule, we are proposing to use a method that is similar to the methodology used under the IPPS. Specifically, for RY 2010, after recalibrating the proposed MS–LTC–DRG proposed relative weights as we do under the methodology as described in detail in Steps 1 through 6 above, we are proposing to calculate and apply a normalization factor to those proposed relative weights to ensure that estimated payments are not influenced by changes in the composition of case types or the changes to the classification system. That is, the normalization adjustment is intended to ensure that the recalibration of the proposed MS–LTC–DRG relative weights (that is, the process itself) neither increases nor decreases total estimated payments.

To calculate the normalization factor for RY 2010, we are proposing to use the following steps: (1) We use the most recent available LTCH claims data (FY 2008) and group them using the proposed RY 2010 GROUPER (Version 27.0) and the proposed RY 2010 MS–LTC–DRG relative weights (determined above in Steps 1 through 6 above) to calculate the average case-mix index (CMI); (2) we group the same LTCH claims data (FY 2008) using the FY 2009 GROUPER (Version 26.0) and FY 2009 relative weights (established in the FY 2009 IPPS final rule (73 FR 48528 through 48551)) and calculate the average CMI; and (3) we compute 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 proposed MS–LTC–DRG relative weights for RY 2010, based on the latest available LTCH claims data, the normalization factor is estimated as 1.1147455, which is applied in determining each proposed RY 2010 MS–LTC–DRG relative weight. That is, each proposed MS–LTC–DRG relative weight is multiplied by 1.1147455 in the first step of the budget neutrality process. Accordingly, the proposed RY 2010 MS–LTC–DRG relative weights in Table 11 in the Addendum of this proposed rule reflect this normalization factor. We also ensure that estimated aggregate LTCH PPS payments (based on the most recent available LTCH claims data) after reclassification and recalibration (the proposed 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 existing RY 2009 MS–LTC–DRG classifications and relative weights).

Therefore, similar to the methodology used to determine the proposed IPPS DRG reclassification and recalibration budget neutrality factor discussed in section II.A.4.a. of the Addendum to this proposed rule, we used FY 2008 discharge data to simulate payments and compare estimated aggregate LTCH PPS payments using the FY 2009 MS–LTC–DRGs and relative weights to estimate aggregate LTCH PPS payments using the proposed RY 2010 MS–LTC–DRGs and relative weights. As noted above, the most recent available LTCH claims data for this proposed rule are from the December 2008 update of the FY 2008 MedPAR file. Consistent with our historical policy of using the best available data, we are proposing to use the most recently available claims data for determining the budget neutrality adjustment factor in the final rule.

Specifically, we determined the proposed RY 2010 budget neutrality adjustment factor in this proposed rule using the following steps: (1) We simulate estimated total LTCH PPS payments using the normalized proposed relative weights for RY 2010 and proposed GROUPER Version 27.0 (as described above in this section); (2) we simulate estimated total LTCH PPS payments using the FY 2009 GROUPER (Version 26.0) and FY 2009 MS–LTC–DRG relative weights (as established in the FY 2009 IPPS final rule (73 FR 48528 through 48551)); and (3) we calculate 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 FY 2009 MS–LTC–DRG relative weights (determined in Step 2) by the estimated total LTCH PPS payments using the proposed RY 2010 GROUPER (Version 27.0) and the normalized proposed MS–LTC–DRG relative weights for RY 2010 (determined in Step 1). Then, each of the normalized proposed relative weights is multiplied by the budget neutrality adjustment factor to determine the proposed budget neutral RY 2010 relative weight for each proposed MS–LTC–DRG.

Accordingly, in determining the proposed RY 2010 MS–LTC–DRG relative weights in this proposed rule, based on the most recent available LTCH claims data, we are proposing to establish a budget neutrality adjustment factor of 0.993192, which is applied to the normalized proposed relative weights (described above). The proposed RY 2010 MS–LTC–DRG relative weights in Table 11 in the Addendum to this proposed rule reflect this proposed budget neutrality factor.

Table 11 in the Addendum to this proposed rule lists the proposed MS–LTC–DRGs and their respective proposed relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used in determining SSO payments under § 412.529) for RY 2010.

C. Proposed 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 with that cost reporting period, LTCHs are 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 would be used to update the LTCH PPS standard Federal rate for the 2010 LTCH PPS rate year that would be effective for LTCH discharges occurring on or after October 1, 2009 through September 30, 2010. When we implemented the LTCH PPS in the August 30, 2002 LTCH PPS final rule (67 FR 56029 through 56031), we computed the LTCH PPS standard Federal payment rate for FY 2003 by updating the latest available (FY 1998 or FY 1999) Medicare inpatient operating and capital cost data, using the excluded hospital market basket.

Section 123(a)(1) of the BBRA requires that the PPS developed for LTCHs be budget neutral for the initial year of implementation. Therefore, in calculating the standard Federal rate under § 412.523(d)(2), we set total estimated LTCH PPS payments equal to estimated payments that would have been made under the reasonable cost-based payment methodology had the LTCH PPS not been implemented. Section 307(a)(2) of the BIPA specified that the increases to the target amounts and the cap on the target amounts for LTCHs for FY 2002 provided for by section 307(a)(1) of the BIPA shall not be considered in the development and implementation of the LTCH PPS. Section 307(a)(2) of the BIPA also specified that enhanced bonus payments for LTCHs provided for by section 122 of BBRA were not to be taken into account in the development and implementation of the LTCH PPS.

Furthermore, as specified at § 412.523(d)(1), the initial standard Federal rate was reduced by an adjustment factor to account for the estimated proportion of outlier payments under the LTCH PPS to total estimated LTCH PPS payments (8 percent). 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 proposed update to the LTCH PPS standard Federal rate for RY 2010 is presented in section V.A. of the Addendum to this proposed rule. Two of the components of the proposed 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. Proposed 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, in this proposed rule, we are proposing to continue to use the FY 2002-based RPL market basket under the LTCH PPS for RY 2010, as 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.

c. Proposed 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, the proposed RY 2010 market basket estimate for the LTCH PPS using the FY 2002-based RPL market basket is 2.4 percent. This includes increases in both the operating section and the capital section of the FY 2002-based RPL market basket. In addition, consistent with our historical practice of using market basket estimates based on the most recent available data, we are proposing that if more recent data are available when we develop the final rule, we would use such data, if appropriate. (As discussed in greater detail in section V. of the Addendum to this proposed rule, for RY 2010, we are proposing to update the LTCH PPS standard Federal rate by −0.2 percent. The proposed update reflects an adjustment based on the most recent market basket estimate (currently 2.4 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. Proposed Labor-Related Share Under the LTCH PPS for RY 2010

As discussed in section V.B. of the Addendum to this proposed rule, under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS 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 are proposing to continue to use the FY 2002-based RPL market basket under the LTCH PPS for RY 2010. Given this, we are proposing to continue to define the labor-related share as the national average proportion of operating costs that are attributable to wages and salaries, employee benefits, contract labor, professional fees, labor-intensive services, and a labor-related portion of capital based on the FY 2002-based RPL market basket. (Additional information on the development of the FY 2002-based RPL market basket used under the LTCH PPS can be found in the RY 2007 LTCH PPS final rule (71 FR 27809 through 27818).)

The proposed labor-related share for RY 2010 would be the sum of the proposed RY 2010 relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2002) and RY 2010. The sum of the proposed relative importance for RY 2010 for operating costs (wages and salaries, employee

benefits, professional fees, and all-other labor-intensive services) would be 71.961 as shown in the chart below. The portion of capital that is influenced by the local labor market is estimated to be 46 percent. Because the relative importance for capital in RY 2010 would be 8.572 percent of the FY 2002-based RPL market basket, we are proposing to take 46 percent of 8.572 percent to determine the proposed labor-related share of capital for RY 2010. The result would be 3.943 percent, which we are proposing to add to 71.961 percent for the operating cost amount to determine the total proposed labor-related share for RY 2010. Thus, the labor-related share that we are proposing to use for LTCH PPS in RY 2010 would be 75.904 percent.

The chart below shows the proposed RY 2010 relative importance labor-related share using the FY 2002-based RPL market basket.

PROPOSED 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	53.064
Employee Benefits	13.880
Professional Fees	2.894
All Other Labor-Intensive Services	2.123
Subtotal	71.961
Labor-Related Share of Capital Costs (46 percent)	3.943
Total Labor-Related Share	75.904

3. Proposed Adjustment for Changes in LTCHs' Case-Mix Due to Changes in Documentation and Coding Practices That Occurred in a Prior Period

a. Background

Beginning in RY 2007, in updating the standard Federal rate for the LTCH PPS, we have accounted for increases in payments from a past period 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 the 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 the 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, we are proposing to analyze LTCHs' case-mix index (CMI) changes in the prior period, FY 2007, and if applicable, determine 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), a 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 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 are proposing to revise our methodology to determine the proposed documentation and coding adjustment, consistent with the IPPS proposed methodology for case-mix analysis under the IPPS, which is discussed in detail in section II.D.4 of the preamble of this proposed rule. We note that section II.D.4 of the preamble of this proposed rule discusses the proposed 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 proposed 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 propose to use the same methodology that we are proposing to use under the IPPS as described in section II.D.4. of the preamble of this proposed rule and which is discussed in further detail below in this section.

Accordingly, consistent with the proposed 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, we performed the proposed analysis plan 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 results in a value of 0.974. Because these are the same FY 2007 LTCH cases grouped using the two GROUPERs, we attribute 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 results 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.

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. We are seeking public comment on our proposed methodology and analysis.

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. 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, we believe it is also appropriate at this time to evaluate documentation and coding changes in FY 2008 based on the most recent available LTCH claims data. Accordingly, analogous to our evaluation of the FY 2007 LTCH claims data as discussed above, 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 results 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 results 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, 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. We are seeking public comment on our proposed methodology and analysis.

d. Proposed RY 2010 Documentation and Coding Adjustment

Based on analysis of the most recent available LTCH claims data as described above, we are proposing to apply a cumulative adjustment for changes in documentation and coding 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 equals −1.8 percent). Accordingly, as discussed in section V.A.2. of the Addendum to this proposed rule, we are proposing to update the proposed RY 2010 LTCH PPS standard Federal rate by 0.6 percent, which is based on the most recent estimate of the market basket increase (2.4 percent) and a proposed adjustment to account for changes in documentation and coding practices (−1.8 percent). We also are proposing that if more recent data are available for the final rule, we would use those data to establish a final update to the RY 2010 LTCH PPS standard Federal rate, if applicable.

D. Monitoring

In the August 30, 2002 final rule (67 FR 56014), we described an ongoing monitoring component to the new LTCH PPS. Specifically, we discussed analysis of the various policies that we believe would provide equitable payment for stays that reflect less than the full course of treatment and reduce the incentives for inappropriate admissions, transfers, or premature discharges of patients that are present in a discharge-based PPS. As a result of our ongoing data analysis, we revisited a number of our original policies and since the FY 2003 implementation of the LTCH PPS, we have identified behaviors by certain LTCHs that lead to inappropriate Medicare payments and have formulated policies that we believe have resulted in fair and reasonable payments for treatments delivered to Medicare beneficiaries by LTCHs.

In the RY 2009 LTCH PPS proposed rule, we summarized policy initiatives that we have issued as a result of our ongoing monitoring program (73 FR 5373 through 5374). While we are not proposing to make any new payment adjustments for RY 2010 as a result of our monitoring activity, we note that we will continue to pursue our ongoing monitoring program that involves the CMS Office of Research and Development (ORDI), existing QIO monitoring, medical review activities conducted by Medicare contractors (that is, fiscal intermediaries or MACs), and studies described in the RY 2006 LTCH PPS final rule (70 FR 24211).

E. Research Conducted by the Research Triangle Institute, International (RTI)

At this time, we are not proposing any additional specific changes to payment policies under the LTCH PPS based on the findings made thus far under our ongoing research contract with the Research Triangle Institute, International (RTI). However, we believe that, in light of continuing concerns regarding RTI's evaluation of the feasibility of establishing patient-level and facility-level criteria for LTCHs, it is appropriate to provide an update on RTI's most recent analyses and findings.

At the beginning of FY 2005, CMS contracted with RTI for a comprehensive evaluation of the feasibility of developing patient-level and facility-level characteristics for LTCHs that could distinguish LTCH patients from those patients treated in other hospitals. In prior **Federal Register** notices, we have summarized the results of the ongoing work and posted the reports on both Phase I and Phase II of RTI's research on the CMS Web site at *http://www.cms.hhs.gov/LongTermCareHospitalPPS/02a_RTIReports.asp#TopOfPage*.

In the RY 2009 LTCH PPS proposed rule, in addition to a description of RTI's research, we described the results of two technical expert panels held during 2007 (73 FR 5374 through 5376). In these analyses, RTI used CY 2004 Medicare claims data to examine the range of patient types admitted to LTCHs, their characteristics to determine if they were all medically complex, as suggested by many, and their outcomes to examine whether the higher cost LTCH service was

distinguishable from outcomes for similar patients treated in areas without LTCHs. These analyses controlled for case-mix severity and examined the differences between beneficiaries discharged from acute care hospitals to LTCHs compared to those who did not use LTCHs. The results suggested LTCH cases were not uniquely distinguishable from those in other acute care settings, in terms of their severity of illness and reasons for admission. RTI's findings, which were consistent with the findings of MedPAC that were included in the MedPAC's June 2004 Report to the Congress (p. 127), indicated that, for a small subset of patients (those that had been in the IPPS for ventilator weaning), LTCHs achieved better outcomes at lower Medicare program costs. RTI's findings also agreed with MedPAC's findings that it found no differences in the other populations and that the severity of cases admitted to LTCHs varied.

In the earlier reports, RTI also examined whether the average Medicare payment per episode (across the IPPS, LTCH, and any other associated services used during the episode of care) differed when LTCHs were used. The issue under examination was whether the payments per episode were similar and whether the outcomes were similar. To examine this, RTI examined the top 50 types of cases likely to be admitted to an LTCH and broke down the costs across an episode of care. Those patients discharged to the LTCH had average payments per episode that were $20,000 higher and no shorter episodes of care or IPPS lengths of stay. Hospital readmission rates were also higher among the LTCH users. However, it is unclear whether this reflects a more complicated case that was not identified as such—being discharged to the LTCH—or whether higher readmission was needed because the patient was transferred from the IPPS inappropriately and needed more general acute care rather than specialized LTCH services. LTCHs restrict their admissions to patients who are hemodynamically stable, unlike IPPS hospitals which provide intensive care, step-down care, and general medical care. However, the analysis also showed variation in the types of cases admitted to LTCHs. Additional analysis of the differences in post-intensive care IPPS use for these two types of cases is also being completed.

In the third phase of this study, RTI presented these findings to a technical expert panel comprised of physicians treating complex cases in LTCHs, IPPS hospitals, IRFs, and SNFs. The technical expert panel members were asked to focus on the more complex cases and consider whether LTCHs treat a unique population or use a unique set of treatment practices. The panel discussed the distinguishing characteristics of their respective populations and found great overlap. The panel, including the LTCH physicians, reached a general consensus that LTCHs do not treat a unique population. The types of cases treated in LTCHs may also be treated in IPPS hospitals or IRFs, depending on the primary condition. The panel noted that these complex cases needed specialized treatments, including higher level nursing and physician oversight, interdisciplinary teams to monitor infections and other complications, as well as adequate numbers of cases to ensure appropriate experience for treating these cases. Many LTCHs have these facility-level characteristics although they were not mandated. Acute care hospitals that treat these types of cases frequently have these characteristics as well. All of the panel members agreed that interdisciplinary teams and higher nurse staffing levels were necessary to meet the needs of these patients. A recommendation was made that Medicare should establish Centers of Excellence for treating the medically complex or critically ill populations. These centers may be LTCHs or other hospitals with the staffing and resources to treat these cases, a critical volume of admissions to ensure experience with these complex cases, and a consistent payment approach for these cases across hospitals. (RTI's Phase III Report is posted on the CMS Web site at: *http://www.cms.hhs.gov*.)

RTI also examined the adequacy of the payment rates for LTCHs. Medicare cost reports were used to analyze trends in overall profitability and Medicare profitability for some of the more common conditions in LTCHs. Service-specific CCRs were computed to estimate costs for individual MedPAR claims in CY 2006. Half of these claims were paid under the rules applicable to LTCH PPS RY 2007. Data on costs and payments of claims were then used to reassess patterns in profitability by LTC–DRG. RTI found that aggregate LTCH facility PPS margins declined from 11.7 percent in FY 2004 to 7.1 percent in FY 2006. For the subset of RY 2007 claims, the aggregate margin was 5.4 percent. The median PPS margin in FY 2006 was 8.7 percent among for-profit LTCHs, 7.2 percent for private nonprofits, and −5.4 percent in publicly-owned LTCHs. However, RTI found that these differences in facility margins by type of ownership were explained by differences in case-mix. Systematic variation in profitability by type of DRG was even stronger in the FY 2006 data than in the FY 2004 data and publicly owned LTCHs continued to admit a larger proportion of patients with lower weighted (and, therefore, lower paid) DRGs.

RTI found that excess LTCH profitability relative to other PPS settings in aggregate appears to have been reduced. However, margins varied substantially for different types of cases. The ratio of PPS payments to PPS costs were more than 30 percent higher than an industry baseline, while cases for aftercare and rehabilitation had payment ratios that were more than 10 percent below the baseline.

Persistent concerns regarding appropriate Medicare payments for patients who are treated in LTCHs as well as in other provider settings resulted in the enactment of a statutory provision under section 114(b) of the MMSEA directing the Secretary to conduct a study for purposes of determining medical necessity, appropriateness of admission, and continued stay at, and discharge from, LTCHs and to submit a report to the Congress within 18 months after the date of enactment of the MMSEA (December 29, 2007) on the study, along with recommendations for legislation and administrative actions for implementing national LTCH facility and patient criteria, as the Secretary determines appropriate. The statute further states that ''[I]n conducting the study and preparing the report under this subsection, the Secretary shall consider—(A) recommendations contained in a report to Congress by the Medicare Payment Advisory Commission in June 2004 for long-term care hospital-specific facility and patient criteria to ensure that patients admitted to long-term care hospitals are medically complex and appropriate to receive long-term care hospital services; and (B) ongoing work by the Secretary to evaluate and determine the feasibility of such recommendations.''

In fulfillment of this statutory mandate, CMS' Office of Research, Development, and Information awarded a contract to Kennell and Associates and RTI for additional analysis of data on Medicare payments and facility costs for the treatment of similar patients in LTCHs and alternative providers as well as patient outcomes and the range of hospital-level care delivered in each setting. We intend to post this report on the CMS Web site once it has been submitted to Congress.

F. Proposed Technical Corrections of LTCH PPS Regulations

While we are not proposing any new payment policy changes at this time, we are taking this 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.

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. Therefore, in this proposed rule, we are proposing 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 proposing to revise § 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 are proposing to clarify our existing policy at § 412.525(d) so that it more accurately reflects 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). Therefore, in order to ensure that the applicable regulatory text reflects existing policy, we are proposing to add a paragraph (d)(5) to § 412.525 that specifically provides 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. 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 proposed policies set forth in this proposed 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 proposed 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.

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*.

XI. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are now available on compact disc (CD) format. However, many of the files are available on the Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS*. Data files and the cost for each file, if applicable, are listed below. Anyone wishing to purchase CDs should submit a written request along with a company check or money order (payable to CMS–PUF) to cover the cost to the following address: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, MD 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. CMS Wage Data Public Use File

This file contains the hospital hours and salaries from Worksheet S–3, Parts II and III from FY 2006 Medicare cost reports used to create the proposed FY 2010 prospective payment system wage index. Multiple versions of this file are created each year. For a complete schedule on the release of different versions of this file, we refer readers to the wage index schedule in section III.K. of the preamble of this proposed rule.

Processing year	Wage data year	PPS fiscal year
2009	2006	2010
2008	2005	2009
2007	2004	2008

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

Periods Available: FY 2007 through FY 2010 IPPS Update.

2. CMS Occupational Mix Data Public Use File

This file contains the 2007–2008 occupational mix survey data to be used to compute the occupational mix adjustment wage indexes. Multiple versions of this file are created each year. For a complete schedule on the release of different versions of this file, we refer readers to the wage index schedule in section III.K. of the preamble of this proposed rule.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

Period Available: FY 2010 IPPS Update.

3. Provider Occupational Mix Adjustment Factors for Each Occupational Category Public Use File

This file contains each hospital's occupational mix adjustment factors by occupational category. Two versions of these files are created each year. They support the following:

- Notice of proposed rulemaking published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

Period Available: FY 2010 IPPS Update.

4. Other Wage Index Files

CMS releases other wage index analysis files after each proposed and final rule.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*.

Periods Available: FY 2007 through FY 2010 IPPS Update.

5. FY 2010 IPPS SSA/FIPS CBSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a historical list of Metropolitan Statistical Areas (MSAs).

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*.

Period Available: FY 2010 IPPS Update.

6. HCRIS Cost Report Data

The data included in this file contain cost reports with fiscal years ending on or after September 30, 1996. These data files contain the highest level of cost report status.

Media: Internet at: *http://www.cms.hhs.gov/CostReports/02_HospitalCostReport.asp* and Compact Disc (CD).

File Cost: $100.00 per year.

7. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's or the MAC's system to compute DRG/MS–DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Internet at: *http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp*.

Period Available: FY 2010 IPPS Update.

8. CMS Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG/MS–DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:

- Notice of proposed rulemaking published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*.

Periods Available: FY 1985 through FY 2010.

9. MS–DRG Relative Weights (Also Table 5—MS–DRGs)

This file contains a listing of MS–DRGs, MS–DRG narrative descriptions, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register**. There are two versions of this file as published in the **Federal Register**.

- Notice of proposed rulemaking.
- Final rule.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*.

Periods Available: FY 2006 through FY 2010 IPPS Update

10. IPPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital impatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register**.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/*

FFD/list.asp#TopOfPage and *http://www.cms.hhs.gov/AcuteInpatientPPS/HIF/list.asp#TopOfPage*.

Periods Available: FY 1994 through FY 2010 IPPS Update.

11. AOR/BOR Tables

This file contains data used to develop the MS–DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by MS–DRG for length of stay and standardized charges. The BOR tables are ''Before Outliers Removed'' and the AOR is ''After Outliers Removed.'' (Outliers refer to statistical outliers, not payment outliers.)

Two versions of this file are created each year. They support the following:

- Notice of proposed rulemaking published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*.

Periods Available: FY 2006 through FY 2010 IPPS Update.

12. Prospective Payment System (PPS) Standardizing File

This file contains information that standardizes the charges used to calculate relative weights to determine payments under the hospital inpatient operating and capital prospective payment systems. Variables include wage index, cost-of-living adjustment (COLA), case-mix index, indirect medical education (IME) adjustment, disproportionate share, and the Core-Based Statistical Area (CBSA). The file supports the following:

- Notice of proposed rulemaking published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Internet at: *http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*.

Periods Available: FY 2010 IPPS Update.

For further information concerning these data files, contact the CMS Public Use Files Hotline at (410) 786–3691.

Commenters interested in discussing any data used in constructing this proposed rule should contact Nisha Bhat at (410) 786–5320.

B. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the 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.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Payment Adjustment for Medicare DSHs (§ 412.106)

Proposed § 412.106(b)(4)(iv) would permit 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 would be 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 proposed requirement would be 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 are soliciting public comments on the possible annual number of submissions pertaining to changes to the methodologies used to count days in the numerator of a hospital's Medicaid fraction of the DPP, and will reevaluate this issue in the final rule stage of rulemaking.

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. of the preamble of this proposed rule, we discuss our proposed change to specify in regulations 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 would 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. The burden associated with this proposed requirement would be 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 proposal because we cannot estimate the additional number of hospitals that would be permitted to submit Medicare GME affiliation agreements in any given year as a result of the proposed change. However, we believe the number of affected hospitals would be very small because, under the proposed change, a hospital would not only have to start training residents after July 1, but would also need to be a new hospital after July 1. We note that this proposal would 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 proposed 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 would amount to a minimal paperwork burden. Nevertheless, we are soliciting public comments on the possible number of annual submissions of Medicare GME affiliation agreements under this proposed change.

C. Additional Information Collection Requirements

This proposed rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this proposed rule also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

1. Present on Admission (POA) Indicator Reporting

Section II.F.6. of the preamble 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. Proposed Add-On Payments for New Services and Technologies

Section II.I.1. of the preamble of this proposed rule discusses add-on payments for new services and technologies. Specifically, this section states that applicants for add-on payments for new medical services or technologies for FY 2011 must submit a formal request. A formal request includes a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement. In addition, the request must contain a significant sample of the data to demonstrate that the medical service or technology meets the high-cost threshold. We detailed the burden associated with this requirement in the September 7, 2001 IPPS final rule (66 FR 46902). As stated in that final rule, collection of the information for this requirement is conducted on an individual case-by-case basis. We believe the associated burden is thereby exempt from the PRA as stipulated under 5 CFR 1320.3(h)(6). Similarly, we also believe the burden associated with this requirement is exempt from the PRA under 5 CFR 1320.3(c), which defines the agency collection of information subject to the requirements of the PRA as information collection imposed on 10 or more persons within any 12-month period. This information collection does not impact 10 or more entities in a 12-month period. In FYs 2008, 2009, and 2010, we received 1, 4, and 5 applications, respectively.

3. Reporting of Hospital Quality Data for Annual Hospital Payment Update

As discussed in section V.A. of the preamble of this proposed 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 proposed rule, we are proposing to add a total of four new measures, to harmonize two existing measures, and to retire one measure, which would increase the total number of measures in the RHQDAPU program from 42 in FY 2010 to 46 in FY 2011. Specifically, we are proposing to add 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 SCIP-Infection-10: Perioperative Temperature Management to the existing SCIP measure set. As stated in V.A.3. of the preamble of this proposed 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 this proposed rule addresses the reconsideration and appeal procedures for a hospital that we believe did not meet the RHQDAPU program requirements. If a hospital disagrees with our determination, it may submit a written request to CMS to reconsider our decision. The hospital's 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 proposed rule discusses the proposed 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.

5. Hospital Applications for Geographic Reclassifications by the MGCRB

Section III.I.3. of the preamble of this proposed rule discusses revisions to the wage index based on hospital redesignations. As stated in that section, under section 1886(d)(10) of the Act, the MGCRB has the authority to accept short-term IPPS hospital applications requesting geographic reclassification for wage index or standardized payment amounts and to issue decisions on these requests by hospitals for geographic reclassification for purposes of payment under the IPPS. The burden associated with this application process is the time and effort necessary for an IPPS hospital to complete and submit an application for reclassification to the MGCRB. While this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0573, with an expiration date of December 31, 2011.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, [CMS–1406–P], Fax: (202) 395–6974; or E-mail: *OIRA_submission@omb.eop.gov*.

C. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Public Law 106–113 (113 Stat. 1501A–332).

2. Section 412.22 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 governing body of 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 412.64 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]

4. In § 412.87, paragraph (b)(1), remove the word ''relating'' and insert in its place the word ''relative''.

5. 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;

* * * * *

6. 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 and the cost reporting period to which the requested change would apply. 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]

7. 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.

8. Section 412.322 is amended by removing and reserving paragraph (c) to read as follows:

§ 412.322 Indirect medical education adjustment factor.

* * * * *

(c) [Reserved].

* * * * *

9. 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 0.6 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

* * * * *

10. 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.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

11. 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).

12. 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, or facilities that furnish only some combination of these services. Clinical diagnostic laboratories operating as parts of CAHs must meet the applicable provider-based requirements.

(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.

* * * * *

13. 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 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 with 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.

* * * * *

14. 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) 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 prior to 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

15. 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]

16. 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 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

17. 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).

18. 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) If relating to an inappropriate transfer, the transfer arises out of the circumstances of the emergency.

(B) If relating to the direction or relocation of an individual to receive medical screening at an alternate location, the direction or relocation 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: April 17, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: May 1, 2009.

Kathleen Sebelius,

Secretary.

Editorial Note: The following Addendum and appendixes will not appear in the Code of Federal Regulations.

Addendum—Proposed Schedule of Standardized Amounts, Update Factors, and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning on or After October 1, 2009

I. Summary and Background

In this Addendum, we are setting forth a description of the methods and data we used to determine the proposed prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs for FY 2010 for acute care hospitals. We also are setting forth the proposed rate-of-increase percentages for updating the target amounts for certain hospitals excluded from the IPPS for FY 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 proposed figures for the standardized amounts, offsets, and budget neutrality factors. Therefore, in this proposed rule, we are proposing 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 proposed standard Federal rate that would 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 Public Law 109–171, MDHs are no longer subject to the 12-percent cap on their DSH payment adjustment factor.

For hospitals located in Puerto Rico, the payment per discharge is based on the sum of 25 percent of an updated Puerto Rico-specific rate based on average costs per case of Puerto Rico hospitals for the base year and 75 percent of the Federal national rate. (We refer readers to section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for acute care hospitals for FY 2010. In section III. of this Addendum, we discuss our proposed policy changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2010. In section IV. of this Addendum, we are setting forth our proposed changes for determining the rate-of-increase limits for certain hospitals excluded from the IPPS for FY 2010. In section V. of this Addendum, we are proposing to make changes in the determination of the standard Federal rate for LTCHs under the LTCH PPS for RY 2010. The tables to which we refer in the preamble of this proposed rule are presented in section VI. of this Addendum.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for Acute Care Hospitals for FY 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 proposed prospective payment rates for FY 2010.

In summary, the proposed standardized amounts set forth in Tables 1A, 1B, and 1C of section VI. of this Addendum reflect—

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv)(II) of the Act, updated by the applicable percentage increase required under sections 1886(b)(3)(B)(i)(XX) and 1886(b)(3)(B)(viii) of the Act.
- The labor-related share that is applied to the standardized amounts and Puerto Rico-specific standardized amounts to give the hospital the highest payment, as provided for under sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act.
- Proposed updates of 2.1 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 specified by the Secretary, relating to the quality of inpatient care furnished by the hospital.
- A proposed 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.
- As discussed below and in section II.D. of the preamble to this proposed rule, an adjustment to eliminate the effect of documentation and coding changes that do not reflect real changes in case-mix provided for under section 1886(d)(3)(A)(vi) of the Act.

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 proposing to continue to apply the rural floor budget neutrality adjustment to hospital wage indices rather than the standardized amount. In addition, instead of applying the budget neutrality adjustment for the imputed floor adopted under section 1886(d)(3)(E) of the Act to the standardized amount, for FY 2010, we are proposing to continue to apply the imputed floor budget neutrality adjustment to the wage indices. As we did for FY 2009, we also are proposing to continue to apply the budget neutrality adjustments for the rural floor and imputed rural floor at the State level rather than the national level. For a complete discussion of the budget neutrality changes concerning the rural floor and the imputed floor, including the within-State budget neutrality adjustment, we refer readers to section III.B.2.b. of the preamble of the FY 2009 IPPS final rule and this proposed rule.

A. Calculation of the Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

In general, the national standardized amount is based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. For Puerto Rico hospitals, the Puerto Rico-specific standardized amount is based on per discharge averages of adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d)(9) of the Act. The September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established for urban and rural hospitals in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043 and 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and 1886(d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, IME costs, and costs to hospitals serving a disproportionate share of low-income patients.

In accordance with section 1886(d)(3)(E) of the Act, the Secretary estimates, from time to time, the proportion of hospitals' costs that are attributable to wages and wage-related costs. In general, the standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered to be the labor-related amount is adjusted by the wage index. Section 1886(d)(3)(E) of the Act requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made. (Section 1886(d)(9)(C)(iv)(II) of the Act extends this provision to the labor-related share for hospitals located in Puerto Rico.)

For FY 2010, we are proposing to rebase and revise 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 proposed rule, we are proposing a labor-related share of 67.1 percent for the national standardized amounts and 60.3 percent for the Puerto Rico-specific standardized amount. Consistent with section 1886(d)(3)(E) of the Act, we are proposing to apply 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 proposing to apply the wage index to a labor-related share of 67.1 percent of the national standardized amount. For hospitals located in Puerto Rico, we are proposing to apply a labor-related share of 60.3 percent if its Puerto Rico-specific wage index is less than or equal to 1.0000. For hospitals located in Puerto Rico whose Puerto Rico-specific wage index values are greater than 1.0000, we are proposing to apply a labor-related share of 62 percent.

The proposed standardized amounts for operating costs appear in Tables 1A, 1B, and 1C of the Addendum to this proposed rule.

2. Computing the Average Standardized Amount

Section 1886(d)(3)(A)(iv)(II) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Section 1886(d)(9)(A)(ii)(II) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we are proposing to calculate 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

proposing to update 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 proposed 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 proposed rule).

Section 1886(b)(3)(B) of the Act specifies the mechanism to be used to update the standardized amount for payment for inpatient hospital operating costs. Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Public Law 109–171, provides for a reduction of 2.0 percentage points from the update percentage increase (also known as the market basket update) for FY 2007 and each subsequent fiscal year for any ''subsection (d) hospital'' that does not submit quality data, as discussed in section V.A. of the preamble of this proposed rule. The proposed standardized amounts in Tables 1A through 1C of section VI. of this Addendum reflect these differential amounts.

Section 412.211(c) states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1) or the percentage increase in the market basket index for prospective payment hospitals for all areas. We are proposing to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the proposed update to the Puerto Rico-specific standardized amount is 2.1 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 proposed rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are proposing to adjust 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.

We also are proposing to adjust the standardized amount this year 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 proposing to apply budget neutrality for the imputed floor to the standardized amount, but to apply it instead to the wage index, as discussed in section III.B.2. of the preamble to this proposed rule. For FY 2010, we also are proposing to apply an adjustment to eliminate the effect of documentation and coding changes that do not reflect real changes in case-mix using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act.

a. Proposed Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble of this proposed rule, we normalized the recalibrated DRG weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E)(i) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. In addition, under section 1886(d)(3)(E)(i) of the Act, as we established in the FY 2006 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 proposed revision of the labor-related share to 67.1 percent (compared to the prior 69.7 percent) (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 proposing to adjust 100 percent of the wage index factor for occupational mix. We describe the occupational mix adjustment in section III.D. of the preamble to this proposed 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 relative weights to aggregate payments using the proposed FY 2010 relative weights. Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 0.997663. As discussed in section IV. of this Addendum, we would also apply the DRG reclassification and recalibration budget neutrality factor of 0.997663 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 proposed FY 2010 rebased and revised labor 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 proposed DRG reclassification and recalibration budget neutrality factor of 0.997663 by using the same methodology described above to determine the proposed DRG reclassification and recalibration budget neutrality factor for the Puerto Rico standardized amount and hospital-specific rates. Secondly, to compute a budget neutrality factor for wage index and labor-related share changes, we used FY 2008 discharge data to simulate payments and compared aggregate payments using the proposed FY 2010 relative weights, FY 2009 wage indices, and applied the FY 2009 labor 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 proposed FY 2010 relative weights, proposed FY 2010 wage indices, and applied the proposed rebased and revised labor share for FY 2010 of 67.1 percent to all hospitals (regardless of whether the hospital's proposed wage index was above or below 1.0). In addition, we applied the proposed DRG reclassification and recalibration budget neutrality factor (derived in the first step) to the rates that were used to simulate payments for this comparison of aggregate payments from FY 2009 to FY 2010. By applying this methodology, we determined a budget neutrality factor for the proposed wage index and labor-related share changes of 1.000404. Finally, we multiplied the proposed DRG reclassification and recalibration proposed budget neutrality factor of 0.997663 (derived in the first step) by the proposed budget neutrality factor for proposed wage index changes of 1.000404 (derived in the second step) to determine the proposed DRG reclassification and recalibration and updated wage index and labor-related share budget neutrality factor of 0.998066.

b. Reclassified Hospitals—Proposed Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. We note that the wage index adjustments provided under section 1886(d)(13) of the Act are not budget neutral. Section 1886(d)(13)(H) of the Act provides that any increase in a wage index under section 1886(d)(13) shall not be taken into account ''in applying any budget neutrality adjustment with respect to such index'' under section 1886(d)(8)(D) of the Act. To calculate the proposed budget neutrality factor for FY 2010, we used FY 2008 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments after such reclassifications. Based on these simulations, we calculated a proposed adjustment factor of 0.991690 to ensure that the effects of these provisions are budget neutral, consistent with the statute.

The proposed 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 proposed FY 2010 budget neutrality adjustment reflects FY 2010 wage index reclassifications approved by the MGCRB or the Administrator.

c. Proposed Rural Floor and Imputed Floor Budget Neutrality Adjustment

As discussed in section III.B.2.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 will be 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 proposed 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 and proposed FY 2010 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 0.997466. This national adjustment was then applied to the wage indices to produce a national rural and imputed floor budget neutral wage index, which was used in determining the proposed FY 2010 blended 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 proposed FY 2010 blended wage indices for the second year of the transition (as described below).

To determine the proposed FY 2010 wage indices for the second year of the transition, we then blended the national and State-level wage index values (computed above) by taking 50 percent of the national rural and imputed floor budget neutral wage index and 50 percent of the State-level rural and imputed floor budget neutral wage index. Because of interactive effects between the payment factors applied under the IPPS and/or rounding issues, the blended wage index calculated above does not necessarily result in overall budget neutrality. That is, aggregate IPPS payments simulated using the blended budget neutral wage index may not be equal to aggregate IPPS payments simulated using the 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 1.00016 must be applied to the blended wage indexes calculated as described above.

d. Proposed Case-Mix Budget Neutrality Adjustment

(1) Adjustment to the Proposed 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.

As discussed in section II.D. of the preamble to this proposed rule, we estimated a 2.5 percent change in FY 2008 case-mix due to changes in documentation and coding that do not reflect real changes in case-mix for discharges occurring during FY 2008, which exceeded the −0.6 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90 by 1.9 percentage points. Under section 7(b)(1)(A) of Public Law 119–90, the Secretary is required to make an appropriate adjustment under section 1886(d)(3)(A)(vi) of the Act to the average standardized amounts for subsequent fiscal years so as to eliminate the full effect of the coding and classification changes that do not reflect real changes in case-mix. 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 under the IPPS to increase due to MS–DRG-related changes in documentation and coding that do not reflect real changes in case-mix.

Therefore, we are proposing to reduce the average standardized amounts under section 1886(d) of the Act in FY 2010 by −1.9 percent, 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. We are proposing 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 not reflective of an increase in real case-mix. Thus, the proposed cumulative adjustment to the average standardized amounts for FY 2010 is −3.4 percent (that is, the existing −1.5 percent plus the proposed −1.9 percent). We note that because we are proposing to apply a cumulative offset of −3.4 percent to the FY 2010 standardized amount, we are proposing to apply a factor of 0.967 (1 divided by

1.034) in determining the FY 2010 standardized amount. We refer readers to section II.D. of the preamble of this proposed rule for a complete discussion of our proposed −1.9 percent adjustment to the average standardized amounts under section 1886(d) of the Act in FY 2010.

As also discussed in section II.D. of the preamble of this proposed rule, we will address any differences between the increase 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 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. Furthermore, we are seeking public comment on the proposed −1.9 percent prospective adjustment to the standardized amounts under section 1886(d) of the Act and addressing in the FY 2011 rulemaking cycle any differences between the 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 and the −0.9 percent prospective documentation and coding adjustment applied under section 7(a) of Public Law 110–90. We note that we are also seeking public comment on our intent to address the requirements of section 7(b)(1)(B) of Public Law 110–90 through future rulemaking.

(2) Proposed Adjustment to the FY 2010 Hospital-Specific Rates for SCHs and MDHs

As discussed in section II.D. of the preamble to this proposed rule, because hospitals (SCHs and MDHs) paid based in whole or in part on the hospital-specific rate use the same MS–DRG system as other hospitals, we believe they have the potential to realize increased payments from documentation and coding changes that do not reflect real increases in patients' severity of illness. Under section 1886(d)(3)(A)(vi) of the Act, Congress stipulated that hospitals paid based on the standardized amount should not receive additional payments based on the effect of documentation and coding changes that do not reflect real changes in case-mix. Similarly, we believe that hospitals paid based on the hospital-specific rate should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. While we continue to believe that section 1886(d)(3)(A)(vi) of the Act does not provide explicit authority for application of the documentation and coding adjustment to the hospital-specific rates, we believe that we have the authority to apply the documentation and coding adjustment to the hospital-specific rates using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. The special exceptions and adjustment authority authorizes us to provide ''for such other exceptions and adjustments to [IPPS] payment amounts * * * as the Secretary deems appropriate.'' 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 also indicated that if we found evidence of significant increases in case-mix for patients treated in these hospitals that does 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.

We performed a retrospective evaluation of the FY 2008 claims data for SCHs and MDHs using the same methodology described in section II.D of the preamble of this proposed rule 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 2.5 percent result discussed earlier, but did not significantly differ from that result.

Therefore, consistent with our statements in prior IPPS rules, we are proposing 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 are proposing 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. This proposed −2.5 percent adjustment to the hospital-specific rates exceeds the proposed −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. We note that because we are proposing to apply a offset of −2.5 percent to the FY 2010 hospital-specific rates, we are proposing to apply a factor of 0.976 (1 divided by 1.025) to adjust the FY 2010 hospital-specific rates. We refer readers to section II.D. of the preamble of this proposed rule for a complete discussion on our proposal to prospectively adjust the hospital-specific rates by −2.5 percent in FY 2010.

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.

We are seeking public comment on the proposed −2.5 percent prospective adjustment to the hospital-specific rates of SCHs and MDHs and addressing 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 intend to update our analysis with FY 2008 data on claims paid through March 2008 for the FY 2010 IPPS final rule.

(3) Proposed Adjustment to the FY 2010 Puerto Rico Standardized Amount

As stated in section II.D. of the preamble to this proposed rule, we believe that we have the authority to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. Similar to SCHs and MDHs that are paid based on the hospital-specific rate, we believe that Puerto Rico hospitals that are paid based on the Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding changes that do not reflect real increases in patients' severity of illness. Consistent with the approach described for SCHs and MDHs, in the FY 2009 final rule, 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 48449) 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.

We performed a retrospective evaluation of the FY 2008 claims data for Puerto Rico hospitals using the same methodology described in section II.D. of the preamble of this proposed rule 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 changes that did not reflect real changes in case-mix for discharges occurring during FY 2008 was approximately 1.1 percent.

Given these documentation and coding increases, consistent with our statements in prior IPPS rules, we are proposing 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. As the proposed −1.1 percent adjustment will be applied to the Puerto Rico-specific rate that accounts for 25 percent of payment to Puerto Rico hospitals and the other 75 percent is accounted for by the similar proposed adjustment that is applied to the national standardized amount, the overall proposed adjustment for documentation and coding changes will be slightly less for Puerto Rico hospitals as compared to other hospitals that are 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. Furthermore, we note that because we are proposing to apply a offset of −1.1 percent to the FY 2010 Puerto Rico-specific standardized amount, we are proposing to apply a factor of 0.989 (1 divided by 1.011) to adjust the FY 2010 Puerto Rico-specific standardized amount. We refer readers to section II.D. of the preamble of this proposed rule for a complete discussion on our proposal to adjust the Puerto Rico-specific standardized amount by −1.1 percent in FY 2010.

We will address in the FY 2011 rulemaking cycle any change 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. 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.

We are seeking public comment on the proposed −1.1 percent prospective adjustment to the Puerto Rico-specific standardized amount under section 1886(d)(5)(I)(i) of the Act and addressing in the FY 2011 rulemaking cycle any changes 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. We intend to update our analysis with FY 2008 data on claims paid through March 2008 for the FY 2010 IPPS final rule.

e. Proposed Outlier Payments

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the ''outlier threshold'' or ''fixed-loss'' amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). We refer to the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the outlier threshold as the outlier ''fixed-loss cost threshold.'' To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to estimated costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the estimated costs above the fixed-loss cost threshold. The marginal cost factor for FY 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. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amount applicable to hospitals located in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage*.

(1) Proposed FY 2010 Outlier Fixed-Loss Cost Threshold

For FY 2010, we are proposing to continue to use the same methodology used for FY 2009 (73 FR 48763 through 48766) to calculate the outlier threshold. Similar to the methodology used in the FY 2009 IPPS final rule, for FY 2010, we are proposing to apply an adjustment factor to the CCRs to account for cost and charge inflation (as explained below). As we have done in the past, to calculate the proposed FY 2010 outlier threshold we simulated payments by applying proposed 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 inflate the charges on the MedPAR claims by 2 years, from FY 2008 to FY 2010.

We are proposing to continue to use a refined methodology that takes into account the lower inflation in hospital charges that are occurring as a result of the outlier final rule (68 FR 34494), which changed our methodology for determining outlier payments by implementing the use of more current CCRs. Our refined methodology uses more recent data that reflect the rate-of-change in hospital charges under the new outlier policy.

Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 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 this proposed rule. This file includes CCRs that reflect implementation of the

changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

As discussed in the FY 2007 IPPS final rule (71 FR 48150), we worked with the Office of Actuary to derive the methodology described below to develop the CCR adjustment factor. For FY 2010, we are proposing 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 proposing to use the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges. Therefore, we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

As stated above, for FY 2010, we are applying 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 proposed rule, our actuaries estimated 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 project 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 proposed 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).

Using this methodology, we are proposing 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.

As we did in establishing the FY 2009 outlier threshold (73 FR 57891), in our projection of FY 2010 outlier payments, we are not proposing to make any

adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We continue to believe that, due to the policy implemented in the June 9, 2003 outlier final rule (68 FR 34494), CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict the specific hospitals that will have CCRs and outlier payments reconciled in any given year. We also noted that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different than the interim CCRs used to calculate outlier payments when a bill is processed. Our simulations assume that CCRs accurately measure hospital costs based on information available to us at the time we set the outlier threshold. For these reasons, we are not making any assumptions about the effects of reconciliation on the outlier threshold calculation.

We also note that there are 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.

(2) Other Proposed Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2010 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.5 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are proposing to reduce the FY 2010 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The outlier adjustment factors that would be applied to the standardized amount for the proposed FY 2010 outlier threshold are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948996	0.945405
Puerto Rico ...	0.952493	0.938327

We are proposing to apply the outlier adjustment factors to the proposed 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 1.183 or capital CCRs greater than 0.146, 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.[11] Table 8A in this Addendum contains the proposed statewide average operating CCRs for urban hospitals and for rural hospitals for which the fiscal intermediary or MAC is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2009, these statewide average ratios would 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 proposed statewide average capital CCRs. Again, the proposed CCRs in Tables 8A and 8B would 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.

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

[11] These figures represent 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals.

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.

f. Proposed Rural Community Hospital Demonstration Program Adjustment (Section 410A of Public Law 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 to this proposed rule, we have satisfied this requirement by proposing 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 $1,124,126. 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 13 participating hospitals, the projected total annual impact of the demonstration program for FY 2010 is $14,613,632. In addition, because the cost reports of all hospitals participating in the demonstration in its first year (that is, FY 2005) 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. For all 13 hospitals that participated in the demonstration in FY 2005, the amount is $7,179,461. Therefore, the projected total annual impact of the demonstration program for FY 2010 is $21,793,093. The proposed budget neutrality adjustment factor applied to the Federal rate to calculate Medicare inpatient prospective payments as a result of the demonstration is 0.999790. This budget neutrality adjustment factor may be different in the FY 2010 IPPS final rule to the extent that we have more recent data.

In order to achieve budget neutrality, we are proposing to adjust the national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are proposing to apply budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration, 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. Proposed FY 2010 Standardized Amount

The proposed adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B of this Addendum contain the national standardized amounts that we are proposing to apply to all hospitals, except hospitals located in Puerto Rico, for FY 2010. The proposed Puerto Rico-specific amounts are shown in Table 1C of this Addendum. The proposed amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is the proposed revised labor-related share of 67.1 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 indexes are less than or equal to 1.0000.

In addition, Tables 1A and 1B include proposed standardized amounts reflecting the proposed full 2.1 percent update for FY 2010, and the proposed 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 proposed amount is set forth in Table 1A). The proposed labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2010 are set forth in Table 1C of this Addendum. This table also includes the proposed Puerto Rico standardized amounts. The labor-related share applied to the proposed Puerto Rico specific standardized amount is the proposed labor-related share of 60.3 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 proposed changes from the FY 2009 national standardized amount. The second column shows the proposed 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 proposed changes for hospitals receiving the reduced update (0.1 percent). The first row of the table shows the proposed updated (through FY 2009) average standardized amount after restoring the FY 2008 offsets for outlier payments, demonstration budget neutrality, the geographic reclassification budget neutrality, and the documentation and coding adjustment for FY 2008 and FY 2009. The DRG reclassification and recalibration and wage index budget neutrality factors are cumulative. Therefore, the FY 2009 factor is 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 PROPOSED 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, Actual FY 08 and FY 09 documentation and coding adjustment, and outlier offset (based on the labor-related share percentage for FY 2010).	Labor: $3,711.57 Nonlabor: $1,819.83	Labor: $3,429.47 Nonlabor: $2,101.93	Labor: $3,711.57 Nonlabor: $1,819.83	Labor: $3,429.47. Nonlabor: $2,101.93.
Proposed FY 2010 Update Factor	1.021	1.021	1.001	1.001.
Proposed FY 2010 DRG Recalibration and Wage Index Budget Neutrality Factor.	0.998066	0.998066	0.998066	0.998066.
Proposed FY 2010 Reclassification Budget Neutrality Factor.	0.991690	0.991690	0.991690	0.991690.
Proposed FY 2010 Outlier Factor	0.948996	0.948996	0.948996	0.948996.
Proposed Rural Demonstration Budget Neutrality Factor.	0.999790	0.999790	0.999790	0.999790.
Proposed FY 2010 Documentation and Coding Adjustment and Actual FY 2008 and FY 2009 Adjustment and Additional Adjustment for FY 2008.	0.967	0.967	0.967	0.967.
Proposed Rate for FY 2010	Labor: $3,441.26 Nonlabor: $1,687.30	Labor: $3,179.71 Nonlabor: $1,948.85	Labor: $3,373.85 Nonlabor: $1,654.25	Labor: $3,117.42. Nonlabor: $1,910.68.

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 proposed labor-related share applied to the Puerto Rico standardized amount is 60.3 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. Proposed Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as set forth in this Addendum, contain the proposed labor-related and nonlabor-related shares that we are using to calculate the proposed 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. Proposed Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble to this proposed rule, we discuss the data and methodology for the proposed FY 2010 wage index.

2. Proposed Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes the Secretary to make an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2010, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the applicable adjustment factor contained in the table below. These proposed factors were obtained from the U.S. Office of Personnel Management (OPM) and are currently also used under the IPPS. In addition, we are proposing that if OPM releases revised COLA factors after publication of this proposed rule, we would use the revised factors for the development of IPPS payments for FY 2010 and publish those revised COLA factors in the final rule.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS

Area	Cost of living adjustment factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS—Continued

Area	Cost of living adjustment factor
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

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

C. Proposed MS–DRG Relative Weights

As discussed in section II.H. of the preamble of this proposed rule, we have developed proposed relative weights for each MS–DRG that reflect the resource utilization of cases in each MS–DRG relative to Medicare cases in other MS–DRGs. Table 5 of this Addendum contains the proposed relative weights that we would apply to discharges occurring in FY 2010. These factors have been recalibrated as explained in section II. of the preamble of this proposed rule.

D. Calculation of the Proposed Prospective Payment Rates

General Formula for Calculation of the Proposed Prospective Payment Rates for FY 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 (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 proposing to increase the hospital-specific rates by 2.1 percent (the proposed 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 Proposed 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. Proposed 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 are proposing to use to determine the capital Federal rate for FY 2010, which would 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 Pulic. Law 105–33, the methodology for operating payments made to hospitals located in Puerto Rico under the IPPS was revised to make payments based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges occurring on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the national capital Federal rate.

As we discussed in the FY 2005 IPPS final rule (69 FR 49185), section 504 of Public Law 108–173 increased the national portion of the operating IPPS payments for hospitals located in Puerto Rico from 50 percent to 62.5 percent and decreased the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004 through September 30, 2004 (refer to the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Public Law 108–173 provided that the national portion of operating IPPS payments for hospitals located in Puerto Rico is equal to 75 percent and the Puerto Rico-specific portion of operating IPPS payments is equal to 25 percent for discharges occurring on or after October 1, 2004. Consistent with that change in operating IPPS payments to hospitals located in Puerto Rico, for FY 2005 (as we discussed in the FY 2005 IPPS final rule), we revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the Puerto Rico-specific capital rate and 75 percent of the national capital Federal rate for discharges occurring on or after October 1, 2004.

A. Determination of Proposed Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the **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 are proposing to use to determine the proposed capital Federal rate for FY 2010. In particular, we explain why the proposed FY 2010 capital Federal rate would decrease approximately 0.8 percent, compared to the FY 2009 capital Federal rate. Furthermore, we estimate that aggregate capital payments would decrease during this same period (approximately $393 million), primarily due to the estimated decrease in capital IME payments in FY 2010 as compared to FY 2009 provided under current law, in addition to the proposed decrease 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 proposed update factor for FY 2010 under that framework is 1.20 percent based on the best data available at this time. The proposed update factor under that framework is based on a projected 1.2 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 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. In addition, as also noted below, the proposed capital rates would be further adjusted 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, discussed in section II.D. of the preamble of this proposed rule. Below we describe the policy adjustments that we are proposing to apply 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 are projecting a 1.0 percent total increase in the case-mix index. We estimate 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 proposed 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 are adjusting for the effects of the FY 2008 DRG reclassification and recalibration as part of our proposed update for FY 2010. To adjust for reclassification and recalibration effects, 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, 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, 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 as discussed in greater detail in section II.D. of the preamble of this proposed rule, we are proposing to make an adjustment to the proposed capital Federal rates based on actuarial estimates of the documentation and coding effects that occurred in FY 2008 (based on FY 2008 claims data). Therefore, we are not adjusting for reclassification and recalibration effects from FY 2008 in the update framework for FY 2010 because we have already accounted for it in the proposed documentation and coding adjustment to the proposed capital Federal rates. Therefore, we are proposing a 0.0 percent adjustment for DRG reclassification in the proposed update for FY 2010, as discussed above.

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 are proposing to make 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 CPI 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 proposed 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, we are proposing to establish a 0.0 percent adjustment for intensity for FY 2010, just 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 proposed 1.2 percent capital update factor under the capital update framework for FY 2010 as shown in the table below.

CMS FY 2010 PROPOSED UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	1.2
Intensity	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	−1.0
Projected Case-Mix Change	1.0
Subtotal	1.2
Effect of FY 2008 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Update	1.2

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. However, in that same report, in assessing the adequacy of current payments and costs, MedPAC recommended an update to the hospital inpatient and outpatient PPS rates equal to the increase in the hospital market basket in FY 2010, concurrent with a quality incentive program. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2009, Section 2A.)

2. Proposed Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier payment methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating IPPS DRG payments.

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 proposed thresholds as set forth in section II.A. of this Addendum, we estimate that outlier payments for capital-related costs would equal 5.46 percent for inpatient capital-related payments based on the proposed capital Federal rate in FY 2010. Therefore, we are proposing to apply an outlier adjustment factor of 0.9454 in

determining the proposed capital Federal rate. Thus, we estimate that the percentage of capital outlier payments to total capital standard payments for FY 2010 would be higher than the percentage for FY 2009. This increase in capital outlier payments is primarily due to the proposed decrease in estimated aggregate capital IPPS payments. That is, because overall payments are projected to be lower in FY 2010 compared to FY 2009, as discussed in section VIII. of Appendix A to this proposed rule, even more cases would qualify for outlier payments.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The proposed FY 2010 outlier adjustment of 0.9454 is a −0.12 percent change from the FY 2009 outlier adjustment of 0.9465. Therefore, the net change in the outlier adjustment to the proposed capital Federal rate for FY 2010 is 0.9988 (0.9454/0.9465). Thus, the proposed outlier adjustment decreases the proposed FY 2010 capital Federal rate by 0.12 percent compared with the FY 2009 outlier adjustment.

3. Proposed Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we no longer use the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the proposed factors for FY 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 proposed FY 2010 MS–DRG classifications and relative weights and the proposed FY 2010 GAFs. In making the comparison, we set the exceptions reduction factor to 1.00. To achieve budget neutrality for the proposed changes in the national GAFs, based on calculations using updated data, we are proposing to apply an incremental budget neutrality adjustment of 0.9999 for FY 2010 to the previous cumulative FY 2009 adjustment of 0.9917, yielding a proposed adjustment of 0.9916, through FY 2010. For the Puerto Rico GAFs, we are proposing to apply an incremental budget neutrality adjustment of 1.0015 for FY 2010 to the previous cumulative FY 2009 adjustment of 0.9960 (calculated with unrounded numbers), yielding a proposed cumulative adjustment of 0.9975 through FY 2010.

We then compared estimated aggregate capital Federal rate payments based on the FY 2009 DRG relative weights and the proposed FY 2010 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the proposed FY 2010 MS–DRG classifications and relative weights and the proposed FY 2010 GAFs. The proposed incremental adjustment for proposed DRG classifications and proposed changes in relative weights is 0.9995 both nationally and for Puerto Rico. The proposed cumulative adjustments for MS–DRG classifications and changes in relative weights and for proposed changes in the GAFs through FY 2010 are 0.9911 (calculated with unrounded numbers) nationally and 0.9969 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BILLING CODE 4210–01–P

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal Year	National				Puerto Rico			
	Incremental Adjustment			Cumulative	Incremental Adjustment			Cumulative
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined		Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	
1992	---	---	---	1.00000	---	---	---	---
1993	---	---	0.99800	0.99800	---	---	---	---
1994	---	---	1.00531	1.00330	---	---	---	---
1995	---	---	0.99980	1.00310	---	---	---	---
1996	---	---	0.99940	1.00250	---	---	---	—
1997	---	---	0.99873	1.00123	---	---	---	---
1998	---	---	0.99892	1.00015	---	---	---	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809	0.99662	1.00468	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028	1.00081	1.00109	0.99736
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028	1.00081	1.00109	0.99736
2005[11]	0.99967[12]	1.00094	1.00061[12]	0.99137	0.99115	1.00094	0.99208	0.98946
2005[13]	0.99946[12]	1.00094	1.00040[12]	0.99117	0.99115	1.00094	0.99208	0.98946
2006	1.00185[14]	0.99892	1.00076[14]	0.99198	1.00762	0.99892	1.00653	0.99592
2007	1.00000	0.99858	0.99858	0.99057	1.00234	0.99858	1.00092	0.99683
2008	1.00172	0.99792	0.99963	0.99021	1.00079	0.99792	0.99870	0.99554
2009[15]	1.00206	0.99945	1.00150	0.99170	1.00097	0.99945	1.00041	0.99595
2010[16]	0.99985	0.99950	0.99935	0.99105	1.00149	0.99950	1.00099	0.99693

[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]Proposed factors for FY 2010.

BILLING CODE 4210–01–C

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 are proposing to establish a GAF/DRG budget neutrality factor of 0.9994. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs. The incremental change in the proposed adjustment from FY 2009 to FY 2010 is 0.9994. The cumulative change in the proposed capital Federal rate due to this proposed adjustment is 0.9911 (the product of the incremental factors for FYs 1995 though 2009 and the proposed incremental factor of 0.9994 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 proposed cumulative adjustment of 0.9911 for FY 2010.)

The proposed factor accounts for the proposed MS–DRG reclassifications and recalibration and for proposed changes in the GAFs. It also incorporates the effects on the proposed GAFs of FY 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 proposed 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 proposed 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 2006 for all five of these hospitals, we calculated the adjustment based on actual cost experience. Using data from cost reports ending in FY 2006 from the December 2008 update of the HCRIS data, we divided the capital special exceptions payment amounts for the five 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 2006, this ratio is rounded to 0.0001. We also computed the ratio for FY 2005, which rounds to 0.0002, and the ratio for FY 2004, which rounds to 0.0003. Based on these data, we are proposing to make an adjustment of 0.0001. Because special exceptions are budget neutral, we are proposing to offset the proposed capital Federal rate by 0.01 percent for special exceptions payments for FY 2010. Therefore, the proposed exceptions adjustment factor is equal to 0.0001 (1–0.9999) to account for special exceptions payments in FY 2009.

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 proposed 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 estimate that exceptions payments in FY 2010 would equal 0.01 percent of aggregate payments based on the proposed FY 2010 capital Federal rate. Therefore, we are proposing to apply an exceptions payment adjustment factor of 0.9999 to the proposed capital Federal rate for FY 2010. The proposed exceptions adjustment factor for FY 2010 is the same as the factor used in determining the FY 2009 capital Federal rate as established in the FY 2009 IPPS final rule. 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 proposed exceptions adjustment factor used in determining the proposed FY 2010 capital Federal rate is 1.0000 (0.9999/0.9999).

5. Proposed 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 proposing an update of 1.2 percent in determining the proposed FY 2010 capital Federal rate for all hospitals. However, as discussed in greater detail in section III.E.1. of the preamble of this proposed rule, under the statutory authority at section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Public Law 110–90, we are proposing an additional 1.9 percent

reduction to the national capital Federal payment rate in FY 2010. The proposed 1.9 percent reduction is based on our Actuary's analysis of the effect of changes in case-mix resulting from documentation and coding changes that do not reflect real changes in the case-mix in light of the adoption of MS–DRGs. Accordingly, we are proposing to apply a cumulative documentation and coding adjustment of −3.4 percent (that is, the existing −1.5 percent adjustment plus the proposed additional −1.9 percent adjustment) by applying a factor of 0.967 (that is 1 divided by 1.034) in determining the national capital Federal rate for FY 2010. (As also discussed in greater detail in section III.E.2. of the preamble of this proposed rule, under the statutory authority at section 1886(g) of the Act, in conjunction with section 1886(d)(3)(A)(vi) of the Act and section 7(b) of Pub. L. 110–90, based on an analysis of the change in case-mix after the implementation of the MS–DRGs for hospitals located in Puerto Rico, we are proposing to apply a 1.1 percent reduction in developing the proposed FY 2010 Puerto Rico-specific capital rate.) As a result of the proposed 1.2 percent update and other proposed budget neutrality factors discussed above, we are proposing to establish a national capital Federal rate of $420.67 for FY 2010. The proposed national capital Federal rate for FY 2010 was calculated as follows:

- The proposed FY 2010 update factor is 1.0120, that is, the update is 1.2 percent.
- The proposed FY 2010 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for proposed changes in the MS–DRG classifications and relative weights and proposed changes in the GAFs is 0.9994.
- The proposed FY 2010 outlier adjustment factor is 0.9454.
- The proposed FY 2010 (special) exceptions payment adjustment factor is 0.9999.
- The proposed FY 2010 adjustment factor applied to the national capital Federal rate for changes in documentation and coding under the MS–DRGs is 0.967.

Because the proposed capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not proposing to make additional adjustments in the capital standard Federal rate for these factors, other than the budget neutrality factor for proposed changes in the MS–DRG classifications and relative weights and for proposed changes in the GAFs.

We are providing the following chart that shows how each of the proposed factors and adjustments for FY 2010 affected the computation of the proposed FY 2010 national capital Federal rate in comparison to the FY 2009 national capital Federal rate. The proposed FY 2010 update factor has the effect of increasing the proposed capital Federal rate by 1.2 percent compared to the FY 2009 capital Federal rate. The proposed GAF/DRG budget neutrality factor has the effect of decreasing the proposed capital Federal rate by 0.06 percent. The proposed FY 2010 outlier adjustment factor has the effect of decreasing the proposed capital Federal rate by 0.12 percent compared to the FY 2009 capital Federal rate. The proposed FY 2010 exceptions payment adjustment factor has no net effect on the proposed capital Federal rate. Furthermore, as shown in the chart below, the resulting cumulative adjustment for changes in documentation and coding that do not reflect real changes in patients' severity of illness (that is, the proposed cumulative adjustment factor of 0.967) has the net effect of decreasing the proposed FY 2010 national capital Federal rate by 1.83 percent as compared to the FY 2009 national capital Federal rate. (As discussed in section VI.E.1. of the preamble of this proposed rule, a cumulative adjustment of −1.5 percent (that is, a factor of 0.985) was applied to 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 proposed changes would decrease the national capital Federal rate by approximately 0.83 percent compared to the FY 2009 national capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2009 CAPITAL FEDERAL RATE AND PROPOSED FY 2010 CAPITAL FEDERAL RATE

	FY 2009	FY 2010	Change	Percent change
Update Factor [1]	1.0090	1.0120	1.0120	1.20
GAF/DRG Adjustment Factor [1]	1.0015	0.9994	0.9994	−0.06
Outlier Adjustment Factor [2]	0.9465	0.9454	0.9988	−0.12
Exceptions Adjustment Factor [2]	0.9999	0.9999	1.0000	0.00
MS–DRG Documentation and Coding Adjustment Factor	0.985	0.967	0.9817	−1.83
Capital Federal Rate	$424.17	$420.67	0.9917	−0.83

[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 proposed 0.9994 GAF/DRG budget neutrality factor for FY 2010 is 0.9994.

[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 proposed FY 2010 outlier adjustment factor is 0.9454/0.9465, or 0.9988.

6. Proposed Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments to hospitals located in Puerto Rico under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. Under the broad authority of section 1886(g) of the Act, as discussed in section VI. of the preamble of this proposed rule, beginning with discharges occurring on or after October 1, 2004, capital payments to hospitals located in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital

costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index, and varies depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated in section III.A.4. of this Addendum, the proposed national GAF budget neutrality factor is 0.9999, while the DRG adjustment is 0.9995, for a combined proposed cumulative adjustment of 0.9994.

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 are proposing to make to the other factors used to determine the proposed capital rate, the proposed FY 2010 special capital rate for hospitals in Puerto Rico is $201.91. As discussed in greater detail in section VI.E.1. of the preamble of this proposed rule, consistent with our development of the proposed Puerto Rico-specific operating standardized amount, we are proposing to reduce the Puerto Rico-specific capital rate by 1.1 percent to account for changes in documentation and coding as a result of the adoption of the MS–DRGs by applying a factor of 0.989 (that is, 1 divided by 1.011) in determining the proposed FY 2010 Puerto Rico-specific capital rate.

B. Calculation of the Proposed 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 proposed payments for each discharge during FY 2010, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor, if applicable). The result is the adjusted capital Federal rate. (As discussed above, under current law, there will no longer be an adjustment for IME under the capital IPPS beginning in FY 2010 (§ 412.322(d).)

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The proposed outlier thresholds for FY 2010 are in section II.A. of this Addendum. For FY 2010, a case would qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments is greater than the prospective payment rate for the MS–DRG plus the proposed fixed-loss amount of $24,240.

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 proposed rule, we are proposing to rebase and revise 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 proposed 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. (first quarter of 2009), we are forecasting the proposed FY 2006-based CIPI to increase 1.2 percent in FY 2010. This reflects a projected 1.7 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a 2.2 percent increase in other capital expense prices in FY 2010, partially offset by a 1.7 percent decline in vintage-weighted interest expenses in FY 2010. The weighted average of these three factors produces the 1.2 percent increase for the proposed FY 2006-based CIPI as a whole in FY 2010.

IV. Proposed Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. 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.)

We are proposing that the FY 2010 rate-of-increase percentage for cancer and children's hospitals and RNHCIs be the estimated 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 are proposing to use the most recent data available to determine the estimated FY 2010 IPPS operating market basket based on IHS Global Insight, Inc.'s first quarter 2009 forecast of the IPPS operating market basket increase, which is estimated to be 2.1 percent. (We are proposing to use more recent data when determining the estimated percentage increase for the FY 2010 IPPS operating market basket for the final rule, to the extent these data are available.)

IRFs, IPFs, and LTCHs were previously paid under the reasonable cost methodology. However, the statute was amended to provide for the implementation of prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provide transitioning periods of varying lengths of time during which a portion of the prospective payment is based on cost-based reimbursement rules under 42 CFR Part 413 (certain providers do not receive a transitioning period or may elect to bypass the transition as applicable under 42 CFR Part 412, Subparts N, O, and P). We note that all of the various transitioning periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended.

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We refer readers to section VIII. of the preamble and section V. of the Addendum to this proposed rule for the proposed update changes to the Federal payment rates for LTCHs under the LTCH PPS for RY 2010. The annual updates for the IRF PPS and the IPF PPS are issued by the agency in separate **Federal Register** documents.

V. Proposed Changes to the Payment Rates for the LTCH PPS for RY 2010

A. Proposed LTCH PPS Standard Federal Rate for FY 2010

1. Background

In section VIII. of the preamble of this proposed rule, we discuss our proposed changes to the payment rates, factors, and specific policies under the LTCH PPS for 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). 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 Proposed RY 2010 LTCH PPS Standard Federal Rate

As noted above and as discussed in greater detail in the RY 2007, RY 2008, and RY 2009 LTCH PPS final rules (71 FR 27819 through 27827, 72 FR 26887 through 2689, and 73 FR 26805 through 26812, respectively), 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 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 proposed rule, we performed a case-mix index (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, we have 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).

At this time, the most recent estimate of the proposed increase in the LTCH PPS market basket (that is, the FY 2002-based RPL market basket) for RY 2010 is 2.4 percent, as discussed in section VIII.B.2. of the preamble of this proposed rule. Consistent with our historical practice, in this proposed rule, we are proposing to update the LTCH PPS standard Federal rate for RY 2010 based on the full proposed LTCH PPS market basket increase estimate of 2.4 percent and a proposed adjustment to account for the increase in case-mix in prior periods (FYs 2007 and 2008) that resulted from changes in documentation and coding practices of 1.8 percent. Therefore, the proposed update factor to the standard Federal rate for RY 2010 is 0.6 percent (that is, we are proposing to apply a factor of 1.006 in determining the proposed LTCH PPS standard Federal rate for RY 2010, calculated as 1.024 × 1 divided by 1.018 = 1.006 or 0.6 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 proposing to specify 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 would be updated by 0.6 percent. In determining the proposed standard Federal rate for RY 2010, we are applying the proposed 1.006 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 proposed standard Federal rate for RY 2010 is $39,349.05. We also are proposing that if more recent data become available, we would use that data, if appropriate, to determine the update to the standard Federal rate for RY 2010 in the final rule, and, thus, the standard Federal rate update noted in the proposed regulation text at § 412.523(c)(3)(vi) could change.

B. Proposed 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 proposed 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. Proposed Updates to the Geographic Classifications/Labor Market Area Definitions

a. Background

As discussed in the August 30, 2002 LTCH PPS final rule, which implemented the LTCH PPS (67 FR 56015 through 56019), in establishing an adjustment for area wage levels 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, 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 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). Since that time, there have been two OMB bulletins announcing revisions to the CBSA designations. 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 proposed 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, we are proposing to apply 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, 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 proposed RY 2010 LTCH PPS wage index values presented in Tables 12A and 12B in the Addendum of this proposed rule reflect the proposed 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; 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, Colorado 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 proposed 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, we are proposing to apply 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 proposed 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 proposed RY 2010 LTCH PPS wage index values presented in Tables 12A and 12B in the Addendum of this proposed rule reflect the revisions to the CBSA-based labor market area 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 proposed rule, the revisions to the CBSA-based designations are also proposed for adoption under the IPPS effective beginning October 1, 2009.

3. Proposed LTCH PPS Labor-Related Share

As noted above in this section, under the adjustment for difference in area wage levels at § 412.525(c), the labor-related share of a LTCH's PPS 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 proposed 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 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 proposed rule, we are proposing to continue to use the FY 2002-based RPL market basket used under the LTCH PPS for RY 2010. Furthermore, for RY 2010, we are proposing to continue to define the LTCH PPS labor-related share as the national average proportion of operating costs that are attributable to wages and salaries, employee benefits, the labor-related portion of professional fees, all other labor-intensive services, and a labor-related portion of capital 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 are proposing to use IHS Global Insight Inc.'s first quarter 2009 forecast of the FY 2002-based RPL market basket for RY 2010 to determine the proposed labor-related share for the LTCH PPS for RY 2010 that would 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 proposed 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 proposing to establish a labor-related share of 75.904 percent under the LTCH PPS for the RY 2010. Furthermore, consistent with our historical practice of using the best data available, we also are proposing that if more recent data are available to determine the labor-related share used under the LTCH PPS for RY 2010, we would use these data for determining the RY 2010 LTCH PPS labor-related share in the final rule.

4. Proposed 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 proposed 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, we are proposing to use 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 proposed 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 proposed 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 propose wage index values using the same wage data to develop the proposed LTCH wage index as is used to develop the proposed 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 proposing to continue to use IPPS wage data as a proxy to determine the proposed 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 proposed 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 proposed rule.) Specifically, for the proposed 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 proposed FY 2010 IPPS wage index discussed in section III.F. of the preamble of this proposed 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 proposed FY 2010 IPPS wage index, the proposed RY 2010 LTCH PPS wage index values for the following CBSAs would 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 proposed rule).

The proposed RY 2010 LTCH PPS wage index values are computed consistent with the urban and rural geographic classifications (labor market areas) discussed in section V.B.2. of the Addendum of this proposed rule and consistent with the pre-reclassified IPPS wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS). The proposed 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 proposed 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 are proposing to use to compute the proposed RY 2010 LTCH PPS wage index).

In this proposed rule, we are proposing to determine 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 propose 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 are proposing to 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 are proposing to use to determine the proposed 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 proposed rule, we calculated the proposed RY 2010 wage index value for CBSA 25980 as the average of the proposed wage index values for all of the other urban areas within the State of Georgia (that is, CBSAs 10500, 12020, 12060, 12260, 15260, 16860, 17980, 19140, 23580, 31420, 40660, 42340, 46660 and 47580) (reflected in Table 12A of the Addendum of this proposed rule). (As noted above, there are currently no LTCHs located in CBSA 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.

We also are proposing to continue 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 are proposing to use to determine the proposed 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 proposed rule, we calculated the proposed 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 proposed RY 2010 LTCH PPS wage index value for rural Massachusetts is computed as the unweighted average of the proposed RY 2010 wage indexes for Barnstable County and Bristol County (reflected in Tables 12A and 12B in the Addendum of this proposed rule). (There are currently no LTCHs located in rural Massachusetts.) As discussed in the RY 2009 final rule (73 FR 26817), as IPPS wage data are dynamic, it is possible that rural areas without IPPS wage data will vary in the future.

The proposed RY 2010 LTCH wage index values that would be 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 proposed rule.

5. Proposed LTCH PPS Cost-of-Living Adjustment for LTCHs Located in Alaska and Hawaii

In the August 30, 2002 final rule (67 FR 56022), we established, under § 412.525(b), a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. In the RY 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.

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 proposing to apply a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the proposed standard Federal payment rate by the factors listed in the chart below because they are the most recent available data at this time. These proposed factors were obtained from the U.S. Office of Personnel Management (OPM) and are also proposed to be used under the IPPS effective October 1, 2009 (section II.B.2. of the Addendum of this proposed rule). In addition, we are proposing that if OPM releases revised COLA factors before publication of the final rule, we would use the revised factors for the development of LTCH PPS payments for RY 2010 and publish those revised COLA factors in the final rule.

PROPOSED 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. Proposed Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases

1. Background

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA, in the regulations at § 412.525(a), we established an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. We refer to these cases as high cost outliers (HCOs). Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level. These additional payments reduce the financial losses that would otherwise be incurred when treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients. We set the outlier threshold before the beginning of the applicable rate year so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS. Outlier payments under the LTCH PPS are determined consistent with the instructions issued for the IPPS outlier policy.

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 (currently 80 percent) 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 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 will result 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 type 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 proposed 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 December 2008 update of the PSF, we are proposing to establish a total CCR ceiling of 1.227 under the LTCH PPS that would be effective for discharges occurring on or after October 1, 2009, and on or before September 30, 2010. We also are proposing that if more recent data become available, we would use them to establish the LTCH PPS CCR ceiling for RY 2010 in the final rule.

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 a LTCH in one of the following circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling (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 a LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

In Table 8C of the Addendum to the FY 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 proposed rule, using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS total CCR data from the December 2008 update of the PSF, we are proposing LTCH PPS statewide average total CCRs for urban and rural hospitals that would be effective for discharges occurring on or after October 1, 2009, and through September 30, 2010, in Table 8C of the Addendum to this proposed rule. We also are proposing that if more recent data become available, we would use them to establish LTCH PPS statewide average total CCRs for urban and rural hospitals for RY 2010 in the 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 proposed rule. This policy is consistent with the policy that we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121) and as 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 proposed rule, there is no rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum of this proposed rule.

In addition, as we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48120 through 48121), in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, in this proposed rule, we use, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We use this proxy because we believe that the CCR data on the PSF for Maryland hospitals may not be entirely accurate (as discussed in greater detail in that same final rule (71 FR 48120)).

d. Reconciliation of LTCH HCO and SSO Payments

We note, 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 Proposed 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 LTCH's hospital specific 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 and 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. Thus, 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).

In this proposed rule, we are proposing to use the same methodology that we used in the RY 2009 final rule to calculate the fixed-loss amount for RY 2010 (using updated data and the proposed rates and policies established in this proposed 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 this proposed rule, in determining the proposed fixed-loss amount for RY 2010, we used the most recent available LTCH claims data and CCR data. Specifically, for this proposed rule, we used LTCH claims data from the December 2008 update of the FY 2008 MedPAR files and CCRs from the December 2008 update of the PSF to determine a fixed-loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments in RY 2010 because these data are the most recent complete LTCH data currently available. Consistent with our historical practice of using the best data available, we are proposing that if more recent LTCH claims data become available, we will use them for determining the fixed-loss amount for the 2010 LTCH PPS rate year in the final rule. We are proposing to determine the proposed 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, proposed Version 27.0 of the GROUPER (discussed in section VIII.B. of the preamble of this proposed rule). Furthermore, in determining the proposed RY 2010 fixed-loss amount using CCRs from the December 2008 update of the PSF, we used the proposed RY 2010 LTCH ''total'' CCR ceiling of 1.227 and the applicable proposed LTCH statewide average ''total'' CCRs presented in Table 8C in the Addendum of this proposed rule such that the proposed applicable statewide average CCR was assigned if, among other things, a LTCH's CCR exceeded the proposed ceiling (1.227). We note that, in determining the proposed RY 2010 fixed-loss amount in this proposed rule using the CCRs from the December 2008 update of the PSF, there was no need for us to independently assign the applicable proposed statewide average CCR to any LTCHs, as none of the LTCHs' CCRs in the PSF exceeds the proposed ceiling.

In this proposed rule, based on the data and policies described earlier in this proposed rule under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we are proposing to establish a fixed-loss amount of $16,059 for the RY 2010. Thus, we would pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the MS–LTC–DRG and the fixed-loss amount of $16,059). The proposed fixed-loss amount for RY 2010 of $16,059 is significantly lower than the RY 2009 fixed-loss amount of $22,960. The proposed decrease in the fixed-loss amount for RY 2010 is primarily due to the projected 2.8 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 proposed 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 December 2008 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 6.1 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 proposed rule, we estimate an increase LTCH PPS payments in RY 2010 due to the proposed 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 proposing to lower the fixed-loss amount is appropriate and necessary to maintain that estimated outlier payments would equal 8 percent

of estimated total LTCH PPS payments as required under § 412.525(a). 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)), proposing to lower the fixed-loss amount results in more cases qualifying as outlier cases as well as increases the amount of the additional payment for a HCO case because the maximum loss that a LTCH must incur before receiving an HCO payment (that is, the fixed-loss amount) would be 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 a HCO target of 8 percent is appropriate, as discussed in greater detail below. However, we are soliciting 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.

As an alternative to proposing to lower the 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 would 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 without lowering the fixed-loss amount, we would pay outlier cases 10 percent more of the estimated costs that exceed the HCO threshold. While this alternative could 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 FR56025). 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 are not proposing to adjust the marginal cost factor under the LTCH PPS HCO policy at this time. However, we are soliciting 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. We note that, as we discussed in the RY 2009 LTCH PPS final rule (73 FR 26824 through 26825), for the past several rate years, in proposing changes to the fixed-loss amount we solicited public comments on whether we should revisit the regression analysis referenced above that was used to establish the existing 8 percent outlier target and 80 percent marginal cost factor, using the most recent available data to evaluate whether the current outlier target of 8 percent or the 80 percent marginal cost factor should be adjusted and, therefore, could have mitigated the magnitude of the change in the fixed-loss amount for RYs 2007, 2008, and 2009, respectively. In response to these solicitations, we received no public comments in support of any option that would allow us to revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor and existing outlier target of 8 percent, and 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.

In summary, we are proposing to establish a fixed-loss amount of $16,059 for RY 2010 based on the best available LTCH data and the policies presented in this proposed rule because we believe a proposed 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 proposed rule, we are projecting an increase in total LTCH PPS payments systemwide. In accordance with § 412.523(d)(1), we reduce the standard Federal rate by 8 percent for the estimated proportion of LTCH PPS HCO payments. Because we are estimating 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 ALOS for the specific MS–LTC–DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the high cost outlier 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 would be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed fixed-loss amount of $16,059 and the amount paid under the SSO policy as specified in § 412.529).

D. Computing the Proposed Adjusted LTCH PPS Federal Prospective Payments for RY 2010

In accordance with § 412.525, the proposed standard Federal rate is adjusted to account for differences in area wages by multiplying the proposed labor-related share of the proposed standard Federal rate by the appropriate proposed LTCH PPS wage index (as shown in Tables 12A and 12B of the Addendum of this proposed rule). The proposed standard Federal rate is also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the proposed nonlabor-related share of the proposed standard Federal rate by the appropriate proposed cost-of-living factor (shown in the chart in section V.C.5. of the Addendum of this proposed rule). In this proposed rule, we are proposing to establish a standard Federal rate for the 2010 LTCH PPS rate year of $39,349.05, as discussed in section V.A.2. of the Addendum of this proposed rule. We illustrate the methodology to adjust the proposed 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 proposed RY 2010 LTCH PPS wage index value for CBSA 16974 is 1.0478 (Table 12A of the Addendum of this proposed rule). The Medicare patient is classified into MS–LTC–DRG 28 (Spinal Procedures with MCC), which has a proposed relative weight for RY 2010 of 1.1175 (Table 11 of the Addendum of this proposed rule).

To calculate the LTCH's total adjusted Federal prospective payment for this Medicare patient, we compute the wage-adjusted proposed Federal prospective payment amount by multiplying the unadjusted proposed standard Federal rate ($39,349.05) by the proposed labor-related share (75.904 percent) and the proposed wage index value (1.0478). This wage-adjusted amount is then added to the proposed nonlabor-related portion of the unadjusted proposed standard Federal rate (24.096 percent; adjusted for cost of living, if applicable) to determine the adjusted proposed Federal rate, which is then multiplied by the proposed MS–LTC–DRG relative weight (1.1175) to calculate the total adjusted proposed Federal prospective payment for the 2010 LTCH PPS rate year ($45,567.98). The table below illustrates the components of the calculations in this example.

Unadjusted Proposed Standard Federal Prospective Payment Rate	$39,349.05
Proposed Labor-Related Share	x 0.75904
Labor-Related Portion of the Proposed Federal Rate	= 29,867.50
Proposed Wage Index (CBSA 16974)	x 1.0478
Proposed Wage-Adjusted Labor Share of Proposed Federal Rate	= 31,295.17
Proposed Nonlabor-Related Portion of the Proposed Federal Rate ($39,349.05 x 0.24096)	+ 9,481.55
Adjusted Proposed Federal Rate Amount	= 40,776.72
Proposed MS–LTC–DRG 9 Relative Weight	x 1.1175
Total Adjusted Proposed Federal Prospective Payment	= 45,567.98

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 1E, 2, 3A, 3B, 4A, 4B, 4C, 4D–1, 4D–2, 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 (67.1 Percent Labor Share/32.9 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—December 2008 GROUPER V26.0 MS–DRGs
Table 7B.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2008 MedPAR Update—December 2008 GROUPER V27.0 MS–DRGs
Table 8A.—Proposed Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—March 2009

BILLING CODE 4210–01–P

Table 8B.—Proposed Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals—March 2009
Table 8C.—Proposed Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs—March 2009
Table 9A.—Hospital Reclassifications and Redesignations—FY 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)—March 2009
Table 11.—Proposed MS–LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for Discharges Occurring from October 1, 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

BILLING CODE 4210–01–P

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (67.1 PERCENT LABOR SHARE/32.9 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
$3,441.26	$1,687.30	$3,373.85	$1654.25

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
$3,179.71	$1,948.85	$3,117.42	$1,910.68

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	$3,441.26	$1,687.30	$3,179.71	1,948.85
Puerto Rico	$1,515.55	$928.88	$1,473.99	$970.44

TABLE 1D.--CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$420.67
Puerto Rico	$201.90

TABLE 1E.—LTCH STANDARD FEDERAL PROSPECTIVE PAYMENT RATE

	Rate
Standard Federal Rate	$39,349.05

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

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	0.8399	23.2195	25.0592	24.8717	24.3916
010005	1.1409	0.8570	23.0203	25.7771	24.9062	24.5787
010006	1.4912	0.7910	23.7502	25.1401	26.7040	25.1577
010007	1.0370	0.7401	21.3492	22.0185	20.0559	21.1221
010008	1.0647	0.7575	22.0793	23.2572	22.8453	22.7506
010009	0.9770	0.8570	25.9011	25.8420	26.1402	25.9554
010010	1.1371	0.8494	22.8602	24.8390	26.2425	24.6363
010011	1.6352	0.8494	27.4668	27.1997	28.5815	27.7573
010012	1.1886	0.8677	25.5767	26.4989	24.8978	25.6327
010015	0.9860	0.7447	27.0806	23.6821	22.9860	24.4257
010016	1.6043	0.8494	26.8611	28.9724	28.7406	28.1987
010018	1.3280	0.8494	24.8974	26.9514	26.7651	26.2064
010019	1.2610	0.7910	23.3460	25.0170	25.7999	24.7072
010021	1.3432	0.7453	21.0624	21.7601	24.3386	22.3604
010022	1.0016	0.9593	27.4318	28.7529	26.5377	27.4930
010023	1.7857	0.8472	26.1739	28.2135	30.0709	28.2510
010024	1.6439	0.8472	25.0715	26.6636	28.1849	26.6962
010025	1.3410	0.8468	23.6186	23.8617	20.1877	22.4610
010027	0.7493	0.7427	17.0513	18.2508	19.7733	18.4082
010029	1.5941	0.8468	25.0468	24.3622	28.3214	25.8269
010032	0.8590	0.7726	18.5545	20.8458	24.7718	21.8600
010033	2.2169	0.8494	29.1471	29.2036	29.3793	29.2497
010034	1.1255	0.8472	19.1549	21.3728	21.0577	20.5460
010035	1.2858	0.8494	24.2746	26.5299	28.0560	26.2295
010036	1.1369	0.7401	24.2887	23.3876	24.9993	24.2317
010038	1.3696	0.7661	27.0752	28.9646	29.7965	28.5755
010039	1.7148	0.8937	28.6462	29.8034	30.6628	29.7277
010040	1.6267	0.8425	24.7657	25.9856	25.2861	25.3467
010043	1.2118	0.8494	23.9121	25.3633	27.5473	25.5107
010044	1.0798	0.7401	24.4276	23.4020	27.3416	25.0199
010045	1.0348	0.7623	23.1695	24.2450	25.1152	24.1988
010046	1.5412	0.8425	25.9105	25.4465	33.3216	27.8326
010047	0.8784	0.7528	19.7542	21.7349	17.0972	19.5634
010049	1.1617	0.7427	22.4248	23.1194	25.4447	23.6307
010050	1.0933	0.8494	24.4060	25.3678	27.0380	25.5741

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)
010051	0.8953	0.8955	18.0305	20.0765	21.4124	19.7502
010052	0.8833	0.8472	36.3638	22.7571	22.1397	27.5750
010054	1.1018	0.8570	24.4810	25.4209	24.6163	24.8378
010055	1.5977	0.8332	22.4145	25.3306	26.4715	24.7204
010056	1.5700	0.8494	24.5754	25.7290	28.5054	26.2908
010058	1.0845	0.8494	17.0150	31.1865	21.7601	22.0014
010059	1.0250	0.8570	24.8199	27.8613	29.5438	27.4642
010061	0.9502	0.8688	25.2454	25.7048	26.5043	25.8290
010062	1.0314	0.7510	21.7112	22.9491	20.8339	21.7852
010064	1.8036	0.8494	27.6149	26.6333	*	27.1325
010065	1.5107	0.8494	24.3346	24.4454	25.9466	24.9241
010066	0.8171	0.7401	25.4612	25.6052	25.9257	25.6609
010068	***	*	24.4145	*	*	24.4145
010069	0.9767	0.7401	23.6272	27.3438	29.4660	26.6106
010073	0.8929	0.7401	19.0046	20.7833	19.9727	19.9246
010078	1.6528	0.7661	24.3828	25.2897	24.5436	24.7422
010079	1.1836	0.8937	22.3034	23.1025	25.4191	23.6305
010083	1.1724	0.7746	24.0036	25.0422	25.3352	24.8204
010084	***	*	26.5079	27.5069	*	26.9470
010085	1.3476	0.8570	23.6280	24.0475	25.6084	24.4039
010086	1.1096	0.7401	21.5584	26.9753	24.9474	24.3214
010087	2.3204	0.7746	24.8320	27.4929	27.2748	26.4872
010089	1.2856	0.8494	26.2628	25.9719	26.9370	26.4009
010090	1.7636	0.8168	26.3957	25.6110	26.8038	26.2726
010091	0.9073	0.7447	22.5272	23.6555	27.8574	24.4934
010092	1.5002	0.8955	26.9959	28.8433	30.3277	28.8001
010095	0.8259	0.8955	17.0024	17.8248	21.6559	18.8633
010097	0.8004	0.8472	19.2481	18.4218	19.5176	19.0364
010099	0.9884	0.7401	20.6736	22.3686	20.8638	21.3014
010100	1.6800	0.8183	25.1460	25.4357	25.8199	25.4811
010101	1.1744	0.8494	25.0974	26.2744	25.0966	25.4900
010102	0.9450	0.8472	26.9859	26.6943	22.6887	25.4345
010103	1.9052	0.8494	28.9636	30.4032	26.8517	28.7008
010104	1.8083	0.8494	28.3126	30.4963	29.1024	29.2740
010108	1.1551	0.8472	25.4325	26.8900	27.7656	26.7717
010109	1.0126	0.7806	21.0449	21.9300	19.3984	20.6950
010110	0.8051	0.7616	19.8738	22.1175	17.9443	20.0584
010112	0.9695	0.7401	20.4027	21.3904	22.0924	21.3255
010113	1.6342	0.7746	24.7170	25.0704	25.7874	25.1934
010114	1.4449	0.8494	25.7090	25.3666	25.8027	25.6247
010118	1.2792	0.8494	22.7191	25.3689	25.7673	24.5853
010120	0.9724	0.7401	22.1868	22.8177	22.0805	22.3629

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)
010125	1.0728	0.7877	22.8911	23.6549	24.1935	23.5857
010126	1.0958	0.8472	24.4957	25.7254	28.9040	26.2608
010128	0.8926	0.7447	24.9881	25.9421	25.1028	25.3658
010129	1.0914	0.7535	21.8502	24.4816	25.2111	23.9308
010130	0.9779	0.8494	24.5644	25.2790	23.8567	24.5053
010131	1.3668	0.8937	27.2707	28.0487	28.6778	28.0344
010137	1.3484	0.8494	28.5843	30.4361	30.7488	29.9880
010138	0.6311	0.7467	14.5551	15.0815	16.7556	15.5099
010139	1.5991	0.8494	28.1473	29.3560	29.3682	28.9596
010143	1.2004	0.8570	24.0674	25.0871	25.1528	24.7498
010144	1.6314	0.7746	22.3916	23.8601	25.4632	23.9064
010145	1.5498	0.8955	25.8293	27.3296	30.2146	27.7362
010146	1.0598	0.7661	22.6879	23.8076	24.6574	23.7086
010148	0.8908	0.7401	23.5714	25.0960	24.8409	24.4809
010149	1.3063	0.8472	25.4354	26.8920	28.1348	26.9321
010150	0.9874	0.7528	24.4098	25.0070	26.3257	25.2189
010152	1.2783	0.7746	23.7803	26.0793	23.0263	24.2093
010157	1.1477	0.7910	24.2206	27.1793	27.5683	26.1836
010158	1.3024	0.7751	25.5905	26.2363	26.8825	26.2369
010163	***	*	34.0325	*	*	34.0325
010164	1.1968	0.8494	23.2447	25.6759	24.4440	24.4682
010165	***	*	28.8040	*	*	28.8040
010166	***	*	29.7256	*	*	29.7256
010167	1.5552	0.8494	*	*	24.7652	24.7652
010168	1.4982	0.8797	*	*	30.2029	30.2029
010169	1.0218	*	*	*	*	*
020001	1.8167	1.1938	36.5298	38.1784	39.2694	38.0220
020006	1.3328	1.1938	37.0211	37.2853	40.5456	38.4165
020008	1.2471	1.1938	39.3432	40.6783	42.8114	40.9895
020012	1.4164	1.1652	33.9375	36.1911	37.0203	35.7424
020014	1.1716	*	30.9722	30.6343	*	30.7977
020017	2.1444	1.1938	35.8804	38.2157	41.2480	38.4892
020018	0.9300	1.9319	*	*	*	*
020024	1.1745	1.1652	38.6934	39.9943	35.9382	38.1707
020026	1.5704	1.9319	*	*	*	*
020027	1.0148	1.9319	*	*	*	*
020028	1.2652	1.1938	*	*	*	*
030001	1.5332	1.0487	33.4178	35.9083	38.1240	35.8267
030002	2.1075	1.0487	31.0818	32.9094	34.3030	32.7844
030006	1.7793	0.9702	27.7421	29.1248	32.1695	29.7588
030007	1.3822	1.1906	33.7213	35.5226	38.1231	35.8238
030010	1.5704	0.9702	30.6261	31.8640	33.3098	31.9879

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)
030011	1.6034	0.9702	28.8203	30.2096	31.8572	30.3475
030012	1.5765	1.0383	29.1042	31.3068	33.0900	31.2714
030013	1.5440	0.9297	31.2815	31.9162	31.1795	31.4593
030014	1.5999	1.0487	29.8296	30.6308	31.8563	30.8227
030016	1.3369	1.0487	30.7896	31.1878	30.6237	30.8688
030017	2.1804	1.0487	34.4852	34.8488	34.9538	34.7662
030018	***	*	31.8056	31.7240	34.2888	32.6107
030019	1.2752	1.0487	30.1934	33.6553	36.3338	33.3229
030022	1.8479	1.0487	30.3746	35.0772	34.3415	33.3719
030023	1.8996	1.2468	35.8287	37.5523	41.8149	38.3568
030024	2.1838	1.0487	33.1797	35.3556	38.5618	35.8586
030027	0.9841	*	*	*	*	*
030030	1.7560	1.0487	34.4166	36.4772	38.9090	36.6624
030033	1.3387	1.1906	29.9383	32.0362	34.0187	32.0783
030036	1.4973	1.0487	33.0523	35.7464	37.1307	35.4209
030037	1.9164	1.0487	34.1079	35.1342	35.8155	35.0016
030038	1.7202	1.0487	31.7238	31.2928	33.8080	32.3983
030043	1.3165	0.8817	27.3856	28.3158	29.0838	28.2535
030055	1.5121	1.0383	27.1621	31.0806	37.2690	31.8419
030061	1.6594	1.0487	28.1337	33.0847	34.2103	31.8065
030062	1.2990	0.8817	28.9587	29.9359	30.3882	29.7840
030064	2.0752	0.9702	29.8226	31.6632	33.1586	31.6038
030065	1.6659	1.0487	31.0817	31.4602	33.8977	32.1771
030067	1.0036	0.9115	27.4497	27.0784	27.4450	27.3255
030068	1.1336	0.8817	23.8792	26.0296	26.8381	25.6220
030069	1.4754	1.1098	29.7802	30.7723	35.1823	32.0606
030071	0.9382	1.4430	*	*	*	*
030073	1.1721	1.4430	*	*	*	*
030074	0.8683	1.4430	*	*	*	*
030077	0.8290	1.4430	*	*	*	*
030078	1.2740	1.4430	*	*	*	*
030080	***	*	28.6568	30.7682	34.2785	31.2802
030083	1.4547	1.0487	33.5302	35.8521	39.0917	36.1873
030084	1.0279	1.4430	*	*	*	*
030085	1.5874	0.9702	28.1388	29.0774	30.7189	29.2802
030087	1.7637	1.0487	31.2331	31.1094	33.0390	31.8932
030088	1.3982	1.0487	29.9758	30.5738	33.5440	31.4083
030089	1.6261	1.0487	30.1591	31.3179	32.8906	31.4860
030092	1.5069	1.0487	30.6343	30.4394	31.6506	30.9462
030093	1.3713	1.0487	27.8821	33.0720	33.5059	31.6316
030094	1.5484	1.0487	33.4050	34.2040	35.9241	34.5892
030099	1.0041	*	26.9227	24.9127	*	25.9405

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)
030100	2.1888	0.9702	34.7532	35.0981	36.9830	35.6074
030101	1.4298	1.1534	30.6764	33.2139	34.1188	32.7163
030102	2.5350	1.0487	33.6247	36.9539	39.4662	36.7183
030103	1.7849	1.0487	32.2833	34.2770	41.6500	36.2812
030105	2.4535	1.0487	32.7449	33.9875	37.6993	34.8564
030106	***	*	36.4667	40.1657	43.9071	40.0078
030107	2.0233	1.0487	35.5386	35.4562	35.9203	35.6345
030108	2.3003	1.0487	29.9395	34.8507	33.2796	33.1020
030110	1.6728	1.0487	29.7949	36.2158	38.0498	34.7306
030111	1.1217	0.9702	33.3711	28.5146	33.3650	31.7726
030112	2.0296	1.0487	36.6601	33.4810	36.1532	35.3536
030113	0.9902	1.4430	*	*	*	*
030114	1.3424	0.9702	*	28.8466	30.2161	29.5503
030115	1.5005	1.0487	*	32.5885	34.8435	33.8340
030117	1.4722	1.0607	*	*	34.5366	34.5366
030118	1.2518	1.0383	*	*	28.2981	28.2981
030119	1.4947	1.0487	*	*	38.2403	38.2403
030120	0.8758	1.0487	*	*	39.8198	39.8198
030121	1.4550	1.0487	*	*	*	*
030122	1.3140	1.0487	*	*	*	*
030123	1.5497	1.0487	*	*	*	*
030124	2.6277	1.0487	*	*	*	*
030125	3.2446	1.0487	*	*	*	*
040001	1.1460	0.8788	22.9948	24.4962	25.0158	24.1496
040002	1.2229	0.7576	25.0000	24.0487	26.2095	25.0837
040004	1.7027	0.8788	28.1117	29.2714	30.1341	29.1924
040007	1.7278	0.8678	29.1941	28.3305	29.1432	28.8698
040010	1.4340	0.8788	26.5287	28.2375	28.0489	27.6258
040011	0.9797	0.7576	22.2431	22.6327	25.6251	23.4894
040014	1.3398	0.8450	28.9855	34.8279	24.1275	27.0303
040015	1.1006	0.7576	20.1061	22.3148	23.2128	21.9433
040016	1.7116	0.8678	26.5911	26.4806	27.6530	26.9313
040017	1.0997	0.8176	23.8768	24.3772	25.3399	24.5300
040018	1.1868	0.8005	25.6751	26.2521	25.3371	25.7515
040019	1.0300	0.8950	24.9113	26.4932	25.5493	25.6458
040020	1.6095	0.8950	23.9470	26.1529	25.9762	25.3558
040021	1.4842	0.8678	26.1853	27.6799	28.7687	27.5157
040022	1.4773	0.8788	27.9902	30.0250	29.6015	29.1808
040026	1.5873	0.9129	29.5299	31.8588	32.2832	31.2258
040027	1.5645	0.8190	23.8220	25.7935	27.2447	25.6463
040029	1.4566	0.8678	25.1479	27.8882	27.8421	26.9710
040036	1.6862	0.8678	29.7150	30.4906	32.0778	30.7581

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)
040039	1.2327	0.8176	21.4819	22.9807	23.4462	22.6304
040041	1.1879	0.8450	26.4964	26.4435	27.8602	26.9331
040042	1.2983	0.9276	19.8709	23.1661	23.5782	22.1184
040047	1.0151	0.7693	23.0358	23.3557	25.0104	23.8202
040050	1.2063	0.7576	18.5119	19.6946	21.0180	19.7284
040051	0.9553	0.7576	22.0394	22.1981	23.4765	22.5828
040054	***	*	19.5353	*	*	19.5353
040055	1.5801	0.8005	24.9164	26.0150	26.3414	25.7607
040062	1.6460	0.8005	25.2303	25.6554	28.5895	26.4626
040067	1.1206	0.7583	18.9872	20.9700	21.3496	20.3712
040069	1.0228	0.8950	24.9996	23.3117	23.0874	23.7804
040071	1.5589	0.8450	25.2840	26.6645	25.0186	25.6335
040072	1.2213	0.7576	22.1058	22.9671	23.3199	22.8093
040074	1.2546	0.8678	26.2661	27.3897	27.4625	27.0451
040076	1.0391	0.8986	23.0954	24.7903	25.7468	24.5138
040078	1.7561	0.8450	26.1937	25.6886	27.9406	26.5902
040080	1.0191	0.7808	24.8760	26.5905	26.9464	26.2010
040081	0.8928	0.7933	17.2536	18.4759	18.5244	18.0700
040084	1.1838	0.8678	26.6449	28.1570	28.7392	27.8416
040085	0.9628	0.8950	25.7215	26.6987	26.3827	26.2723
040088	1.6482	0.7937	23.6276	24.7119	26.7054	25.0333
040091	1.2277	0.8165	23.1913	22.3311	27.7985	24.3836
040100	***	*	22.6131	24.5458	24.7762	24.0070
040114	1.8912	0.8678	27.7928	28.5702	29.1211	28.4893
040118	1.4432	0.7576	26.8908	26.5783	27.3369	26.9378
040119	1.4207	0.8450	24.2419	25.6779	26.9583	25.6891
040126	***	*	17.3715	*	*	17.3715
040132	***	*	22.0054	21.8140	*	21.8932
040134	2.3335	0.8678	32.2832	34.9673	35.2081	34.1844
040137	1.3572	0.8678	27.7360	27.7638	26.8334	27.4000
040138	1.4653	0.8788	28.3342	33.0073	31.0018	30.8214
040141	***	*	30.3475	33.8791	34.8519	33.1076
040142	1.5793	0.9129	23.8620	23.1302	24.4871	23.8491
040145	2.0152	0.7808	24.4367	20.3878	22.1725	22.2321
040146	***	*	33.7876	*	*	33.7876
040147	1.9243	0.8678	*	35.7669	33.6425	34.5578
040149	2.8606	0.7775	*	*	*	*
040150	3.5552	0.8678	*	*	*	*
040151	0.8493	0.8788	*	*	*	*
050002	1.5196	1.5998	41.7336	43.1760	42.3868	42.4377
050006	1.6996	1.3431	37.1639	41.7714	43.8938	40.7748
050007	1.5151	1.5703	45.8773	49.5271	60.1822	51.6924

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)
050008	1.4465	1.5557	46.8706	50.9569	50.4785	49.4544
050009	1.7181	1.4503	46.2186	49.7177	51.4536	49.2527
050013	1.9116	1.4503	43.5623	43.4906	46.1312	44.4239
050014	1.2225	1.3320	37.4135	42.2044	42.7320	40.8901
050016	1.3829	1.2106	31.0653	34.3863	36.3692	34.0771
050017	2.0091	1.3570	42.2200	44.4857	46.6239	44.4936
050018	1.3631	1.1890	31.8310	34.0338	34.2900	33.3251
050022	1.6861	1.1660	33.0592	36.6360	38.9235	36.3354
050024	1.1893	1.1660	33.4334	33.5247	34.6946	33.8905
050025	1.8351	1.1660	32.7476	36.9233	39.5393	36.4690
050026	1.6001	1.1660	33.1277	35.0306	36.3345	34.8713
050028	1.2936	1.1660	28.5736	28.1584	28.5492	28.4277
050030	1.2416	1.1660	30.9014	33.5654	33.2466	32.5843
050036	1.6646	1.1660	36.0905	37.4298	38.7908	37.4969
050038	1.6570	1.5905	48.7483	55.2197	54.9995	53.0794
050039	1.5904	1.1660	36.6943	34.9262	37.8150	36.4256
050040	1.4532	1.1890	35.7054	38.1665	42.2236	38.7149
050042	1.5233	1.3431	40.3326	40.5791	45.6138	42.1911
050043	1.6918	1.5998	48.2283	51.9529	55.4727	51.9216
050045	1.3659	1.1660	27.0676	28.5952	27.8923	27.8527
050046	1.2228	1.1769	29.1125	34.2529	32.8738	31.9527
050047	1.8073	1.5557	45.1675	48.5961	51.4339	48.4735
050054	1.2588	1.1660	24.0338	27.1320	27.9088	26.4596
050055	1.4222	1.5557	44.2926	48.2796	52.0022	48.1332
050056	1.4442	1.1890	32.7693	34.7964	33.2699	33.6031
050057	1.7461	1.1660	31.7467	33.7574	35.6374	33.7446
050058	1.6682	1.1890	37.2538	38.9843	41.4853	39.3090
050060	1.5631	1.1660	32.0196	34.1183	35.1074	33.7626
050063	1.5708	1.1890	36.3085	36.6301	40.9612	37.9252
050065	***	*	38.2421	42.0085	*	40.1992
050067	1.2534	1.2363	40.1393	41.8988	41.1620	41.0593
050069	1.7808	1.1769	35.3850	38.1339	40.0532	37.8950
050070	1.2439	1.5703	46.4009	48.9362	53.8353	49.9362
050071	1.4802	1.5905	49.6495	52.0696	55.4056	52.4778
050072	1.4521	1.5801	50.0343	51.4538	54.7822	52.2526
050073	1.3603	1.5801	49.0069	50.6523	54.2351	51.3945
050075	1.3951	1.5998	49.8290	51.1187	54.8387	52.0438
050076	1.7639	1.5801	50.2039	50.5761	53.8102	51.6073
050077	1.6289	1.1660	36.5384	37.4989	38.5840	37.6661
050078	1.3063	1.1890	30.4274	37.1940	38.9291	35.3292
050079	1.6133	1.5801	48.8994	48.3017	50.6640	49.2660
050082	1.7923	1.1769	37.8905	42.0181	41.8896	40.5709

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)
050084	1.5813	1.3320	39.5748	41.1276	42.0198	40.9424
050089	1.3725	1.1769	36.4018	39.6297	39.9747	38.6938
050090	1.4013	1.5557	37.7421	41.6026	44.0926	41.1635
050091	1.0100	1.1890	37.1223	40.1063	34.8216	37.2737
050093	1.5711	1.1660	36.8486	37.7244	38.5726	37.7327
050095	***	*	*	44.2400	*	44.2400
050096	1.4421	1.1890	33.1322	33.3803	27.6273	31.3765
050099	1.5777	1.1769	32.0650	34.3507	35.4746	33.9247
050100	1.7931	1.1660	33.3959	34.2839	36.9542	34.8753
050101	1.4703	1.5801	47.9327	48.7495	54.5233	50.5658
050102	1.3981	1.1660	32.8434	33.2837	35.4764	33.8527
050103	1.6019	1.1890	35.6773	37.3608	38.8473	37.3588
050104	1.4962	1.1890	33.6204	37.4417	39.1163	36.8301
050107	1.5857	1.2093	33.5687	36.5843	40.5338	36.9076
050108	1.9026	1.3570	42.0131	45.3460	48.8207	45.3574
050110	1.2987	1.2093	28.0670	30.9054	31.9696	30.3347
050111	1.1580	1.1890	31.8766	31.9394	31.1156	31.6502
050112	1.5420	1.1890	38.9483	39.9951	41.8330	40.3302
050113	1.2549	1.5703	42.8884	46.3471	43.1285	44.0572
050114	***	*	35.7274	37.5924	36.6590	36.6722
050115	1.5039	1.1660	32.5257	33.3013	37.7662	34.4885
050116	1.6781	1.1890	37.6018	45.7510	40.4068	41.3932
050117	***	*	35.0531	*	*	35.0531
050118	1.1957	1.2363	41.6701	41.8191	43.4521	42.3390
050121	1.2641	1.1660	34.6244	35.1135	36.9085	35.7130
050122	1.5158	1.2372	34.0259	36.8821	40.4569	37.0809
050124	1.2944	1.1890	29.9944	31.7690	33.3098	31.7162
050125	1.4989	1.5905	47.7578	53.6300	57.6303	53.5781
050126	1.5931	1.1890	32.6686	35.1909	34.9820	34.3237
050127	1.4551	1.3570	40.7610	42.5226	46.3861	43.4284
050128	1.5539	1.1660	33.4233	34.2364	36.7019	34.8522
050129	1.9164	1.1769	36.9887	40.3786	41.4298	39.6604
050131	1.4334	1.5801	47.5257	52.8228	56.6611	52.5385
050132	1.5288	1.1890	39.6807	43.6747	42.7978	42.0779
050133	1.5143	1.3320	33.1814	35.2433	36.2555	35.0282
050135	0.9807	1.1890	25.3209	25.4431	28.5105	26.3901
050136	1.4274	1.5557	46.6619	51.8508	52.5462	50.5803
050137	1.4648	1.1890	40.2457	43.5305	45.2117	43.0529
050138	1.8689	1.1890	40.6343	45.1011	47.3887	44.4033
050139	1.3088	1.1890	38.7385	43.0734	44.5792	42.1928
050140	1.4429	1.1769	39.4954	42.7590	44.8962	42.4531
050144	***	*	38.2424	40.4760	*	39.2990

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)
050145	1.6200	1.5332	48.0796	49.4479	54.8936	50.8996
050146	1.8067	*	*	*	*	*
050149	1.5452	1.1890	37.3616	43.1926	42.8051	41.2061
050150	1.2599	1.3320	37.9946	43.5937	44.2895	41.8957
050152	1.5144	1.5801	51.6567	54.7176	55.9672	54.2061
050153	1.5122	1.5905	47.6374	50.4884	53.5991	50.7696
050155	***	*	16.7756	*	*	16.7756
050158	1.3845	1.1890	39.9160	42.7874	42.9522	41.9397
050159	1.4248	1.1769	34.6915	35.0153	40.2133	36.8507
050167	1.5002	1.2372	34.0418	38.0742	40.0942	37.4419
050168	1.6098	1.1769	40.5973	40.8362	37.9780	39.7321
050169	1.5655	1.1890	31.4115	33.1130	35.4877	33.4729
050173	1.4207	1.1769	31.6717	32.3265	31.8384	31.9458
050174	1.6658	1.5557	48.1740	53.7113	54.8012	52.3569
050175	***	*	35.0152	*	*	35.0152
050179	1.2229	1.2363	31.6651	34.6558	36.2164	34.2273
050180	1.6323	1.5801	45.7099	48.7425	51.1874	48.6980
050188	1.5131	1.5905	43.7381	45.8501	49.6773	46.1958
050189	1.0309	1.5332	28.7580	31.5805	27.5328	29.3169
050191	1.6446	1.1890	37.8756	41.7185	40.0521	39.9212
050192	0.9710	1.1660	27.8386	27.4611	29.4408	28.2636
050193	1.2713	1.1769	29.0623	36.7240	39.0210	34.3185
050194	1.3831	1.5998	49.0030	49.8539	49.9971	49.6270
050195	1.6096	1.5998	53.5583	57.6563	61.8361	57.7956
050196	1.1775	1.1660	32.8293	41.1300	43.7637	39.0928
050197	2.0396	1.5998	52.9998	55.3173	59.0395	55.8976
050204	1.4472	1.1890	35.3954	38.8689	37.4040	37.2654
050205	1.4418	1.1890	30.6322	30.6117	30.2831	30.5108
050207	***	*	31.3431	*	*	31.3431
050211	1.3307	1.5998	35.0289	42.9254	44.8819	41.1584
050215	***	*	50.7578	*	*	50.7578
050219	1.4820	1.1890	25.8378	26.7061	26.9040	26.4635
050222	1.6843	1.1660	33.7510	35.4045	36.0249	35.1314
050224	1.6925	1.1769	35.7280	37.3442	39.5627	37.6064
050225	1.5265	1.1660	35.1227	37.5252	38.9312	37.2730
050226	1.5128	1.1769	35.4597	36.5354	38.4990	36.8633
050228	1.3094	1.5557	47.1430	49.9063	54.5712	50.6440
050230	1.7510	1.1769	35.8490	38.8901	39.8649	38.2015
050231	1.8197	1.1890	33.7139	37.0245	38.7319	36.5676
050232	1.6133	1.2106	34.3242	35.4055	39.4322	36.5191
050234	1.5286	1.1660	34.8308	37.7125	37.6835	36.8286
050235	1.4931	1.1890	37.0858	39.1744	40.0999	38.8119

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)
050236	1.4684	1.1769	32.6462	34.4257	42.5874	36.3675
050238	1.6730	1.1890	34.0823	35.1268	36.4309	35.2661
050239	1.6564	1.1890	35.9041	36.3257	36.5490	36.2697
050240	***	*	40.7427	*	*	40.7427
050242	1.4639	1.5998	50.9882	53.8385	58.5544	54.5393
050243	1.6149	1.1660	36.1209	37.8538	40.0594	37.9814
050245	1.3581	1.1769	33.2556	34.7153	34.4434	34.1532
050248	1.1522	1.5332	40.4941	46.0329	47.7719	44.8167
050254	1.3280	1.3570	33.0865	33.5069	34.8372	33.8494
050256	***	*	32.7159	32.6841	*	32.7009
050257	0.8700	1.1660	24.0737	29.2651	30.7776	28.1659
050261	1.2833	1.1660	30.8704	33.7196	34.8195	33.2171
050262	2.1742	1.1890	41.4835	43.7709	40.8211	41.9376
050264	1.4465	1.5998	43.4181	50.1691	54.4079	49.3545
050270	***	*	36.0111	*	*	36.0111
050272	1.4714	1.1769	30.9290	32.2584	34.2921	32.5407
050276	1.0620	1.5801	43.7943	47.2432	49.2237	46.7609
050277	1.2188	1.1890	35.0079	*	49.0354	41.4944
050278	1.5881	1.1890	34.3798	38.5689	39.5966	37.5522
050279	1.3431	1.1769	31.6738	32.1695	31.0903	31.6408
050280	1.8076	1.3431	41.3912	43.6243	46.1346	43.8248
050281	1.4591	1.1890	31.6639	31.0706	31.4184	31.3831
050283	1.6751	1.5998	43.6855	45.1132	50.3102	46.4260
050289	1.6482	1.5703	50.1762	52.0918	53.8632	52.0958
050290	1.7628	1.1890	40.6192	42.0099	42.2300	41.6264
050291	2.1154	1.5557	41.2100	44.6102	49.7686	45.4275
050292	1.0695	1.1660	27.3365	35.0372	34.6460	32.6141
050295	1.4457	1.1660	38.4256	39.7399	39.0114	39.0875
050296	1.1929	1.5998	42.5405	44.8135	48.2663	45.2635
050298	1.2155	1.1671	33.7864	33.6947	31.7390	33.0210
050299	***	*	32.3707	*	*	32.3707
050300	1.3876	1.1769	33.6821	37.1275	39.2752	36.7813
050301	1.3188	1.5070	37.1103	36.3681	36.7584	36.7460
050305	1.4748	1.5998	48.5339	56.9756	55.7270	53.7719
050308	1.5475	1.5905	46.4180	49.0132	50.2949	48.6588
050309	1.4681	1.3570	40.1499	42.9280	45.2729	42.7936
050313	1.1794	1.2372	37.5024	39.0663	42.4039	39.6968
050315	1.4955	1.1660	32.5538	37.3560	40.3190	36.9230
050320	1.2617	1.5998	46.2071	50.6708	50.9832	49.3705
050324	1.7981	1.1660	36.3474	37.1883	38.9555	37.5514
050325	0.7197	1.1693	37.0441	34.0343	24.9337	31.6423
050327	1.7444	1.1769	35.9349	36.9550	37.7715	36.9199

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)
050329	1.3362	1.1660	33.0390	36.7669	37.6751	35.8670
050333	1.8307	*	18.6534	*	*	18.6534
050334	1.6541	1.5998	47.2968	50.9834	54.9394	51.1773
050335	1.4391	1.2363	34.7192	37.2347	37.1725	36.4067
050336	1.2541	1.2372	31.5480	33.0325	35.3758	33.3944
050342	1.3022	1.1660	30.4226	29.8389	31.6867	30.6675
050348	1.8134	1.1769	32.7107	33.5276	35.1148	33.7931
050349	0.9151	1.1660	25.4266	23.1095	23.5282	23.9346
050350	1.3978	1.1890	31.7908	34.6747	36.1872	34.1762
050351	1.5717	1.1890	33.3064	35.0042	35.6119	34.6730
050352	1.4089	1.3570	37.0807	38.6265	40.7335	38.8159
050353	1.5551	1.1890	30.4206	37.1716	37.4432	34.8143
050357	1.4846	1.2093	36.2089	38.9244	41.3525	38.8005
050359	1.2193	1.1660	31.3391	30.3988	30.9755	30.8948
050360	1.5683	1.5801	52.3811	55.3738	59.2202	55.9392
050366	1.1372	1.1675	37.1527	41.8324	42.7897	40.5495
050367	1.5054	1.5801	40.1904	40.0453	41.1185	40.4589
050369	1.4846	1.1890	32.2467	33.3357	34.7420	33.4832
050373	1.4160	1.1890	34.3737	37.6695	40.9408	37.6247
050376	1.7385	1.1890	35.2837	36.7270	39.8314	37.4112
050378	1.0804	1.1890	40.1923	42.0480	50.0820	43.7419
050380	1.7334	1.5905	49.4258	52.5804	58.6462	53.6484
050382	1.5274	1.1890	32.6683	32.9248	34.3736	33.3532
050385	1.3823	1.5557	36.4188	36.5644	38.9805	37.2282
050390	1.2352	1.1660	27.9359	33.0463	31.4151	30.7035
050393	1.4095	1.1890	35.6356	35.1887	35.5725	35.4650
050394	1.7539	1.1769	32.1894	32.9572	34.7273	33.2884
050396	1.6051	1.2093	37.3972	38.9944	41.8225	39.4567
050397	0.8791	1.1660	29.6825	31.1621	32.3704	31.2141
050407	1.1109	1.5557	44.6839	47.5591	47.7964	46.7108
050411	1.3188	1.1890	38.6328	42.9884	44.3454	42.1166
050414	1.2606	1.3570	41.8688	45.1621	45.8103	44.3873
050417	1.3676	1.1660	36.1222	37.9951	38.9080	37.6859
050420	***	*	39.9237	*	*	39.9237
050423	0.9097	1.1660	31.9751	32.4108	41.3137	35.2262
050424	1.8835	1.1660	36.6091	37.5246	39.8868	38.1038
050425	1.4006	1.3570	46.6628	45.3743	52.0427	48.0412
050426	1.5848	1.1769	34.9855	37.6505	*	36.2570
050430	1.0024	1.1660	24.5327	25.9368	28.7242	26.6691
050432	***	*	35.2416	*	*	35.2416
050433	***	*	21.1287	23.0949	*	21.8861
050434	1.0072	1.1660	33.7794	35.4807	34.4715	34.5582

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)
050435	1.2399	1.1660	33.0372	35.7427	35.3102	34.7326
050438	1.5712	1.1890	36.2044	38.2855	34.7181	36.3416
050441	2.0461	1.5905	46.6160	49.2129	50.0753	48.7446
050444	1.4405	1.1893	37.6821	39.3947	32.8862	36.2742
050447	***	*	29.0780	27.1271	*	28.1938
050448	1.3163	1.1660	32.7748	32.6682	34.7137	33.3786
050454	2.0707	1.5557	40.2811	43.5230	46.9650	43.7251
050455	1.5338	1.1660	34.5445	35.0232	38.9918	36.1704
050456	***	*	27.7659	27.9702	28.1481	27.9262
050457	1.6229	1.5557	50.0282	53.3175	54.5276	52.6809
050464	1.8237	1.2363	41.6235	42.6699	44.9193	43.0421
050468	1.6473	1.1890	35.7409	37.3416	35.7134	36.2584
050470	***	*	31.0466	32.5041	*	31.8030
050471	1.7355	1.1890	36.8680	36.8185	37.6677	37.1240
050476	1.4978	*	41.1042	41.7566	*	41.4396
050477	***	*	40.1566	*	*	40.1566
050478	0.9651	1.2093	41.1668	41.5635	45.5425	42.8357
050481	1.6084	1.1890	38.8650	42.8536	47.2370	43.0188
050485	1.6760	1.1890	34.6219	34.7078	37.4241	35.6435
050488	1.5050	1.5998	45.0630	49.3604	53.8054	49.5804
050492	1.3426	1.1660	30.7718	32.6609	35.6870	33.0864
050494	1.3521	*	40.6384	*	*	40.6384
050496	1.8005	1.5801	51.6363	56.7446	57.1074	55.2321
050498	1.3732	1.3570	41.0350	45.3508	46.6592	44.3008
050502	1.6773	1.1890	31.8872	32.9791	39.8013	34.7766
050503	1.5669	1.1660	37.3605	37.7210	40.7380	38.6906
050506	1.4880	1.2106	39.8586	40.6534	42.3734	40.9615
050510	1.2416	1.5801	49.4533	51.3143	54.8762	52.0463
050512	1.4151	1.5998	48.8057	50.1470	53.9344	51.1349
050515	1.3519	1.1660	40.2957	42.0106	45.1016	42.5007
050516	1.5617	1.3570	43.0249	45.6228	48.5312	45.8186
050517	1.3003	1.1769	22.4096	29.3694	29.8405	27.1492
050523	1.3076	1.5801	43.4579	46.9870	49.5066	46.8196
050526	1.3356	1.1769	33.3964	35.5457	*	34.4882
050528	1.1847	1.1660	36.2908	38.3051	41.9954	38.8621
050531	1.1644	1.1890	28.3348	28.4890	28.4986	28.4433
050534	1.4960	1.1660	36.6447	38.1892	39.7714	38.2256
050535	***	*	37.8174	*	*	37.8174
050537	1.5653	1.3570	38.2145	41.5275	43.1793	40.9287
050541	1.5957	1.5998	48.0867	51.4545	55.2645	51.6575
050543	0.7581	1.1769	24.4913	32.8367	29.0543	28.4739
050545	0.8643	1.1890	35.3209	*	27.4885	30.7614

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)
050546	0.9013	1.1660	36.5099	*	*	36.5099
050547	1.0661	1.5557	33.8036	*	*	33.8036
050548	0.8853	1.1769	41.1075	*	*	41.1075
050549	1.6842	1.1769	38.3927	40.6796	44.6753	41.2531
050550	***	*	34.9476	39.2163	*	37.0016
050551	1.3734	1.1769	37.2506	37.6223	39.4100	38.1102
050552	0.9575	1.1890	33.9810	35.3468	38.6815	36.0010
050557	1.6013	1.2363	35.7023	39.2224	41.9353	38.9762
050561	1.3332	1.1890	38.2543	40.1567	43.1181	40.5710
050567	1.4772	1.1769	37.6384	39.0114	41.7276	39.5098
050568	1.2403	1.1660	26.0908	26.7733	28.7738	27.2395
050570	1.6746	1.1769	38.4373	40.6761	40.3457	39.7885
050571	***	*	39.0649	*	*	39.0649
050573	1.5704	1.1660	35.2842	36.8561	38.0205	36.7526
050575	1.3669	1.1890	23.7990	22.1018	32.0999	25.7383
050578	***	*	31.3639	43.4917	*	37.7526
050580	1.2357	1.1769	34.1531	35.0966	36.7991	35.3675
050581	1.4706	1.1890	37.7567	40.0909	41.9827	39.9323
050583	***	*	37.4450	40.5845	41.3975	39.8243
050584	***	*	30.7839	31.9910	30.8692	31.2239
050586	1.5377	1.1769	31.3513	31.1932	32.7383	31.7635
050588	1.4009	1.1890	37.7387	39.4251	39.0379	38.7494
050589	1.2342	1.1769	37.6886	37.2056	39.2680	38.0668
050590	1.4082	1.3570	41.7519	44.3382	50.0403	45.4204
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	35.6662	33.4001
050599	1.9445	1.3570	34.7187	36.6146	38.9926	36.8252
050601	1.5350	1.1890	39.7717	43.2404	43.3374	42.1206
050603	1.4831	1.1769	35.0279	35.4809	37.4382	36.0756
050604	1.3745	1.5905	49.4446	49.6068	54.1742	51.1402
050608	1.3372	1.1660	31.2909	30.7280	28.3117	30.0681
050609	1.5110	1.1769	39.7397	43.4555	45.2545	42.8912
050613	***	*	42.9930	*	*	42.9930
050615	***	*	39.1299	*	*	39.1299
050616	1.5516	1.1769	37.1200	40.7388	45.2648	40.9065
050618	0.9849	1.1660	33.1472	34.9177	34.0630	34.0435
050624	1.4376	1.1890	35.9346	39.2553	40.2428	38.5847
050625	1.8200	1.1890	41.0439	44.8482	48.1865	44.7886
050633	1.2200	1.2106	38.4916	40.7383	41.1853	40.1498
050636	1.3104	1.1660	33.0718	35.4565	38.8898	35.8026

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)
050641	1.1910	1.1890	32.3586	32.0508	33.1461	32.5238
050644	1.0129	1.1890	30.7981	33.2777	32.1496	32.1012
050660	1.7720	*	*	*	*	*
050662	***	*	38.3017	*	*	38.3017
050663	1.3408	1.1890	17.7035	17.7252	30.4121	21.1169
050667	0.9232	1.4503	25.9161	25.8460	30.0709	27.2276
050668	1.2168	1.5801	51.6049	52.7011	62.7734	55.8809
050674	1.3224	1.3570	47.0720	48.6880	51.3570	49.1871
050677	1.4663	1.1890	39.2161	41.8130	44.4628	41.9200
050678	1.3068	1.1769	33.7633	35.8411	38.3404	36.1403
050680	1.3167	1.5801	37.9856	39.0389	40.7650	39.2954
050682	0.9113	1.1660	22.2193	22.3903	22.4443	22.3448
050684	1.2784	1.1660	28.8378	33.5915	33.1012	31.9265
050686	1.3842	1.1660	39.7757	42.1444	45.2286	42.4530
050688	1.2433	1.5905	49.4062	53.2741	54.5466	52.4935
050689	1.5846	1.5801	48.8533	48.9935	50.3005	49.4111
050690	1.2351	1.5557	49.0226	51.6179	55.1056	52.0165
050693	1.3762	1.1769	39.6838	42.8266	41.9676	41.4913
050694	1.1180	1.1660	32.1065	34.8486	33.8576	33.6254
050695	***	*	49.0340	*	*	49.0340
050696	2.3948	1.1890	39.8963	39.4353	41.2376	40.1564
050697	1.1598	1.3431	22.1441	26.7600	29.0853	25.7538
050699	***	*	21.5725	*	*	21.5725
050701	1.3618	1.1660	34.9876	37.2839	38.2252	36.9139
050704	1.0676	1.1890	31.6097	32.2017	31.7093	31.8439
050707	***	*	43.5555	44.0254	49.4742	45.9258
050708	1.7654	1.1660	31.8442	28.3074	34.4100	31.2589
050709	1.5764	1.1769	24.5621	29.5364	30.4591	28.2560
050710	1.4735	1.1660	44.2482	46.2533	51.1504	47.3154
050713	***	*	21.4825	*	*	21.4825
050714	1.4691	1.5998	34.1542	42.9797	45.2842	40.9238
050717	1.6051	1.1890	38.8773	37.0875	42.4184	39.5193
050718	***	*	31.9622	*	*	31.9622
050720	1.5874	1.1769	30.3595	32.1173	33.8822	32.0763
050722	0.9344	1.1660	33.7991	35.6741	35.1844	34.9279
050723	1.4007	1.1890	38.7140	42.1571	43.3900	41.4787
050724	1.9522	1.1660	35.2344	35.1020	35.5264	35.2825
050725	0.9466	1.1890	30.0580	28.8389	27.8602	28.8154
050726	1.5877	1.2363	28.6361	30.6105	35.4014	31.5348
050727	1.2979	1.1890	32.7783	33.0932	29.0817	31.5712
050728	***	*	41.8263	*	*	41.8263
050729	***	*	38.1882	*	*	38.1882

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)
050730	***	*	39.2046	*	*	39.2046
050732	2.3521	1.1660	33.6831	34.3475	37.4362	35.2463
050733	1.6232	1.3431	40.1517	40.6320	44.7542	41.6970
050734	***	*	31.2883	*	*	31.2883
050735	1.4251	1.1890	*	36.6081	34.3895	35.4572
050736	1.3360	1.1890	*	41.8938	38.0938	39.9681
050737	1.6114	1.1890	*	38.0424	36.4569	37.2389
050738	1.6097	1.1890	*	43.9259	40.3102	42.0931
050739	1.7028	1.1890	*	57.2480	44.0598	49.3605
050740	1.6572	1.1890	*	54.0370	45.2699	48.8737
050741	***	*	*	51.1526	44.0363	47.5944
050742	1.5424	1.1890	*	39.2532	41.1150	40.1714
050744	1.8433	1.1769	*	48.4951	56.6486	52.3303
050745	1.4422	1.1769	*	42.5523	48.2814	45.4477
050746	1.7960	1.1769	*	43.2015	46.3606	44.7908
050747	1.6108	1.1769	*	44.5887	47.8264	46.1436
050748	1.2906	1.2372	*	43.1008	50.6431	46.9333
050749	1.3957	1.1769	*	28.2000	39.6018	32.7011
050750	***	*	*	33.9915	*	33.9915
050751	3.0315	1.1890	*	29.5488	34.0481	31.4131
050752	1.3624	1.1890	*	39.8035	41.3838	40.5997
050753	1.5385	1.1890	*	*	*	*
050754	1.2776	1.5703	*	*	56.3669	56.3669
050755	1.6247	1.1890	*	*	36.5235	36.5235
050756	***	*	*	*	33.4996	33.4996
050757	1.7287	1.1660	*	*	*	*
050758	1.5404	1.1769	*	*	17.6533	17.6533
050759	3.0472	1.1660	*	*	*	*
060001	1.4560	1.0403	31.0018	32.4226	32.5263	31.9811
060003	1.4711	1.0403	31.3616	31.8637	33.6300	32.3012
060004	1.1952	1.0566	32.0095	34.8428	34.5779	33.8335
060006	1.3126	0.9674	27.2057	27.6453	30.5686	28.4718
060008	1.4079	0.9674	26.5175	27.2071	26.1133	26.5892
060009	1.4709	1.0566	32.4208	34.0151	35.8433	34.0856
060010	1.4511	0.9828	29.5304	30.6424	33.5573	31.2894
060011	1.5392	1.0566	32.1001	34.4171	34.6362	33.7598
060012	1.5450	0.9674	28.7724	29.4365	29.6985	29.2980
060013	1.5050	0.9674	27.9145	28.0800	29.5130	28.5167
060014	1.9395	1.0566	31.9389	33.0366	35.3055	33.4303
060015	1.9029	1.0566	32.2927	36.3296	36.6933	35.0151
060016	1.2360	0.9674	27.1430	28.3055	30.0651	28.4793
060018	1.2844	*	25.3897	26.5788	*	25.9769

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)
060020	1.6066	0.9674	25.9147	26.7362	26.9022	26.5264
060022	1.6032	0.9674	29.3379	31.9376	32.0612	31.1478
060023	1.6803	1.0403	31.1556	32.7922	33.4822	32.4812
060024	1.9044	1.0566	31.5411	32.8206	36.1954	33.5952
060027	1.5644	1.0403	30.9212	31.6134	33.4911	31.9228
060028	1.5999	1.0566	32.1656	33.4966	35.8261	33.8038
060030	1.4402	0.9828	29.9513	31.2932	31.2772	30.8377
060031	1.5476	1.0403	29.3907	30.7381	32.0225	30.6990
060032	1.6158	1.0566	32.7383	34.6447	35.6535	34.2981
060034	1.7000	1.0566	32.1252	33.3656	34.6266	33.3767
060036	1.1593	0.9674	22.8256	20.9370	24.8253	22.8354
060041	0.8805	*	25.9710	31.4739	*	28.4919
060043	0.9166	0.9674	21.9955	23.3908	20.0087	21.8624
060044	1.1810	0.9674	24.8352	28.9200	32.0467	28.3600
060049	1.3879	0.9828	30.2192	32.1589	34.5282	32.3663
060054	1.4378	0.9868	25.0980	24.6721	28.0342	26.0812
060064	1.7366	1.0566	33.2428	37.2407	34.7521	35.0377
060065	1.4969	1.0566	33.8538	34.9205	36.1714	34.9868
060071	1.1517	0.9674	28.1762	31.5388	32.1390	30.7114
060075	1.3373	0.9868	37.6023	35.8081	37.3043	36.8963
060076	1.2429	0.9674	30.7808	31.6044	31.5037	31.2856
060096	1.8177	1.0403	37.8243	38.2249	40.5986	39.0100
060100	1.7223	1.0566	33.2145	33.5356	35.8060	34.1702
060103	1.4470	1.0403	32.9690	33.7542	35.0043	33.9375
060104	1.3977	1.0566	35.4409	37.1434	37.4735	36.7077
060107	0.7177	1.0566	28.0660	30.3991	30.0378	29.5209
060112	1.7334	1.0566	34.7116	35.1308	36.4125	35.4995
060113	1.4690	1.0566	32.6073	35.2097	36.0863	34.6740
060114	1.5251	1.0566	34.8536	35.3056	37.1481	35.8949
060115	0.9100	0.9674	*	*	*	*
060116	1.4165	1.0403	*	33.1547	36.3598	34.9064
060117	1.4845	0.9674	*	28.3112	31.2614	29.9467
060118	1.5547	0.9674	*	*	40.2216	40.2216
060119	1.9723	0.9828	*	*	*	*
060120	1.1273	*	*	*	*	*
060121	1.6971	1.0403	*	*	*	*
070001	1.6437	1.2380	37.0403	37.9438	38.4909	37.8326
070002	1.7686	1.1359	34.7636	36.4269	36.6673	35.9572
070003	1.1240	1.1355	35.6320	36.0524	36.6578	36.1207
070004	1.2203	1.1927	29.9557	31.2115	34.3903	31.8459
070005	1.5631	1.2380	34.9404	36.5502	37.2509	36.2821
070006	1.5739	1.2865	39.3935	41.2165	41.9608	40.8733

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)
070007	1.3316	1.1578	36.2914	37.0984	38.9867	37.4776
070008	1.2975	1.1359	30.7305	35.4969	34.0634	33.4317
070009	***	*	35.5670	36.6382	38.1432	36.8195
070010	1.6536	1.2865	36.7227	38.6114	38.8784	38.0691
070011	1.4419	1.1355	31.6843	32.6835	34.8610	33.0803
070012	1.3909	1.1359	31.9345	33.2477	35.4765	33.5976
070015	1.5383	1.2865	37.3454	39.9249	42.4771	39.9533
070016	1.5279	1.2380	33.2391	34.1266	34.5473	33.9823
070017	1.4330	1.2380	35.6456	37.5855	35.4449	36.2220
070018	1.4603	1.2865	41.8460	42.4771	43.9214	42.7755
070019	1.4701	1.2380	33.7246	35.8618	37.0704	35.5314
070020	1.3518	1.1404	32.9714	35.6542	40.5555	36.6121
070021	1.1698	1.1355	38.5623	39.7793	41.9147	40.0679
070022	1.6796	1.2380	40.2283	41.4721	41.5585	41.1114
070024	1.4602	1.1578	34.7419	36.8997	38.6333	36.7538
070025	1.7451	1.1359	34.5887	36.1322	38.7121	36.4424
070027	1.5357	1.1359	30.4433	33.5979	36.4835	33.5109
070028	1.5644	1.2865	38.0855	40.9645	41.2197	40.1326
070029	1.3106	1.1359	31.0662	32.8504	34.6754	32.8676
070031	1.3370	1.2380	30.4054	30.5924	33.2648	31.4437
070033	1.4800	1.2865	41.7955	44.6717	46.6012	44.4118
070034	1.4667	1.2865	40.1685	42.4111	45.7738	42.8170
070035	1.3288	1.1359	32.2766	33.4047	37.3840	34.4259
070036	1.6717	1.1927	42.3391	43.6374	44.0853	43.3689
070038	***	*	35.8053	29.9516	33.5141	32.5923
070039	1.0328	1.2380	34.7219	32.7153	35.9361	34.6235
070040	1.0864	1.1359	*	*	32.0857	32.0857
080001	1.6614	1.0544	33.5310	34.9507	37.4164	35.3611
080002	***	*	31.3391	33.0404	33.3496	32.5980
080003	1.5758	1.0544	34.3048	30.5132	29.0207	31.2330
080004	1.6244	1.0648	32.2443	34.3854	33.6217	33.4400
080006	1.3945	1.0013	28.8862	31.0327	30.8015	30.2671
080007	1.6231	1.0417	31.1645	33.4782	35.5451	33.4442
090001	1.7367	1.0749	38.3043	40.1658	38.3920	38.8924
090003	1.3179	1.0749	32.1960	34.4430	37.2160	34.4952
090004	2.0841	1.0787	37.3798	38.5681	39.9075	38.6840
090005	1.4076	1.0749	33.7448	35.2884	35.1369	34.7227
090006	1.4218	1.0749	31.3562	32.3654	32.6053	32.1095
090008	1.4753	1.0749	33.7471	36.6633	40.3308	36.5416
090011	2.0832	1.0787	38.0654	39.0111	39.5470	38.8974
100001	1.6239	0.9117	27.2809	27.8526	30.5282	28.6132
100002	1.5154	1.0394	28.7068	30.6668	33.1130	30.8345

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)
100006	1.6602	0.8979	28.3673	28.9769	29.2725	28.8884
100007	1.6163	0.8979	29.0472	30.3379	30.6716	30.0338
100008	1.7215	1.0043	30.3392	32.1679	32.3431	31.6259
100009	1.4498	1.0043	27.8618	30.0492	32.0274	29.9214
100012	1.6667	0.9073	29.8353	30.8626	30.2084	30.3149
100014	1.5339	0.8979	27.4019	27.4064	28.8697	27.9050
100015	1.2213	0.9020	27.2483	28.6825	29.9778	28.5517
100017	1.5765	0.8979	28.2402	29.8705	31.2342	29.8007
100018	1.7327	0.9765	30.6545	32.8642	34.2112	32.6170
100019	1.6305	0.9171	30.3008	31.4549	32.2662	31.3543
100022	1.6564	1.0394	36.7912	36.3355	40.4720	37.8250
100023	1.6300	0.8979	25.4270	27.1032	27.7845	26.8369
100024	1.3715	1.0043	29.5423	29.8918	31.5171	30.2760
100025	1.7470	0.8607	26.7013	27.1665	28.7736	27.5703
100026	1.6150	0.8607	26.0147	27.3044	28.5888	27.3359
100028	1.4075	0.9171	27.5664	28.7801	28.1537	28.1579
100029	1.3318	1.0043	30.5382	31.6006	33.2992	31.7951
100030	1.3934	0.8979	25.3513	26.3113	27.1000	26.2749
100032	1.7893	0.9020	26.9275	27.8942	29.3707	28.0695
100034	1.8072	1.0043	27.2915	28.9387	29.9028	28.7382
100035	1.5991	0.9501	30.2382	32.5593	31.2077	31.3232
100038	1.6243	1.0394	31.6657	32.8392	37.0987	33.8761
100039	1.7946	1.0394	29.3699	29.0236	32.6895	30.4323
100040	1.6868	0.9117	27.2835	28.3366	29.8059	28.4743
100043	1.3901	0.9020	27.0054	26.8417	29.1029	27.5710
100044	1.5505	0.9913	33.1141	34.3920	34.4777	34.0047
100045	1.3385	0.8979	26.5413	25.5621	27.8544	26.6571
100046	1.5479	0.9020	26.7702	27.7878	29.7867	28.2320
100047	1.6638	0.9501	29.9729	31.4072	31.9024	31.1108
100048	0.9362	0.8607	20.2657	21.7693	22.7267	21.5705
100049	1.3363	0.8607	24.5571	27.6316	26.9149	26.3321
100050	1.2006	1.0043	25.3354	23.5222	23.7439	24.1615
100051	1.4271	0.8979	28.6225	30.1492	28.7397	29.1657
100052	1.4136	0.8607	23.4036	25.1110	27.6606	25.4481
100053	1.3706	1.0043	31.7415	31.9268	33.7008	32.4346
100054	1.3650	0.8665	30.5515	30.9840	33.2252	31.6012
100055	1.4441	0.9020	27.3826	29.7027	28.5846	28.5124
100057	1.4403	0.8979	26.3134	27.7045	30.8150	28.2997
100061	1.5941	1.0043	30.4528	31.9174	33.9825	32.1197
100062	1.6563	0.8659	25.9597	26.3067	28.0849	26.7688
100063	1.3785	0.9020	26.4139	27.0769	29.5878	27.7074
100067	1.4230	0.9020	27.4762	27.5501	30.0567	28.3306

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)
100068	1.7586	0.8979	27.6576	27.7707	28.5200	27.9894
100069	1.5924	0.9020	27.2108	29.0486	33.4058	29.8101
100070	1.6608	0.9501	29.2005	29.1117	27.1329	28.4657
100071	1.3154	0.9020	25.3667	25.1883	25.6875	25.4260
100072	1.4374	0.8979	27.1889	27.6947	28.6461	27.8664
100073	1.7718	1.0394	29.4165	31.0395	33.8914	31.4719
100075	1.5331	0.9020	27.6534	26.7571	29.3013	27.8943
100076	1.2369	1.0043	24.0412	24.0280	23.7114	23.9218
100077	1.3998	0.9501	30.7564	27.9783	28.0192	28.9152
100079	1.6119	*	*	*	*	*
100080	1.5873	1.0394	29.5346	31.0516	33.2122	31.2504
100081	1.0165	0.8607	19.5711	19.7406	17.2548	18.8849
100084	1.6823	0.8979	32.7503	30.6301	30.7191	31.3027
100086	1.4021	1.0394	29.9072	31.3187	33.0745	31.4537
100087	1.8527	0.9501	30.5938	32.1314	33.4126	32.0468
100088	1.6483	0.9117	28.2825	29.4952	30.3544	29.4770
100090	1.4460	0.9117	27.6175	28.9581	27.5025	28.0367
100092	1.5851	0.9171	26.6315	28.6782	29.1453	28.1638
100093	1.7028	0.8607	22.5555	23.4847	24.9513	23.6785
100099	1.0617	0.8607	26.2395	28.0688	28.2959	27.5701
100102	1.0999	0.8607	27.8551	29.0396	30.0830	29.0027
100105	1.5979	0.9776	30.9915	30.8936	31.5332	31.1597
100106	1.0802	0.8607	24.8098	25.6288	20.6443	23.6266
100107	1.2020	0.9073	30.5764	31.2954	30.9684	30.9652
100108	0.8283	0.8607	22.6270	22.8153	17.9571	20.9194
100109	1.3250	0.8979	26.2446	26.7380	29.1419	27.4376
100110	1.5831	0.8979	29.5985	30.3758	32.4114	30.8338
100113	2.0689	0.9212	29.2429	30.6037	30.9870	30.3071
100114	***	*	30.2544	32.3956	34.3681	32.2200
100117	1.2538	0.9117	28.4928	30.0281	30.6968	29.7990
100118	1.4293	0.8607	27.0981	28.3201	31.3855	29.0184
100121	1.1867	0.8607	27.9353	25.0320	20.0824	24.0506
100122	1.2620	0.8665	26.7175	27.6178	27.9995	27.4507
100124	1.1606	0.8607	24.8880	26.2329	28.2675	26.4080
100125	1.2889	1.0043	31.7749	33.3499	35.2630	33.5433
100126	1.3306	0.9020	28.3213	28.9164	30.3898	29.1642
100127	1.5987	0.9020	27.4632	27.0686	29.3873	27.9826
100128	2.1643	0.9020	30.0324	30.6202	29.6819	30.1060
100130	1.1574	1.0394	28.3651	29.5763	29.9740	29.3226
100131	1.4319	1.0043	29.7647	30.9614	32.2119	31.0775
100132	1.2971	0.9020	27.8180	27.6632	29.3400	28.2867
100134	0.8177	0.8607	21.6544	22.9635	24.7901	23.1464

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)
100135	1.6606	0.8607	29.1856	29.8452	30.2115	29.7517
100137	1.4036	0.8607	26.8391	28.3000	27.8801	27.6861
100139	0.8320	0.9212	21.1310	21.4418	22.1648	21.5292
100140	1.1339	0.9117	27.8352	28.5485	29.7522	28.7327
100142	1.1823	0.8607	25.6999	26.8995	26.8828	26.5041
100150	1.2240	1.0043	27.7740	29.3711	33.0157	29.9701
100151	1.8286	0.9117	29.7267	31.3846	33.1756	31.4103
100154	1.6366	1.0043	29.7332	31.3640	32.3823	31.1668
100156	1.1428	0.9212	28.3927	28.3060	29.9044	28.8993
100157	1.6070	0.9020	30.3086	30.3359	30.4893	30.3801
100160	1.2338	1.0043	30.6902	32.3136	33.8458	32.3372
100161	1.5819	0.8979	29.5673	30.8984	32.6461	31.0416
100166	1.5769	0.9501	30.1811	31.9072	33.0034	31.6504
100167	1.3065	1.0394	31.7813	32.4740	34.8113	32.9898
100168	1.6446	1.0394	27.0938	28.0543	31.1465	28.8720
100172	***	*	22.2183	20.5518	*	21.5848
100173	1.6179	0.9020	28.6402	30.2491	30.3621	29.7642
100175	1.0537	0.8607	25.0913	26.1723	26.8830	26.0430
100176	1.8175	1.0394	33.3181	35.5849	35.7476	34.8936
100177	1.4181	0.9171	29.6284	31.0085	31.3953	30.6987
100179	1.7523	0.9117	29.2795	30.5439	31.8818	30.5818
100180	1.4569	0.9020	31.0099	31.5485	32.3805	31.6681
100181	1.3100	1.0043	23.9656	26.0682	26.0934	25.3742
100183	1.2700	1.0043	30.5042	32.9893	31.6833	31.7134
100187	1.4704	1.0043	30.7705	31.6660	31.8059	31.4242
100189	1.4257	1.0394	29.9376	30.5516	32.8875	31.1347
100191	1.3320	0.9020	29.4533	30.9212	31.6052	30.6373
100200	1.3674	1.0394	29.6400	29.0731	32.5627	30.4193
100204	1.5813	0.9212	27.2819	29.9334	30.6276	29.3198
100206	1.3174	0.9020	27.7551	28.8625	30.4569	29.0686
100209	1.6080	1.0043	28.5336	29.0462	30.5613	29.3617
100210	1.5330	1.0394	32.0830	32.4566	33.3065	32.6029
100211	1.1826	0.9020	26.2859	28.8328	30.5902	28.5406
100212	1.5297	0.8659	27.7960	29.2500	30.5168	29.1934
100213	1.5712	0.9501	29.5218	30.2271	31.4323	30.3998
100217	1.2729	0.9776	27.7683	30.3325	33.5886	30.4959
100220	1.6219	0.9073	29.3601	30.8292	31.8408	30.6708
100223	1.5879	0.8665	26.1115	27.6775	28.6465	27.4856
100224	1.2677	1.0394	28.0455	29.2008	31.0323	29.4173
100225	***	*	30.8782	32.6906	31.8093	31.8069
100226	1.3583	0.9117	28.8791	30.2857	30.8934	30.0376
100228	1.4394	1.0394	30.1635	31.0222	32.2697	31.1518

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)
100230	1.3169	1.0394	31.9448	34.6133	35.9386	34.2817
100231	1.6836	0.8607	26.6773	28.3652	28.7499	27.9215
100232	1.3171	0.9117	28.3892	29.3797	30.3779	29.3633
100234	1.3548	1.0394	28.8835	29.7818	33.1528	30.5624
100236	1.4614	0.9501	28.3017	30.5719	31.4395	30.1222
100237	1.8253	1.0394	33.1536	33.9626	33.9741	33.6789
100238	1.6104	0.9020	31.4198	31.6353	32.8762	31.9931
100239	1.4042	0.9020	29.0650	30.3234	32.7172	30.7144
100240	1.1217	1.0043	29.7000	31.0951	35.4571	32.1775
100242	1.5321	0.8607	26.1988	27.8169	28.5047	27.5148
100243	1.5327	0.9020	28.3894	29.8323	31.4882	29.8859
100244	1.4475	0.9073	28.2881	29.8287	29.1626	29.0942
100246	1.5751	0.9913	30.1061	30.0467	32.5093	30.8924
100248	1.5512	0.9020	30.2133	32.4725	33.7676	32.1369
100249	1.3608	0.9020	26.4676	28.5117	29.8021	28.2863
100252	1.2125	0.9776	27.1639	29.1448	31.5648	29.2790
100253	1.4480	1.0394	28.7770	28.5617	29.4979	28.9514
100254	1.5411	0.8607	27.4900	28.5262	28.9116	28.3144
100255	1.2773	0.9020	27.3866	29.5172	30.0463	29.0075
100256	1.7058	0.9020	30.2093	33.3936	34.6665	32.6793
100258	1.6302	1.0394	33.8630	35.2225	34.2909	34.4762
100259	1.2698	0.9020	29.0612	29.9294	32.2285	30.4196
100260	1.4306	0.9913	28.2301	29.4907	31.5693	29.7578
100264	1.5318	0.9020	28.0370	30.1980	31.5073	29.9432
100265	1.3376	0.9020	26.3326	26.6940	28.6933	27.3178
100266	1.4423	0.8607	24.2517	25.6382	26.4508	25.5176
100267	1.2193	0.9501	28.9674	30.6051	32.3977	30.6398
100268	1.2375	1.0394	30.5750	33.6225	33.5357	32.5816
100269	1.3939	1.0394	27.8407	28.3745	30.9595	29.0353
100271	2.1578	*	*	*	*	*
100275	1.3788	1.0394	28.7797	31.0487	31.5455	30.5154
100276	1.3254	1.0394	30.5720	31.7067	32.4011	31.5736
100277	1.5878	1.0043	24.1122	25.5926	27.0991	25.7545
100279	5.1231	0.9073	29.2257	31.1951	32.4333	31.0451
100281	1.3398	1.0394	30.9131	32.8840	36.3236	33.4707
100284	1.1491	1.0043	25.2637	21.4420	24.4173	23.4791
100285	1.2090	1.0394	41.9481	34.7999	36.2168	38.5437
100286	1.5263	0.9765	25.8085	26.5809	26.1515	26.1940
100287	1.4739	1.0394	29.7536	30.3085	32.3745	30.7644
100288	1.5913	1.0394	31.0506	32.9587	35.3411	33.0551
100289	1.6516	1.0394	31.9011	31.4727	31.7723	31.7118
100290	1.2455	0.8945	28.7111	29.7588	31.7132	30.1647

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)
100291	1.3472	0.9171	28.1515	28.3780	28.3477	28.3044
100292	1.4035	0.8607	27.7644	28.5807	29.8224	28.7793
100296	1.3598	1.0043	29.3870	31.1475	31.8761	30.8686
100297	***	*	32.1536	*	*	32.1536
100298	0.9638	0.8607	19.0297	21.9247	17.9701	19.3470
100299	1.3862	0.9501	34.3697	31.6840	31.4103	32.5483
100300	***	*	*	33.1693	*	33.1693
100301	***	*	*	*	33.6293	33.6293
100302	1.1378	0.8979	*	*	27.9375	27.9375
100303	3.3572	0.8607	*	*	*	*
100305	2.9508	0.9212	*	*	*	*
100306	2.1590	0.8607	*	*	*	*
100307	1.3368	0.9117	*	*	*	*
100308	3.5561	0.9020	*	*	*	*
100309	2.8615	0.9761	*	*	*	*
110001	1.4065	0.8688	26.5640	27.6480	28.5472	27.5851
110002	1.3243	0.9593	26.2228	28.9013	32.2915	29.1015
110003	1.3116	0.7836	24.2097	25.0089	26.0317	25.0918
110004	1.3526	0.8869	25.1846	27.2528	26.8838	26.3975
110005	1.3270	0.9593	27.2826	29.6009	30.4937	29.3135
110006	1.5835	0.9218	*	30.8495	32.2683	31.5899
110007	1.6372	0.8944	26.3133	28.0684	29.8636	28.0718
110008	1.4386	0.9593	30.9757	31.8387	33.5626	32.1920
110010	2.3056	0.9593	33.2396	33.9848	33.7099	33.6516
110011	1.3616	0.9593	28.5892	30.3534	32.2024	30.4314
110015	1.0999	0.9593	28.8796	30.5016	31.7246	30.4450
110016	1.3018	0.8468	24.3563	25.9209	26.3462	25.5342
110018	1.3150	0.9593	30.1849	30.9422	30.8335	30.6739
110020	***	*	27.5559	29.4641	30.4765	29.2917
110023	1.3954	0.9593	29.3282	29.2018	31.1902	29.9368
110024	1.4809	0.8980	27.3357	28.5660	30.7227	28.8746
110025	1.5127	0.9505	30.2845	31.8968	31.6783	31.2963
110026	1.1131	0.7836	22.8820	24.3863	25.6948	24.2844
110027	1.0277	0.7836	25.5291	25.6532	26.2664	25.7973
110028	1.7942	0.9167	31.4568	32.8706	*	32.1584
110029	1.7961	0.9593	29.2134	30.1146	31.6454	30.2871
110030	1.4207	0.9593	29.9531	32.0275	33.2166	31.8238
110031	1.2725	0.9593	29.5533	30.7462	30.4838	30.2718
110032	1.2052	0.7836	25.1896	24.4968	23.1173	24.2214
110033	***	*	32.4178	32.7039	31.9414	32.3613
110034	1.7484	0.9167	28.7915	29.6819	30.4085	29.6408
110035	1.7606	0.9593	30.1852	31.5737	31.8362	31.2280

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)
110036	1.9336	0.8980	27.2280	28.4041	29.4945	28.3987
110038	1.5425	0.8208	22.9685	23.3669	24.2745	23.5611
110039	1.3284	0.9167	26.2485	28.4376	28.9634	27.7627
110040	1.0813	0.9593	23.9526	21.5762	21.1942	22.1284
110041	1.2739	0.9593	26.1948	27.6609	29.2073	27.6868
110042	1.0764	0.9593	33.4391	34.5137	34.0268	34.0064
110043	1.7850	0.8980	28.8551	30.3728	31.1652	30.1299
110044	1.1359	0.7836	24.3772	27.0431	25.0453	25.4616
110045	1.1037	0.9593	27.7619	28.2232	31.6774	29.1576
110046	1.2115	0.9593	*	28.6286	27.4758	28.0247
110050	1.0606	0.8537	27.0651	27.1533	29.2760	27.8460
110051	1.1292	0.7836	21.4898	22.1491	23.3859	22.3991
110054	1.4414	0.9593	29.4691	31.5798	27.9780	29.6365
110059	1.1390	0.7836	24.7838	24.9271	24.4418	24.7131
110064	1.6805	0.8797	26.9363	28.7296	30.0248	28.5644
110069	1.3820	0.9876	29.9098	30.6465	31.0192	30.5361
110071	1.0432	0.7836	21.2041	23.6499	22.6387	22.5383
110073	1.1060	0.7836	23.3571	23.0072	23.4564	23.2747
110074	1.5120	0.9218	31.0062	29.0310	30.4329	30.1238
110075	1.3815	0.8980	24.8244	26.1089	27.3267	26.0706
110076	1.5636	0.9593	29.4344	31.0661	30.4842	30.2909
110078	2.1084	0.9593	30.5196	32.0516	35.8486	32.7735
110079	1.5339	0.9593	27.3274	29.0905	28.9890	28.4659
110082	1.9797	0.9593	30.1072	31.1478	33.1150	31.5013
110083	2.0534	0.9593	34.0610	34.5798	34.7477	34.4682
110086	1.1613	0.7836	22.9959	23.4772	23.1302	23.1992
110087	1.5144	0.9593	31.0403	32.8029	33.9064	32.6458
110089	1.1643	0.7836	24.3327	26.0116	25.4964	25.2778
110091	1.3568	0.9593	27.0994	28.0637	29.4922	28.2150
110092	1.0634	0.7836	21.4168	22.8602	24.5258	22.8787
110095	1.4660	0.8399	28.0526	28.0480	31.2302	29.1795
110100	0.9836	0.8626	20.8201	20.0638	22.8988	21.4335
110101	0.9840	0.7903	21.0983	23.8601	25.5956	23.4692
110104	1.2142	0.7836	21.8966	22.2596	22.3740	22.1798
110105	1.2672	0.8399	23.4010	23.7752	24.6132	23.9334
110107	1.9376	1.0178	30.1027	31.5783	34.3650	32.0433
110109	1.0740	0.7836	21.6023	21.6019	22.5723	21.9328
110111	1.2026	0.9167	25.7084	27.6501	25.7347	26.3319
110112	1.0229	0.8399	26.4089	24.2935	23.2430	24.5678
110113	0.9454	0.9167	22.0793	22.0472	24.2940	22.7796
110115	1.8004	0.9593	32.7927	33.3902	34.4900	33.5532
110121	1.0646	0.8208	23.4571	24.5653	27.4396	25.1434

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)
110122	1.5890	0.8208	25.4439	26.3071	27.8701	26.5188
110124	1.0579	0.7836	22.9571	24.8552	28.7549	25.5343
110125	1.2945	0.9876	24.7347	26.5006	29.3253	26.8067
110128	1.2492	0.8980	25.4190	24.5284	27.1994	25.6827
110129	1.5637	0.8797	30.0444	29.7332	26.8444	28.8369
110130	0.8834	0.7836	20.4349	21.7089	21.0340	21.0501
110132	1.0641	0.7836	21.2642	21.6039	22.3814	21.7486
110135	1.3125	0.7836	24.0945	25.1027	25.6598	24.9437
110142	0.9770	0.8021	21.6286	22.2164	21.2834	21.6948
110143	1.4290	0.9593	29.9139	30.9621	31.3425	30.7632
110146	0.9861	0.9505	29.0193	30.1181	32.7312	30.6289
110150	1.3165	0.9593	26.9884	27.7920	28.7572	27.8361
110153	1.1832	0.9876	29.3305	30.5108	30.2311	30.0229
110161	1.5735	0.9593	31.5001	32.0002	32.9492	32.1610
110163	1.4631	0.8944	27.7679	29.5693	30.7815	29.3951
110164	1.7364	1.0178	30.0145	31.2830	32.7891	31.3976
110165	1.5150	0.9593	28.7902	28.7925	28.4350	28.6758
110168	1.7935	0.9593	29.7774	30.8750	31.8939	30.8536
110172	***	*	31.3999	33.0452	34.0287	32.7875
110177	1.8711	0.9167	29.7079	30.5526	31.9342	30.7335
110183	1.3392	0.9593	28.3505	29.6622	32.3146	30.1187
110184	1.2398	0.9593	29.4071	30.2920	30.8198	30.2157
110186	1.3207	0.8797	28.2880	29.6503	32.0619	29.9587
110187	1.2008	0.9593	26.9638	31.0164	27.6732	28.5076
110189	1.0914	0.9593	26.2799	27.4207	28.9474	27.5876
110190	1.0719	0.8077	24.5224	29.4198	28.7841	27.3898
110191	1.3815	0.9593	30.9481	28.7505	30.0181	29.8310
110192	1.4382	0.9593	30.0843	31.6627	32.6420	31.5168
110194	0.8548	0.7836	21.0826	20.5267	23.2386	21.6186
110198	1.4743	0.9593	32.8171	34.0050	33.2506	33.3650
110200	2.1135	0.8797	27.2974	29.4633	29.6282	28.8425
110201	1.5189	1.0178	32.0967	33.4292	34.9059	33.4692
110203	0.9714	0.9593	32.3441	32.0594	33.0130	32.4906
110205	1.1841	0.8343	23.9738	26.1973	25.5344	25.2435
110209	0.7357	0.7836	21.2428	22.4549	21.6694	21.7990
110212	1.2022	0.8096	*	*	23.4391	23.4391
110215	1.4674	0.9593	29.5238	30.1793	31.2803	30.3942
110219	1.4192	0.9593	32.2603	33.4481	34.8934	33.5292
110223	***	*	25.3071	*	*	25.3071
110224	***	*	33.6464	*	*	33.6464
110225	1.3692	0.9593	29.5373	28.9773	29.6283	29.3778
110226	1.2006	0.9593	*	32.1840	30.2178	31.1797

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)
110229	1.3761	0.9593	*	*	*	*
110230	1.4757	0.8688	*	*	*	*
110231	1.4634	0.9218	*	*	*	*
120001	1.8604	1.1477	39.6348	39.0371	39.1942	39.2696
120002	1.3740	1.1299	34.1709	37.7287	38.3476	36.8654
120004	1.3430	1.1477	31.3555	32.5164	33.3934	32.4417
120005	1.2475	1.1299	33.6942	35.1996	38.2969	35.7861
120006	1.3846	1.1477	34.2231	35.7089	37.6398	35.9131
120007	1.6210	1.1477	30.8773	35.0193	34.8601	33.5307
120010	2.0845	1.1477	30.8526	34.3371	37.3267	33.7846
120011	1.6378	1.1477	39.1941	43.7527	45.9887	43.2181
120014	1.3808	1.1299	30.9839	34.2127	38.1489	34.3406
120019	1.1661	1.1299	33.0114	36.1879	37.4616	35.6068
120022	1.9295	1.1477	32.5326	34.9048	35.4068	34.3153
120026	1.5069	1.1477	34.2244	35.8413	38.2161	36.1123
120027	1.4759	1.1477	29.5825	31.8177	32.7144	31.3728
120028	1.3762	1.1299	34.0451	34.6354	34.7514	34.4886
120029	***	*	44.6382	*	*	44.6382
130002	1.4568	0.9128	24.7266	24.3501	26.4749	25.2157
130003	1.6576	1.0004	28.6136	29.8793	31.4296	29.9309
130006	1.7740	0.9307	28.0048	29.0504	30.0031	29.0499
130007	1.7510	0.9307	30.4958	31.2268	33.1365	31.6834
130013	1.4063	0.9307	36.1570	33.8928	33.6184	34.5455
130014	1.2651	0.9307	27.5936	28.2831	29.1212	28.3413
130018	1.7751	0.9432	28.4041	30.2047	31.8747	30.1398
130024	1.2050	0.8329	24.8035	25.3197	24.4768	24.8606
130025	1.2542	0.7654	22.7962	23.8592	24.2452	23.6590
130028	1.6133	0.9032	28.4934	29.3374	30.2891	29.3929
130049	1.6098	1.0259	29.0185	29.7211	30.8332	29.8738
130062	***	*	29.1925	28.3419	38.1397	32.3987
130063	1.4761	0.9307	27.7607	27.7697	28.8948	28.1414
130065	2.0455	0.9432	30.4547	25.8998	29.4974	28.2278
130066	2.1453	0.9394	28.9883	28.1502	29.3086	28.8044
130067	2.0677	0.9432	21.3867	26.8285	28.6496	25.2327
130068	***	*	*	*	25.8432	25.8432
130069	2.0001	0.9307	*	*	*	*
130070	2.0028	0.9307	*	*	*	*
140001	1.1968	0.8686	22.2003	23.2233	23.7495	23.0892
140002	1.4373	0.9059	27.4779	29.1097	29.6326	28.7979
140007	1.4343	1.0397	31.4024	32.4449	34.2643	32.7598
140008	1.5299	1.0410	31.8008	32.7618	33.2594	32.5988
140010[3]	1.5470	1.0410	40.1360	39.3727	39.7277	39.7458

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)
140B10[3]	***	*	40.1360	39.3727	39.7277	39.7452
140011	1.2026	0.8317	25.8864	26.2135	27.0025	26.4073
140012	1.2222	1.0278	31.8213	31.9613	33.0217	32.3078
140013	1.4258	0.9239	25.0951	26.4199	28.2801	26.6090
140015	1.3548	0.8947	24.6409	25.2504	25.8313	25.2470
140018	1.3811	1.0410	30.7398	31.5624	31.2581	31.1826
140019	0.9180	0.8317	22.3179	22.2907	22.9194	22.5137
140026	1.1635	0.8632	26.0493	28.1718	28.5522	27.6107
140029	1.5829	1.0397	36.7722	34.8938	37.7322	36.4698
140030	1.5871	1.0397	31.6822	32.1135	32.8958	32.2104
140032	1.2418	0.8947	27.5367	28.5242	28.4667	28.1798
140033	***	*	29.5256	31.4347	32.3490	30.3324
140034	1.2070	0.8947	24.4653	26.7250	27.6142	26.2899
140040	1.2491	0.9239	24.5589	28.5016	30.5876	27.6370
140043	1.2990	0.8441	29.8633	31.3754	33.1411	31.4816
140046	1.4501	0.8947	25.6230	25.7925	26.8405	26.0841
140048	1.3597	1.0410	30.6686	31.6290	34.4409	32.2726
140049	1.5303	1.0410	30.8617	32.0239	33.6158	32.1330
140051	1.5483	1.0410	32.1730	32.6517	32.7960	32.5498
140052	1.3745	0.9059	26.9907	26.7916	27.7951	27.1876
140053	1.7906	0.9336	28.4513	29.9487	32.7137	30.2922
140054	1.4833	1.0410	34.2378	34.5369	36.9880	35.2640
140058	1.2026	0.9336	25.2568	26.5671	28.6955	26.8639
140059	1.0395	0.9059	21.6230	22.8597	24.6256	23.0782
140062	1.4017	1.0410	36.8271	36.6718	38.3440	37.3004
140063	1.4656	1.0410	30.5465	31.1266	34.4760	32.0684
140064	1.2770	0.9239	25.7551	26.6249	28.5972	27.0199
140065	1.4644	1.0410	31.5510	32.4661	34.4025	32.8054
140066	1.0275	0.9059	22.0225	23.6304	24.3885	23.3532
140067	1.8393	0.9239	29.8982	30.6911	31.7125	30.7941
140068	1.3420	1.0410	26.7166	31.3463	32.8722	30.2088
140075	1.1673	1.0410	35.9507	33.6872	34.9404	34.7961
140077	1.0274	0.9059	21.6468	22.5074	24.2027	22.7812
140080	1.4942	1.0410	29.9067	30.3788	32.7691	31.0062
140082	1.5906	1.0410	31.0516	32.0562	33.4716	32.1973
140083	1.0481	1.0410	27.2189	26.1639	29.5132	27.6543
140084	1.3364	1.0410	30.7251	31.3307	32.1362	31.4320
140088	1.9984	1.0410	32.6866	34.4137	36.7084	34.6202
140089	1.2277	0.8317	24.9120	26.6955	27.5310	26.4000
140091	1.7572	1.0018	28.2095	29.7381	33.7881	30.5800
140093	1.2900	0.8748	28.6709	31.2973	29.3386	29.8080
140094	0.8432	1.0410	28.7647	28.8621	27.9427	28.5306

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)
140095	1.2220	1.0410	29.7385	29.9626	35.7901	31.7409
140100	1.3593	1.0410	37.2961	37.3044	39.0437	37.8916
140101	1.2669	1.0397	28.9723	31.0070	32.4300	30.8225
140103	1.1553	1.0410	24.0926	25.3630	26.4269	25.3212
140105	***	*	29.6590	30.7154	*	30.0527
140110	1.0813	1.0278	30.3432	31.3486	33.7288	31.8475
140113	1.5529	1.0018	30.2542	31.6191	33.2382	31.7332
140114	1.5397	1.0410	29.8316	31.1412	31.7091	30.9104
140115	1.2560	1.0410	25.4576	26.2606	30.2130	27.2050
140116	1.4609	1.0410	34.3876	34.2519	35.6763	34.7912
140117	1.5999	1.0410	30.9679	28.5809	34.6852	31.2726
140118	1.4773	1.0410	33.1987	33.8168	34.9392	33.9836
140119	1.8620	1.0410	32.2185	34.6543	35.5166	34.1046
140120	1.2800	0.9239	25.9275	26.2418	27.0704	26.4514
140122	1.5436	1.0397	30.2888	32.4750	34.2538	32.3356
140124	1.2526	1.0410	38.2191	38.8976	39.9294	39.0088
140125	1.1804	0.9059	26.5801	27.6352	28.3586	27.5174
140127	1.5423	0.9489	27.8363	29.3352	30.9158	29.3665
140130	1.2912	1.0410	32.5425	34.9907	35.8398	34.4166
140133	1.3502	1.0410	30.3259	32.8941	34.0265	32.4222
140135	1.4166	0.9069	24.6645	25.9057	26.6858	25.7584
140137	1.0416	0.9059	31.4349	*	27.0632	28.6031
140143	1.1345	1.0278	26.1126	27.0312	27.3019	26.8396
140145	1.1239	0.9059	25.2040	26.9344	28.3699	26.8747
140147	1.1010	0.8317	21.1817	22.1035	22.6522	21.9897
140148	1.6734	0.9336	27.0038	28.9471	30.1485	28.7507
140150	1.7461	1.0410	35.5951	39.0316	41.6233	38.7664
140151	0.8556	1.0410	26.0825	27.3552	28.0804	27.2016
140152	***	*	29.8647	32.2803	*	31.0650
140155	1.3090	1.0278	32.7960	35.0825	36.2375	34.7294
140158	1.3728	1.0410	30.4445	32.0137	31.7619	31.4199
140160	1.2165	1.0015	27.6905	28.9043	30.0142	28.8980
140161	1.2955	1.0278	28.8266	28.8150	33.5183	30.3915
140162	1.6006	0.9489	32.1810	33.0995	33.2400	32.8589
140164	1.7393	0.8947	25.9726	27.3133	27.5993	26.9926
140166	1.2159	0.9069	26.2875	27.6725	27.5421	27.1934
140167	1.1516	0.8317	24.9904	24.2749	21.2492	23.4243
140172	1.3717	1.0410	33.0926	33.4616	36.8437	34.4727
140174	1.6566	1.0397	31.2231	33.9382	35.1558	33.4967
140176	1.2318	1.0410	32.6145	33.2235	34.3935	33.4305
140177	0.9941	1.0410	25.5725	26.0727	28.0770	26.6146
140179	1.3153	1.0410	30.2944	31.3624	30.7028	30.7740

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)
140180	1.3265	1.0410	29.1352	29.8009	31.5327	30.1753
140181	1.2527	1.0410	27.6835	27.5414	29.0943	28.0939
140182	1.4679	1.0410	32.8972	26.4103	34.5000	30.8749
140184	1.3467	0.8317	26.6104	27.5858	28.2206	27.4929
140185	1.4600	0.9059	26.5398	27.9433	29.7770	28.0823
140186	1.5201	1.0278	30.7212	32.8063	32.5190	32.0107
140187	1.5738	0.9059	25.5873	26.9265	29.2370	27.2926
140189	1.1746	0.8317	24.7013	29.1371	25.9215	26.5410
140191	1.3429	1.0410	31.9943	29.7684	31.4117	31.0276
140197	1.0562	1.0410	24.9103	24.8715	26.9967	25.5655
140200	1.5427	1.0397	30.6641	31.3712	33.2936	31.7667
140202	1.5085	1.0410	32.9433	34.3789	38.4353	35.3566
140206	1.1540	1.0410	29.6275	31.1406	31.5257	30.7451
140207	1.0074	1.0410	28.2262	31.6818	25.8094	28.4476
140208	1.7124	1.0410	31.4035	26.1749	26.2458	27.6877
140209	1.5941	0.9239	29.7965	28.8774	31.5394	30.0590
140210	1.0347	0.8317	19.2053	22.2512	24.1216	21.9398
140211	1.3464	1.0397	31.4539	34.5917	36.0427	34.0489
140213	1.2507	1.0397	32.1031	33.3932	33.6385	33.0762
140217	1.5109	1.0397	32.9404	33.2172	34.8509	33.7214
140223	1.5276	1.0410	33.5083	34.6997	36.6474	34.9335
140224	1.3933	1.0410	31.2237	30.2241	34.4047	31.8231
140228	1.4678	1.0157	28.2855	28.7462	30.7405	29.3368
140231	1.5434	1.0397	34.8291	35.6724	36.3640	35.6627
140233	1.6775	1.0157	31.5168	32.3376	35.7788	33.2500
140234	1.0951	0.8632	25.7353	25.7660	26.9688	26.1664
140239	1.6308	1.0157	31.0918	33.7264	35.6462	33.4321
140240	1.4039	1.0410	32.7986	28.0986	32.7474	31.1803
140242	1.6003	1.0397	35.2351	36.8032	40.7526	37.6472
140250	1.2801	1.0410	31.2533	32.9414	33.7407	32.6363
140251	1.4311	1.0410	28.3598	29.5941	31.2586	29.6973
140252	1.4971	1.0410	35.8762	36.1531	37.6070	36.5807
140258	1.6797	1.0410	33.0093	34.5696	34.9234	34.1890
140275	1.3417	0.8441	28.5064	26.7394	26.7130	27.2982
140276	1.9321	1.0410	32.1048	32.7073	33.1643	32.6648
140280	1.5051	0.8441	26.6536	26.9835	28.0412	27.2545
140281	1.7385	1.0410	35.6589	37.5700	38.6695	37.3683
140286	1.1924	1.0397	32.0048	32.2246	38.2088	34.1773
140288	1.5250	1.0397	31.5944	32.5472	34.1199	32.7534
140289	1.3211	0.9059	25.6847	26.0872	26.7595	26.1906
140290	1.4213	1.0410	32.5247	35.9679	34.5802	34.3736
140291	1.5611	1.0410	33.8706	32.7884	34.3018	33.6518

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)
140292	1.2497	1.0397	30.6917	32.4496	32.9699	32.0384
140294	1.1689	0.8317	26.1595	26.9789	27.4129	26.8906
140300	1.1828	1.0410	42.5240	37.4508	35.5917	38.3780
140301	1.1272	1.0410	39.4295	35.9742	*	37.7232
140303	2.1772	1.0410	*	33.0359	31.4733	32.2211
140304	1.4432	1.0397	*	*	*	*
150001	1.1725	0.9784	31.8089	32.9804	32.5121	32.4574
150002	1.5533	1.0277	27.6481	28.1076	28.4427	28.0632
150003	1.5959	0.9128	26.9771	29.3660	30.1333	28.7557
150004	1.5569	1.0277	30.9626	31.7867	34.4917	32.3395
150005	1.3308	0.9784	30.5367	31.6090	32.3563	31.5193
150006	1.4297	0.9333	27.1364	28.3403	29.7303	28.4275
150007	1.5164	0.9682	30.0500	31.0384	32.4931	31.2151
150008	1.4773	1.0277	27.0525	29.1492	30.9455	29.0497
150009	1.5117	0.8915	25.7616	26.1517	25.9641	25.9566
150010	1.5927	0.9682	28.4118	28.2616	32.4365	29.6390
150011	1.3847	0.9669	26.7686	27.7870	27.1914	27.2425
150012	1.5407	0.9615	31.2282	31.6762	32.0158	31.6396
150015	1.4286	0.9222	27.3811	30.2516	32.7020	29.9458
150017	1.7920	0.8964	26.3379	27.1262	27.4560	26.9914
150018	1.6508	0.9333	29.1137	30.0928	30.9531	30.0865
150021	1.7310	0.8964	30.0030	31.1158	33.1531	31.4257
150022	1.0299	0.8664	23.8971	26.9525	29.7761	26.7678
150023	1.5518	0.9669	27.7520	30.3667	30.3710	29.4838
150024	1.5122	0.9784	28.4170	30.6154	32.1884	30.3887
150026	1.2976	0.9333	30.4967	31.9397	33.1247	31.8963
150029	1.2806	0.9615	29.9307	31.0692	32.1202	31.0214
150030	1.2271	0.9669	29.3588	31.1986	34.4745	31.7123
150033	1.4617	0.9784	29.7744	32.9469	31.7338	31.4598
150034	1.4759	1.0277	28.0434	30.0048	30.9980	29.7433
150035	1.4912	0.9222	27.8904	29.2039	27.9466	28.3416
150037	1.4136	0.9784	29.0161	30.4640	32.3031	30.6187
150038	1.1309	0.9784	33.0112	31.9552	32.2607	32.3845
150042	1.3349	0.8512	25.1403	25.2456	25.2228	25.2020
150044	1.4816	0.8915	25.2685	25.9284	26.6413	25.9829
150045	1.0021	0.8964	27.5340	29.4323	30.0065	28.9707
150046	1.5321	0.8989	26.5876	27.6228	29.7193	27.9617
150047	1.7080	0.8964	25.8497	27.1847	27.9379	26.9816
150048	1.4729	0.9409	28.1525	29.5588	30.5010	29.4323
150051	1.6481	0.9669	28.9157	30.3764	31.2059	30.1829
150056	2.0611	0.9784	29.3500	30.5777	32.9403	30.9463
150057	2.1160	0.9784	30.3287	29.2358	30.4510	30.0014

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)
150058	1.5993	0.9615	29.1255	31.7558	32.4069	31.0865
150059	1.4572	0.9784	31.3362	36.2570	30.4222	32.4867
150061	1.1780	0.8506	22.6746	23.2427	24.7818	23.6142
150064	1.2134	0.8506	28.7978	28.9430	29.6843	29.1444
150065	1.2860	0.9669	30.2053	30.7970	31.7598	30.9474
150069	1.1710	0.9409	26.0909	27.0740	28.6543	27.3019
150072	1.1684	0.8611	21.7644	23.0619	24.6631	23.1424
150074	1.4549	0.9784	28.5655	29.4135	31.6060	29.9533
150075	1.0841	0.8964	25.7245	26.5987	27.1441	26.5071
150076	1.2653	0.9333	30.1120	30.2972	29.4691	29.9446
150082	1.5853	0.8506	26.4544	28.1302	28.0035	27.5666
150084	1.8740	0.9784	33.1784	35.0288	35.0891	34.4428
150086	1.2710	0.9409	26.6745	27.2580	28.8288	27.6088
150088	1.3096	0.9669	29.1509	30.2396	31.9190	30.3924
150089	1.6750	0.8645	24.8045	26.7290	27.5502	26.3627
150090	1.4701	1.0277	30.6412	30.9274	33.6838	31.7083
150091	1.1835	0.8964	32.1627	33.0421	32.9057	32.7086
150097	1.2026	0.9784	29.1359	29.4797	29.9999	29.5460
150100	1.6289	0.8506	26.9724	27.6339	30.0270	28.2165
150101	1.0273	0.8964	30.5475	31.6031	32.5889	31.5859
150102	1.1055	0.9222	25.8742	25.4717	30.4962	27.1710
150104	1.1612	0.9784	28.7788	30.8984	31.2259	30.3314
150109	1.5142	0.9128	26.8464	29.0076	31.0771	28.8918
150112	1.4838	0.9562	29.8540	31.7966	32.0685	31.2600
150113	1.2401	0.9669	25.9814	26.9098	29.0484	27.3194
150115	1.3437	0.8506	22.5793	22.3571	25.0231	23.3540
150125	1.5271	1.0277	29.3596	30.7113	31.7780	30.6445
150126	1.3364	1.0277	29.4300	32.6488	34.5106	32.1237
150128	1.4890	0.9784	29.5008	31.1071	30.7592	30.4995
150129	1.3316	0.9784	31.4317	32.9629	36.4779	33.7045
150133	1.1303	0.9333	24.2538	23.0662	25.1438	24.1516
150134	***	*	21.6740	27.3983	30.4467	25.8417
150146	1.1710	0.9478	30.3343	31.8757	32.9512	31.7514
150147	***	*	26.1646	28.9269	28.9228	28.1179
150149	1.0401	0.8506	24.9629	25.3350	26.4618	25.6430
150150	1.3415	0.8964	26.7700	26.5984	26.5041	26.6095
150153	2.3006	0.9784	35.0617	37.3948	38.6979	37.2034
150154	2.5281	0.9784	29.8894	30.5775	32.3472	30.9955
150157	1.7766	0.9784	32.3106	32.9167	35.4457	33.6019
150158	1.3191	0.9784	*	30.4355	31.5468	31.0230
150159	***	*	*	27.5595	*	27.5595
150160	2.0916	0.9784	*	27.6375	31.2985	29.5450

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)
150161	1.6725	0.9784	*	*	32.4944	32.4944
150162	1.8560	0.9784	*	*	32.2342	32.2342
150163	1.0425	0.8915	*	*	26.0439	26.0439
150164	1.1932	0.9304	*	*	*	*
150165	1.5320	1.0277	*	*	*	*
150166	1.1615	1.0277	*	*	*	*
150167	2.3410	0.8964	*	*	*	*
150168	2.1329	0.8964	*	*	*	*
150169	1.5371	0.9784	*	*	*	*
150171	1.8740	0.8964	*	*	*	*
160001	1.3686	0.9523	25.7255	25.8686	27.4211	26.3438
160005	1.2953	0.8659	24.7755	24.8597	25.6212	25.1251
160008	1.0200	0.8659	22.4758	24.1282	24.3714	23.6312
160013	1.2284	0.8838	24.4099	25.5162	26.6940	25.5260
160016	1.6000	0.9277	27.1460	26.6537	27.9902	27.2623
160024	1.5372	0.9523	29.3756	32.4253	32.7789	31.5369
160028	1.4010	0.9540	30.0576	29.8343	32.4656	30.8424
160029	1.5012	0.9410	30.6687	32.2035	33.7703	32.2205
160030	1.3995	0.9550	30.9415	30.4779	32.0459	31.1674
160032	1.0291	0.8894	26.2935	28.5645	29.0344	28.0272
160033	1.6484	0.8659	27.2060	27.4810	27.6561	27.4493
160040	1.3622	0.8659	26.8110	28.2982	27.9821	27.7002
160045	1.6809	0.8909	27.5289	28.1681	30.0083	28.6150
160047	1.3087	0.9540	28.1280	29.4286	31.2930	29.5501
160057	1.4489	0.9279	25.6274	27.7969	28.3652	27.2819
160058	2.0218	0.9410	28.9924	29.8975	31.2788	30.0777
160064	1.5270	0.9272	28.4209	33.6082	32.7870	31.5388
160067	1.4504	0.8659	26.0243	26.7679	27.2058	26.6735
160069	1.4998	0.8659	27.6157	28.4081	29.0999	28.3345
160079	1.4987	0.8909	26.1618	28.5034	29.8356	28.1664
160080	1.2451	0.8659	27.2370	27.8745	27.4420	27.5182
160082	1.7794	0.9523	28.7831	31.7508	34.0638	31.5762
160083	1.6421	0.9523	28.3921	29.9489	31.0537	29.8216
160089	1.3192	0.9279	23.2888	23.9194	*	23.6015
160101	1.1734	0.9523	25.4740	26.8515	27.1965	26.5184
160104	1.5904	0.8659	29.8126	27.0538	27.8493	28.1147
160110	1.5327	0.8659	28.8134	29.9094	30.8893	29.9211
160112	1.2320	0.8659	25.2886	26.1721	26.7146	26.0924
160117	1.3972	0.8659	27.3927	24.3326	28.8448	26.7326
160122	1.1643	0.8659	24.4996	25.3192	26.6231	25.5059
160124	1.0816	0.8659	24.3063	25.5048	27.2953	25.7013
160146	1.4455	0.8940	24.8485	25.1834	27.1343	25.7299

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)
160147	1.2432	0.9277	29.8992	33.6394	37.2073	33.4686
160153	1.6868	0.8940	30.6173	30.4356	32.1376	31.0457
160155	***	*	*	*	30.2331	30.2331
170001	1.1832	0.8192	23.8863	24.5942	26.5644	25.0196
170006	1.3263	0.8499	27.1033	28.3527	30.5620	28.7060
170009	1.1077	0.9575	29.6386	32.2847	29.3373	30.3548
170010	1.1872	0.8192	25.5573	28.1802	28.6744	27.4654
170012	1.5885	0.8720	27.1195	28.7878	30.0408	28.6605
170013	1.6593	0.8720	26.7124	28.3051	29.6529	28.2222
170014	1.0016	0.9575	24.2322	25.8165	27.2929	25.7785
170016	1.6196	0.8995	26.7536	28.6817	30.3811	28.5945
170017	1.1826	0.8927	27.2925	29.1463	29.5471	28.7256
170020	1.5366	0.8720	24.1149	25.0561	26.1277	25.1241
170023	1.4632	0.8720	23.9812	24.8827	24.9556	24.6278
170027	1.4283	0.8192	23.4037	24.1133	24.6771	24.0696
170033	1.2548	0.8720	24.1882	25.0404	26.4567	25.1871
170039	0.9519	0.8927	26.0952	23.5975	24.1350	24.5123
170040	1.9435	0.9575	30.2468	30.0828	33.3834	31.2072
170049	1.4916	0.9575	26.4086	31.8595	34.8241	31.1355
170058	1.0749	0.8192	26.5949	28.1330	28.6257	27.7863
170068	1.1475	0.8481	23.8812	23.8509	25.6814	24.4759
170074	1.2012	0.8192	23.0567	24.8871	26.7291	24.8950
170075	0.8714	0.8192	19.9351	21.1965	20.9103	20.6683
170086	1.5733	0.8995	26.3615	28.5260	30.0119	28.3723
170094	0.9310	0.8192	16.5136	17.1719	26.4829	19.4262
170103	1.3484	0.8927	24.2003	25.5671	26.2650	25.3589
170104	1.4224	0.9575	27.6211	29.7793	31.7086	29.7323
170105	1.0731	0.8192	22.7412	23.4332	24.4265	23.5405
170109	1.0775	0.9575	23.8515	29.0197	33.0278	28.8416
170110	0.9253	0.8192	23.9572	24.7927	26.7395	25.1746
170120	1.4309	0.8499	22.2805	23.5287	24.9841	23.6385
170122	1.7614	0.8927	28.7175	29.6337	30.7301	29.7041
170123	1.7329	0.8927	27.0843	28.7627	29.1619	28.3597
170133	1.0294	0.9575	25.2301	25.7129	27.6157	26.1898
170137	1.4194	0.8192	25.3395	26.8029	28.6573	26.9676
170142	1.4654	0.8812	24.6019	25.5567	26.4086	25.5269
170145	1.1012	0.8192	23.3967	25.3745	26.6005	25.1207
170146	1.5770	0.9575	29.0720	31.7023	31.6480	30.7943
170147	***	*	24.3268	21.4581	*	23.4961
170150	1.1485	0.8358	19.6160	22.0265	22.2393	21.2885
170166	0.9665	0.8192	22.6968	24.1079	24.4580	23.7585
170175	1.3259	0.8720	26.7229	31.7600	30.1469	29.5414

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)
170176	1.6402	0.9575	29.0735	30.1135	31.4080	30.2127
170182	1.5125	0.9575	28.9710	30.3805	32.3934	30.5970
170183	2.0035	0.8927	26.1890	27.7207	27.5573	27.1533
170185	1.3066	0.9575	28.1780	29.3226	31.0840	29.6238
170186	2.4251	0.8927	30.2613	30.7673	36.3577	32.4439
170187	1.6254	0.8192	24.1461	24.6419	26.2677	25.0712
170188	1.9992	0.9575	32.2573	33.7247	35.2796	33.8132
170190	1.0256	0.8192	26.2625	27.3041	28.7416	27.4722
170191	1.8703	0.8192	24.3813	26.0305	26.2358	25.6319
170192	1.8190	0.8927	27.7421	30.9230	31.7559	30.3013
170193	***	*	24.8531	24.4131	21.9178	23.8013
170194	1.4669	0.9575	27.6989	28.2004	29.7918	28.4754
170195	2.3084	0.9575	29.5947	29.1787	31.0206	30.0290
170196	2.3898	0.8927	32.1832	29.9671	29.9259	30.5759
170197	2.2189	0.8927	*	*	*	*
170198	1.9441	0.8192	*	*	*	*
180001	1.2683	0.9410	29.7423	29.9674	29.7842	29.8323
180002	1.0743	0.8112	26.5488	27.3344	28.4032	27.4055
180004	1.1352	0.7964	20.8805	22.0626	25.7525	22.8656
180005	1.1988	0.8759	25.6159	27.4317	27.9690	27.0219
180007	***	*	27.1924	26.9440	29.3498	27.7493
180009	1.7730	0.9049	27.3228	28.7048	28.9817	28.3809
180010	1.9559	0.8856	27.7600	28.2168	29.8845	28.6068
180011	1.6685	0.8745	24.9909	25.0372	26.6096	25.6023
180012	1.4949	0.8916	26.7279	27.2851	27.8413	27.2898
180013	1.5314	0.9363	24.8125	26.8108	28.6225	26.7320
180016	1.2951	0.8916	24.7091	26.9539	28.2996	26.6069
180017	1.3225	0.8091	21.9715	25.4174	26.0928	24.4705
180018	1.4070	0.7964	23.3035	24.9874	25.0097	24.4730
180019	1.1812	0.7964	24.6279	27.6801	27.5970	26.6718
180020	1.0377	0.8112	25.9975	26.8865	29.8095	27.5351
180021	0.9692	0.7964	22.0740	22.3768	24.2139	22.8935
180024	1.1508	0.8916	26.3532	26.9553	27.8188	27.0436
180025	1.3182	0.8916	28.5935	28.4172	30.2580	29.1129
180027	1.2165	0.8119	21.7639	23.3881	24.0046	22.9970
180029	1.4620	0.8745	26.1528	26.3907	29.1413	27.1465
180035	1.4925	0.9410	32.8461	34.0370	36.5548	34.5154
180036	1.3978	0.9049	25.6959	30.2643	32.0007	29.1872
180037	***	*	27.8506	33.1897	28.5759	29.8992
180038	1.6241	0.7964	26.9752	28.2430	28.5261	27.9454
180040	1.8495	0.8916	28.5162	30.2471	28.9587	29.2000
180043	1.0886	0.7964	20.6439	24.0582	25.0476	23.2158

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)
180044	1.6560	0.8759	25.8060	25.7990	27.7941	26.4856
180045	1.4039	0.9410	29.4127	29.9366	29.9409	29.7648
180046	1.1591	0.8856	27.0962	28.5568	30.0558	28.5851
180048	1.3827	0.8916	24.3696	24.6800	25.3504	24.8081
180049	1.4334	0.8745	24.3699	23.5756	25.8941	24.5967
180050	1.1349	0.8111	25.9557	26.7726	29.9908	27.5275
180051	1.3017	0.8119	24.3916	25.2369	26.2564	25.3291
180053	0.9566	0.7964	22.1921	23.0302	24.6724	23.3455
180056	1.1811	0.8468	24.5326	26.3973	26.6253	25.8502
180064	1.2187	0.8278	20.1799	21.9517	22.5101	21.5837
180066	1.1276	0.9363	23.7860	24.9542	27.2187	25.3440
180067	1.8774	0.8856	27.9852	29.6053	28.9942	28.8967
180069	1.0872	0.8759	26.6714	27.6785	29.9384	27.9862
180070	1.2363	0.8204	20.2189	21.3707	22.8465	21.5190
180078	1.0786	0.8759	28.2762	29.2136	27.4682	28.3059
180079	1.1090	0.8223	23.6005	24.9911	27.2722	25.2314
180080	1.3026	0.7964	23.7788	25.3013	27.2420	25.4633
180087	1.2455	0.7964	22.0302	22.1063	23.2639	22.4643
180088	1.7132	0.8916	28.6107	30.7954	31.8184	30.4228
180092	1.1404	0.8856	23.7866	25.2900	27.0345	25.4098
180093	1.6091	0.8163	21.4392	22.3330	23.5815	22.4849
180095	1.0495	0.7964	21.5639	21.2162	23.9890	22.3013
180101	1.2826	0.8856	28.1621	28.8772	29.6183	28.9240
180102	1.4734	0.8119	25.2343	27.3901	27.6782	26.7658
180103	1.9527	0.8856	28.1734	29.7648	31.7193	29.8800
180104	1.5623	0.8119	25.9689	27.1292	28.7681	27.3218
180105	0.9802	0.7964	23.1917	24.3663	22.9885	23.5219
180106	0.8947	0.7964	20.7220	21.2271	20.1892	20.7140
180115	0.9015	0.7964	20.3089	22.7095	24.9642	22.6500
180116	1.2135	0.8119	25.8927	26.8850	26.9056	26.5807
180117	0.9102	0.7964	24.7378	24.9571	25.9594	25.1973
180124	1.3557	0.9363	25.4664	27.1359	28.2525	26.9382
180127	1.2937	0.8916	26.3947	28.3635	29.8634	28.2074
180128	0.9315	0.7964	23.8144	23.7778	23.9141	23.8363
180130	1.7038	0.8916	29.1712	29.6751	31.2777	30.0648
180132	1.4745	0.8745	25.3789	29.0563	29.5886	28.0466
180138	1.1991	0.8916	28.6871	29.2603	30.7165	29.5835
180139	1.0549	0.7964	24.7575	26.2450	28.3498	26.3776
180141	1.8400	0.8916	27.5912	28.7329	29.5363	28.6376
180143	1.7056	0.8856	30.8734	28.0780	29.0353	29.2286
180147	***	*	31.1615	*	*	31.1615
180148	***	*	30.1250	*	*	30.1250

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)
180149	1.0505	0.7964	*	16.4918	16.3678	16.4259
180150	***	*	*	*	27.9412	27.9412
180151	1.4008	0.8856	*	*	*	*
190001	1.1659	0.7834	22.1569	22.5331	25.3853	23.4845
190002	1.6796	0.8581	24.6984	25.9387	27.1780	25.9335
190003	1.3683	0.8581	26.7844	28.0899	30.5365	28.4589
190004	1.4950	0.8014	25.0803	24.6563	27.0811	25.6373
190005	1.5995	0.9026	24.2899	28.3308	32.9958	27.0169
190006	1.3700	0.8581	24.8836	25.4826	28.9176	26.6117
190007	1.1835	0.7834	23.1426	24.0538	24.6124	23.9475
190008	1.6815	0.8014	26.3638	27.2683	28.1218	27.2582
190009	1.1266	0.8169	24.0696	25.0269	24.8267	24.6632
190011	1.0093	0.7937	21.6991	21.9174	24.2069	22.5653
190013	1.5045	0.7983	23.7333	22.8380	25.2484	23.9484
190014	1.1670	0.7834	22.6405	24.5410	25.6058	24.1850
190015	1.3378	0.9026	25.1767	26.9591	29.5256	27.2789
190017	1.4681	0.8581	24.7537	25.5477	26.9628	25.8075
190019	1.7143	0.8169	25.4624	27.6057	28.6328	27.3155
190020	1.3331	0.8253	23.4602	24.2361	25.9271	24.6046
190025	1.2924	0.7834	24.5024	26.5949	26.6289	25.8630
190026	1.6151	0.8169	24.1556	25.3752	27.0888	25.5392
190027	1.6608	0.7983	26.7132	31.5047	29.4817	29.1964
190034	1.1465	0.8023	21.2130	22.9920	23.8367	22.6863
190036	1.7573	0.9026	25.6551	29.1818	27.7989	27.4259
190037	0.6682	0.7983	20.7271	28.0463	19.5969	23.0592
190039	1.5103	0.9026	25.4003	24.6848	29.0768	26.5110
190040	1.4304	0.9026	28.0169	28.2444	29.0926	28.4727
190041	1.4935	0.8476	28.0050	28.7702	29.3312	28.7077
190044	1.3050	0.8095	21.2604	22.2462	23.1682	22.2463
190045	1.6126	0.9026	27.1996	27.5873	29.3608	28.0848
190046	1.5640	0.9026	24.7370	25.1890	30.9790	27.0747
190050	1.2007	0.7878	20.9142	22.7962	23.6920	22.4517
190053	1.2337	0.7935	18.5819	20.6289	22.1393	20.4288
190054	1.3269	0.7919	22.7011	23.5137	26.5590	24.2997
190060	1.4394	0.7983	22.6291	19.8911	25.1512	22.3805
190064	1.6731	0.8253	23.7298	26.9960	28.6411	26.5272
190065	1.6818	0.8253	23.1202	22.9861	24.3673	23.5086
190078	1.0789	0.8021	22.2346	25.6943	26.0167	24.7752
190079	1.1872	0.9026	23.8192	25.3344	28.0333	25.8281
190081	0.8642	0.7834	21.4510	20.4111	21.2222	21.0110
190086	1.2487	0.7937	22.2895	22.2852	24.2086	22.8681
190088	1.1204	0.8476	23.1638	24.7450	29.5998	25.8159

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)
190090	0.9966	0.7834	24.3303	25.8610	25.0668	25.0720
190098	1.7782	0.8476	25.7449	27.5058	27.8873	27.0720
190099	1.0635	0.8023	23.2343	25.7488	25.7133	24.9053
190102	1.5406	0.8581	26.9700	28.3090	28.6185	27.9322
190106	1.0697	0.8169	26.6227	24.2759	25.5176	25.4703
190111	1.7194	0.8476	26.5722	27.3192	28.8415	27.6047
190114	1.0893	0.7834	19.1586	20.3651	21.1449	20.2387
190115	0.7557	0.8476	26.0797	26.0285	25.6978	25.9429
190116	1.1912	0.7919	23.4013	24.2154	24.4442	24.0257
190118	1.0069	0.8476	21.2580	22.6572	22.3374	22.1123
190122	1.2753	0.8253	22.2371	22.8681	24.5706	23.3152
190124	***	*	27.9484	28.6713	*	28.2761
190125	1.5619	0.7937	24.8256	26.6269	26.9823	26.2683
190128	1.0861	0.8253	29.6682	31.1819	32.2128	31.0719
190131	1.3145	0.8253	28.6795	28.5946	29.9868	29.0896
190133	0.8928	0.7936	22.4311	23.9550	27.2749	24.6365
190135	1.4861	0.9026	30.5646	35.0547	43.3979	32.5962
190140	0.9899	0.7869	23.0485	23.6713	23.2336	23.3092
190144	1.2770	0.8476	23.7875	24.8866	25.8495	24.8633
190145	0.9612	0.7924	20.8579	21.3988	22.1296	21.4710
190146	1.6525	0.9026	28.7200	28.5984	29.8377	29.0748
190151	0.9246	0.7834	18.8391	20.6970	23.0044	20.7536
190152	***	*	30.8512	34.6508	34.7102	33.2518
190158	***	*	30.6450	21.5594	*	28.7353
190160	1.5983	0.7937	24.7822	25.8646	26.4466	25.6890
190161	1.1846	0.7983	22.9035	23.8073	24.8255	23.8715
190164	1.2139	0.8169	26.6207	27.7265	28.6757	27.7045
190167	1.2453	0.8581	25.3283	27.1981	29.3966	27.2482
190175	1.3371	0.9026	27.4256	30.5948	31.4058	29.7940
190176	1.8725	0.9026	26.2596	28.2192	32.2955	28.5357
190177	1.6458	0.9026	28.2751	29.7252	30.9181	29.6572
190182	***	*	29.8656	30.7058	*	30.2958
190183	1.2897	0.8014	22.0119	23.3462	25.0403	23.5198
190184	0.9825	0.7937	24.1626	22.6144	22.4993	23.1014
190185	***	*	28.9759	36.7317	*	32.3103
190190	0.9308	0.7937	26.7043	27.5051	27.5857	27.2772
190191	1.3231	0.8581	26.1628	26.9656	28.1123	27.0710
190196	0.8194	0.8581	25.8472	27.7824	28.4715	27.3963
190197	***	*	26.4825	28.7044	29.4111	28.0880
190199	1.1099	0.8253	32.0194	36.7128	29.8307	32.8662
190200	***	*	27.4781	*	*	27.4781
190201	1.1055	0.7983	24.4563	26.8550	27.8250	26.4094

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)
190202	1.4668	0.8253	29.6612	27.6463	27.8793	28.2440
190203	***	*	29.9753	*	*	29.9753
190204	1.4472	0.9026	30.5140	32.9140	31.9053	31.7478
190205	1.6616	0.8581	28.2484	30.1687	31.6106	30.0146
190206	***	*	29.2371	32.0180	30.4351	30.5641
190208	0.8276	0.7834	27.9908	24.9405	27.5203	26.7276
190218	0.8972	0.8476	28.1039	26.5251	26.9315	27.1544
190236	1.4436	0.8476	26.4614	26.9059	28.6485	27.3619
190241	1.8680	0.8014	25.7906	26.5320	27.2126	26.5353
190242	1.2094	0.8253	25.0035	26.9729	28.7323	27.0165
190245	1.7537	0.7937	26.7642	26.4166	26.6402	26.6020
190246	2.0632	0.7909	22.7833	31.7158	31.5007	28.9110
190249	1.2200	0.8253	25.2523	27.0975	28.3267	26.8162
190250	2.0955	0.9026	33.3302	32.8381	35.2726	33.8525
190251	1.3383	0.8253	23.8389	25.1594	27.3656	25.6324
190253	***	*	23.8037	22.2227	*	23.2564
190255	0.7839	0.8581	16.1593	23.8035	27.8082	21.9260
190256	0.8683	0.9026	25.9577	25.9365	28.7131	27.0056
190257	1.7413	0.7937	26.5505	22.7512	24.2942	24.5517
190258	1.4357	0.8476	26.1141	25.1993	26.7653	25.9833
190259	2.1970	0.8581	26.5084	27.5518	28.9189	27.6660
190260	***	*	29.3947	33.6227	*	31.1721
190261	1.5148	0.7937	27.0441	25.4757	28.8014	27.1193
190262	***	*	30.3719	*	*	30.3719
190263	2.2819	0.8581	26.4202	29.7063	36.3114	30.5082
190264	***	*	26.5842	*	*	26.5842
190265	***	*	22.6231	30.9260	*	27.1327
190266	2.7287	0.8253	*	24.3809	32.3437	28.2722
190267	1.5630	0.9026	*	24.2794	27.6310	26.0734
190268	1.7733	0.8581	*	29.1425	25.8644	27.2311
190270	1.8922	0.9026	*	*	28.5378	28.5378
190272	1.3385	0.8581	*	28.4558	28.4212	28.4343
190273	1.7562	0.8253	*	*	22.7604	22.7604
190274	1.6650	0.9026	*	*	*	*
190275	1.4932	0.9026	*	*	*	*
190278	2.0229	0.8476	*	*	*	*
190297	1.1945	0.7834	*	*	*	*
200001	1.3760	1.0040	26.3045	28.1145	28.9866	27.8243
200002	1.1755	0.9759	27.1151	33.2695	30.4991	30.1515
200008	1.3944	1.0217	29.1836	29.3538	32.4012	30.3511
200009	1.9174	1.0217	32.5812	35.0743	37.0116	34.8233
200018	1.2559	0.8568	22.5027	24.6790	25.4265	24.2191

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)
200019	1.2986	1.0217	27.7896	28.3413	30.1260	28.7416
200020	1.3309	1.0221	34.0916	34.5762	36.9209	35.2235
200021	1.2135	1.0217	29.2054	28.7614	31.8397	29.9813
200024	1.7091	0.9759	29.7817	31.0799	31.6997	30.9001
200025	1.1787	1.0217	28.5750	29.3607	30.2891	29.4798
200031	1.2947	0.8568	22.2151	23.7553	25.6012	23.8965
200032	1.1200	0.8935	26.8993	27.2276	27.8453	27.3346
200033	1.8345	1.0040	31.7007	33.6293	34.8062	33.4091
200034	1.4504	0.9759	27.0103	28.0417	28.5635	27.9050
200037	1.1852	0.8568	24.9418	26.7815	27.9229	26.6760
200039	1.3100	0.9759	26.6409	28.8043	29.9992	28.5082
200040	1.1326	1.0217	27.8053	25.5519	29.6239	27.6263
200041	1.2416	0.8568	26.6777	27.5067	28.7651	27.6498
200050	1.2105	1.0040	29.5033	30.1473	32.0404	30.6044
200052	1.0760	0.8568	24.4204	25.6238	24.4570	24.8161
200063	1.2086	0.8568	27.9748	28.2203	29.6929	28.6851
210001	1.4210	0.9446	29.3471	31.2355	30.9243	30.5144
210002	1.9785	1.0159	33.7388	36.0252	36.8822	35.5874
210003	1.6023	1.0729	30.7334	28.2566	34.4168	31.0363
210004	1.4965	1.0800	31.7132	33.9037	32.4583	32.7039
210005	1.3091	1.0800	29.5835	32.4081	32.2259	31.4429
210006	1.0998	1.0159	27.3620	27.9859	31.8541	29.1155
210007	1.7809	1.0159	30.7124	31.4125	35.3056	32.4467
210008	1.4329	1.0159	28.8850	31.8535	33.0386	31.3117
210009	1.8235	1.0159	30.2661	31.8273	34.4423	32.2382
210011	1.4984	1.0159	31.0966	30.7547	29.7731	30.5126
210012	1.6726	1.0159	31.1778	32.5327	33.8131	32.5681
210013	1.3739	1.0159	28.9917	32.1180	35.6389	32.2747
210015	1.3195	1.0159	32.2774	31.6903	34.7999	32.9830
210016	1.7595	1.0800	33.5493	35.3253	37.1507	35.3027
210017	1.2898	0.9259	26.8592	26.6208	27.9673	27.1551
210018	1.2384	1.0800	29.6521	31.5460	33.7339	31.6519
210019	1.7723	0.9259	28.7844	30.5485	30.8143	30.0665
210022	1.5208	1.0800	37.3092	36.1833	35.8432	36.4021
210023	1.5173	1.0238	33.0212	34.1664	35.8309	34.3730
210024	1.8013	1.0159	32.9434	34.5548	36.7951	34.8160
210025	1.2731	0.9259	24.8570	23.5175	28.4009	25.5490
210027	1.3801	0.9259	24.4821	25.2143	25.6378	25.1383
210028	1.0688	0.9642	26.7462	28.5214	31.7841	29.1360
210029	1.3454	1.0159	31.8539	32.9100	33.9175	32.9350
210030	1.2154	0.9259	32.2033	29.1790	33.8860	31.7518
210032	1.2238	1.0765	27.9359	29.2785	31.6561	29.6495

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)
210033	1.2363	1.0159	29.2504	28.4350	33.1004	30.2715
210034	1.3227	1.0159	32.3827	33.0407	35.1570	33.5694
210035	1.2998	1.0729	27.3901	30.6692	28.7221	28.8794
210037	1.2209	0.9259	27.8394	28.8708	31.0216	29.2755
210038	1.3087	1.0159	32.3206	31.1563	32.7446	32.0861
210039	1.1428	1.0729	32.4139	35.1172	33.7585	33.7776
210040	1.2377	1.0159	29.2390	31.0882	30.5866	30.3234
210043	1.3476	1.0238	32.6961	29.2762	31.9230	31.2210
210044	1.3966	1.0159	30.3349	31.5463	31.9097	31.2833
210045	0.9757	0.9259	16.3724	19.6112	23.8460	19.7630
210048	1.4318	1.0159	26.0650	29.2464	30.6684	28.6056
210049	1.2521	1.0159	27.0161	28.5970	31.5770	29.2150
210051	1.3607	1.0729	29.5219	30.7954	33.0394	31.1747
210054	1.2815	1.0729	27.7607	28.6905	32.3100	29.6225
210055	1.2774	1.0729	31.4905	30.2010	36.7686	32.6883
210056	1.3575	1.0159	32.3518	33.2271	35.5629	33.6957
210057	1.3739	1.0800	32.8299	33.7287	34.3679	33.6483
210058	1.2373	1.0159	31.1988	32.0669	32.9605	32.0739
210060	1.2126	1.0729	29.9626	32.5141	34.1998	32.3014
210061	1.4139	0.9447	25.0253	26.6842	28.6588	26.8386
220001	1.2996	1.1581	31.2316	32.0843	34.4024	32.6233
220002	1.3969	1.1581	33.6649	35.9765	37.9233	35.9199
220006	***	*	33.6438	*	*	33.6438
220008	1.3364	1.1581	34.7924	35.8680	37.3834	36.0326
220010	1.2171	1.1581	32.0925	33.7392	36.1793	34.0041
220011	1.1564	1.1581	36.5640	39.1234	41.0273	38.9836
220012	1.4525	1.2598	39.7564	41.7080	43.0582	41.5136
220015	1.3026	1.0430	32.4903	35.2373	36.6447	34.8295
220016	1.0694	1.0430	32.5863	33.1424	34.9737	33.5949
220017	1.2802	1.2276	33.3020	34.6575	38.0754	35.3472
220019	1.1270	1.1581	25.7855	26.3018	28.0101	26.7041
220020	1.1520	1.1581	30.8458	32.1528	33.6428	32.2177
220024	1.2872	1.0430	31.9491	33.0415	33.6452	32.9067
220025	1.0399	1.1581	30.4369	27.6973	26.6109	28.1405
220028	***	*	39.3089	*	*	39.3089
220029	1.2058	1.1581	31.6363	32.6792	34.8335	33.0960
220030	1.1143	1.0430	28.1347	29.3714	27.6291	28.3638
220031	1.5285	1.2276	38.9433	39.4214	43.8082	40.7997
220033	1.1898	1.1581	32.3495	34.7005	36.1974	34.4484
220035	1.4387	1.1581	34.8739	36.1799	37.2910	36.2788
220036	1.5378	1.2276	35.9124	37.7301	37.1059	36.9182
220046	1.4893	1.0752	31.4510	33.8604	36.3388	33.9264

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)
220049	1.2094	1.1581	32.4652	35.1134	35.7572	34.4845
220050	1.0888	1.0430	29.5194	30.3176	32.4712	30.8121
220051	1.3228	1.0373	30.1022	32.8693	34.7865	32.5327
220052	1.2230	1.2276	32.3532	34.9151	34.9573	34.0675
220058	0.9683	1.1581	27.8893	30.0344	31.9551	29.9450
220060	1.1933	1.2276	34.7336	36.8668	39.1209	37.0252
220062	0.6748	1.1581	25.4224	27.4755	27.3987	26.7765
220063	1.1771	1.1581	32.9283	32.2442	34.6036	33.3008
220065	1.2214	1.0430	30.1103	32.3814	33.6358	32.0481
220066	1.3670	1.0430	29.9736	*	32.6323	31.2839
220067	1.2580	1.2276	32.4019	33.9836	35.7651	34.0851
220070	1.1593	1.1581	34.2598	35.6271	37.3679	35.7666
220071	1.8640	1.2276	37.4087	40.0313	43.6533	40.3335
220073	1.2461	1.1581	36.0289	37.4249	39.0017	37.4776
220074[4]	1.3644	1.1581	31.4730	33.2081	34.5557	33.1078
220B74[4]	***	*	31.4731	33.2082	34.5557	33.1114
220075	1.4356	1.2276	32.2957	33.3578	33.9787	33.2116
220077	1.6077	1.1226	34.0168	34.7345	36.3513	35.0670
220080	1.2605	1.1581	31.1268	33.1640	36.8144	33.6207
220082	1.2811	1.1581	30.8230	32.2124	33.0800	32.0621
220083	1.0634	1.2276	34.5969	35.2758	37.6560	35.9339
220084	1.2120	1.1581	31.6955	34.6275	36.1182	34.1436
220086	1.7507	1.2276	35.3451	36.2385	38.7996	36.8619
220088	1.9620	1.2276	34.7637	37.0840	37.3930	36.4667
220089	***	*	34.8205	*	*	34.8205
220090	1.2313	1.1581	34.1963	35.8969	36.8658	35.7073
220095	1.1639	1.1581	30.8626	31.1644	34.1531	32.0806
220098	1.1179	1.1581	31.5403	31.1288	32.1995	31.6226
220100	1.3276	1.2276	34.6599	35.7309	36.5750	35.6916
220101	1.3167	1.1581	37.7809	37.7292	39.3979	38.3311
220105	1.2140	1.1581	34.4029	35.8179	36.6474	35.6442
220108	1.2329	1.2276	33.8854	35.7009	37.2003	35.6383
220110	2.0220	1.2276	40.7382	43.8444	45.3743	43.3760
220111	1.2485	1.2276	34.2498	35.6223	36.8849	35.6124
220116	1.9010	1.2276	38.8799	40.0982	44.6724	41.1829
220119	1.1248	1.2276	32.0863	33.7200	36.2776	34.0563
220126	1.2024	1.2276	32.6938	35.6278	40.5382	36.1652
220133	***	*	34.9182	*	*	34.9182
220135	1.3106	1.2598	37.5189	39.0296	40.3045	38.9715
220153	***	*	19.8085	20.5063	*	20.1966
220154	***	*	28.7680	*	*	28.7680
220162	1.6601	*	*	*	*	*

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)
220163	1.6658	1.1581	37.4968	39.4893	41.6535	39.6088
220171	1.6226	1.1581	35.9948	36.4567	39.7507	37.4811
220174	1.2524	1.1581	30.9503	32.9140	35.8915	33.2597
220175	1.3049	*	*	34.1572	36.6407	35.3639
220176	1.6163	1.1581	*	31.4220	36.2806	33.7068
220177	0.9179	1.0373	*	*	*	*
230002	1.3653	0.9865	32.7578	33.9708	34.2947	33.7059
230003	1.3339	0.9384	28.4716	28.9886	28.5058	28.6500
230004	1.7143	0.9845	31.5136	33.4644	33.1590	32.7286
230005	1.2516	0.9279	27.7463	29.0634	30.0733	28.9860
230013	1.2969	0.9869	27.2075	28.6430	29.9071	28.5307
230015	1.0886	0.9101	27.2541	28.9601	29.8907	28.7187
230017	1.6711	1.0266	32.5396	36.8045	35.5315	34.9913
230019	1.6269	0.9869	34.3213	35.1440	34.8369	34.7704
230020	1.7176	0.9865	29.5324	29.9492	30.3912	29.9570
230021	1.6015	0.9915	28.6169	29.5414	30.4328	29.5382
230022	1.1811	0.9477	30.1195	25.7846	29.5736	28.3428
230024	1.6944	0.9865	32.5892	34.5278	35.0357	34.0551
230029	1.6738	0.9869	32.3845	33.1482	35.5286	33.7385
230030	1.3489	0.9309	25.1100	25.1929	27.8571	26.0263
230031	1.4455	0.9883	30.0120	30.8870	30.8722	30.5958
230034	1.2847	0.8806	24.4141	29.1098	29.8732	27.6518
230035	1.2673	0.9309	25.6715	25.7099	27.0384	26.1412
230036	1.3868	0.9189	29.9642	31.0938	31.9878	31.0262
230037	1.2270	0.9865	28.5311	28.8547	31.4447	29.6312
230038	1.7965	0.9384	29.1263	30.1040	31.5617	30.2953
230040	1.1648	0.9309	26.3190	27.2850	27.6954	27.1158
230041	1.5679	0.9512	27.9569	30.3082	31.7254	30.0001
230046	1.9506	1.0259	32.2924	33.5304	34.4018	33.4485
230047	1.5115	0.9869	31.7075	32.0248	33.2336	32.3347
230053	1.6981	0.9865	32.1566	33.5440	34.2016	33.3343
230054	1.8082	0.9340	26.3251	28.1229	28.5268	27.6383
230055	1.2584	0.8806	28.4787	28.1881	28.2656	28.3130
230058	1.1460	0.8806	27.3156	27.9643	29.2198	28.1652
230059	1.5781	0.9384	28.5875	28.3602	30.3974	29.1249
230060	1.2083	0.8806	27.0288	28.7760	30.7552	28.9075
230066	1.3615	0.9845	30.2104	32.3582	32.8412	31.8154
230069	1.2825	0.9865	31.3406	31.9675	33.3162	32.2358
230070	1.6531	0.9609	26.8315	28.0366	32.2319	28.9966
230071	1.0770	0.9869	29.6728	28.8879	29.6205	29.3903
230072	1.4691	0.9384	27.4742	28.8024	29.3280	28.5589
230075	1.3842	1.0137	30.9525	32.1166	33.3047	32.1359

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)
230077	1.8322	1.0709	30.5567	31.0123	32.2088	31.2585
230078	1.1465	0.8806	25.7232	27.0069	27.7195	26.7694
230080	1.2636	0.9189	24.5432	25.6204	25.9091	25.3735
230081	1.2772	0.8806	26.4337	27.8106	27.9655	27.4003
230085	1.2079	1.0266	25.4289	27.6474	28.1413	27.1062
230089	1.3866	0.9865	32.8450	32.2311	34.4136	33.1543
230092	1.4181	0.9865	29.3442	30.5417	29.5279	29.8016
230093	1.2002	0.8864	27.4463	27.0572	27.7301	27.4129
230095	1.2581	0.9189	25.1854	25.9210	25.9794	25.6966
230096	1.1833	0.9915	31.7399	29.7225	30.9361	30.7853
230097	1.6992	0.9309	29.8962	31.5174	32.3099	31.2555
230099	1.2143	0.9865	29.3720	29.0975	30.7421	29.7570
230100	1.2821	0.8806	25.2118	25.6594	25.9539	25.6173
230101	1.1829	0.8806	28.4372	28.8608	29.4148	28.9076
230104[5]	1.6700	0.9865	32.4125	34.0195	34.0217	33.4547
230B04[5]	***	*	*	34.0195	34.0217	34.0203
230105	1.7865	0.9189	30.5515	32.1124	33.0466	31.9356
230106	1.1444	0.9384	27.8584	30.0223	29.0361	28.9563
230108	1.1871	0.8806	24.4337	25.7477	25.4754	25.2406
230110	1.2150	0.8806	25.7196	27.0280	29.0940	27.2916
230117	1.8015	1.0266	33.0602	33.9176	33.7007	33.5664
230118	1.0293	0.8806	24.8890	24.8638	27.1343	25.6359
230119	***	*	31.9696	33.2050	33.6569	32.9928
230121	1.3052	0.9477	26.8361	27.7512	28.9531	27.8635
230130	1.7088	0.9869	31.2744	32.5613	33.6655	32.5236
230132	1.6088	1.0993	35.5304	38.2454	39.2986	37.6713
230133	1.3924	0.8806	25.0647	25.8537	26.1820	25.7155
230135	0.9986	0.9865	23.6005	31.5194	32.6576	28.8415
230141	1.5949	1.0993	33.2553	36.3124	34.9261	34.8221
230142	1.2859	0.9865	29.7417	29.9911	30.2192	29.9919
230144	1.8441	1.0259	*	*	*	*
230146	1.4613	0.9865	27.2621	29.0218	29.3373	28.5604
230151	1.3841	0.9869	29.8366	28.6724	28.6465	29.0226
230156	1.6904	1.0259	33.9034	34.7865	35.1736	34.6266
230165	1.6175	0.9865	31.4242	32.2855	31.9920	31.9058
230167	1.5521	0.9614	31.0657	32.8092	35.4649	33.1222
230174	1.3602	0.9384	29.7488	31.2469	31.6406	30.8821
230176	1.3618	0.9865	28.9798	29.2688	29.5310	29.2647
230180	1.1855	0.8806	24.9696	24.6007	28.1403	25.7940
230190	***	*	33.8229	33.6724	30.7945	32.8159
230193	1.4013	0.9883	26.4728	28.4641	29.1489	28.0431
230195	1.4731	0.9869	30.9702	32.5549	33.5004	32.3718

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)
230197	1.6702	1.0993	33.7128	34.8066	36.4153	35.0122
230204	1.4671	0.9869	32.2882	30.1982	31.3522	31.2746
230207	1.3807	0.9869	25.1983	26.8231	27.2079	26.4045
230208	1.1715	0.9309	24.3476	25.2481	25.8894	25.1749
230212	1.0373	1.0259	32.8567	33.4379	34.3938	33.5669
230216	1.4786	0.9883	29.2061	28.9586	30.7502	29.6396
230217	1.4588	1.0137	31.9732	33.0839	35.4980	33.5980
230222	1.6119	0.9189	30.6482	32.4404	30.6300	31.2247
230223	***	*	29.8430	31.8146	34.3005	31.9723
230227	1.5648	0.9869	33.6716	34.2762	35.4401	34.4522
230230	1.4716	0.9614	31.1712	31.4953	30.8398	31.1644
230236	1.5563	0.9384	30.8556	31.9100	32.2034	31.6864
230239	1.3079	0.8806	22.1579	23.5461	26.8493	24.1590
230241	1.2163	0.9883	28.5516	30.0248	30.7898	29.8348
230244	1.4512	0.9865	30.0405	32.5586	33.0146	31.8937
230254	1.5715	0.9869	29.5874	31.6332	34.2290	31.8432
230257	1.0951	0.9869	30.6372	30.0674	32.6318	31.1734
230259	1.4025	1.0259	27.5982	27.9572	28.7685	28.1199
230264	2.2388	0.9869	28.5416	29.2202	35.1009	30.9145
230269	1.4995	0.9869	31.3800	34.2694	34.4208	33.4356
230270	1.3974	0.9865	28.8173	29.2408	29.0443	29.0342
230273	1.4572	0.9865	31.5396	32.5730	32.8697	32.3385
230275	0.5680	0.9609	25.2133	22.3740	*	23.7200
230277	1.5259	0.9869	31.4023	32.2545	33.2235	32.3150
230279	0.6319	0.9865	27.9726	26.8552	26.8581	27.1893
230296	***	*	34.2107	*	*	34.2107
230297	1.8300	0.9865	*	*	35.4314	35.4314
230300	***	*	*	*	40.1809	40.1809
230301	1.1204	0.9869	*	*	*	*
240001	1.5407	1.0964	34.7673	37.2211	38.4084	36.7894
240002	1.8403	1.0659	33.1051	34.6368	36.8865	34.9355
240004	1.7019	1.0964	32.5777	33.4596	36.5529	34.2406
240006	1.2343	1.0928	33.4777	32.8229	29.6643	31.0346
240010	1.9915	1.0928	32.7261	35.9131	37.5511	35.4674
240014	1.0912	1.0964	30.7519	33.4492	35.0695	33.1210
240018	1.3882	1.0095	29.4995	30.5645	32.3309	30.8467
240019	1.1417	1.0659	32.7052	34.2547	36.7110	34.5919
240020	1.0989	1.0964	33.2449	34.5703	34.6148	34.1502
240022	1.0878	0.9290	27.3137	28.5905	29.9322	28.5920
240030	1.5345	1.0789	27.1312	27.6596	29.4250	28.0678
240036	1.6080	1.0964	34.2980	37.2207	39.2455	37.0518
240038	1.5699	1.0964	33.0554	34.7357	35.8391	34.5716

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)
240040	1.0499	1.0659	28.9009	30.0255	31.3288	30.1186
240043	1.2037	0.9290	24.0708	25.7424	27.1533	25.6887
240044	1.0928	0.9915	26.8681	28.5705	29.8386	28.4493
240047	1.4761	1.0659	29.7835	35.6763	36.7132	33.8645
240050	1.1785	1.0964	30.9805	33.7964	34.6304	33.2093
240052	1.1849	0.9290	29.4617	31.0934	33.1536	31.2578
240053	1.5445	1.0964	33.1148	34.4210	35.4773	34.3720
240056	1.3198	1.0964	34.0845	35.8603	36.1104	35.3786
240057	1.8467	1.0964	33.4713	34.8374	35.4465	34.6132
240059	1.1242	1.0964	32.4803	32.5958	33.5807	32.9086
240061	1.8540	1.0928	32.0828	34.6031	36.2590	34.3992
240063	1.6095	1.0964	35.2877	36.9822	38.3763	36.9572
240064	1.2967	1.0659	27.2407	29.9917	34.2311	30.3956
240066	1.6088	1.0964	36.0705	39.6609	38.4970	38.1108
240069	1.1933	1.0964	30.9719	31.1673	31.6341	31.2691
240071	1.1508	1.0964	31.7754	32.5460	33.1104	32.4824
240075	1.2475	1.0789	29.1171	30.3230	31.5990	30.3836
240076	1.0247	1.0964	33.1439	33.7950	35.4150	34.1358
240078	1.6596	1.0964	34.6118	36.2276	37.5207	36.1663
240080	2.0358	1.0964	34.8064	36.5390	37.7382	36.3776
240084	1.0372	1.0659	27.0995	29.0275	30.3802	28.8003
240088	1.3085	1.0789	29.1387	30.7240	31.4214	30.4515
240093	1.5000	1.0964	29.1717	30.4744	31.3553	30.3889
240100	1.3149	0.9290	31.5774	30.9481	33.2412	31.9165
240101	1.2397	0.9290	26.8849	28.5503	28.7121	28.0867
240104	1.2748	1.0964	35.0736	35.8839	36.0738	35.7076
240106	1.6319	1.0964	32.8156	33.9984	36.8978	34.5776
240115	1.4874	1.0964	33.5288	36.2788	37.5842	35.9032
240117	1.1412	0.9817	27.6950	29.0894	30.4440	29.0768
240132	1.3479	1.0964	34.6191	36.4252	37.0975	36.0441
240141	1.1588	1.0964	32.8689	34.2473	35.8875	34.3469
240166	1.1875	0.9290	26.5328	26.1732	27.3172	26.6985
240187	1.2635	0.9290	29.1582	30.9646	33.5190	31.2459
240196	0.9062	1.0964	34.3743	35.0345	35.4470	34.9598
240206	0.8906	1.4430	*	*	*	*
240207	1.3031	1.0964	34.6792	36.4569	37.7207	36.3423
240210	1.3246	1.0964	34.4184	36.5950	37.7098	36.2880
240211	0.9904	1.0102	17.4044	16.6158	15.9632	16.6713
240213	1.3869	1.0964	35.7818	37.4608	38.4263	37.2914
250001	2.0968	0.8204	23.7773	24.3404	26.7095	24.9401
250002	0.9022	0.7728	25.4201	25.0342	31.2365	27.1184
250004	1.7651	0.8950	25.8722	24.8086	29.1104	26.5104

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)
250006	1.1447	0.8950	25.9199	27.0511	26.9208	26.6473
250007	1.2274	0.8735	27.7665	29.3479	32.6684	29.9111
250009	1.4375	0.8422	23.4866	24.9118	25.9271	24.7833
250010	1.0238	0.7728	21.8665	22.7988	23.8756	22.8455
250012	0.9577	0.9276	23.4837	26.4110	27.3606	25.6043
250015	1.2101	0.7728	22.2803	22.3685	22.7780	22.4807
250017	1.0550	0.7728	33.6840	25.7404	25.5011	27.8780
250018	0.8861	0.7728	17.9025	19.1108	19.5545	18.8726
250019	1.5888	0.8735	26.2199	27.7230	28.4769	27.4567
250020	0.9937	0.7728	23.7245	23.1521	26.9609	24.6043
250023	0.8371	0.8312	18.5067	19.5081	22.2933	20.2223
250025	1.1810	0.7728	23.1738	23.0555	26.0584	24.0629
250027	0.9354	0.7728	26.9922	32.5451	26.7610	28.6736
250031	1.3374	0.8204	25.9189	26.7507	28.6358	27.0955
250034	1.6208	0.8950	26.7996	27.9279	29.3372	28.0770
250035	0.8389	0.7728	19.1038	20.5251	24.0679	21.2796
250036	1.0214	0.8297	19.7951	22.5676	22.6794	21.6101
250038	0.9810	0.8204	26.9621	30.7960	27.1951	28.1716
250040	1.5419	0.8312	27.3366	26.2268	28.4445	27.3188
250042	1.2623	0.8950	26.1190	27.4610	25.8809	26.4759
250043	1.0002	0.7728	20.8841	21.1265	22.4604	21.5019
250044	1.0099	0.7728	24.9199	26.1732	26.9458	26.0339
250048	1.6049	0.8204	24.7659	27.6339	27.4206	26.5934
250049	0.9197	0.7728	20.4775	24.2227	24.2088	22.8491
250050	1.2726	0.7728	21.1657	22.4429	22.6863	22.1193
250051	0.8114	0.7728	13.9532	14.1662	15.6985	14.6376
250057	1.1770	0.7728	24.3654	22.9683	22.5532	23.2123
250058	1.2723	0.7728	18.9970	19.6720	20.4761	19.7242
250059	0.9451	0.7728	26.7491	25.5982	24.8117	25.7276
250060	0.8105	0.7728	25.4779	27.0354	31.0702	27.5305
250061	0.8608	0.7728	18.7413	25.1495	23.3002	22.3051
250067	1.0828	0.7728	25.2189	23.8027	28.2885	25.7077
250069	1.5677	0.8414	22.4194	23.4495	25.8467	23.9259
250072	1.6307	0.8204	25.5337	27.5791	30.5430	27.8711
250077	1.0270	0.7728	19.0416	19.6333	19.3962	19.3590
250078	1.5964	0.8312	22.8430	23.9598	26.5434	24.4583
250079	0.8380	0.8204	43.0845	46.0349	32.3758	41.1228
250081	1.4224	0.8414	25.6808	24.8281	23.1397	24.4907
250082	1.4526	0.7778	23.5399	25.6218	27.8101	25.8049
250084	1.1762	0.7728	19.1604	19.5694	20.1213	19.6266
250085	0.9510	0.7728	24.2915	24.6757	24.5765	24.5152
250093	1.2290	0.7728	23.9128	26.4351	27.0938	25.9271

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)
250094	1.5708	0.8312	24.7718	25.4232	26.1351	25.4569
250095	1.0321	0.7728	23.6140	25.9021	30.7517	26.6690
250096	1.2796	0.8204	26.3743	27.7291	27.5216	27.2331
250097	1.5772	0.8253	22.0211	22.7916	23.6676	22.8692
250099	1.3926	0.8204	21.5656	27.5757	25.0095	24.6036
250100	1.3860	0.8414	27.0286	27.5484	28.2033	27.5970
250102	1.5609	0.8204	25.4050	25.5327	27.8774	26.2731
250104	1.4240	0.8414	24.4311	25.4008	26.3158	25.3907
250112	0.9669	0.7728	26.3357	27.4162	29.6994	27.8337
250117	1.1609	0.8312	23.7337	24.5706	26.0981	24.8284
250120	***	*	26.6522	*	*	26.6522
250122	1.1460	0.7728	27.4424	23.4908	27.3630	26.0905
250123	1.3636	0.8735	27.9058	29.8299	29.5530	29.0979
250124	0.8867	0.8204	20.5667	21.9420	22.4246	21.6647
250125	1.3275	0.8735	26.7687	32.7411	29.0835	29.1812
250126	0.9988	0.9276	25.0019	25.2581	26.8681	25.8023
250127	0.8968	1.4430	*	*	*	*
250128	0.9732	0.8174	21.7882	23.5918	24.7132	23.6848
250134	0.9334	0.8204	21.0211	22.0846	40.7973	27.2249
250136	0.9910	0.8204	25.2241	27.1479	27.8294	26.7381
250138	1.3815	0.8204	25.2642	27.3132	27.0705	26.5411
250141	1.5321	0.9276	30.5112	33.4413	32.1516	32.0769
250149	0.9588	0.7728	17.2268	17.0964	17.2425	17.1922
250151	0.6092	0.7728	22.8238	*	17.3978	20.4563
250152	0.9322	0.8204	26.4559	28.5526	29.8226	28.1435
250156	***	*	16.8659	*	*	16.8659
250157	***	*	29.6398	*	*	29.6398
250161	***	*	*	*	26.0087	26.0087
250162	1.0984	0.8749	*	*	*	*
260001	1.7138	0.8499	29.5271	31.1866	28.6708	29.7456
260004	0.9623	0.8176	21.3629	23.9584	22.8320	22.7747
260005	1.6825	0.9059	27.9477	31.1050	33.1040	30.8382
260006	1.4754	0.8176	27.3754	33.8253	34.3559	32.0545
260009	1.1937	0.9576	25.7546	26.6685	27.3309	26.5988
260011	1.6354	0.8882	27.5762	31.2612	31.4422	30.1667
260015	1.1583	0.8176	25.0640	25.0250	25.1572	25.0835
260017	1.3478	0.8882	25.0461	26.2621	27.4599	26.2584
260020	1.7345	0.9059	29.3080	30.9599	32.0919	30.8208
260021	1.5210	0.9059	32.6735	19.5810	19.8538	23.1176
260022	1.2836	0.8676	24.8713	25.9391	25.6877	25.4988
260023	1.4153	0.9059	25.4314	25.5899	26.7656	25.9576
260024	1.1686	0.8176	19.2199	20.7136	21.8416	20.5872

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)
260025	1.4287	0.8947	24.0358	24.5042	24.4961	24.3406
260027	1.7446	0.9576	29.3811	31.0236	32.3090	30.8160
260032	1.8891	0.9059	27.4857	28.7183	29.8281	28.6947
260034	0.9891	0.9576	27.1685	28.7736	27.9908	27.9952
260040	1.7348	0.8190	25.9074	27.3680	28.5063	27.2464
260047	1.4174	0.8176	26.6343	27.2667	27.1997	27.0395
260048	1.2162	0.9576	28.1515	29.6969	30.0636	29.3373
260050	1.1266	0.8176	26.2346	27.8065	27.6090	27.2809
260052	1.3082	0.9059	27.6360	29.6998	31.5744	29.7028
260057	1.1162	0.9576	21.5925	23.8181	27.0145	24.3359
260059	1.3213	0.8253	22.3885	25.3025	26.9530	24.9486
260061	1.1521	0.8176	22.8589	23.6717	24.7825	23.7432
260062	1.2852	0.9576	28.4975	29.6156	30.7182	29.6522
260064	1.3734	0.8456	23.3498	21.4932	23.5992	22.8280
260065	1.7136	0.8190	29.3564	28.3411	27.1333	28.2205
260068	1.6419	0.8582	27.3475	28.1246	29.3994	28.2874
260070	0.9228	0.8176	21.9701	25.2997	26.2374	24.6744
260074	1.1892	0.8456	28.0468	28.6216	28.4205	28.3755
260077	1.6916	0.9059	27.6624	28.7204	28.9984	28.4736
260078	1.2647	0.8176	21.1539	23.1785	24.7794	23.0608
260080	1.1006	0.8176	18.6070	18.6813	19.0051	18.7560
260081	1.5997	0.9059	29.1890	32.0799	34.8787	32.0824
260085	1.5578	0.9576	28.0306	29.6514	30.4757	29.3642
260091	1.5380	0.9059	28.5473	30.2636	32.9648	30.6430
260094	1.7350	0.8190	23.8654	25.1491	27.0141	25.3579
260095	1.5171	0.9576	27.6196	29.9090	30.9168	29.4353
260096	1.5480	0.9576	30.7267	32.9383	33.1832	32.3045
260097	1.1909	0.8476	25.5634	27.3129	28.2458	27.0636
260102	1.0197	0.9576	26.7624	30.7678	30.7182	29.4473
260104	1.6558	0.9059	28.0235	29.5891	32.0146	29.9298
260105	1.7897	0.9059	29.4766	32.4292	33.4333	31.7126
260107	***	*	27.9710	29.7775	38.3493	31.7425
260108	1.8342	0.9059	27.0758	28.5654	30.1092	28.5857
260110	1.6498	0.8947	26.6030	28.0381	28.5382	27.7432
260113	1.2035	0.8317	21.8884	23.0826	23.6758	22.8417
260115	1.1975	0.9059	24.6389	25.5658	26.5285	25.5841
260116	1.0586	0.8317	20.7479	22.5536	25.1770	22.7065
260119	1.3354	0.8696	31.5490	31.5003	26.4393	29.7132
260137	1.8051	0.8499	27.6592	31.4091	28.3567	29.1287
260138	1.9625	0.9576	30.6284	31.7582	33.4197	31.9614
260141	2.0088	0.8582	25.5663	26.6684	28.3502	26.9583
260142	1.1792	0.8176	21.7609	22.8205	25.2498	23.3605

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)
260147	0.8853	0.8176	22.1928	22.9689	22.8336	22.6483
260159	***	*	23.9515	24.3027	25.5051	24.5919
260160	1.0657	0.8320	25.5096	26.6715	27.9595	26.8679
260162	1.4366	0.9059	28.4660	30.5761	32.3630	30.4697
260163	1.2937	0.8263	21.5566	23.8644	25.0454	23.5122
260166	***	*	28.5858	29.5259	30.5880	29.5713
260175	1.0799	0.9576	24.6064	25.7069	26.5839	25.6428
260176	1.6938	0.9059	31.1056	30.6205	32.5020	31.4273
260177	1.2460	0.9576	28.7942	29.0815	31.1700	29.7020
260178	2.0287	0.8582	27.1201	26.9902	28.9177	27.7065
260179	1.5715	0.9059	28.3234	29.6316	30.3304	29.4313
260180	1.6616	0.9059	29.3820	30.7336	31.4752	30.5103
260183	1.6669	0.8947	29.2684	31.4916	32.2641	31.0417
260186	1.4540	0.8882	28.8610	29.1874	30.8731	29.6527
260190	1.2417	0.9576	30.5343	30.9003	32.2098	31.2057
260191	1.5435	0.9059	26.3244	27.8648	28.6103	27.6511
260193	1.2592	0.9576	28.1060	29.5436	30.5214	29.3877
260195	1.3064	0.8176	24.0411	25.0294	25.6715	24.9053
260198	***	*	27.2555	27.9093	31.4763	28.7652
260200	1.4024	0.9059	27.4784	30.5032	32.0933	30.2467
260207	1.1350	0.8190	22.9579	23.6392	22.8401	23.1574
260209	1.1108	0.8882	25.0749	26.4203	33.7389	28.4898
260210	1.2388	0.9059	30.5975	36.4055	33.5680	33.2788
260211	1.3993	0.9576	35.9113	37.1557	42.4335	38.2833
260213	***	*	34.8953	*	*	34.8953
260214	1.2467	0.9576	*	31.0175	31.7980	31.3944
260216	1.3063	0.9576	*	*	32.4072	32.4072
260217	***	*	*	*	12.2887	12.2887
260219	1.2780	0.9059	*	*	*	*
260220	3.6835	0.8499	*	*	*	*
260221	2.3337	0.8190	*	*	*	*
260222	2.2476	0.9576	*	*	*	*
270002	1.2003	0.8326	25.2907	28.3379	26.9696	26.8760
270003	1.2487	0.8377	29.1938	28.0543	28.5130	28.5449
270004	1.6838	0.9035	26.6779	28.5869	29.4741	28.2762
270011	1.1209	*	24.4696	*	*	24.4696
270012	1.5883	0.8377	26.5854	28.0672	27.9100	27.5361
270014	1.9544	0.9075	27.4811	28.2582	30.1110	28.6213
270017	1.2846	0.8940	27.4150	29.3542	29.4275	28.6988
270023	1.5407	0.9080	26.3076	28.1896	30.9919	28.4316
270032	1.0024	0.8326	20.4330	21.6360	21.5116	21.2043
270049	1.7989	0.9035	28.6880	29.8891	31.3965	30.0468

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)
270051	1.5007	0.8940	24.9371	29.3941	29.2656	27.8300
270057	1.3472	0.8326	27.1838	28.3627	29.5335	28.4316
270074	0.9280	1.4430	*	*	*	*
270081	1.0515	*	20.0438	*	*	20.0438
270086	1.4294	0.8377	20.7976	21.9017	27.4011	23.1327
270087	1.5455	0.8326	24.8022	24.9197	24.6133	24.7671
270088	1.6143	0.9035	*	*	*	*
280003	1.7510	0.9444	30.1057	32.3780	33.7720	32.0047
280009	1.8003	0.9210	29.3634	28.1559	29.9489	29.1522
280013	1.7312	0.9559	27.9523	30.3120	31.9823	30.1160
280020	1.6230	0.9444	32.3896	29.4831	30.3751	30.6737
280023	1.3434	0.9210	29.5132	30.0717	31.9442	30.5147
280030	1.8262	0.9559	30.6991	31.8758	33.4599	31.9821
280032	1.3492	0.9210	24.7539	25.6549	25.8727	25.4253
280040	1.6103	0.9559	29.5276	30.7406	32.1036	30.7888
280060	1.7504	0.9559	30.3049	30.4625	32.0133	30.9436
280061	1.4769	0.9190	26.4824	28.9591	29.2238	28.2497
280065	1.2898	0.9454	28.0132	29.5470	30.1157	29.2028
280077	1.3185	0.9210	28.2206	29.9223	29.7386	29.3150
280081	1.6725	0.9559	31.1212	28.9696	31.0784	30.3824
280105	1.2192	0.9559	29.8488	30.0472	33.3209	31.1288
280111	1.1563	0.8567	27.4853	28.3541	28.8669	28.2321
280119	0.8360	1.4430	*	*	*	*
280123	***	*	22.2185	20.2741	20.6329	20.8905
280125	1.5106	0.8567	23.2900	24.7466	25.1221	24.4231
280127	1.8858	0.9444	25.6806	26.5659	28.4601	27.0725
280128	2.8447	0.9444	28.8734	27.1024	20.6564	25.3520
280129	2.0467	0.9559	27.8793	27.9511	30.4288	28.8753
280130	1.4113	0.9559	29.8588	29.9645	32.4264	30.8844
290001	1.7319	1.0285	35.5113	33.3318	32.3635	33.6809
290002	0.9345	1.0161	23.9348	22.7362	25.4468	24.0585
290003	1.7724	1.1822	32.8182	34.6433	36.8519	34.8139
290005	1.5214	1.1822	31.7107	34.2373	34.2537	33.3761
290006	1.0892	1.0285	31.9838	33.3243	32.9259	32.7704
290007	1.7953	1.1822	39.7323	41.2395	44.0888	41.7282
290008	1.2515	1.0041	31.1116	33.2473	36.1651	33.5090
290009	1.6985	1.0285	32.3348	34.2103	38.6724	34.8343
290012	1.4489	1.1822	35.7988	38.3731	38.1524	37.4482
290019	1.5018	1.0285	30.5964	32.2817	34.3277	32.5070
290020	0.9720	1.0041	27.6277	27.2908	25.3597	26.7661
290021	1.6492	1.1822	36.7310	36.8728	39.4662	37.6904
290022	1.7381	1.1822	33.5330	38.8262	40.7353	37.5890

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)
290027	0.8915	1.0041	23.9818	29.1123	25.1477	25.7824
290032	1.4063	1.0285	34.6589	36.9175	38.9686	36.8219
290039	1.5566	1.1822	34.9622	34.6359	37.5754	35.7989
290041	1.5093	1.1822	37.6077	38.4445	40.0319	38.7789
290042	***	*	22.4859	*	*	22.4859
290045	1.7766	1.1822	34.4584	38.2560	38.5468	37.1810
290046	1.4656	1.1822	38.7966	38.3112	41.6819	39.7044
290047	1.5656	1.1822	33.4695	35.6381	38.6923	35.9441
290049	1.4106	1.0285	26.0725	33.4278	33.2028	31.1793
290051	2.0373	1.0331	*	32.5277	37.2753	34.7340
290053	1.6839	1.1822	*	*	*	*
290054	1.2788	1.1822	*	*	*	*
300001	1.5197	1.0532	29.8145	31.0122	31.4583	30.8177
300003	2.0504	1.0532	37.0886	37.7246	37.2599	37.3591
300005	1.4019	1.0532	27.8431	28.8402	29.4967	28.7611
300011	1.3668	1.0978	31.8928	33.0785	32.7474	32.5830
300012	1.3995	1.0978	31.2655	33.0569	34.8550	33.1376
300014	1.2275	1.0532	29.1847	30.7735	32.8329	30.9965
300017	1.2612	1.0765	31.6699	33.4164	35.2065	33.4398
300018	1.3426	1.0532	31.7891	31.5028	32.7025	32.0409
300019	1.2770	1.0978	28.2287	28.3114	30.5387	29.1032
300020	1.2596	1.0978	30.9783	32.4655	34.7788	32.8241
300023	1.4921	1.0765	31.2726	32.3202	34.2664	32.6736
300029	1.8723	1.0765	31.4429	32.0033	35.3145	32.9686
300034	1.8110	1.0978	31.6880	33.5537	33.7472	33.0352
310001	1.8211	1.2986	39.3391	41.4946	43.4149	41.4214
310002	1.8480	1.2684	37.8652	37.9484	39.7650	38.5500
310003	1.2851	1.2986	39.0785	40.1543	39.8712	39.7215
310005	1.3653	1.1349	33.6311	34.7657	34.4137	34.2895
310006	1.4778	1.2986	28.7321	30.4296	29.1071	29.4436
310008	1.4124	1.2986	33.3172	34.3268	36.2956	34.6686
310009	1.4222	1.2684	33.6165	35.4624	37.9138	35.6670
310010	1.3029	1.1349	33.7009	36.0823	34.1107	34.6229
310011	1.2635	1.1349	34.3497	37.4855	34.0850	35.2683
310012	1.5820	1.2986	39.8568	41.9630	41.3855	41.0801
310013	***	*	35.6260	32.9488	*	34.3351
310014	1.8604	1.1349	32.9016	35.0124	35.5476	34.5473
310015	1.9526	1.2684	39.2928	40.8229	39.3185	39.7989
310016	1.3298	1.2986	38.2740	41.0363	39.7608	39.6616
310017	1.3448	1.2684	35.7308	35.9806	34.8931	35.5293
310018	1.1786	1.2684	32.9704	32.6956	33.5117	33.0690
310019	1.5544	1.2986	30.6369	31.8930	34.6677	32.3846

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)
310020	***	*	37.3372	38.4266	34.8494	36.8995
310021	1.6643	1.1349	31.6562	32.2064	33.2576	32.3750
310022	1.3422	1.1349	31.1951	32.8079	32.8480	32.2853
310024	1.4475	1.1349	33.8622	36.8666	34.7044	35.1523
310025	1.4099	1.2986	32.2630	32.1481	35.2620	33.1796
310026	1.2488	1.2986	30.1392	30.1321	31.9956	30.7369
310027	1.5509	1.1349	31.5967	34.6471	34.0138	33.4220
310028	1.1675	1.1349	33.9911	34.8332	37.3090	35.4188
310029	1.8232	1.1349	33.6695	35.2084	36.5276	35.1438
310031	2.8500	1.1349	39.3783	39.5911	38.2614	39.0891
310032	1.3727	1.1349	33.0258	35.2402	35.8153	34.6925
310034	1.4456	1.1349	32.7523	36.8614	37.1225	35.5477
310037	1.3090	1.2986	38.2865	40.4642	44.3204	40.8614
310038	1.9228	1.2684	36.3344	39.8707	40.7496	39.0053
310039	1.3348	1.2684	33.2100	32.6425	33.4284	33.0863
310040	1.2607	1.2986	37.7945	41.2246	38.3292	39.0637
310041	1.3298	1.1349	33.9799	35.2009	34.4346	34.5409
310044	1.3853	1.1349	33.7614	33.5868	36.0025	34.4376
310045	1.6244	1.2986	38.4424	39.2097	40.3265	39.3557
310047	1.3194	1.1349	37.3695	37.7220	38.1243	37.7461
310048	1.4282	1.1349	33.9506	34.5256	33.9686	34.1464
310050	1.3393	1.2684	32.3686	37.9214	32.5237	34.0938
310051	1.5305	1.1349	38.1174	39.7671	37.9134	38.5977
310052	1.3898	1.1349	33.5849	36.5494	36.2075	35.4745
310054	1.4187	1.2684	36.9095	38.2432	37.2875	37.4834
310057	1.4337	1.1349	31.8933	34.2052	32.8887	32.9744
310058	1.0839	1.2986	30.4080	30.4436	32.1400	30.9814
310060	1.2940	1.1349	27.8242	27.9134	30.4699	28.7298
310061	1.2783	1.1349	39.0538	33.5586	33.6200	35.5139
310063	1.4103	1.1349	33.8519	38.1481	36.7166	36.1709
310064	1.5678	1.1349	38.6310	39.8091	39.9546	39.4927
310069	1.2298	1.1349	34.4669	35.1376	36.9535	35.5165
310070	1.4413	1.2684	36.3279	36.9999	36.9031	36.7474
310073	1.7924	1.1349	34.2858	36.9249	37.5346	36.2743
310074	1.3726	1.2986	39.6196	39.0729	35.9091	38.2141
310075	1.3970	1.1349	32.5338	33.5253	33.9028	33.3216
310076	1.7144	1.2684	37.5163	38.1671	39.0443	38.2404
310081	1.3099	1.1349	31.0699	31.7981	32.1279	31.6689
310083	1.3697	1.2684	31.9151	28.3406	28.2904	29.3830
310084	1.2852	1.1349	32.6051	34.9626	34.3155	33.9551
310086	1.2532	1.1349	29.8794	30.9467	31.4869	30.7831
310088	1.1450	1.1349	30.3552	31.2437	28.1753	29.9396

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)
310090	***	*	33.4615	33.9174	36.2554	34.5208
310091	1.1575	1.1349	31.9762	35.2913	34.8749	34.0196
310092	1.5445	1.1349	32.7054	32.8431	34.8069	33.4714
310093	1.2441	1.2684	30.2860	32.3860	33.4508	32.0480
310096	1.8766	1.2684	35.0707	34.2014	36.3268	35.2134
310105	1.2394	1.2986	32.5672	32.0277	31.3473	31.9725
310108	1.4508	1.2684	34.5866	36.2848	38.3442	36.4187
310110	1.3335	1.1349	33.4809	35.6825	36.5266	35.2692
310111	1.2838	1.1349	34.8284	36.0748	38.3560	36.4544
310112	1.3354	1.1349	32.2676	34.5337	33.6235	33.4530
310113	1.3080	1.1349	33.6771	35.0245	38.0117	35.6477
310115	1.3215	1.1349	31.9208	32.1197	33.7086	32.6076
310116	1.2914	1.2986	29.8144	27.8677	35.3861	30.8011
310118	1.4057	1.2986	31.2296	32.8286	33.2270	32.4401
310119	1.8872	1.2684	41.5702	41.2997	46.1439	42.9835
310120	1.1045	1.1349	33.3861	35.1661	36.3388	34.9302
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	***	*	*	*	40.1416	40.1416
320001	1.7469	0.9589	30.0077	31.4193	33.8175	31.8169
320002	1.4888	1.0592	33.1342	34.1610	35.6066	34.3288
320003	1.1527	1.0159	31.4473	31.5792	31.4481	31.4933
320004	1.2873	0.8968	26.2073	28.2407	30.5129	28.3775
320005	1.5147	0.9402	28.7893	25.2168	26.4658	26.7181
320006	1.2953	0.9402	28.0964	28.5177	31.6980	29.4924
320009	1.6468	0.9589	27.8084	31.3296	31.7234	30.2846
320011	1.2204	0.9305	27.9522	28.9951	30.6189	29.1921
320013	1.1896	1.0159	30.5865	31.2890	31.6730	31.1999
320014	1.0312	0.8968	28.7089	30.4803	29.8630	29.6837
320016	1.1768	0.8968	27.1492	26.6392	27.6746	27.1706
320017	1.3330	0.9589	33.3496	30.5787	30.9272	31.4185
320018	1.5219	0.8992	25.9248	28.3465	29.9069	28.0223
320019	***	*	35.0217	28.7067	31.8626	32.0103
320021	1.6334	0.9589	28.8504	29.6464	31.3664	30.0606
320022	1.1405	0.8968	25.3707	27.5152	28.7205	27.2392
320030	1.0707	0.8968	24.4497	25.5267	28.5253	26.3222
320033	1.2166	1.0159	30.1471	30.1846	32.8648	31.0782
320037	1.2619	0.9589	25.2876	27.8982	28.7085	27.3067
320038	1.2265	0.8968	32.7192	31.6526	33.1697	32.5145

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)
320057	0.8499	1.4395	*	*	*	*
320058	0.8144	1.4395	*	*	*	*
320059	1.0060	1.4395	*	*	*	*
320060	1.0476	1.4395	*	*	*	*
320061	0.9434	1.4395	*	*	*	*
320062	0.9142	1.4395	*	*	*	*
320063	1.3091	0.9339	26.0104	27.4946	30.6943	28.0694
320065	1.2953	0.9339	25.7945	26.9130	28.0334	26.9286
320067	0.9186	0.8968	24.7025	25.4121	23.6356	24.5792
320069	1.0456	0.8968	23.9863	25.3151	26.5162	25.2622
320070	0.9494	1.4395	*	*	*	*
320074	1.3074	0.9589	28.4396	28.8088	29.8325	29.0617
320079	***	*	27.6877	31.5661	30.3723	29.9073
320083	2.2696	0.9589	29.5483	32.9476	35.1159	32.3931
320084	0.9736	0.8968	22.7706	24.2902	24.5906	23.9673
320085	1.6864	0.8992	27.4100	28.4537	28.7140	28.2204
320086	1.3534	0.8968	*	*	*	*
320087	1.7232	1.0592	*	*	*	*
320088	2.6497	0.8992	*	*	*	*
330002	1.6978	1.3174	32.1956	34.7270	35.3594	34.1033
330003	1.4220	0.8823	25.2223	26.8363	27.7202	26.5915
330004	1.3373	1.1010	30.2236	30.3221	30.8349	30.4628
330005	1.6639	0.9815	31.5030	33.2851	34.1067	32.9719
330006	1.3884	1.3174	34.2001	36.3305	38.6682	36.3834
330008	1.1656	0.9815	25.2005	26.2141	25.9943	25.7976
330009	1.4044	1.3174	38.9166	41.3797	42.4214	40.9320
330010	1.0215	0.8446	19.7098	20.5805	24.3047	22.1956
330011	1.3068	0.8977	27.4747	26.8269	29.2720	27.8787
330013	1.9166	0.8823	26.8382	28.8039	29.3055	28.3433
330014	1.3853	1.3174	45.7619	46.3170	48.1109	46.7330
330016	***	*	23.0769	*	*	23.0769
330019	1.2623	1.3174	39.7429	44.5669	46.8232	43.6549
330023	1.5109	1.2867	36.4736	37.5135	40.9716	38.3981
330024	1.9004	1.3174	43.2342	44.8070	45.8373	44.6472
330025	1.0358	0.9815	23.2424	24.2702	26.5558	24.6993
330027	1.3567	1.2867	45.1920	45.9571	49.0615	46.6612
330028	1.6539	1.3174	36.2901	38.0149	38.0676	37.4637
330029	0.5859	0.9815	24.0679	22.9332	23.7576	23.5741
330030	1.2250	0.8743	25.3454	25.5089	27.4466	26.1119
330033	1.1279	0.8602	24.8022	25.0215	26.7586	25.5257
330036	1.2319	1.3174	30.3757	30.4659	31.2789	30.7217
330037	1.1440	0.8743	21.9246	23.4915	24.4440	23.2700

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)
330041	1.4242	1.3174	36.9934	37.1651	41.2571	38.3142
330043	1.4450	1.2721	38.8060	40.6094	42.0866	40.4408
330044	1.3944	0.8733	28.2293	28.2638	29.4911	28.6673
330045	1.4592	1.2721	40.0326	41.6565	44.7682	42.1466
330046	1.4134	1.3174	47.4975	52.2397	53.4650	50.9950
330047	1.2124	0.8446	24.9934	22.9948	27.4410	25.1837
330049	1.5474	1.2529	34.8585	34.9740	37.9724	35.9921
330053	1.1418	0.8743	21.8383	20.1303	21.4845	21.0995
330055	1.6065	1.3174	42.2007	44.2343	44.6945	43.7385
330056	1.6186	1.3174	38.8910	39.9662	40.5567	39.7950
330057	1.6698	0.8823	27.7121	30.1821	30.4865	29.4750
330058	1.2904	0.8743	22.6852	23.6296	25.3726	23.9199
330059	1.5820	1.3174	44.9162	45.3691	46.4988	45.6146
330061	1.2140	1.3174	37.8828	37.8649	38.8821	38.2207
330064	1.3838	1.3174	38.2332	41.5737	39.6057	39.8321
330065	1.0754	0.9815	24.4004	26.2288	28.6830	26.4276
330066	1.3306	0.8823	25.8174	27.2085	30.7045	27.8439
330067	1.4022	1.2529	29.2571	30.7537	31.5592	30.5001
330072	1.4768	1.3174	39.6996	41.4605	40.6029	40.5781
330073	1.1738	0.8743	23.4020	25.1392	24.7759	24.4481
330074	1.1760	0.8743	23.4576	23.1016	24.6998	23.7228
330075	1.1863	0.9865	24.2552	23.7522	27.5360	25.1965
330078	1.4914	0.9815	27.2870	27.6682	30.8249	28.6019
330079	1.3765	0.9417	24.9941	27.9479	28.7399	27.2037
330080	1.2022	1.3174	38.9405	40.2067	47.4562	42.2955
330084	1.1086	0.8379	25.6880	27.3434	28.8653	27.3150
330085	1.1677	0.9504	26.6235	27.1707	27.7235	27.1964
330086	1.5104	1.3174	35.5269	40.9768	47.7654	41.3257
330088	1.0072	1.2721	35.3871	37.4716	41.8732	38.1597
330090	1.4753	0.9275	26.8730	27.7306	29.5677	28.0594
330091	1.3851	0.9815	27.0040	28.3034	30.9544	28.7647
330094	1.2726	1.0277	26.9148	28.6213	33.1078	29.5210
330096	1.1944	0.8379	24.2422	24.7895	24.8709	24.6356
330100	1.0959	1.3174	39.6244	39.3170	41.6072	40.2022
330101	1.9607	1.3174	43.7944	45.5412	49.6500	46.3471
330102	1.4768	0.9815	26.6887	27.2543	31.6369	28.4519
330103	1.2692	0.8510	24.5585	25.4919	26.1070	25.3903
330104	1.4086	1.3174	35.1076	36.5894	38.4301	36.6706
330106	1.6464	1.2844	46.3657	48.2903	47.2329	47.2985
330107	1.2407	1.2721	35.7384	38.0262	40.2549	37.9772
330108	1.1153	0.8421	23.9368	25.3023	25.5498	24.9099
330111	0.9946	0.9815	40.4349	23.2134	25.1578	27.3537

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)
330115	1.2014	0.9865	23.8235	24.3898	27.0372	25.1066
330119	1.8425	1.3174	42.2901	41.2365	45.4182	42.9359
330125	1.8230	0.8743	28.0584	29.4817	30.2861	29.3020
330126	1.3626	1.2867	36.5689	37.7807	40.0567	38.1480
330127	1.3966	1.3174	45.2993	45.2554	51.9112	47.4869
330128	1.2789	1.3174	41.7790	43.3437	41.7903	42.2935
330132	1.1340	0.8510	21.7648	22.1452	23.4458	22.4496
330133	1.3595	1.3174	38.5228	39.9025	*	39.1945
330135	1.2423	1.1938	32.0525	33.2314	35.3674	33.5956
330136	1.5602	0.9504	26.6680	25.4198	27.9546	26.6860
330140	1.8110	0.9865	29.3461	31.1333	32.7905	31.1114
330141	1.3420	1.2721	39.3741	39.1733	41.3080	39.9773
330144	0.9667	0.8435	23.3874	24.9304	26.0621	24.7482
330151	1.3372	0.8435	19.7959	21.6339	23.4671	21.6188
330152	1.3918	1.3174	38.2079	39.5754	45.9382	40.9934
330153	1.6674	0.8823	28.4446	28.9944	31.7633	29.7368
330154	1.6868	*	*	*	*	*
330157	1.3318	0.9504	27.1432	29.7622	30.2766	29.0555
330158	1.8491	1.3174	41.7010	39.5946	41.6865	40.9951
330159	1.3442	0.9865	31.7835	33.8484	35.6942	33.7893
330160	1.5891	1.3174	37.1915	39.0970	42.1928	39.4694
330162	1.3012	1.3174	37.6226	38.7638	39.3476	38.6046
330163	1.1499	0.9815	28.3910	28.6252	26.3070	27.7735
330164	1.5125	0.8743	27.8746	29.8458	30.3043	29.3926
330166	0.9895	0.8379	20.7121	22.8506	23.2781	22.2902
330167	1.6734	1.2867	39.1251	39.2421	40.8790	39.7630
330169	1.4033	1.3174	46.4939	47.5404	49.8013	47.8606
330171	***	*	35.1577	*	*	35.1577
330175	1.1400	0.8639	24.1005	26.7883	28.4938	26.4587
330177	1.0241	0.8379	22.9834	23.4299	26.0387	24.1394
330180	1.2656	0.8823	25.4170	26.8658	28.1011	26.8184
330181	1.3412	1.2867	43.0977	46.2181	47.2581	45.4830
330182	2.2325	1.2867	41.3033	42.7962	46.6862	43.6033
330184	1.4050	1.3174	39.0437	39.7242	41.3973	40.0561
330185	1.3391	1.2721	38.4002	39.6724	42.2343	40.1184
330188	1.2661	0.9815	27.5988	29.7318	30.7242	29.3721
330189	0.9949	0.8823	22.4383	25.8125	26.4245	24.9037
330191	1.3428	0.8823	26.4328	28.2949	29.3762	28.0874
330193	1.4968	1.3174	39.8910	40.0280	40.7290	40.2258
330194	1.7547	1.3174	46.8880	49.8886	49.9280	48.9077
330195	1.6714	1.3174	41.7885	43.3213	46.0951	43.7137
330196	1.4204	1.3174	38.2525	38.6949	42.8158	39.9787

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)
330197	1.0795	0.8379	25.9872	26.5525	27.6446	26.7549
330198	1.4522	1.2867	34.8985	35.8715	37.9678	36.3122
330199	1.1689	1.3174	40.3948	39.4076	47.5087	42.4510
330201	1.7436	1.3174	42.6707	46.5114	51.2238	46.8676
330202	1.3173	1.3174	37.4158	38.7624	42.1130	39.4820
330203	1.4671	0.9865	34.0499	34.6525	33.9189	34.2046
330204	1.4490	1.3174	41.9953	39.5324	44.8187	42.1108
330205	1.2381	1.1938	33.9418	35.3792	37.0223	35.4788
330208	1.2740	1.3174	33.5287	37.1735	38.7339	36.4301
330211	1.1795	0.8379	25.8752	24.9432	25.9173	25.5876
330213	1.0900	0.8379	27.4890	28.5370	30.0957	28.7098
330214	1.8808	1.3174	42.1339	43.3229	43.7363	43.1296
330215	1.3047	0.8733	23.9583	26.3978	28.4030	26.1852
330218	1.0903	0.9865	26.9982	28.4113	28.4408	27.9714
330219	1.7322	0.9815	32.5658	33.2147	38.3396	34.6224
330221	1.4805	1.3174	40.0514	42.5486	39.5536	40.7517
330222	1.3615	0.8823	27.7198	28.7858	30.5173	29.0618
330223	0.9895	0.8379	26.1264	27.1970	28.2643	27.2173
330224	1.2541	1.1010	29.1738	30.4784	32.4543	30.7004
330225	1.2075	1.2867	35.7651	32.9036	33.7083	34.1550
330226	1.4006	0.8743	24.8471	26.3685	25.1515	25.4532
330229	1.2695	0.8379	23.0577	23.9243	24.9986	23.9953
330230	***	*	38.6569	39.3863	39.5106	39.1858
330231	1.1030	1.3174	44.9422	48.9021	49.2328	47.6933
330232	1.2198	0.8823	27.4639	27.9615	28.7297	28.0525
330233	1.5719	1.3174	52.7070	40.8539	43.4890	44.8333
330234	2.3835	1.3174	49.3219	49.8804	55.2252	51.5819
330235	1.1996	0.8379	29.4346	30.8034	31.2296	30.4578
330236	1.5677	1.3174	42.8981	42.6205	44.9072	43.4676
330238	1.2127	0.8743	21.8386	23.3953	24.7091	23.3365
330239	1.2587	0.8379	23.1885	24.6391	24.7263	24.1737
330240	1.2517	1.3174	40.5001	41.6132	42.5948	41.6026
330241	1.8174	0.9865	32.7683	32.9275	34.6701	33.4504
330242	1.3282	1.3174	36.9015	38.7875	40.2288	38.6309
330245	1.6935	0.8733	27.4326	28.6698	29.3850	28.5294
330246	1.3355	1.2721	35.7416	35.9577	39.4730	37.0865
330247	1.0217	1.3174	39.0219	41.3465	39.8515	40.0497
330249	1.3619	0.9865	24.6091	26.9856	29.4113	27.0068
330250	1.3872	1.0224	29.0080	29.6186	32.1769	30.2756
330259	1.5187	1.2867	36.4788	39.0213	38.5957	37.9814
330261	1.2797	1.3174	40.2579	38.0216	37.9623	38.6187
330263	1.0225	0.8379	24.1333	24.2125	25.5984	24.6612

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)
330264	1.4062	1.1938	31.0557	32.5050	35.4382	33.0171
330265	1.2565	0.8743	23.9081	22.7433	22.8154	23.0487
330267	1.5240	1.3174	34.9885	35.3907	38.1654	36.2738
330268	0.8926	0.8379	23.8793	23.9135	25.7822	24.5411
330270	2.1208	1.3174	55.2136	52.3154	55.7427	54.4679
330273	1.3931	1.3174	35.9298	39.7880	41.3633	39.0468
330276	1.0990	0.8415	26.0935	27.0445	28.5847	27.2457
330277	1.1935	0.9275	30.9053	30.8156	30.8641	30.8625
330279	1.7026	0.9815	29.6385	31.2393	33.7319	31.5308
330285	1.9061	0.8743	31.1235	31.8987	33.1145	32.0735
330286	1.3472	1.2721	37.6040	38.8556	40.3150	38.9492
330290	1.6594	1.3174	40.6933	39.8036	42.4874	40.9831
330304	1.3013	1.3174	37.3537	39.4632	39.8023	38.9126
330306	1.4666	1.3174	38.7713	39.0409	40.3338	39.3945
330307	1.2798	1.0028	29.5885	30.8121	33.6305	31.3247
330314	***	*	28.1788	22.6885	38.7331	26.5099
330316	1.3040	1.3174	37.1766	37.9357	40.3833	38.5232
330331	1.3291	1.2867	41.2694	44.1734	44.4001	43.3062
330332	1.3587	1.2867	37.0111	38.6932	40.8593	38.8534
330339	1.3992	0.8823	24.3066	25.0057	26.9012	25.3900
330340	1.2799	1.2721	37.4161	38.4726	38.4269	38.1012
330350	1.5276	1.3174	44.4617	44.2389	47.8602	45.5835
330353	1.3608	1.3174	45.0977	46.0215	47.8832	46.3533
330354	2.0360	*	*	*	*	*
330357	1.4087	1.3174	40.3850	40.2132	44.4231	41.2486
330372	1.2862	1.2867	35.1297	37.0323	40.3397	37.4471
330385	1.1438	1.3174	49.0859	47.4017	51.5681	49.3917
330386	1.3174	1.1246	33.3216	32.9990	34.6899	33.6601
330389	1.7997	1.3174	39.6871	37.5908	39.3648	38.8695
330390	1.3413	1.3174	35.5562	38.7652	35.4602	36.5033
330393	1.7006	1.2721	39.2186	38.9324	40.1484	39.4580
330394	1.6089	0.8977	28.4597	28.8074	30.5583	29.2953
330395	1.4434	1.3174	37.5791	50.1316	41.6548	42.5324
330396	1.4391	1.3174	39.4904	39.1956	41.6341	40.1418
330397	1.5843	1.3174	41.4448	41.1682	41.0716	41.2427
330399	1.2438	1.3174	36.7626	39.8023	42.0167	39.5143
330401	1.3730	1.2721	40.4485	41.7839	44.3877	42.2393
330403	0.9708	0.8743	25.2937	28.7282	26.7505	26.7864
330404	1.0396	1.3174	*	36.1069	36.8832	36.4872
330405	1.0229	1.3174	*	35.2720	31.3514	33.6009
330406	1.0353	0.8823	*	28.2733	28.0948	28.1836
330407	1.0352	0.8823	*	*	*	*

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)
340001	1.5066	0.9334	29.5709	29.9718	30.6948	30.1038
340002	1.7529	0.9112	29.6622	30.7403	31.7086	30.7178
340003	1.3269	0.8597	26.0888	26.6831	28.0754	27.0136
340004	1.4984	0.9019	27.5283	27.9200	30.6133	28.7033
340008	1.2936	0.9325	27.7206	29.0661	30.7606	29.2070
340010	1.4513	0.9254	28.7544	29.5232	31.0349	29.8059
340011	1.1552	0.8597	22.0047	22.5152	23.6059	22.7129
340012	1.2986	0.8597	24.7576	24.9271	26.1561	25.2672
340013	1.2840	0.9334	26.3607	26.9152	29.2528	27.5127
340014	1.6688	0.9019	27.8384	29.5350	29.4798	28.9768
340015	1.4709	0.9334	28.3928	30.0979	30.7658	29.7485
340016	1.3780	0.8597	27.2365	27.9651	27.2249	27.4711
340017	1.3498	0.9112	27.5672	28.4866	28.4826	28.1801
340020	1.2554	0.8753	27.5473	28.3461	30.5541	28.8321
340021	1.4180	0.9334	29.3835	31.3630	32.5694	31.1435
340023	1.4340	0.9268	26.2716	27.6921	30.1664	28.0909
340024	1.2572	0.8774	26.4001	26.9001	27.4782	26.9273
340025	1.2846	0.9112	24.0101	25.2846	25.8213	25.0539
340027	1.2932	0.9255	26.3840	26.6528	27.2809	26.7749
340028	1.5251	0.9472	30.7591	31.9872	31.7644	31.5002
340030	2.0257	0.9525	30.4591	31.2051	31.0563	30.9185
340032	1.5629	0.9334	28.7636	29.2080	29.3954	29.1312
340035	1.0591	0.8597	24.6262	26.0846	26.8840	25.8665
340036	1.2453	0.9534	27.3860	29.0646	29.9262	28.8317
340037	1.2327	0.8759	29.0618	30.5362	32.0552	30.6155
340038	1.2027	0.8850	24.2111	26.2600	26.9504	25.8559
340039	1.2981	0.9019	27.8228	29.5069	30.2982	29.2150
340040	1.8720	0.9360	28.7434	30.1280	31.3898	30.1221
340041	1.4092	0.8947	26.8314	27.1285	27.8417	27.2769
340042	1.2511	0.8597	25.6349	27.0597	27.0746	26.6113
340047	1.7947	0.9019	28.4968	28.7620	30.5532	29.2577
340049	1.8486	0.9525	29.6826	31.5555	35.4206	32.3062
340050	1.3256	0.9325	27.5274	29.2290	30.4556	29.1047
340051	1.2515	0.8751	24.4561	25.4981	25.4180	25.1284
340053	1.5897	0.9334	28.9355	30.8342	30.9302	30.2615
340055	1.3259	0.8947	26.5752	29.0116	29.5058	28.3042
340060	1.1252	0.9164	25.1791	26.8387	27.3478	26.4783
340061	1.7855	0.9525	29.8574	31.2910	33.4843	31.5732
340064	1.2448	0.8597	23.9701	25.0814	27.2219	25.4862
340068	1.3681	0.8597	23.6757	24.7409	27.3524	25.3082
340069	1.8150	0.9525	31.4951	32.2171	32.5394	32.1098
340070	1.2650	0.9029	26.6546	27.7679	29.0411	27.8537

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)
340071	1.1624	0.9534	27.9748	29.7343	31.3776	29.8365
340072	***	*	24.1350	*	*	24.1350
340073	1.7585	0.9525	31.6803	33.1054	33.2736	32.6960
340075	1.3200	0.8947	25.1438	26.8315	29.1519	27.0653
340084	1.1597	0.9334	23.1300	25.6885	27.4353	25.3785
340085	1.2417	0.9029	27.9572	29.1095	29.9196	29.0177
340087	1.2422	0.8597	25.4730	23.8360	25.0106	24.7832
340090	1.3516	0.9534	26.7428	28.3615	27.9452	27.7253
340091	1.6405	0.9019	28.8044	30.4371	31.2679	30.1864
340096	1.3172	0.9029	26.5438	26.5814	26.8127	26.6502
340097	1.2054	0.8597	29.8005	27.9810	29.8729	29.2113
340098	1.5287	0.9334	29.7180	31.3916	31.8494	31.0122
340099	1.3223	0.8597	23.9702	26.0077	28.1164	26.0188
340104	0.5942	0.8759	17.0165	19.9492	20.2902	19.1560
340106	1.1370	0.8597	26.1340	24.5154	24.4270	24.9483
340107	1.2404	0.8924	26.5626	27.3565	28.5887	27.5268
340109	1.2682	0.8943	26.6383	26.6479	28.6320	27.3198
340113	1.9563	0.9334	30.3841	32.3786	32.5003	31.7844
340114	1.5702	0.9525	28.1311	30.1207	32.3755	30.2676
340115	1.6831	0.9525	27.2781	28.0974	28.9278	28.1069
340116	1.6608	0.8947	29.3698	29.9447	30.8586	30.0577
340119	1.3211	0.9334	29.4470	27.2938	28.1105	28.2340
340120	1.1057	0.8597	25.5399	26.1465	26.5371	26.0765
340121	1.2208	0.9138	23.8854	25.1577	25.7494	24.9493
340123	1.3839	0.9164	28.5669	28.7150	29.9109	29.0920
340124	***	*	23.5480	25.7294	25.2499	24.6686
340126	1.3640	0.9534	28.2247	30.6902	31.7296	30.2644
340127	1.2348	0.9525	28.2161	28.8675	30.8170	29.3523
340129	1.3579	0.9334	26.7606	31.7863	27.7501	28.6378
340130	1.3664	0.9334	28.1594	29.5294	30.4914	29.4634
340131	1.4244	0.9255	28.8542	29.6571	32.1793	30.2599
340132	1.2471	0.8597	24.6162	25.3264	25.9172	25.3014
340133	1.0373	0.8857	24.8579	26.8850	27.2685	26.4284
340137	***	*	28.9672	27.0874	28.8756	28.3116
340138	0.8080	0.9525	*	*	*	*
340141	1.7271	0.9138	29.3171	29.3372	30.8660	29.8516
340142	1.2764	0.8597	27.7555	28.2413	28.4966	28.1785
340143	1.5556	0.8947	27.9777	29.3861	30.7181	29.3963
340144	1.2884	0.9334	27.0150	27.6548	26.5602	27.0669
340145	1.3595	0.9334	26.7482	28.0647	28.4250	27.7576
340147	1.3647	0.9534	28.2626	29.6960	30.2651	29.4132
340148	1.6298	0.9019	25.8325	27.9136	28.6611	27.5046

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)
340151	1.2296	0.8649	23.2158	24.5782	25.9653	24.6033
340153	2.0094	0.9334	28.5979	29.8278	30.9121	29.7946
340155	1.5164	0.9525	30.9501	31.7570	31.6751	31.4659
340156	0.9295	1.4430	*	*	*	*
340158	1.1630	0.9138	27.6526	29.4110	29.2583	28.8168
340159	1.2553	0.9525	25.3108	28.1706	27.8468	27.1188
340160	1.3943	0.8597	23.4631	24.2016	24.9137	24.2274
340166	1.4417	0.9334	28.5395	29.9122	31.0821	29.8335
340168	0.6145	0.9138	*	*	*	*
340171	1.2285	0.9334	27.4701	31.1954	31.7866	30.2737
340173	1.3175	0.9525	30.2815	30.9843	30.9064	30.7411
340183	1.2409	0.9334	*	30.1261	31.4721	30.8608
340184	1.2239	0.9112	*	*	*	*
350002	1.8663	0.7981	23.5869	23.6051	25.2983	24.1523
350003	1.2813	0.7981	24.9975	24.5812	27.3557	25.6249
350006	1.5976	0.7981	22.4626	23.4343	26.6538	24.1401
350009	1.1664	0.8289	24.5737	23.9795	25.3366	24.6269
350010	***	*	20.4198	*	*	20.4198
350011	1.9612	0.8289	24.1135	26.0201	27.3941	25.8547
350014	***	*	17.5837	*	*	17.5837
350015	1.8126	0.7981	21.3342	22.9120	27.7094	24.0903
350017	1.2005	*	21.6187	24.0968	*	22.8560
350019	1.6853	0.8067	24.9615	24.9890	27.0972	25.7253
350030	1.0422	*	22.5976	23.1023	*	22.8546
350063	0.9123	1.4407	*	*	*	*
350064	0.6955	1.4407	*	*	*	*
350070	1.8205	0.8289	26.2454	26.2871	28.1444	26.9112
360001	1.5607	0.9405	28.8623	30.1038	31.8534	30.2853
360002	1.3364	0.8672	25.4859	25.2209	26.7563	25.8275
360003	1.8114	0.9405	30.7812	31.8976	31.9338	31.5553
360006	1.8697	1.0102	30.9806	31.8814	35.0703	32.6565
360008	1.3625	0.8754	27.5683	28.0202	28.6007	28.0820
360009	1.5514	0.9337	27.0618	28.2423	30.2469	28.5205
360010	1.2748	0.8657	24.7352	26.6040	27.3222	26.2408
360011	1.3533	0.9830	31.5587	29.9882	30.5936	30.6632
360012	1.4002	1.0102	31.0526	31.9837	32.9163	31.9746
360013	1.1420	0.9337	29.8412	30.2406	30.9360	30.3476
360014	1.1103	0.9830	27.0743	28.1811	28.9662	28.1273
360016	1.5707	0.9405	29.6298	30.2190	30.5914	30.1510
360017	1.7815	1.0102	31.7081	32.6006	34.8806	33.0517
360019	1.3183	0.8938	27.2997	28.8568	29.3541	28.5127
360020	1.6075	0.8938	25.6328	27.8079	29.5347	27.6279

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)
360025	1.4739	0.9295	27.1546	28.4761	29.5329	28.3991
360026	1.3689	0.9235	25.2945	27.5757	27.3646	26.7452
360027	1.5095	0.8938	28.2923	29.9449	30.8916	29.7353
360029	1.1798	0.9469	26.4208	28.0191	29.0637	27.8578
360032	1.2136	0.8531	25.9916	27.2636	27.4091	26.8919
360035	1.6664	1.0102	31.3181	32.0858	32.5654	31.9786
360036	1.2235	0.9087	29.3514	29.9410	31.5040	30.2760
360037	1.5599	0.8938	30.0446	30.6552	31.5250	30.7327
360038	1.5793	0.9405	31.0611	31.3776	32.3124	31.5436
360039	1.4810	0.9830	24.7873	25.8216	27.3655	25.9928
360040	1.1869	0.8918	25.5337	26.7450	28.4423	26.9613
360041	1.4027	0.8938	26.6755	28.4439	29.3340	28.1335
360044	1.1592	0.8658	24.3840	24.7698	25.7030	24.9528
360046	1.2922	0.9405	26.2417	28.2972	28.5635	27.7334
360048	1.7868	0.9469	29.4378	30.0390	33.3308	30.9523
360051	1.7014	0.9235	28.1167	29.4434	30.5968	29.3970
360052	1.6230	0.9235	26.8806	28.4731	29.8107	28.3736
360054	1.3757	0.8754	24.8248	23.6606	27.9363	25.4882
360055	1.4300	0.8938	30.0143	31.4794	31.2758	30.9027
360056	1.5521	0.9405	30.3677	31.3936	31.8388	31.2304
360058	1.1201	0.8531	24.5003	25.9295	27.7104	26.0480
360059	1.6226	0.8938	30.6173	30.6294	31.4095	30.8965
360062	***	*	32.8893	32.9025	35.2102	33.6868
360064	1.6626	0.8603	27.7795	28.6101	27.6929	28.0255
360065	1.2596	0.9295	29.7155	31.5066	31.6790	30.9855
360066	1.4393	0.9337	29.7605	30.9652	32.1169	30.9770
360068	1.8538	0.9469	26.6933	28.6335	30.0233	28.4134
360070	1.7423	0.8662	27.8891	28.8739	30.0214	28.9297
360071	1.1536	0.8566	26.4081	25.7956	26.6158	26.2776
360072	1.4856	1.0102	27.2286	29.1514	29.8898	28.7636
360074	1.3374	0.9469	27.5328	28.0283	30.1346	28.5620
360075	1.3141	0.8938	26.1657	28.3930	29.8233	28.1946
360076	1.6092	0.9405	29.0148	29.5342	28.8486	29.1315
360077	1.5667	0.8938	28.0133	28.3022	26.2980	27.4917
360078	1.3208	0.8938	27.4689	27.3652	28.2995	27.7275
360079	1.8157	0.9235	30.1230	31.3132	32.1046	31.1906
360080	1.1597	0.8531	22.7020	21.8806	22.9888	22.5211
360081	1.3545	0.9469	29.5312	31.4293	33.2550	31.4022
360082	1.3992	0.8938	28.7925	30.5837	29.7457	29.6933
360084	1.6359	0.8662	28.5402	29.2489	29.1285	28.9820
360085	1.9807	1.0102	32.8502	33.1295	35.9704	34.0317
360086	1.6056	0.9235	27.3124	29.1579	31.9710	29.4349

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)
360087	1.4318	0.8938	28.4185	28.6336	30.0108	29.0060
360089	1.2023	0.8531	25.5608	28.0779	28.5199	27.3212
360090	1.4398	0.9469	30.7530	29.2662	30.3184	30.0985
360091	1.3141	0.8938	27.6809	28.2009	29.6351	28.5140
360092	1.2645	1.0102	25.4055	28.0813	28.3591	27.2597
360095	1.5273	0.9337	29.3787	30.2138	30.1008	29.9028
360096	1.1435	0.8531	26.8653	27.9514	29.8710	28.2202
360098	1.4309	0.8938	26.6382	26.5839	27.6795	26.9763
360100	***	*	23.6167	25.8143	25.9644	25.0987
360101	1.4105	0.8938	29.7817	30.6650	29.4676	29.9671
360107	1.1328	0.8650	26.0534	26.8180	29.9903	27.7009
360109	1.0726	0.9830	30.1382	30.4643	30.7885	30.4702
360112	1.7901	0.9971	31.1356	32.4403	34.6116	32.7317
360113	1.2521	0.9405	30.2871	30.3914	33.3315	31.3820
360115	1.3555	0.8938	26.1821	27.9711	29.0972	27.7753
360116	1.3242	0.9405	26.4968	26.8632	29.3138	27.5372
360118	1.4846	0.9087	28.5643	29.9823	30.1194	29.5133
360121	1.2447	0.9295	28.3835	31.6766	22.1967	26.6669
360123	1.4144	0.8938	28.0334	28.5435	30.0887	28.9085
360125	1.2911	0.8531	25.9067	27.1776	28.8251	27.2839
360130	1.3791	0.8938	26.3986	28.1811	28.5447	27.6940
360131	1.4538	0.8662	26.6635	27.3426	28.3639	27.4686
360132	1.4465	0.9405	29.4070	29.8411	29.5774	29.6114
360133	1.6852	0.9405	31.7521	33.1812	33.9646	32.9729
360134	1.7627	0.9405	28.5141	29.9198	31.9470	30.1688
360137	1.7979	0.8938	27.6894	30.3116	32.2775	30.1276
360141	1.6707	0.8603	31.1778	31.9397	32.0756	31.7218
360143	1.3738	0.8938	26.9394	28.0693	27.0055	27.3503
360144	1.3538	0.8938	28.9177	29.6547	29.5100	29.3663
360145	1.6090	0.8938	28.1835	29.3271	29.8714	29.1450
360147	1.3579	0.8531	27.5548	29.2371	28.0808	28.2829
360148	1.2348	0.8531	26.3399	25.7460	28.4553	26.8313
360150	1.4290	0.8938	28.2561	27.8840	27.8893	27.9984
360151	1.3190	0.8662	26.5636	26.9672	28.3935	27.3634
360152	1.5536	1.0102	31.5377	33.1017	35.3677	33.3237
360153	1.0022	0.8531	20.2147	21.8416	22.3029	21.4281
360155	1.4579	0.8938	28.9521	29.1711	30.0281	29.3875
360156	1.1646	0.8650	25.0833	26.2268	27.4201	26.2860
360159	1.3993	0.9830	28.6174	29.0187	29.1735	28.9575
360161	1.3911	0.8618	27.0875	27.7423	29.4741	28.1245
360163	1.8912	0.9405	30.0724	31.2087	31.1244	30.8101
360170	1.2489	1.0102	29.5954	30.0688	30.9923	30.2530

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)
360172	1.3460	0.8938	28.8283	30.2330	31.2628	30.0983
360174	1.2888	0.9235	28.3143	28.3769	29.2443	28.6567
360175	1.3249	0.9830	28.3054	29.7499	31.8382	29.9881
360179	1.5580	0.9405	29.8299	31.3540	30.6849	30.6202
360180	2.3340	0.8938	31.4342	32.0225	30.3041	31.2212
360185	1.3620	0.8531	26.1080	26.4210	27.4007	26.6480
360187	1.4761	0.9235	25.7600	27.3745	28.2649	27.0972
360189	1.0867	1.0102	27.5097	28.3738	28.8950	28.2768
360192	1.3888	0.8938	27.5991	29.1999	31.8069	29.6386
360195	1.1185	0.8938	27.6155	27.2630	28.4940	27.7987
360197	1.1653	0.9830	28.9207	28.5267	30.3333	29.2821
360203	1.1852	0.8531	25.3692	27.7569	28.7988	27.3131
360210	1.2436	1.0102	29.6476	31.8182	35.1711	32.3210
360211	1.5170	0.8573	26.5459	27.5081	26.9529	27.0042
360212	1.3260	0.8938	26.6976	28.5882	28.8952	28.0404
360218	1.2766	1.0102	30.0101	31.1641	31.4490	30.9028
360230	1.5326	0.8938	30.0661	30.5995	29.4150	30.0200
360234	1.4273	0.9405	31.0656	30.7926	29.5423	30.4548
360236	1.3148	0.9405	29.5321	29.9367	31.7596	30.4376
360239	1.3753	0.9235	30.7728	31.7938	32.3548	31.6883
360241	***	*	25.7290	25.8137	28.0304	26.4969
360242	1.9371	*	*	*	*	*
360245	0.7356	0.8938	20.3426	20.4589	20.8616	20.5776
360247	0.6145	1.0102	*	*	*	*
360253	2.1310	0.9235	34.3347	34.6887	33.3161	34.1062
360259	1.3348	0.9469	27.2902	28.0886	29.3702	28.2517
360261	1.1020	0.9045	25.6332	26.6262	28.2281	26.8699
360262	1.2865	0.9469	30.1559	31.5637	33.1920	31.6652
360263	1.9394	0.9337	25.4864	28.1671	25.5112	26.3370
360266	2.1261	1.0102	31.7565	29.8385	31.3711	30.9189
360267	***	*	34.0936	*	*	34.0936
360268	***	*	34.0526	*	*	34.0526
360269	1.9404	0.9405	24.8552	25.5191	26.4007	25.7822
360270	1.1419	0.8531	*	28.8677	30.0596	29.6028
360271	1.7291	0.9405	*	28.4353	30.8067	29.6449
360272	***	*	*	38.1014	*	38.1014
360273	***	*	*	37.6645	*	37.6645
360274	1.6487	0.9235	*	*	*	*
360275	2.8444	0.9469	*	*	*	*
360276	1.1953	0.8603	*	*	*	*
360346	3.5298	1.0102	*	*	*	*
360347	1.2385	1.0102	*	*	*	*

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)
360348	1.1501	1.0102	*	*	*	*
370001	1.6674	0.8770	26.8884	28.4907	27.2887	27.5720
370002	1.1318	0.7800	23.6886	26.2486	25.7362	25.2259
370004	1.1954	0.8499	26.8521	28.2804	27.2396	27.4666
370006	1.2536	0.8721	23.9935	25.2307	27.5337	25.4498
370007	0.9573	0.7800	20.3706	21.1260	25.7676	22.4657
370008	1.3634	0.8840	26.6563	27.9944	28.9304	27.9057
370011	0.9976	0.8840	22.3391	23.1761	24.4060	23.3100
370013	1.5272	0.8840	27.2667	28.3502	29.7984	28.5408
370014	1.1835	0.8451	26.4488	28.8962	29.3393	28.2690
370015	1.0245	0.8770	25.5815	27.8061	27.6080	27.0202
370016	1.5401	0.8679	29.8284	30.4672	29.6764	29.9902
370018	1.4891	0.8770	24.6868	31.2335	29.3301	28.4561
370019	1.1668	0.7800	25.2814	26.7613	30.3821	27.4650
370020	1.5207	0.8679	22.7566	24.7520	23.8736	23.7876
370022	1.2432	0.7937	22.2289	26.4836	24.4747	24.2830
370023	1.3253	0.7890	24.0376	24.9580	27.4260	25.5127
370025	1.3266	0.8770	24.5547	24.8336	27.0219	25.4190
370026	1.4828	0.8679	25.5172	26.0203	26.8094	26.1099
370028	1.9032	0.8840	28.5619	29.9849	31.0461	29.8971
370029	1.1436	0.7800	28.5309	30.0134	30.3698	29.6056
370030	1.0184	0.8770	25.8212	26.0831	26.5844	26.1543
370032	1.5257	0.8840	26.2642	28.0739	29.6055	27.9106
370034	1.2292	0.7800	20.4106	23.2192	23.9067	22.5565
370036	1.1324	0.7800	19.8162	21.1544	22.1119	21.1310
370037	1.6188	0.8840	25.2350	26.8992	28.1440	26.7681
370039	1.0938	0.8770	23.5745	25.3422	26.7620	25.2088
370040	1.0031	0.8005	26.7395	19.7644	21.6756	22.8168
370041	0.8542	0.8770	22.9834	29.5074	26.4368	26.0976
370047	1.4823	0.8451	24.4766	27.8937	29.6849	27.4426
370048	0.9921	0.7800	22.0627	23.4848	24.0976	23.1950
370049	1.3679	0.8679	22.8755	24.2099	23.0150	23.3420
370051	1.0644	0.7800	19.3222	21.8716	22.8406	21.2865
370054	1.2403	0.7800	25.2142	23.4644	25.4816	24.7144
370056	1.7228	0.8163	25.5453	27.6178	26.9546	26.7138
370057	1.0595	0.8770	22.1337	23.1814	21.0807	22.1014
370060	***	*	23.3858	25.5571	29.0356	25.8854
370065	0.9985	0.7896	23.5815	24.0062	23.7282	23.7646
370072	0.8313	0.8058	13.0963	22.8598	17.2619	16.6035
370078	1.6683	0.8770	26.6972	30.4837	28.7508	28.5905
370080	0.9725	0.7800	22.4113	23.7231	22.3685	22.8034
370083	0.9363	0.7851	20.9878	21.9162	21.3131	21.4070

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)
370084	1.0542	0.7800	20.7326	17.4202	17.6667	18.5106
370089	1.4348	0.7800	22.1523	22.0607	23.7710	22.7436
370091	1.6433	0.8770	25.8697	28.0487	28.3968	27.4524
370093	1.8009	0.8840	27.5356	26.7272	29.0186	27.7537
370094	1.3942	0.8840	26.5265	28.3512	29.5950	28.1565
370097	1.3342	0.8163	26.8138	28.0911	28.1224	27.6646
370099	1.0499	0.8679	26.7206	30.5437	28.8898	28.7271
370100	0.8729	0.7900	19.4002	20.6298	18.2271	19.4039
370103	1.0384	0.7800	19.4273	22.2675	23.4762	21.6724
370105	2.0833	0.8840	26.6399	30.5438	31.4227	29.2640
370106	1.4250	0.8840	28.5957	29.6797	31.4450	29.9111
370112	1.0152	0.8005	16.7888	19.0130	20.2256	18.7070
370113	1.1336	0.8788	26.4608	30.0061	28.3526	28.2687
370114	1.6767	0.8770	25.9841	27.1348	32.9948	28.5441
370138	1.1124	0.7800	22.1675	23.6348	24.7629	23.4791
370139	0.9455	0.7800	20.5156	21.0759	19.4842	20.3378
370148	1.4441	0.8840	28.1933	29.3447	30.8803	29.5572
370149	1.2955	0.8679	23.3423	23.0764	25.1552	23.8353
370153	1.0986	0.7800	24.1667	25.9238	30.0877	26.7600
370156	0.9997	0.7921	23.0104	22.7140	22.3368	22.6846
370158	0.9448	0.8840	21.5228	22.0056	22.1169	21.8875
370166	0.8775	0.8770	24.7251	26.3420	22.9738	24.6758
370169	0.8182	0.7963	16.6752	24.5389	20.4824	20.8300
370170	0.8438	1.4430	*	*	*	*
370171	1.0650	1.4430	*	*	*	*
370172	0.8359	1.4688	*	*	*	*
370173	0.9508	1.4430	*	*	*	*
370176	***	*	24.9650	26.6687	27.2921	26.3296
370178	0.9123	0.7800	16.0747	15.6720	17.3093	16.3332
370180	1.1032	1.4430	*	*	*	*
370183	0.9814	0.8770	23.8419	30.3850	25.4200	26.6332
370190	1.3985	0.8770	34.6942	32.5635	35.6063	34.2867
370192	1.9077	0.8840	19.0638	19.1346	28.7425	22.4504
370196	***	*	20.8296	24.6984	*	23.0172
370199	0.9892	0.8840	23.7412	23.9376	25.7846	24.5543
370200	***	*	21.7153	19.7060	27.9225	23.0121
370201	1.6485	0.8840	24.2364	25.5882	30.1955	26.5835
370202	1.4854	0.8770	25.7966	25.8261	29.3944	27.0849
370203	2.0990	0.8840	25.7770	30.3641	31.3919	29.7462
370206	1.8396	0.8840	27.5752	30.8151	28.7342	29.0277
370210	1.9798	0.8770	27.2111	25.7905	29.4089	27.4920
370211	1.1954	0.8840	28.6537	30.9656	32.7912	31.0663

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)
370212	1.9460	0.8840	20.3495	20.0919	23.2428	21.2771
370214	1.2047	0.7921	21.0732	20.1495	22.3225	21.1911
370215	2.2509	0.8840	32.4087	32.0950	34.0249	32.9091
370216	2.1463	0.8770	25.8260	29.6658	29.1213	28.3031
370218	1.3377	0.8770	30.3445	23.7517	29.6394	27.5220
370219	***	*	*	41.4392	*	41.4392
370220	1.8290	0.8840	*	21.3168	22.0429	21.6903
370222	1.8621	0.8840	*	26.9175	28.6131	27.7666
370223	***	*	*	24.0154	*	24.0154
370224	***	*	*	*	21.3942	21.3942
370225	1.4917	0.8840	*	*	*	*
370227	1.0366	0.8770	*	*	*	*
370228	1.2798	0.8770	*	*	*	*
370229	1.0388	0.7800	*	*	*	*
380001	1.3168	1.1217	32.0770	33.8490	36.3345	34.1205
380002	1.2815	1.0255	31.5246	32.6830	32.7767	32.3441
380004	1.6919	1.1217	34.5432	36.1021	37.5281	36.0796
380005	1.4524	1.0255	33.2849	33.5765	33.5521	33.4700
380007	2.0141	1.1217	35.1697	36.4222	38.0130	36.5292
380009	2.1647	1.1217	34.5635	36.5688	36.8501	36.0302
380014	1.8988	1.0853	33.1928	35.7101	36.4408	35.1448
380017	1.8124	1.1217	35.3734	36.8103	37.5942	36.6133
380018	1.8952	1.0255	31.8181	32.4884	32.4748	32.2676
380020	1.4172	1.1073	34.6183	35.7392	37.4380	35.9331
380021	1.5544	1.1217	32.6142	33.0628	33.3945	33.0416
380022	1.2889	1.0476	29.6224	30.9181	32.6171	31.0768
380025	1.2048	1.1217	36.4910	38.1507	38.8210	37.8362
380027	1.3998	1.1073	28.0247	31.4398	33.7134	31.1084
380029	1.3234	1.0933	29.4461	33.3368	34.4943	32.6114
380033	1.7495	1.1073	34.0094	36.0798	36.6621	35.6181
380037	1.4160	1.1217	32.7922	34.0321	36.0740	34.4795
380038	1.3481	1.1217	35.1105	35.0350	36.3651	35.5153
380040	1.4954	1.0255	32.9081	34.4500	37.3237	34.9736
380047	1.8726	1.1073	32.8188	35.8165	37.9933	35.6506
380050	1.4313	1.0255	29.7329	31.3088	32.4410	31.2363
380051	1.7773	1.1217	32.8545	35.0114	37.3434	35.1056
380052	1.3051	1.0255	28.6119	27.7656	29.1463	28.5109
380056	1.2196	1.0933	29.1686	31.0210	31.9057	30.6371
380060	1.4828	1.1217	33.8863	35.1106	37.7937	35.6582
380061	1.6939	1.1217	34.5230	35.8922	37.8684	36.0985
380071	1.3673	1.1217	31.0901	31.6821	32.7496	31.8321
380075	1.4129	1.0255	31.6884	34.0197	36.0151	33.9220

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** (3 years)
380082	1.3018	1.1217	35.7821	37.7268	38.8948	37.4988
380089	1.3615	1.1217	35.4850	37.0017	37.8737	36.8230
380090	1.3115	1.1073	35.5535	41.4540	41.3589	39.4561
380091	1.4122	1.1217	40.5066	39.7431	47.7045	42.8616
380100	***	*	*	45.3882	*	45.3882
380101	1.3251	1.1217	*	*	*	*
380102	1.7411	1.1073	*	*	*	*
390001	1.6169	0.8375	24.3251	25.4188	27.9779	25.8497
390002	1.4033	0.8575	25.0860	25.9827	26.9688	26.0303
390003	1.2336	0.8375	24.5099	26.2872	26.6618	25.7820
390004	1.6450	0.9199	25.2424	26.5054	29.3261	26.9239
390006	1.9180	0.9199	28.6926	30.9914	32.8137	30.9576
390008	1.0760	0.8435	22.6297	22.9417	25.0205	23.5269
390009	1.7957	0.8446	26.7234	29.0286	27.1030	27.6183
390010	1.1457	0.8575	24.8196	26.0966	27.8970	26.2540
390011	***	*	20.2291	*	*	20.2291
390012	1.2596	1.0710	32.4856	34.2004	35.6384	34.0825
390013	1.4529	0.9199	26.2323	28.3039	26.8802	27.1587
390016	1.2851	0.8575	24.3488	26.1802	25.6685	25.3801
390019	1.1517	0.9848	25.7515	25.3185	25.2057	25.4378
390022	***	*	29.6308	*	*	29.6308
390023	1.2533	1.0710	34.7787	36.2618	37.4675	36.1624
390024	***	*	38.8750	37.4815	*	38.0669
390025	0.5781	1.0710	20.3878	*	*	20.3878
390026	1.2082	1.0710	31.8309	36.0608	37.1694	34.9355
390027	1.7604	1.0710	39.2158	40.9110	42.5734	40.8789
390028	1.6878	0.8575	27.1451	29.6218	31.3889	29.2913
390030	1.1978	0.8996	24.6343	26.5678	26.9690	26.1033
390031	1.2183	0.8996	27.2033	26.1258	27.5747	26.9778
390032	1.3069	0.8575	24.5243	25.3756	27.3328	25.7511
390035	1.1997	1.0710	29.5417	27.2130	27.6114	28.0620
390036	1.5305	0.8575	24.4917	26.1956	29.3163	26.6239
390037	1.4665	0.8575	25.2296	27.0788	30.8468	27.6490
390039	1.3053	0.8411	23.2300	22.1531	23.3478	22.8935
390041	1.2718	0.8575	24.2257	25.1190	26.4436	25.2989
390042	1.4569	0.8575	28.0996	29.6213	30.6744	29.4902
390043	1.2182	0.8375	24.2087	24.3590	26.4456	25.0115
390044	1.5285	1.0541	29.4057	29.9959	30.6955	30.0650
390045	1.5159	0.8375	24.6495	25.8800	26.4468	25.6641
390046	1.7411	0.9480	30.5115	32.5273	32.1174	31.7497
390048	1.1562	0.9199	28.3152	28.4563	29.0275	28.6088
390049	1.5732	0.9848	30.7431	31.0290	32.7236	31.5091

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)
390050	2.0707	0.8575	27.3481	29.6715	32.0961	29.7222
390052	1.1760	0.8422	25.1462	26.3700	27.4022	26.3424
390054	***	*	27.4805	27.5696	*	27.5206
390056	1.1684	0.8411	23.5821	24.7038	25.5919	24.6315
390057	1.3193	1.0710	30.9198	31.0279	33.9602	31.9644
390058	1.3916	0.9199	27.7296	29.6620	29.4670	28.9801
390061	1.5690	0.9626	30.0597	30.9208	30.2331	30.4042
390062	1.2310	0.8835	21.0713	22.8856	37.2860	27.1982
390063	1.8685	0.8446	26.8381	28.3987	30.3714	28.5733
390065	1.3538	1.0784	29.5654	31.8841	31.2642	30.9320
390066	1.4364	0.9199	25.4407	29.0033	28.3768	27.6167
390067	1.8037	0.9480	30.6128	32.2891	30.5626	31.1563
390068	1.3698	0.9626	29.0962	29.6984	28.2197	28.9560
390070	1.3003	1.0710	34.4935	34.5501	33.4995	34.1784
390071	0.9975	0.8375	24.8467	26.3830	27.8738	26.3386
390072	1.0792	0.8375	26.2568	28.8145	28.0741	27.6875
390073	1.6900	0.8835	26.4083	27.0876	28.8538	27.4787
390074	***	*	25.4098	*	*	25.4098
390076	1.3445	1.0710	32.7671	33.9908	34.3674	33.7077
390079	1.8256	0.8757	24.4452	26.0199	26.9695	25.8139
390080	1.4385	1.0710	29.2645	31.6210	32.9833	31.2969
390081	1.3085	1.0710	33.6247	36.4788	37.7678	35.9781
390084	1.1829	0.8375	24.3372	24.3191	24.8040	24.4842
390086	1.6557	0.8375	25.0992	24.7454	25.3100	25.0505
390090	1.8906	0.8575	27.0122	30.1256	31.0260	29.3606
390091	1.2331	0.8388	23.3562	23.2118	23.9444	23.5154
390093	1.2064	0.8388	22.6023	23.8846	23.5300	23.3373
390095	1.1995	0.8375	24.6290	25.3859	25.9599	25.3028
390096	1.6052	1.0541	28.6055	30.3910	31.7462	30.2631
390097	1.2827	1.0710	27.9858	28.1285	30.4969	28.8547
390100	1.6602	0.9626	30.0234	32.7836	32.8989	31.9684
390101	1.3166	0.9324	24.8377	25.9850	28.6634	26.5233
390102	1.4447	0.8575	24.4589	25.5336	26.3730	25.4809
390103	***	*	20.4446	*	*	20.4446
390104	1.0655	0.8375	19.6630	20.4552	26.8389	22.6280
390107	1.6613	0.8575	24.6565	25.6790	26.6320	25.7189
390108	1.3060	1.0710	28.5928	34.3066	33.3057	32.0217
390110	1.6335	0.8575	25.3407	25.7159	28.5342	26.6602
390111	2.3129	1.0710	34.8756	37.7322	34.5616	35.7160
390112	1.2372	0.8411	21.5439	18.4185	19.5362	19.7345
390113	1.3526	0.8388	24.2593	24.8669	25.9972	25.0523
390114	1.5644	0.8575	27.9184	28.5336	28.2109	28.2335

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)
390115	1.4438	1.0710	30.8063	32.5058	31.9262	31.7683
390116	1.3384	1.0710	33.2562	33.9295	34.3477	33.8514
390117	1.1540	0.8377	21.5038	22.2327	26.0652	23.2902
390118	1.2083	0.8375	21.8917	23.6535	23.7143	23.0914
390119	1.3594	0.8375	24.3245	25.3907	25.9792	25.2332
390122	1.1601	0.8428	23.3220	24.6434	24.0432	23.9974
390123	1.2056	1.0710	34.0062	35.1244	34.1207	34.4214
390125	1.2420	0.8397	22.8816	24.0199	24.4695	23.8069
390127	1.4603	1.0710	33.6557	33.1227	34.6563	33.7948
390128	1.2836	0.8575	24.1390	25.1858	26.0454	25.1418
390130	1.2719	0.8375	23.2504	30.7083	26.7315	26.7541
390131	1.3964	0.8575	23.5783	27.7146	26.9205	26.1186
390132	1.4785	1.0710	31.1168	30.0751	33.1894	31.4348
390133	1.7733	1.0541	32.9812	33.0604	35.0188	33.7428
390137	1.5165	0.8375	26.1457	26.9156	27.9089	27.0063
390138	1.2426	0.9189	27.4231	27.7565	29.0245	28.0897
390139	1.3995	1.0710	34.0836	36.5001	36.8382	35.8451
390142	1.5455	1.0710	34.5773	33.3509	38.1819	35.3748
390145	1.6077	0.8575	25.6980	26.9212	27.6534	26.7679
390146	1.1785	0.8397	25.1805	23.9878	27.5284	25.5621
390147	1.4284	0.8575	28.6606	29.0995	30.4830	29.4258
390150	1.0895	0.8575	22.7668	22.6483	27.2962	24.3333
390151	1.4035	1.0784	31.4067	31.8967	35.0638	32.8286
390153	1.3781	1.0710	33.2427	36.0287	36.9666	35.4759
390154	1.2729	0.8375	23.3559	23.9785	24.6873	24.0204
390156	1.4011	1.0710	32.8999	33.7057	34.9106	33.8272
390157	1.2643	0.8575	22.1112	23.0989	23.7221	22.9935
390160	1.3626	0.8575	22.9696	25.2043	27.5239	25.2360
390162	1.5460	1.1243	34.5809	35.1844	36.7114	35.4840
390163	1.2612	0.8575	22.8341	24.8761	25.4631	24.4084
390164	2.1723	0.8575	27.1950	29.7778	29.0577	28.6765
390166	***	*	23.3255	28.2178	*	25.5801
390168	1.5829	0.8575	26.9816	27.3674	28.2597	27.5474
390169	1.4104	0.8375	26.2643	26.6063	28.4624	27.1535
390173	1.2404	0.8409	25.6455	27.6039	28.1012	27.1418
390174	1.7449	1.0710	34.8999	35.1118	36.5434	35.5423
390176	1.1253	0.8575	24.1247	*	27.5295	25.5569
390178	1.4030	0.8605	23.1452	23.9166	25.2336	24.0963
390179	1.4269	1.0710	30.1219	31.5498	33.9953	31.9600
390180	1.4618	1.0710	35.5291	38.2997	37.8727	37.2547
390181	***	*	26.6021	27.8833	*	27.2407
390183	1.1518	0.8375	27.8358	28.2211	28.8378	28.3036

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)
390184	1.0990	0.8575	23.9736	23.9973	24.1483	24.0413
390185	1.2411	0.9669	27.1119	25.5318	28.1349	26.9990
390189	1.1261	0.8375	23.6215	23.4902	25.3678	24.1725
390192	1.0514	0.8375	23.6171	23.7958	24.7432	24.0525
390194	1.2334	0.9848	26.3152	23.7367	27.8249	25.8745
390195	1.5690	1.0710	34.5594	37.2504	36.8509	36.2305
390196	1.5711	*	*	*	*	*
390197	1.3634	0.9848	27.2455	27.7303	28.2033	27.7354
390198	1.0232	0.8446	20.4350	21.0861	21.3592	20.9633
390199	1.1065	0.8375	23.0046	24.5469	24.9637	24.1861
390201	1.5128	0.9669	27.3542	28.5668	28.7839	28.2504
390203	1.5048	1.0710	29.1370	30.7244	33.0105	30.9867
390204	1.3453	1.0710	30.7346	32.0242	33.8160	32.1656
390211	1.3591	0.8605	26.5052	27.7875	28.0827	27.4560
390217	1.2357	0.8575	24.1886	26.2706	25.6933	25.3906
390219	1.3585	0.8575	26.1196	26.3263	27.2828	26.5790
390220	1.1379	1.0710	30.7435	32.0891	33.6287	32.1262
390222	1.3721	1.0710	31.7361	32.7077	34.5846	33.0514
390223	1.9067	1.0710	34.3280	36.5784	35.8126	35.5994
390225	1.3113	0.9626	27.2555	26.3642	*	26.7274
390226	1.7263	1.0710	32.6508	35.4683	35.5599	34.5687
390228	1.4809	0.8575	24.2242	25.5120	28.4346	26.0667
390231	1.4354	1.0710	32.8353	35.2312	35.0706	34.4340
390233	1.4672	0.8375	27.2597	28.3660	29.5947	28.4435
390236	1.0126	0.8378	23.1290	24.5574	25.1876	24.2551
390237	1.6731	0.8375	28.4337	29.9748	29.6932	29.3996
390246	***	*	26.0179	*	*	26.0179
390256	1.9014	0.9199	28.8970	28.5887	31.6491	29.7484
390258	1.4759	1.0710	31.7164	32.0551	33.7417	32.5254
390263	1.5401	0.9848	29.9850	30.2069	32.0566	30.8106
390265	1.5596	0.8575	25.0166	27.7795	27.8259	26.8722
390266	1.1766	0.8605	22.2228	23.0142	23.5260	22.9195
390267	1.3552	0.8575	24.8309	25.7571	28.2409	26.2700
390268	1.4249	0.8963	26.7342	28.4200	30.0664	28.4464
390270	1.6993	0.8375	26.5010	27.0301	29.3647	27.7277
390272	0.6254	1.0710	*	32.9918	29.3655	31.0398
390278	0.6753	1.0710	28.6323	28.8318	33.9659	30.4997
390285	***	*	37.6669	38.4703	43.0857	39.5216
390286	***	*	31.3393	31.7337	32.7046	31.9300
390287	***	*	42.2401	*	*	42.2401
390290	1.8452	1.0710	41.1426	47.7663	41.9167	43.5157
390304	1.3235	1.0710	32.1633	33.4134	35.0769	33.5420

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)
390305	***	*	29.3217	*	*	29.3217
390306	***	*	40.3789	*	*	40.3789
390307	2.0351	0.8605	24.5393	22.9474	27.2076	24.8311
390308	***	*	36.1737	*	*	36.1737
390309	***	*	37.8924	*	*	37.8924
390310	***	*	44.3991	*	*	44.3991
390311	***	*	*	49.9027	*	49.9027
390312	1.3269	1.0710	*	51.3372	42.3513	46.0965
390313	1.1428	0.8996	*	*	27.3035	27.3035
390314	1.9236	0.9848	*	*	*	*
390316	2.0583	0.9416	*	*	*	*
390317	0.9463	1.0710	*	*	*	*
390318	1.2983	0.9848	*	*	*	*
390319	0.8794	0.8575	*	*	*	*
390320	1.1450	1.0710	*	*	*	*
400001	1.3957	0.4361	14.9151	15.4249	15.9186	15.4272
400002	***	*	12.9440	12.9793	14.2946	13.3765
400003	1.4540	0.4222	15.7906	14.6859	15.8816	15.4534
400004	1.2236	0.4361	12.5928	13.5197	14.5536	13.5877
400005	1.2316	0.4361	11.1152	11.7590	12.6510	11.8651
400006	1.2983	0.4361	8.1381	*	*	8.1381
400007	1.3357	0.4361	12.0743	10.4934	10.7763	11.1305
400009	1.1438	0.3539	9.5114	10.1212	14.0016	10.9165
400010	0.9453	0.3369	10.7993	10.4206	12.8582	11.2363
400011	1.1843	0.4361	8.5503	9.4068	10.7615	9.5777
400012	1.5766	0.4361	10.1156	*	11.1548	10.6500
400013	1.3294	0.4361	11.4222	12.3073	12.7895	12.1952
400014	1.4402	0.3669	9.9395	12.3301	11.0721	11.0731
400015	1.3375	0.4361	22.2017	21.9225	17.6936	20.4552
400016	1.5904	0.4361	16.1931	17.9107	19.1572	17.7510
400017	***	*	9.9185	10.0590	*	9.9834
400018	1.2773	0.4361	12.3942	13.1572	13.6086	13.0712
400019	1.4801	0.4361	14.7133	15.2364	15.0594	14.9875
400021	1.4966	0.4742	13.9217	14.9779	16.3677	15.0813
400022	1.5237	0.4222	15.3625	15.2124	15.3660	15.3143
400024	0.9101	0.3669	12.6226	13.7215	14.2706	13.3756
400026	1.2146	0.3539	7.1179	8.9064	9.8155	8.5696
400028	1.0865	0.4222	10.6711	9.6941	11.1923	10.4831
400032	1.1891	0.4361	10.7141	10.7844	11.9008	11.1569
400044	1.5933	0.4222	11.3551	12.1393	13.4579	12.3287
400048	1.4706	0.3539	9.6860	10.5176	11.5766	10.6023
400061	2.2278	0.4361	18.0093	17.4504	18.5319	17.9897

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)
400079	1.2798	0.3369	10.4599	10.6127	11.3548	10.8204
400087	1.3984	0.4361	11.4162	12.0034	12.6227	12.0135
400098	1.2954	0.4361	13.7878	12.8756	13.2363	13.2768
400102	1.1382	0.4361	12.1761	12.1257	12.6309	12.3093
400103	1.9028	0.3669	11.7488	11.3314	12.7289	11.9275
400104	1.2065	0.4361	12.8404	12.6934	12.9610	12.8318
400105	1.1950	0.4361	16.9029	17.0463	25.3813	18.7976
400106	1.2536	0.4361	12.9272	14.8544	14.1771	13.9718
400109	1.4018	0.4361	14.8208	14.5713	15.4904	14.9660
400110	1.2776	0.3349	9.9278	10.8214	11.2311	10.6665
400111	1.1860	0.3369	10.2141	10.7892	11.0465	10.6892
400112	1.3018	0.4361	13.5177	11.2303	9.6177	11.3250
400113	1.2682	0.4222	10.9503	11.5948	11.9672	11.5248
400114	1.2012	0.4361	10.8913	11.6872	11.5509	11.3984
400115	1.1375	0.4361	9.6200	10.6809	12.0196	10.9082
400117	1.1338	0.4361	11.6258	12.1540	12.2153	11.9942
400118	1.3427	0.4361	12.7861	12.6199	13.3977	12.9416
400120	1.3341	0.4361	14.0817	14.5205	14.6585	14.4290
400121	1.0481	0.4361	9.1826	9.9713	11.7457	10.4347
400122	2.0582	0.4361	9.5814	10.0966	13.1846	10.6818
400123	1.2393	0.3669	12.5609	13.8601	13.4312	13.2747
400124	2.6950	0.4361	17.9140	19.1704	21.9074	19.6592
400125	1.2469	0.3791	13.5394	13.1078	12.7141	13.0689
400126	1.2047	0.4742	16.5726	*	14.2108	15.0677
400127	1.7226	0.4361	20.7775	*	12.0792	14.9822
400128	1.0695	0.4361	12.3520	*	23.6342	16.5268
410001	1.3432	1.1581	30.0315	30.5865	30.8061	30.4780
410004	1.3679	1.1581	31.3023	35.2384	33.7275	33.4448
410005	1.2848	1.1581	31.4387	34.2846	38.2856	34.6408
410006	1.3437	1.0801	32.8456	33.9961	35.4489	34.0988
410007	1.5997	1.1581	32.0730	34.4774	37.0323	34.5473
410008	1.3264	1.0801	32.5889	33.6384	34.6159	33.6237
410009	1.2503	1.0801	32.8422	34.3427	36.0927	34.4532
410010	1.1448	1.1581	32.7379	34.9330	38.4630	35.3895
410011	1.4804	1.1581	30.1941	36.7668	38.6571	35.1740
410012	1.5315	1.1581	37.0299	36.5207	37.5255	37.0270
410013	1.2162	1.1580	41.0010	39.8659	38.2284	39.6699
420002	1.5952	0.9333	30.5111	31.2247	32.3658	31.3750
420004	1.9950	0.9198	28.9250	30.0764	31.5268	30.2188
420005	1.2093	0.8380	24.6968	26.5044	27.9935	26.3011
420006	1.2439	0.9198	27.7764	29.1404	31.5455	29.4564
420007	1.6919	0.9266	29.0901	28.9557	31.1104	29.7364

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)
420009	1.4100	0.9266	29.9378	28.6648	29.1023	29.2164
420010	1.1520	0.8380	25.5710	26.5523	27.0442	26.3877
420011	1.1710	0.9702	25.5130	26.0585	24.7686	25.4577
420015	1.2753	0.9702	26.3499	27.4929	27.9777	27.2843
420016	0.9421	0.8380	22.5681	23.4323	23.2135	23.0763
420018	1.8675	0.8858	27.5563	29.0923	29.0490	28.5830
420019	1.0673	0.8538	25.4954	25.8119	23.7905	25.0569
420020	1.3243	0.9198	27.5000	29.2935	28.7843	28.5417
420023	1.7895	0.9702	28.9321	30.4492	31.2383	30.2821
420026	1.8472	0.8858	28.0647	29.5066	30.8174	29.4502
420027	1.6396	0.9266	28.5621	31.3797	29.9671	29.9533
420030	1.4016	0.9198	28.4433	30.3424	31.3274	30.0581
420033	1.1867	0.9702	31.1608	32.4287	33.6556	32.3990
420036	1.2522	0.9332	24.6505	26.3480	27.1759	26.0618
420037	1.4533	0.9702	30.9556	32.7124	33.3407	32.3127
420038	1.3251	0.9702	26.6435	27.1524	29.5696	27.7913
420039	1.0882	0.9001	26.5582	26.3127	24.5420	25.7947
420043	1.1537	0.8537	25.7951	25.8366	24.2730	25.2823
420048	1.2904	0.8858	26.9625	27.4353	29.9433	28.1629
420049	1.3235	0.8683	25.7060	28.0920	28.5078	27.4831
420051	1.7878	0.8380	26.4710	27.6130	28.0533	27.3853
420053	1.1780	0.8415	24.4793	25.4820	26.5019	25.4888
420054	1.1731	0.8382	25.6444	26.7900	27.1574	26.5073
420055	1.0934	0.8380	25.1738	25.3144	25.9017	25.4464
420056	1.3359	0.8380	28.4512	29.7774	28.1130	28.7827
420057	1.2491	0.8380	26.2489	27.7137	29.5669	27.7790
420062	1.0594	0.9332	25.9569	27.2263	28.3137	27.1888
420064	1.5168	0.8683	24.6507	25.0654	26.3964	25.3881
420065	1.4283	0.9198	26.8118	28.1896	28.4630	27.8373
420066	1.0159	0.8380	25.0932	20.5743	26.0299	23.6374
420067	1.3662	0.8977	26.5658	27.7167	29.0397	27.7873
420068	1.4370	0.9056	27.7315	28.0316	28.1203	27.9533
420069	1.2663	0.8380	23.7494	24.4656	25.2021	24.4938
420070	1.3418	0.8858	27.5988	27.6431	28.4023	27.8841
420071	1.4302	0.9266	27.6371	28.1099	28.4165	28.0602
420072	1.0532	0.8380	21.6587	20.7716	24.4954	22.3026
420073	1.4257	0.8858	26.1120	28.2671	29.5812	28.0320
420078	1.9124	0.9702	30.9001	32.8731	34.0992	32.6114
420079	1.5300	0.9198	28.6374	30.5981	31.7712	30.3663
420080	1.4118	0.8977	31.5670	32.8712	33.8818	32.7554
420082	1.4714	0.9166	33.9874	34.8864	33.5359	34.1149
420083	1.4280	0.9266	28.9007	29.6587	29.2288	29.2675

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)
420085	1.5563	0.9136	29.1127	29.9085	31.3413	30.1481
420086	1.5261	0.8858	27.9523	29.6349	30.2191	29.3102
420087	1.7716	0.9198	26.8409	28.4632	29.0548	28.1200
420089	1.4538	0.9198	29.5862	31.7367	33.0955	31.5017
420091	1.4931	0.8380	27.2520	27.9062	28.3474	27.8537
420093	***	*	33.0474	*	*	33.0474
420098	1.2157	0.8508	27.1939	27.6722	27.1110	27.3266
420099	***	*	30.3089	*	*	30.3089
420100	***	*	*	29.2979	*	29.2979
420101	1.1099	0.8977	*	33.1995	34.1813	33.6600
420102	1.8338	0.9702	*	*	*	*
430005	1.4026	0.8293	23.8694	25.4385	27.1830	25.4902
430008	1.1374	0.8828	26.0873	27.2275	27.2632	26.8938
430012	1.3131	0.9054	25.2030	27.0195	28.5822	26.9447
430013	1.2349	0.9054	27.0427	28.4962	28.3701	27.9791
430014	1.5014	0.8303	27.9288	28.9295	29.2938	28.7282
430015	1.3340	0.8293	26.5787	28.0414	28.5863	27.7508
430016	1.6001	0.9054	32.8765	31.1336	31.5920	31.8088
430027	1.7563	0.9054	27.5759	29.2617	29.2463	28.7343
430048	1.2370	0.8422	25.1715	25.6428	26.9553	25.9325
430060	0.7994	0.8293	*	*	11.8204	11.8204
430064	1.0087	0.8293	16.4916	17.7334	18.8455	17.7188
430077	1.7546	1.0170	27.2116	31.1945	35.3478	31.1559
430081	0.7923	1.4430	*	*	*	*
430082	0.8617	1.4430	*	*	*	*
430083	0.9252	1.4430	*	*	*	*
430084	0.8708	1.4430	*	*	*	*
430089	1.9427	0.8958	23.2467	24.9060	28.3217	25.6660
430090	1.8687	0.9054	29.0197	32.7395	33.8352	31.9285
430091	2.1343	1.0293	24.7274	26.7258	28.3511	26.5874
430092	1.9037	0.8293	21.9197	23.2527	26.6752	23.8830
430093	1.0219	1.0293	26.0232	24.7426	30.7367	27.0433
430094	1.9087	0.8422	23.2894	23.6624	23.8982	23.6305
430095	2.4076	0.9054	32.2326	32.5881	31.8165	32.2123
430096	2.0558	0.8293	24.6041	24.9623	28.0618	25.8250
440001	1.1681	0.7894	21.5755	25.4855	23.9414	23.6562
440002	1.7170	0.8931	26.3802	26.9133	28.4834	27.2896
440003	1.3870	0.9597	28.3557	26.0115	31.4174	28.4435
440006	1.5532	0.9597	31.5533	31.7394	32.6938	32.0221
440007	0.9755	0.8113	18.8273	22.7571	23.4891	21.6128
440008	0.9856	0.8343	27.3732	26.8857	26.2014	26.7714
440009	1.2062	0.7894	23.8148	24.4423	25.1180	24.4600

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)
440010	0.9257	0.7894	19.6231	20.2497	23.8062	21.0797
440011	1.3574	0.7894	23.6698	24.8300	25.7914	24.7899
440012	1.5621	0.8103	23.7871	24.9261	26.2093	25.0352
440015	1.9489	0.7894	26.0601	27.1603	28.1407	27.1264
440016	1.0608	0.8038	24.5812	25.2512	25.4187	25.0952
440017	1.8022	0.8103	24.6707	26.1820	28.6152	26.5729
440018	1.1314	0.7894	25.0780	24.8568	26.0764	25.3486
440019	1.7874	0.7894	25.2230	26.2464	28.0406	26.4701
440020	1.0614	0.8552	24.7785	27.5626	28.0249	26.7494
440024	***	*	24.7705	26.2534	25.4435	25.5234
440025	1.2362	0.8579	22.6571	24.0289	25.5653	24.1028
440026	***	*	26.8153	28.4615	26.5868	27.3422
440029	1.4909	0.9597	31.2310	31.4652	31.8952	31.5420
440030	1.3360	0.7894	22.2607	22.3144	23.1127	22.5592
440031	1.1971	0.7913	22.6790	22.0711	23.0926	22.6112
440032	1.2087	0.8094	21.0380	23.8030	25.4133	23.4927
440033	1.0945	0.7921	22.7991	23.9792	24.3193	23.7152
440034	1.6950	0.7894	25.5061	25.9138	26.7989	26.0832
440035	1.4003	0.9344	26.2451	27.9217	26.8737	26.9982
440039	2.0964	0.9597	30.1790	30.1918	32.4218	30.9661
440040	0.8811	0.7894	20.8817	21.1288	21.3776	21.1291
440046	1.3511	0.9597	29.7377	30.7334	31.5163	30.6884
440047	0.9600	0.8232	22.8323	25.2150	26.8023	24.9294
440048	1.8069	0.9257	29.3187	30.6725	31.5607	30.5023
440049	1.6962	0.9257	28.8742	29.8623	31.7224	30.1546
440050	1.3689	0.7903	24.9694	26.3825	27.4223	26.3090
440051	0.9664	0.7976	23.4866	23.6560	23.1780	23.4348
440052	1.0071	0.7894	22.6128	24.4071	28.1831	24.8996
440053	1.3336	0.9597	27.8180	30.3907	31.3203	29.8836
440054	1.1938	0.7894	23.7931	21.9641	25.7778	23.7445
440056	1.2197	0.7894	23.2313	24.0635	25.2058	24.1767
440057	1.2124	0.7915	17.2176	19.3546	25.1517	20.2004
440058	1.1849	0.8670	26.0706	29.1184	28.5095	27.9179
440059	1.5133	0.9344	27.9467	29.4532	30.4521	29.3327
440060	1.1743	0.8232	25.0795	26.5867	26.5501	26.0644
440061	1.1467	0.7894	23.7360	25.4134	25.9991	25.0590
440063	1.6800	0.7894	23.9644	26.0763	24.3782	24.8154
440064	0.9901	0.8850	26.1246	26.7957	26.9018	26.6000
440065	1.3793	0.9597	25.8536	25.6111	27.3522	26.2569
440067	1.1389	0.8094	24.6553	26.0866	26.5098	25.7739
440068	1.1768	0.8670	26.1071	27.9082	27.2654	27.0986
440070	1.0041	0.8003	21.9166	23.2228	24.4456	23.1570

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)
440072	1.0622	0.7894	25.7089	26.1661	27.7039	26.5291
440073	1.3762	0.9344	27.6154	27.5133	28.3965	27.8401
440081	1.2013	0.7946	20.7688	21.9681	23.3010	22.0284
440082	1.9325	0.9597	32.2479	32.8941	34.4556	33.1520
440083	0.9661	0.7894	23.6356	25.7074	25.5371	24.9476
440084	1.2160	0.7919	18.8699	19.8950	21.3869	20.0619
440091	1.7700	0.8850	28.1989	28.9697	30.0671	29.0966
440102	1.0501	0.7894	21.6762	22.1114	23.5517	22.4268
440104	1.9269	0.8850	27.9756	28.0905	29.7350	28.6027
440105	0.9836	0.7894	22.7962	23.7154	24.6036	23.7338
440109	1.0056	0.7964	21.4629	22.5878	23.8433	22.7038
440110	1.0908	0.7894	22.5929	23.6275	23.8020	23.4290
440111	1.3335	0.9597	28.8453	29.7461	33.0904	30.4729
440115	1.0344	0.8232	23.7107	24.9778	25.2495	24.6323
440120	1.5542	0.7894	24.7572	26.0621	28.0289	26.2977
440125	1.7960	0.7894	23.6328	24.0934	24.7913	24.1755
440130	1.0491	0.7894	25.1262	26.3192	27.5526	26.3049
440131	1.1167	0.9257	26.9649	28.3162	29.0557	28.0861
440132	1.2305	0.7894	24.0708	29.3377	26.1819	26.4548
440133	1.7145	0.9597	29.6093	32.5726	33.2336	31.7118
440135	***	*	27.7037	27.2094	28.7612	27.7521
440137	1.0334	0.8632	22.9547	24.6143	25.6943	24.4014
440141	1.0392	0.7894	24.9917	24.8737	24.3552	24.7388
440144	1.2864	0.9344	25.2293	26.3225	26.6293	26.0763
440147	***	*	34.8199	36.6978	33.5858	35.1181
440148	1.1629	0.9344	22.6188	28.0708	25.6516	25.3513
440150	1.5147	0.9597	29.4381	30.5513	32.9874	31.0241
440151	1.2049	0.9344	28.2203	28.6585	28.8405	28.5701
440152	2.0822	0.9257	28.4612	29.0588	28.7397	28.7567
440153	1.1009	0.7894	24.9388	23.3790	23.8808	24.0476
440156	1.7122	0.8850	28.5645	30.5161	31.0526	30.0406
440159	1.4313	0.9257	25.8289	27.2785	26.2695	26.4619
440161	1.9816	0.9597	29.9894	31.0667	32.3244	31.1248
440162	***	*	24.8705	24.6425	27.8625	25.6841
440168	0.9921	0.9257	29.4028	31.3316	37.0923	32.5372
440173	1.4718	0.7894	24.0621	23.1370	23.5499	23.5416
440174	0.8237	0.8931	26.2087	27.4579	27.4614	27.0593
440175	1.0356	0.7894	24.7869	26.7705	29.2708	26.9023
440176	1.3859	0.8103	23.7695	24.9420	25.1844	24.6020
440180	1.1931	0.7921	22.3070	24.3376	26.9305	24.4678
440181	0.9704	0.8259	25.9450	26.4763	26.2234	26.2203
440182	0.9597	0.8038	25.0111	24.9899	24.4205	24.7854

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)
440183	1.6032	0.9257	30.6599	30.9923	31.9209	31.1981
440184	1.1026	0.7894	23.3970	26.9086	25.3298	25.1941
440185	1.1910	0.8670	26.7473	26.3974	25.6042	26.0015
440186	1.0070	0.9597	28.9124	28.2840	30.0760	29.2168
440187	1.0742	0.7894	25.8238	27.4034	27.2656	26.8308
440189	1.3762	0.8522	28.8974	30.5786	29.9118	29.8121
440192	1.0644	0.9344	29.6272	30.6533	32.0735	30.7909
440193	1.3049	0.9597	25.2124	25.9726	27.8135	26.3286
440194	1.3381	0.9597	30.8593	32.3020	32.1082	31.7960
440197	1.4319	0.9597	30.1184	31.4317	32.3258	31.2735
440200	1.0491	0.9597	23.8654	23.8288	21.8066	23.1607
440203	***	*	17.9041	*	*	17.9041
440217	1.4535	0.9257	29.8888	31.6650	33.8704	31.8221
440218	2.2276	0.9597	18.7275	36.9273	31.7891	28.6662
440222	0.4461	0.9257	29.0062	30.5148	32.4245	30.6509
440225	0.9600	0.7894	27.8860	26.9687	29.8267	28.4537
440226	1.6528	0.7894	27.1348	28.3199	28.4506	27.9545
440227	1.3377	0.9597	30.7785	31.9119	32.1877	31.6661
440228	1.5956	0.9257	28.3687	29.5372	31.2079	29.8356
450002	1.5341	0.8653	28.8521	29.7180	30.0594	29.5216
450005	1.1780	0.8336	24.5405	27.3473	27.9818	26.6740
450007	1.3224	0.8913	23.9490	24.4630	26.2560	24.8935
450008	1.4626	0.8770	24.5965	24.4372	26.1228	25.0333
450010	1.6138	0.9534	25.5582	30.1034	32.9106	29.4018
450011	1.6453	0.8956	28.5329	29.9302	30.3486	29.6008
450015	1.6528	0.9791	29.4919	30.3168	30.3334	30.0636
450018	1.6259	0.9939	30.7852	31.3131	33.0011	31.6844
450021	1.9128	0.9791	31.3107	31.7360	34.5489	32.5714
450023	1.3772	0.7954	25.5346	25.1683	25.6365	25.4490
450024	1.6424	0.8653	28.2047	27.3814	27.8855	27.8251
450028	1.6054	0.9313	29.5792	29.5689	29.8054	29.6531
450029	1.5777	0.8388	26.9361	28.6465	27.2747	27.6113
450031	***	*	30.3542	29.2141	28.8931	29.4769
450032	1.2893	0.8218	25.5785	26.3159	25.7999	25.8821
450033	1.6290	0.9313	27.8680	29.7668	31.6560	29.7125
450034	1.5775	0.8336	27.6929	29.6309	28.2775	28.5876
450035	1.5658	0.9939	28.8049	30.3369	30.8593	29.9713
450037	1.5618	0.8218	28.3403	28.2622	26.8690	27.7979
450039	1.7271	0.9620	28.2081	29.8145	29.5159	29.2115
450040	1.7040	0.8847	26.8412	28.5469	30.0844	28.4892
450042	1.7439	0.8621	26.5429	27.6131	28.3657	27.5549
450044	1.7966	0.9791	29.4293	32.9921	36.3838	32.9391

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)
450046	1.6278	0.8673	25.5903	27.2439	28.4311	27.1384
450047	1.4946	0.9313	23.8457	24.9670	24.6298	24.4419
450051	1.9896	0.9791	29.9038	30.3976	31.0767	30.4723
450052	1.0420	0.7954	23.0007	24.3964	25.8121	24.3370
450054	1.7644	0.8770	26.5599	30.2211	30.7234	29.1926
450055	1.0273	0.7954	23.6382	24.1418	24.6418	24.1468
450056	1.7042	0.9538	31.4971	32.0902	33.7665	32.4967
450058	1.6192	0.8913	26.9918	27.7318	27.8969	27.5666
450059	1.2657	0.8988	27.3856	28.5645	29.9354	28.6180
450064	1.5627	0.9620	28.2786	29.0495	30.6734	29.3627
450068	2.1541	0.9939	30.5001	32.0372	34.9171	32.5255
450072	1.2471	0.9939	27.1081	28.0921	28.2278	27.8313
450073	0.8985	0.7954	26.1567	22.2322	23.1435	23.7794
450076	1.6978	*	*	*	*	*
450078	0.8990	0.7954	20.0758	20.7800	21.0818	20.6870
450079	1.6161	0.9791	30.5968	36.8936	40.0730	35.6950
450080	1.2896	0.9620	26.2439	26.8111	28.6344	27.2079
450082	1.1750	0.7954	24.2018	25.5654	27.1314	25.5425
450083	1.7873	0.8461	32.6462	30.2054	28.6645	30.4153
450085	1.0884	0.7954	25.6440	26.3610	28.1638	26.7007
450087	1.5138	0.9620	31.2668	32.6556	34.2512	32.7602
450090	1.2553	0.8604	21.8839	22.7822	22.2161	22.3074
450092	1.3425	0.7954	26.2781	28.2278	28.3968	27.6788
450096	***	*	28.1902	*	*	28.1902
450097	1.5629	0.9939	29.8734	31.9782	33.8925	31.8844
450099	1.3638	0.8481	31.7829	29.8491	25.4883	28.9680
450101	1.6205	0.8621	26.7457	28.4220	29.3867	28.2210
450102	1.7298	0.8461	26.4161	27.3364	27.5166	27.1228
450104	1.1987	0.8913	28.8063	27.7851	30.4651	28.9972
450107	1.6306	0.8653	27.8177	29.0328	29.6769	28.8485
450108	1.2102	0.8913	19.3245	22.4293	21.7624	21.2045
450119	1.5818	0.8865	31.1026	34.4161	30.9868	31.9165
450121	***	*	27.7472	*	*	27.7472
450123	1.1626	0.8336	26.2469	24.0433	27.6453	26.0571
450124	1.8022	0.9538	30.9140	31.9797	32.9800	32.0209
450126	1.4041	0.9939	30.5540	32.0370	32.4891	31.7320
450128	1.3154	0.8865	26.3296	28.3171	28.9738	27.8239
450130	1.2560	0.8913	24.3842	26.9208	28.3780	26.6104
450132	1.5872	0.9661	31.9981	31.1361	34.0369	32.3900
450133	1.5731	0.9361	30.0648	30.9622	31.3923	30.7944
450135	1.6951	0.9620	30.1385	30.7909	30.8769	30.6162
450137	1.6389	0.9620	31.9644	35.7775	33.8262	33.9379

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)
450143	1.0079	0.9538	23.6834	24.4346	25.1709	24.4380
450144	1.0148	0.9361	29.2987	31.1552	31.4020	30.6141
450147	1.5111	0.8673	24.7221	26.3032	27.3611	26.1126
450148	1.2965	0.9620	29.6777	30.0542	29.9536	29.8988
450151	***	*	26.2011	22.8768	*	24.4313
450152	1.2361	0.8770	23.1056	24.3442	25.7544	24.4545
450154	1.3803	0.7954	22.9357	24.2582	23.2191	23.4571
450155	0.9665	0.7954	24.8052	24.8773	25.2537	24.9663
450162	1.2136	0.8847	32.9317	33.7823	27.2027	31.3378
450163	1.0701	0.8008	24.7857	27.0967	27.6274	26.4577
450165	1.1140	0.8913	29.1839	30.2236	30.3804	29.9472
450176	1.5142	0.8865	24.4338	25.8587	28.4593	26.3679
450177	1.1276	0.7954	24.4064	26.0895	27.7781	26.1265
450178	0.9422	0.9361	27.1184	28.5990	27.5746	27.7476
450184	1.6571	0.9939	29.5940	30.9726	32.7109	31.0742
450187	1.2029	0.9939	27.7374	29.2749	29.3047	28.7781
450188	0.9059	0.7954	23.2280	24.6823	23.0847	23.6822
450191	1.2724	0.9538	28.3937	31.1339	30.0691	29.8494
450192	1.0798	0.8225	26.4722	26.9884	27.5544	27.0244
450193	2.1739	0.9939	36.4793	37.1906	38.2933	37.3378
450194	1.2833	0.8167	24.3531	30.4381	28.6826	27.5564
450196	1.4613	0.7954	23.4577	25.4842	29.8187	26.1515
450200	1.6242	0.8165	25.6413	27.9843	27.5128	27.0050
450201	0.8832	*	23.2800	22.5464	*	22.8923
450203	1.2705	0.9448	27.8795	28.0986	29.4702	28.5079
450209	1.8398	0.8608	30.6146	31.9882	30.4169	30.9808
450210	1.0572	0.8105	22.5736	22.9055	23.7759	23.0253
450211	1.3669	0.8218	28.3770	28.8485	27.7430	28.3007
450213	1.8582	0.8913	26.8566	28.0307	29.2104	28.0668
450214	1.2733	0.9939	27.9913	28.2261	27.0638	27.7653
450219	0.9895	0.7954	23.9636	24.7274	28.0586	25.5336
450221	1.0409	0.7954	21.3721	20.7118	23.9451	21.9164
450222	1.7247	0.9939	30.3801	31.9255	33.2184	31.8262
450224	1.3848	0.8461	28.4382	28.7931	29.8421	29.0117
450229	1.6517	0.8348	25.1370	26.8039	27.2211	26.3510
450231	1.6810	0.8608	26.9783	27.0545	27.7389	27.2569
450234	0.9997	0.7954	20.4659	21.6799	23.2679	22.0276
450235	0.9717	0.7954	21.8967	23.8001	24.3306	23.3224
450236	1.1613	0.8343	22.9622	24.5942	24.1412	23.8938
450237	1.7146	0.8913	30.5885	31.2197	36.8443	32.7365
450239	0.9716	0.8770	19.1359	18.4234	19.1202	18.8870
450241	1.0885	0.7954	21.3641	28.4948	24.3482	24.7236

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)
450243	0.9550	0.7954	17.2966	19.0180	19.9811	18.7971
450253	0.8958	0.9939	24.1056	22.9918	24.3614	23.8227
450270	1.2553	0.8225	19.8180	12.9999	18.9660	16.6603
450271	1.4195	0.9448	24.1269	23.9534	27.4615	25.2835
450272	1.1688	0.9538	27.0521	29.0917	29.8305	28.6726
450280	1.5642	0.9791	31.6575	34.9349	33.8329	33.4760
450283	1.0776	0.9620	24.1754	28.2094	24.2556	25.4019
450289	1.4997	0.9939	32.6533	32.6137	32.4677	32.5776
450292	1.2632	0.9791	26.8110	29.0243	29.2496	28.3703
450293	0.8881	0.7954	24.0827	24.1556	23.6726	23.9695
450296	1.0740	0.9939	31.5596	33.4545	34.1734	33.0243
450299	1.5616	0.8956	28.4171	29.4593	29.7209	29.2447
450306	0.9008	0.8348	22.9486	22.6818	25.9846	23.7658
450315	1.9177	0.9791	*	31.4227	32.3885	31.9609
450324	1.6449	0.9620	26.6093	27.9899	26.8043	27.1412
450330	1.2720	0.9939	27.1100	27.7419	29.4486	28.1015
450340	1.3442	0.8232	25.6791	29.6617	30.2529	28.5409
450346	1.5153	0.8336	23.8720	24.8434	26.7812	25.2177
450347	1.2846	0.9939	30.7825	28.5789	30.0647	29.8230
450348	0.9987	0.7954	21.0484	22.6828	23.1171	22.2858
450351	1.1913	0.9448	29.2560	29.9598	30.3463	29.8451
450352	1.1072	0.9791	27.2983	27.6480	29.3556	28.1249
450353	***	*	27.9576	*	*	27.9576
450358	2.0165	0.9939	32.5922	33.9103	36.9918	34.5058
450369	0.9205	0.7954	22.8525	24.1953	22.7405	23.1988
450370	1.3004	0.9939	26.3235	29.0816	28.8330	28.0409
450372	1.4118	0.9791	29.5022	30.9345	33.7044	31.4126
450373	0.8443	0.7954	27.0726	27.4251	25.3689	26.6276
450378	1.2317	0.9939	32.2278	33.0583	33.9883	33.0952
450379	1.3439	0.9791	35.3807	35.0637	35.9218	35.4446
450388	1.7199	0.8913	27.8155	29.5386	30.2420	29.2200
450389	1.1353	0.9620	26.9638	26.8499	24.6744	26.1621
450393	0.6145	0.8451	*	39.0266	12.9293	23.0130
450395	1.0959	0.8395	26.7743	28.4272	27.2701	27.4936
450399	0.9053	0.7954	22.1731	20.6307	23.2712	22.0162
450400	1.0937	0.7954	26.2871	29.5020	29.8969	28.4063
450403	1.3474	0.9791	29.8643	31.7065	33.1739	31.6530
450411	1.0156	0.7954	21.5746	21.7877	20.9095	21.4206
450419	1.4465	0.9620	34.2427	34.9972	33.6868	34.2804
450422	1.0342	0.9791	31.3454	32.4669	36.7316	33.3797
450424	1.4314	0.9939	30.7228	29.8290	32.4709	31.0255
450431	1.7394	0.9538	27.3926	28.5289	29.6469	28.5465

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)
450438	1.1937	0.9939	26.5223	27.7734	25.0977	26.4727
450446	0.7700	0.9939	17.2871	15.4641	12.4402	15.0187
450447	1.1800	0.9620	26.5238	28.3724	29.0258	27.9858
450451	1.1077	0.8490	26.5477	25.8836	26.5417	26.3263
450460	0.9546	0.8007	24.9870	25.2165	27.6184	25.9419
450462	1.6663	0.9791	30.1466	30.6516	31.7347	30.8451
450465	1.2032	0.9939	27.0835	28.1853	27.9102	27.7494
450469	1.4654	0.9620	26.3445	31.1348	29.2185	28.8579
450475	1.2340	0.8218	24.5176	24.7037	25.0643	24.7746
450484	1.4622	0.8218	28.3913	27.7792	28.4722	28.2123
450488	1.3668	0.8218	23.7985	24.9109	26.6086	24.9763
450489	0.9673	0.7954	25.2680	26.9543	25.3679	25.8544
450497	1.0350	0.8329	23.1860	23.0712	24.6040	23.6309
450498	0.9862	0.7954	20.2475	20.6873	19.3041	20.0698
450508	1.4188	0.8218	27.2850	29.1519	30.4834	29.0027
450514	***	*	27.3043	26.4196	*	26.8548
450518	1.4298	0.8336	29.1322	27.5880	28.9973	28.5034
450530	1.3209	0.9939	29.9720	30.7745	31.5042	30.7515
450537	1.5827	0.9791	28.7448	30.9167	33.1525	30.8960
450539	1.1649	0.8021	24.2151	25.0191	25.5246	24.9152
450547	0.9435	0.9620	34.3349	25.4140	24.6594	27.5542
450558	1.7672	0.8348	28.0655	28.7747	30.9439	29.2594
450563	1.5301	0.9620	32.0507	32.6875	35.8886	33.5374
450565	1.2719	0.9448	28.1741	27.4774	28.0392	27.8914
450571	1.6075	0.8232	27.4605	26.5313	26.2036	26.7206
450573	1.1286	0.8080	22.1492	24.6750	28.8501	25.2437
450578	0.9834	0.7954	25.0498	25.2478	25.7917	25.3853
450580	1.0385	0.7954	23.9004	25.9881	23.7931	24.5461
450584	1.0287	0.7954	22.5204	23.6044	23.7301	23.2717
450586	0.9974	0.7954	20.6699	18.3289	19.8622	19.6238
450587	1.1871	0.7954	25.0174	25.9364	27.8963	26.2455
450591	1.1634	0.9939	27.1744	27.9867	26.8815	27.3415
450596	1.2725	0.9448	29.8462	31.6590	30.9762	30.8623
450597	0.9831	0.7954	24.2586	24.8443	26.3280	25.1059
450604	1.4107	0.7954	25.9133	29.1543	27.9988	27.7151
450605	1.0350	0.8673	23.9332	14.8039	23.3182	20.2006
450610	1.5957	0.9939	28.3713	30.5977	32.1329	30.2860
450615	1.0208	0.7987	24.1902	22.6331	25.0369	23.9326
450617	1.5930	0.9939	28.8323	30.2923	31.5714	30.2396
450620	1.0663	0.7954	20.3723	21.2535	21.7850	21.1308
450630	1.5593	0.9939	29.8431	31.8014	30.5507	30.7279
450634	1.6794	0.9791	30.3274	31.8008	31.9696	31.3603

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)
450638	1.6656	0.9939	32.4911	33.3237	34.1860	33.3000
450639	1.5194	0.9620	32.6255	34.3754	33.3996	33.4638
450641	0.9429	0.8329	20.2483	21.7292	20.0210	20.6565
450643	1.3395	0.8388	24.4999	27.2538	28.7385	26.8324
450644	1.5683	0.9939	30.7815	31.6874	33.5296	32.0385
450646	1.5571	0.8653	26.8060	27.4631	27.8368	27.3621
450647	1.9320	0.9791	32.4236	34.1016	35.2732	33.9624
450651	1.7455	0.9791	31.9261	33.6498	34.9949	33.4913
450653	1.1436	0.7954	26.1756	26.5361	27.8588	26.8560
450654	0.9489	0.7954	22.5447	25.0755	23.5011	23.6796
450656	1.4697	0.8218	28.1493	29.7290	30.0724	29.2791
450658	0.9753	0.7954	24.7856	22.7090	21.8182	23.0156
450659	1.5238	0.9939	34.2380	34.2657	35.0066	34.4841
450661	1.5198	0.9661	30.0751	29.2381	29.1708	29.4735
450662	1.6918	0.9313	29.0532	30.9630	32.8948	31.0036
450668	1.5626	0.8653	30.6114	30.2083	30.7729	30.5264
450669	1.2242	0.9791	30.2374	32.1244	32.6802	31.6628
450670	1.5707	0.9939	26.4266	26.2954	28.8412	27.2212
450672	1.7704	0.9620	31.8420	33.0858	34.5095	33.1809
450674	1.0249	0.9939	29.8971	31.9316	33.4747	31.8232
450675	1.4724	0.9620	30.9562	32.6380	34.4080	32.7268
450677	1.2959	0.9620	27.2760	27.1603	29.5814	28.0299
450678	1.5536	0.9791	33.3386	33.5513	33.6199	33.5028
450683	1.1546	0.9791	21.1737	24.8440	28.8023	24.1914
450684	1.3944	0.9939	30.2139	31.2765	31.8810	31.1232
450686	1.6274	0.8847	25.8530	26.4871	28.8237	27.1425
450688	1.4836	0.9791	26.9897	29.4393	30.4163	28.8324
450690	1.4246	0.8461	26.1743	30.0577	31.8688	29.0572
450694	1.1525	0.7954	24.0031	27.0862	28.3444	26.2520
450697	1.5110	0.8913	26.4132	28.3002	29.0155	27.9324
450698	0.9076	0.8081	21.5742	23.3062	21.5447	22.0599
450702	1.5383	0.8218	26.3696	27.1318	26.6742	26.7301
450709	1.5117	0.9939	27.1077	31.3239	31.0347	29.8762
450711	1.5475	0.8865	27.5622	28.1040	29.2959	28.3195
450713	1.6625	0.9538	29.4980	30.4933	31.3298	30.4679
450715	1.2672	0.9791	17.0235	*	27.1019	20.6544
450716	1.4238	0.9939	33.7096	33.9926	33.5000	33.7332
450718	1.5519	0.9538	28.1560	29.7609	30.9719	29.6902
450723	1.4975	0.9791	30.1704	31.0481	32.1344	31.1344
450730	1.3480	0.9791	32.7293	32.8920	34.9218	33.4762
450742	1.2318	0.9791	30.0583	30.4204	31.4306	30.6464
450743	1.4610	0.9791	28.4736	29.5098	30.3331	29.5117

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)
450746	1.0168	0.7954	22.7873	23.3484	22.6721	22.9387
450747	1.2242	0.8461	25.8175	28.3935	27.1981	27.1096
450749	0.9484	0.7954	22.1562	23.9269	23.0246	23.0063
450751	***	*	21.4223	*	*	21.4223
450754	0.9626	0.7954	24.7797	22.8572	23.4611	23.6055
450755	0.9619	0.8230	22.2006	24.7428	22.4183	23.0467
450758	***	*	28.2803	28.3305	29.5053	28.6032
450760	***	*	25.1637	23.7157	24.0733	24.3325
450766	1.9124	0.9791	30.2341	31.2084	33.3489	31.5464
450770	1.2334	0.9538	24.3244	23.6093	25.4947	24.4730
450771	1.5931	0.9791	32.0500	32.5014	32.6239	32.4022
450774	1.7583	0.9939	25.7436	27.5065	29.1144	27.5416
450775	1.4383	0.9939	29.8230	31.6656	33.1602	31.6047
450779	1.3582	0.9620	31.8403	32.0770	31.4381	31.7644
450780	2.1986	0.8913	27.0084	28.5560	29.4949	28.3795
450788	1.5370	0.8673	28.3759	29.7667	31.5614	29.8896
450795	1.2428	0.9939	32.9803	43.8574	31.1863	36.0867
450796	1.9000	0.8608	37.6274	39.4762	31.6598	36.0574
450797	***	*	24.8598	26.0302	29.7035	26.8177
450801	1.5512	0.8165	23.6072	25.6379	27.2655	25.5056
450803	1.2318	0.9939	29.0106	28.7041	28.4445	28.7261
450804	1.9634	0.9939	29.1282	31.1891	33.2789	31.2479
450808	1.9079	0.9538	23.0312	29.6476	27.4157	26.6475
450809	1.6269	0.9538	27.3080	29.4696	30.4054	29.1006
450811	1.0131	0.8865	31.2208	31.3007	32.1814	31.5562
450813	1.0733	0.8080	22.9289	26.5803	23.9942	24.4705
450820	1.6399	0.9939	33.9030	34.7445	36.4857	35.1491
450822	1.4897	0.9791	32.2145	34.4060	34.7786	33.8540
450824	2.6241	0.9538	33.3653	31.8413	34.8338	33.3127
450825	1.4589	0.8865	25.1521	25.8006	23.6700	24.8639
450827	1.4259	0.9534	24.1984	24.3659	23.6607	24.0685
450828	1.3210	0.7954	24.8236	26.9553	26.3229	25.9967
450829	***	*	19.5842	*	*	19.5842
450830	1.0676	0.9361	27.8005	28.4007	30.4961	28.9198
450831	1.5344	0.9939	23.9467	24.4141	24.2725	24.1919
450832	1.4673	0.9939	27.3290	28.1389	31.2847	29.0584
450833	1.2357	0.9791	27.9649	29.0256	30.3601	29.1581
450834	1.5917	0.8956	27.4844	26.7253	27.5734	27.2481
450838	0.9160	0.8080	18.9620	19.2949	20.2313	19.4683
450839	0.9870	0.7954	27.2199	27.5330	28.0097	27.5814
450840	1.3170	0.9791	32.2538	32.4162	34.1447	33.0779
450841	2.0854	0.9313	20.9424	24.4389	24.6328	23.4301

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)
450844	1.3785	0.9939	33.7978	33.0758	34.7128	33.8896
450845	1.8836	0.8653	29.9265	28.5039	30.9610	29.7805
450847	1.3062	0.9939	29.7356	30.7431	31.6049	30.7349
450848	1.3685	0.9939	30.5546	31.1476	32.0490	31.2639
450850	***	*	31.9606	27.2653	*	29.4295
450851	2.1789	0.9791	35.1102	32.8377	35.2128	34.3496
450853	1.9978	0.9791	37.1043	38.3600	37.5252	37.6878
450855	1.6791	0.9313	32.6916	30.7353	33.0225	32.0849
450856	2.2420	0.8913	37.7362	35.5006	35.5245	36.2147
450860	1.8054	0.9939	29.1075	33.3404	36.0050	32.7585
450862	1.6682	0.9939	31.8095	33.7962	34.2197	33.3761
450864	2.2651	0.8461	24.5049	25.3535	26.6600	25.6148
450865	1.1199	0.9538	29.9559	31.9200	34.6354	32.2803
450867	1.2503	0.9538	29.5879	31.4953	33.8736	31.6914
450868	***	*	25.3486	27.7501	27.9521	26.9573
450869	2.0556	0.8865	26.1616	28.7422	27.9558	28.0494
450871	1.8884	0.9538	28.9150	32.3990	35.2830	32.1881
450872	1.4202	0.9620	27.2833	31.7345	30.7542	30.2029
450873	***	*	14.8821	*	*	14.8821
450874	2.0151	0.9791	34.6083	35.6839	37.4483	36.0755
450875	1.8486	0.8608	23.2763	23.2962	26.9935	24.4517
450876	1.8214	0.8847	28.4343	30.3515	31.9127	30.3435
450877	1.5117	0.8653	26.1867	29.2353	28.0553	27.8251
450878	2.5628	0.8913	31.6750	33.6269	33.5255	32.9499
450879	***	*	35.5672	36.4874	31.1588	34.0558
450880	1.7282	0.9620	35.9572	32.6713	32.1237	33.3467
450881	***	*	24.5464	*	*	24.5464
450882	***	*	26.6910	*	*	26.6910
450883	2.9981	0.9791	35.2646	37.1525	38.5929	37.1225
450884	0.9428	0.8267	27.8213	23.5799	25.0235	25.3644
450885	1.4667	0.9791	34.1148	36.0954	33.7657	34.6340
450886	1.4731	0.9620	*	30.1571	33.2045	31.7425
450887	***	*	*	25.5590	*	25.5590
450888	1.8917	0.9472	*	28.5995	26.3054	27.2945
450889	2.0193	0.9791	*	35.6151	29.1188	31.7673
450890	1.5522	0.9791	*	32.2000	33.9098	33.1698
450891	1.7321	0.9791	*	39.0890	29.7873	33.7211
450892	***	*	*	39.5333	*	39.5333
450893	1.5130	0.9791	*	36.2660	37.8330	37.0950
450894	2.2251	0.9791	*	25.9441	34.3435	30.3295
450895	***	*	18.4142	*	*	18.4142
460001	1.9740	0.9459	30.0040	30.7040	32.3289	31.0515

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)
460003	1.6340	0.9465	32.3427	29.6450	31.8145	31.2764
460004	1.7841	0.9465	29.6342	29.8773	32.2780	30.6297
460005	1.5557	0.9465	26.0731	29.4188	29.6969	28.4168
460006	1.6503	0.9465	28.3678	28.9653	30.3819	29.2383
460007	1.2729	0.9400	28.0035	29.1191	30.8597	29.3995
460008	***	*	31.5485	27.6906	30.5401	29.9047
460009	1.9058	0.9465	28.3836	29.4705	31.5227	29.8470
460010	2.0519	0.9465	30.4606	30.9813	32.8182	31.4464
460011	1.3313	0.8454	24.9677	26.5486	27.0197	26.1917
460013	1.4545	0.9459	29.2731	29.7252	31.2967	30.1038
460014	1.1400	0.9465	29.5963	30.6450	30.0265	30.0859
460015	1.4607	0.9028	29.1318	28.8014	30.7394	29.5816
460017	1.3646	0.8837	26.1589	28.7126	29.8576	28.2657
460018	1.0089	0.8454	22.8028	22.0935	24.7925	23.2461
460019	1.1464	0.8454	23.2202	25.1615	24.9579	24.4662
460021	1.8769	1.1534	29.5761	29.7397	31.5237	30.3183
460023	1.3298	0.9459	28.5884	28.9473	30.5917	29.4332
460026	0.9996	0.9458	27.9487	29.2775	31.3563	29.5598
460030	1.1111	0.8454	24.4218	26.8979	30.0723	27.0886
460033	0.8479	0.8454	26.6606	27.9108	29.0378	27.8805
460035	0.9356	0.8454	21.9115	23.8682	23.4748	23.0726
460039	1.0362	0.9428	30.4912	30.0677	32.8034	31.1597
460041	1.4614	0.9465	26.3807	26.7356	29.4578	27.5039
460042	1.5794	0.9465	26.8389	36.2903	35.5714	32.5493
460043	1.1877	0.9459	28.6668	29.5660	31.2753	29.8869
460044	1.3504	0.9465	28.7023	29.5079	31.4493	29.9091
460047	1.6969	0.9465	29.9990	31.0020	33.0325	31.3350
460049	2.0061	0.9465	28.4884	28.6267	32.0333	29.8127
460051	1.4927	0.9465	27.8841	28.1140	28.6574	28.2619
460052	1.6830	0.9459	27.1995	28.7455	30.2636	28.8228
460054	1.6314	0.9028	25.7870	26.3939	28.1501	26.7785
470001	1.2744	1.0014	29.7540	32.2887	34.5913	32.0554
470003	1.8557	1.0476	30.1973	30.0535	35.8953	32.2944
470005	1.3232	0.9604	33.1981	33.9969	32.1114	33.0918
470011	1.1987	0.9604	29.6269	30.8742	32.1684	30.9247
470012	1.2633	1.0277	27.0751	29.8259	30.9855	29.3187
470024	1.2604	1.0476	26.6351	27.3106	28.9211	27.6167
490001	1.0881	0.8112	24.0368	24.6883	25.2696	24.6824
490002	0.9770	0.8112	21.7092	24.0672	26.2537	23.9080
490004	1.3432	0.9155	27.5890	28.8660	30.6671	29.0477
490005	1.6316	1.0716	30.5349	31.4909	32.7194	31.6206
490007	2.0639	0.8943	29.3098	30.7411	31.5977	30.5813

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)
490009	2.0365	0.9258	28.4642	31.4260	30.5785	30.1502
490011	1.5989	0.8943	27.4764	28.8780	30.5539	28.9364
490012	1.0707	0.8112	22.9922	21.8322	22.3323	22.3873
490013	1.3957	0.9525	25.5560	27.3486	27.4110	26.7617
490017	1.5008	0.8943	27.5902	29.6784	29.5862	28.9563
490018	1.3696	0.9155	27.2644	27.8682	28.8502	28.0014
490019	1.1960	1.0716	25.8264	29.8891	33.5663	29.5318
490020	1.3234	0.9382	29.3468	30.6013	32.5630	30.8121
490021	1.4594	0.8336	27.0641	28.1254	28.1368	27.7747
490022	1.4481	1.0716	30.1203	31.7985	34.5394	32.2958
490023	1.3489	1.0716	30.9920	32.6308	33.4577	32.3827
490024	1.6983	0.8816	27.9689	29.0407	29.7383	28.9350
490027	1.2394	0.8112	23.0017	24.3834	23.6868	23.5949
490032	2.0591	0.9382	28.5897	28.0120	30.0354	28.8901
490033	1.1536	1.0716	31.8282	30.9910	32.1866	31.6641
490037	1.2278	0.8112	25.2859	26.2951	28.9012	26.8440
490038	1.1734	0.8112	22.6504	24.0852	25.7230	24.1535
490040	1.5211	1.0716	34.1841	35.6822	36.5578	35.4772
490041	1.6040	0.8943	27.1613	29.1244	30.4209	28.9380
490042	1.3335	0.8702	25.7333	26.6078	28.2014	26.8382
490043	1.3812	1.0787	35.8872	36.5982	33.4392	35.2336
490044	1.4387	0.8943	23.3793	24.1763	30.3616	25.9958
490045	1.3576	1.0716	30.3772	32.8774	34.0318	32.4478
490046	1.5600	0.8943	27.9604	29.3882	30.5468	29.3259
490048	1.4892	0.8816	27.0620	28.0320	29.1966	28.0890
490050	1.5406	1.0716	32.2993	31.1370	33.4002	32.2730
490052	1.7255	0.8943	25.0046	25.4179	26.5871	25.6603
490053	1.2093	0.8112	23.8004	24.6206	25.5311	24.6565
490057	1.6632	0.8943	27.4918	29.0700	30.5186	29.0750
490059	1.7112	0.9382	30.8669	32.1031	32.7913	31.9421
490060	1.0553	0.8112	24.3192	25.7765	26.2626	25.4414
490063	1.8888	1.0787	31.6069	34.1179	35.7754	33.8572
490066	1.4008	0.9382	29.5917	31.4298	31.1974	30.7546
490067	1.2778	0.9382	25.9497	26.7802	27.5207	26.7403
490069	1.6622	0.9382	29.1527	30.1482	33.1157	30.8312
490071	1.4811	0.9382	31.7061	33.7118	36.1324	33.8127
490073	***	*	34.5774	46.4210	*	38.3199
490075	1.3989	0.8310	25.7323	27.3424	27.8679	26.9138
490077	1.4740	0.9258	28.1506	31.0016	33.5277	30.9258
490079	1.3080	0.9019	25.2340	24.2066	25.3822	24.9296
490084	1.2031	0.8299	25.7657	26.3234	28.0872	26.7502
490088	1.0737	0.8336	25.0619	26.0285	26.5147	25.8819

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)
490089	1.1556	0.8816	25.9902	27.4587	28.7234	27.4164
490090	1.1096	0.8112	25.5418	27.0760	28.1285	26.9255
490092	1.0140	0.8112	25.7405	27.5277	26.9584	26.7468
490093	1.5421	0.8943	26.7886	28.7122	29.2183	28.2645
490094	1.0235	0.9382	28.9155	29.7990	33.4981	30.8352
490097	1.0939	0.9382	27.1470	27.4608	27.3901	27.3367
490098	1.2631	0.8112	25.1625	26.7152	29.1194	27.0537
490101	1.4788	1.0787	32.3695	32.9516	36.2532	33.9016
490104	0.8552	0.9382	17.0548	19.0056	21.5138	19.0763
490105	0.7736	0.8112	26.3827	*	*	26.3827
490106	0.8850	0.8112	25.7352	26.2318	28.0073	26.6295
490107	1.4508	1.0787	33.5430	35.0272	36.3879	35.0191
490108	1.0375	0.8336	23.3204	27.8717	26.8478	26.0301
490109	0.8876	0.8943	24.2296	21.6711	26.3121	24.0664
490110	1.4059	0.8526	24.9861	26.3089	28.3845	26.5330
490111	1.1788	0.8112	22.7336	26.4297	25.9818	24.8673
490112	1.8421	0.9382	29.0816	31.2549	32.6961	30.9728
490113	1.3312	1.0716	32.4547	34.7841	34.3648	33.8948
490114	1.2331	0.8112	22.1387	23.0533	23.6213	22.9869
490115	1.1689	0.8112	23.5718	23.2118	24.2057	23.6643
490116	1.1350	0.8112	24.3853	25.0351	26.8981	25.4473
490117	1.0820	0.8112	18.1138	20.3038	19.0636	19.1477
490118	1.6707	0.9382	29.0569	31.2407	32.7719	30.9825
490119	1.3137	0.8943	27.8866	29.5222	30.2427	29.2578
490120	1.4783	0.8943	25.9610	27.1990	29.8246	27.7057
490122	1.6156	1.0787	33.3719	35.2234	36.8382	35.1665
490123	1.1418	0.8112	24.2254	24.6011	25.9030	24.9125
490126	1.2742	0.8112	24.0908	25.3294	26.4290	25.2592
490127	1.1263	0.8112	23.5161	23.1399	23.5164	23.3913
490130	1.2723	0.8943	25.3352	25.9782	27.8923	26.4181
490134	0.8132	0.8112	33.2405	31.1495	36.6298	33.6269
490135	0.7928	0.8816	25.9998	27.2795	29.4840	27.5778
490136	1.4979	0.9382	*	31.2911	33.2274	32.4133
490137	***	*	*	*	33.7227	33.7227
490138	2.2840	0.8336	*	*	*	*
490139	2.7551	0.9382	*	*	*	*
500001	1.6102	1.1403	33.0901	37.5323	34.4093	34.9345
500002	1.4327	1.0133	29.1448	30.1872	32.8338	30.8066
500003	1.3632	1.1253	32.1262	32.7983	34.5899	33.2523
500005	1.8826	1.1403	35.0997	36.0918	36.7666	35.9778
500007	1.3163	1.1253	30.5263	31.0313	32.8223	31.4992
500008	1.9890	1.1403	33.5666	34.7810	37.6651	35.3368

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)
500011	1.4404	1.1403	32.6223	38.3979	35.9591	35.5231
500012	1.6881	1.0133	33.8101	33.1685	34.1676	33.7199
500014	1.7126	1.1403	36.5833	37.2698	36.3944	36.7448
500015	1.4132	1.1403	37.5724	40.8683	41.8950	40.1050
500016	1.6525	1.1253	32.9177	34.2828	35.1976	34.1771
500019	1.2624	1.0264	31.6242	33.8882	33.3170	32.9651
500021	1.3087	1.1253	32.4702	33.5610	34.1744	33.4287
500024	1.6981	1.1190	36.1647	37.4529	38.1182	37.2467
500025	1.9310	1.1403	40.6369	44.7105	45.7999	43.8508
500026	1.5367	1.1403	34.5881	35.5080	38.9317	36.2910
500027	1.5037	1.1403	39.2906	42.4974	43.3605	41.7642
500030	1.6550	1.1296	34.9174	36.9489	37.8965	36.6146
500031	1.3350	1.1190	33.2391	34.1651	37.1428	34.9068
500033	1.2905	1.0133	31.8891	32.6753	33.5629	32.7478
500036	1.3216	1.0133	30.5938	31.9164	33.0959	31.9632
500037	1.0778	1.0133	31.2654	29.1773	31.5236	30.6546
500039	1.5611	1.1253	33.5606	34.5739	35.7561	34.6905
500041	1.4894	1.1226	34.2017	36.9273	37.1862	36.2506
500044	1.9133	1.0452	31.0936	32.0743	32.9262	32.0711
500049	1.4338	1.0133	29.8189	30.8135	32.9918	31.2364
500050	1.6242	1.1226	33.7713	35.7254	35.8632	35.1386
500051	1.8035	1.1403	34.7610	36.4764	38.1828	36.4726
500052	1.3105	1.1403	*	*	*	*
500053	1.2195	1.0281	30.2811	28.5664	35.5823	31.7720
500054	1.9866	1.0452	32.5105	34.8114	36.0193	34.4622
500058	1.6170	1.0281	30.7034	32.6843	33.9149	32.4990
500060	1.3185	1.1403	38.7682	40.3040	33.4177	37.1018
500064	2.0432	1.1403	32.3581	34.7925	36.5976	34.6303
500072	1.3287	1.0497	32.5269	33.1148	33.7713	33.1483
500077	1.5291	1.0452	33.2223	34.3114	35.6382	34.4333
500079	1.4138	1.1253	32.5809	34.2420	35.0309	33.9273
500084	1.2876	1.1403	32.7883	33.3072	35.9628	34.0385
500088	1.4753	1.1403	36.7953	38.5194	39.5349	38.3353
500108	1.6440	1.1253	34.3872	35.8918	36.9915	35.7483
500119	1.4085	1.0452	31.2233	31.7125	33.3116	32.1843
500124	1.5218	1.1403	34.4790	36.3338	36.2605	35.7241
500129	1.6514	1.1253	34.4447	37.3189	39.0499	36.9836
500134	***	*	28.1374	28.9759	27.6042	28.2162
500138	2.5522	*	*	*	*	*
500139	1.5705	1.1190	34.6412	37.5709	37.3081	36.4403
500141	1.3048	1.1403	33.7532	34.2384	35.1042	34.3765
500143	0.6636	1.1190	25.3099	26.3893	27.6978	26.4519

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)
500148	1.2444	1.0133	37.7830	24.6347	29.1613	30.5603
500150	1.3442	1.1226	*	34.8480	37.2177	36.0524
510001	1.8311	0.8567	25.8693	26.7924	27.6676	26.8140
510002	1.2656	0.8692	23.7270	24.8846	25.3779	24.6485
510006	1.3698	0.8585	24.8777	26.6421	27.5043	26.3128
510007	1.6741	0.9039	27.1149	28.5783	29.7138	28.4786
510008	1.3748	0.9180	27.5241	27.4709	30.6417	28.6015
510012	0.9673	0.7604	20.8455	22.9038	23.9238	22.5462
510013	1.1468	0.7480	22.8779	22.9612	22.1863	22.6740
510018	1.1290	0.8195	23.1043	23.7736	22.6590	23.1834
510022	1.8740	0.8310	26.8328	27.6119	28.4944	27.6605
510023	1.2667	0.7480	21.0940	23.1461	21.1494	21.7762
510024	1.7025	0.8567	26.6621	31.1327	32.3045	30.0832
510026	0.9969	0.7480	19.2025	17.8275	18.6676	18.5429
510029	1.3627	0.8310	24.0872	25.3925	24.6754	24.7020
510030	1.1655	0.7480	24.2007	25.5600	26.0192	25.2800
510031	1.5328	0.8310	24.0237	26.7872	29.5940	26.6785
510033	1.5122	0.7667	24.0796	24.2839	24.4156	24.2600
510038	1.0712	0.7480	20.9180	21.7545	21.1188	21.2691
510039	1.2959	0.7480	20.4719	21.3819	21.7190	21.2021
510046	1.3878	0.7523	22.2935	24.7187	23.2629	23.4221
510047	1.2046	0.8567	27.6859	28.8794	30.0479	28.9185
510048	1.2529	0.7480	22.7930	23.6396	25.0997	23.8230
510050	1.6608	0.8567	21.9009	23.5794	24.3096	23.2374
510053	0.9858	0.7480	21.5338	22.6288	24.3865	22.8601
510055	1.5437	0.9039	29.4111	30.7382	32.3314	30.8697
510058	1.3729	0.7667	25.3248	24.8770	24.9372	25.0454
510059	0.7523	0.8310	20.8847	21.9053	20.5658	21.0655
510062	1.1932	0.7480	26.7066	27.7971	30.4538	28.3071
510067	***	*	25.2130	25.2248	25.4511	25.2850
510070	1.2990	0.8195	23.9742	25.4981	26.1226	25.1762
510071	1.3043	0.7523	23.2954	23.4553	21.7096	22.8406
510072	1.0095	0.7480	19.4370	20.2387	20.2000	19.9467
510077	1.0677	0.8749	25.9515	27.1611	24.7860	25.9588
510082	1.1525	0.7480	20.3279	21.1665	24.7568	22.2112
510085	1.3595	0.8310	26.2617	26.8133	27.6224	26.8696
510086	1.1870	0.7480	19.2606	20.1965	21.2591	20.1971
510090	***	*	*	39.0787	*	39.0787
520002	1.2941	0.9481	29.0501	28.3413	28.2881	28.5053
520004	1.5470	0.9957	28.9857	30.9212	32.9940	30.9740
520008	1.5742	1.0172	33.8057	33.6774	36.6725	34.8271
520009	1.6203	0.9257	28.8591	29.6290	31.0702	29.8755

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)
520011	1.3143	0.9237	28.0224	29.5024	31.8463	29.7784
520013	1.5238	1.0962	30.1834	32.1721	33.9230	32.1446
520017	1.1684	0.9510	29.3278	31.0537	31.8532	30.7722
520019	1.2905	0.9237	29.8640	30.2189	28.8274	29.5194
520021	1.3449	1.0276	29.1129	29.7809	29.0574	29.3167
520027	1.4473	1.0172	32.4137	33.5836	33.5771	33.2097
520028	1.3295	1.1008	28.0813	29.4694	28.1136	28.5771
520030	1.6907	0.9659	30.5724	31.6807	32.0693	31.4381
520033	1.2332	0.9237	29.0236	30.2631	29.5805	29.6292
520034	1.3278	0.9237	26.8886	28.1819	30.2173	28.4724
520035	1.5013	0.9347	28.1048	29.4076	31.0995	29.5924
520037	1.7070	0.9481	32.2144	32.2206	33.1640	32.5457
520038	1.2120	1.0172	29.6339	30.5267	32.6521	30.9450
520040	***	*	31.2038	35.9652	*	33.6870
520041	1.1136	1.1238	25.3764	26.1586	28.3899	26.6404
520044	1.2966	0.9347	28.2382	28.6620	*	28.4590
520045	1.6508	0.9259	29.2556	30.0856	29.6265	29.6564
520048	1.5494	0.9259	29.1870	30.1483	31.8620	30.3225
520049	1.9346	0.9460	28.0936	29.4238	29.8719	29.1465
520051	1.5293	1.0172	31.5974	32.4131	32.5601	32.2878
520057	1.2514	0.9430	29.1158	29.1597	31.7844	30.0727
520059	1.4089	1.0044	30.4491	31.1798	32.1920	31.2801
520062	1.3074	1.0172	32.8584	32.7015	37.5657	34.4582
520063	1.1993	1.0172	30.3391	31.5200	32.6396	31.5376
520064	1.5393	1.0172	31.5723	33.1269	34.1956	32.9735
520066	1.4451	0.9461	31.0644	31.6793	31.2308	31.3120
520070	1.7850	0.9510	28.2059	30.0475	30.2478	29.5406
520071	1.2686	1.0044	30.6930	31.5452	33.0053	31.7934
520075	1.7166	0.9460	30.1582	32.2773	33.5406	31.9876
520076	1.2100	1.0044	27.4423	26.8943	28.0874	27.4831
520078	1.4660	1.0172	31.6606	32.0200	32.8391	32.1535
520083	1.7208	1.1238	32.7728	34.7230	36.8202	34.8193
520087	1.7034	0.9957	30.5659	31.9771	33.5781	32.0489
520088	1.3258	0.9810	30.6657	30.7482	32.9077	31.4562
520089	1.5580	1.1238	33.4098	34.9357	36.3851	34.9254
520091	1.3038	0.9237	27.3442	28.7180	29.9342	28.6980
520095	1.2320	1.1008	32.0381	33.2426	33.3380	32.8501
520096	1.3908	1.0044	29.5985	29.2895	31.5050	30.1756
520097	1.3771	0.9460	29.9998	30.5442	32.2237	30.9345
520098	2.0135	1.1238	36.5776	38.0993	39.1568	37.9760
520100	1.3408	0.9461	29.9458	31.7772	32.4066	31.3822
520102	1.2398	1.0044	30.7990	31.5756	31.9296	31.4313

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)
520103	1.5202	1.0172	32.6269	34.5640	35.3929	34.2311
520107	1.3548	0.9656	29.4178	30.0354	31.6572	30.3687
520109	1.0568	0.9237	25.0697	25.9740	27.2802	26.1319
520113	1.3020	0.9338	33.3475	33.3040	34.9737	33.8690
520116	1.2949	1.0044	30.2156	31.6702	32.7118	31.5577
520132	***	*	27.3431	*	*	27.3431
520136	1.6767	1.0172	32.1479	32.3504	32.8382	32.4504
520138	1.9040	1.0172	31.6581	32.5677	33.5522	32.6113
520139	1.3339	1.0172	30.4903	31.7086	32.9403	31.7717
520140	***	*	31.1315	*	*	31.1315
520160	1.8053	0.9257	29.5582	30.3052	31.0408	30.2945
520170	1.4915	1.0172	31.4710	31.7610	35.2657	32.7670
520173	1.1280	*	31.0599	*	*	31.0599
520177	1.6716	1.0172	32.5714	33.1243	34.7051	33.5360
520189	1.2359	1.0276	29.0295	29.2229	29.0345	29.0969
520193	1.8217	0.9460	29.2007	29.4737	30.8101	29.8936
520194	1.6744	1.0172	31.4379	31.0015	36.9500	33.1937
520195	0.4461	*	36.2900	41.6120	37.8962	38.5622
520196	1.8260	0.9510	31.1175	33.4890	32.0202	32.2471
520197	***	*	30.1917	*	*	30.1917
520198	1.3475	0.9259	28.5975	29.9803	30.6321	29.7438
520199	2.0244	1.0172	36.5699	37.0128	45.6018	40.3627
520202	1.6987	0.9659	*	*	33.6443	33.6443
530002	1.1129	0.9360	29.2069	29.2418	32.5676	30.3694
530006	1.2627	0.9360	29.2104	30.3724	31.9200	30.4700
530008	1.0872	0.9360	26.5180	30.6010	30.6617	29.2139
530009	0.8947	0.9360	26.0490	27.0555	27.1979	26.7642
530010	1.3091	0.9360	27.4121	28.5534	30.1151	28.7219
530011	1.1542	0.9360	27.8613	31.1329	31.8973	30.1427
530012	1.6535	1.0170	28.7524	30.6109	31.9383	30.4707
530014	1.5359	0.9454	28.5469	29.6724	31.2599	29.8911
530015	1.3590	0.9360	29.8306	33.4903	35.9746	33.0896
530017	0.9126	0.9360	31.1105	25.8183	24.0913	26.6138
530025	1.2867	0.9360	29.4346	28.8963	31.4635	29.9302
530032	1.0953	0.9360	24.6580	25.4267	26.7062	25.6163
530033	1.4679	1.0170	*	*	*	*
670002	1.2742	0.9791	*	29.1376	29.9586	29.5461
670003	***	*	*	33.8986	33.4727	33.6777
670004	1.1443	0.7954	*	25.3706	25.5706	25.4639
670005	1.2663	0.9939	*	31.9464	41.2074	36.4115
670006	2.2324	0.9538	*	27.1064	34.6815	30.1960
670007	***	*	*	*	29.5994	29.5994

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)
670008	1.5756	0.9939	*	*	30.3999	30.3999
670009	***	*	*	*	31.8088	31.8088
670010	0.7783	0.9791	*	*	35.6669	35.6669
670011	1.0303	0.9538	*	*	32.1884	32.1884
670012	2.0379	0.9939	*	*	24.1579	24.1579
670013	***	*	*	*	29.4926	29.4926
670014	***	*	*	*	34.6195	34.6195
670015	***	*	*	*	35.3090	35.3090
670017	1.0751	0.9939	*	*	*	*
670018	0.9086	0.9939	*	*	*	*
670019	1.8140	0.9939	*	*	*	*
670021	1.4912	0.8913	*	*	*	*
670022	***	*	*	*	32.9934	32.9934
670023	1.3728	0.9448	*	*	*	*
670024	1.4630	0.9939	*	*	*	*
670025	3.1528	0.9791	*	*	*	*
670026	1.3704	0.8653	*	*	*	*
670027	1.8146	0.9939	*	*	*	*
670028	0.7323	0.8847	*	*	*	*
670029	1.2035	0.9939	*	*	*	*
670030	2.2698	0.8770	*	*	*	*
670031	1.3282	0.9939	*	*	*	*
670032	1.2566	0.9939	*	*	*	*
670033	1.3535	0.9791	*	*	*	*
670034	1.3447	0.9538	*	*	*	*
670038	1.5668	0.9939	*	*	*	*
670039	1.2235	0.9791	*	*	*	*
670040	1.0329	0.9939	*	*	*	*
670041	1.4480	0.9538	*	*	*	*
670042	2.3956	0.9472	*	*	*	*
670043	1.2067	0.9538	*	*	*	*
670044	1.3399	0.9791	*	*	*	*
670046	1.1866	0.9472	*	*	*	*
670047	1.2390	0.8653	*	*	*	*
670048	1.1884	0.9939	*	*	*	*
670049	1.3626	0.9791	*	*	*	*

[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 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 multi-campus provider that is allocated to CBSA 29404; provider number 140010 indicates the portion of wages and hours of the multi-campus provider that is allocated to CBSA 16974.

[4] Provider 220074 is part of a multi-campus provider 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 multi-campus provider that is allocated to CBSA 14484; provider number 220074 indicates the portion of wages and hours of the multi-campus provider is allocated to CBSA 39300.

[5] Provider 230104 is part of a multi-campus provider 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 multi-campus provider that is allocated to CBSA 47644; provider number 230104 indicates the portion of wages and hours of the multi-campus provider 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	27.9957	26.8757
10380	Aguadilla-Isabela-San Sebastián, PR	11.2990	10.7913
10420	Akron, OH	29.7005	28.4159
10500	Albany, GA	29.9948	28.2517
10580	Albany-Schenectady-Troy, NY	29.5880	28.3429
10740	Albuquerque, NM	32.2349	30.9439
10780	Alexandria, LA	27.3754	26.1147
10900	Allentown-Bethlehem-Easton, PA-NJ	33.0357	31.7762
11020	Altoona, PA	29.6339	27.4527
11100	Amarillo, TX	28.8680	28.7522
11180	Ames, IA	32.0459	31.1674
11260	Anchorage, AK	39.7856	38.1542
11300	Anderson, IN	30.6196	29.0441
11340	Anderson, SC	29.9671	29.9533
11460	Ann Arbor, MI	34.4030	33.5683
11500	Anniston-Oxford, AL	25.5340	25.3588
11540	Appleton, WI	31.0529	30.1277
11700	Asheville, NC	30.5550	29.5885
12020	Athens-Clarke County, GA	30.9160	30.4124
12060	Atlanta-Sandy Springs-Marietta, GA	32.1690	31.3914
12100	Atlantic City-Hammonton, NJ	38.3314	38.0327
12220	Auburn-Opelika, AL	28.3214	25.8269
12260	Augusta-Richmond County, GA-SC	30.7388	30.4649
12420	Austin-Round Rock, TX	31.9870	30.7661
12540	Bakersfield, CA	38.0346	36.4678
12580	Baltimore-Towson, MD	34.0256	32.4830
12620	Bangor, ME	33.6705	32.3350
12700	Barnstable Town, MA	42.2488	40.7749
12940	Baton Rouge, LA	27.6762	26.3435
12980	Battle Creek, MI	33.8374	32.4819

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
13020	Bay City, MI	31.7254	30.0001
13140	Beaumont-Port Arthur, TX	27.9573	27.4816
13380	Bellingham, WA	37.8965	36.6146
13460	Bend, OR	37.8913	35.5461
13644	Bethesda-Frederick-Rockville, MD	34.1116	33.5073
13740	Billings, MT	30.2970	29.0284
13780	Binghamton, NY	30.1039	28.8001
13820	Birmingham-Hoover, AL	28.4856	28.0875
13900	Bismarck, ND	26.5844	24.1201
13980	Blacksburg-Christiansburg-Radford, VA	27.9705	26.4437
14020	Bloomington, IN	31.2059	30.1829
14060	Bloomington-Normal, IL	31.8220	30.6610
14260	Boise City-Nampa, ID	31.2136	30.2714
14484	Boston-Quincy, MA	41.1662	38.8860
14500	Boulder, CO	34.5513	32.8583
14540	Bowling Green, KY	28.5349	26.8082
14600	Bradenton-Sarasota-Venice, FL	31.8873	31.2332
14740	Bremerton-Silverdale, WA	35.7561	34.6905
14860	Bridgeport-Stamford-Norwalk, CT	43.1138	41.5337
15180	Brownsville-Harlingen, TX	31.2332	29.8225
15260	Brunswick, GA	31.6783	31.2963
15380	Buffalo-Niagara Falls, NY	32.9153	31.1916
15500	Burlington, NC	29.0411	27.8537
15540	Burlington-South Burlington, VT	35.1299	31.7191
15764	Cambridge-Newton-Framingham, MA	37.9060	36.2262
15804	Camden, NJ	33.9239	33.4842
15940	Canton-Massillon, OH	29.0456	28.4234
15980	Cape Coral-Fort Myers, FL	30.4484	30.2030
16020	[2]Cape Girardeau-Jackson, MO-IL	30.0244	29.2771
16180	Carson City, NV	34.6461	32.6998
16220	Casper, WY	31.9383	30.4707
16300	Cedar Rapids, IA	29.9380	28.4273
16580	Champaign-Urbana, IL	33.5984	30.9687
16620	Charleston, WV	27.9001	27.0213

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
16700	Charleston-North Charleston-Summerville	30.8527	29.6269
16740	Charlotte-Gastonia-Concord, NC-SC	31.3031	30.5803
16820	Charlottesville, VA	31.0494	30.2782
16860	Chattanooga, TN-GA	29.7427	28.7204
16940	Cheyenne, WY	31.2599	29.8911
16974	Chicago-Naperville-Joliet, IL	34.8670	33.6586
17020	Chico, CA	36.8806	35.6018
17140	Cincinnati-Middletown, OH-KY-IN	31.5351	30.8243
17300	Clarksville, TN-KY	26.5975	26.2809
17420	Cleveland, TN	25.5310	25.7105
17460	Cleveland-Elyria-Mentor, OH	29.9902	29.6439
17660	Coeur d'Alene, ID	30.4324	29.7142
17780	College Station-Bryan, TX	30.0347	29.3825
17820	Colorado Springs, CO	32.0459	30.9629
17860	Columbia, MO	28.7824	27.5371
17900	Columbia, SC	29.7136	28.7238
17980	Columbus, GA-AL	29.4999	28.9135
18020	Columbus, IN	32.0685	31.2600
18140	Columbus, OH	33.8948	32.3321
18580	Corpus Christi, TX	29.0846	27.5761
18700	Corvallis, OR	36.4408	35.1448
19060	Cumberland, MD-WV	27.1122	25.3659
19124	Dallas-Plano-Irving, TX	32.8369	31.6823
19140	Dalton, GA	28.6318	27.6151
19180	Danville, IL	29.3386	29.8080
19260	Danville, VA	27.8679	26.9138
19340	Davenport-Moline-Rock Island, IA-IL	27.7453	27.4212
19380	Dayton, OH	30.9834	29.9520
19460	Decatur, AL	25.8420	24.9163
19500	Decatur, IL	26.9614	26.2145
19660	Deltona-Daytona Beach-Ormond Beach, FL	29.8128	28.6965
19740	Denver-Aurora-Broomfield, CO	35.6048	34.0786
19780	Des Moines-West Des Moines,IA	31.9991	30.3670
19804	Detroit-Livonia-Dearborn, MI	32.8367	32.1572

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
20020	Dothan, AL	25.1829	24.3914
20100	Dover, DE	33.6217	33.4400
20220	Dubuque, IA	28.9900	27.6534
20260	Duluth, MN-WI	35.7427	33.6521
20500	Durham-Chapel Hill, NC	31.9428	31.1507
20740	Eau Claire, WI	31.8981	30.7536
20764	Edison-New Brunswick, NJ	36.7247	35.7479
20940	El Centro, CA	29.5241	29.0239
21060	Elizabethtown, KY	27.8413	27.2898
21140	Elkhart-Goshen, IN	31.6973	30.7092
21300	Elmira, NY	28.2409	26.9862
21340	El Paso, TX	29.0199	28.6448
21500	Erie, PA	28.3312	27.6608
21660	Eugene-Springfield, OR	36.7989	35.6764
21780	Evansville, IN-KY	28.3985	27.4184
21820	Fairbanks, AK	37.0203	35.7424
21940	Fajardo, PR	12.7141	13.0689
22020	Fargo, ND-MN	27.5861	26.1244
22140	Farmington, NM	26.4658	26.7181
22180	Fayetteville, NC	31.7643	31.5002
22220	Fayetteville-Springdale-Rogers, AR-MO	29.4707	28.8106
22380	Flagstaff, AZ	41.8149	38.3568
22420	Flint, MI	36.8668	35.7759
22500	Florence, SC	27.9758	27.2516
22520	Florence-Muscle Shoals, AL	26.5272	25.1490
22540	Fond du Lac, WI	32.9077	31.4562
22660	Fort Collins-Loveland, CO	32.9381	31.1634
22744	Ft Lauderdale-Pompano Beach-Deerfield	34.2003	32.3588
22900	Fort Smith, AR-OK	26.8463	25.6946
23020	Fort Walton Beach-Crestview-Destin, FL	29.0825	28.0292
23060	Fort Wayne, IN	29.9787	28.9887
23104	Fort Worth-Arlington, TX	31.6845	30.9573
23420	Fresno, CA	37.6475	35.8962
23460	Gadsden, AL	28.0461	26.3462

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
23540	Gainesville, FL	30.9175	30.1087
23580	Gainesville, GA	31.6454	30.2871
23844	Gary, IN	30.8371	29.8286
24020	Glens Falls, NY	29.3762	28.0874
24140	Goldsboro, NC	31.0349	29.8059
24220	Grand Forks, ND-MN	27.0972	25.7254
24300	Grand Junction, CO	32.3272	31.2415
24340	Grand Rapids-Wyoming, MI	31.2181	30.0934
24500	Great Falls, MT	27.9003	27.4408
24540	Greeley, CO	32.5263	31.9811
24580	Green Bay, WI	31.7301	30.6099
24660	Greensboro-High Point, NC	30.7329	29.5018
24780	Greenville, NC	31.3898	30.1221
24860	Greenville-Mauldin-Easley, SC	32.5443	31.3126
25020	Guayama, PR	11.8662	10.3190
25060	Gulfport-Biloxi, MS	29.2929	28.1840
25180	Hagerstown-Martinsburg, MD-WV	30.8233	29.8333
25260	Hanford-Corcoran, CA	37.7595	35.6959
25420	Harrisburg-Carlisle, PA	30.7668	29.6353
25500	Harrisonburg, VA	30.6671	29.0477
25540	Hartford-West Hartford-East Hartford, C	38.1003	36.1246
25620	Hattiesburg, MS	26.4486	24.7083
25860	Hickory-Lenoir-Morganton, NC	30.0031	28.8981
25980	[1]Hinesville-Fort Stewart, GA		
26100	Holland-Grand Haven, MI	29.6596	29.0497
26180	Honolulu, HI	38.4883	37.0177
26300	Hot Springs, AR	30.6125	29.4486
26380	Houma-Bayou Cane-Thibodaux, LA	26.8761	25.6872
26420	Houston-Sugar Land-Baytown, TX	33.3323	32.1196
26580	Huntington-Ashland, WV-KY-OH	30.3479	29.1316
26620	Huntsville, AL	29.9713	28.9935
26820	Idaho Falls, ID	31.6299	29.8724
26900	Indianapolis-Carmel, IN	32.8168	31.5947
26980	Iowa City, IA	31.6166	30.3745

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
27060	Ithaca, NY	33.6305	31.3247
27100	Jackson, MI	29.5279	29.8016
27140	Jackson, MS	27.5106	26.0340
27180	Jackson, TN	28.6391	27.5611
27260	Jacksonville, FL	30.5949	29.4169
27340	Jacksonville, NC	27.0747	26.6114
27500	Janesville, WI	31.7365	31.3437
27620	Jefferson City, MO	29.7844	28.6881
27740	Johnson City, TN	24.5911	24.7941
27780	Johnstown, PA	28.4399	26.0029
27860	Jonesboro, AR	26.0948	25.5648
27900	Joplin, MO	28.5026	29.4211
28020	Kalamazoo-Portage, MI	34.4285	34.0720
28100	Kankakee-Bradley, IL	33.9065	32.9933
28140	Kansas City, MO-KS	32.1149	30.5285
28420	Kennewick-Pasco-Richland, WA	34.4914	32.2613
28660	Killeen-Temple-Fort Hood, TX	29.4104	27.9369
28700	Kingsport-Bristol-Bristol, TN-VA	27.0091	25.5183
28740	Kingston, NY	31.6168	30.5785
28940	Knoxville, TN	26.4156	25.5805
29020	Kokomo, IN	32.4704	30.5542
29100	La Crosse, WI-MN	33.3997	31.7122
29140	Lafayette, IN	30.6179	28.8252
29180	Lafayette, LA	28.7766	27.2778
29340	Lake Charles, LA	26.7711	25.1391
29404	Lake County-Kenosha County, IL-WI	34.9090	33.7610
29420	Lake Havasu City-Kingman, AZ	35.5715	32.2632
29460	Lakeland-Winter Haven, FL	28.7355	28.1179
29540	Lancaster, PA	32.2911	31.0069
29620	Lansing-East Lansing, MI	32.2413	31.7800
29700	Laredo, TX	28.1304	27.6408
29740	Las Cruces, NM	29.4351	28.0972
29820	Las Vegas-Paradise, NV	39.6476	37.6277
29940	Lawrence, KS	28.6573	26.9676

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
30020	Lawton, OK	27.3753	27.0905
30140	Lebanon, PA	28.3768	27.6167
30300	Lewiston, ID-WA	31.4296	29.9309
30340	Lewiston-Auburn, ME	30.5984	29.8807
30460	Lexington-Fayette, KY	29.6988	28.8537
30620	Lima, OH	31.3307	30.0284
30700	Lincoln, NE	31.6714	31.0936
30780	Little Rock-N.Little Rock-Conway,AR	29.1037	28.4310
30860	Logan, UT-ID	30.2733	29.0587
30980	Longview, TX	26.5735	27.0450
31020	Longview, WA	37.1862	36.2506
31084	Los Angeles-Long Beach-Santa Ana, CA	40.0226	38.4185
31140	Louisville-Jefferson County, KY-IN	29.8984	29.2603
31180	Lubbock, TX	29.6674	28.2157
31340	Lynchburg, VA	27.9536	27.5435
31420	Macon, GA	34.1321	32.0210
31460	Madera-Chowchilla, CA	28.7738	27.2395
31540	Madison, WI	37.6983	36.2395
31700	Manchester-Nashua, NH	34.1982	32.9484
31740	[2]Mahattan, KS	26.6414	25.4121
31860	[2]Mankato-North Mankato, MN	31.3553	30.3889
31900	Mansfield, OH	30.1194	29.5133
32420	Mayagüez, PR	12.3049	12.0565
32580	McAllen-Edinburg-Mission, TX	29.7296	29.1535
32780	Medford, OR	33.6537	32.9041
32820	Memphis, TN-MS-AR	31.1078	30.0283
32900	Merced, CA	34.6161	36.8106
33124	Miami-Fort Lauderdale-Pompano Beach, FL	33.7030	32.2058
33140	Michigan City-La Porte, IN	30.9356	29.0978
33260	Midland, TX	31.3923	30.7629
33340	Milwaukee-Waukesha-West Allis, WI	34.1210	32.9876
33460	Minneapolis-St. Paul-Bloomington, MN-WI	36.7688	35.3694
33540	Missoula, MT	30.4481	28.5463
33660	Mobile, AL	25.9783	25.3220

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
33700	Modesto, CA	41.6139	39.3137
33740	Monroe, LA	26.6176	25.5981
33780	Monroe, MI	30.7421	29.7570
33860	Montgomery, AL	28.4123	26.8888
34060	Morgantown, WV	28.8234	27.6422
34100	Morristown, TN	24.3708	23.6393
34580	Mount Vernon-Anacortes, WA	34.0272	32.6754
34620	Muncie, IN	27.5502	26.3661
34740	Muskegon-Norton Shores, MI	33.0153	32.3140
34820	Myrtle Beach-North Myrtle Beach-Conway	29.1272	28.0355
34900	Napa, CA	47.9025	45.5679
34940	Naples-Marco Island, FL	32.7746	31.4802
34980	Nashville-Davidson-Murfreesboro-Frankli	32.2509	30.8752
35004	Nassau-Suffolk, NY	42.6607	41.2158
35084	Newark-Union, NJ-PA	37.7125	37.0935
35300	New Haven-Milford, CT	38.6152	37.9596
35380	New Orleans-Metairie-Kenner, LA	30.2678	28.5602
35644	New York-White Plains-Wayne, NY-NJ	44.1779	42.4244
35660	Niles-Benton Harbor, MI	30.1977	29.2818
35980	Norwich-New London, CT	38.8310	37.1536
36084	Oakland-Fremont-Hayward, CA	53.1856	50.5665
36100	Ocala, FL	29.0632	27.6932
36140	Ocean City, NJ	34.0850	35.2683
36220	Odessa, TX	32.3984	31.2174
36260	Ogden-Clearfield, UT	31.5994	29.8430
36420	Oklahoma City, OK	29.6452	28.2948
36500	Olympia, WA	37.5438	36.6539
36540	Omaha-Council Bluffs, NE-IA	32.0576	30.5899
36740	Orlando-Kissimmee, FL	30.1355	29.5527
36780	Oshkosh-Neenah, WI	30.4550	29.8745
36980	Owensboro, KY	28.5261	27.9454
37100	Oxnard-Thousand Oaks-Ventura, CA	40.5204	37.6908
37340	Palm Bay-Melbourne-Titusville, FL	30.7807	30.0966
37380	Palm Coast, FL	31.3855	29.0184

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
37460	Panama City-Lynn Haven-Panama City Beach, FL	28.5612	27.4220
37620	Parkersburg-Marietta-Vienna, WV-OH	25.7421	25.7627
37700	Pascagoula, MS	27.8236	26.7187
37764	Peabody, MA	36.5465	34.6213
37860	Pensacola-Ferry Pass-Brent, FL	27.4398	26.2750
37900	Peoria, IL	30.9845	29.8903
37964	Philadelphia, PA	35.9257	35.0518
38060	Phoenix-Mesa-Scottsdale, AZ	35.1699	33.3209
38220	Pine Bluff, AR	25.0186	25.6335
38300	Pittsburgh, PA	28.7628	27.5536
38340	Pittsfield, MA	36.0559	33.6544
38540	Pocatello, ID	30.2891	29.3929
38660	Ponce, PR	14.1569	13.5589
38860	Portland-South Portland-Biddeford, ME	34.2645	32.4184
38900	Portland-Vancouver-Beaverton, OR-WA	37.6622	36.2624
38940	Port St. Lucie,FL	33.2706	32.1430
39100	Poughkeepsie-Newburgh-Middletown, NY	37.8810	35.7862
39140	Prescott, AZ	33.9397	32.7002
39300	Providence-New Bedford-Fall River, RI-M	36.2222	34.4871
39340	Provo-Orem, UT	31.7171	30.4518
39380	Pueblo, CO	27.9937	27.6376
39460	Punta Gorda, FL	30.4575	30.0374
39540	Racine, WI	31.5965	30.3296
39580	Raleigh-Cary, NC	31.9720	31.0877
39660	Rapid City, SD	34.5184	30.6086
39740	Reading, PA	30.9433	30.1131
39820	Redding, CA	45.2083	42.2982
39900	Reno-Sparks, NV	34.4922	33.9635
40060	Richmond, VA	31.4638	29.9449
40140	Riverside-San Bernardino-Ontario, CA	37.2186	35.8849
40220	Roanoke, VA	29.5640	28.6070
40340	Rochester, MN	36.6497	34.9551
40380	Rochester, NY	29.3194	28.5861

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
40420	Rockford, IL	34.0630	32.1124
40484	Rockingham County, NH	33.9320	32.4171
40580	Rocky Mount, NC	29.9265	29.0400
40660	Rome, GA	29.6985	30.1873
40900	Sacramento--Arden-Arcade--Roseville, CA	45.6742	42.9561
40980	Saginaw-Saginaw Township North, MI	32.2226	29.8545
41060	St. Cloud, MN	39.2455	37.0518
41100	St. George, UT	31.5237	30.3183
41140	St. Joseph, MO-KS	34.3559	32.0545
41180	St. Louis, MO-IL	30.3799	29.0965
41420	Salem, OR	36.7093	34.5777
41500	Salinas, CA	51.6066	48.3986
41540	Salisbury, MD	30.2707	29.1916
41620	Salt Lake City, UT	31.7429	30.3620
41660	San Angelo, TX	27.6088	27.3254
41700	San Antonio, TX	29.8910	28.8014
41740	San Diego-Carlsbad-San Marcos, CA	38.5566	36.5919
41780	Sandusky, OH	29.5329	28.3991
41884	San Francisco-San Mateo-Redwood City,CA	52.3639	49.1662
41900	San Germán-Cabo Rojo, PR	15.9029	15.0796
41940	San Jose-Sunnyvale-Santa Clara, CA	53.3412	50.8904
41980	San Juan-Caguas-Guaynabo, PR	14.6235	14.2919
42020	San Luis Obispo-Paso Robles, CA	40.4408	38.7118
42044	Santa Ana-Anaheim-Irvine, CA	39.5550	37.9011
42060	Santa Barbara-Santa Maria-Goleta, CA	40.7059	38.0116
42100	Santa Cruz-Watsonville, CA	54.6035	51.6772
42140	Santa Fe, NM	35.6066	34.3288
42220	Santa Rosa-Petaluma, CA	52.2495	48.9125
42340	Savannah, GA	30.1155	28.8521
42540	Scranton--Wilkes-Barre, PA	28.0099	26.8394
42644	Seattle-Bellevue-Everett, WA	38.2547	36.9702
42680	Sebastian-Vero Beach,FL	32.0151	30.9881
43100	Sheboygan, WI	31.0995	29.2011
43300	Sherman-Denison, TX	27.5653	27.9912

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
43340	Shreveport-Bossier City, LA	28.4248	27.5212
43580	Sioux City, IA-NE-SD	30.0402	28.8333
43620	Sioux Falls, SD	30.3628	30.0963
43780	South Bend-Mishawaka, IN-MI	32.2470	31.2643
43900	Spartanburg, SC	30.7071	29.6622
44060	Spokane, WA	35.0663	33.7859
44100	Springfield, IL	31.3096	29.4931
44140	Springfield, MA	34.9758	33.7930
44180	Springfield, MO	27.4632	27.4348
44220	Springfield, OH	30.0337	28.1935
44300	State College, PA	30.0664	28.4464
44700	Stockton, CA	41.1995	38.9159
44940	Sumter, SC	28.4023	27.8841
45060	Syracuse, NY	33.0831	31.9275
45104	Tacoma, WA	37.2587	35.7219
45220	Tallahassee, FL	28.6915	28.5684
45300	Tampa-St. Petersburg-Clearwater, FL	30.2537	29.1698
45460	Terre Haute, IN	30.1503	28.9758
45500	Texarkana, TX-Texarkana, AR	27.3459	25.9189
45780	Toledo, OH	31.7726	30.1352
45820	Topeka, KS	30.1678	28.4701
45940	Trenton-Ewing, NJ	35.0714	34.2479
46060	Tucson, AZ	32.5341	30.8026
46140	Tulsa, OK	29.4108	27.8689
46220	Tuscaloosa, AL	30.0310	28.2980
46340	Tyler, TX	28.3757	28.5155
46540	U a-Rome, NY	29.2861	28.2148
46660	Valdosta, GA	27.1502	26.3371
46700	Vallejo-Fairfield, CA	48.8181	46.4872
47020	Victoria, TX	26.3834	25.7435
47220	Vineland-Millville-Bridgeton, NJ	35.8153	34.6925
47260	Virginia Beach-Norfolk-Newport News, VA	29.9914	28.6311
47300	Visalia-Porterville, CA	34.6915	33.2013
47380	Waco, TX	28.9105	27.9165

CBSA Code	Urban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
47580	Warner Robins, GA	30.8943	30.4547
47644	Warren-Troy-Farmington-Hills, MI	33.1403	32.1595
47894	Washington-Arlington-Alexandria DC-VA	35.9340	34.5261
47940	Waterloo-Cedar Falls, IA	28.6256	27.9281
48140	Wausau, WI	32.3991	31.6170
48260	Weirton-Steubenville, WV-OH	24.5738	25.0221
48300	Wenatchee-East Wenatchee, WA	32.7812	32.6969
48424	West Palm Beach-Boca Raton-Boynton FL	32.7588	31.1896
48540	Wheeling, WV-OH	23.1637	22.5123
48620	Wichita, KS	29.9406	28.8777
48660	Wichita Falls, TX	31.9728	28.9065
48700	Williamsport, PA	26.4468	25.6641
48864	Wilmington, DE-MD-NJ	36.0561	34.4479
48900	Wilmington, NC	30.4724	29.5279
49020	Winchester, VA-WV	32.7194	31.6206
49180	Winston-Salem, NC	30.0282	29.0907
49340	Worcester, MA	37.7895	36.1312
49420	Yakima, WA	33.2507	32.3522
49500	Yauco, PR	11.2311	10.6665
49620	York-Hanover, PA	31.2769	30.5432
49660	Youngstown-Warren-Boardman, OH-PA	28.8648	28.5190
49700	Yuba City, CA	36.2555	34.6299
49740	Yuma, AZ	31.1795	31.4593

[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 HOSPITALS 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	24.8199	24.3166
02	Alaska	39.0772	38.2836
03	Arizona	29.5680	28.5241
04	Arkansas	25.3031	24.4252
05	California	39.2489	38.0964
06	Colorado	32.5964	30.7010
07	Connecticut	38.0856	36.3340
08	Delaware	33.5795	32.2657
10	Florida	28.8849	27.8168
11	Georgia	26.2776	25.3219
12	Hawaii	37.8909	35.8151
13	Idaho	25.6686	24.8071
14	Illinois	27.8917	27.0028
15	Indiana	28.5306	27.5005
16	Iowa	29.0945	27.8301
17	Kansas	27.3360	25.9624
18	Kentucky	26.5160	25.3588
19	Louisiana	26.2709	24.8692
20	Maine	28.7338	27.5637
21	Maryland	31.0117	29.0529
22	Massachusetts[1]	--	--
23	Michigan	29.5303	28.5992
24	Minnesota	30.7895	29.4402
25	Mississippi	25.9188	24.8668
26	Missouri	26.3112	25.9330
27	Montana	27.9188	27.2131
28	Nebraska	28.7306	27.9854
29	Nevada	32.4949	31.4510
30	New Hampshire	33.5232	33.1705
31	New Jersey[2]	--	--
32	New Mexico	30.1471	28.8706
33	New York	28.0993	26.8835
34	North Carolina	28.8318	27.7959
35	North Dakota	26.6203	24.0703

CBSA Code	Nonurban Area	FY 2010 Average Hourly Wage	3-Year Average Hourly Wage
36	Ohio	28.6223	27.7963
37	Oklahoma	26.1568	25.2354
38	Oregon	34.2460	32.7445
39	Pennsylvania	28.0439	26.9596
40	Puerto Rico[2]	--	--
41	Rhode Island[2]	--	--
42	South Carolina	28.1101	27.6442
43	South Dakota	27.8111	26.9646
44	Tennessee	26.5314	25.5308
45	Texas	26.6739	26.1221
46	Utah	28.3520	26.9916
47	Vermont	32.2081	31.4946
49	Virginia	27.0874	26.0137
50	Washington	33.9968	32.7415
51	West Virginia	25.1150	24.4101
52	Wisconsin	30.9835	30.4960
53	Wyoming	31.3918	29.8346

[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.]

CBSA Code	Urban Area	State	Wage Index	GAF
10180	Abilene, TX	TX	0.8348	0.8837
10380	Aguadilla-Isabela-San Sebastion, PR	PR	0.3369	0.4747
10420	Akron, OH	OH	0.8852	0.9199
10500	Albany, GA	GA	0.8944	0.9264
10580	Albany-Schenectady-Troy, NY	NY	0.8823	0.9178
10740	Albuquerque, NM	NM	0.9589	0.9717
10780	Alexandria, LA	LA	0.8169	0.8707
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1349	1.0905
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9848	0.9896
11020	Altoona, PA	PA	0.8835	0.9187
11100	Amarillo, TX	TX	0.8608	0.9024
11180	Ames, IA	IA	0.9537	0.9681
11260	Anchorage, AK	AK	1.1938	1.1290
11300	Anderson, IN	IN	0.9129	0.9395
11340	Anderson, SC	SC	0.8933	0.9256
11460	Ann Arbor, MI	MI	1.0259	1.0177
11500	Anniston-Oxford, AL	AL	0.7614	0.8297
11540	Appleton, WI	WI	0.9257	0.9485
11700	Asheville, NC	NC	0.9112	0.9383
12020	Athens-Clarke County, GA	GA	0.9218	0.9458
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9593	0.9719
12100	Atlantic City-Hammonton, NJ	NJ	1.1349	1.0905
12220	Auburn-Opelika, AL	AL	0.8445	0.8907
12260	Augusta-Richmond County, GA-SC	GA	0.9167	0.9422
12260	Augusta-Richmond County, GA-SC	SC	0.9164	0.9420
12420	Austin-Round Rock, TX	TX	0.9538	0.9681
12540	Bakersfield, CA	CA	1.1660	1.1109
12580	Baltimore-Towson, MD	MD	1.0159	1.0109
12620	Bangor, ME	ME	1.0040	1.0027
12700	Barnstable Town, MA	MA	1.2598	1.1713
12940	Baton Rouge, LA	LA	0.8253	0.8768
12980	Battle Creek, MI	MI	1.0090	1.0062
13020	Bay City, MI	MI	0.9460	0.9627
13140	Beaumont-Port Arthur, TX	TX	0.8336	0.8828
13380	Bellingham, WA	WA	1.1296	1.0870
13460	Bend, OR	OR	1.1285	1.0863

CBSA Code	Urban Area	State	Wage Index	GAF
13644	Bethesda-Frederick-Rockville, MD	MD	1.0800	1.0541
13740	Billings, MT	MT	0.9035	0.9329
13780	Binghamton, NY	NY	0.8977	0.9288
13820	Birmingham-Hoover, AL	AL	0.8494	0.8942
13900	Bismarck, ND	ND	0.7981	0.8569
13980	Blacksburg-Christiansburg-Radford, VA	VA	0.8341	0.8832
14020	Bloomington, IN	IN	0.9304	0.9518
14060	Bloomington-Normal, IL	IL	0.9489	0.9647
14260	Boise City-Nampa, ID	ID	0.9307	0.9520
14484	Boston-Quincy, MA	MA	1.2276	1.1508
14500	Boulder, CO	CO	1.0254	1.0173
14540	Bowling Green, KY	KY	0.8509	0.8953
14600	Bradenton-Sarasota-Venice, FL	FL	0.9501	0.9656
14740	Bremerton-Silverdale, WA	WA	1.0658	1.0446
14860	Bridgeport-Stamford-Norwalk, CT	CT	1.2854	1.1876
15180	Brownsville-Harlingen, TX	TX	0.9313	0.9524
15260	Brunswick, GA	GA	0.9505	0.9658
15380	Buffalo-Niagara Falls, NY	NY	0.9815	0.9873
15500	Burlington, NC	NC	0.8660	0.9062
15540	Burlington-South Burlington, VT	VT	1.0476	1.0324
15764	Cambridge-Newton-Framingham, MA	MA	1.1303	1.0875
15804	Camden, NJ	NJ	1.1349	1.0905
15940	Canton-Massillon, OH	OH	0.8657	0.9060
15980	Cape Coral-Fort Myers, FL	FL	0.9073	0.9356
16020	Cape Girardeau-Jackson, MO-IL	IL	0.8953	0.9271
16020	Cape Girardeau-Jackson, MO-IL	MO	0.8953	0.9271
16180	Carson City, NV	NV	1.0331	1.0226
16220	Casper, WY	WY	1.0170	1.0116
16300	Cedar Rapids, IA	IA	0.8909	0.9239
16580	Champaign-Urbana, IL	IL	1.0018	1.0012
16620	Charleston, WV	WV	0.8310	0.8809
16700	Charleston-North Charleston-Summerville, SC	SC	0.9198	0.9444
16740	Charlotte-Gastonia-Concord, NC-SC	NC	0.9334	0.9539
16740	Charlotte-Gastonia-Concord, NC-SC	SC	0.9332	0.9538
16820	Charlottesville, VA	VA	0.9258	0.9486
16860	Chattanooga, TN-GA	GA	0.8869	0.9211
16860	Chattanooga, TN-GA	TN	0.8850	0.9197
16940	Cheyenne, WY	WY	0.9360	0.9557
16974	Chicago-Naperville-Joliet, IL	IL	1.0397	1.0270
17020	Chico, CA	CA	1.1660	1.1109
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9409	0.9591

CBSA Code	Urban Area	State	Wage Index	GAF
17140	Cincinnati-Middletown, OH-KY-IN	KY	0.9410	0.9592
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9405	0.9589
17300	Clarksville, TN-KY	KY	0.8119	0.8670
17300	Clarksville, TN-KY	TN	0.8102	0.8658
17420	Cleveland, TN	TN	0.7894	0.8505
17460	Cleveland-Elyria-Mentor, OH	OH	0.8938	0.9260
17660	Coeur d'Alene, ID	ID	0.9075	0.9357
17780	College Station-Bryan, TX	TX	0.8956	0.9273
17820	Colorado Springs, CO	CO	0.9674	0.9776
17860	Columbia, MO	MO	0.8582	0.9006
17900	Columbia, SC	SC	0.8858	0.9203
17980	Columbus, GA-AL	AL	0.8797	0.9160
17980	Columbus, GA-AL	GA	0.8797	0.9160
18020	Columbus, IN	IN	0.9562	0.9698
18140	Columbus, OH	OH	1.0102	1.0070
18580	Corpus Christi, TX	TX	0.8673	0.9071
18700	Corvallis, OR	OR	1.0853	1.0577
19060	Cumberland, MD-WV	MD	0.9259	0.9486
19060	Cumberland, MD-WV	WV	0.8075	0.8638
19124	Dallas-Plano-Irving, TX	TX	0.9791	0.9856
19140	Dalton, GA	GA	0.8537	0.8973
19180	Danville, IL	IL	0.8748	0.9125
19260	Danville, VA	VA	0.8310	0.8809
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8441	0.8904
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8659	0.9061
19380	Dayton, OH	OH	0.9235	0.9470
19460	Decatur, AL	AL	0.7751	0.8399
19500	Decatur, IL	IL	0.8317	0.8814
19660	Deltona-Daytona Beach-Ormond Beach, FL	FL	0.8883	0.9221
19740	Denver-Aurora-Broomfield, CO	CO	1.0566	1.0384
19780	Des Moines-West Des Moines, IA	IA	0.9523	0.9671
19804	Detroit-Livonia-Dearborn, MI	MI	0.9869	0.9910
20020	Dothan, AL	AL	0.7510	0.8219
20100	Dover, DE	DE	1.0025	1.0017
20220	Dubuque, IA	IA	0.8659	0.9061
20260	Duluth, MN-WI	MN	1.0659	1.0447
20260	Duluth, MN-WI	WI	1.0656	1.0445
20500	Durham-Chapel Hill, NC	NC	0.9525	0.9672
20740	Eau Claire, WI	WI	0.9510	0.9662
20764	Edison-New Brunswick, NJ	NJ	1.1349	1.0905
20940	El Centro, CA	CA	1.1660	1.1109

CBSA Code	Urban Area	State	Wage Index	GAF
21060	Elizabethtown, KY	KY	0.8301	0.8803
21140	Elkhart-Goshen, IN	IN	0.9478	0.9640
21300	Elmira, NY	NY	0.8421	0.8890
21340	El Paso, TX	TX	0.8653	0.9057
21500	Erie, PA	PA	0.8446	0.8908
21660	Eugene-Springfield, OR	OR	1.1073	1.0723
21780	Evansville, IN-KY	IN	0.8506	0.8951
21780	Evansville, IN-KY	KY	0.8468	0.8924
21820	Fairbanks, AK	AK	1.1652	1.1104
21940	Fajardo, PR	PR	0.3791	0.5147
22020	Fargo, ND-MN	MN	0.9290	0.9508
22020	Fargo, ND-MN	ND	0.8289	0.8794
22140	Farmington, NM	NM	0.8968	0.9281
22180	Fayetteville, NC	NC	0.9472	0.9635
22220	Fayetteville-Springdale-Rogers, AR-MO	AR	0.8788	0.9153
22220	Fayetteville-Springdale-Rogers, AR-MO	MO	0.8788	0.9153
22380	Flagstaff, AZ	AZ	1.2468	1.1631
22420	Flint, MI	MI	1.0993	1.0670
22500	Florence, SC	SC	0.8380	0.8860
22520	Florence-Muscle Shoals, AL	AL	0.7910	0.8517
22540	Fond du Lac, WI	WI	0.9810	0.9869
22660	Fort Collins-Loveland, CO	CO	0.9828	0.9882
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0394	1.0268
22900	Fort Smith, AR-OK	AR	0.8005	0.8587
22900	Fort Smith, AR-OK	OK	0.8005	0.8587
23020	Fort Walton Beach-Crestview-Destin, FL	FL	0.8665	0.9065
23060	Fort Wayne, IN	IN	0.8964	0.9278
23104	Fort Worth-Arlington, TX	TX	0.9448	0.9619
23420	Fresno, CA	CA	1.1660	1.1109
23460	Gadsden, AL	AL	0.8364	0.8848
23540	Gainesville, FL	FL	0.9212	0.9453
23580	Gainesville, GA	GA	0.9436	0.9610
23844	Gary, IN	IN	0.9222	0.9460
24020	Glens Falls, NY	NY	0.8760	0.9133
24140	Goldsboro, NC	NC	0.9254	0.9483
24220	Grand Forks, ND-MN	MN	0.9290	0.9508
24220	Grand Forks, ND-MN	ND	0.8067	0.8632
24300	Grand Junction, CO	CO	0.9868	0.9909
24340	Grand Rapids-Wyoming, MI	MI	0.9309	0.9521
24500	Great Falls, MT	MT	0.8377	0.8858
24540	Greeley, CO	CO	0.9674	0.9776

CBSA Code	Urban Area	State	Wage Index	GAF
24580	Green Bay, WI	WI	0.9460	0.9627
24660	Greensboro-High Point, NC	NC	0.9164	0.9420
24780	Greenville, NC	NC	0.9360	0.9557
24860	Greenville-Mauldin-Easley, SC	SC	0.9702	0.9795
25020	Guayama, PR	PR	0.3539	0.4910
25060	Gulfport-Biloxi, MS	MS	0.8735	0.9115
25180	Hagerstown-Martinsburg, MD-WV	MD	0.9259	0.9486
25180	Hagerstown-Martinsburg, MD-WV	WV	0.9180	0.9431
25260	Hanford-Corcoran, CA	CA	1.1660	1.1109
25420	Harrisburg-Carlisle, PA	PA	0.9199	0.9444
25500	Harrisonburg, VA	VA	0.9145	0.9406
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1359	1.0912
25620	Hattiesburg, MS	MS	0.7887	0.8500
25860	Hickory-Lenoir-Morganton, NC	NC	0.8947	0.9266
26100	Holland-Grand Haven, MI	MI	0.8844	0.9193
26180	Honolulu, HI	HI	1.1477	1.0989
26300	Hot Springs, AR	AR	0.9129	0.9395
26380	Houma-Bayou Cane-Thibodaux, LA	LA	0.8014	0.8593
26420	Houston-Sugar Land-Baytown, TX	TX	0.9939	0.9958
26580	Huntington-Ashland, WV-KY-OH	KY	0.9049	0.9339
26580	Huntington-Ashland, WV-KY-OH	OH	0.9045	0.9336
26580	Huntington-Ashland, WV-KY-OH	WV	0.9039	0.9331
26620	Huntsville, AL	AL	0.8937	0.9259
26820	Idaho Falls, ID	ID	0.9432	0.9607
26900	Indianapolis-Carmel, IN	IN	0.9784	0.9852
26980	Iowa City, IA	IA	0.9410	0.9592
27060	Ithaca, NY	NY	1.0028	1.0019
27100	Jackson, MI	MI	0.8806	0.9166
27140	Jackson, MS	MS	0.8204	0.8732
27180	Jackson, TN	TN	0.8522	0.8963
27260	Jacksonville, FL	FL	0.9117	0.9387
27340	Jacksonville, NC	NC	0.8597	0.9017
27500	Janesville, WI	WI	0.9461	0.9628
27620	Jefferson City, MO	MO	0.8882	0.9220
27740	Johnson City, TN	TN	0.7894	0.8505
27780	Johnstown, PA	PA	0.8478	0.8931
27860	Jonesboro, AR	AR	0.7808	0.8441
27900	Joplin, MO	MO	0.8499	0.8946
28020	Kalamazoo-Portage, MI	MI	1.0266	1.0181
28100	Kankakee-Bradley, IL	IL	1.0110	1.0075
28140	Kansas City, MO-KS	KS	0.9575	0.9707

CBSA Code	Urban Area	State	Wage Index	GAF
28140	Kansas City, MO-KS	MO	0.9576	0.9708
28420	Kennewick-Pasco-Richland, WA	WA	1.0281	1.0192
28660	Killeen-Temple-Fort Hood, TX	TX	0.8770	0.9140
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.8094	0.8652
28700	Kingsport-Bristol-Bristol, TN-VA	VA	0.8112	0.8665
28740	Kingston, NY	NY	0.9428	0.9605
28940	Knoxville, TN	TN	0.7894	0.8505
29020	Kokomo, IN	IN	0.9682	0.9781
29100	La Crosse, WI-MN	MN	0.9960	0.9973
29100	La Crosse, WI-MN	WI	0.9957	0.9971
29140	Lafayette, IN	IN	0.9128	0.9394
29180	Lafayette, LA	LA	0.8581	0.9005
29340	Lake Charles, LA	LA	0.7983	0.8570
29404	Lake County-Kenosha County, IL-WI	IL	1.0410	1.0279
29404	Lake County-Kenosha County, IL-WI	WI	1.0407	1.0277
29420	Lake Havasu City-Kingman, AZ	AZ	1.0607	1.0412
29460	Lakeland-Winter Haven, FL	FL	0.8607	0.9024
29540	Lancaster, PA	PA	0.9626	0.9742
29620	Lansing-East Lansing, MI	MI	0.9614	0.9734
29700	Laredo, TX	TX	0.8388	0.8866
29740	Las Cruces, NM	NM	0.8968	0.9281
29820	Las Vegas-Paradise, NV	NV	1.1822	1.1214
29940	Lawrence, KS	KS	0.8545	0.8979
30020	Lawton, OK	OK	0.8163	0.8702
30140	Lebanon, PA	PA	0.8459	0.8917
30300	Lewiston, ID-WA	ID	0.9372	0.9566
30300	Lewiston, ID-WA	WA	1.0133	1.0091
30340	Lewiston-Auburn, ME	ME	0.9125	0.9392
30460	Lexington-Fayette, KY	KY	0.8856	0.9202
30620	Lima, OH	OH	0.9337	0.9541
30700	Lincoln, NE	NE	0.9444	0.9616
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8678	0.9075
30860	Logan, UT-ID	ID	0.9028	0.9324
30860	Logan, UT-ID	UT	0.9028	0.9324
30980	Longview, TX	TX	0.8218	0.8742
31020	Longview, WA	WA	1.1084	1.0730
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.1890	1.1259
31140	Louisville-Jefferson County, KY-IN	IN	0.8915	0.9244
31140	Louisville-Jefferson County, KY-IN	KY	0.8916	0.9244
31180	Lubbock, TX	TX	0.8847	0.9195
31340	Lynchburg, VA	VA	0.8336	0.8828

CBSA Code	Urban Area	State	Wage Index	GAF
31420	Macon, GA	GA	1.0178	1.0122
31460	Madera-Chowchilla, CA	CA	1.1660	1.1109
31540	Madison, WI	WI	1.1238	1.0832
31700	Manchester-Nashua, NH	NH	1.0532	1.0361
31740	Manhattan, KS	KS	0.8192	0.8723
31860	Mankato-North Mankato, MN	MN	0.9350	0.9550
31900	Mansfield, OH	OH	0.9087	0.9365
32420	Mayaguez, PR	PR	0.3669	0.5033
32580	McAllen-Edinburg-Mission, TX	TX	0.8865	0.9208
32780	Medford, OR	OR	1.0255	1.0174
32820	Memphis, TN-MS-AR	AR	0.9276	0.9498
32820	Memphis, TN-MS-AR	MS	0.9276	0.9498
32820	Memphis, TN-MS-AR	TN	0.9257	0.9485
32900	Merced, CA	CA	1.1660	1.1109
33124	Miami-Miami Beach-Kendall, FL	FL	1.0043	1.0029
33140	Michigan City-La Porte, IN	IN	0.9223	0.9461
33260	Midland, TX	TX	0.9361	0.9558
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0172	1.0117
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.0964	1.0651
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.0962	1.0649
33540	Missoula, MT	MT	0.9080	0.9360
33660	Mobile, AL	AL	0.7746	0.8395
33700	Modesto, CA	CA	1.2363	1.1563
33740	Monroe, LA	LA	0.7937	0.8537
33780	Monroe, MI	MI	0.9977	0.9984
33860	Montgomery, AL	AL	0.8472	0.8927
34060	Morgantown, WV	WV	0.8585	0.9008
34100	Morristown, TN	TN	0.7894	0.8505
34580	Mount Vernon-Anacortes, WA	WA	1.0142	1.0097
34620	Muncie, IN	IN	0.8506	0.8951
34740	Muskegon-Norton Shores, MI	MI	0.9845	0.9894
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	SC	0.8683	0.9078
34900	Napa, CA	CA	1.4231	1.2733
34940	Naples-Marco Island, FL	FL	0.9765	0.9838
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9597	0.9722
35004	Nassau-Suffolk, NY	NY	1.2721	1.1792
35084	Newark-Union, NJ-PA	NJ	1.1349	1.0905
35084	Newark-Union, NJ-PA	PA	1.1243	1.0835
35300	New Haven-Milford, CT	CT	1.1513	1.1013
35380	New Orleans-Metairie-Kenner, LA	LA	0.9026	0.9322
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.2986	1.1959

CBSA Code	Urban Area	State	Wage Index	GAF
35644	New York-White Plains-Wayne, NY-NJ	NY	1.3174	1.2078
35660	Niles-Benton Harbor, MI	MI	0.9005	0.9307
35980	Norwich-New London, CT	CT	1.1578	1.1055
36084	Oakland-Fremont-Hayward, CA	CA	1.5801	1.3679
36100	Ocala, FL	FL	0.8659	0.9061
36140	Ocean City, NJ	NJ	1.1349	1.0905
36220	Odessa, TX	TX	0.9661	0.9767
36260	Ogden-Clearfield, UT	UT	0.9428	0.9605
36420	Oklahoma City, OK	OK	0.8840	0.9190
36500	Olympia, WA	WA	1.1190	1.0800
36540	Omaha-Council Bluffs, NE-IA	IA	0.9540	0.9683
36540	Omaha-Council Bluffs, NE-IA	NE	0.9559	0.9696
36740	Orlando-Kissimmee, FL	FL	0.8979	0.9289
36780	Oshkosh-Neenah, WI	WI	0.9237	0.9471
36980	Owensboro, KY	KY	0.8506	0.8951
37100	Oxnard-Thousand Oaks-Ventura, CA	CA	1.2038	1.1354
37340	Palm Bay-Melbourne-Titusville, FL	FL	0.9171	0.9425
37380	Palm Coast, FL	FL	0.9352	0.9552
37460	Panama City-Lynn Haven-Panama City Beach, FL	FL	0.8607	0.9024
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8531	0.8969
37620	Parkersburg-Marietta-Vienna, WV-OH	WV	0.7667	0.8337
37700	Pascagoula, MS	MS	0.8297	0.8800
37764	Peabody, MA	MA	1.0898	1.0607
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8607	0.9024
37900	Peoria, IL	IL	0.9239	0.9472
37964	Philadelphia, PA	PA	1.0710	1.0481
38060	Phoenix-Mesa-Scottsdale, AZ	AZ	1.0487	1.0331
38220	Pine Bluff, AR	AR	0.7778	0.8419
38300	Pittsburgh, PA	PA	0.8575	0.9001
38340	Pittsfield, MA	MA	1.0752	1.0509
38540	Pocatello, ID	ID	0.9032	0.9327
38660	Ponce, PR	PR	0.4222	0.5541
38860	Portland-South Portland-Biddeford, ME	ME	1.0217	1.0148
38900	Portland-Vancouver-Beaverton, OR-WA	OR	1.1217	1.0818
38900	Portland-Vancouver-Beaverton, OR-WA	WA	1.1226	1.0824
38940	Port St. Lucie, FL	FL	0.9913	0.9940
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.1296	1.0870
39140	Prescott, AZ	AZ	1.0383	1.0261
39300	Providence-New Bedford-Fall River, RI-MA	MA	1.0801	1.0542
39300	Providence-New Bedford-Fall River, RI-MA	RI	1.0801	1.0542
39340	Provo-Orem, UT	UT	0.9458	0.9626

CBSA Code	Urban Area	State	Wage Index	GAF
39380	Pueblo, CO	CO	0.9674	0.9776
39460	Punta Gorda, FL	FL	0.9076	0.9358
39540	Racine, WI	WI	0.9420	0.9599
39580	Raleigh-Cary, NC	NC	0.9534	0.9678
39660	Rapid City, SD	SD	1.0293	1.0200
39740	Reading, PA	PA	0.9225	0.9463
39820	Redding, CA	CA	1.3431	1.2239
39900	Reno-Sparks, NV	NV	1.0285	1.0194
40060	Richmond, VA	VA	0.9382	0.9573
40140	Riverside-San Bernardino-Ontario, CA	CA	1.1660	1.1109
40220	Roanoke, VA	VA	0.8816	0.9173
40340	Rochester, MN	MN	1.0928	1.0627
40380	Rochester, NY	NY	0.8743	0.9121
40420	Rockford, IL	IL	1.0157	1.0107
40484	Rockingham County-Strafford County, NH	NH	1.0532	1.0361
40580	Rocky Mount, NC	NC	0.8924	0.9250
40660	Rome, GA	GA	0.8856	0.9202
40900	Sacramento--Arden-Arcade--Roseville, CA	CA	1.3570	1.2325
40980	Saginaw-Saginaw Township North, MI	MI	0.9609	0.9731
41060	St. Cloud, MN	MN	1.1702	1.1136
41100	St. George, UT	UT	0.9400	0.9585
41140	St. Joseph, MO-KS	KS	1.0243	1.0166
41140	St. Joseph, MO-KS	MO	1.0244	1.0166
41180	St. Louis, MO-IL	IL	0.9059	0.9346
41180	St. Louis, MO-IL	MO	0.9059	0.9346
41420	Salem, OR	OR	1.0933	1.0630
41500	Salinas, CA	CA	1.5332	1.3400
41540	Salisbury, MD	MD	0.9259	0.9486
41620	Salt Lake City, UT	UT	0.9465	0.9630
41660	San Angelo, TX	TX	0.8232	0.8753
41700	San Antonio, TX	TX	0.8913	0.9242
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.1660	1.1109
41780	Sandusky, OH	OH	0.8801	0.9163
41884	San Francisco-San Mateo-Redwood City, CA	CA	1.5557	1.3534
41900	San German-Cabo Rojo, PR	PR	0.4742	0.5999
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.5998	1.3796
41980	San Juan-Caguas-Guaynabo, PR	PR	0.4361	0.5665
42020	San Luis Obispo-Paso Robles, CA	CA	1.2014	1.1339
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.1752	1.1169
42060	Santa Barbara-Santa Maria-Goleta, CA	CA	1.2093	1.1390
42100	Santa Cruz-Watsonville, CA	CA	1.6222	1.3928

CBSA Code	Urban Area	State	Wage Index	GAF
42140	Santa Fe, NM	NM	1.0592	1.0402
42220	Santa Rosa-Petaluma, CA	CA	1.5523	1.3514
42340	Savannah, GA	GA	0.8980	0.9290
42540	Scranton--Wilkes-Barre, PA	PA	0.8375	0.8856
42644	Seattle-Bellevue-Everett, WA	WA	1.1403	1.0941
42680	Sebastian-Vero Beach, FL	FL	0.9540	0.9683
43100	Sheboygan, WI	WI	0.9271	0.9495
43300	Sherman-Denison, TX	TX	0.8451	0.8911
43340	Shreveport-Bossier City, LA	LA	0.8476	0.8929
43580	Sioux City, IA-NE-SD	IA	0.8940	0.9261
43580	Sioux City, IA-NE-SD	NE	0.8958	0.9274
43580	Sioux City, IA-NE-SD	SD	0.8958	0.9274
43620	Sioux Falls, SD	SD	0.9054	0.9342
43780	South Bend-Mishawaka, IN-MI	IN	0.9615	0.9735
43780	South Bend-Mishawaka, IN-MI	MI	0.9616	0.9735
43900	Spartanburg, SC	SC	0.9154	0.9413
44060	Spokane, WA	WA	1.0452	1.0307
44100	Springfield, IL	IL	0.9336	0.9540
44140	Springfield, MA	MA	1.0430	1.0293
44180	Springfield, MO	MO	0.8190	0.8722
44220	Springfield, OH	OH	0.8951	0.9269
44300	State College, PA	PA	0.8963	0.9278
44700	Stockton, CA	CA	1.2240	1.1485
44940	Sumter, SC	SC	0.8467	0.8923
45060	Syracuse, NY	NY	0.9865	0.9907
45104	Tacoma, WA	WA	1.1105	1.0744
45220	Tallahassee, FL	FL	0.8607	0.9024
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.9020	0.9318
45460	Terre Haute, IN	IN	0.8989	0.9296
45500	Texarkana, TX-Texarkana, AR	AR	0.8165	0.8704
45500	Texarkana, TX-Texarkana, AR	TX	0.8165	0.8704
45780	Toledo, OH	OH	0.9469	0.9633
45820	Topeka, KS	KS	0.8995	0.9300
45940	Trenton-Ewing, NJ	NJ	1.1349	1.0905
46060	Tucson, AZ	AZ	0.9702	0.9795
46140	Tulsa, OK	OK	0.8770	0.9140
46220	Tuscaloosa, AL	AL	0.8955	0.9272
46340	Tyler, TX	TX	0.8461	0.8919
46540	Utica-Rome, NY	NY	0.8733	0.9114
46660	Valdosta, GA	GA	0.8096	0.8653
46700	Vallejo-Fairfield, CA	CA	1.4503	1.2899

CBSA Code	Urban Area	State	Wage Index	GAF
47020	Victoria, TX	TX	0.7954	0.8549
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1349	1.0905
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8943	0.9264
47260	Virginia Beach-Norfolk-Newport News, VA	VA	0.8943	0.9264
47300	Visalia-Porterville, CA	CA	1.1660	1.1109
47380	Waco, TX	TX	0.8621	0.9034
47580	Warner Robins, GA	GA	0.9212	0.9453
47644	Warren-Troy-Farmington-Hills, MI	MI	0.9883	0.9920
47894	Washington-Arlington-Alexandria, DC-VA	DC	1.0716	1.0485
47894	Washington-Arlington-Alexandria, DC-VA	MD	1.0729	1.0494
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0716	1.0485
47894	Washington-Arlington-Alexandria, DC-VA	WV	1.0703	1.0476
47940	Waterloo-Cedar Falls, IA	IA	0.8659	0.9061
48140	Wausau, WI	WI	0.9659	0.9765
48260	Weirton-Steubenville, WV-OH	OH	0.8531	0.8969
48260	Weirton-Steubenville, WV-OH	WV	0.7480	0.8197
48300	Wenatchee-East Wenatchee, WA	WA	1.0133	1.0091
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	FL	0.9761	0.9836
48540	Wheeling, WV-OH	OH	0.8531	0.8969
48540	Wheeling, WV-OH	WV	0.7480	0.8197
48620	Wichita, KS	KS	0.8927	0.9252
48660	Wichita Falls, TX	TX	0.9534	0.9678
48700	Williamsport, PA	PA	0.8375	0.8856
48864	Wilmington, DE-MD-NJ	DE	1.0752	1.0509
48864	Wilmington, DE-MD-NJ	MD	1.0765	1.0518
48864	Wilmington, DE-MD-NJ	NJ	1.1349	1.0905
48900	Wilmington, NC	NC	0.9138	0.9401
49020	Winchester, VA-WV	VA	0.9757	0.9833
49020	Winchester, VA-WV	WV	0.9745	0.9825
49180	Winston-Salem, NC	NC	0.9019	0.9317
49340	Worcester, MA	MA	1.1269	1.0853
49420	Yakima, WA	WA	1.0133	1.0091
49500	Yauco, PR	PR	0.3349	0.4728
49620	York-Hanover, PA	PA	0.9324	0.9532
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8603	0.9021
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8605	0.9022
49700	Yuba City, CA	CA	1.1660	1.1109
49740	Yuma, AZ	AZ	0.9297	0.9513

TABLE 4B.--WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR ACUTE CARE HOSPITALS IN RURAL AREAS BY CBSA AND BY STATE--FY 2010

CBSA Code	Rural Area	State	Wage Index	GAF
01	Alabama	AL	0.7401	0.8137
02	Alaska	AK	1.1652	1.1104
03	Arizona	AZ	0.8817	0.9174
04	Arkansas	AR	0.7576	0.8269
05	California	CA	1.1660	1.1109
06	Colorado	CO	0.9674	0.9776
07	Connecticut	CT	1.1355	1.0909
08	Delaware	DE	1.0013	1.0009
10	Florida	FL	0.8607	0.9024
11	Georgia	GA	0.7836	0.8462
12	Hawaii	HI	1.1299	1.0872
13	Idaho	ID	0.7654	0.8327
14	Illinois	IL	0.8317	0.8814
15	Indiana	IN	0.8506	0.8951
16	Iowa	IA	0.8659	0.9061
17	Kansas	KS	0.8192	0.8723
18	Kentucky	KY	0.7964	0.8556
19	Louisiana	LA	0.7834	0.8461
20	Maine	ME	0.8568	0.8996
21	Maryland	MD	0.9259	0.9486
22	Massachusetts	MA	1.0373	1.0254
23	Michigan	MI	0.8806	0.9166
24	Minnesota	MN	0.9290	0.9508
25	Mississippi	MS	0.7728	0.8382
26	Missouri	MO	0.8176	0.8712
27	Montana	MT	0.8326	0.8821
28	Nebraska	NE	0.8567	0.8995
29	Nevada	NV	1.0041	1.0028
30	New Hampshire	NH	1.0532	1.0361
31	New Jersey[1]	NJ	1.1349	1.0905
32	New Mexico	NM	0.8968	0.9281
33	New York	NY	0.8379	0.8859
34	North Carolina	NC	0.8597	0.9017
35	North Dakota	ND	0.7981	0.8569
36	Ohio	OH	0.8531	0.8969
37	Oklahoma	OK	0.7800	0.8435
38	Oregon	OR	1.0255	1.0174

CBSA Code	Rural Area	State	Wage Index	GAF
39	Pennsylvania	PA	0.8375	0.8856
40	Puerto Rico[1]	PR	-----	-----
41	Rhode Island[1]	RI	-----	-----
42	South Carolina	SC	0.8380	0.8860
43	South Dakota	SD	0.8293	0.8797
44	Tennessee	TN	0.7894	0.8505
45	Texas	TX	0.7954	0.8549
46	Utah	UT	0.8454	0.8914
47	Vermont	VT	0.9604	0.9727
49	Virginia	VA	0.8112	0.8665
50	Washington	WA	1.0133	1.0091
51	West Virginia	WV	0.7480	0.8197
52	Wisconsin	WI	0.9237	0.9471
53	Wyoming	WY	0.9360	0.9557

[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 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

CBSA Code	Area	State	Wage Index	GAF
10500	Albany, GA	AL	0.8399	0.8874
10500	Albany, GA	GA	0.8399	0.8874
10580	Albany-Schenectady-Troy, NY	NY	0.8823	0.9178
10740	Albuquerque, NM	NM	0.9402	0.9587
10780	Alexandria, LA	LA	0.8169	0.8707
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9669	0.9772
11100	Amarillo, TX	KS	0.8481	0.8933
11100	Amarillo, TX	TX	0.8481	0.8933
11180	Ames, IA	IA	0.9277	0.9499
11260	Anchorage, AK	AK	1.1938	1.1290
11300	Anderson, IN	IN	0.8645	0.9051
11460	Ann Arbor, MI	MI	0.9865	0.9907
12060	Atlanta-Sandy Springs-Marietta, GA	AL	0.9593	0.9719
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9593	0.9719
12260	Augusta-Richmond County, GA-SC	SC	0.9056	0.9344
12420	Austin-Round Rock, TX	TX	0.9538	0.9681
12620	Bangor, ME	ME	1.0040	1.0027
12940	Baton Rouge, LA	MS	0.8253	0.8768
13020	Bay City, MI	MI	0.9189	0.9437
13644	Bethesda-Frederick-Rockville, MD	DC	1.0787	1.0532
13644	Bethesda-Frederick-Rockville, MD	PA	1.0784	1.0530
13644	Bethesda-Frederick-Rockville, MD	VA	1.0787	1.0532
13780	Binghamton, NY	PA	0.8757	0.9131
13820	Birmingham-Hoover, AL	AL	0.8494	0.8942
13980	Blacksburg-Christiansburg-Radford, VA	WV	0.7523	0.8229
14260	Boise City-Nampa, ID	ID	0.9128	0.9394
14484	Boston-Quincy, MA	MA	1.1581	1.1057
14484	Boston-Quincy, MA	RI	1.1581	1.1057
14600	Bradenton-Sarasota-Venice, FL	FL	0.9501	0.9656
14740	Bremerton-Silverdale, WA	WA	1.0497	1.0338
14860	Bridgeport-Stamford-Norwalk, CT	NY	1.2529	1.1670
15260	Brunswick, GA	GA	0.9505	0.9658
15380	Buffalo-Niagara Falls, NY	NY	0.9815	0.9873
15540	Burlington-South Burlington, VT	NY	1.0224	1.0153
15764	Cambridge-Newton-Framingham, MA	NH	1.0978	1.0660
15940	Canton-Massillon, OH	OH	0.8657	0.9060
16020	Cape Girardeau-Jackson, MO-IL	MO	0.8696	0.9088

CBSA Code	Area	State	Wage Index	GAF
16180	Carson City, NV	NV	1.0161	1.0110
16220	Casper, WY	SD	1.0170	1.0116
16580	Champaign-Urbana, IL	IL	0.9069	0.9353
16620	Charleston, WV	WV	0.8195	0.8726
16700	Charleston-North Charleston-Summerville, SC	SC	0.9198	0.9444
16740	Charlotte-Gastonia-Concord, NC-SC	NC	0.9334	0.9539
16740	Charlotte-Gastonia-Concord, NC-SC	SC	0.9332	0.9538
16820	Charlottesville, VA	VA	0.9155	0.9413
16860	Chattanooga, TN-GA	AL	0.8688	0.9082
16860	Chattanooga, TN-GA	GA	0.8688	0.9082
16860	Chattanooga, TN-GA	TN	0.8670	0.9069
16974	Chicago-Naperville-Joliet, IL	IL	1.0278	1.0190
16974	Chicago-Naperville-Joliet, IL	IN	1.0277	1.0189
16974	Chicago-Naperville-Joliet, IL	WI	1.0276	1.0188
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9409	0.9591
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9405	0.9589
17300	Clarksville, TN-KY	KY	0.8119	0.8670
17460	Cleveland-Elyria-Mentor, OH	OH	0.8938	0.9260
17660	Coeur d'Alene, ID	MT	0.9075	0.9357
17820	Colorado Springs, CO	CO	0.9674	0.9776
17860	Columbia, MO	MO	0.8456	0.8915
17900	Columbia, SC	SC	0.8858	0.9203
17980	Columbus, GA-AL	AL	0.8468	0.8924
17980	Columbus, GA-AL	GA	0.8468	0.8924
18140	Columbus, OH	OH	0.9830	0.9883
18580	Corpus Christi, TX	TX	0.8673	0.9071
18700	Corvallis, OR	OR	1.0476	1.0324
19124	Dallas-Plano-Irving, TX	TX	0.9620	0.9738
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8441	0.8904
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8659	0.9061
19380	Dayton, OH	OH	0.9235	0.9470
19460	Decatur, AL	AL	0.7751	0.8399
19740	Denver-Aurora-Broomfield, CO	CO	1.0403	1.0274
19780	Des Moines-West Des Moines, IA	IA	0.9523	0.9671
19804	Detroit-Livonia-Dearborn, MI	MI	0.9869	0.9910
20100	Dover, DE	DE	1.0013	1.0009
20260	Duluth, MN-WI	MN	1.0659	1.0447
20500	Durham-Chapel Hill, NC	NC	0.9525	0.9672
20500	Durham-Chapel Hill, NC	VA	0.9525	0.9672
20764	Edison-New Brunswick, NJ	NJ	1.1349	1.0905
21060	Elizabethtown, KY	KY	0.8091	0.8650

CBSA Code	Area	State	Wage Index	GAF
21140	Elkhart-Goshen, IN	IN	0.9478	0.9640
21500	Erie, PA	NY	0.8379	0.8859
21660	Eugene-Springfield, OR	OR	1.1073	1.0723
21780	Evansville, IN-KY	IN	0.8506	0.8951
21780	Evansville, IN-KY	KY	0.8163	0.8702
22020	Fargo, ND-MN	ND	0.8289	0.8794
22020	Fargo, ND-MN	SD	0.8303	0.8804
22180	Fayetteville, NC	NC	0.9325	0.9533
22220	Fayetteville-Springdale-Rogers, AR-MO	OK	0.8788	0.9153
22380	Flagstaff, AZ	AZ	1.1906	1.1269
22420	Flint, MI	MI	1.0709	1.0480
22540	Fond du Lac, WI	WI	0.9656	0.9763
22660	Fort Collins-Loveland, CO	CO	0.9828	0.9882
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0394	1.0268
23020	Fort Walton Beach-Crestview-Destin, FL	FL	0.8607	0.9024
23060	Fort Wayne, IN	IN	0.8964	0.9278
23104	Fort Worth-Arlington, TX	TX	0.9448	0.9619
23540	Gainesville, FL	FL	0.9212	0.9453
23844	Gary, IN	IN	0.9222	0.9460
24300	Grand Junction, CO	CO	0.9868	0.9909
24340	Grand Rapids-Wyoming, MI	MI	0.9309	0.9521
24500	Great Falls, MT	MT	0.8377	0.8858
24540	Greeley, CO	NE	0.9454	0.9623
24540	Greeley, CO	WY	0.9454	0.9623
24580	Green Bay, WI	MI	0.9340	0.9543
24580	Green Bay, WI	WI	0.9338	0.9542
24660	Greensboro-High Point, NC	NC	0.9029	0.9324
24780	Greenville, NC	NC	0.9255	0.9484
24860	Greenville-Mauldin-Easley, SC	NC	0.9268	0.9493
24860	Greenville-Mauldin-Easley, SC	SC	0.9266	0.9491
25060	Gulfport-Biloxi, MS	MS	0.8312	0.8811
25180	Hagerstown-Martinsburg, MD-WV	PA	0.9189	0.9437
25420	Harrisburg-Carlisle, PA	PA	0.9199	0.9444
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1355	1.0909
25540	Hartford-West Hartford-East Hartford, CT	MA	1.1226	1.0824
25860	Hickory-Lenoir-Morganton, NC	NC	0.8751	0.9127
26300	Hot Springs, AR	AR	0.8986	0.9294
26420	Houston-Sugar Land-Baytown, TX	TX	0.9939	0.9958
26580	Huntington-Ashland, WV-KY-OH	KY	0.8759	0.9133
26580	Huntington-Ashland, WV-KY-OH	OH	0.8754	0.9129

CBSA Code	Area	State	Wage Index	GAF
26580	Huntington-Ashland, WV-KY-OH	WV	0.8749	0.9125
26620	Huntsville, AL	AL	0.8570	0.8997
26620	Huntsville, AL	TN	0.8552	0.8984
26820	Idaho Falls, ID	ID	0.9432	0.9607
26900	Indianapolis-Carmel, IN	IN	0.9669	0.9772
26980	Iowa City, IA	IA	0.9279	0.9500
27060	Ithaca, NY	NY	0.9275	0.9498
27140	Jackson, MS	MS	0.8204	0.8732
27180	Jackson, TN	MS	0.8422	0.8890
27260	Jacksonville, FL	FL	0.9117	0.9387
27620	Jefferson City, MO	MO	0.8882	0.9220
27860	Jonesboro, AR	AR	0.7808	0.8441
27900	Joplin, MO	KS	0.8499	0.8946
27900	Joplin, MO	OK	0.8499	0.8946
28020	Kalamazoo-Portage, MI	MI	0.9915	0.9942
28140	Kansas City, MO-KS	MO	0.9576	0.9708
28420	Kennewick-Pasco-Richland, WA	ID	1.0004	1.0003
28420	Kennewick-Pasco-Richland, WA	WA	1.0133	1.0091
28700	Kingsport-Bristol-Bristol, TN-VA	KY	0.8111	0.8664
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.8094	0.8652
28940	Knoxville, TN	KY	0.7964	0.8556
28940	Knoxville, TN	TN	0.7894	0.8505
29180	Lafayette, LA	LA	0.8581	0.9005
29404	Lake County-Kenosha County, IL-WI	IL	1.0410	1.0279
29460	Lakeland-Winter Haven, FL	FL	0.8607	0.9024
29540	Lancaster, PA	PA	0.9480	0.9641
29620	Lansing-East Lansing, MI	MI	0.9477	0.9639
29740	Las Cruces, NM	NM	0.8968	0.9281
29820	Las Vegas-Paradise, NV	AZ	1.1534	1.1027
29820	Las Vegas-Paradise, NV	UT	1.1534	1.1027
30020	Lawton, OK	OK	0.7937	0.8537
30460	Lexington-Fayette, KY	KY	0.8745	0.9123
30620	Lima, OH	OH	0.9337	0.9541
30700	Lincoln, NE	NE	0.9210	0.9452
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8450	0.8911
30980	Longview, TX	TX	0.8218	0.8742
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.1769	1.1180
31140	Louisville-Jefferson County, KY-IN	KY	0.8916	0.9244
31420	Macon, GA	GA	0.9876	0.9915
31540	Madison, WI	WI	1.1008	1.0680
31700	Manchester-Nashua, NH	NH	1.0532	1.0361

CBSA Code	Area	State	Wage Index	GAF
31900	Mansfield, OH	OH	0.9087	0.9365
32780	Medford, OR	OR	1.0255	1.0174
32820	Memphis, TN-MS-AR	AR	0.8950	0.9268
32820	Memphis, TN-MS-AR	MS	0.8950	0.9268
32820	Memphis, TN-MS-AR	TN	0.8931	0.9255
33124	Miami-Miami Beach-Kendall, FL	FL	1.0043	1.0029
33260	Midland, TX	TX	0.9361	0.9558
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0044	1.0030
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.0964	1.0651
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.0962	1.0649
33540	Missoula, MT	MT	0.8940	0.9261
33660	Mobile, AL	AL	0.7746	0.8395
33700	Modesto, CA	CA	1.2363	1.1563
33740	Monroe, LA	AR	0.7937	0.8537
33740	Monroe, LA	LA	0.7937	0.8537
33780	Monroe, MI	OH	0.9971	0.9980
33860	Montgomery, AL	AL	0.8472	0.8927
34060	Morgantown, WV	WV	0.8585	0.9008
34740	Muskegon-Norton Shores, MI	MI	0.9384	0.9574
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	NC	0.8597	0.9017
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	SC	0.8508	0.8953
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	KY	0.9363	0.9559
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9344	0.9546
35004	Nassau-Suffolk, NY	CT	1.2380	1.1574
35084	Newark-Union, NJ-PA	NJ	1.1349	1.0905
35084	Newark-Union, NJ-PA	NY	1.1246	1.0837
35084	Newark-Union, NJ-PA	PA	1.1243	1.0835
35380	New Orleans-Metairie-Kenner, LA	LA	0.9026	0.9322
35644	New York-White Plains-Wayne, NY-NJ	CT	1.2865	1.1883
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.2684	1.1768
35644	New York-White Plains-Wayne, NY-NJ	NY	1.2867	1.1884
35980	Norwich-New London, CT	RI	1.1580	1.1057
36084	Oakland-Fremont-Hayward, CA	CA	1.5801	1.3679
36140	Ocean City, NJ	DE	1.0417	1.0284
36220	Odessa, TX	NM	0.9339	0.9542
36220	Odessa, TX	TX	0.9361	0.9558
36260	Ogden-Clearfield, UT	UT	0.9428	0.9605
36420	Oklahoma City, OK	OK	0.8679	0.9075
36500	Olympia, WA	WA	1.1190	1.0800
36740	Orlando-Kissimmee, FL	FL	0.8979	0.9289
37460	Panama City-Lynn Haven-Panama City Beach, FL	AL	0.8332	0.8825

CBSA Code	Area	State	Wage Index	GAF
37700	Pascagoula, MS	AL	0.8168	0.8706
37764	Peabody, MA	NH	1.0765	1.0518
37860	Pensacola-Ferry Pass-Brent, FL	AL	0.8183	0.8717
37900	Peoria, IL	IL	0.9239	0.9472
37964	Philadelphia, PA	DE	1.0544	1.0369
37964	Philadelphia, PA	NJ	1.1349	1.0905
37964	Philadelphia, PA	PA	1.0541	1.0367
38220	Pine Bluff, AR	MS	0.7778	0.8419
38300	Pittsburgh, PA	OH	0.8573	0.8999
38300	Pittsburgh, PA	PA	0.8575	0.9001
38300	Pittsburgh, PA	WV	0.8567	0.8995
38340	Pittsfield, MA	NY	1.0277	1.0189
38340	Pittsfield, MA	VT	1.0277	1.0189
38860	Portland-South Portland-Biddeford, ME	ME	0.9759	0.9834
38900	Portland-Vancouver-Beaverton, OR-WA	OR	1.1217	1.0818
38900	Portland-Vancouver-Beaverton, OR-WA	WA	1.1226	1.0824
38940	Port St. Lucie, FL	FL	0.9776	0.9846
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.1010	1.0681
39140	Prescott, AZ	AZ	1.0383	1.0261
39340	Provo-Orem, UT	UT	0.9458	0.9626
39580	Raleigh-Cary, NC	NC	0.9534	0.9678
39740	Reading, PA	PA	0.8996	0.9301
39820	Redding, CA	CA	1.3431	1.2239
39900	Reno-Sparks, NV	NV	1.0285	1.0194
40060	Richmond, VA	VA	0.9382	0.9573
40140	Riverside-San Bernardino-Ontario, CA	AZ	1.1098	1.0739
40220	Roanoke, VA	VA	0.8702	0.9092
40220	Roanoke, VA	WV	0.8692	0.9085
40380	Rochester, NY	NY	0.8743	0.9121
40420	Rockford, IL	IL	1.0015	1.0010
40484	Rockingham County-Strafford County, NH	ME	1.0221	1.0151
40660	Rome, GA	AL	0.8677	0.9074
40900	Sacramento--Arden-Arcade--Roseville, CA	CA	1.3320	1.2169
41060	St. Cloud, MN	MN	1.0789	1.0534
41100	St. George, UT	UT	0.9400	0.9585
41180	St. Louis, MO-IL	IL	0.8947	0.9266
41180	St. Louis, MO-IL	MO	0.8947	0.9266
41620	Salt Lake City, UT	UT	0.9465	0.9630
41700	San Antonio, TX	TX	0.8913	0.9242
41884	San Francisco-San Mateo-Redwood City, CA	CA	1.5557	1.3534
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.5998	1.3796

CBSA Code	Area	State	Wage Index	GAF
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.1660	1.1109
42100	Santa Cruz-Watsonville, CA	CA	1.5905	1.3741
42140	Santa Fe, NM	NM	1.0159	1.0109
42220	Santa Rosa-Petaluma, CA	CA	1.5070	1.3243
42340	Savannah, GA	GA	0.8980	0.9290
42340	Savannah, GA	SC	0.8977	0.9288
42644	Seattle-Bellevue-Everett, WA	WA	1.1253	1.0842
43300	Sherman-Denison, TX	OK	0.8451	0.8911
43340	Shreveport-Bossier City, LA	LA	0.8476	0.8929
43580	Sioux City, IA-NE-SD	NE	0.8567	0.8995
43620	Sioux Falls, SD	SD	0.9054	0.9342
43780	South Bend-Mishawaka, IN-MI	IN	0.9333	0.9538
43900	Spartanburg, SC	SC	0.9001	0.9305
44060	Spokane, WA	ID	1.0259	1.0177
44100	Springfield, IL	IL	0.9336	0.9540
44180	Springfield, MO	AR	0.8190	0.8722
44180	Springfield, MO	MO	0.8190	0.8722
44300	State College, PA	PA	0.8375	0.8856
44940	Sumter, SC	SC	0.8380	0.8860
45060	Syracuse, NY	NY	0.9504	0.9658
45220	Tallahassee, FL	GA	0.8208	0.8735
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.9020	0.9318
45460	Terre Haute, IN	IN	0.8512	0.8955
45500	Texarkana, TX-Texarkana, AR	AR	0.8165	0.8704
45780	Toledo, OH	OH	0.9295	0.9512
45820	Topeka, KS	KS	0.8812	0.9170
46140	Tulsa, OK	OK	0.8770	0.9140
46220	Tuscaloosa, AL	MS	0.8414	0.8885
46340	Tyler, TX	TX	0.8461	0.8919
46700	Vallejo-Fairfield, CA	CA	1.4503	1.2899
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8943	0.9264
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0716	1.0485
48140	Wausau, WI	WI	0.9481	0.9642
48620	Wichita, KS	KS	0.8720	0.9105
48620	Wichita, KS	OK	0.8721	0.9105
48700	Williamsport, PA	PA	0.8375	0.8856
48864	Wilmington, DE-MD-NJ	DE	1.0648	1.0439
48864	Wilmington, DE-MD-NJ	NJ	1.1349	1.0905
48900	Wilmington, NC	SC	0.9136	0.9400
49180	Winston-Salem, NC	NC	0.9019	0.9317
49180	Winston-Salem, NC	VA	0.9019	0.9317

CBSA Code	Area	State	Wage Index	GAF
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8531	0.8969
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8388	0.8866
04	Arkansas	AR	0.7576	0.8269
05	California	CA	1.1660	1.1109
07	Connecticut	CT	1.1927	1.1283
10	Florida	FL	0.8607	0.9024
14	Illinois	IL	0.8317	0.8814
14	Illinois	MO	0.8317	0.8814
16	Iowa	MO	0.8676	0.9073
17	Kansas	KS	0.8192	0.8723
18	Kentucky	KY	0.7964	0.8556
22	Massachusetts	MA	1.0373	1.0254
23	Michigan	MI	0.8806	0.9166
24	Minnesota	IA	0.9272	0.9496
25	Mississippi	MS	0.7728	0.8382
26	Missouri	AR	0.8176	0.8712
26	Missouri	MO	0.8176	0.8712
30	New Hampshire	VT	1.0014	1.0010
33	New York	NY	0.8379	0.8859
34	North Carolina	TN	0.8579	0.9004
36	Ohio	OH	0.8531	0.8969
37	Oklahoma	OK	0.7800	0.8435
38	Oregon	OR	1.0255	1.0174
39	Pennsylvania	PA	0.8375	0.8856
44	Tennessee	KY	0.7964	0.8556
45	Texas	TX	0.7954	0.8549
47	Vermont	NY	0.9417	0.9597
49	Virginia	KY	0.8112	0.8665
49	Virginia	VA	0.8112	0.8665
50	Washington	WA	1.0133	1.0091
53	Wyoming	NE	0.9190	0.9438

TABLE 4D-1.—RURAL FLOOR BUDGET NEUTRALITY FACTORS FOR ACUTE CARE HOSPITALS—FY 2010

[*For FY 2010, hospitals will receive a rural floor budget neutrality adjustment factor that blended this factor (weighted at 50 percent) and a nationwide factor (50 percent).]

State	Rural Floor Budget Neutrality Adjustment Factor
Alabama	0.99875
Alaska	0.99875
Arizona	0.99875
Arkansas	0.99875
California	0.99506
Colorado	0.99401
Connecticut	0.99860
Delaware	0.99875
Washington, D.C.	0.99875
Florida	0.99798
Georgia	0.99875
Hawaii	0.99875
Idaho	0.99875
Illinois	0.99875
Indiana	0.99861
Iowa	0.99678
Kansas	0.99866
Kentucky	0.99872
Louisiana	0.99875
Maine	0.99875
Maryland	------
Massachusetts	0.99875
Michigan	0.99875
Minnesota	0.99875
Mississippi	0.99875
Missouri	0.99875
Montana	0.99875
Nebraska	0.99875
Nevada	0.99875
New Hampshire	0.99742
New Jersey**	0.98457
New Mexico	0.99633
New York	0.99875
North Carolina	0.99874

State	Rural Floor Budget Neutrality Adjustment Factor
North Dakota	0.99715
Ohio	0.99823
Oklahoma	0.99875
Oregon	0.99755
Pennsylvania	0.99848
Puerto Rico	0.99875
Rhode Island	0.99875
South Carolina	0.99849
South Dakota	0.99875
Tennessee	0.99664
Texas	0.99872
Utah	0.99875
Vermont	0.99875
Virginia	0.99875
Washington	0.99832
West Virginia	0.99755
Wisconsin	0.99851
Wyoming	0.99875

* 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.]

CBSA Code	Urban Area	State*	Rural or Imputed Floor Wage Index
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1349
12100	Atlantic City-Hammonton, NJ	NJ	1.1349
12540	Bakersfield, CA	CA	1.1660
13900	Bismarck, ND	ND	0.7981
15804	Camden, NJ	NJ	1.1349
16940	Cheyenne, WY	WY	0.9360
17020	Chico, CA	CA	1.1660
17420	Cleveland, TN	TN	0.7894
17820	Colorado Springs, CO	CO	0.9674
19060	Cumberland, MD-WV	MD	0.9259
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8659
19500	Decatur, IL	IL	0.8317
20220	Dubuque, IA	IA	0.8659
20764	Edison-New Brunswick, NJ	NJ	1.1349
20940	El Centro, CA	CA	1.1660
21780	Evansville, IN-KY	IN	0.8506
21820	Fairbanks, AK	AK	1.1652
22020	Fargo, ND-MN	MN	0.9290
22140	Farmington, NM	NM	0.8968
22500	Florence, SC	SC	0.8380
23420	Fresno, CA	CA	1.1660
24220	Grand Forks, ND-MN	MN	0.9290
24540	Greeley, CO	CO	0.9674
25180	Hagerstown-Martinsburg, MD-WV	MD	0.9259
25260	Hanford-Corcoran, CA	CA	1.1660
27100	Jackson, MI	MI	0.8806
27340	Jacksonville, NC	NC	0.8597
27740	Johnson City, TN	TN	0.7894
28700	Kingsport-Bristol-Bristol, TN-VA	VA	0.8112
28940	Knoxville, TN	TN	0.7894
29460	Lakeland-Winter Haven, FL	FL	0.8607
29740	Las Cruces, NM	NM	0.8968

CBSA Code	Urban Area	State*	Rural or Imputed Floor Wage Index
30300	Lewiston, ID-WA	WA	1.0133
31460	Madera-Chowchilla, CA	CA	1.1660
31700	Manchester-Nashua, NH	NH	1.0532
31740	Mahattan, KS	KS	0.8192
32780	Medford, OR	OR	1.0255
32900	Merced, CA	CA	1.1660
34100	Morristown, TN	TN	0.7894
34620	Muncie, IN	IN	0.8506
35084	Newark-Union, NJ-PA	NJ	1.1349
36140	Ocean City, NJ	NJ	1.1349
36780	Oshkosh-Neenah, WI	WI	0.9237
37460	Panama City-Lynn Haven-Panama City Beac	FL	0.8607
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8531
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8607
39380	Pueblo, CO	CO	0.9674
40140	Riverside-San Bernardino-Ontario, CA	CA	1.1660
40484	Rockingham County-Strafford County, NH	NH	1.0532
41540	Salisbury, MD	MD	0.9259
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.1660
42540	Scranton--Wilkes-Barre, PA	PA	0.8375
45220	Tallahassee, FL	FL	0.8607
45940	Trenton-Ewing, NJ	NJ	1.1349
47020	Victoria, TX	TX	0.7954
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1349
47300	Visalia-Porterville, CA	CA	1.1660
47940	Waterloo-Cedar Falls, IA	IA	0.8659
48260	Weirton-Steubenville, WV-OH	OH	0.8531
48260	Weirton-Steubenville, WV-OH	WV	0.7480
48300	Wenatchee-East Wenatchee, WA	WA	1.0133
48540	Wheeling, WV-OH	OH	0.8531
48540	Wheeling, WV-OH	WV	0.7480
48700	Williamsport, PA	PA	0.8375
48864	Wilmington, DE-MD-NJ	NJ	1.1349
49420	Yakima, WA	WA	1.0133
49700	Yuba City, CA	CA	1.1660

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

CBSA Code	Urban Area (Constituent Counties)
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

CBSA Code	Urban Area (Constituent Counties)
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

[1] Large urban area.

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 will automatically assume that hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act wish to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Section 1886(d)(10) hospitals that wish to receive the out-migration adjustment, rather than their reclassification, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this proposed rule. Otherwise, they will be deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8)(B) of the Act will be deemed to have waived the out-migration adjustment, unless they explicitly notify CMS that they elected to receive the out-migration adjustment instead within 45 days from the publication of this proposed rule. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attn.: Wage Index Adjustment Waivers, Division of Acute Care, Room C4-08-06, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Provider Number	Reclassified for FY 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	*	0.0390	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

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
010049		0.0026	COFFEE	01150
010052	*	0.0246	TALLAPOOSA	01610
010059	*	0.0071	LAWRENCE	01390
010061	*	0.0542	JACKSON	01350
010065	*	0.0246	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	*	0.1000	HOT SPRING	04290
040081		0.0357	PIKE	04540
040149		0.0199	WHITE	04720
050002	*	0.0010	ALAMEDA	05000
050007		0.0146	SAN MATEO	05510
050009	*	0.0180	NAPA	05380
050013	*	0.0180	NAPA	05380
050014	*	0.0139	AMADOR	05020
050016		0.0092	SAN LUIS OBISPO	05500
050042	*	0.0162	TEHAMA	05620
050043	*	0.0010	ALAMEDA	05000
050069	*	0.0013	ORANGE	05400
050070		0.0146	SAN MATEO	05510

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
050073	*	0.0171	SOLANO	05580
050075	*	0.0010	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
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	*	0.0010	ALAMEDA	05000
050197	*	0.0146	SAN MATEO	05510
050211	*	0.0010	ALAMEDA	05000
050224	*	0.0013	ORANGE	05400
050226	*	0.0013	ORANGE	05400
050230	*	0.0013	ORANGE	05400
050232		0.0092	SAN LUIS OBISPO	05500
050245	*	0.0011	SAN BERNARDINO	05460
050264	*	0.0010	ALAMEDA	05000
050272	*	0.0011	SAN BERNARDINO	05460
050279	*	0.0011	SAN BERNARDINO	05460
050283	*	0.0010	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	*	0.0010	ALAMEDA	05000
050313		0.0132	SAN JOAQUIN	05490
050320	*	0.0010	ALAMEDA	05000
050325		0.0033	TUOLUMNE	05650
050327	*	0.0011	SAN BERNARDINO	05460

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
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
050476	*	0.0278	LAKE	05160
050488	*	0.0010	ALAMEDA	05000
050506		0.0092	SAN LUIS OBISPO	05500
050512	*	0.0010	ALAMEDA	05000
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
050633		0.0092	SAN LUIS OBISPO	05500
050667	*	0.0180	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

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
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
070003	*	0.0037	WINDHAM	07070
070004	*	0.0075	LITCHFIELD	07020
070006	*	0.0045	FAIRFIELD	07000
070010	*	0.0045	FAIRFIELD	07000
070011	*	0.0075	LITCHFIELD	07020
070015	*	0.0075	LITCHFIELD	07020
070018	*	0.0045	FAIRFIELD	07000
070020		0.0045	MIDDLESEX	07030
070021	*	0.0037	WINDHAM	07070
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
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

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
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		0.0790	JEFFERSON	11620
110101		0.0067	COOK	11311
110142		0.0185	EVANS	11441
110146	*	0.0393	CAMDEN	11170
110150	*	0.0227	BALDWIN	11030
110187	*	0.0643	LUMPKIN	11701
110189	*	0.0066	FANNIN	11450
110190		0.0241	MACON	11710
110205		0.0507	GILMER	11471
130003	*	0.0235	NEZ PERCE	13340
130024		0.0675	BONNER	13080
130049	*	0.0319	KOOTENAI	13270
130066		0.0319	KOOTENAI	13270
130067	*	0.0725	BINGHAM	13050
140001		0.0369	FULTON	14370
140026		0.0315	LA SALLE	14580
140043	*	0.0056	WHITESIDE	14988
140058	*	0.0126	MORGAN	14770
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	*	0.0050	HUNTINGTON	15340
150102	*	0.0108	STARKE	15740
150113	*	0.0111	MADISON	15470

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
150133	*	0.0193	KOSCIUSKO	15420
150146	*	0.0090	NOBLE	15560
160013		0.0179	MUSCATINE	16690
160030		0.0013	STORY	16840
160032		0.0235	JASPER	16490
160080	*	0.0066	CLINTON	16220
170040		0.0000	WYANDOTTE	17986
170137	*	0.0421	DOUGLAS	17220
170146		0.0000	WYANDOTTE	17986
170150		0.0166	COWLEY	17170
180012	*	0.0080	HARDIN	18460
180017	*	0.0035	BARREN	18040
180049	*	0.0488	MADISON	18750
180064		0.0314	MONTGOMERY	18860
180066	*	0.0439	LOGAN	18700
180070		0.0240	GRAYSON	18420
180079		0.0259	HARRISON	18480
190003	*	0.0085	IBERIA	19220
190015	*	0.0243	TANGIPAHOA	19520
190017	*	0.0187	ST. LANDRY	19480
190034		0.0189	VERMILION	19560
190044		0.0261	ACADIA	19000
190050		0.0044	BEAUREGARD	19050
190053		0.0101	JEFFRSON DAVIS	19260
190054		0.0085	IBERIA	19220
190078		0.0187	ST. LANDRY	19480
190086	*	0.0061	LINCOLN	19300
190088	*	0.0387	WEBSTER	19590
190099		0.0189	AVOYELLES	19040
190106	*	0.0102	ALLEN	19010
190116		0.0085	MOREHOUSE	19330
190133		0.0102	ALLEN	19010
190140		0.0035	FRANKLIN	19200
190144	*	0.0387	WEBSTER	19590
190145		0.0090	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

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
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
220176	*	0.0072	WORCESTER	22170
230002	*	0.0027	WAYNE	23810
230003	*	0.0220	OTTAWA	23690
230005		0.0473	LENAWEE	23450
230013	*	0.0025	OAKLAND	23620
230015		0.0295	ST. JOSEPH	23740
230019	*	0.0025	OAKLAND	23620
230020	*	0.0027	WAYNE	23810

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
230021	*	0.0101	BERRIEN	23100
230022	*	0.0212	BRANCH	23110
230024	*	0.0027	WAYNE	23810
230029	*	0.0025	OAKLAND	23620
230035	*	0.0095	MONTCALM	23580
230037	*	0.0210	HILLSDALE	23290
230041		0.0052	BAY	23080
230047	*	0.0021	MACOMB	23490
230053	*	0.0027	WAYNE	23810
230069	*	0.0210	LIVINGSTON	23460
230071	*	0.0025	OAKLAND	23620
230072	*	0.0220	OTTAWA	23690
230075		0.0047	CALHOUN	23120
230078	*	0.0101	BERRIEN	23100
230089	*	0.0027	WAYNE	23810
230092	*	0.0223	JACKSON	23370
230093		0.0058	MECOSTA	23530
230096	*	0.0295	ST. JOSEPH	23740
230099	*	0.0231	MONROE	23570
230104	*	0.0027	WAYNE	23810
230121	*	0.0678	SHIAWASSEE	23770
230130	*	0.0025	OAKLAND	23620
230135	*	0.0027	WAYNE	23810
230142	*	0.0027	WAYNE	23810
230146	*	0.0027	WAYNE	23810
230151	*	0.0025	OAKLAND	23620
230165	*	0.0027	WAYNE	23810
230174	*	0.0220	OTTAWA	23690
230176	*	0.0027	WAYNE	23810
230195	*	0.0021	MACOMB	23490
230204	*	0.0021	MACOMB	23490
230207	*	0.0025	OAKLAND	23620
230208	*	0.0095	MONTCALM	23580
230217		0.0047	CALHOUN	23120
230222	*	0.0035	MIDLAND	23550
230227	*	0.0021	MACOMB	23490
230244	*	0.0027	WAYNE	23810
230254	*	0.0025	OAKLAND	23620
230257	*	0.0021	MACOMB	23490
230264	*	0.0021	MACOMB	23490
230269	*	0.0025	OAKLAND	23620

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
230270	*	0.0027	WAYNE	23810
230273	*	0.0027	WAYNE	23810
230277	*	0.0025	OAKLAND	23620
230279	*	0.0210	LIVINGSTON	23460
230297	*	0.0027	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		0.0300	JOHNSON	26500
260116	*	0.0087	ST. FRANCOIS	26930
260160		0.0144	STODDARD	26985
260163		0.0087	ST. FRANCOIS	26930
280077	*	0.0080	DODGE	28260
290002	*	0.0277	LYON	29090
300011	*	0.0049	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
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

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
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	*	0.0480	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		0.0260	CORTLAND	33210
330181	*	0.0123	NASSAU	33400
330182	*	0.0123	NASSAU	33400
330191	*	0.0017	WARREN	33750
330198	*	0.0123	NASSAU	33400
330205		0.0642	ORANGE	33540
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

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
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	*	0.0250	DAVIDSON	34280
340096	*	0.0250	DAVIDSON	34280
340104		0.0162	CLEVELAND	34220
340114	*	0.0015	WAKE	34910
340126	*	0.0100	WILSON	34970
340129	*	0.0101	IREDELL	34480
340133		0.0260	MARTIN	34580
340138	*	0.0015	WAKE	34910
340144	*	0.0101	IREDELL	34480
340145	*	0.0336	LINCOLN	34540
340151		0.0052	HALIFAX	34410
340173	*	0.0015	WAKE	34910
360002		0.0141	ASHLAND	36020
360010	*	0.0074	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0077	ERIE	36220
360036	*	0.0126	WAYNE	36860
360040		0.0387	KNOX	36430
360044		0.0127	DARKE	36190
360055	*	0.0015	TRUMBULL	36790
360065	*	0.0075	HURON	36400
360070		0.0005	STARK	36770
360071		0.0035	VAN WERT	36820
360084		0.0005	STARK	36770

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
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		0.0015	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		0.0090	STEPHENS	37680
370065		0.0096	CRAIG	37170
370072		0.0258	LATIMER	37380
370083		0.0051	PUSHMATAHA	37630
370100		0.0100	CHOCTAW	37110
370149	*	0.0302	POTTAWATOMIE	37620
370156		0.0121	GARVIN	37240
370169		0.0163	MCINTOSH	37450
370172		0.0258	LATIMER	37380
370214		0.0121	GARVIN	37240
380022	*	0.0067	LINN	38210
390008		0.0060	LAWRENCE	39450
390016	*	0.0060	LAWRENCE	39450
390030	*	0.0149	SCHUYLKILL	39650
390031	*	0.0149	SCHUYLKILL	39650
390039		0.0036	SOMERSET	39680
390044	*	0.0191	BERKS	39110
390052		0.0047	CLEARFIELD	39230
390056		0.0036	HUNTINGDON	39380
390065	*	0.0532	ADAMS	39000
390066	*	0.0372	LEBANON	39460
390079	*	0.0003	BRADFORD	39130
390086	*	0.0047	CLEARFIELD	39230
390096	*	0.0191	BERKS	39110
390110	*	0.0003	CAMBRIA	39160
390112		0.0036	SOMERSET	39680
390113	*	0.0053	CRAWFORD	39260

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
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		0.0034	INDIANA	39390
390183	*	0.0149	SCHUYLKILL	39650
390201	*	0.1170	MONROE	39550
390236		0.0003	BRADFORD	39130
390313	*	0.0149	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	*	0.0110	UNION	42430
420043		0.0157	CHEROKEE	42100
420053		0.0035	NEWBERRY	42350
420054		0.0002	MARLBORO	42340
420062	*	0.0128	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
440017		0.0009	SULLIVAN	44810

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
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
440070		0.0109	DECATUR	44190
440081		0.0052	SEVIER	44770
440084		0.0025	MONROE	44610
440109		0.0070	HARDIN	44350
440115		0.0338	GIBSON	44260
440137		0.0738	BEDFORD	44010
440144	*	0.0219	COFFEE	44150
440148	*	0.0296	DE KALB	44200
440174	*	0.0312	HAYWOOD	44370
440176		0.0009	SULLIVAN	44810
440180		0.0027	CAMPBELL	44060
440181		0.0365	HARDEMAN	44340
440182		0.0144	CARROLL	44080
440185	*	0.0230	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		0.0650	COOKE	45340
450099	*	0.0145	GRAY	45563
450135	*	0.0024	TARRANT	45910
450137	*	0.0024	TARRANT	45910
450144	*	0.0559	ANDREWS	45010
450163		0.0054	KLEBERG	45743
450192		0.0271	HILL	45651
450194		0.0213	CHEROKEE	45281
450210		0.0151	PANOLA	45842
450224	*	0.0195	WOOD	45974
450236		0.0389	HOPKINS	45654
450270		0.0271	HILL	45651

Provider Number	Reclassified for FY 2010	Out-Migration Adjustment	Qualifying County Name	County Code
450283	*	0.0653	VAN ZANDT	45947
450347	*	0.0370	WALKER	45949
450348	*	0.0059	FALLS	45500
450370	*	0.0235	COLORADO	45312
450389	*	0.0618	HENDERSON	45640
450395		0.0441	POLK	45850
450419	*	0.0024	TARRANT	45910
450438	*	0.0235	COLORADO	45312
450451		0.0536	SOMERVELL	45893
450460		0.0053	TYLER	45942
450497		0.0375	MONTAGUE	45800
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
490019	*	0.1088	CULPEPER	49230
490084		0.0187	ESSEX	49280
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	*	0.0020	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
670042		0.0024	TARRANT	45910
670046		0.0024	TARRANT	45910

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 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
001	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	25.1254	31 5	43.4
002	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	12.0884	16.6	21.5
003	Yes	No	PRE	SURG	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.1456	31.4	38.0
004	Yes	No	PRE	SURG	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O R.	11.1452	22.9	28.0
005	No	No	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.7983	16.0	21.4
006	No	No	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.9885	9.2	10.2
007	No	No	PRE	SURG	LUNG TRANSPLANT	9.9992	15.7	18.8
008	No	No	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.1271	10.4	12.3
009	No	No	PRE	SURG	BONE MARROW TRANSPLANT	6.5861	17.6	21.2
010	No	No	PRE	SURG	PANCREAS TRANSPLANT	4.3277	8.9	10.0
011	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	4.7416	12.7	16.2
012	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	3.0445	8.7	10.5
013	No	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	1.8803	5.7	6.9
020	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	8.5124	14.8	18.2
021	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	6.2533	12.2	14.4
022	No	No	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	4.4148	7.6	9.0
023	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	4.9609	8.5	12.1
024	No	No	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.2814	5.7	8.1
025	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.8502	9.4	12.1
026	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	2.9745	6.1	7.8
027	Yes	No	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.1122	3.2	4.1
028	Yes	Yes	01	SURG	SPINAL PROCEDURES W MCC	5.1273	10.3	13.4
029	Yes	Yes	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	2.7970	4.8	6.7
030	Yes	Yes	01	SURG	SPINAL PROCEDURES W/O CC/MCC	1.6100	2.6	3.5
031	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.5792	9.1	13.2
032	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	1.9276	3.7	5.5
033	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.3419	2.2	2.8
034	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.2190	4.4	6.9
035	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.0329	2.0	2.9

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
036	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.5909	1.3	1.6
037	No	No	01	SURG	EXTRACRANIAL PROCEDURES W MCC	2.9314	5.7	8.3
038	No	No	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.4948	2.4	3.5
039	No	No	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.0165	1.4	1.7
040	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.9326	9.4	12.8
041	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.1224	5.2	7.0
042	Yes	Yes	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.6557	2.4	3.3
052	No	No	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.4801	4.5	6.3
053	No	No	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.8417	3.1	4.0
054	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.5593	4.9	6.7
055	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0575	3.6	4.8
056	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	1.6778	5.7	7.6
057	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	0.8967	3.8	4.9
058	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.5423	5.8	7.8
059	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	0.9514	4.1	5.0
060	No	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.7096	3.2	3.8
061	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	2.9267	6.5	8.7
062	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	1.9476	5.0	5.9
063	No	No	01	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	1.5337	3.7	4.2
064	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8203	5.3	7.2
065	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	1.1542	4.1	5.0
066	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.8222	2.9	3.5
067	No	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.3313	4.3	5.5
068	No	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8544	2.7	3.4
069	No	No	01	MED	TRANSIENT ISCHEMIA	0.7265	2.4	2.9
070	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.7775	5.6	7.4
071	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0983	4.1	5.2
072	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7558	2.6	3.3
073	No	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.2888	4.5	6 0
074	No	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.8328	3.3	4.1
075	No	No	01	MED	VIRAL MENINGITIS W CC/MCC	1.6705	5.7	7.3
076	No	No	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.8357	3.3	3 9

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
077	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.6279	5.3	6.6
078	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	0.9766	3.6	4.3
079	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7349	2.7	3.2
080	No	No	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.1382	3.7	5.0
081	No	No	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.7071	2.7	3.4
082	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.0129	3.7	6.3
083	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.3124	3.7	4.9
084	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.8583	2.2	2.9
085	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.0601	5.3	7.4
086	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.2097	3.8	4.9
087	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.7841	2.4	3.1
088	No	No	01	MED	CONCUSSION W MCC	1.4406	4.2	5.5
089	No	No	01	MED	CONCUSSION W CC	0.9203	2.9	3.7
090	No	No	01	MED	CONCUSSION W/O CC/MCC	0.6775	1.9	2.4
091	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.5367	4.5	6.2
092	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9101	3.4	4.3
093	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.6670	2.4	3.0
094	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.4117	9.0	11.7
095	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.2460	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	3.0065	9.1	11.5
098	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.8032	6.3	8.0
099	No	No	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2030	4.5	5.4
100	Yes	No	01	MED	SEIZURES W MCC	1.4734	4.5	6.1
101	Yes	No	01	MED	SEIZURES W/O MCC	0.7533	2.8	3.5
102	No	No	01	MED	HEADACHES W MCC	0.9685	3.2	4.4
103	No	No	01	MED	HEADACHES W/O MCC	0.6354	2.4	3.0
113	No	No	02	SURG	ORBITAL PROCEDURES W CC/MCC	1.7856	4.1	5.7
114	No	No	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	0.8879	2.0	2.6
115	No	No	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.1697	3.2	4.4
116	No	No	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.1435	2.7	4.0
117	No	No	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	0.6950	1.6	2.1
121	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	0.9961	4.4	5.6
122	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.6686	3.4	4.2
123	No	No	02	MED	NEUROLOGICAL EYE DISORDERS	0.7182	2.3	2.8

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
124	No	No	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.1833	4.1	5.6
125	No	No	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.6616	2.6	3.3
129	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.0708	3.6	5.2
130	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.2150	2.4	3.0
131	No	No	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.0276	4.0	5.7
132	No	No	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.1438	2.1	2.7
133	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	1.5900	3.7	5.5
134	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	0.8226	1.7	2.2
135	No	No	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	1.8517	4.3	6.5
136	No	No	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	0.9123	1.7	2.2
137	No	No	03	SURG	MOUTH PROCEDURES W CC/MCC	1.3993	4.0	5.4
138	No	No	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.7545	1.9	2.4
139	No	No	03	SURG	SALIVARY GLAND PROCEDURES	0.8179	1.4	1.7
146	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	2.1164	6.7	9.4
147	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2139	4.0	5.7
148	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.6983	2.3	3.2
149	No	No	03	MED	DYSEQUILIBRIUM	0.6267	2.2	2.7
150	No	No	03	MED	EPISTAXIS W MCC	1.3268	4.0	5.4
151	No	No	03	MED	EPISTAXIS W/O MCC	0.6149	2.3	2.9
152	No	No	03	MED	OTITIS MEDIA & URI W MCC	0.9410	3.6	4.6
153	No	No	03	MED	OTITIS MEDIA & URI W/O MCC	0.6067	2.7	3.3
154	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.3784	4.5	6.0
155	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.8782	3.4	4.3
156	No	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6187	2.4	3.0
157	No	No	03	MED	DENTAL & ORAL DISEASES W MCC	1.4834	4.8	6.6
158	No	No	03	MED	DENTAL & ORAL DISEASES W CC	0.9205	3.5	4.5
159	No	No	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.5906	2.3	2.9
163	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W MCC	4.9863	11.7	14.3
164	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W CC	2.5380	6.3	7.5
165	Yes	No	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.7824	4.0	4.8
166	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.7244	9.8	12.5
167	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.0102	6.0	7.6
168	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3086	3.4	4.6
175	Yes	No	04	MED	PULMONARY EMBOLISM W MCC	1.6100	5.9	7.1
176	Yes	No	04	MED	PULMONARY EMBOLISM W/O MCC	1.0675	4.3	5.1
177	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	2.0405	7.1	8.9

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
178	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.4783	5.8	7.1
179	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	1.0041	4.3	5.2
180	No	No	04	MED	RESPIRATORY NEOPLASMS W MCC	1.7138	5.8	7.6
181	No	No	04	MED	RESPIRATORY NEOPLASMS W CC	1.2008	4.3	5.6
182	No	No	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.8134	2.9	3.8
183	No	No	04	MED	MAJOR CHEST TRAUMA W MCC	1.4383	5.2	6.6
184	No	No	04	MED	MAJOR CHEST TRAUMA W CC	0.9435	3.7	4.5
185	No	No	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.6630	2.7	3.2
186	Yes	No	04	MED	PLEURAL EFFUSION W MCC	1.5927	5.5	7.1
187	Yes	No	04	MED	PLEURAL EFFUSION W CC	1.0638	3.9	5.0
188	Yes	No	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7613	2.9	3.6
189	No	No	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3376	4.7	5.9
190	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.2010	4.7	5.8
191	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9579	4.0	4.8
192	Yes	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7143	3.2	3.8
193	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4329	5.3	6.6
194	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9921	4.2	5.1
195	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7058	3.3	3.8
196	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.5388	5.6	7.0
197	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.0625	4.2	5.1
198	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.8122	3.2	3.9
199	No	No	04	MED	PNEUMOTHORAX W MCC	1.8232	6 5	8.3
200	No	No	04	MED	PNEUMOTHORAX W CC	0.9732	3.7	4.8
201	No	No	04	MED	PNEUMOTHORAX W/O CC/MCC	0.7115	2.9	3 8
202	No	No	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.8341	3.5	4 3
203	No	No	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6027	2.7	3 3
204	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.6442	2.1	2.8
205	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.2551	4.0	5.4
206	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.7282	2.6	3.3
207	Yes	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	5.1644	12.8	15.0
208	No	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	2.2369	5.1	7.2
215	No	No	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.8905	6.9	14.3
216	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	10.2827	15.5	18.1
217	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.6668	10.1	11.2
218	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.3485	7.7	8.4

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
219	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	7.9995	11.1	13.5
220	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.2351	7.3	8.0
221	Yes	Yes	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.4389	5.7	6.1
222	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.5132	9.8	12.3
223	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.2678	3.8	5.4
224	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.5894	7.8	9.9
225	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	5.8736	4.0	5.0
226	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.5882	5.7	8.5
227	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.0837	1.8	2.8
228	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	7.6151	11.8	14.2
229	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W CC	4.9085	7.5	8.5
230	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O CC/MCC	3 8147	5.0	5.9
231	No	No	05	SURG	CORONARY BYPASS W PTCA W MCC	7.7134	10.8	12.8
232	No	No	05	SURG	CORONARY BYPASS W PTCA W/O MCC	5.5818	8.3	9.1
233	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	6.9655	12.0	13.6
234	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	4.6664	8.1	8.7
235	Yes	No	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.7377	9.4	11.1
236	Yes	No	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.6484	6.0	6.5
237	No	No	05	SURG	MAJOR CARDIOVASC PROCEDURES W MCC OR THORACIC AORTIC ANEURYSM REPAIR	5.0544	7.3	10.4
238	No	No	05	SURG	MAJOR CARDIOVASC PROCEDURES W/O MCC	2.9664	3.0	4.3
239	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.7211	12.2	15.4
240	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.5326	7.8	9.7
241	Yes	No	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.4880	5.2	6.3
242	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.5950	6.3	8 1
243	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.5774	3.6	4.8
244	Yes	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	1.9972	2.1	2.7
245	No	No	05	SURG	AICD GENERATOR PROCEDURES	4.0883	2.2	3.4
246	No	No	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	3.1152	3.5	5.0
247	No	No	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	1.9249	1.7	2.1
248	No	No	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-	2.8576	4.3	6.1

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					ELUTING STENT W MCC OR 4+ VES/STENTS			
249	No	No	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.6910	2.0	2.5
250	No	No	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.7564	5.0	7.0
251	No	No	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.6509	2.0	2.7
252	No	No	05	SURG	OTHER VASCULAR PROCEDURES W MCC	2.9572	5.3	8.2
253	No	No	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.2937	4.2	5.9
254	No	No	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.5861	1.9	2.6
255	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.5224	7.4	9.9
256	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.5436	5.6	7.0
257	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	0.9482	3.3	4.5
258	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	2.8101	5.0	6.8
259	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	1.7228	2.0	2.8
260	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.2731	7.4	10.6
261	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.4735	2.9	4.1
262	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.0552	1.9	2.5
263	No	No	05	SURG	VEIN LIGATION & STRIPPING	1.6282	3.3	5.4
264	Yes	No	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.5031	5.6	8.5
265	No	No	05	SURG	AICD LEAD PROCEDURES	2.2676	2.3	3.4
280	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.8250	5.4	6.8
281	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	1.1601	3.6	4.4
282	Yes	No	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.8161	2.3	2.9
283	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.6724	3.3	5.3
284	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0 8021	1.9	2.7
285	No	No	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5646	1.5	1.9
286	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	1.9637	5.0	6.7
287	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.0346	2.4	3.1
288	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	3.0651	9.1	11.7
289	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.8373	6.6	7.9
290	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.2368	4.4	5.5
291	Yes	No	05	MED	HEART FAILURE & SHOCK W MCC	1.4560	5.0	6.4
292	Yes	No	05	MED	HEART FAILURE & SHOCK W CC	0.9696	3.9	4.7
293	Yes	No	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6902	2.9	3.4

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
294	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	0.9980	4.6	5.6
295	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.6429	3.6	4.2
296	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC	1.1668	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	0.4468	1.1	1.2
299	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4014	5.0	6.4
300	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9332	3.9	4.9
301	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.6501	2.9	3.6
302	No	No	05	MED	ATHEROSCLEROSIS W MCC	0.9959	3.1	4.1
303	No	No	05	MED	ATHEROSCLEROSIS W/O MCC	0.5657	2.0	2.4
304	No	No	05	MED	HYPERTENSION W MCC	1.0168	3.7	4.8
305	No	No	05	MED	HYPERTENSION W/O MCC	0.5945	2.2	2.8
306	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.3222	4.1	5.6
307	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.7599	2.6	3.3
308	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2140	4.0	5.2
309	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8177	3.0	3.8
310	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5696	2.1	2.6
311	No	No	05	MED	ANGINA PECTORIS	0.5115	1.8	2.3
312	No	No	05	MED	SYNCOPE & COLLAPSE	0.7179	2.4	3.1
313	No	No	05	MED	CHEST PAIN	0.5401	1.7	2.1
314	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	1.7553	5.0	6.9
315	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9562	3.4	4.3
316	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.6201	2.2	2.7
326	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	5.6732	12 8	16.5
327	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.7127	7.2	9.2
328	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.4042	3.0	4.0
329	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	5.1336	12.7	15.6
330	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2 5010	7.9	9.2
331	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6000	4.9	5.5
332	Yes	No	06	SURG	RECTAL RESECTION W MCC	4.7650	12.1	14.4
333	Yes	No	06	SURG	RECTAL RESECTION W CC	2.4264	7.3	8.4
334	Yes	No	06	SURG	RECTAL RESECTION W/O CC/MCC	1.6350	4.5	5.2
335	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.1616	11.5	14.0
336	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.2475	7.3	8.8
337	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.4494	4.2	5.3

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
338	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	3.0741	8.6	10.2
339	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.8108	5.7	6.6
340	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.2251	3.4	3.9
341	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.2118	5.0	6.7
342	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.3224	3.1	4.0
343	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	0.9423	1.7	2.1
344	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	3.0324	9.1	11.3
345	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6194	5.9	6.9
346	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.1835	4.2	4.8
347	No	No	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.2681	6.4	8.7
348	No	No	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3169	4.2	5.5
349	No	No	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.7713	2.3	2.9
350	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.2921	5 7	7.8
351	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.2668	3.4	4.4
352	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	0.8262	1.9	2.4
353	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.5515	6.4	8.4
354	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.4389	3.9	4.9
355	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	0.9938	2.3	2.8
356	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	3.9578	9.4	13.0
357	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1183	5.9	7.6
358	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3027	3.3	4.3
368	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.6534	5.0	6.5
369	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.0472	3.7	4.6
370	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.7481	2.7	3.2
371	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	1.9138	6.7	8.7
372	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.2819	5.4	6.6
373	Yes	No	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.8568	4.1	4.8
374	Yes	No	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0001	6.3	8.5
375	Yes	No	06	MED	DIGESTIVE MALIGNANCY W CC	1.2544	4.5	5.8
376	Yes	No	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.8861	3.0	3.9
377	Yes	No	06	MED	G.I. HEMORRHAGE W MCC	1.6118	4.9	6.3
378	Yes	No	06	MED	G.I. HEMORRHAGE W CC	0.9842	3.6	4.2

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
379	Yes	No	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.7165	2.7	3.2
380	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.7291	5.5	7.0
381	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W CC	1.0835	3.9	4.8
382	Yes	No	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.7774	2.9	3.5
383	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.2352	4.4	5.5
384	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8154	3.1	3.8
385	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.7116	6.0	7.9
386	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W CC	1.0359	4.3	5.4
387	No	No	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.7846	3.4	4.1
388	Yes	No	06	MED	G.I. OBSTRUCTION W MCC	1.4959	5.3	7.0
389	Yes	No	06	MED	G.I. OBSTRUCTION W CC	0.9217	3.9	4.9
390	Yes	No	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.6323	2.9	3.4
391	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.0929	3.9	5.1
392	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.6896	2.8	3.4
393	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.5580	4.9	6 8
394	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9529	3.7	4.7
395	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6643	2.5	3.2
405	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.6416	12.4	16 6
406	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.7035	6.6	8.5
407	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	1.8175	4.1	5.2
408	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	4.2300	11.3	14.1
409	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.3437	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	1.6254	5.2	6.1
411	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.9497	10.4	12.5
412	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.4065	7.3	8.4
413	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.6404	4.5	5.4
414	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.6239	9.6	11.7
415	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	1.9879	6.2	7.2
416	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.2932	3.8	4.5
417	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.4044	6.3	8.0
418	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6376	4.3	5.3
419	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.1413	2.4	3.0
420	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	4.2129	10.3	14.0
421	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES	1.7357	4.9	6.8

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					W CC			
422	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.1858	3.2	4 4
423	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	4.2617	11.2	14.8
424	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.2391	6.8	8.8
425	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.4672	3.9	5.2
432	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.6462	5.1	6.8
433	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	0.9200	3.6	4.6
434	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6523	2.7	3.4
435	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.7315	5.6	7.4
436	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.1825	4.3	5.6
437	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.8894	3.0	3.9
438	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.7033	5.5	7.4
439	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	0.9916	4.0	5.0
440	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6844	3.0	3.6
441	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.7378	5 2	7.1
442	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9432	3.7	4.8
443	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6651	2.8	3.5
444	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.5033	4.8	6.3
445	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0342	3.6	4.5
446	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7226	2.5	3 1
453	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	10.1232	11.2	14.3
454	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	6.9904	5.8	7.2
455	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.0661	3.3	4.0
456	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W MCC	8.8467	11.2	13.9
457	No	No	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR 9+ FUS W CC	6.0280	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	4.9051	3.8	4.3
459	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.1836	7.5	9.3
460	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	3.7354	3.5	4.0
461	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.5738	6.5	8.0
462	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.2033	3.8	4.2
463	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.2907	12.1	16.7

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
464	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.8319	7.3	9.5
465	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.8068	4.4	5.7
466	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	4.6759	7.4	9.1
467	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.1376	4.5	5.2
468	Yes	No	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.5349	3.4	3.7
469	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	3.3402	6.6	7.9
470	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0721	3.5	3.8
471	No	No	08	SURG	CERVICAL SPINAL FUSION W MCC	4.6412	7.1	10.0
472	No	No	08	SURG	CERVICAL SPINAL FUSION W CC	2.7757	2.8	4.1
473	No	No	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.0222	1.5	1.9
474	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.4895	9.6	12.5
475	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	1.9150	6.2	8.0
476	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	1.0640	3.5	4.6
477	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.1336	8.6	11.0
478	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.1382	4.6	6.5
479	Yes	Yes	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.5212	1.9	2.8
480	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	2.8743	7.6	8.9
481	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	1.8393	5.2	5.7
482	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.5112	4.3	4.6
483	Yes	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W CC/MCC	2.3172	3.2	3.9
484	Yes	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROC OF UPPER EXTREMITY W/O CC/MCC	1.8528	2.0	2.3
485	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.0652	9.2	11.3
486	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.0520	6.4	7.5
487	No	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.4319	4.5	5.1
488	Yes	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	1.6886	3.9	5.0
489	Yes	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.1859	2.5	2.9
490	No	No	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	1.7832	3.0	4.3
491	No	No	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	0.9650	1.7	2.1
492	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	2.8393	6.7	8.4

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
493	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	1.7821	4.2	5.1
494	Yes	Yes	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.2669	2.7	3.2
495	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	2.8586	7.4	10.0
496	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.6278	4 2	5.7
497	Yes	Yes	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.0405	2.0	2.6
498	No	No	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	1.9574	5.4	7.5
499	No	No	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	0.9017	2.2	2.8
500	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W MCC	3.0054	8.1	11.0
501	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5208	4.6	6.0
502	Yes	Yes	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	0.9873	2.3	2.8
503	No	No	08	SURG	FOOT PROCEDURES W MCC	2.1822	6.8	8.8
504	No	No	08	SURG	FOOT PROCEDURES W CC	1.5108	5.1	6 4
505	No	No	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.0361	2.5	3.2
506	No	No	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.1405	2.5	3.6
507	No	No	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.8279	3.5	4.8
508	No	No	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.2667	1.7	2.0
509	No	No	08	SURG	ARTHROSCOPY	1.2062	2.2	3.1
510	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.1553	4.9	6.4
511	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.3741	3.2	3.9
512	Yes	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.0064	1.8	2.2
513	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.2191	3.5	4.7
514	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.7792	2.0	2.5
515	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.0348	7.8	10.1
516	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.8407	4.5	5.8
517	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.3704	2.2	3.0
533	Yes	No	08	MED	FRACTURES OF FEMUR W MCC	1.5582	5.0	6.9
534	Yes	No	08	MED	FRACTURES OF FEMUR W/O MCC	0.7307	3.2	3.9
535	Yes	No	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.2865	4.5	5.8
536	Yes	No	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7076	3.3	3.8
537	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.8694	3.6	4.3
538	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.5819	2.5	3.0
539	Yes	No	08	MED	OSTEOMYELITIS W MCC	2.2784	7.9	10.4
540	Yes	No	08	MED	OSTEOMYELITIS W CC	1.3822	5.7	7.2

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
541	Yes	No	08	MED	OSTEOMYELITIS W/O CC/MCC	0.9354	4.1	5.2
542	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.9421	6.6	8.6
543	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.1116	4.6	5.7
544	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7632	3.6	4.2
545	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.2808	6.3	8.7
546	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.0728	4.3	5.3
547	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.7407	3.0	3.7
548	No	No	08	MED	SEPTIC ARTHRITIS W MCC	1.9249	6.7	9.0
549	No	No	08	MED	SEPTIC ARTHRITIS W CC	1.1597	4.9	6.2
550	No	No	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.7056	3.3	4.1
551	Yes	No	08	MED	MEDICAL BACK PROBLEMS W MCC	1.5396	5.3	6.9
552	Yes	No	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.7898	3.3	4.1
553	No	No	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.0975	4.5	5.7
554	No	No	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.6435	2.9	3.6
555	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	0.9708	3.4	4.7
556	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.5999	2.5	3.1
557	Yes	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.4589	5.3	6.6
558	Yes	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8345	3.6	4.3
559	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.7436	5.2	7.2
560	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	0.9821	3.7	4.8
561	Yes	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.5931	2.1	2.7
562	Yes	No	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.3719	4.8	6.1
563	Yes	No	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.6881	3.0	3.6
564	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.5115	5.3	7.0
565	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9036	3.9	4.8
566	No	No	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.6399	2.7	3.5
573	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W MCC	3.4798	9.9	13.7
574	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.8936	6.8	8.9
575	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC/MCC	1.1201	4.5	5.6
576	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W MCC	3.2998	8.2	12.3
577	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W CC	1.7213	4.1	6.2
578	No	No	09	SURG	SKIN GRAFT &/OR DEBRID EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.0023	2.4	3.2
579	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W	2.8440	8.0	10.6

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					MCC			
580	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.3919	3.6	5.3
581	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	0.8624	1.8	2.4
582	No	No	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.0231	2.1	2.8
583	No	No	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	0.7945	1.5	1.7
584	No	No	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.4804	3.6	5.5
585	No	No	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	0.8619	1.6	2.1
592	Yes	No	09	MED	SKIN ULCERS W MCC	1.8282	6.6	8.8
593	Yes	No	09	MED	SKIN ULCERS W CC	1.0672	4.9	6.2
594	Yes	No	09	MED	SKIN ULCERS W/O CC/MCC	0 7471	3.7	4.7
595	No	No	09	MED	MAJOR SKIN DISORDERS W MCC	1.7727	6.0	8.1
596	No	No	09	MED	MAJOR SKIN DISORDERS W/O MCC	0.8238	3.7	4.6
597	No	No	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.6184	5.6	8.0
598	No	No	09	MED	MALIGNANT BREAST DISORDERS W CC	1.0613	4 2	5.6
599	No	No	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.5989	2.6	3.5
600	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9723	4.2	5.4
601	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.5891	3.0	3.6
602	Yes	No	09	MED	CELLULITIS W MCC	1.4244	5.5	6.9
603	Yes	No	09	MED	CELLULITIS W/O MCC	0.8112	3.8	4.6
604	No	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.1602	4.1	5.4
605	No	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.6787	2.7	3.4
606	No	No	09	MED	MINOR SKIN DISORDERS W MCC	1.1841	4.3	5.9
607	No	No	09	MED	MINOR SKIN DISORDERS W/O MCC	0.6355	2.8	3.6
614	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.6604	5.0	7.0
615	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.4114	2.6	3.1
616	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.8152	13.1	16.6
617	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0220	6.9	8.4
618	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.2511	5.0	6.1
619	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	3.6101	5.0	7.9
620	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8416	2.6	3.4
621	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.4640	1.7	1.9
622	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	4.1552	11.1	15.8
623	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	2.0127	6.9	8.9
624	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC,	0.9724	4.5	5.5

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					NUTRIT & METAB DIS W/O CC/MCC			
625	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.2329	4.7	7.0
626	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.1383	2.0	2.9
627	No	No	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	0.7640	1.3	1.4
628	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.3916	7.4	11.0
629	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.2918	6.8	8.5
630	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.4432	3.4	4.7
637	Yes	No	10	MED	DIABETES W MCC	1.3236	4.3	5.8
638	Yes	No	10	MED	DIABETES W CC	0.8209	3.3	4.2
639	Yes	No	10	MED	DIABETES W/O CC/MCC	0.5528	2.4	2.9
640	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS W MCC	1.0865	3.7	5.1
641	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS W/O MCC	0.6797	2.9	3.7
642	No	No	10	MED	INBORN ERRORS OF METABOLISM	1.0385	3.6	4.9
643	Yes	No	10	MED	ENDOCRINE DISORDERS W MCC	1.6303	5.8	7.3
644	Yes	No	10	MED	ENDOCRINE DISORDERS W CC	1.0400	4.2	5.2
645	Yes	No	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7160	3.0	3.7
652	No	No	11	SURG	KIDNEY TRANSPLANT	3.0194	6.5	7.6
653	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W MCC	5.8671	13.3	16.4
654	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W CC	2.8920	8.2	9.3
655	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	1.9194	4.9	5.9
656	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.2663	7 7	9.9
657	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	1.8600	4.8	5.6
658	No	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.3827	3.1	3.5
659	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	3.3040	7.8	10.7
660	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.8245	4.4	6.0
661	Yes	No	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.2936	2.4	3.0
662	No	No	11	SURG	MINOR BLADDER PROCEDURES W MCC	2.7840	7.4	10.2
663	No	No	11	SURG	MINOR BLADDER PROCEDURES W CC	1.3685	3.4	4.9
664	No	No	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.0311	1.5	1.9
665	No	No	11	SURG	PROSTATECTOMY W MCC	2.7941	9 0	11.4
666	No	No	11	SURG	PROSTATECTOMY W CC	1.5438	4.1	6.1
667	No	No	11	SURG	PROSTATECTOMY W/O CC/MCC	0.7681	1.8	2.3
668	No	No	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.2336	6.1	8.3
669	No	No	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1963	3 0	4.2
670	No	No	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.7595	1.8	2.3

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
671	No	No	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.4625	4.0	5.9
672	No	No	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	0.7723	1.9	2.4
673	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	2.9147	5.7	9.6
674	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.0622	4.5	6.8
675	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.3208	1.5	2.1
682	Yes	No	11	MED	RENAL FAILURE W MCC	1.6400	5.2	7.0
683	Yes	No	11	MED	RENAL FAILURE W CC	1.0505	4.2	5.2
684	Yes	No	11	MED	RENAL FAILURE W/O CC/MCC	0.6734	2.9	3.5
685	No	No	11	MED	ADMIT FOR RENAL DIALYSIS	0.9013	2.5	3.5
686	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.5321	5.4	7.2
687	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0180	3.9	5.1
688	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.6838	2.3	3.0
689	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.2040	4.8	5.9
690	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7654	3.4	4.1
691	No	No	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.4723	3.1	4.1
692	No	No	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1043	1.9	2.4
693	No	No	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.1487	3.5	4.6
694	No	No	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.6530	2.0	2.5
695	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.2477	4.2	5.8
696	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.6428	2.6	3.2
697	No	No	11	MED	URETHRAL STRICTURE	0.8087	2.5	3.4
698	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.4872	5.0	6.6
699	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	0.9475	3.7	4.7
700	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.6504	2.6	3.3
707	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.6839	3.2	4.3
708	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.2157	1.7	2.0
709	No	No	12	SURG	PENIS PROCEDURES W CC/MCC	1.8309	3.6	6.0
710	No	No	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.3286	1.3	1.6
711	No	No	12	SURG	TESTES PROCEDURES W CC/MCC	1.7006	5.0	7.3
712	No	No	12	SURG	TESTES PROCEDURES W/O CC/MCC	0.7736	2.0	2.6
713	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.1321	2.9	4.1
714	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.6408	1.6	1.9
715	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	1.7359	4.0	6.2

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
716	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	0.9853	1.3	1.4
717	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.6608	4.7	6.8
718	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	0.7929	2.0	2.7
722	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.4738	5.4	6.9
723	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	0.9705	3.9	5.0
724	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6247	2.1	2.8
725	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.0531	3.8	5.1
726	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.6866	2.7	3.5
727	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.3148	5.0	6.4
728	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.7267	3.3	4.1
729	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	0.9688	3.7	4.9
730	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.5734	2.2	2.8
734	No	No	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.5664	5.6	7.7
735	No	No	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.1481	2.5	3.0
736	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.3826	11.4	14.0
737	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	1.9753	5.8	6 8
738	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.1865	3.2	3.7
739	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.0775	7.6	9.9
740	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.5140	4.1	4.9
741	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1 0660	2.4	2.8
742	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.3539	3.3	4.3
743	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	0.8860	1.9	2.2
744	No	No	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.4626	4.1	5.7
745	No	No	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	0.7744	2.0	2.5
746	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.2369	2.9	4.0
747	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.8585	1.6	1.8
748	No	No	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.8865	1.5	1.7
749	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.4209	6.5	9.1
750	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.0271	2.3	3.0
754	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE	1.8666	6.1	8.5

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					SYSTEM W MCC			
755	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1046	4.0	5.4
756	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.5940	2.2	2.9
757	No	No	13	MED	INFECTIONS. FEMALE REPRODUCTIVE SYSTEM W MCC	1.7218	6.6	8.4
758	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0847	4.7	5.9
759	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7676	3.5	4.4
760	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.7935	3.0	3.9
761	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.4960	1.9	2.4
765	No	No	14	SURG	CESAREAN SECTION W CC/MCC	1.1108	4.0	5.2
766	No	No	14	SURG	CESAREAN SECTION W/O CC/MCC	0.7510	2.9	3.0
767	No	No	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.8344	2.6	3.0
768	No	No	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.7711	0.0	0.0
769	No	No	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.9086	3.8	6.9
770	No	No	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5349	1.5	1.9
774	No	No	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.6822	2.6	3.3
775	No	No	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4956	2.1	2.3
776	No	No	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6719	2.6	3.5
777	No	No	14	MED	ECTOPIC PREGNANCY	0.7934	1.9	2.3
778	No	No	14	MED	THREATENED ABORTION	0.4260	2.0	3.0
779	No	No	14	MED	ABORTION W/O D&C	0.4445	1.6	2.1
780	No	No	14	MED	FALSE LABOR	0.2001	1.2	1.3
781	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.6319	2.7	3.8
782	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4553	1.7	2.4
789	No	No	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.4548	0.0	0 0
790	No	No	15	MED	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.7973	0.0	0.0
791	No	No	15	MED	PREMATURITY W MAJOR PROBLEMS	3.2764	0.0	0.0
792	No	No	15	MED	PREMATURITY W/O MAJOR PROBLEMS	1.9769	0.0	0.0
793	No	No	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.3656	0.0	0.0
794	No	No	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1912	0.0	0.0
795	No	No	15	MED	NORMAL NEWBORN	0.1613	0.0	0.0
799	No	No	16	SURG	SPLENECTOMY W MCC	5.1460	10.5	13.8
800	No	No	16	SURG	SPLENECTOMY W CC	2.5374	5.7	7.4

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
801	No	No	16	SURG	SPLENECTOMY W/O CC/MCC	1.6005	3.3	4.1
802	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.4567	8.7	11.7
803	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.7626	4.9	6.8
804	No	No	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.0401	2.4	3.2
808	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.0520	6.2	8.2
809	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.1733	4.1	5.2
810	No	No	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.8724	3.0	3.9
811	No	No	16	MED	RED BLOOD CELL DISORDERS W MCC	1.2401	3.9	5.4
812	No	No	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.7714	2.8	3.7
813	No	No	16	MED	COAGULATION DISORDERS	1.3923	3.7	5.2
814	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.5293	5.1	6.8
815	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9555	3.6	4.6
816	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.6913	2.7	3.4
820	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.3768	12.8	16.6
821	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.2641	5.2	7.5
822	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.1787	2.4	3.3
823	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W MCC	3.8898	11.4	14.6
824	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.1408	6.3	8.5
825	No	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC/MCC	1.2064	2.9	4.2
826	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	4.5475	11.6	14.8
827	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.0218	5.2	6.9
828	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.2428	2.8	3.5
829	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W CC/MCC	2.6098	6.4	9.6
830	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC W/O CC/MCC	0.9887	2.3	3.1
834	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	4.3690	9.2	15.0
835	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.4525	5.8	9.6
836	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.2484	3.2	4.8
837	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	6.4326	18.1	23.4
838	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	3.1132	8.5	12.9
839	No	No	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.2767	4.8	5.9

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
840	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	2.7110	7.7	10.4
841	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.5032	5.0	6.6
842	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	0.9773	3.2	4.2
843	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	1.6881	5.9	8.0
844	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.2000	4.5	6.0
845	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8046	3.1	4.1
846	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.1809	5.9	8.5
847	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	0.9517	2.7	3.4
848	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.8229	2.6	3.2
849	No	No	17	MED	RADIOTHERAPY	1.2819	4.4	6.2
853	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.4702	12.4	16.2
854	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.7190	8.7	10 7
855	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.6838	5.4	7.2
856	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	4.8925	11.3	15.3
857	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O R. PROC W CC	2.0371	6.3	8.1
858	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3547	4.4	5.5
862	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.8959	6.0	8.0
863	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.9681	4.1	5.1
864	No	No	18	MED	FEVER	0.8137	3.1	3.9
865	No	No	18	MED	VIRAL ILLNESS W MCC	1.3585	4.4	6.1
866	No	No	18	MED	VIRAL ILLNESS W/O MCC	0.6708	2.8	3.4
867	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.3829	7.0	9.4
868	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	1.0586	4.2	5.4
869	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7401	3.3	4.0
870	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	5.8005	12.9	15.4
871	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	1.8372	5.4	7.3
872	Yes	No	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1.1083	4.5	5.6
876	No	No	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.5731	8.0	13.0
880	No	No	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6161	2.3	3.1
881	No	No	19	MED	DEPRESSIVE NEUROSES	0.5914	3 1	4.2
882	No	No	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.6594	3.1	4.4
883	No	No	19	MED	DISORDERS OF PERSONALITY & IMPULSE	1.0863	4.9	8.1

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					CONTROL			
884	Yes	No	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.9303	4.1	5.6
885	No	No	19	MED	PSYCHOSES	0.8758	5 4	7.4
886	No	No	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.7808	3.7	6.0
887	No	No	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.8238	3.1	4.6
894	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.3997	2.1	2.9
895	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	0.9548	8.2	10.5
896	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.4032	4.9	6.7
897	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.6242	3.2	4.0
901	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	3.9803	9.8	14.8
902	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.7745	5.6	8.0
903	No	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.0118	3.3	4.5
904	No	No	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	2.8459	7.3	11.1
905	No	No	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.0841	3.4	4.6
906	No	No	21	SURG	HAND PROCEDURES FOR INJURIES	1.0115	2.1	3.1
907	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	3.8142	8 1	11.6
908	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.8644	4.7	6.4
909	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.1241	2 6	3.4
913	No	No	21	MED	TRAUMATIC INJURY W MCC	1.3267	4.1	5.9
914	No	No	21	MED	TRAUMATIC INJURY W/O MCC	0.6749	2.6	3.4
915	No	No	21	MED	ALLERGIC REACTIONS W MCC	1.2579	3.3	4.6
916	No	No	21	MED	ALLERGIC REACTIONS W/O MCC	0.4477	1.7	2.1
917	Yes	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4425	3.7	5.2
918	Yes	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.5845	2.0	2.7
919	No	No	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.5871	4.5	6.3
920	No	No	21	MED	COMPLICATIONS OF TREATMENT W CC	0.9368	3.2	4.2
921	No	No	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.6101	2.2	2.8
922	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.3073	3.8	5.4
923	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.6551	2.3	3.2
927	No	No	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT	13.9591	24.2	32.9
928	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	5.3471	11.7	16.4
929	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.0042	4.9	7.2
933	No	No	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT	2.3969	2.5	5.9
934	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	1.3561	4.2	6.1

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
935	No	No	22	MED	NON-EXTENSIVE BURNS	1.2452	3.5	5.3
939	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	2.8437	7.2	10.8
940	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	1.6795	3.5	5.7
941	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.1399	2.0	2.6
945	Yes	No	23	MED	REHABILITATION W CC/MCC	1.2471	8.3	10.1
946	Yes	No	23	MED	REHABILITATION W/O CC/MCC	1.1057	6.7	7.7
947	Yes	No	23	MED	SIGNS & SYMPTOMS W MCC	1.0875	3.8	5.1
948	Yes	No	23	MED	SIGNS & SYMPTOMS W/O MCC	0.6654	2.7	3.5
949	No	No	23	MED	AFTERCARE W CC/MCC	0.9713	2.7	4.8
950	No	No	23	MED	AFTERCARE W/O CC/MCC	0.5338	2.4	3.3
951	No	No	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.7175	2.1	4 1
955	No	No	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.7257	9.0	12.9
956	Yes	No	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.3900	7.3	9.0
957	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	6.3537	10 6	15.1
958	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	3.7140	7.4	9.5
959	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.2046	4.5	5.8
963	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.7751	6.3	9.2
964	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.4930	4.6	5.8
965	No	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9668	3.1	3.8
969	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.4975	13.3	18.8
970	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.4858	6.1	8.8
974	No	No	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.4775	7.1	10.0
975	No	No	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.3560	5.1	6 8
976	No	No	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.8919	3.7	4.7
977	No	No	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0439	3.7	5.0
981	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	5.0290	11.3	14.5
982	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.9036	7.0	9.0
983	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.8246	3.4	4.6
984	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3203	11.6	14.5
985	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.9564	6.2	8.7
986	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.1070	2.9	4.3
987	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3985	9.4	12.5
988	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO	1.7793	5.4	7.3

MS-DRG	FY 2010 Proposed Rule Post-Acute DRG	FY 2010 Proposed Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geo-metric mean LOS	Arith-metic mean LOS
					PRINCIPAL DIAGNOSIS W CC			
989	Yes	No		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.0417	2.6	3.6
998	No	No		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
999	No	No		**	UNGROUPABLE	0.0000	0.0	0.0

MS-DRGs 998 and 999 contain cases that could not be assigned to valid DRGs.
Note: If there is no value in either the geometric mean length of stay or the arithmetic mean length of stay columns, the volume of cases is insufficient to determine a meaningful computation of these statistics.

TABLE 6A.--NEW DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
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	Merkel cell carcinoma, unknown primary site	N	09	595, 596
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]

Diagnosis Code	Description	CC	MDC	MS-DRG
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
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 axillary veins	CC	05	299, 300, 301
453.75	Chronic venous embolism and	CC	05	299, 300, 301

Diagnosis Code	Description	CC	MDC	MS-DRG
	thrombosis of subclavian veins			
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
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
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

Diagnosis Code	Description	CC	MDC	MS-DRG
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

Diagnosis Code	Description	CC	MDC	MS-DRG
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
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

Diagnosis Code	Description	CC	MDC	MS-DRG
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 type of 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	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

Diagnosis Code	Description	CC	MDC	MS-DRG
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:
[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
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
33.73	Endoscopic insertion or replacement of bronchial valve(s), multiple lobes	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

Procedure Code	Description	O.R.	MDC	MS-DRG
46.86	Endoscopic insertion of colonic stent(s)	N		
46.87	Other insertion of colonic stent(s)	N		

TABLE 6C.--INVALID DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	MS-DRG
239.8	Neoplasms of unspecified nature, 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
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.

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
453.40	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 of distal lower extremity	CC	05	299, 300, 301
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 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

Diagnosis Code	Description	CC	MDC	MS-DRG
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

Diagnosis Code	Description	CC	MDC	MS-DRG
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:

[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]
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
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

Procedure Code	Description	O.R.	MDC	MS-DRG
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:

[1] Assigned to DRG 264 when both 0056 and 0057 are reported.

[2] Note proposed MS-DRG change.

TABLE 7A.--MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2008 MedPAR UPDATE--DECEMBER 2008 GROUPER V26.0 MS-DRGs

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	793	43.3947	11	20	32	56	88
2	210	21.5000	8	10	15	25	40
3	23,339	38.0577	15	22	31	46	65
4	22,243	28.0387	11	16	23	34	48
5	616	21.4773	7	9	15	26	44
6	167	10.2455	6	7	9	11	17
7	361	18.7673	8	10	15	21	34
8	488	12.3033	6	7	9	13	23
9	1,541	21.2219	8	16	19	24	34
10	137	9.9708	5	6	9	11	16
11	1,419	16.2016	6	8	12	19	29
12	2,009	10.5142	4	6	9	13	19
13	1,085	6.8949	3	4	6	8	11
20	1,045	18.2220	6	11	17	23	31
21	487	14.4004	5	9	14	18	23
22	157	9.0191	3	6	9	12	14
23	4,348	12.1097	2	5	10	16	24
24	2,095	8.0549	1	3	7	11	16
25	10,354	12.1228	4	6	10	16	23
26	11,695	7.7535	2	4	7	10	14
27	12,615	4.1317	1	2	3	5	8
28	1,751	13.4118	4	7	10	17	26
29	3,503	6.6646	1	3	5	9	14
30	3,459	3.5432	1	1	3	5	7
31	1,103	13.2457	3	5	10	17	28
32	2,782	5.5234	1	2	4	7	12
33	3,340	2.8485	1	1	2	3	5
34	864	6.9329	1	2	5	9	15
35	2,422	2.9232	1	1	2	4	7
36	5,993	1.5767	1	1	1	2	3
37	5,577	8.2666	2	3	6	11	16
38	14,867	3.4587	1	1	2	4	8
39	48,660	1.7240	1	1	1	2	3
40	5,091	12.7739	3	6	10	16	25
41	7,775	7.0046	1	3	6	9	13
42	4,188	3.3405	1	1	2	4	7
52	1,410	6.2589	2	3	5	8	12
53	588	4.0306	1	2	3	5	7
54	6,761	6.7173	2	3	5	8	14

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
55	14,752	4.8435	1	2	4	6	9
56	10,661	7.6271	2	3	6	9	15
57	47,070	4.9476	2	3	4	6	9
58	898	7.7829	2	4	6	9	14
59	3,293	5.0310	2	3	4	6	9
60	3,780	3.8026	1	2	3	5	6
61	2,055	8.6764	2	4	7	11	17
62	3,080	5.9282	3	3	5	7	10
63	1,230	4.1878	2	3	4	5	7
64	65,770	7.1672	2	3	6	9	14
65	112,706	4.9917	2	3	4	6	9
66	74,884	3.4551	1	2	3	4	6
67	1,995	5.5193	2	3	4	7	10
68	12,189	3.3854	1	2	3	4	6
69	100,473	2.9169	1	2	2	4	5
70	10,457	7.3940	2	4	6	9	14
71	11,844	5.2242	2	3	4	6	9
72	5,411	3.2645	1	2	3	4	6
73	10,865	5.9770	2	3	4	7	12
74	31,990	4.1075	1	2	3	5	8
75	1,319	7.3389	2	4	6	9	14
76	730	3.9151	2	2	3	5	7
77	1,666	6.6248	2	3	5	8	12
78	1,751	4.3347	2	2	3	5	8
79	900	3.2100	1	2	3	4	6
80	1,757	4.9698	1	2	4	6	10
81	5,980	3.4064	1	2	3	4	6
82	2,255	6.3299	1	1	4	9	14
83	2,403	4.9055	1	2	4	6	9
84	2,572	2.9199	1	1	2	4	6
85	7,221	7.3846	2	3	6	9	15
86	13,070	4.8685	1	2	4	6	9
87	12,492	3.0544	1	1	2	4	6
88	1,010	5.4644	1	3	4	7	10
89	2,983	3.7110	1	2	3	5	7
90	2,855	2.4000	1	1	2	3	4
91	10,113	6.1790	2	3	5	8	12
92	19,005	4.3178	1	2	3	5	8
93	15,332	3.0117	1	2	3	4	5
94	1,556	11.6780	4	6	10	15	21
95	1,193	8.0855	2	4	7	11	15
96	624	5.8942	1	3	5	7	10
97	1,352	11.4822	4	6	9	15	21

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
98	1,037	8.0125	3	4	6	10	15
99	525	5.4495	2	3	5	7	9
100	19,464	6.0779	2	3	4	7	12
101	56,938	3.5375	1	2	3	4	6
102	1,306	4.4012	1	2	3	5	9
103	13,161	3.0335	1	1	2	4	6
113	644	5.7283	1	2	4	7	11
114	463	2.6242	1	1	2	3	5
115	1,030	4.3854	1	2	4	5	7
116	531	3.9510	1	1	2	4	6
117	833	2.0600	1	1	1	2	3
121	770	5.5506	2	3	4	7	10
122	513	4.1774	2	2	3	5	7
123	2,898	2.8357	1	2	2	3	5
124	877	5.5690	1	2	4	7	10
125	4,170	3.3007	1	2	3	4	6
129	1,544	5.1949	1	2	4	6	10
130	951	2.9600	1	1	2	4	6
131	1,006	5.6730	1	2	4	7	12
132	833	2.6759	1	1	2	3	5
133	2,204	5.4796	1	2	4	7	12
134	2,882	2.1790	1	1	1	2	4
135	389	6.5064	1	2	5	8	14
136	422	2.1564	1	1	1	3	5
137	851	5.4395	1	2	4	7	10
138	817	2.4247	1	1	2	3	5
139	1,466	1.6999	1	1	1	2	3
146	844	9.4076	2	4	7	12	18
147	1,502	5.7450	1	2	4	7	11
148	723	3.1646	1	1	2	4	7
149	36,609	2.6943	1	1	2	3	5
150	1,300	5.3654	1	2	4	7	11
151	6,366	2.8677	1	1	2	4	5
152	3,521	4.6407	1	2	4	6	9
153	17,443	3.3134	1	2	3	4	6
154	2,496	6.0469	2	3	5	8	12
155	5,701	4.3192	1	2	4	5	8
156	4,285	3.0264	1	1	2	4	6
157	1,436	6.5891	2	3	5	8	13
158	3,705	4.5455	1	2	3	6	9
159	1,935	2.9339	1	1	2	4	5
163	14,350	14.3208	5	8	12	18	26
164	19,111	7.5432	3	4	6	9	13

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
165	11,029	4.7676	2	3	4	6	8
166	24,958	12.5049	4	7	10	15	23
167	20,609	7.6074	2	4	6	10	14
168	5,127	4.6066	1	2	4	6	9
175	15,526	7.1117	3	4	6	9	12
176	37,833	5.0757	2	3	5	6	8
177	73,033	8.8511	3	5	7	11	16
178	74,662	7.0612	3	4	6	9	13
179	20,207	5.2159	2	3	4	7	9
180	23,582	7.6185	2	4	6	10	15
181	29,169	5.6175	2	3	4	7	11
182	3,795	3.8121	1	2	3	5	7
183	2,698	6.5730	2	3	5	8	12
184	4,885	4.5146	2	3	4	6	8
185	2,251	3.1644	1	2	3	4	6
186	10,894	7.0624	2	3	6	9	14
187	10,569	4.9640	2	2	4	6	9
188	3,792	3.5886	1	2	3	5	7
189	134,237	5.9595	2	3	5	8	11
190	130,697	5.7798	2	3	5	7	10
191	143,853	4.8016	2	3	4	6	9
192	159,639	3.7940	1	2	3	5	7
193	106,201	6.5990	2	4	5	8	12
194	225,158	5.0828	2	3	4	6	9
195	109,919	3.8443	2	2	3	5	7
196	6,909	6.9945	2	4	6	9	13
197	7,112	5.1294	2	3	4	7	9
198	3,610	3.9213	1	2	3	5	7
199	3,866	8.2809	2	4	7	11	16
200	8,693	4.8049	1	2	4	6	9
201	3,113	3.7527	1	2	3	5	7
202	38,666	4.2877	2	2	4	5	8
203	35,936	3.2853	1	2	3	4	6
204	25,583	2.7546	1	1	2	3	5
205	6,944	5.4159	1	2	4	7	11
206	21,350	3.3146	1	2	3	4	6
207	39,269	15.0382	6	9	13	18	25
208	79,781	7.1732	1	3	6	10	14
215	137	14.3139	1	3	7	17	30
216	10,141	18.0888	8	11	16	22	31
217	6,633	11.1963	6	7	10	14	18
218	1,457	8.3624	5	6	7	10	13
219	12,768	13.5365	6	7	11	17	25

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
220	14,704	8.0099	4	6	7	9	13
221	5,071	6.0919	4	5	6	7	9
222	3,342	12.3432	4	7	10	15	23
223	4,553	5.4386	1	2	5	8	11
224	3,009	9.9435	3	5	8	13	19
225	4,886	5.0526	1	2	4	7	9
226	8,272	8.5204	1	3	7	11	17
227	34,151	2.7643	1	1	1	3	7
228	3,276	14.2088	6	8	12	17	24
229	3,437	8.4713	4	6	7	10	14
230	1,197	5.8588	2	4	6	7	10
231	1,625	12.7723	6	8	11	15	23
232	1,306	9.1340	5	7	9	11	14
233	18,256	13.6374	7	9	12	16	23
234	29,030	8.7370	5	6	8	10	13
235	10,761	11.1170	5	7	9	13	19
236	26,652	6.5366	4	5	6	8	10
237	24,593	10.4289	2	5	8	14	21
238	40,498	4.2736	1	1	3	6	9
239	11,898	15.4481	5	8	12	20	29
240	11,062	9.6743	3	5	8	12	18
241	1,982	6.2608	3	3	5	8	11
242	21,622	8.0614	2	4	7	10	15
243	39,375	4.7748	1	2	4	6	9
244	52,950	2.7365	1	1	2	4	6
245	4,193	3.3754	1	1	2	4	8
246	31,288	5.0316	1	2	4	7	11
247	152,978	2.0938	1	1	1	3	4
248	20,209	6.0493	1	3	5	8	12
249	70,094	2.5098	1	1	2	3	5
250	8,331	6.9692	2	3	5	9	14
251	38,976	2.7250	1	1	2	4	6
252	45,045	8.2052	1	3	6	11	17
253	44,358	5.8970	1	2	5	8	12
254	46,157	2.6143	1	1	2	3	6
255	2,554	9.8512	3	5	8	12	18
256	3,154	7.0282	2	4	6	9	13
257	504	4.5238	1	2	3	6	9
258	856	6.8271	2	3	5	8	13
259	6,370	2.7793	1	1	2	4	6
260	1,793	10.6012	2	4	8	13	21
261	3,926	4.0815	1	1	3	5	8
262	2,929	2.4950	1	1	2	3	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
263	578	5.4273	1	1	3	7	12
264	25,148	8.5237	1	3	6	11	18
265	2,127	3.4452	1	1	2	4	7
280	81,221	6.8105	2	4	6	9	12
281	52,956	4.4422	1	2	4	6	8
282	42,780	2.8932	1	1	2	4	5
283	15,866	5.2942	1	1	3	7	12
284	3,311	2.7197	1	1	2	3	6
285	1,855	1.9030	1	1	1	2	4
286	30,113	6.6965	2	3	5	8	13
287	145,874	3.0556	1	1	2	4	6
288	3,087	11.7023	4	6	9	14	21
289	1,209	7.9404	3	5	7	10	13
290	311	5.5402	2	3	5	7	9
291	208,180	6.3725	2	3	5	8	12
292	215,057	4.7277	2	3	4	6	8
293	144,230	3.4298	1	2	3	4	6
294	1,606	5.6258	2	3	5	7	10
295	1,051	4.2103	2	3	4	5	7
296	2,223	2.9663	1	1	1	3	7
297	744	1.7702	1	1	1	2	3
298	495	1.2364	1	1	1	1	1
299	23,717	6.3749	2	3	5	8	12
300	46,995	4.9501	2	3	4	6	9
301	32,544	3.5632	1	2	3	5	6
302	8,808	4.1437	1	2	3	5	8
303	61,359	2.4402	1	1	2	3	4
304	2,795	4.7903	1	2	4	6	9
305	32,828	2.7771	1	1	2	3	5
306	2,605	5.5543	1	3	4	7	10
307	6,003	3.3258	1	2	3	4	6
308	58,293	5.2471	2	3	4	7	10
309	95,774	3.7594	1	2	3	5	7
310	142,159	2.5841	1	1	2	3	5
311	19,309	2.2734	1	1	2	3	4
312	169,548	3.0591	1	2	2	4	6
313	195,950	2.0973	1	1	2	3	4
314	66,868	6.9094	2	3	5	9	14
315	31,185	4.3429	1	2	3	6	8
316	15,665	2.7391	1	1	2	3	5
326	11,818	16.4855	6	8	13	21	31
327	10,398	9.2186	3	5	8	12	17
328	8,224	3.9618	1	2	3	5	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
329	51,629	15.6116	6	8	13	19	28
330	62,460	9.2140	4	6	8	11	16
331	26,549	5.4753	3	4	5	7	8
332	2,086	14.3821	6	8	12	18	26
333	5,872	8.3893	4	5	7	10	14
334	3,439	5.1876	2	3	5	7	8
335	8,195	13.9824	5	8	12	18	25
336	12,806	8.7853	3	5	8	11	15
337	8,096	5.2538	1	3	5	7	10
338	1,672	10.2482	4	6	9	13	18
339	3,231	6.6227	3	4	6	8	11
340	3,503	3.9438	2	2	4	5	7
341	1,023	6.7253	2	3	5	9	13
342	2,843	3.9595	1	2	3	5	8
343	7,009	2.0648	1	1	2	3	4
344	1,029	11.2663	4	6	9	14	21
345	3,055	6.9303	3	4	6	8	12
346	2,900	4.7541	2	3	4	6	7
347	1,670	8.7102	2	4	7	11	18
348	4,356	5.4970	1	3	4	7	10
349	4,584	2.9191	1	1	2	4	6
350	1,955	7.8266	2	3	6	10	16
351	4,606	4.4390	1	2	4	6	9
352	7,371	2.3725	1	1	2	3	5
353	3,762	8.4272	2	4	7	11	16
354	9,075	4.9438	1	3	4	6	9
355	14,176	2.8165	1	1	2	4	5
356	8,746	12.9670	3	6	10	16	25
357	7,767	7.6291	2	4	6	9	14
358	2,142	4.3375	1	2	4	6	8
368	3,838	6.5422	2	3	5	8	13
369	5,693	4.5631	2	3	4	6	8
370	2,318	3.2325	1	2	3	4	6
371	28,649	8.6596	3	4	7	11	17
372	29,950	6.6003	2	4	5	8	12
373	13,070	4.7820	2	3	4	6	8
374	10,020	8.5017	2	4	7	11	16
375	17,919	5.8483	2	3	5	7	11
376	3,237	3.8848	1	2	3	5	7
377	62,213	6.2565	2	3	5	8	12
378	127,843	4.2395	2	2	4	5	7
379	64,406	3.1571	1	2	3	4	5
380	3,437	7.0201	2	3	6	9	13

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
381	6,099	4.7964	2	3	4	6	9
382	3,336	3.4664	1	2	3	4	6
383	1,631	5.4856	2	3	4	7	10
384	7,574	3.7527	1	2	3	5	7
385	2,952	7.9394	2	4	6	10	16
386	8,069	5.3599	2	3	4	7	10
387	4,410	4.1132	1	2	3	5	7
388	22,994	6.9898	2	3	5	9	14
389	50,225	4.8550	2	3	4	6	9
390	44,859	3.4444	1	2	3	4	6
391	50,585	5.1404	1	2	4	6	10
392	252,286	3.4450	1	2	3	4	6
393	25,366	6.7993	2	3	5	8	14
394	49,604	4.6898	1	2	4	6	9
395	21,921	3.1720	1	2	3	4	6
405	4,383	16.5747	5	8	13	21	32
406	5,291	8.4593	2	5	7	10	15
407	1,950	5.1897	1	3	5	7	9
408	1,671	14.1364	5	7	12	17	26
409	1,438	8.7566	4	5	8	11	15
410	509	6.0982	2	4	6	8	10
411	941	12.4527	5	7	10	15	22
412	906	8.4272	4	5	7	10	14
413	631	5.3693	2	3	5	7	9
414	5,426	11.6742	4	7	9	14	20
415	5,863	7.2185	3	4	6	9	12
416	4,680	4.4583	2	3	4	6	7
417	20,207	7.9868	3	4	6	10	15
418	26,846	5.3043	2	3	5	7	10
419	32,727	3.0418	1	1	2	4	6
420	829	13.9831	3	6	11	18	29
421	1,039	6.7546	2	3	5	8	14
422	258	4.3721	1	2	4	5	8
423	1,634	14.7944	4	7	11	19	28
424	822	8.8029	3	4	7	11	17
425	93	5.1613	1	2	5	7	9
432	14,948	6.7699	2	3	5	8	13
433	9,242	4.5610	1	2	4	6	8
434	603	3.4129	1	2	3	4	6
435	14,078	7.3820	2	3	6	9	14
436	12,509	5.6050	2	3	4	7	11
437	2,867	3.9219	1	2	3	5	8
438	17,583	7.4331	2	3	5	9	15

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
439	25,610	5.0299	2	3	4	6	9
440	21,822	3.6092	1	2	3	4	6
441	14,600	7.1405	2	3	5	9	14
442	15,637	4.7673	2	2	4	6	9
443	5,574	3.4740	1	2	3	4	6
444	14,181	6.3417	2	3	5	8	12
445	17,774	4.5492	1	2	4	6	8
446	14,328	3.1145	1	2	3	4	6
453	1,113	14.3360	5	7	11	18	28
454	2,411	7.1721	3	4	6	8	13
455	2,064	4.0262	1	2	4	5	7
456	1,122	13.9358	5	7	11	17	26
457	2,874	7.2363	3	4	6	8	13
458	1,477	4.2986	2	3	4	5	7
459	4,244	9.2931	4	5	7	11	17
460	56,842	4.0429	2	3	4	5	6
461	1,019	8.0137	3	4	6	9	15
462	12,816	4.1525	3	3	4	5	6
463	3,902	17.8398	5	8	13	21	35
464	6,424	10.3534	3	5	8	12	20
465	1,995	5.7193	1	3	4	7	11
466	4,353	9.3094	3	5	7	11	17
467	18,086	5.1962	3	3	4	6	9
468	17,838	3.7445	2	3	3	4	6
469	34,657	7.8917	3	4	6	9	14
470	422,777	3.7928	3	3	3	4	6
471	2,810	10.0356	2	4	8	14	20
472	7,911	4.0760	1	1	3	5	9
473	24,049	1.8870	1	1	1	2	3
474	2,789	12.5378	4	6	10	16	23
475	3,554	8.0850	3	4	6	10	15
476	1,326	4.6026	1	2	3	6	9
477	2,992	11.0642	3	6	9	14	21
478	9,479	6.4737	1	3	5	9	13
479	9,611	2.8434	1	1	1	4	7
480	30,277	9.0006	4	5	7	11	16
481	79,644	5.7397	3	4	5	7	9
482	40,573	4.6645	3	3	4	5	7
483	9,448	3.9178	2	2	3	5	7
484	17,697	2.3014	1	2	2	3	3
485	1,313	11.6085	4	6	9	14	22
486	2,392	7.6342	3	4	6	9	13
487	1,263	5.2407	3	3	5	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
488	3,077	4.9870	2	3	4	6	9
489	5,544	2.8746	1	2	3	3	5
490	24,413	4.2859	1	1	3	5	9
491	49,867	2.1256	1	1	2	3	4
492	5,973	8.4291	3	4	7	10	15
493	19,019	5.0552	2	3	4	6	9
494	27,794	3.2192	1	2	3	4	6
495	1,949	10.4197	3	5	8	13	20
496	6,239	5.9532	2	3	5	7	11
497	6,348	2.9020	1	1	2	4	6
498	1,363	7.4967	2	3	6	9	15
499	1,014	2.8264	1	1	2	3	6
500	1,814	10.9912	3	5	9	14	21
501	4,512	5.9865	2	3	5	8	11
502	6,034	2.8462	1	1	2	3	5
503	869	8.7710	3	5	7	11	16
504	2,426	6.3920	2	3	5	8	12
505	2,572	3.2473	1	1	3	4	6
506	737	3.5658	1	1	2	4	7
507	990	4.8313	1	2	3	6	9
508	2,112	1.9938	1	1	2	2	3
509	447	3.1409	1	1	2	4	7
510	1,205	6.3668	2	3	5	8	12
511	4,384	3.9245	1	2	3	5	7
512	9,682	2.1644	1	1	2	3	4
513	1,264	4.6701	1	2	4	6	9
514	1,026	2.5263	1	1	2	3	5
515	4,333	10.0879	3	5	8	13	18
516	11,990	5.8308	1	3	5	8	11
517	14,573	3.0425	1	1	2	4	7
533	886	6.8984	2	3	5	8	13
534	3,367	3.9109	1	2	3	5	7
535	8,407	5.8464	2	3	4	7	11
536	33,989	3.8485	1	3	3	5	6
537	864	4.3275	2	3	3	5	7
538	912	3.0033	1	2	3	4	5
539	2,770	10.4419	3	5	8	12	19
540	5,133	7.1946	2	4	6	8	12
541	1,513	5.2459	2	3	4	6	9
542	6,477	8.5594	3	4	7	11	16
543	17,165	5.7439	2	3	5	7	11
544	8,698	4.1857	2	3	4	5	7
545	4,469	8.7178	2	4	6	11	18

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
546	5,732	5.3210	2	3	4	7	10
547	4,024	3.7127	1	2	3	5	7
548	662	8.9789	2	4	7	11	17
549	1,180	6.2195	2	3	5	7	11
550	629	4.0684	1	2	4	5	7
551	12,554	6.9083	2	3	5	9	13
552	81,135	4.0657	1	2	3	5	7
553	3,473	5.6931	2	3	5	7	11
554	17,960	3.5925	1	2	3	4	6
555	2,213	4.6652	1	2	3	6	9
556	16,721	3.1086	1	1	3	4	6
557	6,351	6.5807	2	4	5	8	12
558	17,001	4.2775	2	3	4	5	7
559	2,060	7.1903	2	3	6	9	14
560	5,261	4.7991	1	2	4	6	9
561	6,494	2.6780	1	1	2	3	5
562	6,817	6.1289	2	3	5	7	11
563	34,758	3.6319	1	2	3	4	6
564	1,897	7.0242	2	3	5	9	13
565	3,921	4.8253	2	3	4	6	9
566	2,235	3.4644	1	2	3	4	6
573	5,202	13.7263	4	6	10	16	27
574	10,285	8.8829	3	4	7	10	16
575	4,285	5.5613	2	3	5	7	10
576	609	12.3021	2	5	8	15	27
577	2,367	6.1639	1	2	4	7	13
578	2,856	3.2342	1	1	2	4	7
579	3,984	10.6473	3	5	8	13	20
580	10,655	5.2710	1	2	4	7	11
581	11,449	2.4068	1	1	2	3	5
582	5,597	2.7938	1	1	2	3	5
583	8,482	1.7449	1	1	1	2	3
584	793	5.4905	1	2	4	7	12
585	1,291	2.1108	1	1	1	2	4
592	5,115	8.7668	3	4	7	10	16
593	11,923	6.1598	2	3	5	7	11
594	2,045	4.6577	1	2	4	6	8
595	1,406	8.1636	2	4	6	10	15
596	5,140	4.6486	1	2	4	6	8
597	589	7.9949	2	3	6	10	15
598	1,347	5.6474	1	3	4	7	10
599	251	3.5060	1	1	2	4	6
600	974	5.3727	2	3	4	6	10

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
601	872	3.5963	1	2	3	5	6
602	25,298	6.8834	2	4	6	8	13
603	133,802	4.5950	2	3	4	6	8
604	3,224	5.4373	1	3	4	7	10
605	20,521	3.3649	1	2	3	4	6
606	1,581	5.8963	1	3	4	7	11
607	6,710	3.6037	1	2	3	4	7
614	1,606	7.0367	2	3	5	8	14
615	1,457	3.0645	1	2	3	4	5
616	1,024	16.6045	6	9	13	20	29
617	7,076	8.4218	3	5	7	11	15
618	173	6.0867	2	3	6	8	10
619	798	7.8972	2	3	5	8	17
620	2,604	3.4224	1	2	3	4	6
621	9,827	1.9012	1	1	2	2	3
622	827	15.7932	4	7	11	19	32
623	3,277	8.8682	3	4	7	11	16
624	349	5.4756	2	3	5	7	10
625	1,367	7.0402	1	2	5	9	16
626	2,905	2.9460	1	1	2	3	6
627	13,455	1.4427	1	1	1	2	2
628	3,389	11.0481	2	4	8	14	22
629	4,538	8.4606	3	5	7	10	15
630	477	4.7191	1	2	4	7	10
637	21,664	5.7534	2	3	4	7	11
638	49,378	4.1705	1	2	3	5	8
639	30,457	2.9371	1	2	2	4	5
640	63,135	5.0934	1	2	4	6	10
641	193,807	3.6784	1	2	3	5	7
642	1,580	4.8994	1	2	4	6	8
643	6,783	7.3211	2	4	6	9	13
644	12,659	5.2367	2	3	4	7	10
645	7,336	3.6882	1	2	3	5	7
652	9,764	7.5631	4	5	6	8	13
653	1,901	16.4298	7	8	13	20	30
654	3,759	9.3113	5	6	8	11	15
655	1,370	5.8577	2	4	6	7	9
656	4,579	9.8609	3	5	8	12	19
657	7,812	5.5988	2	3	5	7	9
658	7,462	3.4598	2	2	3	4	5
659	5,030	10.7362	3	5	8	13	21
660	7,275	5.9908	2	3	5	7	12
661	4,065	3.0273	1	2	2	4	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
662	969	10.2033	2	5	8	13	20
663	1,987	4.8712	1	2	3	6	10
664	3,813	1.9226	1	1	1	2	4
665	802	11.3641	3	6	10	15	20
666	2,195	6.0770	1	2	4	8	13
667	3,259	2.2844	1	1	2	2	4
668	4,807	8.3035	2	4	6	11	16
669	12,983	4.2204	1	2	3	5	9
670	10,420	2.3239	1	1	2	3	5
671	895	5.9095	1	2	4	8	12
672	782	2.4322	1	1	2	3	5
673	12,756	9.5731	1	3	7	13	20
674	10,388	6.8027	1	2	5	9	14
675	5,310	2.0516	1	1	1	2	4
682	100,573	7.0067	2	3	5	9	14
683	139,997	5.2246	2	3	4	7	9
684	35,054	3.5261	1	2	3	4	6
685	2,420	3.4632	1	1	2	4	7
686	2,017	7.2226	2	3	6	9	14
687	3,177	5.0872	1	2	4	7	9
688	956	2.9623	1	1	2	4	6
689	61,977	5.9422	2	3	5	7	11
690	207,889	4.1437	2	2	3	5	7
691	1,007	4.1470	1	2	3	5	8
692	430	2.3651	1	1	2	3	5
693	3,324	4.5752	1	2	3	6	9
694	16,666	2.4510	1	1	2	3	5
695	1,035	5.7874	1	2	4	7	11
696	10,263	3.1953	1	2	3	4	6
697	576	3.4236	1	1	2	4	7
698	26,595	6.5699	2	3	5	8	13
699	26,394	4.6624	1	2	4	6	9
700	10,514	3.3064	1	2	3	4	6
707	5,996	4.2523	1	2	3	5	8
708	18,257	1.9853	1	1	2	2	3
709	816	5.9681	1	2	4	7	13
710	1,772	1.6236	1	1	1	2	3
711	782	7.3478	1	3	6	10	15
712	534	2.5805	1	1	2	3	5
713	10,934	4.0802	1	2	3	5	9
714	26,578	1.8649	1	1	2	2	3
715	545	6.2110	1	2	4	9	14
716	1,112	1.4433	1	1	1	1	2

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
717	816	6.7672	1	3	5	8	14
718	560	2.6554	1	1	2	3	5
722	872	6.9484	2	3	5	9	13
723	1,833	5.0371	1	2	4	6	9
724	401	2.8254	1	1	2	3	5
725	992	5.0927	2	2	4	6	10
726	3,430	3.4685	1	2	3	4	7
727	1,497	6.3507	2	3	5	8	12
728	5,886	4.0753	1	2	3	5	7
729	758	4.9063	1	2	4	6	9
730	362	2.7541	1	1	2	4	5
734	1,621	7.7193	2	3	5	9	15
735	1,053	2.9820	1	2	3	4	5
736	974	14.0462	5	8	11	18	25
737	3,285	6.8301	3	4	6	8	12
738	760	3.6868	2	3	3	4	6
739	1,087	9.8813	3	5	7	12	20
740	4,528	4.9282	2	3	4	6	8
741	5,659	2.7487	1	2	3	3	4
742	11,105	4.2674	1	2	3	5	8
743	30,411	2.1669	1	1	2	3	3
744	1,703	5.6876	1	2	4	7	11
745	1,433	2.5108	1	1	2	3	4
746	2,749	4.0135	1	2	3	5	8
747	8,406	1.8256	1	1	2	2	3
748	19,833	1.7145	1	1	1	2	3
749	1,045	9.0775	2	4	7	11	18
750	409	3.0098	1	1	2	4	6
754	1,302	8.4524	2	4	6	10	15
755	3,220	5.4398	1	2	4	7	10
756	545	2.9266	1	1	2	4	6
757	1,560	8.4250	3	4	6	11	16
758	1,977	5.8786	2	3	5	7	11
759	1,266	4.3910	2	2	4	5	8
760	1,848	3.8853	1	2	3	5	8
761	1,342	2.4247	1	1	2	3	4
765	3,110	5.1849	2	3	4	5	7
766	2,787	3.0377	2	2	3	3	4
767	139	3.0144	2	2	2	3	4
768	9	5.5556	2	3	5	6	8
769	85	6.9294	1	2	4	7	15
770	223	1.8879	1	1	1	2	4
774	1,622	3.2528	2	2	2	3	4

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
775	5,839	2.2875	1	2	2	3	3
776	559	3.5063	1	2	2	4	6
777	232	2.2802	1	1	2	3	4
778	444	3.0045	1	1	2	3	5
779	124	2.1290	1	1	1	2	3
780	45	1.2889	1	1	1	1	3
781	3,106	3.8200	1	1	2	4	7
782	179	2.4022	1	1	1	3	4
799	628	13.7516	5	7	11	17	26
800	693	7.4343	2	4	6	9	14
801	420	4.0905	1	2	3	5	7
802	912	11.7072	3	5	9	15	23
803	1,168	6.8493	2	3	5	9	14
804	839	3.1955	1	1	2	4	6
808	7,773	8.1536	3	4	6	10	15
809	13,784	5.1756	2	3	4	6	9
810	2,552	3.8617	1	2	3	5	7
811	27,903	5.4114	1	2	4	7	11
812	93,101	3.6599	1	2	3	5	7
813	13,623	5.1863	1	2	4	6	10
814	1,921	6.7590	2	3	5	8	13
815	3,765	4.6359	1	2	4	6	9
816	1,890	3.3762	1	2	3	4	6
820	1,383	16.6457	5	8	13	21	31
821	2,230	7.4785	1	3	6	10	15
822	1,873	3.2814	1	1	2	4	7
823	2,433	14.6038	4	7	12	18	27
824	2,982	8.5332	2	4	7	11	16
825	1,626	4.1667	1	1	3	6	9
826	654	14.7875	5	7	12	19	27
827	1,316	6.9347	2	3	6	9	13
828	795	3.4994	1	2	3	5	7
829	1,362	9.5661	2	3	7	12	21
830	410	3.0878	1	1	2	4	6
834	4,232	14.9702	2	4	9	23	34
835	2,806	9.5937	2	3	6	11	27
836	1,385	4.8123	1	2	3	5	9
837	1,213	23.4386	5	10	23	31	43
838	1,459	12.8876	3	4	6	22	30
839	1,437	5.9395	3	4	5	6	8
840	9,999	10.4429	3	5	8	13	21
841	10,004	6.6273	2	3	5	8	13
842	4,494	4.2401	1	2	3	6	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
843	1,842	7.9772	2	4	6	10	15
844	2,712	5.9687	2	3	5	8	11
845	609	4.0706	1	2	3	5	8
846	2,630	8.4700	2	4	6	10	18
847	23,046	3.3681	1	2	3	4	6
848	1,411	3.2296	1	1	3	4	5
849	1,104	6.2002	1	3	5	6	13
853	39,110	16.1920	5	8	13	20	30
854	8,336	10.7035	4	6	9	13	19
855	452	7.1549	2	4	6	9	13
856	5,925	15.3473	4	7	12	19	29
857	9,538	8.1035	3	4	6	10	15
858	2,695	5.5206	2	3	5	7	10
862	9,377	7.9542	2	4	6	10	15
863	21,889	5.0721	2	3	4	6	9
864	18,070	3.8687	1	2	3	5	7
865	2,890	6.1453	2	3	4	7	12
866	9,446	3.4428	1	2	3	4	6
867	5,466	9.4050	3	4	7	12	19
868	2,833	5.3484	2	3	4	7	10
869	981	4.0438	1	2	3	5	7
870	25,347	15.4319	6	9	13	19	26
871	263,754	7.3081	2	3	6	9	14
872	93,114	5.5501	2	3	5	7	10
876	705	12.9504	2	4	8	15	25
880	8,770	3.1447	1	1	2	4	6
881	4,670	4.2499	1	2	3	5	8
882	1,722	4.4245	1	2	3	5	8
883	897	8.0870	1	3	5	8	16
884	19,658	5.6097	2	3	4	6	10
885	85,367	7.4228	2	3	6	9	14
886	514	6.0486	1	2	4	7	12
887	576	4.6372	1	2	3	5	10
894	4,310	2.9353	1	1	2	3	4
895	6,585	10.5333	3	4	6	8	9
896	6,846	6.7463	2	3	5	8	13
897	35,895	4.0188	1	2	3	5	6
901	928	14.8384	3	6	10	19	30
902	1,986	7.9678	2	3	6	10	16
903	1,138	4.4754	1	2	3	6	9
904	1,492	11.1340	2	4	7	13	21
905	846	4.5697	1	2	4	6	8
906	708	3.1412	1	1	2	3	6

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
907	8,861	11.6114	3	5	8	14	23
908	8,851	6.3926	2	3	5	8	12
909	5,121	3.3677	1	1	3	4	6
913	1,060	5.9226	1	3	4	7	11
914	5,928	3.3568	1	2	3	4	6
915	1,372	4.6173	1	2	3	6	10
916	5,382	2.0970	1	1	2	2	4
917	20,240	5.1708	1	2	4	6	10
918	35,780	2.6687	1	1	2	3	5
919	11,478	6.3055	2	3	4	8	12
920	15,001	4.2333	1	2	3	5	8
921	8,518	2.8282	1	1	2	3	5
922	1,301	5.4374	1	2	4	7	11
923	3,349	3.1541	1	1	2	4	6
927	164	32.9146	7	16	26	43	64
928	871	16.3605	3	7	13	21	31
929	422	7.2275	1	2	5	10	15
933	153	5.9281	1	1	1	5	17
934	707	6.1259	1	2	5	8	12
935	2,092	5.2729	1	2	3	6	11
939	783	10.8135	2	4	8	13	22
940	1,710	5.6942	1	2	3	7	12
941	1,755	2.5624	1	1	2	3	5
945	6,771	10.1167	4	6	8	11	14
946	3,072	7.6891	3	4	6	7	8
947	12,264	5.0761	1	2	4	6	10
948	54,429	3.4542	1	2	3	4	6
949	716	4.7807	1	1	2	5	8
950	307	3.3029	1	1	2	4	6
951	906	4.0519	1	1	2	3	6
955	473	12.8943	2	6	10	17	24
956	4,304	9.0244	4	5	7	10	16
957	1,451	15.1392	3	7	13	20	28
958	1,137	9.5163	3	5	8	12	17
959	233	5.8112	1	3	5	7	11
963	1,862	9.2240	1	4	7	12	19
964	2,777	5.7523	2	3	5	7	10
965	955	3.8408	1	2	3	5	7
969	642	18.7508	5	8	14	22	35
970	120	8.8167	2	3	6	11	15
974	6,102	10.0003	2	4	7	13	20
975	4,414	6.8382	2	3	5	8	13
976	1,949	4.6634	1	2	4	6	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
977	4,007	5.0142	1	2	4	6	9
981	30,196	14.5442	5	7	12	18	27
982	20,228	8.9547	3	5	7	11	16
983	5,817	4.6208	1	2	4	6	9
984	776	14.5361	5	8	12	18	26
985	940	8.7277	2	3	7	12	17
986	564	4.2500	1	1	3	6	10
987	8,946	12.5372	3	6	10	16	23
988	11,127	7.2871	2	3	6	9	14
989	4,785	3.6474	1	1	3	5	8
998	1	2.0000	2	2	2	2	2
	11,601,794						

TABLE 7B.--MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2008 MedPAR UPDATE--DECEMBER 2008 GROUPER V27.0 MS-DRGs

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	793	43.3947	11	20	32	56	88
2	210	21.5000	8	10	15	25	40
3	23,339	38.0577	15	22	31	46	65
4	22,243	28.0387	11	16	23	34	48
5	616	21.4773	7	9	15	26	44
6	167	10.2455	6	7	9	11	17
7	361	18.7673	8	10	15	21	34
8	488	12.3033	6	7	9	13	23
9	1,541	21.2219	8	16	19	24	34
10	137	9.9708	5	6	9	11	16
11	1,419	16.2016	6	8	12	19	29
12	2,009	10.5142	4	6	9	13	19
13	1,085	6.8949	3	4	6	8	11
20	1,045	18.2220	6	11	17	23	31
21	487	14.4004	5	9	14	18	23
22	157	9.0191	3	6	9	12	14
23	4,348	12.1097	2	5	10	16	24
24	2,095	8.0549	1	3	7	11	16
25	10,354	12.1228	4	6	10	16	23
26	11,695	7.7535	2	4	7	10	14
27	12,615	4.1317	1	2	3	5	8
28	1,751	13.4118	4	7	10	17	26
29	3,503	6.6646	1	3	5	9	14
30	3,459	3.5432	1	1	3	5	7
31	1,103	13.2457	3	5	10	17	28
32	2,782	5.5234	1	2	4	7	12
33	3,340	2.8485	1	1	2	3	5
34	864	6.9329	1	2	5	9	15
35	2,422	2.9232	1	1	2	4	7
36	5,993	1.5767	1	1	1	2	3
37	5,577	8.2666	2	3	6	11	16
38	14,867	3.4587	1	1	2	4	8
39	48,660	1.7240	1	1	1	2	3
40	5,091	12.7739	3	6	10	16	25
41	7,775	7.0046	1	3	6	9	13
42	4,188	3.3405	1	1	2	4	7
52	1,410	6.2589	2	3	5	8	12
53	588	4.0306	1	2	3	5	7
54	6,761	6.7173	2	3	5	8	14
55	14,752	4.8435	1	2	4	6	9
56	10,661	7.6271	2	3	6	9	15
57	47,070	4.9476	2	3	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
58	898	7.7829	2	4	6	9	14
59	3,293	5.0310	2	3	4	6	9
60	3,780	3.8026	1	2	3	5	6
61	2,055	8.6764	2	4	7	11	17
62	3,080	5.9282	3	3	5	7	10
63	1,230	4.1878	2	3	4	5	7
64	65,770	7.1672	2	3	6	9	14
65	112,706	4.9917	2	3	4	6	9
66	74,884	3.4551	1	2	3	4	6
67	1,995	5.5193	2	3	4	7	10
68	12,189	3.3854	1	2	3	4	6
69	100,473	2.9169	1	2	2	4	5
70	10,457	7.3940	2	4	6	9	14
71	11,844	5.2242	2	3	4	6	9
72	5,411	3.2645	1	2	3	4	6
73	10,865	5.9770	2	3	4	7	12
74	31,990	4.1075	1	2	3	5	8
75	1,319	7.3389	2	4	6	9	14
76	730	3.9151	2	2	3	5	7
77	1,666	6.6248	2	3	5	8	12
78	1,751	4.3347	2	2	3	5	8
79	900	3.2100	1	2	3	4	6
80	1,757	4.9698	1	2	4	6	10
81	5,980	3.4064	1	2	3	4	6
82	2,255	6.3299	1	1	4	9	14
83	2,403	4.9055	1	2	4	6	9
84	2,572	2.9199	1	1	2	4	6
85	7,221	7.3846	2	3	6	9	15
86	13,070	4.8685	1	2	4	6	9
87	12,492	3.0544	1	1	2	4	6
88	1,010	5.4644	1	3	4	7	10
89	2,983	3.7110	1	2	3	5	7
90	2,855	2.4000	1	1	2	3	4
91	10,113	6.1790	2	3	5	8	12
92	19,005	4.3178	1	2	3	5	8
93	15,332	3.0117	1	2	3	4	5
94	1,556	11.6780	4	6	10	15	21
95	1,193	8.0855	2	4	7	11	15
96	624	5.8942	1	3	5	7	10
97	1,352	11.4822	4	6	9	15	21
98	1,037	8.0125	3	4	6	10	15
99	525	5.4495	2	3	5	7	9
100	19,464	6.0779	2	3	4	7	12
101	56,938	3.5375	1	2	3	4	6
102	1,306	4.4012	1	2	3	5	9
103	13,161	3.0335	1	1	2	4	6
113	644	5.7283	1	2	4	7	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
114	463	2.6242	1	1	2	3	5
115	1,030	4.3854	1	2	4	5	7
116	531	3.9510	1	1	2	4	6
117	833	2.0600	1	1	1	2	3
121	770	5.5506	2	3	4	7	10
122	513	4.1774	2	2	3	5	7
123	2,898	2.8357	1	2	2	3	5
124	877	5.5690	1	2	4	7	10
125	4,170	3.3007	1	2	3	4	6
129	1,544	5.1949	1	2	4	6	10
130	951	2.9600	1	1	2	4	6
131	1,006	5.6730	1	2	4	7	12
132	833	2.6759	1	1	2	3	5
133	2,204	5.4796	1	2	4	7	12
134	2,882	2.1790	1	1	1	2	4
135	389	6.5064	1	2	5	8	14
136	422	2.1564	1	1	1	3	5
137	851	5.4395	1	2	4	7	10
138	817	2.4247	1	1	2	3	5
139	1,466	1.6999	1	1	1	2	3
146	844	9.4076	2	4	7	12	18
147	1,502	5.7450	1	2	4	7	11
148	723	3.1646	1	1	2	4	7
149	36,609	2.6943	1	1	2	3	5
150	1,300	5.3654	1	2	4	7	11
151	6,366	2.8677	1	1	2	4	5
152	3,521	4.6407	1	2	4	6	9
153	17,443	3.3134	1	2	3	4	6
154	2,496	6.0469	2	3	5	8	12
155	5,701	4.3192	1	2	4	5	8
156	4,285	3.0264	1	1	2	4	6
157	1,436	6.5891	2	3	5	8	13
158	3,705	4.5455	1	2	3	6	9
159	1,935	2.9339	1	1	2	4	5
163	14,350	14.3208	5	8	12	18	26
164	19,111	7.5432	3	4	6	9	13
165	11,029	4.7676	2	3	4	6	8
166	24,958	12.5049	4	7	10	15	23
167	20,609	7.6074	2	4	6	10	14
168	5,127	4.6066	1	2	4	6	9
175	15,526	7.1117	3	4	6	9	12
176	37,833	5.0757	2	3	5	6	8
177	73,033	8.8511	3	5	7	11	16
178	74,662	7.0612	3	4	6	9	13
179	20,207	5.2159	2	3	4	7	9
180	23,582	7.6185	2	4	6	10	15
181	29,169	5.6175	2	3	4	7	11

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
182	3,795	3.8121	1	2	3	5	7
183	2,698	6.5730	2	3	5	8	12
184	4,885	4.5146	2	3	4	6	8
185	2,251	3.1644	1	2	3	4	6
186	10,894	7.0624	2	3	6	9	14
187	10,569	4.9640	2	2	4	6	9
188	3,792	3.5886	1	2	3	5	7
189	134,237	5.9595	2	3	5	8	11
190	130,697	5.7798	2	3	5	7	10
191	143,853	4.8016	2	3	4	6	9
192	159,639	3.7940	1	2	3	5	7
193	106,201	6.5990	2	4	5	8	12
194	225,158	5.0828	2	3	4	6	9
195	109,919	3.8443	2	2	3	5	7
196	6,909	6.9945	2	4	6	9	13
197	7,112	5.1294	2	3	4	7	9
198	3,610	3.9213	1	2	3	5	7
199	3,866	8.2809	2	4	7	11	16
200	8,693	4.8049	1	2	4	6	9
201	3,113	3.7527	1	2	3	5	7
202	38,666	4.2877	2	2	4	5	8
203	35,936	3.2853	1	2	3	4	6
204	25,583	2.7546	1	1	2	3	5
205	6,944	5.4159	1	2	4	7	11
206	21,350	3.3146	1	2	3	4	6
207	39,269	15.0382	6	9	13	18	25
208	79,781	7.1732	1	3	6	10	14
215	137	14.3139	1	3	7	17	30
216	10,141	18.0888	8	11	16	22	31
217	6,633	11.1963	6	7	10	14	18
218	1,457	8.3624	5	6	7	10	13
219	12,768	13.5365	6	7	11	17	25
220	14,704	8.0099	4	6	7	9	13
221	5,071	6.0919	4	5	6	7	9
222	3,342	12.3432	4	7	10	15	23
223	4,553	5.4386	1	2	5	8	11
224	3,009	9.9435	3	5	8	13	19
225	4,886	5.0526	1	2	4	7	9
226	8,272	8.5204	1	3	7	11	17
227	34,151	2.7643	1	1	1	3	7
228	3,276	14.2088	6	8	12	17	24
229	3,437	8.4713	4	6	7	10	14
230	1,197	5.8588	2	4	6	7	10
231	1,625	12.7723	6	8	11	15	23
232	1,306	9.1340	5	7	9	11	14
233	18,256	13.6374	7	9	12	16	23
234	29,030	8.7370	5	6	8	10	13

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
235	10,761	11.1170	5	7	9	13	19
236	26,652	6.5366	4	5	6	8	10
237	24,593	10.4289	2	5	8	14	21
238	40,498	4.2736	1	1	3	6	9
239	11,898	15.4481	5	8	12	20	29
240	11,062	9.6743	3	5	8	12	18
241	1,982	6.2608	3	3	5	8	11
242	21,622	8.0614	2	4	7	10	15
243	39,375	4.7748	1	2	4	6	9
244	52,950	2.7365	1	1	2	4	6
245	4,193	3.3754	1	1	2	4	8
246	31,288	5.0316	1	2	4	7	11
247	152,978	2.0938	1	1	1	3	4
248	20,209	6.0493	1	3	5	8	12
249	70,094	2.5098	1	1	2	3	5
250	8,331	6.9692	2	3	5	9	14
251	38,976	2.7250	1	1	2	4	6
252	45,045	8.2052	1	3	6	11	17
253	44,358	5.8970	1	2	5	8	12
254	46,157	2.6143	1	1	2	3	6
255	2,554	9.8512	3	5	8	12	18
256	3,154	7.0282	2	4	6	9	13
257	504	4.5238	1	2	3	6	9
258	856	6.8271	2	3	5	8	13
259	6,370	2.7793	1	1	2	4	6
260	1,793	10.6012	2	4	8	13	21
261	3,926	4.0815	1	1	3	5	8
262	2,929	2.4950	1	1	2	3	5
263	578	5.4273	1	1	3	7	12
264	25,148	8.5237	1	3	6	11	18
265	2,127	3.4452	1	1	2	4	7
280	81,221	6.8105	2	4	6	9	12
281	52,956	4.4422	1	2	4	6	8
282	42,780	2.8932	1	1	2	4	5
283	15,866	5.2942	1	1	3	7	12
284	3,311	2.7197	1	1	2	3	6
285	1,855	1.9030	1	1	1	2	4
286	30,113	6.6965	2	3	5	8	13
287	145,874	3.0556	1	1	2	4	6
288	3,087	11.7023	4	6	9	14	21
289	1,209	7.9404	3	5	7	10	13
290	311	5.5402	2	3	5	7	9
291	208,180	6.3725	2	3	5	8	12
292	215,057	4.7277	2	3	4	6	8
293	144,230	3.4298	1	2	3	4	6
294	1,606	5.6258	2	3	5	7	10
295	1,051	4.2103	2	3	4	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
296	2,223	2.9663	1	1	1	3	7
297	744	1.7702	1	1	1	2	3
298	495	1.2364	1	1	1	1	1
299	23,717	6.3749	2	3	5	8	12
300	46,995	4.9501	2	3	4	6	9
301	32,544	3.5632	1	2	3	5	6
302	8,808	4.1437	1	2	3	5	8
303	61,359	2.4402	1	1	2	3	4
304	2,795	4.7903	1	2	4	6	9
305	32,828	2.7771	1	1	2	3	5
306	2,605	5.5543	1	3	4	7	10
307	6,003	3.3258	1	2	3	4	6
308	58,293	5.2471	2	3	4	7	10
309	95,774	3.7594	1	2	3	5	7
310	142,159	2.5841	1	1	2	3	5
311	19,309	2.2734	1	1	2	3	4
312	169,548	3.0591	1	2	2	4	6
313	195,950	2.0973	1	1	2	3	4
314	66,868	6.9094	2	3	5	9	14
315	31,185	4.3429	1	2	3	6	8
316	15,665	2.7391	1	1	2	3	5
326	11,818	16.4855	6	8	13	21	31
327	10,398	9.2186	3	5	8	12	17
328	8,224	3.9618	1	2	3	5	8
329	51,629	15.6116	6	8	13	19	28
330	62,460	9.2140	4	6	8	11	16
331	26,549	5.4753	3	4	5	7	8
332	2,086	14.3821	6	8	12	18	26
333	5,872	8.3893	4	5	7	10	14
334	3,439	5.1876	2	3	5	7	8
335	8,195	13.9824	5	8	12	18	25
336	12,806	8.7853	3	5	8	11	15
337	8,096	5.2538	1	3	5	7	10
338	1,672	10.2482	4	6	9	13	18
339	3,231	6.6227	3	4	6	8	11
340	3,503	3.9438	2	2	4	5	7
341	1,023	6.7253	2	3	5	9	13
342	2,843	3.9595	1	2	3	5	8
343	7,009	2.0648	1	1	2	3	4
344	1,029	11.2663	4	6	9	14	21
345	3,055	6.9303	3	4	6	8	12
346	2,900	4.7541	2	3	4	6	7
347	1,670	8.7102	2	4	7	11	18
348	4,356	5.4970	1	3	4	7	10
349	4,584	2.9191	1	1	2	4	6
350	1,955	7.8266	2	3	6	10	16
351	4,606	4.4390	1	2	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
352	7,371	2.3725	1	1	2	3	5
353	3,762	8.4272	2	4	7	11	16
354	9,075	4.9438	1	3	4	6	9
355	14,176	2.8165	1	1	2	4	5
356	8,746	12.9670	3	6	10	16	25
357	7,767	7.6291	2	4	6	9	14
358	2,142	4.3375	1	2	4	6	8
368	3,838	6.5422	2	3	5	8	13
369	5,693	4.5631	2	3	4	6	8
370	2,318	3.2325	1	2	3	4	6
371	28,649	8.6596	3	4	7	11	17
372	29,950	6.6003	2	4	5	8	12
373	13,070	4.7820	2	3	4	6	8
374	10,020	8.5017	2	4	7	11	16
375	17,919	5.8483	2	3	5	7	11
376	3,237	3.8848	1	2	3	5	7
377	62,213	6.2565	2	3	5	8	12
378	127,843	4.2395	2	2	4	5	7
379	64,406	3.1571	1	2	3	4	5
380	3,437	7.0201	2	3	6	9	13
381	6,099	4.7964	2	3	4	6	9
382	3,336	3.4664	1	2	3	4	6
383	1,631	5.4856	2	3	4	7	10
384	7,574	3.7527	1	2	3	5	7
385	2,952	7.9394	2	4	6	10	16
386	8,069	5.3599	2	3	4	7	10
387	4,410	4.1132	1	2	3	5	7
388	22,994	6.9898	2	3	5	9	14
389	50,225	4.8550	2	3	4	6	9
390	44,859	3.4444	1	2	3	4	6
391	50,585	5.1404	1	2	4	6	10
392	252,286	3.4450	1	2	3	4	6
393	25,366	6.7993	2	3	5	8	14
394	49,604	4.6898	1	2	4	6	9
395	21,921	3.1720	1	2	3	4	6
405	4,383	16.5747	5	8	13	21	32
406	5,291	8.4593	2	5	7	10	15
407	1,950	5.1897	1	3	5	7	9
408	1,671	14.1364	5	7	12	17	26
409	1,438	8.7566	4	5	8	11	15
410	509	6.0982	2	4	6	8	10
411	941	12.4527	5	7	10	15	22
412	906	8.4272	4	5	7	10	14
413	631	5.3693	2	3	5	7	9
414	5,426	11.6742	4	7	9	14	20
415	5,863	7.2185	3	4	6	9	12
416	4,680	4.4583	2	3	4	6	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
417	20,207	7.9868	3	4	6	10	15
418	26,846	5.3043	2	3	5	7	10
419	32,727	3.0418	1	1	2	4	6
420	829	13.9831	3	6	11	18	29
421	1,039	6.7546	2	3	5	8	14
422	258	4.3721	1	2	4	5	8
423	1,634	14.7944	4	7	11	19	28
424	822	8.8029	3	4	7	11	17
425	93	5.1613	1	2	5	7	9
432	14,948	6.7699	2	3	5	8	13
433	9,242	4.5610	1	2	4	6	8
434	603	3.4129	1	2	3	4	6
435	14,078	7.3820	2	3	6	9	14
436	12,509	5.6050	2	3	4	7	11
437	2,867	3.9219	1	2	3	5	8
438	17,583	7.4331	2	3	5	9	15
439	25,610	5.0299	2	3	4	6	9
440	21,822	3.6092	1	2	3	4	6
441	14,600	7.1405	2	3	5	9	14
442	15,637	4.7673	2	2	4	6	9
443	5,574	3.4740	1	2	3	4	6
444	14,181	6.3417	2	3	5	8	12
445	17,774	4.5492	1	2	4	6	8
446	14,328	3.1145	1	2	3	4	6
453	1,113	14.3360	5	7	11	18	28
454	2,411	7.1721	3	4	6	8	13
455	2,064	4.0262	1	2	4	5	7
456	1,122	13.9358	5	7	11	17	26
457	2,874	7.2363	3	4	6	8	13
458	1,477	4.2986	2	3	4	5	7
459	4,244	9.2931	4	5	7	11	17
460	56,842	4.0429	2	3	4	5	6
461	1,019	8.0137	3	4	6	9	15
462	12,816	4.1525	3	3	4	5	6
463	5,341	16.6677	5	7	12	20	33
464	9,652	9.4818	3	5	7	11	18
465	3,340	5.7000	2	3	5	7	10
466	4,270	9.1494	3	5	7	11	16
467	17,925	5.1518	3	3	4	6	8
468	17,767	3.7294	2	3	3	4	6
469	34,634	7.8840	3	4	6	9	14
470	422,686	3.7924	3	3	3	4	6
471	2,810	10.0356	2	4	8	14	20
472	7,911	4.0760	1	1	3	5	9
473	24,049	1.8870	1	1	1	2	3
474	2,773	12.4832	4	6	10	16	23
475	3,535	7.9997	3	4	6	10	15

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
476	1,324	4.6057	1	2	3	6	9
477	2,982	11.0423	3	6	9	14	20
478	9,466	6.4678	1	3	5	9	13
479	9,608	2.8420	1	1	1	4	7
480	29,668	8.8940	4	5	7	11	15
481	78,586	5.7034	3	4	5	7	9
482	40,251	4.6476	3	3	4	5	7
483	9,448	3.9178	2	2	3	5	7
484	17,697	2.3014	1	2	2	3	3
485	1,147	11.3200	4	6	9	14	21
486	2,043	7.5144	3	4	6	9	13
487	1,137	5.1495	2	3	5	6	9
488	3,012	4.9542	2	3	4	6	9
489	5,509	2.8715	1	2	3	3	5
490	24,411	4.2856	1	1	3	5	9
491	49,867	2.1256	1	1	2	3	4
492	5,972	8.4300	3	4	7	10	15
493	18,998	5.0538	2	3	4	6	9
494	27,786	3.2192	1	2	3	4	6
495	1,431	10.0342	3	5	8	12	19
496	4,754	5.6916	1	3	4	7	11
497	5,593	2.6018	1	1	2	3	5
498	1,363	7.4967	2	3	6	9	15
499	1,014	2.8264	1	1	2	3	6
500	1,814	10.9912	3	5	9	14	21
501	4,512	5.9865	2	3	5	8	11
502	6,034	2.8462	1	1	2	3	5
503	869	8.7710	3	5	7	11	16
504	2,426	6.3920	2	3	5	8	12
505	2,572	3.2473	1	1	3	4	6
506	737	3.5658	1	1	2	4	7
507	990	4.8313	1	2	3	6	9
508	2,112	1.9938	1	1	2	2	3
509	447	3.1409	1	1	2	4	7
510	1,205	6.3668	2	3	5	8	12
511	4,384	3.9245	1	2	3	5	7
512	9,682	2.1644	1	1	2	3	4
513	1,264	4.6701	1	2	4	6	9
514	1,026	2.5263	1	1	2	3	5
515	4,333	10.0879	3	5	8	13	18
516	11,990	5.8308	1	3	5	8	11
517	14,573	3.0425	1	1	2	4	7
533	886	6.8984	2	3	5	8	13
534	3,367	3.9109	1	2	3	5	7
535	8,407	5.8464	2	3	4	7	11
536	33,989	3.8485	1	3	3	5	6
537	864	4.3275	2	3	3	5	7

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
538	912	3.0033	1	2	3	4	5
539	2,770	10.4419	3	5	8	12	19
540	5,133	7.1946	2	4	6	8	12
541	1,513	5.2459	2	3	4	6	9
542	6,477	8.5594	3	4	7	11	16
543	17,165	5.7439	2	3	5	7	11
544	8,698	4.1857	2	3	4	5	7
545	4,469	8.7178	2	4	6	11	18
546	5,732	5.3210	2	3	4	7	10
547	4,024	3.7127	1	2	3	5	7
548	662	8.9789	2	4	7	11	17
549	1,180	6.2195	2	3	5	7	11
550	629	4.0684	1	2	4	5	7
551	12,554	6.9083	2	3	5	9	13
552	81,135	4.0657	1	2	3	5	7
553	3,473	5.6931	2	3	5	7	11
554	17,960	3.5925	1	2	3	4	6
555	2,213	4.6652	1	2	3	6	9
556	16,721	3.1086	1	1	3	4	6
557	6,351	6.5807	2	4	5	8	12
558	17,001	4.2775	2	3	4	5	7
559	2,060	7.1903	2	3	6	9	14
560	5,261	4.7991	1	2	4	6	9
561	6,494	2.6780	1	1	2	3	5
562	6,817	6.1289	2	3	5	7	11
563	34,758	3.6319	1	2	3	4	6
564	1,897	7.0242	2	3	5	9	13
565	3,921	4.8253	2	3	4	6	9
566	2,235	3.4644	1	2	3	4	6
573	5,202	13.7263	4	6	10	16	27
574	10,285	8.8829	3	4	7	10	16
575	4,285	5.5613	2	3	5	7	10
576	609	12.3021	2	5	8	15	27
577	2,367	6.1639	1	2	4	7	13
578	2,856	3.2342	1	1	2	4	7
579	3,984	10.6473	3	5	8	13	20
580	10,655	5.2710	1	2	4	7	11
581	11,449	2.4068	1	1	2	3	5
582	5,597	2.7938	1	1	2	3	5
583	8,482	1.7449	1	1	1	2	3
584	793	5.4905	1	2	4	7	12
585	1,291	2.1108	1	1	1	2	4
592	5,115	8.7668	3	4	7	10	16
593	11,923	6.1598	2	3	5	7	11
594	2,045	4.6577	1	2	4	6	8
595	1,406	8.1636	2	4	6	10	15
596	5,140	4.6486	1	2	4	6	8

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
597	589	7.9949	2	3	6	10	15
598	1,347	5.6474	1	3	4	7	10
599	251	3.5060	1	1	2	4	6
600	974	5.3727	2	3	4	6	10
601	872	3.5963	1	2	3	5	6
602	25,298	6.8834	2	4	6	8	13
603	133,802	4.5950	2	3	4	6	8
604	3,224	5.4373	1	3	4	7	10
605	20,521	3.3649	1	2	3	4	6
606	1,581	5.8963	1	3	4	7	11
607	6,710	3.6037	1	2	3	4	7
614	1,606	7.0367	2	3	5	8	14
615	1,457	3.0645	1	2	3	4	5
616	1,024	16.6045	6	9	13	20	29
617	7,076	8.4218	3	5	7	11	15
618	173	6.0867	2	3	6	8	10
619	798	7.8972	2	3	5	8	17
620	2,604	3.4224	1	2	3	4	6
621	9,827	1.9012	1	1	2	2	3
622	827	15.7932	4	7	11	19	32
623	3,277	8.8682	3	4	7	11	16
624	349	5.4756	2	3	5	7	10
625	1,367	7.0402	1	2	5	9	16
626	2,905	2.9460	1	1	2	3	6
627	13,455	1.4427	1	1	1	2	2
628	3,389	11.0481	2	4	8	14	22
629	4,538	8.4606	3	5	7	10	15
630	477	4.7191	1	2	4	7	10
637	21,664	5.7534	2	3	4	7	11
638	49,378	4.1705	1	2	3	5	8
639	30,457	2.9371	1	2	2	4	5
640	63,135	5.0934	1	2	4	6	10
641	193,807	3.6784	1	2	3	5	7
642	1,580	4.8994	1	2	4	6	8
643	6,783	7.3211	2	4	6	9	13
644	12,659	5.2367	2	3	4	7	10
645	7,336	3.6882	1	2	3	5	7
652	9,764	7.5631	4	5	6	8	13
653	1,901	16.4298	7	8	13	20	30
654	3,759	9.3113	5	6	8	11	15
655	1,370	5.8577	2	4	6	7	9
656	4,579	9.8609	3	5	8	12	19
657	7,812	5.5988	2	3	5	7	9
658	7,462	3.4598	2	2	3	4	5
659	5,030	10.7362	3	5	8	13	21
660	7,275	5.9908	2	3	5	7	12
661	4,065	3.0273	1	2	2	4	5

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
662	969	10.2033	2	5	8	13	20
663	1,987	4.8712	1	2	3	6	10
664	3,813	1.9226	1	1	1	2	4
665	802	11.3641	3	6	10	15	20
666	2,195	6.0770	1	2	4	8	13
667	3,259	2.2844	1	1	2	2	4
668	4,807	8.3035	2	4	6	11	16
669	12,983	4.2204	1	2	3	5	9
670	10,420	2.3239	1	1	2	3	5
671	895	5.9095	1	2	4	8	12
672	782	2.4322	1	1	2	3	5
673	12,756	9.5731	1	3	7	13	20
674	10,388	6.8027	1	2	5	9	14
675	5,310	2.0516	1	1	1	2	4
682	100,573	7.0067	2	3	5	9	14
683	139,997	5.2246	2	3	4	7	9
684	35,054	3.5261	1	2	3	4	6
685	2,420	3.4632	1	1	2	4	7
686	2,017	7.2226	2	3	6	9	14
687	3,177	5.0872	1	2	4	7	9
688	956	2.9623	1	1	2	4	6
689	61,977	5.9422	2	3	5	7	11
690	207,889	4.1437	2	2	3	5	7
691	1,007	4.1470	1	2	3	5	8
692	430	2.3651	1	1	2	3	5
693	3,324	4.5752	1	2	3	6	9
694	16,666	2.4510	1	1	2	3	5
695	1,035	5.7874	1	2	4	7	11
696	10,263	3.1953	1	2	3	4	6
697	576	3.4236	1	1	2	4	7
698	26,595	6.5699	2	3	5	8	13
699	26,394	4.6624	1	2	4	6	9
700	10,514	3.3064	1	2	3	4	6
707	5,996	4.2523	1	2	3	5	8
708	18,257	1.9853	1	1	2	2	3
709	816	5.9681	1	2	4	7	13
710	1,772	1.6236	1	1	1	2	3
711	782	7.3478	1	3	6	10	15
712	534	2.5805	1	1	2	3	5
713	10,934	4.0802	1	2	3	5	9
714	26,578	1.8649	1	1	2	2	3
715	545	6.2110	1	2	4	9	14
716	1,112	1.4433	1	1	1	1	2
717	816	6.7672	1	3	5	8	14
718	560	2.6554	1	1	2	3	5
722	872	6.9484	2	3	5	9	13
723	1,833	5.0371	1	2	4	6	9

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
724	401	2.8254	1	1	2	3	5
725	992	5.0927	2	2	4	6	10
726	3,430	3.4685	1	2	3	4	7
727	1,497	6.3507	2	3	5	8	12
728	5,886	4.0753	1	2	3	5	7
729	758	4.9063	1	2	4	6	9
730	362	2.7541	1	1	2	4	5
734	1,621	7.7193	2	3	5	9	15
735	1,053	2.9820	1	2	3	4	5
736	974	14.0462	5	8	11	18	25
737	3,285	6.8301	3	4	6	8	12
738	760	3.6868	2	3	3	4	6
739	1,087	9.8813	3	5	7	12	20
740	4,528	4.9282	2	3	4	6	8
741	5,659	2.7487	1	2	3	3	4
742	11,105	4.2674	1	2	3	5	8
743	30,411	2.1669	1	1	2	3	3
744	1,703	5.6876	1	2	4	7	11
745	1,433	2.5108	1	1	2	3	4
746	2,749	4.0135	1	2	3	5	8
747	8,406	1.8256	1	1	2	2	3
748	19,833	1.7145	1	1	1	2	3
749	1,045	9.0775	2	4	7	11	18
750	409	3.0098	1	1	2	4	6
754	1,302	8.4524	2	4	6	10	15
755	3,220	5.4398	1	2	4	7	10
756	545	2.9266	1	1	2	4	6
757	1,560	8.4250	3	4	6	11	16
758	1,977	5.8786	2	3	5	7	11
759	1,266	4.3910	2	2	4	5	8
760	1,848	3.8853	1	2	3	5	8
761	1,342	2.4247	1	1	2	3	4
765	3,110	5.1849	2	3	4	5	7
766	2,787	3.0377	2	2	3	3	4
767	139	3.0144	2	2	2	3	4
768	9	5.5556	2	3	5	6	8
769	85	6.9294	1	2	4	7	15
770	223	1.8879	1	1	1	2	4
774	1,622	3.2528	2	2	2	3	4
775	5,839	2.2875	1	2	2	3	3
776	559	3.5063	1	2	2	4	6
777	232	2.2802	1	1	2	3	4
778	444	3.0045	1	1	2	3	5
779	124	2.1290	1	1	1	2	3
780	45	1.2889	1	1	1	1	3
781	3,106	3.8200	1	1	2	4	7
782	179	2.4022	1	1	1	3	4

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
799	628	13.7516	5	7	11	17	26
800	693	7.4343	2	4	6	9	14
801	420	4.0905	1	2	3	5	7
802	912	11.7072	3	5	9	15	23
803	1,168	6.8493	2	3	5	9	14
804	839	3.1955	1	1	2	4	6
808	7,773	8.1536	3	4	6	10	15
809	13,784	5.1756	2	3	4	6	9
810	2,552	3.8617	1	2	3	5	7
811	27,903	5.4114	1	2	4	7	11
812	93,101	3.6599	1	2	3	5	7
813	13,623	5.1863	1	2	4	6	10
814	1,921	6.7590	2	3	5	8	13
815	3,765	4.6359	1	2	4	6	9
816	1,890	3.3762	1	2	3	4	6
820	1,383	16.6457	5	8	13	21	31
821	2,230	7.4785	1	3	6	10	15
822	1,873	3.2814	1	1	2	4	7
823	2,433	14.6038	4	7	12	18	27
824	2,982	8.5332	2	4	7	11	16
825	1,626	4.1667	1	1	3	6	9
826	654	14.7875	5	7	12	19	27
827	1,316	6.9347	2	3	6	9	13
828	795	3.4994	1	2	3	5	7
829	1,362	9.5661	2	3	7	12	21
830	410	3.0878	1	1	2	4	6
834	4,232	14.9702	2	4	9	23	34
835	2,806	9.5937	2	3	6	11	27
836	1,385	4.8123	1	2	3	5	9
837	1,213	23.4386	5	10	23	31	43
838	1,459	12.8876	3	4	6	22	30
839	1,437	5.9395	3	4	5	6	8
840	9,999	10.4429	3	5	8	13	21
841	10,004	6.6273	2	3	5	8	13
842	4,494	4.2401	1	2	3	6	8
843	1,842	7.9772	2	4	6	10	15
844	2,712	5.9687	2	3	5	8	11
845	609	4.0706	1	2	3	5	8
846	2,630	8.4700	2	4	6	10	18
847	23,046	3.3681	1	2	3	4	6
848	1,411	3.2296	1	1	3	4	5
849	1,104	6.2002	1	3	5	6	13
853	39,110	16.1920	5	8	13	20	30
854	8,336	10.7035	4	6	9	13	19
855	452	7.1549	2	4	6	9	13
856	5,925	15.3473	4	7	12	19	29
857	9,538	8.1035	3	4	6	10	15

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
858	2,695	5.5206	2	3	5	7	10
862	9,377	7.9542	2	4	6	10	15
863	21,889	5.0721	2	3	4	6	9
864	18,070	3.8687	1	2	3	5	7
865	2,890	6.1453	2	3	4	7	12
866	9,446	3.4428	1	2	3	4	6
867	5,466	9.4050	3	4	7	12	19
868	2,833	5.3484	2	3	4	7	10
869	981	4.0438	1	2	3	5	7
870	25,347	15.4319	6	9	13	19	26
871	263,754	7.3081	2	3	6	9	14
872	93,114	5.5501	2	3	5	7	10
876	705	12.9504	2	4	8	15	25
880	8,770	3.1447	1	1	2	4	6
881	4,670	4.2499	1	2	3	5	8
882	1,722	4.4245	1	2	3	5	8
883	897	8.0870	1	3	5	8	16
884	19,658	5.6097	2	3	4	6	10
885	85,367	7.4228	2	3	6	9	14
886	514	6.0486	1	2	4	7	12
887	576	4.6372	1	2	3	5	10
894	4,310	2.9353	1	1	2	3	4
895	6,585	10.5333	3	4	6	8	9
896	6,846	6.7463	2	3	5	8	13
897	35,895	4.0188	1	2	3	5	6
901	928	14.8384	3	6	10	19	30
902	1,986	7.9678	2	3	6	10	16
903	1,138	4.4754	1	2	3	6	9
904	1,492	11.1340	2	4	7	13	21
905	846	4.5697	1	2	4	6	8
906	708	3.1412	1	1	2	3	6
907	8,861	11.6114	3	5	8	14	23
908	8,851	6.3926	2	3	5	8	12
909	5,121	3.3677	1	1	3	4	6
913	1,060	5.9226	1	3	4	7	11
914	5,928	3.3568	1	2	3	4	6
915	1,372	4.6173	1	2	3	6	10
916	5,382	2.0970	1	1	2	2	4
917	20,240	5.1708	1	2	4	6	10
918	35,780	2.6687	1	1	2	3	5
919	11,478	6.3055	2	3	4	8	12
920	15,001	4.2333	1	2	3	5	8
921	8,518	2.8282	1	1	2	3	5
922	1,301	5.4374	1	2	4	7	11
923	3,349	3.1541	1	1	2	4	6
927	164	32.9146	7	16	26	43	64
928	871	16.3605	3	7	13	21	31

MS-DRG	Number of Discharges	Arithmetic Mean LOS	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
929	422	7.2275	1	2	5	10	15
933	153	5.9281	1	1	1	5	17
934	707	6.1259	1	2	5	8	12
935	2,092	5.2729	1	2	3	6	11
939	783	10.8135	2	4	8	13	22
940	1,710	5.6942	1	2	3	7	12
941	1,755	2.5624	1	1	2	3	5
945	6,771	10.1167	4	6	8	11	14
946	3,072	7.6891	3	4	6	7	8
947	12,264	5.0761	1	2	4	6	10
948	54,429	3.4542	1	2	3	4	6
949	716	4.7807	1	1	2	5	8
950	307	3.3029	1	1	2	4	6
951	906	4.0519	1	1	2	3	6
955	473	12.8943	2	6	10	17	24
956	4,304	9.0244	4	5	7	10	16
957	1,451	15.1392	3	7	13	20	28
958	1,137	9.5163	3	5	8	12	17
959	233	5.8112	1	3	5	7	11
963	1,862	9.2240	1	4	7	12	19
964	2,777	5.7523	2	3	5	7	10
965	955	3.8408	1	2	3	5	7
969	642	18.7508	5	8	14	22	35
970	120	8.8167	2	3	6	11	15
974	6,102	10.0003	2	4	7	13	20
975	4,414	6.8382	2	3	5	8	13
976	1,949	4.6634	1	2	4	6	8
977	4,007	5.0142	1	2	4	6	9
981	30,196	14.5442	5	7	12	18	27
982	20,228	8.9547	3	5	7	11	16
983	5,817	4.6208	1	2	4	6	9
984	776	14.5361	5	8	12	18	26
985	940	8.7277	2	3	7	12	17
986	564	4.2500	1	1	3	6	10
987	8,946	12.5372	3	6	10	16	23
988	11,127	7.2871	2	3	6	9	14
989	4,785	3.6474	1	1	3	5	8
998	1	2.0000	2	2	2	2	2
	11,601,794						

TABLE 8A.—PROPOSED STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS (CCRs) FOR ACUTE CARE HOSPITALS—MARCH 2009

State	Urban	Rural
Alabama	0.25	0.32
Alaska	0.365	0.698
Arizona	0.277	0.391
Arkansas	0.314	0.338
California	0.219	0.288
Colorado	0.277	0.418
Connecticut	0.406	0.51
Delaware	0.491	0.434
District of Columbia*	0.335	---
Florida	0.23	0.261
Georgia	0.315	0.379
Hawaii	0.382	0.497
Idaho	0.462	0.595
Illinois	0.302	0.374
Indiana	0.382	0.439
Iowa	0.343	0.448
Kansas	0.29	0.42
Kentucky	0.37	0.366
Louisiana	0.289	0.341
Maine	0.491	0.462
Maryland	0.704	0.82
Massachusetts*	0.464	1.12
Michigan	0.362	0.454
Minnesota	0.385	0.513
Mississippi	0.294	0.352
Missouri	0.321	0.355
Montana	0.421	0.463
Nebraska	0.33	0.447
Nevada	0.208	0.448
New Hampshire	0.419	0.407
New Jersey*	0.175	---
New Mexico	0.363	0.345
New York	0.348	0.521
North Carolina	0.388	0.384
North Dakota	0.434	0.438
Ohio	0.324	0.505

State	Urban	Rural
Oklahoma	0.291	0.378
Oregon	0.45	0.416
Pennsylvania	0.262	0.406
Puerto Rico*	0.474	---
Rhode Island*	0.386	---
South Carolina	0.282	0.307
South Dakota	0.319	0.407
Tennessee	0.284	0.358
Texas	0.249	0.325
Utah	0.417	0.543
Vermont	0.557	0.621
Virginia	0.351	0.353
Washington	0.36	0.434
West Virginia	0.47	0.442
Wisconsin	0.407	0.446
Wyoming	0.41	0.529

*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 March 2009.

TABLE 8B.—PROPOSED STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CCRs) FOR ACUTE CARE HOSPITALS—MARCH 2009

State	Ratio
Alabama	0.025
Alaska	0.038
Arizona	0.024
Arkansas	0.025
California	0.014
Colorado	0.03
Connecticut	0.027
Delaware	0.033
District of Columbia	0.02
Florida	0.021
Georgia	0.028
Hawaii	0.03
Idaho	0.037
Illinois	0.025
Indiana	0.037
Iowa	0.027
Kansas	0.03
Kentucky	0.028
Louisiana	0.026
Maine	0.029
Maryland	0.054
Massachusetts	0.031
Michigan	0.029
Minnesota	0.028
Mississippi	0.027
Missouri	0.027
Montana	0.035
Nebraska	0.036
Nevada	0.021
New Hampshire	0.031
New Jersey	0.013
New Mexico	0.034
New York	0.026
North Carolina	0.032
North Dakota	0.034
Ohio	0.029

State	Ratio
Oklahoma	0.026
Oregon	0.032
Pennsylvania	0.021
Puerto Rico	0.041
Rhode Island	0.019
South Carolina	0.025
South Dakota	0.028
Tennessee	0.028
Texas	0.025
Utah	0.032
Vermont	0.046
Virginia	0.034
Washington	0.028
West Virginia	0.034
Wisconsin	0.036
Wyoming	0.04

TABLE 8C.—PROPOSED STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS (CCRs) FOR LTCHs—MARCH 2009

State	Urban	Rural
Alabama	0.273	0.351
Alaska	0.397	0.775
Arizona	0.301	0.418
Arkansas	0.337	0.369
California	0.234	0.307
Colorado	0.305	0.462
Connecticut	0.432	0.557
Delaware	0.523	0.47
District of Columbia*	0.355	---
Florida	0.251	0.29
Georgia	0.342	0.413
Hawaii	0.411	0.53
Idaho	0.498	0.632
Illinois	0.326	0.406
Indiana	0.419	0.48
Iowa	0.366	0.485
Kansas	0.318	0.457
Kentucky	0.396	0.396
Louisiana	0.315	0.367
Maine	0.522	0.486
Maryland**	0.332	0.425
Massachusetts*	0.495	1.208
Michigan	0.391	0.488
Minnesota	0.411	0.556
Mississippi	0.321	0.379
Missouri	0.348	0.388
Montana	0.453	0.504
Nebraska	0.363	0.489
Nevada	0.228	0.512
New Hampshire	0.451	0.438
New Jersey*	0.188	---
New Mexico	0.396	0.381
New York	0.374	0.556
North Carolina	0.42	0.417
North Dakota	0.467	0.475
Ohio	0.351	0.547
Oklahoma	0.316	0.407

State	Urban	Rural
Oregon	0.482	0.443
Pennsylvania	0.282	0.441
Puerto Rico*	0.515	---
Rhode Island*	0.406	---
South Carolina	0.306	0.333
South Dakota	0.345	0.441
Tennessee	0.311	0.391
Texas	0.273	0.359
Utah	0.448	0.596
Vermont	0.611	0.659
Virginia	0.384	0.39
Washington	0.388	0.465
West Virginia	0.505	0.476
Wisconsin	0.443	0.481
Wyoming	0.445	0.575

*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 March 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	33660	
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	19460	
010164	01	13820	
020008	02	11260	
030007	39140	22380	
030033	03	22380	
030055	29420	39140	
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
040078	26300	30780	
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	
050038	41940	42100	
050042	05	39820	
050043	36084	41940	
050046	37100	31084	
050054	40140	42044	
050069	42044	31084	
050071	41940	42100	
050073	46700	36084	
050075	36084	41940	
050076	41884	36084	
050082	37100	31084	
050084	44700	40900	
050089	40140	31084	
050090	42220	41884	
050095	36084	41940	
050099	40140	31084	
050101	46700	36084	
050102	40140	42044	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050118	44700	33700	
050125	41940	42100	
050129	40140	31084	
050131	41884	36084	
050133	49700	40900	
050136	42220	41884	
050140	40140	31084	
050150	05	40900	
050152	41884	36084	
050153	41940	42100	
050159	37100	31084	
050168	42044	31084	
050173	42044	31084	
050174	42220	41884	
050188	41940	42100	
050193	42044	31084	
050194	42100	41940	
050195	36084	41940	
050197	41884	41940	
050211	36084	41940	
050224	42044	31084	
050226	42044	31084	
050230	42044	31084	
050236	37100	31084	
050242	42100	41940	
050243	40140	42044	
050245	40140	31084	
050264	36084	41940	
050272	40140	31084	
050279	40140	31084	
050283	36084	41940	
050291	42220	41884	
050292	40140	42044	
050300	40140	31084	
050301	05	42220	
050305	36084	41940	
050308	41940	42100	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050320	36084	41940	
050327	40140	31084	
050329	40140	42044	
050334	41500	41940	
050335	05	33700	
050348	42044	31084	
050360	41884	36084	
050367	46700	36084	
050380	41940	42100	
050385	42220	41884	
050390	40140	42044	
050394	37100	31084	
050423	40140	42044	
050426	42044	31084	
050441	41940	42100	
050488	36084	41940	
050510	41884	36084	
050512	36084	41940	
050517	40140	31084	
050526	42044	31084	
050534	40140	42044	
050541	41884	41940	
050543	42044	31084	
050547	42220	41884	
050548	42044	31084	
050549	37100	31084	
050551	42044	31084	
050567	42044	31084	
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050586	40140	31084	
050589	42044	31084	
050603	42044	31084	
050604	41940	42100	
050609	42044	31084	
050616	37100	31084	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
050662	41940	42100	
050667	34900	46700	
050668	41884	36084	
050678	42044	31084	
050680	46700	36084	
050684	40140	42044	
050686	40140	42044	
050688	41940	42100	
050690	42220	41884	
050693	42044	31084	
050694	40140	42044	
050701	40140	42044	
050709	40140	31084	
050714	42100	41940	
050720	42044	31084	
050744	42044	31084	
050745	42044	31084	
050746	42044	31084	
050747	42044	31084	
050749	37100	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	
060116	14500	19740	
060121	24540	19740	
070001	35300	35004	
070003	07	25540	LUGAR
070005	35300	35004	
070006	14860	35644	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
070010	14860	35644	
070011	07	25540	LUGAR
070015	07	35644	
070016	35300	35004	
070017	35300	35004	
070018	14860	35644	
070019	35300	35004	
070021	07	25540	LUGAR
070022	35300	35004	
070028	14860	35644	
070031	35300	35004	
070033	14860	35644	
070034	14860	35644	
070038	35300	35004	
070039	35300	35004	
080001	48864	37964	
080003	48864	37964	
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	
100080	48424	22744	
100081	10	23020	LUGAR
100105	42680	38940	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
110095	11	10500	
110105	11	10500	
110112	11	10500	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
140068	16974	29404	
140075	16974	29404	
140080	16974	29404	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
140082	16974	29404	
140083	16974	29404	
140088	16974	29404	
140094	16974	29404	
140095	16974	29404	
140103	16974	29404	
140110	14	16974	
140114	16974	29404	
140115	16974	29404	
140116	16974	29404	
140117	16974	29404	
140118	16974	29404	
140119	16974	29404	
140124	16974	29404	
140133	16974	29404	
140135	19500	16580	
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	
140176	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	
140207	16974	29404	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
140208	16974	29404	
140223	16974	29404	
140224	16974	29404	
140240	16974	29404	
140250	16974	29404	
140251	16974	29404	
140252	16974	29404	
140258	16974	29404	
140276	16974	29404	
140281	16974	29404	
140290	16974	29404	
140300	16974	29404	
140301	16974	29404	
140303	16974	29404	
150002	23844	16974	
150004	23844	16974	
150006	33140	43780	
150008	23844	16974	
150011	15	26900	
150015	33140	23844	
150018	21140	43780	
150023	45460	26900	
150026	21140	43780	
150030	15	26900	LUGAR
150034	23844	16974	
150042	15	45460	
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

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
150113	11300	26900	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
180044	18	26580	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
220008	39300	14484	
220010	37764	14484	
220011	15764	14484	
220019	49340	14484	
220020	39300	14484	
220025	49340	14484	
220029	37764	14484	
220033	37764	14484	
220035	37764	14484	
220049	15764	14484	
220058	49340	14484	
220062	49340	14484	
220063	15764	14484	
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	19804	
230019	47644	19804	
230020	19804	11460	
230021	35660	28020	
230022	23	29620	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
230024	19804	11460	
230029	47644	19804	
230030	23	24340	
230035	23	24340	LUGAR
230036	23	13020	
230037	23	11460	
230038	24340	34740	
230047	47644	19804	
230053	19804	11460	
230054	23	24580	
230059	24340	34740	
230069	47644	11460	
230071	47644	19804	
230072	26100	34740	
230077	40980	22420	
230080	23	13020	
230089	19804	11460	
230092	27100	11460	
230095	23	13020	
230096	23	28020	
230097	23	24340	
230099	33780	11460	
230104	19804	11460	
230105	23	13020	
230106	24340	34740	
230121	23	29620	LUGAR
230130	47644	19804	
230135	19804	11460	
230142	19804	11460	
230146	19804	11460	
230151	47644	19804	
230165	19804	11460	
230174	26100	34740	
230176	19804	11460	
230195	47644	19804	
230204	47644	19804	
230207	47644	19804	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
230208	23	24340	LUGAR
230222	23	13020	
230227	47644	19804	
230236	24340	34740	
230244	19804	11460	
230254	47644	19804	
230257	47644	19804	
230264	47644	19804	
230269	47644	19804	
230270	19804	11460	
230273	19804	11460	
230277	47644	19804	
230279	47644	11460	
230297	19804	11460	
230301	47644	19804	
230B04	47644	19804	
230B95	19804	11460	.
240030	24	41060	
240036	41060	33460	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
260025	26	41180	
260064	26	17860	
260074	26	17860	
260094	26	44180	
260110	16020	41180	
260113	26	14	
260116	26	14	
260119	26	16020	
260175	26	28140	
260183	16020	41180	
260186	26	27620	
270003	27	24500	
270014	33540	17660	
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	
290019	16180	39900	
300001	30	31700	
300011	31700	15764	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
300012	31700	15764	
300017	40484	37764	
300019	30	15764	
300020	31700	15764	
300023	40484	37764	
300029	40484	37764	
300034	31700	15764	
310002	35084	35644	
310009	35084	35644	
310014	15804	37964	
310015	35084	35644	
310017	35084	35644	
310018	35084	35644	
310022	15804	37964	
310029	15804	37964	
310031	15804	20764	
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

Provider Number	Geographic CBSA	Reclassified CBSA	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	
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	
340004	24660	49180	
340008	34	22180	
340013	34	16740	
340015	34	16740	
340021	34	16740	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
340023	11700	24860	
340027	34	24780	
340039	34	49180	
340050	34	22180	
340051	34	25860	
340068	34	34820	
340069	39580	20500	
340070	15500	24660	
340071	34	39580	LUGAR
340073	39580	20500	
340085	34	24660	LUGAR
340091	24660	49180	
340096	34	24660	LUGAR
340109	34	47260	
340114	39580	20500	
340115	34	20500	
340126	34	39580	
340127	34	20500	LUGAR
340129	34	16740	
340131	34	24780	
340138	39580	20500	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
340173	39580	20500	
350009	35	22020	
360008	36	26580	
360010	36	15940	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	45780	
360027	10420	17460	
360036	36	31900	
360039	36	18140	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
360054	36	26580	
360055	49660	17460	
360065	36	45780	
360078	10420	17460	
360086	44220	19380	
360095	36	30620	
360096	36	49660	LUGAR
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	
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	43300	
370049	37	36420	
370099	37	36420	
370113	37	22220	
370149	37	36420	
380001	38	38900	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
380022	38	18700	LUGAR
380027	38	21660	
380047	13460	21660	
380050	38	32780	
380051	41420	38900	
380090	38	21660	
390006	39	25420	
390013	39	25420	
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	
390096	39740	37964	
390110	27780	38300	
390113	39	49660	
390133	10900	37964	
390138	39	25180	
390150	39	38300	LUGAR
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
430013	43	43620	
430014	43	22020	
430077	39660	16220	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
450830	45	36220	
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	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
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	
520013	20740	33460	
520021	29404	16974	
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	

Provider Number	Geographic CBSA	Reclassified CBSA	LUGAR
520116	52	33340	LUGAR
520189	29404	16974	
530014	16940	24540	

TABLE 9C.--HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT--FY 2010

Provider No.	Geographic CBSA	Redesignated Rural Area
040118	27860	04
050192	23420	05
050528	32900	05
050618	40140	05
070004	07	07
070036	25540	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
260047	27620	26
260195	44180	26
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)—MARCH 2009[1]

MS-DRG	Number of Cases	Threshold
1	793	$400,445
2	210	$202,667
3	23,323	$272,435
4	22,231	$165,475
5	615	$185,393
6	167	$108,556
7	361	$178,474
8	488	$105,936
9	1,541	$110,496
10	137	$91,675
11	1,419	$80,657
12	2,008	$59,052
13	1,084	$40,675
20	1,045	$159,458
21	487	$120,483
22	157	$86,609
23	4,347	$92,306
24	2,095	$63,727
25	10,353	$84,792
26	11,693	$59,077
27	12,614	$47,231
28	1,751	$84,156
29	3,503	$53,090
30	3,459	$34,698
31	1,103	$70,661
32	2,782	$40,403
33	3,337	$33,253
34	864	$63,946
35	2,416	$47,034
36	5,968	$40,784
37	5,576	$57,543
38	14,864	$36,913
39	48,630	$27,850
40	5,091	$65,510

MS-DRG	Number of Cases	Threshold
41	7,775	$43,556
42	4,188	$37,827
52	1,410	$32,920
53	588	$22,538
54	6,759	$33,299
55	14,750	$28,066
56	10,657	$32,293
57	47,039	$21,170
58	898	$32,602
59	3,293	$24,443
60	3,777	$18,518
61	2,055	$59,823
62	3,079	$46,927
63	1,227	$41,512
64	65,762	$37,296
65	112,662	$29,669
66	74,828	$22,593
67	1,993	$32,945
68	12,179	$24,951
69	100,439	$20,522
70	10,454	$36,367
71	11,840	$28,406
72	5,409	$21,103
73	10,862	$29,797
74	31,976	$22,488
75	1,318	$37,991
76	730	$23,961
77	1,666	$36,693
78	1,750	$26,617
79	898	$20,665
80	1,757	$28,104
81	5,980	$18,933
82	2,255	$38,311
83	2,403	$31,296
84	2,572	$23,295
85	7,220	$38,879
86	13,067	$29,334
87	12,486	$20,462
88	1,009	$32,927
89	2,982	$25,116
90	2,854	$19,401

MS-DRG	Number of Cases	Threshold
91	10,112	$32,560
92	19,002	$23,286
93	15,323	$18,136
94	1,556	$61,113
95	1,190	$44,930
96	624	$39,564
97	1,352	$57,448
98	1,037	$39,159
99	525	$30,898
100	19,462	$31,799
101	56,930	$20,296
102	1,305	$26,508
103	13,157	$18,217
113	644	$38,508
114	463	$23,930
115	1,029	$29,882
116	531	$29,191
117	833	$18,646
121	770	$24,783
122	513	$16,184
123	2,893	$20,901
124	877	$27,974
125	4,170	$17,700
129	1,544	$44,697
130	950	$33,004
131	1,004	$42,178
132	831	$30,679
133	2,204	$34,773
134	2,879	$22,385
135	389	$40,079
136	421	$25,436
137	851	$32,301
138	815	$20,556
139	1,464	$22,476
146	844	$39,499
147	1,502	$27,862
148	723	$18,836
149	36,595	$17,504
150	1,300	$27,917
151	6,363	$14,777
152	3,520	$24,280

MS-DRG	Number of Cases	Threshold
153	17,441	$16,161
154	2,496	$30,973
155	5,698	$23,266
156	4,284	$16,736
157	1,436	$31,618
158	3,705	$23,700
159	1,935	$15,809
163	14,349	$87,375
164	19,104	$53,344
165	11,026	$42,320
166	24,954	$65,593
167	20,604	$43,762
168	5,126	$33,269
175	15,523	$36,987
176	37,820	$27,671
177	73,025	$40,549
178	74,648	$33,008
179	20,200	$25,350
180	23,571	$36,880
181	29,164	$29,814
182	3,792	$22,867
183	2,698	$33,347
184	4,884	$24,681
185	2,251	$17,434
186	10,893	$35,032
187	10,567	$27,957
188	3,791	$20,358
189	134,173	$32,134
190	130,681	$29,762
191	143,833	$24,927
192	159,598	$18,747
193	106,182	$32,519
194	225,120	$25,586
195	109,887	$18,409
196	6,906	$34,090
197	7,111	$27,778
198	3,610	$21,586
199	3,865	$38,101
200	8,692	$25,285
201	3,112	$18,131
202	38,660	$21,856

MS-DRG	Number of Cases	Threshold
203	35,931	$15,897
204	25,574	$18,365
205	6,942	$29,152
206	21,344	$19,816
207	39,220	$92,931
208	79,769	$46,630
215	137	$192,903
216	10,140	$178,051
217	6,633	$126,449
218	1,457	$108,629
219	12,766	$142,662
220	14,701	$103,556
221	5,069	$91,843
222	3,340	$161,426
223	4,552	$123,451
224	3,006	$145,958
225	4,884	$117,135
226	8,270	$121,571
227	34,055	$98,137
228	3,276	$138,584
229	3,433	$99,507
230	1,196	$80,557
231	1,625	$157,578
232	1,306	$122,751
233	18,253	$131,931
234	29,021	$99,044
235	10,760	$105,854
236	26,639	$78,339
237	24,589	$92,875
238	40,496	$61,758
239	11,894	$69,342
240	11,058	$44,618
241	1,982	$32,799
242	21,615	$68,568
243	39,352	$55,149
244	52,850	$46,284
245	4,189	$78,872
246	31,276	$70,395
247	152,721	$51,671
248	20,203	$65,185
249	70,040	$47,552

MS-DRG	Number of Cases	Threshold
250	8,326	$60,100
251	38,931	$45,220
252	45,040	$55,086
253	44,354	$49,543
254	46,123	$39,904
255	2,554	$44,225
256	3,154	$33,347
257	504	$23,390
258	856	$55,979
259	6,353	$40,082
260	1,793	$56,835
261	3,925	$33,580
262	2,924	$27,926
263	577	$32,340
264	25,146	$43,864
265	2,127	$44,655
280	81,207	$37,787
281	52,950	$30,347
282	42,763	$23,243
283	15,862	$34,185
284	3,309	$22,685
285	1,850	$16,281
286	30,104	$44,843
287	145,764	$31,869
288	3,085	$52,623
289	1,209	$38,700
290	311	$29,220
291	208,147	$31,984
292	215,011	$24,349
293	144,187	$17,752
294	1,606	$24,520
295	1,051	$14,939
296	2,218	$29,780
297	742	$19,264
298	494	$13,061
299	23,712	$30,880
300	46,985	$22,738
301	32,535	$16,119
302	8,803	$25,484
303	61,328	$15,908
304	2,794	$27,218

MS-DRG	Number of Cases	Threshold
305	32,820	$16,401
306	2,603	$29,133
307	6,000	$19,764
308	58,285	$29,273
309	95,745	$21,481
310	142,120	$15,429
311	19,303	$14,480
312	169,509	$19,589
313	195,897	$16,028
314	66,848	$34,088
315	31,177	$24,738
316	15,657	$16,944
326	11,815	$94,545
327	10,393	$53,527
328	8,223	$35,171
329	51,616	$87,966
330	62,446	$51,630
331	26,538	$38,814
332	2,086	$82,448
333	5,868	$50,789
334	3,437	$38,194
335	8,191	$75,544
336	12,801	$48,346
337	8,094	$36,359
338	1,671	$62,785
339	3,229	$43,908
340	3,499	$33,108
341	1,023	$47,893
342	2,841	$35,973
343	6,997	$26,505
344	1,029	$57,407
345	3,054	$37,456
346	2,899	$29,610
347	1,668	$42,550
348	4,354	$31,874
349	4,582	$20,560
350	1,955	$46,389
351	4,603	$32,748
352	7,362	$22,125
353	3,760	$50,753
354	9,072	$35,595

MS-DRG	Number of Cases	Threshold
355	14,160	$25,834
356	8,744	$67,301
357	7,767	$44,766
358	2,141	$33,715
368	3,835	$36,101
369	5,693	$27,744
370	2,318	$20,297
371	28,644	$36,417
372	29,943	$29,860
373	13,069	$21,336
374	10,018	$39,117
375	17,908	$30,081
376	3,233	$24,191
377	62,193	$34,368
378	127,788	$25,112
379	64,383	$18,767
380	3,435	$36,936
381	6,097	$28,568
382	3,335	$21,344
383	1,631	$31,846
384	7,570	$23,496
385	2,951	$35,613
386	8,067	$27,684
387	4,409	$21,370
388	22,991	$32,826
389	50,216	$24,356
390	44,843	$17,278
391	50,581	$27,723
392	252,219	$19,402
393	25,356	$33,180
394	49,590	$25,320
395	21,908	$18,268
405	4,382	$91,912
406	5,288	$54,641
407	1,949	$40,824
408	1,671	$74,866
409	1,437	$50,466
410	509	$38,952
411	941	$75,713
412	905	$54,025
413	631	$40,873

MS-DRG	Number of Cases	Threshold
414	5,423	$66,207
415	5,862	$44,678
416	4,675	$33,802
417	20,200	$52,044
418	26,839	$41,168
419	32,695	$31,850
420	829	$72,060
421	1,039	$39,591
422	258	$31,678
423	1,634	$73,606
424	822	$47,892
425	93	$37,502
432	14,943	$34,635
433	9,235	$24,969
434	603	$18,286
435	14,074	$37,253
436	12,503	$29,799
437	2,866	$25,579
438	17,578	$35,476
439	25,602	$27,601
440	21,814	$19,533
441	14,590	$34,106
442	15,631	$24,422
443	5,572	$18,216
444	14,177	$34,451
445	17,769	$28,819
446	14,311	$21,079
453	1,113	$176,429
454	2,408	$124,457
455	2,062	$94,155
456	1,122	$154,223
457	2,873	$107,635
458	1,475	$89,184
459	4,241	$105,311
460	56,782	$71,613
461	1,019	$86,727
462	12,800	$65,976
463	5,340	$73,982
464	9,652	$49,806
465	3,340	$38,174
466	4,268	$80,409

MS-DRG	Number of Cases	Threshold
467	17,909	$61,594
468	17,739	$52,692
469	34,608	$62,700
470	422,073	$47,237
471	2,810	$84,300
472	7,909	$56,992
473	24,007	$46,429
474	2,772	$56,654
475	3,534	$38,264
476	1,323	$26,189
477	2,981	$61,093
478	9,466	$47,568
479	9,604	$38,265
480	29,653	$56,453
481	78,530	$42,755
482	40,195	$36,894
483	9,440	$51,068
484	17,658	$44,194
485	1,146	$59,310
486	2,041	$45,671
487	1,137	$35,938
488	3,012	$37,839
489	5,507	$29,804
490	24,407	$39,983
491	49,807	$25,819
492	5,971	$55,142
493	18,985	$41,152
494	27,752	$32,347
495	1,428	$52,149
496	4,752	$36,933
497	5,590	$27,262
498	1,362	$40,371
499	1,013	$23,147
500	1,814	$53,317
501	4,511	$35,118
502	6,032	$25,397
503	869	$43,192
504	2,424	$35,014
505	2,572	$26,690
506	737	$29,454
507	990	$40,401

MS-DRG	Number of Cases	Threshold
508	2,110	$32,421
509	447	$30,612
510	1,203	$45,349
511	4,382	$35,176
512	9,665	$26,561
513	1,263	$31,223
514	1,026	$20,795
515	4,333	$56,785
516	11,988	$42,036
517	14,568	$34,598
533	886	$30,702
534	3,364	$16,918
535	8,403	$28,692
536	33,981	$16,576
537	864	$21,810
538	912	$14,565
539	2,769	$40,413
540	5,132	$30,425
541	1,513	$22,689
542	6,474	$37,444
543	17,158	$27,796
544	8,696	$18,800
545	4,469	$38,737
546	5,731	$27,276
547	4,021	$19,299
548	660	$37,151
549	1,180	$28,044
550	629	$18,120
551	12,550	$33,006
552	81,124	$20,409
553	3,468	$26,620
554	17,949	$16,116
555	2,213	$24,556
556	16,720	$15,929
557	6,350	$32,894
558	16,999	$21,337
559	2,059	$32,759
560	5,257	$23,138
561	6,493	$14,690
562	6,816	$29,735
563	34,748	$16,618

MS-DRG	Number of Cases	Threshold
564	1,897	$31,729
565	3,921	$23,030
566	2,234	$16,169
573	5,202	$50,057
574	10,285	$35,428
575	4,285	$26,726
576	609	$53,159
577	2,366	$36,036
578	2,856	$26,332
579	3,982	$48,785
580	10,653	$32,852
581	11,444	$23,806
582	5,590	$27,480
583	8,471	$21,665
584	793	$33,529
585	1,287	$23,727
592	5,115	$33,206
593	11,917	$24,347
594	2,044	$16,925
595	1,405	$33,005
596	5,137	$20,333
597	589	$33,280
598	1,347	$26,620
599	251	$16,108
600	974	$23,667
601	871	$14,779
602	25,288	$30,470
603	133,766	$19,482
604	3,221	$28,099
605	20,518	$17,555
606	1,581	$26,460
607	6,709	$15,767
614	1,605	$51,192
615	1,456	$37,182
616	1,024	$72,738
617	7,075	$40,330
618	173	$29,994
619	798	$61,620
620	2,604	$42,832
621	9,811	$37,508
622	827	$56,389

MS-DRG	Number of Cases	Threshold
623	3,276	$36,837
624	349	$24,020
625	1,366	$45,060
626	2,905	$30,859
627	13,427	$21,222
628	3,389	$58,500
629	4,535	$44,586
630	477	$34,307
637	21,656	$29,589
638	49,371	$20,507
639	30,452	$14,195
640	63,123	$26,101
641	193,776	$17,387
642	1,579	$24,971
643	6,782	$34,120
644	12,655	$26,606
645	7,332	$19,053
652	9,763	$65,949
653	1,901	$94,761
654	3,758	$58,954
655	1,370	$43,684
656	4,578	$62,662
657	7,809	$43,438
658	7,459	$35,551
659	5,029	$56,347
660	7,274	$40,334
661	4,063	$34,425
662	969	$49,335
663	1,987	$32,514
664	3,810	$26,890
665	801	$52,899
666	2,195	$34,253
667	3,256	$20,106
668	4,805	$44,590
669	12,979	$31,514
670	10,413	$20,284
671	895	$32,939
672	782	$20,720
673	12,755	$49,611

MS-DRG	Number of Cases	Threshold
674	10,385	$42,958
675	5,302	$35,893
682	100,542	$33,405
683	139,967	$26,321
684	35,044	$17,535
685	2,419	$21,845
686	2,017	$33,365
687	3,177	$27,265
688	954	$19,285
689	61,962	$28,531
690	207,855	$19,306
691	1,005	$36,089
692	429	$27,676
693	3,324	$29,819
694	16,654	$19,038
695	1,034	$27,789
696	10,263	$16,157
697	576	$21,284
698	26,586	$31,472
699	26,389	$23,919
700	10,510	$16,980
707	5,990	$40,230
708	18,222	$32,967
709	816	$37,883
710	1,770	$32,469
711	782	$37,114
712	534	$20,538
713	10,931	$28,895
714	26,547	$16,768
715	545	$39,086
716	1,112	$31,247
717	816	$34,733
718	560	$20,466
722	872	$32,380
723	1,833	$25,697
724	401	$17,168
725	992	$25,615
726	3,429	$17,757
727	1,497	$29,742

MS-DRG	Number of Cases	Threshold
728	5,886	$18,821
729	758	$24,510
730	361	$15,104
734	1,621	$48,053
735	1,053	$30,726
736	974	$79,292
737	3,282	$44,152
738	760	$31,266
739	1,087	$57,406
740	4,527	$36,952
741	5,652	$28,162
742	11,095	$33,768
743	30,361	$23,551
744	1,703	$33,388
745	1,430	$22,388
746	2,748	$31,571
747	8,398	$22,923
748	19,808	$23,410
749	1,045	$46,573
750	409	$27,663
754	1,302	$36,061
755	3,217	$27,509
756	544	$16,307
757	1,560	$36,136
758	1,977	$27,866
759	1,266	$20,017
760	1,846	$20,615
761	1,342	$13,733
765	3,106	$21,884
766	2,782	$14,588
767	139	$16,990
769	85	$33,956
770	223	$14,860
774	1,622	$13,489
775	5,832	$9,423
776	559	$16,661
777	232	$22,223
778	444	$9,163
779	124	$11,086

MS-DRG	Number of Cases	Threshold
780	45	$4,553
781	3,106	$14,371
782	179	$10,367
799	628	$91,119
800	693	$52,252
801	420	$38,572
802	912	$59,501
803	1,168	$39,205
804	838	$28,269
808	7,772	$39,988
809	13,777	$28,975
810	2,549	$23,222
811	27,894	$28,330
812	93,068	$19,658
813	13,586	$29,186
814	1,920	$33,078
815	3,765	$26,145
816	1,889	$19,305
820	1,383	$94,467
821	2,230	$46,506
822	1,872	$31,876
823	2,433	$71,181
824	2,982	$45,982
825	1,626	$32,154
826	653	$81,103
827	1,315	$44,119
828	795	$32,615
829	1,362	$48,079
830	410	$27,706
834	4,229	$61,187
835	2,806	$38,668
836	1,383	$26,593
837	1,213	$104,193
838	1,459	$51,732
839	1,437	$30,578
840	9,996	$46,963
841	9,996	$33,410
842	4,492	$26,327
843	1,842	$36,194

MS-DRG	Number of Cases	Threshold
844	2,712	$29,345
845	609	$22,578
846	2,630	$41,446
847	23,037	$27,985
848	1,411	$24,097
849	1,102	$30,909
853	39,102	$88,143
854	8,333	$51,411
855	452	$38,126
856	5,924	$70,704
857	9,537	$39,521
858	2,695	$31,614
862	9,374	$36,262
863	21,882	$23,566
864	18,067	$21,735
865	2,890	$29,438
866	9,441	$17,959
867	5,466	$41,716
868	2,831	$26,514
869	981	$19,417
870	25,325	$102,306
871	263,725	$37,472
872	93,098	$28,038
876	705	$44,627
880	8,765	$16,695
881	4,670	$12,612
882	1,721	$13,538
883	897	$20,248
884	19,656	$20,780
885	85,358	$16,400
886	514	$15,670
887	576	$19,773
894	4,310	$8,816
895	6,584	$17,023
896	6,844	$29,282
897	35,889	$14,464
901	927	$59,029
902	1,986	$35,387
903	1,138	$25,315

MS-DRG	Number of Cases	Threshold
904	1,492	$46,845
905	846	$26,797
906	708	$26,093
907	8,857	$61,594
908	8,848	$38,828
909	5,117	$29,326
913	1,060	$29,432
914	5,927	$17,717
915	1,372	$27,722
916	5,377	$11,315
917	20,237	$31,700
918	35,735	$15,320
919	11,472	$32,272
920	14,999	$24,000
921	8,515	$15,951
922	1,300	$29,304
923	3,349	$16,887
927	164	$200,823
928	871	$71,208
929	422	$37,476
933	153	$34,625
934	707	$26,181
935	2,092	$24,322
939	783	$49,487
940	1,710	$35,896
941	1,755	$30,299
945	6,749	$21,089
946	3,069	$18,560
947	12,263	$26,829
948	54,416	$17,238
949	716	$22,360
950	307	$12,788
951	906	$16,429
955	473	$100,033
956	4,301	$61,135
957	1,451	$110,675
958	1,137	$70,716
959	233	$48,328
963	1,862	$51,632

MS-DRG	Number of Cases	Threshold
964	2,777	$34,692
965	955	$25,781
969	642	$86,013
970	120	$49,759
974	6,101	$43,142
975	4,414	$30,594
976	1,949	$23,394
977	4,005	$26,087
981	30,187	$83,890
982	20,225	$55,602
983	5,814	$39,982
984	776	$62,080
985	940	$41,163
986	564	$28,570
987	8,944	$58,086
988	11,125	$38,726
989	4,783	$27,572
999	85	$106,410

[1]Cases taken from the FY 2008 MedPAR file; MS-DRGs are from GROUPER Version 27.0.

TABLE 11.—PROPOSED MS-LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND SHORT-STAY OUTLIER (SSO) THRESHOLD FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2010 UNDER THE LTCH PPS

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
1	1	Heart transplant or implant of heart assist system w MCC	0	0.0000	0.0	0.0
2	1	Heart transplant or implant of heart assist system w/o MCC	0	0.0000	0.0	0.0
3	3	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	281	4.6419	64.3	53.6
4	4	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	1,385	3.2334	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	1.7130	37.2	31.0
10	10	Pancreas transplant	0	0.0000	0.0	0.0
11	11	Tracheostomy for face,mouth & neck diagnoses w MCC*	2	1.7130	37.2	31.0
12	11	Tracheostomy for face,mouth & neck diagnoses w CC*	0	1.2199	24.3	20.3
13	11	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC*	0	1.2199	24.3	20.3
20	20	Intracranial vascular procedures w PDX hemorrhage w MCC	0	1.7130	37.2	31.0
21	20	Intracranial vascular procedures w PDX hemorrhage w CC	0	0.6705	21.6	18.0
22	20	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	0	0.6705	21.6	18.0
23	23	Craniotomy w major device implant or acute complex CNS PDX w MCC*	1	0.7836	23.8	19.8
24	23	Craniotomy w major device implant or acute complex CNS PDX w/o MCC*	0	0.7836	23.8	19.8
25	25	Craniotomy & endovascular intracranial procedures w MCC*	3	1.7130	37.2	31.0
26	25	Craniotomy & endovascular intracranial procedures w CC*	1	0.4994	19.3	16.1
27	25	Craniotomy & endovascular intracranial procedures w/o CC/MCC*	0	0.4994	19.3	16.1
28	28	Spinal procedures w MCC	15	1.1175	27.0	22.5
29	28	Spinal procedures w CC	12	0.7836	23.8	19.8
30	28	Spinal procedures w/o CC/MCC	1	0.7836	23.8	19.8
31	31	Ventricular shunt procedures w MCC	4	1.7130	37.2	31.0
32	31	Ventricular shunt procedures w CC	2	0.6705	21.6	18.0
33	31	Ventricular shunt procedures w/o CC/MCC	1	0.6705	21.6	18.0
34	34	Carotid artery stent procedure w MCC	0	1.7130	37.2	31.0
35	34	Carotid artery stent procedurew CC	0	1.7130	37.2	31.0
36	34	Carotid artery stent procedure w/o CC/MCC	0	1.7130	37.2	31.0
37	37	Extracranial procedures w MCC	18	1.7130	37.2	31.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
38	37	Extracranial procedures w CC	4	1.7130	37.2	31.0
39	37	Extracranial procedures w/o CC/MCC	0	1.7130	37.2	31.0
40	40	Periph & cranial nerve & other nerv syst proc w MCC	122	1.4720	35.3	29.4
41	40	Periph & cranial nerve & other nerv syst proc w CC	90	0.9825	29.9	24.9
42	40	Periph & cranial nerve & other nerv syst proc w/o CC/MCC	5	0.6705	21.6	18.0
52	52	Spinal disorders & injuries w CC/MCC	86	1.0403	33.6	28.0
53	52	Spinal disorders & injuries w/o CC/MCC	8	0.4994	19.3	16.1
54	54	Nervous system neoplasms w MCC	39	0.9432	22.6	18.8
55	54	Nervous system neoplasms w/o MCC	38	0.6295	22.6	18.8
56	56	Degenerative nervous system disorders w MCC	1,141	0.8234	25.8	21.5
57	56	Degenerative nervous system disorders w/o MCC	1,435	0.6129	24.0	20.0
58	58	Multiple sclerosis & cerebellar ataxia w MCC	14	0.7836	23.8	19.8
59	58	Multiple sclerosis & cerebellar ataxia w CC	31	0.6091	21.5	17.9
60	58	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	4	0.4994	19.3	16.1
61	61	Acute ischemic stroke w use of thrombolytic agent w MCC	0	0.8612	24.7	20.6
62	61	Acute ischemic stroke w use of thrombolytic agent w CC	0	0.6889	24.1	20.1
63	61	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	0	0.4994	19.3	16.1
64	64	Intracranial hemorrhage or cerebral infarction w MCC	152	0.9159	24.6	20.5
65	64	Intracranial hemorrhage or cerebral infarction w CC	60	0.5778	23.7	19.8
66	64	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	8	0.4994	19.3	16.1
67	67	Nonspecific cva & precerebral occlusion w/o infarct w MCC	3	0.6705	21.6	18.0
68	67	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC	2	0.4994	19.3	16.1
69	69	Transient ischemia	6	0.4994	19.3	16.1
70	70	Nonspecific cerebrovascular disorders w MCC	141	0.8612	24.7	20.6
71	70	Nonspecific cerebrovascular disorders w CC	74	0.6889	24.1	20.1
72	70	Nonspecific cerebrovascular disorders w/o CC/MCC	9	0.4994	19.3	16.1
73	73	Cranial & peripheral nerve disorders w MCC	104	0.9973	26.8	22.3
74	73	Cranial & peripheral nerve disorders w/o MCC	128	0.6078	23.5	19.6
75	75	Viral meningitis w CC/MCC	19	0.7836	23.8	19.8
76	75	Viral meningitis w/o CC/MCC	0	0.7836	23.8	19.8
77	77	Hypertensive encephalopathy w MCC	2	1.1175	27.0	22.5
78	77	Hypertensive encephalopathy w CC	1	0.4994	19.3	16.1
79	77	Hypertensive encephalopathy w/o CC/MCC	0	0.4724	18.9	15.8
80	80	Nontraumatic stupor & coma w MCC	23	0.6705	21.6	18.0
81	80	Nontraumatic stupor & coma w/o MCC	11	0.4994	19.3	16.1
82	82	Traumatic stupor & coma, coma >1 hr w MCC	11	1.1175	27.0	22.5
83	82	Traumatic stupor & coma, coma >1 hr w CC	8	0.7836	23.8	19.8
84	82	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	2	0.7836	23.8	19.8
85	85	Traumatic stupor & coma, coma <1 hr w MCC	99	0.8755	24.4	20.3
86	85	Traumatic stupor & coma, coma <1 hr w CC	80	0.6526	23.8	19.8
87	85	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	18	0.6526	23.8	19.8

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
88	88	Concussion w MCC	2	0.6705	21.6	18.0
89	88	Concussion w CC	2	0.4994	19.3	16.1
90	88	Concussion w/o CC/MCC	1	0.4994	19.3	16.1
91	91	Other disorders of nervous system w MCC	229	0.8770	23.7	19.8
92	91	Other disorders of nervous system w CC	104	0.6672	22.6	18.8
93	91	Other disorders of nervous system w/o CC/MCC	12	0.4994	19.3	16.1
94	94	Bacterial & tuberculous infections of nervous system w MCC	258	1.0633	28.0	23.3
95	94	Bacterial & tuberculous infections of nervous system w CC	99	0.8340	26.9	22.4
96	94	Bacterial & tuberculous infections of nervous system w/o CC/MCC	16	0.6705	21.6	18.0
97	97	Non-bacterial infect of nervous sys exc viral meningitis w MCC	51	0.9309	22.1	18.4
98	97	Non-bacterial infect of nervous sys exc viral meningitis w CC	28	0.7854	22.0	18.3
99	97	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC	3	0.7836	23.8	19.8
100	100	Seizures w MCC	52	0.9108	24.9	20.8
101	100	Seizures w/o MCC	26	0.6128	23.3	19.4
102	102	Headaches w MCC	5	0.6705	21.6	18.0
103	102	Headaches w/o MCC	4	0.4994	19.3	16.1
113	113	Orbital procedures w CC/MCC	0	1.2199	24.3	20.3
114	113	Orbital procedures w/o CC/MCC	0	1.0753	26.4	22.0
115	115	Extraocular procedures except orbit	1	0.4994	19.3	16.1
116	116	Intraocular procedures w CC/MCC	0	0.6705	21.6	18.0
117	116	Intraocular procedures w/o CC/MCC	0	0.6705	21.6	18.0
121	121	Acute major eye infections w CC/MCC	5	0.7836	23.8	19.8
122	121	Acute major eye infections w/o CC/MCC	0	0.6705	21.6	18.0
123	123	Neurological eye disorders	0	0.6705	21.6	18.0
124	124	Other disorders of the eye w MCC	4	0.7836	23.8	19.8
125	124	Other disorders of the eye w/o MCC	12	0.6705	21.6	18.0
129	129	Major head & neck procedures w CC/MCC or major device	0	1.2199	24.3	20.3
130	129	Major head & neck procedures w/o CC/MCC	0	1.0753	26.4	22.0
131	131	Cranial/facial procedures w CC/MCC	1	1.1175	27.0	22.5
132	131	Cranial/facial procedures w/o CC/MCC	0	1.1175	27.0	22.5
133	133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC	9	1.1175	27.0	22.5
134	133	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	0	1.1175	27.0	22.5
135	135	Sinus & mastoid procedures w CC/MCC	3	1.7130	37.2	31.0
136	135	Sinus & mastoid procedures w/o CC/MCC	0	1.1175	27.0	22.5
137	137	Mouth procedures w CC/MCC	0	1.1175	27.0	22.5
138	137	Mouth procedures w/o CC/MCC	0	1.1175	27.0	22.5
139	139	Salivary gland procedures	1	0.4994	19.3	16.1
146	146	Ear, nose, mouth & throat malignancy w MCC	52	1.2199	24.3	20.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
147	146	Ear, nose, mouth & throat malignancy w CC	31	1.0753	26.4	22.0
148	146	Ear, nose, mouth & throat malignancy w/o CC/MCC	3	1.0753	26.4	22.0
149	149	Dysequilibrium	8	0.4994	19.3	16.1
150	150	Epistaxis w MCC	0	0.7590	21.3	17.8
151	150	Epistaxis w/o MCC	0	0.6570	20.5	17.1
152	152	Otitis media & URI w MCC	29	0.7590	21.3	17.8
153	152	Otitis media & URI w/o MCC	30	0.6570	20.5	17.1
154	154	Nasal trauma & deformity w MCC	53	0.9849	24.2	20.2
155	154	Nasal trauma & deformity w CC	36	0.6718	21.1	17.6
156	154	Nasal trauma & deformity w/o CC/MCC	9	0.6718	21.1	17.6
157	157	Dental & Oral Diseases w MCC	15	1.1175	27.0	22.5
158	157	Dental & Oral Diseases w CC	16	0.7836	23.8	19.8
159	157	Dental & Oral Diseases w/o CC/MCC	6	0.6705	21.6	18.0
163	163	Major chest procedures w MCC	31	2.5033	39.2	32.7
164	163	Major chest procedures w CC	6	1.7130	37.2	31.0
165	163	Major chest procedures w/o CC/MCC	0	1.0757	29.2	24.3
166	166	Other resp system O.R. procedures w MCC	1,515	2.5653	42.2	35.2
167	166	Other resp system O.R. procedures w CC	296	1.9987	38.5	32.1
168	166	Other resp system O.R. procedures w/o CC/MCC	8	1.7130	37.2	31.0
175	175	Pulmonary embolism w MCC	152	0.8343	23.8	19.8
176	175	Pulmonary embolism w/o MCC	113	0.5911	20.4	17.0
177	177	Respiratory infections & inflammations w MCC	3,568	0.9278	23.4	19.5
178	177	Respiratory infections & inflammations w CC	2,231	0.7554	21.7	18.1
179	177	Respiratory infections & inflammations w/o CC/MCC	226	0.5981	18.6	15.5
180	180	Respiratory neoplasms w MCC	133	0.8121	19.9	16.6
181	180	Respiratory neoplasms w CC	84	0.6433	18.8	15.7
182	180	Respiratory neoplasms w/o CC/MCC	10	0.6433	18.8	15.7
183	183	Major chest trauma w MCC*	3	0.6705	21.6	18.0
184	183	Major chest trauma w CC*	1	0.4994	19.3	16.1
185	183	Major chest trauma w/o CC/MCC*	0	0.4994	19.3	16.1
186	186	Pleural effusion w MCC	167	0.8239	21.7	18.1
187	186	Pleural effusion w CC	48	0.6886	20.9	17.4
188	186	Pleural effusion w/o CC/MCC	7	0.6886	20.9	17.4
189	189	Pulmonary edema & respiratory failure	7,708	1.0067	23.8	19.8
190	190	Chronic obstructive pulmonary disease w MCC	2,240	0.7531	20.3	16.9
191	190	Chronic obstructive pulmonary disease w CC	1,328	0.6352	18.9	15.8
192	190	Chronic obstructive pulmonary disease w/o CC/MCC	445	0.4988	16.4	13.7
193	193	Simple pneumonia & pleurisy w MCC	2,131	0.7949	21.2	17.7
194	193	Simple pneumonia & pleurisy w CC	1,793	0.6227	19.5	16.3
195	193	Simple pneumonia & pleurisy w/o CC/MCC	262	0.5322	17.0	14.2
196	196	Interstitial lung disease w MCC	105	0.7557	21.5	17.9
197	196	Interstitial lung disease w CC	70	0.5828	18.0	15.0
198	196	Interstitial lung disease w/o CC/MCC	12	0.4994	19.3	16.1
199	199	Pneumothorax w MCC	57	0.8138	20.7	17.3
200	199	Pneumothorax w CC	30	0.6326	18.7	15.6

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
201	199	Pneumothorax w/o CC/MCC	4	0.4994	19.3	16.1
202	202	Bronchitis & asthma w CC/MCC	128	0.6856	20.7	17.3
203	202	Bronchitis & asthma w/o CC/MCC	17	0.4994	19.3	16.1
204	204	Respiratory signs & symptoms	161	0.8618	23.1	19.3
205	205	Other respiratory system diagnoses w MCC	402	0.8924	22.6	18.8
206	205	Other respiratory system diagnoses w/o MCC	155	0.6983	20.6	17.2
207	207	Respiratory system diagnosis w ventilator support 96+ hours	14,524	2.1043	33.7	28.1
208	208	Respiratory system diagnosis w ventilator support <96 hours	1,657	1.1918	22.8	19.0
215	215	Other heart assist system implant	0	1.0757	29.2	24.3
216	216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC*	0	1.1175	27.0	22.5
217	216	Cardiac valve & oth maj cardiothoracic proc w card cath w CC*	0	1.0757	29.2	24.3
218	216	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC*	0	1.0757	29.2	24.3
219	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC*	0	1.1175	27.0	22.5
220	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC*	0	1.0757	29.2	24.3
221	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC*	0	1.0757	29.2	24.3
222	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	1	1.7130	37.2	31.0
223	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	0	1.1175	27.0	22.5
224	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	0	1.7130	37.2	31.0
225	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	0	1.1175	27.0	22.5
226	226	Cardiac defibrillator implant w/o cardiac cath w MCC	12	1.7130	37.2	31.0
227	226	Cardiac defibrillator implant w/o cardiac cath w/o MCC	2	1.7130	37.2	31.0
228	228	Other cardiothoracic procedures w MCC	0	1.4789	31.2	26.0
229	228	Other cardiothoracic procedures w CC	0	1.0757	29.2	24.3
230	228	Other cardiothoracic procedures w/o CC/MCC	0	1.0757	29.2	24.3
231	231	Coronary bypass w PTCA w MCC	0	1.1175	27.0	22.5
232	231	Coronary bypass w PTCA w/o MCC	0	1.0757	29.2	24.3
233	233	Coronary bypass w cardiac cath w MCC	0	1.1175	27.0	22.5
234	233	Coronary bypass w cardiac cath w/o MCC	0	1.0757	29.2	24.3
235	235	Coronary bypass w/o cardiac cath w MCC	0	1.1175	27.0	22.5
236	235	Coronary bypass w/o cardiac cath w/o MCC	0	1.0757	29.2	24.3
237	237	Major cardiovascular procedures w MCC	2	1.1175	27.0	22.5
238	237	Major cardiovascular procedures w/o MCC	0	1.0757	29.2	24.3
239	239	Amputation for circ sys disorders exc upper limb & toe w MCC	139	1.5821	38.4	32.0
240	239	Amputation for circ sys disorders exc upper limb & toe w CC	61	1.1528	33.8	28.2

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
241	239	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	3	0.7836	23.8	19.8
242	242	Permanent cardiac pacemaker implant w MCC	5	1.7130	37.2	31.0
243	242	Permanent cardiac pacemaker implant w CC	7	1.1175	27.0	22.5
244	242	Permanent cardiac pacemaker implant w/o CC/MCC	3	1.1175	27.0	22.5
245	245	AICD generator procedures	1	1.7130	37.2	31.0
246	246	Percutaneous cardiovascular proc w drug-eluting stent w MCC	0	1.4789	31.2	26.0
247	246	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC	0	1.0757	29.2	24.3
248	248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC	0	1.4789	31.2	26.0
249	248	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC	0	1.0757	29.2	24.3
250	250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	4	1.7130	37.2	31.0
251	250	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	0	1.7130	37.2	31.0
252	252	Other vascular procedures w MCC	130	1.4789	31.2	26.0
253	252	Other vascular procedures w CC	58	1.0757	29.2	24.3
254	252	Other vascular procedures w/o CC/MCC	1	1.0757	29.2	24.3
255	255	Upper limb & toe amputation for circ system disorders w MCC	46	1.3708	34.8	29.0
256	255	Upper limb & toe amputation for circ system disorders w CC	28	0.9314	27.7	23.1
257	255	Upper limb & toe amputation for circ system disorders w/o CC/MCC	2	0.6705	21.6	18.0
258	258	Cardiac pacemaker device replacement w MCC	0	0.6705	21.6	18.0
259	258	Cardiac pacemaker device replacement w/o MCC	1	0.6705	21.6	18.0
260	260	Cardiac pacemaker revision except device replacement w MCC	7	1.7130	37.2	31.0
261	260	Cardiac pacemaker revision except device replacement w CC	0	0.6705	21.6	18.0
262	260	Cardiac pacemaker revision except device replacement w/o CC/MCC	0	0.6705	21.6	18.0
263	263	Vein ligation & stripping	0	0.4690	19.3	16.1
264	264	Other circulatory system O.R. procedures	539	1.0717	30.6	25.5
265	265	AICD lead procedures	0	0.6705	21.6	18.0
280	280	Circulatory disorders w AMI, discharged alive w MCC	265	0.7783	22.3	18.6
281	280	Circulatory disorders w AMI, discharged alive w CC	116	0.5846	20.1	16.8
282	280	Circulatory disorders w AMI, discharged alive w/o CC/MCC	25	0.5438	17.6	14.7
283	283	Circulatory disorders w AMI, expired w MCC	40	0.9947	19.6	16.3
284	283	Circulatory disorders w AMI, expired w CC	9	0.6705	21.6	18.0
285	283	Circulatory disorders w AMI, expired w/o CC/MCC	2	0.6705	21.6	18.0
286	286	Circulatory disorders except AMI, w card cath w MCC	10	1.1175	27.0	22.5
287	286	Circulatory disorders except AMI, w card cath w/o MCC	5	1.1175	27.0	22.5
288	288	Acute & subacute endocarditis w MCC	648	1.0354	26.2	21.8
289	288	Acute & subacute endocarditis w CC	210	0.8393	26.7	22.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
290	288	Acute & subacute endocarditis w/o CC/MCC	20	0.7836	23.8	19.8
291	291	Heart failure & shock w MCC	1,441	0.7723	21.6	18.0
292	291	Heart failure & shock w CC	740	0.6234	20.1	16.8
293	291	Heart failure & shock w/o CC/MCC	157	0.5472	18.7	15.6
294	294	Deep vein thrombophlebitis w CC/MCC	5	0.6705	21.6	18.0
295	294	Deep vein thrombophlebitis w/o CC/MCC	0	0.6705	21.6	18.0
296	296	Cardiac arrest, unexplained w MCC	0	0.9947	19.6	16.3
297	296	Cardiac arrest, unexplained w CC	0	0.6705	21.6	18.0
298	296	Cardiac arrest, unexplained w/o CC/MCC	0	0.6705	21.6	18.0
299	299	Peripheral vascular disorders w MCC	678	0.8169	23.5	19.6
300	299	Peripheral vascular disorders w CC	770	0.6136	22.2	18.5
301	299	Peripheral vascular disorders w/o CC/MCC	62	0.4690	19.3	16.1
302	302	Atherosclerosis w MCC	31	0.7655	23.0	19.2
303	302	Atherosclerosis w/o MCC	26	0.4570	17.5	14.6
304	304	Hypertension w MCC	9	1.1175	27.0	22.5
305	304	Hypertension w/o MCC	27	0.4724	18.9	15.8
306	306	Cardiac congenital & valvular disorders w MCC	74	0.8342	21.8	18.2
307	306	Cardiac congenital & valvular disorders w/o MCC	37	0.7798	26.0	21.7
308	308	Cardiac arrhythmia & conduction disorders w MCC	112	0.7728	23.0	19.2
309	308	Cardiac arrhythmia & conduction disorders w CC	85	0.5997	20.6	17.2
310	308	Cardiac arrhythmia & conduction disorders w/o CC/MCC	23	0.4994	19.3	16.1
311	311	Angina pectoris	3	0.6705	21.6	18.0
312	312	Syncope & collapse	38	0.4870	19.1	15.9
313	313	Chest pain	2	0.4994	19.3	16.1
314	314	Other circulatory system diagnoses w MCC	1,372	0.9268	23.5	19.6
315	314	Other circulatory system diagnoses w CC	279	0.6445	21.4	17.8
316	314	Other circulatory system diagnoses w/o CC/MCC	43	0.5404	18.5	15.4
326	326	Stomach, esophageal & duodenal proc w MCC	25	2.2775	43.9	36.6
327	326	Stomach, esophageal & duodenal proc w CC	6	0.7836	23.8	19.8
328	326	Stomach, esophageal & duodenal proc w/o CC/MCC	0	0.4994	19.3	16.1
329	329	Major small & large bowel procedures w MCC	35	2.3114	39.6	33.0
330	329	Major small & large bowel procedures w CC	14	1.7130	37.2	31.0
331	329	Major small & large bowel procedures w/o CC/MCC	1	0.7836	23.8	19.8
332	332	Rectal resection w MCC	0	1.7817	37.0	30.8
333	332	Rectal resection w CC	0	1.2903	33.0	27.5
334	332	Rectal resection w/o CC/MCC	0	0.4994	19.3	16.1
335	335	Peritoneal adhesiolysis w MCC	6	1.7130	37.2	31.0
336	335	Peritoneal adhesiolysis w CC	1	1.7130	37.2	31.0
337	335	Peritoneal adhesiolysis w/o CC/MCC	0	1.7130	37.2	31.0
338	338	Appendectomy w complicated principal diag w MCC	1	1.1175	27.0	22.5
339	338	Appendectomy w complicated principal diag w CC	0	0.7369	22.5	18.8
340	338	Appendectomy w complicated principal diag w/o CC/MCC	0	0.5675	19.1	15.9
341	341	Appendectomy w/o complicated principal diag w MCC	0	0.9835	24.5	20.4
342	341	Appendectomy w/o complicated principal diag w CC	0	0.7369	22.5	18.8

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
343	341	Appendectomy w/o complicated principal diag w/o CC/MCC	0	0.5675	19.1	15.9
344	344	Minor small & large bowel procedures w MCC	1	1.1175	27.0	22.5
345	344	Minor small & large bowel procedures w CC	0	1.1175	27.0	22.5
346	344	Minor small & large bowel procedures w/o CC/MCC	0	1.1175	27.0	22.5
347	347	Anal & stomal procedures w MCC	4	1.1175	27.0	22.5
348	347	Anal & stomal procedures w CC	2	0.7836	23.8	19.8
349	347	Anal & stomal procedures w/o CC/MCC	0	0.7836	23.8	19.8
350	350	Inguinal & femoral hernia procedures w MCC*	1	0.4994	19.3	16.1
351	350	Inguinal & femoral hernia procedures w CC*	0	0.4994	19.3	16.1
352	350	Inguinal & femoral hernia procedures w/o CC/MCC*	0	0.4994	19.3	16.1
353	353	Hernia procedures except inguinal & femoral w MCC	1	1.1175	27.0	22.5
354	353	Hernia procedures except inguinal & femoral w CC	1	1.1175	27.0	22.5
355	353	Hernia procedures except inguinal & femoral w/o CC/MCC	0	1.1175	27.0	22.5
356	356	Other digestive system O.R. procedures w MCC	116	1.7817	37.0	30.8
357	356	Other digestive system O.R. procedures w CC	45	1.2903	33.0	27.5
358	356	Other digestive system O.R. procedures w/o CC/MCC	1	0.4994	19.3	16.1
368	368	Major esophageal disorders w MCC	35	1.0454	26.5	22.1
369	368	Major esophageal disorders w CC	13	1.0454	26.5	22.1
370	368	Major esophageal disorders w/o CC/MCC	1	0.4994	19.3	16.1
371	371	Major gastrointestinal disorders & peritoneal infections w MCC	845	0.9835	24.5	20.4
372	371	Major gastrointestinal disorders & peritoneal infections w CC	365	0.7369	22.5	18.8
373	371	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	37	0.5675	19.1	15.9
374	374	Digestive malignancy w MCC	110	1.1219	25.4	21.2
375	374	Digestive malignancy w CC	66	0.6957	21.6	18.0
376	374	Digestive malignancy w/o CC/MCC	4	0.4994	19.3	16.1
377	377	G.I. hemorrhage w MCC	76	1.0019	24.0	20.0
378	377	G.I. hemorrhage w CC	43	0.6087	20.1	16.8
379	377	G.I. hemorrhage w/o CC/MCC	8	0.6087	20.1	16.8
380	380	Complicated peptic ulcer w MCC	16	1.1175	27.0	22.5
381	380	Complicated peptic ulcer w CC	17	0.7836	23.8	19.8
382	380	Complicated peptic ulcer w/o CC/MCC	1	0.7836	23.8	19.8
383	383	Uncomplicated peptic ulcer w MCC	8	0.7836	23.8	19.8
384	383	Uncomplicated peptic ulcer w/o MCC	5	0.6705	21.6	18.0
385	385	Inflammatory bowel disease w MCC	32	1.2985	26.1	21.8
386	385	Inflammatory bowel disease w CC	19	0.6705	21.6	18.0
387	385	Inflammatory bowel disease w/o CC/MCC	2	0.4994	19.3	16.1
388	388	G.I. obstruction w MCC	185	1.0520	23.9	19.9
389	388	G.I. obstruction w CC	96	0.7535	21.3	17.8
390	388	G.I. obstruction w/o CC/MCC	14	0.6705	21.6	18.0
391	391	Esophagitis, gastroent & misc digest disorders w MCC	371	0.9156	23.4	19.5
392	391	Esophagitis, gastroent & misc digest disorders w/o MCC	236	0.6570	21.1	17.6
393	393	Other digestive system diagnoses w MCC	841	1.1412	27.2	22.7

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
394	393	Other digestive system diagnoses w CC	449	0.7709	22.8	19.0
395	393	Other digestive system diagnoses w/o CC/MCC	39	0.6251	19.8	16.5
405	405	Pancreas, liver & shunt procedures w MCC	10	1.7130	37.2	31.0
406	405	Pancreas, liver & shunt procedures w CC	4	1.7130	37.2	31.0
407	405	Pancreas, liver & shunt procedures w/o CC/MCC	0	1.7130	37.2	31.0
408	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	0	0.7836	23.8	19.8
409	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	0	0.7836	23.8	19.8
410	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	0	0.7836	23.8	19.8
411	411	Cholecystectomy w c.d.e. w MCC	0	0.6705	21.6	18.0
412	411	Cholecystectomy w c.d.e. w CC	0	0.6705	21.6	18.0
413	411	Cholecystectomy w c.d.e. w/o CC/MCC	0	0.6705	21.6	18.0
414	414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	6	1.7130	37.2	31.0
415	414	Cholecystectomy except by laparoscope w/o c.d.e. w CC	0	0.6705	21.6	18.0
416	414	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	0	0.6705	21.6	18.0
417	417	Laparoscopic cholecystectomy w/o c.d.e. w MCC	9	1.7130	37.2	31.0
418	417	Laparoscopic cholecystectomy w/o c.d.e. w CC	2	0.6705	21.6	18.0
419	417	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	0	0.6705	21.6	18.0
420	420	Hepatobiliary diagnostic procedures w MCC	2	1.7130	37.2	31.0
421	420	Hepatobiliary diagnostic procedures w CC	0	0.7836	23.8	19.8
422	420	Hepatobiliary diagnostic procedures w/o CC/MCC	0	0.7836	23.8	19.8
423	423	Other hepatobiliary or pancreas O.R. procedures w MCC	18	1.1175	27.0	22.5
424	423	Other hepatobiliary or pancreas O.R. procedures w CC	4	0.7836	23.8	19.8
425	423	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	0	0.7836	23.8	19.8
432	432	Cirrhosis & alcoholic hepatitis w MCC	67	0.7198	19.9	16.6
433	432	Cirrhosis & alcoholic hepatitis w CC	22	0.6705	21.6	18.0
434	432	Cirrhosis & alcoholic hepatitis w/o CC/MCC	0	0.6705	21.6	18.0
435	435	Malignancy of hepatobiliary system or pancreas w MCC	33	0.7958	21.2	17.7
436	435	Malignancy of hepatobiliary system or pancreas w CC	21	0.6705	21.6	18.0
437	435	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	2	0.4994	19.3	16.1
438	438	Disorders of pancreas except malignancy w MCC	315	1.1123	24.5	20.4
439	438	Disorders of pancreas except malignancy w CC	126	0.8329	20.5	17.1
440	438	Disorders of pancreas except malignancy w/o CC/MCC	12	0.4994	19.3	16.1
441	441	Disorders of liver except malig,cirr,alc hepa w MCC	169	0.8531	22.0	18.3
442	441	Disorders of liver except malig,cirr,alc hepa w CC	69	0.6710	22.1	18.4
443	441	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC	8	0.4994	19.3	16.1
444	444	Disorders of the biliary tract w MCC	118	0.8907	22.8	19.0
445	444	Disorders of the biliary tract w CC	47	0.6174	21.0	17.5
446	444	Disorders of the biliary tract w/o CC/MCC	9	0.4994	19.3	16.1
453	453	Combined anterior/posterior spinal fusion w MCC	1	1.7130	37.2	31.0
454	453	Combined anterior/posterior spinal fusion w CC	1	1.7130	37.2	31.0
455	453	Combined anterior/posterior spinal fusion w/o CC/MCC	0	1.7130	37.2	31.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
456	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC	1	1.7130	37.2	31.0
457	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC	1	1.7130	37.2	31.0
458	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC	0	1.7130	37.2	31.0
459	459	Spinal fusion except cervical w MCC	3	1.7130	37.2	31.0
460	459	Spinal fusion except cervical w/o MCC	0	1.7130	37.2	31.0
461	461	Bilateral or multiple major joint procs of lower extremity w MCC	0	1.7130	37.2	31.0
462	461	Bilateral or multiple major joint procs of lower extremity w/o MCC	0	1.7130	37.2	31.0
463	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	584	1.5069	38.7	32.3
464	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	552	1.1750	36.3	30.3
465	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	60	0.9717	33.1	27.6
466	466	Revision of hip or knee replacement w MCC	5	1.7130	37.2	31.0
467	466	Revision of hip or knee replacement w CC	6	1.7130	37.2	31.0
468	466	Revision of hip or knee replacement w/o CC/MCC	0	1.7130	37.2	31.0
469	469	Major joint replacement or reattachment of lower extremity w MCC	1	1.7130	37.2	31.0
470	469	Major joint replacement or reattachment of lower extremity w/o MCC	3	1.7130	37.2	31.0
471	471	Cervical spinal fusion w MCC	3	1.1175	27.0	22.5
472	471	Cervical spinal fusion w CC	2	0.7836	23.8	19.8
473	471	Cervical spinal fusion w/o CC/MCC	0	0.7836	23.8	19.8
474	474	Amputation for musculoskeletal sys & conn tissue dis w MCC	89	1.3983	35.6	29.7
475	474	Amputation for musculoskeletal sys & conn tissue dis w CC	73	1.1016	32.3	26.9
476	474	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	4	0.7836	23.8	19.8
477	477	Biopsies of musculoskeletal system & connective tissue w MCC	34	1.4113	35.4	29.5
478	477	Biopsies of musculoskeletal system & connective tissue w CC	28	1.3470	39.1	32.6
479	477	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	3	0.6705	21.6	18.0
480	480	Hip & femur procedures except major joint w MCC	13	1.7130	37.2	31.0
481	480	Hip & femur procedures except major joint w CC	8	1.7130	37.2	31.0
482	480	Hip & femur procedures except major joint w/o CC/MCC	0	1.7130	37.2	31.0
483	483	Major joint & limb reattachment proc of upper extremity w CC/MCC	0	1.7130	37.2	31.0
484	483	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	0	1.7130	37.2	31.0
485	485	Knee procedures w pdx of infection w MCC	8	1.7130	37.2	31.0
486	485	Knee procedures w pdx of infection w CC	4	1.7130	37.2	31.0
487	485	Knee procedures w pdx of infection w/o CC/MCC	2	0.7836	23.8	19.8

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
488	488	Knee procedures w/o pdx of infection w CC/MCC*	4	1.1175	27.0	22.5
489	488	Knee procedures w/o pdx of infection w/o CC/MCC*	0	1.1175	27.0	22.5
490	490	Back & neck procedures except spinal fusion w CC/MCC or disc devices	4	1.1175	27.0	22.5
491	490	Back & neck procedures except spinal fusion w/o CC/MCC	0	1.1175	27.0	22.5
492	492	Lower extrem & humer proc except hip,foot,femur w MCC*	4	1.7130	37.2	31.0
493	492	Lower extrem & humer proc except hip,foot,femur w CC*	9	0.7836	23.8	19.8
494	492	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC*	0	0.7836	23.8	19.8
495	495	Local excision & removal int fix devices exc hip & femur w MCC	30	1.3505	38.1	31.8
496	495	Local excision & removal int fix devices exc hip & femur w CC	41	1.1874	34.5	28.8
497	495	Local excision & removal int fix devices exc hip & femur w/o CC/MCC	5	0.6705	21.6	18.0
498	498	Local excision & removal int fix devices of hip & femur w CC/MCC	19	1.7130	37.2	31.0
499	498	Local excision & removal int fix devices of hip & femur w/o CC/MCC	1	0.7836	23.8	19.8
500	500	Soft tissue procedures w MCC	105	1.4559	36.9	30.8
501	500	Soft tissue procedures w CC	72	1.0546	32.9	27.4
502	500	Soft tissue procedures w/o CC/MCC	7	1.0546	32.9	27.4
503	503	Foot procedures w MCC	24	1.1175	27.0	22.5
504	503	Foot procedures w CC	29	1.0707	31.1	25.9
505	503	Foot procedures w/o CC/MCC	4	1.0707	31.1	25.9
506	506	Major thumb or joint procedures	0	1.1175	27.0	22.5
507	507	Major shoulder or elbow joint procedures w CC/MCC	2	1.7130	37.2	31.0
508	507	Major shoulder or elbow joint procedures w/o CC/MCC	0	1.7130	37.2	31.0
509	509	Arthroscopy	0	1.0707	31.1	25.9
510	510	Shoulder,elbow or forearm proc,exc major joint proc w MCC	3	1.1175	27.0	22.5
511	510	Shoulder,elbow or forearm proc,exc major joint proc w CC	2	0.7836	23.8	19.8
512	510	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	0	0.7836	23.8	19.8
513	513	Hand or wrist proc, except major thumb or joint proc w CC/MCC	9	1.1175	27.0	22.5
514	513	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	1	1.1175	27.0	22.5
515	515	Other musculoskelet sys & conn tiss O.R. proc w MCC	45	1.2370	30.1	25.1
516	515	Other musculoskelet sys & conn tiss O.R. proc w CC	20	1.1175	27.0	22.5
517	515	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	1	0.7836	23.8	19.8
533	533	Fractures of femur w MCC	0	1.7130	37.2	31.0
534	533	Fractures of femur w/o MCC	1	0.4994	19.3	16.1
535	535	Fractures of hip & pelvis w MCC	14	0.6705	21.6	18.0
536	535	Fractures of hip & pelvis w/o MCC	12	0.4994	19.3	16.1

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
537	537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	1	1.1175	27.0	22.5
538	537	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	0	1.1175	27.0	22.5
539	539	Osteomyelitis w MCC	1,280	1.0691	30.0	25.0
540	539	Osteomyelitis w CC	1,286	0.8341	28.7	23.9
541	539	Osteomyelitis w/o CC/MCC	201	0.7245	26.6	22.2
542	542	Pathological fractures & musculoskelet & conn tiss malig w MCC	40	0.8397	23.8	19.8
543	542	Pathological fractures & musculoskelet & conn tiss malig w CC	34	0.6389	21.6	18.0
544	542	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC	3	0.4994	19.3	16.1
545	545	Connective tissue disorders w MCC	55	0.8377	21.8	18.2
546	545	Connective tissue disorders w CC	31	0.6004	21.1	17.6
547	545	Connective tissue disorders w/o CC/MCC	4	0.4994	19.3	16.1
548	548	Septic arthritis w MCC	227	0.8846	26.5	22.1
549	548	Septic arthritis w CC	177	0.7649	25.6	21.3
550	548	Septic arthritis w/o CC/MCC	61	0.5437	23.4	19.5
551	551	Medical back problems w MCC	104	0.9377	27.3	22.8
552	551	Medical back problems w/o MCC	132	0.6158	23.1	19.3
553	553	Bone diseases & arthropathies w MCC	16	0.6705	21.6	18.0
554	553	Bone diseases & arthropathies w/o MCC	34	0.4873	19.9	16.6
555	555	Signs & symptoms of musculoskeletal system & conn tissue w MCC	7	0.7836	23.8	19.8
556	555	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC	17	0.4994	19.3	16.1
557	557	Tendonitis, myositis & bursitis w MCC	112	0.9095	24.6	20.5
558	557	Tendonitis, myositis & bursitis w/o MCC	127	0.7145	22.9	19.1
559	559	Aftercare, musculoskeletal system & connective tissue w MCC	1,567	0.8482	25.7	21.4
560	559	Aftercare, musculoskeletal system & connective tissue w CC	1,588	0.7059	25.4	21.2
561	559	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	431	0.5579	22.2	18.5
562	562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC	21	0.7530	24.0	20.0
563	562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC	8	0.7530	24.0	20.0
564	564	Other musculoskeletal sys & connective tissue diagnoses w MCC	339	0.9248	24.5	20.4
565	564	Other musculoskeletal sys & connective tissue diagnoses w CC	263	0.7163	24.2	20.2
566	564	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC	32	0.5385	21.4	17.8
573	573	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	1,834	1.4209	37.8	31.5
574	573	Skin graft &/or debrid for skn ulcer or cellulitis w CC	1,350	1.0474	35.0	29.2
575	573	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	94	0.8335	28.7	23.9

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
576	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	43	1.2886	32.3	26.9
577	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	23	1.1175	27.0	22.5
578	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC	6	0.4994	19.3	16.1
579	579	Other skin, subcut tiss & breast proc w MCC	552	1.3684	35.7	29.8
580	579	Other skin, subcut tiss & breast proc w CC	292	0.9845	32.2	26.8
581	579	Other skin, subcut tiss & breast proc w/o CC/MCC	23	0.7836	23.8	19.8
582	582	Mastectomy for malignancy w CC/MCC	4	0.7836	23.8	19.8
583	582	Mastectomy for malignancy w/o CC/MCC	0	0.7836	23.8	19.8
584	584	Breast biopsy, local excision & other breast procedures w CC/MCC	2	1.1175	27.0	22.5
585	584	Breast biopsy, local excision & other breast procedures w/o CC/MCC	0	1.1175	27.0	22.5
592	592	Skin ulcers w MCC	3,617	0.9681	26.7	22.3
593	592	Skin ulcers w CC	2,502	0.7178	25.5	21.3
594	592	Skin ulcers w/o CC/MCC	228	0.5945	22.0	18.3
595	595	Major skin disorders w MCC	36	0.7147	23.2	19.3
596	595	Major skin disorders w/o MCC	34	0.5287	19.6	16.3
597	597	Malignant breast disorders w MCC*	10	0.7836	23.8	19.8
598	597	Malignant breast disorders w CC*	8	0.6705	21.6	18.0
599	597	Malignant breast disorders w/o CC/MCC*	0	0.6705	21.6	18.0
600	600	Non-malignant breast disorders w CC/MCC	18	0.6705	21.6	18.0
601	600	Non-malignant breast disorders w/o CC/MCC	3	0.4994	19.3	16.1
602	602	Cellulitis w MCC	946	0.7381	22.6	18.8
603	602	Cellulitis w/o MCC	1,431	0.5355	19.3	16.1
604	604	Trauma to the skin, subcut tiss & breast w MCC	44	0.8788	25.6	21.3
605	604	Trauma to the skin, subcut tiss & breast w/o MCC	45	0.6033	21.0	17.5
606	606	Minor skin disorders w MCC	90	1.2436	27.3	22.8
607	606	Minor skin disorders w/o MCC	105	0.5976	21.7	18.1
614	614	Adrenal & pituitary procedures w CC/MCC	0	1.0794	31.6	26.3
615	614	Adrenal & pituitary procedures w/o CC/MCC	0	1.0794	31.6	26.3
616	616	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC	62	1.6313	38.2	31.8
617	616	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC	143	1.1354	31.4	26.2
618	616	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	0	1.1354	31.4	26.2
619	619	O.R. procedures for obesity w MCC*	1	1.7130	37.2	31.0
620	619	O.R. procedures for obesity w CC*	2	0.7836	23.8	19.8
621	619	O.R. procedures for obesity w/o CC/MCC*	0	0.7836	23.8	19.8
622	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	119	1.3087	33.7	28.1
623	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	334	1.0313	30.7	25.6
624	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC	12	1.0313	30.7	25.6
625	625	Thyroid, parathyroid & thyroglossal procedures w MCC	0	1.4964	34.0	28.3

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
626	625	Thyroid, parathyroid & thyroglossal procedures w CC	0	1.0794	31.6	26.3
627	625	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	0	1.0794	31.6	26.3
628	628	Other endocrine, nutrit & metab O.R. proc w MCC	60	1.4964	34.0	28.3
629	628	Other endocrine, nutrit & metab O.R. proc w CC	122	1.0794	31.6	26.3
630	628	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	0	1.0794	31.6	26.3
637	637	Diabetes w MCC	432	0.9107	25.8	21.5
638	637	Diabetes w CC	1,185	0.7255	24.3	20.3
639	637	Diabetes w/o CC/MCC	38	0.4238	18.0	15.0
640	640	Nutritional & misc metabolic disorders w MCC	679	0.8458	22.3	18.6
641	640	Nutritional & misc metabolic disorders w/o MCC	520	0.6746	21.5	17.9
642	642	Inborn errors of metabolism	7	1.7130	37.2	31.0
643	643	Endocrine disorders w MCC	19	0.7836	23.8	19.8
644	643	Endocrine disorders w CC	18	0.6705	21.6	18.0
645	643	Endocrine disorders w/o CC/MCC	3	0.6705	21.6	18.0
652	652	Kidney transplant	0	0.0000	0.0	0.0
653	653	Major bladder procedures w MCC	0	0.7836	23.8	19.8
654	653	Major bladder procedures w CC	0	0.7836	23.8	19.8
655	653	Major bladder procedures w/o CC/MCC	0	0.7836	23.8	19.8
656	656	Kidney & ureter procedures for neoplasm w MCC	2	0.7836	23.8	19.8
657	656	Kidney & ureter procedures forneoplasm w CC	0	0.7836	23.8	19.8
658	656	Kidney & ureter procedures for neoplasm w/o CC/MCC	0	0.7836	23.8	19.8
659	659	Kidney & ureter procedures for non-neoplasm w MCC*	4	1.7130	37.2	31.0
660	659	Kidney & ureter procedures for non-neoplasm w CC*	9	0.7836	23.8	19.8
661	659	Kidney & ureter procedures for non-neoplasm w/o CC/MCC*	0	0.7836	23.8	19.8
662	662	Minor bladder procedures w MCC	1	1.7130	37.2	31.0
663	662	Minor bladder procedures w CC	3	0.6705	21.6	18.0
664	662	Minor bladder procedures w/o CC/MCC	0	0.6705	21.6	18.0
665	665	Prostatectomy w MCC	0	0.7836	23.8	19.8
666	665	Prostatectomy w CC	1	0.7836	23.8	19.8
667	665	Prostatectomy w/o CC/MCC	1	0.4994	19.3	16.1
668	668	Transurethral procedures w MCC	3	0.7836	23.8	19.8
669	668	Transurethral procedures w CC	7	0.7836	23.8	19.8
670	668	Transurethral procedures w/o CC/MCC	0	0.7836	23.8	19.8
671	671	Urethral procedures w CC/MCC	2	1.1175	27.0	22.5
672	671	Urethral procedures w/o CC/MCC	0	1.1175	27.0	22.5
673	673	Other kidney & urinary tract procedures w MCC	154	1.3829	32.1	26.8
674	673	Other kidney & urinary tract procedures w CC	56	0.9850	28.7	23.9
675	673	Other kidney & urinary tract procedures w/o CC/MCC	5	0.6705	21.6	18.0
682	682	Renal failure w MCC	1,476	0.9344	23.3	19.4
683	682	Renal failure w CC	587	0.7463	22.1	18.4
684	682	Renal failure w/o CC/MCC	36	0.5532	17.9	14.9
685	685	Admit for renal dialysis	10	0.6705	21.6	18.0
686	686	Kidney & urinary tract neoplasms w MCC*	31	0.8313	23.5	19.6
687	686	Kidney & urinary tract neoplasms w CC*	20	0.7836	23.8	19.8

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
688	686	Kidney & urinary tract neoplasms w/o CC/MCC*	0	0.7836	23.8	19.8
689	689	Kidney & urinary tract infections w MCC	895	0.7012	22.6	18.8
690	689	Kidney & urinary tract infections w/o MCC	703	0.5519	19.8	16.5
691	691	Urinary stones w esw lithotripsy w CC/MCC	1	1.1175	27.0	22.5
692	691	Urinary stones w esw lithotripsy w/o CC/MCC	0	0.4994	19.3	16.1
693	693	Urinary stones w/o esw lithotripsy w MCC	5	0.7836	23.8	19.8
694	693	Urinary stones w/ot esw lithotripsy w/o MCC	2	0.4994	19.3	16.1
695	695	Kidney & urinary tract signs & symptoms w MCC	3	0.7836	23.8	19.8
696	695	Kidney & urinary tract signs & symptoms w/o MCC	2	0.4994	19.3	16.1
697	697	Urethral stricture	1	0.6705	21.6	18.0
698	698	Other kidney & urinary tract diagnoses w MCC	237	0.9032	23.2	19.3
699	698	Other kidney & urinary tract diagnoses w CC	142	0.7441	22.4	18.7
700	698	Other kidney & urinary tract diagnoses w/o CC/MCC	13	0.6705	21.6	18.0
707	707	Major male pelvic procedures w CC/MCC	0	0.7836	23.8	19.8
708	707	Major male pelvic procedures w/o CC/MCC	0	0.7836	23.8	19.8
709	709	Penis procedures w CC/MCC	2	1.7130	37.2	31.0
710	709	Penis procedures w/o CC/MCC	0	1.7130	37.2	31.0
711	711	Testes procedures w CC/MCC	8	1.1175	27.0	22.5
712	711	Testes procedures w/o CC/MCC	0	1.1175	27.0	22.5
713	713	Transurethral prostatectomy w CC/MCC	0	0.7836	23.8	19.8
714	713	Transurethral prostatectomy w/o CC/MCC	0	0.7836	23.8	19.8
715	715	Other male reproductive system O.R. proc for malignancy w CC/MCC	0	1.7130	37.2	31.0
716	715	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	0	1.7130	37.2	31.0
717	717	Other male reproductive system O.R. proc exc malignancy w CC/MCC	12	1.7130	37.2	31.0
718	717	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	0	1.7130	37.2	31.0
722	722	Malignancy, male reproductive system w MCC	8	0.6705	21.6	18.0
723	722	Malignancy, male reproductive system w CC	10	0.6705	21.6	18.0
724	722	Malignancy, male reproductive system w/o CC/MCC	0	0.6705	21.6	18.0
725	725	Benign prostatic hypertrophy w MCC	4	0.4994	19.3	16.1
726	725	Benign prostatic hypertrophy w/o MCC	1	0.4994	19.3	16.1
727	727	Inflammation of the male reproductive system w MCC	66	0.8012	24.0	20.0
728	727	Inflammation of the male reproductive system w/o MCC	66	0.5176	20.7	17.3
729	729	Other male reproductive system diagnoses w CC/MCC	72	0.8812	23.7	19.8
730	729	Other male reproductive system diagnoses w/o CC/MCC	1	0.4994	19.3	16.1
734	734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	0	1.7130	37.2	31.0
735	734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	0	1.7130	37.2	31.0
736	736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC*	0	0.9710	22.3	18.6
737	736	Uterine & adnexa proc for ovarian or adnexal malignancy w CC*	0	0.6705	21.6	18.0

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
738	736	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC*	0	0.6705	21.6	18.0
739	739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC*	0	1.4964	34.0	28.3
740	739	Uterine,adnexa proc for non-ovarian/adnexal malig w CC*	0	0.6705	21.6	18.0
741	739	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC*	0	0.6705	21.6	18.0
742	742	Uterine & adnexa proc for non-malignancy w CC/MCC*	0	0.6705	21.6	18.0
743	742	Uterine & adnexa proc for non-malignancy w/o CC/MCC*	0	0.6705	21.6	18.0
744	744	D&C, conization, laparascopy & tubal interruption w CC/MCC	0	0.7836	23.8	19.8
745	744	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	0	0.7836	23.8	19.8
746	746	Vagina, cervix & vulva procedures w CC/MCC	1	0.6705	21.6	18.0
747	746	Vagina, cervix & vulva procedures w/o CC/MCC	1	0.6705	21.6	18.0
748	748	Female reproductive system reconstructive procedures	0	0.7836	23.8	19.8
749	749	Other female reproductive system O.R. procedures w CC/MCC	4	0.7836	23.8	19.8
750	749	Other female reproductive system O.R. procedures w/o CC/MCC	0	0.7836	23.8	19.8
754	754	Malignancy, female reproductive system w MCC	25	0.9710	22.3	18.6
755	754	Malignancy, female reproductive system w CC	19	0.6705	21.6	18.0
756	754	Malignancy, female reproductive system w/o CC/MCC	0	0.6705	21.6	18.0
757	757	Infections, female reproductive system w MCC	78	0.9102	24.2	20.2
758	757	Infections, female reproductive system w CC	34	0.8197	21.3	17.8
759	757	Infections, female reproductive system w/o CC/MCC	2	0.6705	21.6	18.0
760	760	Menstrual & other female reproductive system disorders w CC/MCC*	11	0.7836	23.8	19.8
761	760	Menstrual & other female reproductive system disorders w/o CC/MCC*	0	0.7836	23.8	19.8
765	765	Cesarean section w CC/MCC	0	1.0794	31.6	26.3
766	765	Cesarean section w/o CC/MCC	0	1.0794	31.6	26.3
767	767	Vaginal delivery w sterilization &/or D&C	0	1.0794	31.6	26.3
768	768	Vaginal delivery w O.R. proc except steril &/or D&C	0	1.0794	31.6	26.3
769	769	Postpartum & post abortion diagnoses w O.R. procedure	0	1.0794	31.6	26.3
770	770	Abortion w D&C, aspiration curettage or hysterotomy	0	1.0794	31.6	26.3
774	774	Vaginal delivery w complicating diagnoses	0	1.0794	31.6	26.3
775	775	Vaginal delivery w/o complicating diagnoses	0	1.0794	31.6	26.3
776	776	Postpartum & post abortion diagnoses w/o O.R. procedure	1	1.7130	37.2	31.0
777	777	Ectopic pregnancy	0	1.0794	31.6	26.3
778	778	Threatened abortion	0	0.6705	21.6	18.0
779	779	Abortion w/o D&C	0	0.6705	21.6	18.0
780	780	False labor	0	0.6705	21.6	18.0
781	781	Other antepartum diagnoses w medical complications	3	0.7836	23.8	19.8
782	782	Other antepartum diagnoses w/o medical complications	0	0.7836	23.8	19.8
789	789	Neonates, died or transferred to another acute care facility	0	0.7836	23.8	19.8
790	790	Extreme immaturity or respiratory distress syndrome, neonate	0	0.7836	23.8	19.8

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
791	791	Prematurity w major problems	0	0.7836	23.8	19.8
792	792	Prematurity w/o major problems	0	0.7836	23.8	19.8
793	793	Full term neonate w major problems	0	0.7836	23.8	19.8
794	794	Neonate w other significant problems	0	0.7836	23.8	19.8
795	795	Normal newborn	0	0.7836	23.8	19.8
799	799	Splenectomy w MCC	0	1.1175	27.0	22.5
800	799	Splenectomy w CC	1	1.1175	27.0	22.5
801	799	Splenectomy w/o CC/MCC	0	1.1175	27.0	22.5
802	802	Other O.R. proc of the blood & blood forming organs w MCC*	2	0.6705	21.6	18.0
803	802	Other O.R. proc of the blood & blood forming organs w CC*	2	0.4994	19.3	16.1
804	802	Other O.R. proc of the blood & blood forming organs w/o CC/MCC*	0	0.4994	19.3	16.1
808	808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC	12	0.7044	19.8	16.5
809	808	Major hematol/immun diag exc sickle cell crisis & coagul w CC	15	0.7044	19.8	16.5
810	808	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	0	0.6009	19.5	16.3
811	811	Red blood cell disorders w MCC	39	0.8604	22.1	18.4
812	811	Red blood cell disorders w/o MCC	40	0.6009	19.5	16.3
813	813	Coagulation disorders	41	0.8569	22.3	18.6
814	814	Reticuloendothelial & immunity disorders w MCC	11	1.1175	27.0	22.5
815	814	Reticuloendothelial & immunity disorders w CC	9	0.6705	21.6	18.0
816	814	Reticuloendothelial & immunity disorders w/o CC/MCC	4	0.6705	21.6	18.0
820	820	Lymphoma & leukemia w major O.R. procedure w MCC*	0	1.7130	37.2	31.0
821	820	Lymphoma & leukemia w major O.R. procedure w CC*	1	0.7836	23.8	19.8
822	820	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC*	0	0.7836	23.8	19.8
823	823	Lymphoma & non-acute leukemia w other O.R. proc w MCC	2	1.7130	37.2	31.0
824	823	Lymphoma & non-acute leukemia w other O.R. proc w CC	2	1.7130	37.2	31.0
825	823	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	0	1.7130	37.2	31.0
826	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	1	1.1175	27.0	22.5
827	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	1	1.1175	27.0	22.5
828	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	0	1.1175	27.0	22.5
829	829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC	14	1.1175	27.0	22.5
830	829	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	0	1.1175	27.0	22.5
834	834	Acute leukemia w/o major O.R. procedure w MCC*	21	1.1175	27.0	22.5
835	834	Acute leukemia w/o major O.R. procedure w CC*	9	0.7836	23.8	19.8
836	834	Acute leukemia w/o major O.R. procedure w/o CC/MCC*	0	0.7836	23.8	19.8

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
837	837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC*	1	0.6705	21.6	18.0
838	837	Chemo w acute leukemia as sdx or w high dose chemo agent w CC*	0	0.6705	21.6	18.0
839	837	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC*	0	0.6705	21.6	18.0
840	840	Lymphoma & non-acute leukemia w MCC	85	1.0412	24.0	20.0
841	840	Lymphoma & non-acute leukemia w CC	58	0.9277	22.3	18.6
842	840	Lymphoma & non-acute leukemia w/o CC/MCC	10	0.6705	21.6	18.0
843	843	Other myeloprolif dis or poorly diff neopl diag w MCC*	14	0.7836	23.8	19.8
844	843	Other myeloprolif dis or poorly diff neopl diag w CC*	13	0.7836	23.8	19.8
845	843	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC*	0	0.7836	23.8	19.8
846	846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	59	1.5695	29.5	24.6
847	846	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	41	1.1446	25.0	20.8
848	846	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	1	1.1446	25.0	20.8
849	849	Radiotherapy	141	0.8249	22.3	18.6
853	853	Infectious & parasitic diseases w O.R. procedure w MCC	748	1.8157	37.9	31.6
854	853	Infectious & parasitic diseases w O.R. procedure w CC	182	1.2635	34.8	29.0
855	853	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC	13	1.1175	27.0	22.5
856	856	Postoperative or post-traumatic infections w O.R. proc w MCC	319	1.4460	35.0	29.2
857	856	Postoperative or post-traumatic infections w O.R. proc w CC	173	1.0729	30.9	25.8
858	856	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	24	0.7836	23.8	19.8
862	862	Postoperative & post-traumatic infections w MCC	1,465	0.9905	25.3	21.1
863	862	Postoperative & post-traumatic infections w/o MCC	1,108	0.7066	23.2	19.3
864	864	Fever of unknown origin	6	0.6705	21.6	18.0
865	865	Viral illness w MCC	34	0.8277	24.2	20.2
866	865	Viral illness w/o MCC	19	0.7836	23.8	19.8
867	867	Other infectious & parasitic diseases diagnoses w MCC	374	1.1773	24.0	20.0
868	867	Other infectious & parasitic diseases diagnoses w CC	69	0.6967	22.0	18.3
869	867	Other infectious & parasitic diseases diagnoses w/o CC/MCC	6	0.4994	19.3	16.1
870	870	Septicemia w MV 96+ hours	1,019	2.2302	32.1	26.8
871	871	Septicemia w/o MV 96+ hours w MCC	5,385	0.8991	23.4	19.5
872	871	Septicemia w/o MV 96+ hours w/o MCC	1,436	0.6643	21.6	18.0
876	876	O.R. procedure w principal diagnoses of mental illness	3	1.7130	37.2	31.0
880	880	Acute adjustment reaction & psychosocial dysfunction	7	0.4994	19.3	16.1
881	881	Depressive neuroses	24	0.4994	19.3	16.1
882	882	Neuroses except depressive	11	0.6705	21.6	18.0
883	883	Disorders of personality & impulse control	5	0.4994	19.3	16.1
884	884	Organic disturbances & mental retardation	84	0.5577	27.8	23.2

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
885	885	Psychoses	1,162	0.4205	22.9	19.1
886	886	Behavioral & developmental disorders	62	0.4122	22.5	18.8
887	887	Other mental disorder diagnoses	0	0.4994	19.3	16.1
894	894	Alcohol/drug abuse or dependence, left ama	1	0.6705	21.6	18.0
895	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1	0.4994	19.3	16.1
896	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	16	0.7836	23.8	19.8
897	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	11	0.4994	19.3	16.1
901	901	Wound debridements for injuries w MCC	216	1.3516	34.0	28.3
902	901	Wound debridements for injuries w CC	143	1.2196	32.7	27.3
903	901	Wound debridements for injuries w/o CC/MCC	14	0.7836	23.8	19.8
904	904	Skin grafts for injuries w CC/MCC	77	1.4581	39.5	32.9
905	904	Skin grafts for injuries w/o CC/MCC	4	0.7836	23.8	19.8
906	906	Hand procedures for injuries	2	0.7836	23.8	19.8
907	907	Other O.R. procedures for injuries w MCC	127	1.7400	38.1	31.8
908	907	Other O.R. procedures for injuries w CC	76	1.2305	33.7	28.1
909	907	Other O.R. procedures for injuries w/o CC/MCC	2	1.1175	27.0	22.5
913	913	Traumatic injury w MCC	65	0.8546	24.3	20.3
914	913	Traumatic injury w/o MCC	64	0.6063	21.7	18.1
915	915	Allergic reactions w MCC	0	0.4994	19.3	16.1
916	915	Allergic reactions w/o MCC	0	0.4994	19.3	16.1
917	917	Poisoning & toxic effects of drugs w MCC	15	1.1175	27.0	22.5
918	917	Poisoning & toxic effects of drugs w/o MCC	9	0.4994	19.3	16.1
919	919	Complications of treatment w MCC	1,400	1.1451	26.6	22.2
920	919	Complications of treatment w CC	908	0.8168	25.0	20.8
921	919	Complications of treatment w/o CC/MCC	82	0.6377	20.3	16.9
922	922	Other injury, poisoning & toxic effect diag w MCC	2	1.1175	27.0	22.5
923	922	Other injury, poisoning & toxic effect diag w/o MCC	2	1.1175	27.0	22.5
927	927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	1	1.1175	27.0	22.5
928	928	Full thickness burn w skin graft or inhal inj w CC/MCC	9	1.1175	27.0	22.5
929	928	Full thickness burn w skin graft or inhal inj w/o CC/MCC	0	0.8566	26.6	22.2
933	933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	7	1.1175	27.0	22.5
934	934	Full thickness burn w/o skin grft or inhal inj	36	0.8566	26.6	22.2
935	935	Non-extensive burns	40	0.9743	25.6	21.3
939	939	O.R. proc w diagnoses of other contact w health services w MCC	238	1.4571	34.2	28.5
940	939	O.R. proc w diagnoses of other contact w health services w CC	101	1.0421	32.4	27.0
941	939	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	13	0.7836	23.8	19.8
945	945	Rehabilitation w CC/MCC	2,101	0.6675	21.8	18.2
946	945	Rehabilitation w/o CC/MCC	197	0.4363	18.5	15.4
947	947	Signs & symptoms w MCC	52	0.7960	22.9	19.1
948	947	Signs & symptoms w/o MCC	53	0.5268	19.9	16.6

MS-LTC-DRG	Base MS-LTC-DRG	MS-LTC-DRG Title	FY 2008 LTCH Cases	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed Short-Stay Outlier (SSO) Threshold[1]
949	949	Aftercare w CC/MCC	3,430	0.7114	22.2	18.5
950	949	Aftercare w/o CC/MCC	264	0.4591	17.0	14.2
951	951	Other factors influencing health status	74	1.5511	32.2	26.8
955	955	Craniotomy for multiple significant trauma	0	0.4994	19.3	16.1
956	956	Limb reattachment, hip & femur proc for multiple significant trauma	0	1.7130	37.2	31.0
957	957	Other O.R. procedures for multiple significant trauma w MCC	3	1.7130	37.2	31.0
958	957	Other O.R. procedures for multiple significant trauma w CC	2	1.1175	27.0	22.5
959	957	Other O.R. procedures for multiple significant trauma w/o CC/MCC	0	1.1175	27.0	22.5
963	963	Other multiple significant trauma w MCC	17	1.1175	27.0	22.5
964	963	Other multiple significant trauma w CC	6	0.4994	19.3	16.1
965	963	Other multiple significant trauma w/o CC/MCC	2	0.4994	19.3	16.1
969	969	HIV w extensive O.R. procedure w MCC	19	1.7130	37.2	31.0
970	969	HIV w extensive O.R. procedure w/o MCC	3	1.7130	37.2	31.0
974	974	HIV w major related condition w MCC	218	1.0652	22.5	18.8
975	974	HIV w major related condition w CC	67	0.7944	20.0	16.7
976	974	HIV w major related condition w/o CC/MCC	8	0.6705	21.6	18.0
977	977	HIV w or w/o other related condition	54	0.6251	19.3	16.1
981	981	Extensive O.R. procedure unrelated to principal diagnosis w MCC	1,140	2.3893	42.4	35.3
982	981	Extensive O.R. procedure unrelated to principal diagnosis w CC	313	1.3812	34.1	28.4
983	981	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC	15	1.1175	27.0	22.5
984	984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	13	1.7130	37.2	31.0
985	984	Prostatic O.R. procedure unrelated to principal diagnosis w CC	5	1.7130	37.2	31.0
986	984	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1	0.6705	21.6	18.0
987	987	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	434	1.8048	37.5	31.3
988	987	Non-extensive O.R. proc unrelated to principal diagnosis w CC	185	1.1277	31.6	26.3
989	987	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC	8	1.1277	31.6	26.3
998	998	Principal diagnosis invalid as discharge diagnosis	0	0.0000	0.0	0.0
999	999	Ungroupable	0	0.0000	0.0	0.0

[1] The SSO Threshold is calculated as 5/6th of the geometric average length of stay of the MS-LTC-DRG (as specified in §412.529(a) in conjunction with §412.503).

* In determining the proposed MS-LTC-DRG relative weights for FY 2010, these MS-LTC-DRGs were adjusted for nonmonotonicity as discussed in section VIII.B.3.f. (step 6) of the preamble of this proposed 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)	Proposed LTCH PPS Wage Index
10180	Abilene, TX	
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	0.7953
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	0.3465
10420	Akron, OH	
	Portage County, OH	
	Summit County, OH	0.8858
10500	Albany, GA	
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	0.8907
10580	Albany-Schenectady-Troy, NY	
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	0.8790
10740	Albuquerque, NM	
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	0.9408
10780	Alexandria, LA	
	Grant Parish, LA	
	Rapides Parish, LA	0.8020

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9641
11020	Altoona, PA Blair County, PA	0.8871
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8697
11180	Ames, IA Story County, IA	0.9505
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2024
11300	Anderson, IN Madison County, IN	0.9060
11340	Anderson, SC Anderson County, SC	0.8819
11460	Ann Arbor, MI Washtenaw County, MI	1.0302
11500	Anniston-Oxford, AL Calhoun County, AL	0.7650
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9298
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9079
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9501

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
12060	Atlanta-Sandy Springs-Marietta, GA	
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	0.9597
12100	Atlantic City, NJ	
	Atlantic County, NJ	1.1565
12220	Auburn-Opelika, AL	
	Lee County, AL	0.8146
12260	Augusta-Richmond County, GA-SC	
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	0.9125

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
12420	Austin-Round Rock, TX	
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	0.9535
12540	Bakersfield, CA	
	Kern County, CA	1.1215
12580	Baltimore-Towson, MD	
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
	Baltimore City, MD	1.0223
12620	Bangor, ME	
	Penobscot County, ME	1.0163
12700	Barnstable Town, MA	
	Barnstable County, MA	1.2629
12940	Baton Rouge, LA	
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	0.8187
12980	Battle Creek, MI	
	Calhoun County, MI	1.0009
13020	Bay City, MI	
	Bay County, MI	0.9276
13140	Beaumont-Port Arthur, TX	
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	0.8391
13380	Bellingham, WA	
	Whatcom County, WA	1.1406

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
13460	Bend, OR Deschutes County, OR	1.1457
13644	Bethesda-Gaithersburg-Frederick, MD Frederick County, MD Montgomery County, MD	1.0307
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8790
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8785
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	0.8530
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7644
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8381
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9031
14060	Bloomington-Normal, IL McLean County, IL	0.9387
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9297

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2160
14500	Boulder, CO Boulder County, CO	1.0276
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8474
14600	Bradenton-Sarasota Venice, FL Manatee County, FL Sarasota County, FL	0.9741
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0765
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2798
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9029
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9371
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9739
15500	Burlington, NC Alamance County, NC	0.8757
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0116
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1288
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0146
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8803

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9084
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9055
16180	Carson City, NV Carson City, NV	1.0540
16220	Casper, WY Natrona County, WY	0.9529
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8992
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0117
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8149
16700	Charleston-North Charleston, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9258
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9483
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9380

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
16860	Chattanooga, TN-GA	
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	0.8839
16940	Cheyenne, WY	
	Laramie County, WY	0.9353
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	1.0478
17020	Chico, CA	
	Butte County, CA	1.1209
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	0.9488
17300	Clarksville, TN-KY	
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	0.7987

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.7571
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.8922
17660	Coeur d'Alene, ID Kootenai County, ID	0.9243
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9507
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9830
17860	Columbia, MO Boone County, MO Howard County, MO	0.8625
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8757
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8732
18020	Columbus, IN Bartholomew County, IN	0.9545

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
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	1.0092
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8701
18700	Corvallis, OR Benton County, OR	1.1013
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8053
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	0.9908
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8674
19180	Danville, IL Vermilion County, IL	0.8746
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8331
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8291

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9220
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7806
19500	Decatur, IL Macon County, IL	0.8002
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8874
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	1.0733
19780	Des Moines,-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9658
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9737
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7413
20100	Dover, DE Kent County, DE	0.9940
20220	Dubuque, IA Dubuque County, IA	0.8877

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0458
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9548
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9575
20764	Edison, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1072
20940	El Centro, CA Imperial County, CA	0.8774
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8396
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9497
21300	Elmira, NY Chemung County, NY	0.8348
21340	El Paso, TX El Paso County, TX	0.8549
21500	Erie, PA Erie County, PA	0.8464
21660	Eugene-Springfield, OR Lane County, OR	1.1045
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8530
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1124

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3793
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8180
22140	Farmington, NM San Juan County, NM	0.7896
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9366
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8772
22380	Flagstaff, AZ Coconino County, AZ	1.2486
22420	Flint, MI Genesee County, MI	1.1134
22500	Florence, SC Darlington County, SC Florence County, SC	0.8141
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7981
22540	Fond du Lac, WI Fond du Lac County, WI	0.9669
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0184
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0393
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7868

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8766
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9020
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9508
23420	Fresno, CA Fresno County, CA	1.1252
23460	Gadsden, AL Etowah County, AL	0.8274
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.8987
23580	Gainesville, GA Hall County, GA	0.9131
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9309
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8464
24140	Goldsboro, NC Wayne County, NC	0.9064
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7782
24300	Grand Junction, CO Mesa County, CO	0.9730
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9187

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
24500	Great Falls, MT Cascade County, MT	0.8361
24540	Greeley, CO Weld County, CO	0.9587
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9630
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9071
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9410
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9940
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3540
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8791
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.8973
25260	Hanford-Corcoran, CA Kings County, CA	1.1020
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9294
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9033

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1190
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7669
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9005
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.9029
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8704
26180	Honolulu, HI Honolulu County, HI	1.1664
26300	Hot Springs, AR Garland County, AR	0.9013
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7882
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	0.9842

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9105
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9073
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9445
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	0.9930
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9557
27060	Ithaca, NY Tompkins County, NY	1.0121
27100	Jackson, MI Jackson County, MI	0.8728
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8193
27180	Jackson, TN Chester County, TN Madison County, TN	0.8589

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9114
27340	Jacksonville, NC Onslow County, NC	0.8033
27500	Janesville, WI Rock County, WI	0.9209
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8717
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7481
27780	Johnstown, PA Cambria County, PA	0.8241
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7729
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8292
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0273
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0183

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
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	0.9701
28420	Kennewick-Richland-Pasco, WA	
	Benton County, WA	
	Franklin County, WA	1.0458
28660	Killeen-Temple-Fort Hood, TX	
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	0.8710
28700	Kingsport-Bristol-Bristol, TN-VA	
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	0.7974
28740	Kingston, NY	
	Ulster County, NY	0.9375
28940	Knoxville, TN	
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	0.7888
29020	Kokomo, IN	
	Howard County, IN	
	Tipton County, IN	0.9825

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9924
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9189
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8524
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7993
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0485
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0577
29460	Lakeland, FL Polk County, FL	0.8398
29540	Lancaster, PA Lancaster County, PA	0.9212
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9659
29700	Laredo, TX Webb County, TX	0.8082
29740	Las Cruces, NM Dona Ana County, NM	0.8947
29820	Las Vegas-Paradise, NV Clark County, NV	1.2133
29940	Lawrence, KS Douglas County, KS	0.8588
30020	Lawton, OK Comanche County, OK	0.7854
30140	Lebanon, PA Lebanon County, PA	0.8127
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9579

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
30340	Lewiston-Auburn, ME	
	Androscoggin County, ME	0.9093
30460	Lexington-Fayette, KY	
	Bourbon County, KY	
	Clark County, KY	
	Fayette County, KY	
	Jessamine County, KY	
	Scott County, KY	
	Woodford County, KY	0.8897
30620	Lima, OH	
	Allen County, OH	0.9371
30700	Lincoln, NE	
	Lancaster County, NE	
	Seward County, NE	0.9572
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	0.8550
30860	Logan, UT-ID	
	Franklin County, ID	
	Cache County, UT	0.9001
30980	Longview, TX	
	Gregg County, TX	
	Rusk County, TX	
	Upshur County, TX	0.8056
31020	Longview, WA	
	Cowlitz County, WA	1.0716
31084	Los Angeles-Long Beach-Glendale, CA	
	Los Angeles County, CA	1.2025

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
31140	Louisville-Jefferson County, KY-IN	
	Clark County, IN	
	Floyd County, IN	
	Harrison County, IN	
	Washington County, IN	
	Bullitt County, KY	
	Henry County, KY	
	Jefferson County, KY	
	Meade County, KY	
	Nelson County, KY	
	Oldham County, KY	
	Shelby County, KY	
	Spencer County, KY	
	Trimble County, KY	0.8972
31180	Lubbock, TX	
	Crosby County, TX	
	Lubbock County, TX	0.8759
31340	Lynchburg, VA	
	Amherst County, VA	
	Appomattox County, VA	
	Bedford County, VA	
	Campbell County, VA	
	Bedford City, VA	
	Lynchburg City, VA	0.8529
31420	Macon, GA	
	Bibb County, GA	
	Crawford County, GA	
	Jones County, GA	
	Monroe County, GA	
	Twiggs County, GA	0.9835
31460	Madera, CA	
	Madera County, CA	0.7965
31540	Madison, WI	
	Columbia County, WI	
	Dane County, WI	
	Iowa County, WI	1.1245
31700	Manchester-Nashua, NH	
	Hillsborough County, NH	1.0180

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
31740	Mahattan, KS Geary County, KS Pottawatomie County, KS Riley County; KS	0.7885
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9185
31900	Mansfield, OH Richland County, OH	0.9108
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3708
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.8828
32780	Medford, OR Jackson County, OR	1.0093
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	0.9277
32900	Merced, CA Merced County, CA	1.0452
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	0.9964
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9320
33260	Midland, TX Midland County, TX	0.9555
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0160

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1108
33540	Missoula, MT Missoula County, MT	0.9215
33660	Mobile, AL Mobile County, AL	0.7792
33700	Modesto, CA Stanislaus County, CA	1.2514
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7759
33780	Monroe, MI Monroe County, MI	0.8893
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8312
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8467
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7208
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0462
34620	Muncie, IN Delaware County, IN	0.8247

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
34740	Muskegon-Norton Shores, MI	
	Muskegon County, MI	0.9832
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	
	Horry County, SC	0.8736
34900	Napa, CA	
	Napa County, CA	1.4449
34940	Naples-Marco Island, FL	
	Collier County, FL	0.9671
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	0.9700
35004	Nassau-Suffolk, NY	
	Nassau County, NY	
	Suffolk County, NY	1.2471
35084	Newark-Union, NJ-PA	
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	
	Pike County, PA	1.1420
35300	New Haven-Milford, CT	
	New Haven County, CT	1.1496

CBSA Code	Urban Area (Constituent Counties)	Proposed 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	0.9100
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	1.2982
35660	Niles-Benton Harbor, MI	
	Berrien County, MI	0.8911
35980	Norwich-New London, CT	
	New London County, CT	1.1409
36084	Oakland-Fremont-Hayward, CA	
	Alameda County, CA	
	Contra Costa County, CA	1.6331
36100	Ocala, FL	
	Marion County, FL	0.8564
36140	Ocean City, NJ	
	Cape May County, NJ	1.0169
36220	Odessa, TX	
	Ector County, TX	0.9871
36260	Ogden-Clearfield, UT	
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	0.9369

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
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	0.8909
36500	Olympia, WA	
	Thurston County, WA	1.1541
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	0.9617
36740	Orlando-Kissimmee, FL	
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	0.8964
36780	Oshkosh-Neenah, WI	
	Winnebago County, WI	0.9160
36980	Owensboro, KY	
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	0.8365
37100	Oxnard-Thousand Oaks-Ventura, CA	
	Ventura County, CA	1.2299
37340	Palm Bay-Melbourne-Titusville, FL	
	Brevard County, FL	0.9069
	Palm Coast, FL	
37380	Flager County, FL	0.9612
37460	Panama City-Lynn Haven, FL	
	Bay County, FL	0.8332

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7723
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8441
37764	Peabody, MA Essex County, MA	1.0881
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8311
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9122
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0735
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0640
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7288
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8604

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
38340	Pittsfield, MA Berkshire County, MA	1.0668
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9247
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4224
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0196
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	1.1502
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9906
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1238
39140	Prescott, AZ Yavapai County, AZ	1.0130
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	1.0792
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9556
39380	Pueblo, CO Pueblo County, CO	0.8578

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
39460	Punta Gorda, FL Charlotte County, FL	0.8782
39540	Racine, WI Racine County, WI	0.9381
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9656
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0055
39740	Reading, PA Berks County, PA	0.9271
39820	Redding, CA Shasta County, CA	1.4027
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0295
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	0.9530

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1234
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8642
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1146
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8652
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0162
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0134
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.8853
40660	Rome, GA Floyd County, GA	0.8923
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4031
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9127
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1117

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
41100	St. George, UT	
	Washington County, UT	0.9245
41140	St. Joseph, MO-KS	
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
	DeKalb County, MO	1.0198
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	0.9110
41420	Salem, OR	
	Marion County, OR	
	Polk County, OR	1.0985
41500	Salinas, CA	
	Monterey County, CA	1.5221
41540	Salisbury, MD	
	Somerset County, MD	
	Wicomico County, MD	0.9119
41620	Salt Lake City, UT	
	Salt Lake County, UT	
	Summit County, UT	
	Tooele County, UT	0.9387
41660	San Angelo, TX	
	Irion County, TX	
	Tom Green County, TX	0.7921

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
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	0.8853
41740	San Diego-Carlsbad-San Marcos, CA	
	San Diego County, CA	1.1759
41780	Sandusky, OH	
	Erie County, OH	0.8896
41884	San Francisco-San Mateo-Redwood City, CA	
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	1.5963
41900	San Germán-Cabo Rojo, PR	
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	0.4745
41940	San Jose-Sunnyvale-Santa Clara, CA	
	San Benito County, CA	
	Santa Clara County, CA	1.6399

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
41980	San Juan-Caguas-Guaynabo, PR	
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	0.4367

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.2561
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1977
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2333
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6749
42140	Santa Fe, NM Santa Fe County, NM	1.0704
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.5914
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9051
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8382
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1587
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9370
43100	Sheboygan, WI Sheboygan County, WI	0.9174
43300	Sherman-Denison, TX Grayson County, TX	0.8071
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8391
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9103

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.8991
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9699
43900	Spartanburg, SC Spartanburg County, SC	0.9350
44060	Spokane, WA Spokane County, WA	1.0453
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9554
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0384
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8058
44220	Springfield, OH Clark County, OH	0.9203
44300	State College, PA Centre County, PA	0.9104
44700	Stockton, CA San Joaquin County, CA	1.2306
44940	Sumter, SC Sumter County, SC	0.8159
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9790
45104	Tacoma, WA Pierce County, WA	1.1206

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8414
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.8990
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.8967
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8121
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9549
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8838
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0561
46060	Tucson, AZ Pima County, AZ	0.9514
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8670

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
46220	Tuscaloosa, AL	
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	0.8706
46340	Tyler, TX	
	Smith County, TX	0.8320
46540	Utica-Rome, NY	
	Herkimer County, NY	
	Oneida County, NY	0.8492
46660	Valdosta, GA	
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	0.7952
46700	Vallejo-Fairfield, CA	
	Solano County, CA	1.4948
47020	Victoria, TX	
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	0.8062
47220	Vineland-Millville-Bridgeton, NJ	
	Cumberland County, NJ	1.0216
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	0.8969
47300	Visalia-Porterville, CA	
	Tulare County, CA	1.0231

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
47380	Waco, TX	
	McLennan County, TX	0.8384
47580	Warner Robins, GA	
	Houston County, GA	0.8762
47644	Warren-Troy-Farmington Hills, MI	
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	0.9825
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	1.0891
47940	Waterloo-Cedar Falls, IA	
	Black Hawk County, IA	
	Bremer County, IA	
	Grundy County, IA	0.8526
48140	Wausau, WI	
	Marathon County, WI	0.9449

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.7375
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	0.9728
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9888
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6876
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8978
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9205
48700	Williamsport, PA Lycoming County, PA	0.7885
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0558
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.8994
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9786
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8942

CBSA Code	Urban Area (Constituent Counties)	Proposed LTCH PPS Wage Index
49340	Worcester, MA Worcester County, MA	1.1099
49420	Yakima, WA Yakima County, WA	0.9958
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3351
49620	York-Hanover, PA York County, PA	0.9308
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8615
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1100
49740	Yuma, AZ Yuma County, AZ	0.9152

TABLE 12B.--LTCH PPS WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2010

CBSA Code	Nonurban Area	Proposed LTCH PPS Wage Index
01	Alabama	0.7335
02	Alaska	1.1680
03	Arizona	0.8801
04	Arkansas	0.7344
05	California	1.1864
06	Colorado	0.9938
07	Connecticut	1.1201
08	Delaware	0.9919
10	Florida	0.8574
11	Georgia	0.7635
12	Hawaii	1.1123
13	Idaho	0.7740
14	Illinois	0.8303

CBSA Code	Nonurban Area	Proposed LTCH PPS Wage Index
15	Indiana	0.8517
16	Iowa	0.8725
17	Kansas	0.8178
18	Kentucky	0.7810
19	Louisiana	0.7617
20	Maine	0.8587
21	Maryland	0.9139
22	Massachusetts	1.1711
23	Michigan	0.8782
24	Minnesota	0.9182
25	Mississippi	0.7645
26	Missouri	0.7698
27	Montana	0.8424
28	Nebraska	0.8606
29	Nevada	0.9683
30	New Hampshire	0.9960
31	New Jersey*	--------
32	New Mexico	0.8946
33	New York	0.8261
34	North Carolina	0.8535
35	North Dakota	0.7792
36	Ohio	0.8504
37	Oklahoma	0.7661
38	Oregon	1.0249
39	Pennsylvania	0.8314
41	Rhode Island*	--------
42	South Carolina	0.8378
43	South Dakota	0.8413
44	Tennessee	0.7817
45	Texas	0.7773
46	Utah	0.8371
47	Vermont	0.9772
49	Virginia	0.7876
50	Washington	1.0233
51	West Virginia	0.7403
52	Wisconsin	0.9211
53	Wyoming	0.9544

* All counties within the State are classified as urban.

Appendix A: Regulatory Impact Analysis

I. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the proposed changes for FY 2010 acute care hospital operating and capital payments would redistribute in excess of $100 million among different types of inpatient cases. The proposed 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 proposed payment changes in this proposed rule, would result in an estimated $586 million decrease in FY 2010 operating payments (or 0.5 percent decrease), and $393 million decrease in FY 2010 capital payments (or 4.8 percent decrease), or a total $979 million decrease in FY 2010 operating and capital payments to acute care hospitals. 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 $135 million (or 2.8 percent).

Our operating impact estimate includes the proposed −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 and capital Federal rates for FY 2010. In addition, our operating impact estimate includes the 2.1 percent market basket update to the standardized amount. The estimates of IPPS operating payments to acute care hospitals do not reflect any changes in hospital admissions or real case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most hospitals and most other providers and suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration definition of a small business (having revenues of $34.5 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers to the Table of Small Business Size Standards for NAIC 622 found on the Small Business Administration Office of Size Standards Web site at: *http://www.sba.gov/contractingopportunities/officials/size/GC-SMALL-BUS-SIZE-STANDARDS.html*.) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that the provisions of this proposed rule relating to acute care hospitals would have a significant impact on small entities as explained in this Appendix. Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary LTCHs. Therefore, we are assuming that all LTCHs are considered small entities for the purpose of the analysis in section IX. of this Appendix. Medicare fiscal intermediaries and MACs are not considered to be small entities. Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our proposed regulatory flexibility analysis. Therefore, we are soliciting public comments on our estimates and analysis of the impact of this proposed rule on those small entities.

The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Public Law 104–121, as amended by section 8302 of Public Law 110–28 (enacted on May 25, 2007), requires an agency to provide compliance guides for each rule or group of related rules for which an agency is required to prepare a final regulatory flexibility analysis. The compliance guides associated with this proposed rule are available on the CMS IPPS Web page at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp.* We also note that the Hospital Center Web page at *http://www.cms.hhs.gov/center/hospital.asp* was developed to assist hospitals in understanding and adapting to changes in Medicare regulations and in billing and payment procedures. This Web page provides hospitals with substantial downloadable explanatory materials.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed or final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS and the LTCH PPS, we continue to classify these hospitals as urban hospitals. (We refer readers to Table 1 and section VI. of this Appendix for the quantitative effects of the proposed policy changes under the IPPS for operating costs.)

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $133 million. This proposed rule 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 proposed rule would not have a substantial effect on State and local governments.

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The proposed rule would affect payments to a substantial number of

small rural hospitals, as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives of the IPPS

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Hospital Insurance Trust Fund.

We believe the proposed changes in this proposed rule would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of the prospective payment systems are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 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 proposed rule, the FY 2008 IPPS final rule with comment period established a documentation and coding adjustment of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 to maintain budget neutrality for the transition to the MS–DRGs. Subsequently, Congress enacted Public Law 110–90. Section 7 of Public Law 110–90 reduced the IPPS documentation and coding adjustment from −1.2 percent to −0.6 percent for FY 2008 and from −1.8 percent to −0.9 percent for FY 2009. For FY 2010, we are proposing to reduce the national standardized amount by an additional 1.9 percent. Based on our analysis, described in II.D. of the preamble of this proposed rule, we believe that, in FY 2008, hospitals experienced a documentation and coding effect of 2.5 percent, which exceeds the FY 2008 documentation and coding adjustment of 0.6 percent by 1.9 percent. Therefore, we are proposing to reduce the national standardized amounts in FY 2010 by −1.9 percent. We will address in the FY 2011 rulemaking cycle any change 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.

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 are proposing 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. We will address any increase in case-mix in FY 2009 due to changes in documentation and coding that do not reflect real changes in case-mix in the FY 2011 rulemaking cycle.

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. For FY 2010, we are proposing to reduce the Puerto Rico-specific standardized amount by 1.1 percent to account for the case-mix increase due to documentation and coding that occurred in FY 2008. We will address any increase in case-mix in FY 2009 for Puerto Rico hospitals in the FY 2011 rulemaking cycle.

The impacts shown below illustrate the impact of the proposed FY 2010 IPPS changes on acute care hospital operating payments, including the proposed −1.9 percent FY 2010 documentation and coding adjustment to the IPPS national standardized amounts, the −2.5 percent FY 2010 documentation and coding adjustment to the hospital-specific rates, and the −1.1 percent FY 2010 documentation and coding adjustment to the Puerto Rico-specific standardized amount. The proposed documentation and coding adjustment that would be applicable to the Federal rate under the LTCH PPS for RY 2010 is discussed in section IX. of this Appendix. As we have done in the previous rules, we are soliciting public comments and information about the anticipated effects of the proposed changes on acute care hospitals and our methodology for estimating them.

IV. Hospitals Included In and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs of acute care hospitals encompass most general short-term, acute care hospitals that participate in the Medicare program. There were 33 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment methodology for these hospitals. Among other short-term, acute care hospitals, only the 46 such hospitals in Maryland remain excluded from the IPPS pursuant to the waiver under section 1814(b)(3) of the Act.

As of March 2009, there are 3,513 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 1,306 CAHs. These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. (We refer readers to section VII. of this Appendix for a further description of the impact of CAH-related proposed policy changes.) There are also 1,228 IPPS-excluded hospitals and 2,209 IPPS-excluded hospital units. These IPPS-excluded hospitals and units include IPFs, IRFs, LTCHs, RNHCIs, children's hospitals, and cancer hospitals, which are paid under separate payment systems. Changes in the prospective payment systems for IPFs and IRFs are made through separate rulemaking. Payment impacts for these IPPS-excluded hospitals and units are not included in this proposed rule. The impact of the proposed update and policy changes to the LTCH PPS for RY 2010 are discussed in section IX. of this Appendix.

V. Effects on Hospitals and Hospital Units Excluded From the IPPS

As of March 2009, there were 1,228 hospitals excluded from the IPPS. Of these 1,228 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, 223 IRFs and 406 LTCHs, are paid the Federal prospective per discharge rate under the IRF PPS and the LTCH PPS, respectively, and 1,312 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 proposed rule. The impacts of the proposed changes to LTCHs are discussed in section IX. of this Appendix. In addition, there are 1,312 IPF units located in hospitals otherwise subject to the IPPS. There are 972 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 proposed update is the percentage increase in the FY 2010 IPPS operating market basket. In compliance with section 404 of the MMA, in this proposed rule, we are proposing 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 current law, based on IHS Global Insight, Inc.'s 2009 first quarter forecast, with historical data through the 2008 fourth 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 proposed 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 first quarter forecast of the IPPS operating market basket increase.

The impact of the proposed update in the rate-of-increase limit on those excluded hospitals depends on the cumulative cost increases experienced by each excluded hospital since its applicable base period. For excluded hospitals that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect is on the level of incentive payments these excluded hospitals receive. Conversely, for excluded hospitals with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect is the amount of excess costs that will not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital that continues to be paid under the TEFRA system, whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, cancer and children's hospitals can obtain payment adjustments for justifiable increases in operating costs that exceed the limit.

VI. Quantitative Effects of the Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing proposed policy changes and payment rate updates for the IPPS for operating costs of acute care hospitals. Updates to the capital payments to acute care hospitals are discussed in section VIII. of this Appendix.

Based on the overall percentage change in payments per case estimated using our payment simulation model, we estimate that total FY 2010 operating payments would decrease by 0.5 percent compared to FY 2009, largely due to the statutorily mandated update to the IPPS rates. This amount also reflects the proposed FY 2010 documentation and coding adjustments described above and in section II.D. of the preamble: −1.9 percent for the IPPS national standardized amounts, −2.5 percent for the IPPS hospital specific rates, and −1.1 percent for the IPPS Puerto Rico-specific standardized amount. The impacts do not illustrate changes in hospital admissions or real case-mix intensity, which would also affect overall payment changes.

We have prepared separate impact analyses of the proposed changes to each system. This section deals with changes to the operating prospective payment system for acute care hospitals. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain proposed changes in this proposed rule. However, there are other proposed changes for which we do not have data available that would allow us to estimate the payment impacts using this model. For those proposed changes, we have attempted to predict the payment impacts based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2008 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the proposed changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, in this analysis, we do not make adjustments for future changes in such variables as admissions, lengths of stay, or underlying growth in real case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each proposed 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 proposed 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 proposed changes to the hospital labor-related share,

where the proposed hospital labor-related share for hospitals with a wage index greater than 1 has been rebased from 69.7 percent to 67.1 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 would 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 would 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 effect of the budget neutrality adjustment being made for the adoption of the MS–DRGs under section 1886(d)(3)(A)(iv) of the Act for the change in aggregate payments that is a result of changes in the documentation and coding of discharges that do not reflect real changes in case-mix. These documentation and coding adjustments include a −1.9 percent documentation and coding adjustment for the national standardized amount, a −2.5 percent documentation and coding adjustment for the hospital-specific rate, and a −1.1 percent documentation and coding adjustment for the Puerto Rico-specific rate.
- The total estimated change in payments based on the proposed FY 2010 policies relative to payments based on FY 2009 policies that include the proposed market basket update of 2.1 percent.

To illustrate the impacts of the proposed FY 2010 changes, our analysis begins with a FY 2009 baseline simulation model using: the proposed 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 proposed 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 proposed changes. This simulation allows us to isolate the effects of each proposed change.

Our final comparison illustrates the proposed percent change in payments per case from FY 2009 to FY 2010. Three factors not discussed separately have significant impacts here. The first is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we are proposing to update the standardized amounts for FY 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 proposed 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 proposed 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 would 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 2010 (as discussed in the Addendum to this proposed 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 proposed 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 3,513 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 2,535 hospitals located in urban areas included in our analysis. Among these, there are 1,386 hospitals located in large urban areas (populations over 1 million), and 1,149 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 978 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 2,585, 1,417, 1,168 and 928, respectively.

The next three groupings examine the impacts of the proposed 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 2,479 nonteaching hospitals in our analysis, 800 teaching hospitals with fewer than 100 residents, and 234 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 proposed changes on rural hospitals by special payment groups (SCHs, RRCs, and MDHs). There were 187 RRCs, 338 SCHs, 181 MDHs, 105 hospitals that are both SCHs and RRCs, and 14 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 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 proposed policy changes on the 20 cardiac hospitals in our analysis.

BILLING CODE 4210–01–P

TABLE I.--IMPACT ANALYSIS OF PROPOSED CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2010

	No. of Hospitals[1]	Proposed FY 2010 Weights & DRG Changes [2](1)	Application of Recalibration Budget Neutrality[3] (2)	Proposed FY 2010 Wage Data and Labor Related Share[4] (3)	Application of Wage Budget Neutrality [5] (4)	FY 2010 DRG, Rel. Wts., Wage Index Changes, Labor-Related Share with Wage and Recalibration Budget Neutrality[6] (5)	FY 2010 MGCRB Reclassifications[7] (6)	Proposed Transitional 1/2 Within State Rural Floor Budget Neutrality and 1/2 National Rural Floor Budget Neutrality [8] (7)	Proposed FY 2010 Out-Migration Adjustment [9] (8)	All Proposed FY 2010 Changes Prior to CMI Adjustment[10] (9)	All Proposed FY 2010 Changes w/CMI Adjustment [11] (10)
All Hospitals	3,513	0.2	0	0	0	-0.1	0	0	0	1.4	-0.5
By Geographic Location:											
Urban hospitals	2,535	0.3	0	0	0	-0.1	-0.2	0	0	1.4	-0.4
Large urban areas	1,386	0.2	0	-0.1	-0.1	-0.1	-0.3	-0.1	0	1.5	-0.4
Other urban areas	1,149	0.3	0	0.1	0.1	-0.1	0	0.1	0	1.3	-0.5
Rural hospitals	978	-0.1	-0.3	0.1	0.1	-0.5	1.7	-0.1	0.1	0.8	-1.3
Bed Size (Urban):											
0-99 beds	643	0.4	0.1	0.2	0.2	0.1	-0.5	0	0	1.5	-0.5
100-199 beds	824	0.2	-0.1	0	0	-0.2	-0.1	0.1	0	1.3	-0.6
200-299 beds	473	0.2	0	0	0	-0.2	-0.1	0	0	1.4	-0.5
300-499 beds	410	0.3	0	-0.1	-0.1	-0.2	-0.2	0	0	1.4	-0.5
500 or more beds	185	0.3	0.1	0.1	0.1	0	-0.3	-0.1	0	1.6	-0.2
Bed Size (Rural):											
0-49 beds	338	-0.4	-0.6	0.1	0.1	-0.8	0.6	-0.1	0.2	1	-1.1
50-99 beds	369	-0.2	-0.4	0.1	0.1	-0.5	0.9	-0	0.1	0.7	-1.5
100-149 beds	166	-0.1	-0.4	0.1	0.1	-0.6	2.3	-0.1	0	0.8	-1.2
150-199 beds	62	0	-0.2	0.2	0.2	-0.3	2.2	-0.1	0	1	-1
200 or more beds	43	0.1	-0.1	0.2	0.2	-0.2	2.8	-0.1	0	0.6	-1.4
Urban by Region:											
New England	119	0.2	0	0.6	0.6	0.6	0.7	-0.1	0	1.5	-0.4

	No. of Hospitals[1]	Proposed FY 2010 Weights & DRG Changes [2](1)	Application of Recalibration Budget Neutrality[3] (2)	Proposed FY 2010 Wage Data and Labor Related Share[4] (3)	Application of Wage Budget Neutrality [5] (4)	FY 2010 DRG, Rel. Wts., Wage Index Changes, Labor-Related Share with Wage and Recalibration Budget Neutrality[6] (5)	FY 2010 MGCRB Reclassifications[7] (6)	Proposed Transitional 1/2 Within State Rural Floor Budget Neutrality and 1/2 National Rural Floor Budget Neutrality [8] (7)	Proposed FY 2010 Out-Migration Adjustment [9] (8)	All Proposed FY 2010 Changes Prior to CMI Adjustment[10] (9)	All Proposed FY 2010 Changes w/CMI Adjustment [11] (10)
Middle Atlantic	344	0.1	-0.1	-0.3	-0.3	-0.5	0.3	0.1	0	1.2	-0.7
South Atlantic	390	0.2	0	-0.1	-0.1	-0.2	-0.4	0	0	1.5	-0.3
East North Central	395	0.3	0	-0.2	-0.2	-0.2	-0.3	-0.1	0	1.3	-0.6
East South Central	160	0.3	0.1	0.2	0.2	-0.1	-0.2	0	0	1.8	-0.1
West North Central	164	0.4	0.1	0.3	0.3	0.2	-0.7	0	0	1.6	-0.2
West South Central	361	0.3	0.1	0	0	-0.1	-0.5	-0.1	0	1.7	-0.1
Mountain	162	0.4	0.1	0.8	0.8	0.8	-0.4	0	0	2.4	0.4
Pacific	389	0.3	0	-0.2	-0.2	-0.2	-0.2	0.1	0	1	-0.9
Puerto Rico	51	-0.1	-0.3	1.8	1.8	-0.4	-0.8	0	0	1.4	-0.3
Rural by Region:											
New England	24	0	-0.3	-0.5	-0.5	-0.8	1.4	0	0	-0.5	-2.5
Middle Atlantic	70	-0.2	-0.4	0.5	0.5	-0.2	1.7	0	0	0.7	-1.5
South Atlantic	171	-0.2	-0.4	0.1	0.1	-0.6	1.7	-0.1	0.1	0.9	-1.1
East North Central	121	-0.1	-0.3	0	0	-0.4	1.6	0	0	0.8	-1.4
East South Central	176	-0.2	-0.4	0.6	0.6	-0.3	2.8	-0.1	0.1	1.7	-0.3
West North Central	103	0	-0.3	-0.1	-0.1	-0.5	0 8	0	0	0.3	-2
West South Central	209	-0.2	-0.3	0.1	0.1	-0.7	2.1	-0.1	0.1	0.6	-1.4
Mountain	72	0.1	-0.1	0.3	0.3	0.1	0.3	0	0	0.7	-1.6
Pacific	32	-0.1	-0.3	-0.4	-0.4	-0.7	1.7	-0.1	0	0.4	-1.8
By Payment Classification:											
Urban hospitals	2,585	0.3	0	0	0	-0.1	-0.2	0	0	1.4	-0.4
Large urban areas	1,417	0.2	0	-0.1	-0.1	-0.1	-0.3	-0.1	0	1.5	-0.4
Other urban areas	1,168	0.3	0	0.1	0.1	-0.1	0	0.1	0	1.3	-0.5
Rural areas	928	-0.1	-0.3	0.1	0.1	-0.5	1.6	-0.1	0.1	0.8	-1.3

	No. of Hospitals[1]	Proposed FY 2010 Weights & DRG Changes [2](1)	Application of Recalibration Budget Neutrality[3] (2)	Proposed FY 2010 Wage Data and Labor Related Share[4] (3)	Application of Wage Budget Neutrality [5] (4)	FY 2010 DRG, Rel. Wts., Wage Index Changes, Labor-Related Share with Wage and Recalibration Budget Neutrality[6] (5)	FY 2010 MGCRB Reclassifications[7] (6)	Proposed Transitional 1/2 Within State Rural Floor Budget Neutrality and 1/2 National Rural Floor Budget Neutrality [8] (7)	Proposed FY 2010 Out-Migration Adjustment [9] (8)	All Proposed FY 2010 Changes Prior to CMI Adjustment[10] (9)	All Proposed FY 2010 Changes w/CMI Adjustment [11] (10)
Teaching Status:											
Nonteaching	2,479	0.1	-0.1	0	0	-0.2	0.2	0	0	1.2	-0.7
Fewer than 100 residents	800	0.3	0	0	0	-0.1	-0.2	0	0	1.4	-0.5
100 or more residents	234	0.3	0.1	0	0	0	-0.2	-0.1	0	1.5	-0.3
Urban DSH:											
Non-DSH	826	0.3	0	-0.1	-0.1	-0.2	-0	0	0	1.2	-0.8
100 or more beds	1,552	0.2	0	0	0	-0.1	-0.2	0	0	1.5	-0.4
Less than 100 beds	339	-0	-0.2	0.1	0.1	-0.2	-0.2	0	0	1.2	-0.7
Rural DSH:											
SCH	398	-0.4	-0.6	0.1	0.1	-0.6	0.3	0	0.1	0.7	-1.5
RRC	207	0	-0.2	0.2	0.2	-0.3	2.7	-0.1	-0	0.8	-1.2
100 or more beds	38	-0	-0.3	0.5	0.5	-0.2	0.9	-0.1	0.2	1.1	-0.8
Less than 100 beds	153	-0.2	-0.4	0.2	0.2	-0.6	1.4	-0.1	0.3	0.9	-0.9
Urban teaching and DSH:											
Both teaching and DSH	811	0.3	0.1	0	0	0	-0.3	0	0	1.5	-0.3
Teaching and no DSH	163	0.3	0	-0.2	-0.2	-0.3	0.1	0.1	0	1	-0.8
No teaching and DSH	1,080	0.2	-0.1	0	0	-0.2	0	0.1	0	1.4	-0.5
No teaching and no DSH	531	0.3	0	0	0	-0.1	-0.2	0	0	1.3	-0.6
Special Hospital Types:											
RRC	187	0.1	-0.1	0.4	0.4	-0.1	3.2	0	0	1.6	-0.3
SCH	338	-0.3	-0.5	0	0	-0.6	0.1	0	0	-0	-2.3
MDH	181	-0.4	-0.6	0.2	0.2	-0.7	0.5	-0.1	0.2	2	-0.1
SCH and RRC	105	0	-0.2	0	0	-0.2	0.7	0	0	0.2	-2

	No. of Hospitals[1]	Proposed FY 2010 Weights & DRG Changes [2](1)	Application of Recalibration Budget Neutrality[3] (2)	Proposed FY 2010 Wage Data and Labor Related Share[4] (3)	Application of Wage Budget Neutrality [5] (4)	FY 2010 DRG, Rel. Wts., Wage Index Changes, Labor-Related Share with Wage and Recalibration Budget Neutrality[6] (5)	FY 2010 MGCRB Reclassifications[7] (6)	Proposed Transitional 1/2 Within State Rural Floor Budget Neutrality and 1/2 National Rural Floor Budget Neutrality [8] (7)	Proposed FY 2010 Out-Migration Adjustment [9] (8)	All Proposed FY 2010 Changes Prior to CMI Adjustment[10] (9)	All Proposed FY 2010 Changes w/CMI Adjustment [11] (10)
MDH and RRC	14	-0.3	-0.6	-0.1	-0.1	-0.7	0.3	0	0	-0.1	-2.4
Type of Ownership:											
Voluntary	2,015	0.2	0	0	0	-0.2	0	0	0	1.3	-0.6
Proprietary	817	0.2	0	0.1	0.1	-0.1	-0	-0.1	0	1.7	-0.2
Government	578	0.1	0	0.1	0.1	-0.1	0	0	0	1.5	-0.4
Medicare Utilization as a Percent of Inpatient Days:											
0-25	241	0.3	0.1	0.3	0.3	0.3	-0.3	-0.1	0	2	0.2
25-50	1,317	0.3	0.1	0	0	-0.1	-0.3	-0	0	1.5	-0.3
50-65	1,423	0.1	-0.1	0	0	-0.3	0.4	0.1	0	1.1	-0.8
Over 65	388	0	-0.2	-0.1	-0.1	-0.5	0.3	0	0	1	-1
FY 2010 Reclassifications by the Medicare Geographic Classification Review Board:											
All Reclassified Hospitals	864	0.2	-0.1	-0.1	-0.1	-0.3	1.7	-0.1	0	1.2	-0.7
Non-Reclassified Hospitals	2,649	0.2	0	0	0	-0.1	-0.6	0	0	1.4	-0.4
Urban Hospitals Reclassified	510	0.2	0	-0.1	-0.1	-0.2	1.4	-0.1	0	1.3	-0.6
Urban Nonreclassified, FY 2010:	2,001	0.3	0	0	0	-0.1	-0.7	0	0	1.5	-0.4
All Rural Hospitals Reclassified Full Year FY 2010:	354	0	-0.2	0.2	0.2	-0.4	2.8	-0.1	0	1	-1.1

	No. of Hospitals[1]	Proposed FY 2010 Weights & DRG Changes [2](1)	Application of Recalibration Budget Neutrality[3] (2)	Proposed FY 2010 Wage Data and Labor Related Share[4] (3)	Application of Wage Budget Neutrality [5] (4)	FY 2010 DRG, Rel. Wts., Wage Index Changes, Labor-Related Share with Wage and Recalibration Budget Neutrality[6] (5)	FY 2010 MGCRB Reclassifications[7] (6)	Proposed Transitional 1/2 Within State Rural Floor Budget Neutrality and 1/2 National Rural Floor Budget Neutrality [8] (7)	Proposed FY 2010 Out-Migration Adjustment [9] (8)	All Proposed FY 2010 Changes Prior to CMI Adjustment[10] (9)	All Proposed FY 2010 Changes w/CMI Adjustment [11] (10)
Rural Nonreclassified Hospitals Full Year FY 2010:	562	-0.3	-0.5	0.1	0.1	-0.6	-0.3	-0.1	0.2	0.6	-1.6
All Section 401 Reclassified Hospitals:	32	-0.2	-0.4	0.1	0.1	-0.3	-0.2	0	0	0	-2.2
Other Reclassified Hospitals (Section 1886(d)(8)(B))	62	-0.3	-0.5	0.1	0.1	-0.6	2.7	0	0	0.4	-1.7
Specialty Hospitals											
Cardiac Hospitals	20	0.4	0.2	0.4	0.4	0.4	-0.8	0	0	2.2	0.3

[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 proposed changes to the V27 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 0.997663, in accordance with 1886(d)(4)(C)(iii) of the Act.

[4]. This column displays the proposed payment impact of the update to wage index data using FY 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 67.1 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 1.000404.

[6] This column displays the combined payment impact of the proposed changes in Columns 2 through 5 and the proposed cumulative budget neutrality factor for 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 0.998066 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 0.991690.

[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 Pub. L. 108-173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

[10] This column shows the proposed changes in payments from FY 2009 to FY 2010 prior to the application of the proposed documentation and coding adjustments.

[11] This column shows proposed changes in payments from FY 2009 to FY 2010. It reflects the impact of the proposed FY 2010 market basket update and the proposed reductions to the FY 2010 standardized amount due to the documentation and coding effect. The proposed FY2010 documentation and coding adjustment is -1.9 percent to the standardized amount, -2.5 percent to the hospital-specific rate and -1.1 documentation and coding adjustment to the Puerto Rico-specific amount. It also reflects changes in hospitals' reclassification status in FY 2010 compared to FY 2009. It incorporates all of the proposed changes displayed in Columns 4, 5, 6, 7 and 8. The sum of these impacts may be different from the proposed percentage changes shown here due to rounding and interactive effects.

BILLING CODE 4210–01–C

C. Effects of the Proposed Changes to the MS–DRG Reclassifications and Relative Cost-Based Weights (Column 1)

In Column 1 of Table I, we present the effects of the proposed DRG reclassifications, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

As discussed in the preamble of this proposed rule, the proposed FY 2010 DRG relative weights would 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 proposed relative weights and the reclassification changes to the GROUPER are described in more detail in section II.H. of the preamble to this proposed rule. The proposed changes to the relative weights and MS–DRGs shown in Column 2 are prior to any offset for budget neutrality. Overall, hospitals would 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 would experience a 0.3 percent increase in payments under the updates to the relative weights and DRGs, while rural hospitals would experience a 0.1 percent decrease in payments. Under the MS–DRG system, rural hospitals would generally experience a decrease 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.

The ''All Hospitals'' line in Column 1 indicates that proposed changes due to MS–DRGs and relative weights would increase payments by 0.2 percent before application of the budget neutrality factor. The proposed recalibration budget neutrality factor is 0.997663, which is applied to the standardized amount. Thus, the impact after accounting only for budget neutrality for proposed changes to the MS–DRG relative weights and classification is somewhat lower than the figures shown in this column (approximately 0.2 percent). Consequentially, urban hospitals would not experience a change in payments when recalibration budget neutrality is applied, while rural hospitals would experience a 0.3 percent decrease in payments due to the lower acuity of services provided.

E. Effects of Proposed Wage Index Changes (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for acute care hospitals for FY 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 proposed FY 2010 pre-reclassification wage index with the proposed 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 proposed 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 proposed rule, we describe our updated methodology and data sources to calculate the national labor-related share. Using the proposed cost category weights from the FY 2006-based IPPS market basket, we calculated a labor-related share of 67.1 percent, approximately 3 percentage points lower than the current labor-related share of 69.7 percent. Accordingly, in this proposed rule, we are implementing a national labor-related share of 67.1 percent for discharges occurring on or after October 1, 2009. This proposal 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 labor-related share proposal. In addition, we are proposing to update the labor-related share for Puerto Rico. Using FY 2006-based Puerto Rico cost category weights, we calculated a labor-related share of 60.347 percent, approximately 2 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 60.3 percent.

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 proposed labor-related share are budget neutral without regard to the lower labor-related share of 62 percent applied to hospitals with a wage index less than or equal to 1. In other words, the wage budget neutrality is calculated under the assumption that all hospitals receive the higher labor-related share of the standardized amount. 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 would lead to a 0.0 percent change for all hospitals before being combined with the proposed 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. Among the regions, the largest increase is in the urban Puerto Rico region, which experiences a 1.8 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 3.9 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 3.9 percent increase in average hourly wage. Of the 3,469 hospitals with wage data for both FYs 2009 and 2010, 1,682, or 48.5 percent, experienced an average hourly wage increase of 3.9 percent or more.

The following chart compares the shifts in proposed wage index values for hospitals for FY 2010 relative to FY 2009. Among urban hospitals, 29 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, 8 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, 955 rural hospitals will experience increases or decreases of less than 5 percent, while 2,427 urban hospitals will experience increases or decreases of less than 5 percent. Thirty-four urban hospitals will experience decreases in their wage index values of more than 5 percent and less than 10 percent. Eight 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 proposed changes in the wage index which is an adjustment to either 67.1 percent or 62 percent of a hospital's proposed 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 would 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	29	8
Increase or decrease less than 5 percent	2,427	955
Decrease more than 5 percent and less than 10 percent	34	0
Decrease more than 10 percent	8	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 proposed labor-related share of 67.1 percent of the standardized amount compared to the current labor-related share of 69.7 percent of the standardized amount. Because the wage data changes did not change overall payments (displayed in Column 3), the wage budget neutrality factor is minimal at 1.000404, and the overall payment change is 0.0 percent.

G. Combined Effects of Proposed MS–DRG and Wage Index Changes (Column 5)

Section 1886(d)(4)(C)(iii) of the Act requires that changes to MS–DRG reclassifications and the relative weights cannot increase or decrease aggregate payments. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. We computed a proposed wage budget neutrality factor of 1.000404, and a proposed recalibration budget neutrality factor of 0.997663 (which is applied to the Puerto Rico specific standardized amount and the hospital-specific rates). The product of the two budget neutrality factors is the cumulative wage and recalibration budget neutrality factor. The proposed cumulative wage and recalibration budget neutrality adjustment is 0.998066 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 cumulative wage and recalibration budget neutrality results in a 0.1 percent decrease in payments relative to no budget neutrality adjustment at all. In Table I, the combined overall impacts of the effects of both the proposed MS–DRG reclassifications and the updated wage index are shown in Column 5. The estimated changes shown in this column reflect the combined effects of the proposed changes in Columns 2, 3,

and 4 and the proposed budget neutrality factors discussed previously.

We estimate that the combined impact of the proposed changes to the relative weights and DRGs, the proposed updated wage data and proposed changes to the labor share with budget neutrality applied will decrease payments to hospitals located in all urban areas by approximately 0.1 percent. Rural hospitals would generally experience a decrease in payments (−0.5 percent) primarily due to payment decreases under the MS–DRGs. Among the rural hospital categories, rural hospitals with less than 50 beds and rural New England hospitals will experience the greatest decline in payment (−0.8 percent) primarily due to the proposed 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 proposed changes in Column 7 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 proposing to apply an adjustment of 0.991690 to ensure that the effects of the section 1886(d)(10) reclassifications are budget neutral. (*See* section II.A. of the Addendum to this proposed rule.) Geographic reclassification generally benefits hospitals in rural areas. We estimate that geographic reclassification will increase payments to rural hospitals by an average of 1.7 percent.

Table 9A of the Addendum to this proposed 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 proposed rule, section 4410 of Public Law 105–33 established the rural floor by requiring that the wage index for a hospital in any urban area cannot be less than the wage index received by rural hospitals in the same State. In FY 2008, we changed how we applied budget neutrality to the rural floor. Rather than applying a budget neutrality adjustment to the standardized amount, a uniform budget neutrality adjustment is applied to the wage index. In the FY 2009 final rule, we finalized the policy to apply the rural floor budget neutrality at the State level with a 3-year transition. In FY 2009, hospitals received a blended wage index that is 20 percent of a wage index with the State level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. 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 0.997466. The within-State rural floor budget neutrality factors applied to the proposed wage index are shown in Table 4D in the Addendum to this proposed rule. After the wage index is blended, an additional adjustment of 1.000017 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 proposed 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 would have a within-State budget neutrality factor applied and 50 percent of the wage index would 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 transition to within-State 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. Rural hospitals located in the South Atlantic, East South Central and West South Central and Pacific regions can expect the decreases in payments by 0.1 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 Proposed Wage Index Adjustment for Out-Migration (Column 8)

Section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county, post-reclassification and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index. With the out-migration adjustment, small rural providers with less than 49 beds and MDHs will experience a 0.2 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 $17 million.

K. Effects of All Proposed Changes Prior to Documentation and Coding (or CMI) Adjustment (Column 9)

Column 9 shows our estimate of the change in operating payments from FY 2009 and FY 2010 resulting from all proposed changes in this rule other than the proposed documentation and coding adjustment. This column includes a 2.1 percent market basket update to the standardized amount. In addition, it reflects the −0.3 percentage point difference between the projected outlier payments in FY 2009 (5.1 percent of total MS–DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2009 (5.4 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule. As a result, payments are projected to be 0.3 percentage points higher in FY 2009 than originally estimated, resulting in a 0.3 percentage point decrease for FY 2010 than would otherwise occur. This analysis also accounts for the impact of expiration of certain special exceptions and section 508 reclassification, a nonbudget neutral provision, which results in a decrease in estimated payments by 0.2 percent. In addition, the separate calculation of wage budget neutrality (which does not account for the 62 percent labor-related share) from the recalibration budget neutrality (which does account for the 62 percent labor-related share) results in a 0.2 percent decrease in payments relative to last year. We estimate that overall payments to hospitals paid under the IPPS would increase 1.4 percent prior to the application of the proposed documentation and coding adjustment. For the proposed rule, we are proposing to apply a −1.9 percent documentation and coding adjustment to the IPPS national standardized amount, a −2.5 documentation and coding adjustment applied to the hospitals-specific rate, and a −1.1 documentation and coding adjustment applied to the Puerto Rico-specific rate. Because SCHs and MDHs are paid in whole or in part based on the hospital-specific rate if higher than the rate based on the national standardized amount, these hospitals may switch between these payment rates in Column 9 and Column 10.

Without the documentation and coding adjustments, hospitals located in urban areas would experience higher payment increases (1.4 percent) than hospitals in rural areas (0.8 percent) because urban hospitals generally treat patients with higher acuity of illness and have a higher case-mix under the MS–DRGs.

L. Effects of All Proposed Changes With CMI Adjustment (Column 10)

Column 10 shows our estimate of the changes in payments per discharge from FY 2009 and FY 2010, resulting from all proposed changes reflected in this proposed rule for FY 2010 (including statutory changes). This column includes the proposed 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, which overall accounts for a 1.9 percent decrease in payments. 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 1.6 percent in FY 2009, the payment models reflect a case-mix growth of 1.6 percent in FY 2009.

Column 10 reflects the impact of all proposed FY 2010 changes relative to FY 2009, including those shown in Columns 1 through 9. The average decrease in payments under the IPPS for all hospitals is approximately 0.5 percent. As described in Column 9, this average decrease 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), the 0.2 percent decrease in payments due to the expiration of section 508 reclassification, and the 0.2 percent decrease in payments due to the calculation of wage and recalibration budget neutrality.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in Column 10 may not equal the sum of the percentage changes described above.

The overall proposed change in payments per discharge for hospitals paid under the IPPS in FY 2010 is estimated to decrease by 0.5 percent. The payment decreases among the hospital categories are largely attributed to the proposed documentation and coding adjustments. Hospitals in urban areas would experience an estimated 0.4 percent decrease in payments per discharge in FY 2010 compared to FY 2009. Hospitals in large urban areas would experience an estimated 0.4 percent decrease and hospitals in other urban areas would experience an estimated 0.5 percent decrease in payments per discharge in FY 2010 as compared to FY 2009. Hospital payments per discharge in rural areas are estimated to decrease by 1.3 percent in FY 2010 as compared to FY 2009. The decreases that are smaller than the national average for larger urban areas and larger than the national average for rural areas are largely attributed to the differential impact of adopting MS–DRGs and due to the −1.9 percent documentation and coding adjustment applied to the national standardized amount and the −2.5 percent documentation and coding adjustment to the hospital-specific rate, applied to SCHs and MDHs which are generally classified as rural hospitals.

Among urban census divisions, the largest estimated payment decreases would be −0.9 percent in the Pacific region and −0.7 percent in the Middle Atlantic region. Among the rural regions, the providers in the New England region would experience the largest decrease in payments (−2.5

percent) primarily due to a combination of the MS–DRG changes, the transition to the State rural floor budget neutrality and the documentation and coding adjustment. The rural providers in the East South Central regions would have the smallest decreases among rural regions at −0.3 percent because the benefits from the MGCRB reclassification partially offset the documentation and coding adjustments.

Among special categories of rural hospitals, MDHs would receive an estimated payment decrease of −0.1 percent. MDHs are paid the higher of the IPPS rate based on the national standardized amount, that is, the Federal rate, or, if the hospital-specific rate exceeds the Federal rate, the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate. MDHs experience a decrease in payments due to the 1.9 percent documentation and coding adjustment applied to the federal rate and the 2.5 percent documentation and coding adjustment applied to the hospital-specific rate. In addition, this payment impact accounts for the corrected wage and recalibration budget neutrality factor, described in section V.B.2. of the preamble of this proposed rule, applied to the hospital-specific rates for MDHs that are paid based on their FY 2002 hospital-specific rate. Overall, SCHs would experience an estimated decrease in payments by −2.3 percent largely due to the proposed −2.5 percent documentation and coding adjustment applied to the hospital-specific rate. In addition, section 112 of Public Law 110–275 (MIPPA) 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 would benefit from the rebased rate and included those rates in our analysis. SCHs are estimated to experience a greater decrease in payments compared to the MDHs because the documentation and coding adjustment applied to the hospital-specific rates impacts SCHs and MDHs differently. SCHs that are paid under the hospital-specific rate have not had their payment rates adjusted for documentation and coding previously and would experience a −2.5 percent documentation and coding adjustment to their rates. However, MDHs, which are paid the Federal rate plus 75 percent of the amount by which the hospital-specific rate exceeds the Federal rate, have had the portion of their payment rate based on the Federal rate adjusted in the past (−0.6 percent adjustment in FY 2008 and −0.9 percent adjustment in FY 2009), whereas the −2.5 percent documentation and coding adjustment applied to the hospital-specific rate affects a relatively smaller portion of their rate based on the hospital-specific rate (compared to SCHs), thereby resulting in a smaller payment impact. Thus, the change in payment for SCHs relative to last year is more significant than the payment change for MDHs.

Urban hospitals reclassified for FY 2010 are anticipated to receive a decrease in payments under the IPPS of 0.6 percent, while urban hospitals that are not reclassified for FY 2010 are expected to receive a decrease of 0.4 percent. Rural hospitals reclassified for FY 2010 are anticipated to receive a −1.1 percent payment decrease, and rural hospitals that are not reclassifying are estimated to receive a payment decrease of −1.6 percent.

Cardiac hospitals are the only category of hospitals under the IPPS expected to experience payment increases in FY 2010 as compared to FY 2009 (an increase of 0.3 percent).

M. 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 three providers will receive the low-volume adjustment for FY 2010. We estimate that low-volume hospitals will experience a 3.1 percent decrease in payments in FY 2010 relative to FY 2009.

N. Impact Analysis of Table II

Table II presents the projected impact of the proposed 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 proposed changes presented in Table I. The estimated percentage changes shown in the last column of Table II equal the estimated percentage changes in average payments per discharge from Column 9 of Table I.

BILLING CODE 4210–01–P

TABLE II.--IMPACT ANALYSIS OF PROPOSED 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 Proposed FY 2010 Payment Per Discharge[1] (3)	All Proposed FY 2010 Changes (4)
All hospitals	3,513	$9,867	$9,816	-0.5
By Geographic Location:				
Urban hospitals	2,535	$10,274	$10,230	-0.4
Large urban areas (populations over 1 million)	1,386	$10,742	$10,704	-0.4
Other urban areas (populations of 1 million or fewer)	1,149	$9,701	$9,649	-0.5
Rural hospitals	978	$7,432	$7,337	-1.3
Bed Size (Urban):				
0-99 beds	643	$7,847	$7,812	-0.5
100-199 beds	824	$8,815	$8,761	-0.6
200-299 beds	473	$9,605	$9,560	-0.5
300-499 beds	410	$10,749	$10,699	-0.5
500 or more beds	185	$12,672	$12,645	-0.2
Bed Size (Rural):				
0-49 beds	338	$6,030	$5,967	-1.1
50-99 beds	369	$6,896	$6,795	-1.5
100-149 beds	166	$7,359	$7,269	-1.2
150-199 beds	62	$8,263	$8,178	-1
200 or more beds	43	$9,208	$9,077	-1.4
Urban by Region:				
New England	119	$10,689	$10,649	-0.4
Middle Atlantic	344	$11,025	$10,949	-0.7
South Atlantic	390	$9,675	$9,643	-0.3
East North Central	395	$9,712	$9,654	-0.6
East South Central	160	$9,283	$9,272	-0.1
West North Central	164	$9,868	$9,845	-0.2
West South Central	361	$9,656	$9,644	-0.1
Mountain	162	$10,419	$10,463	0.4
Pacific	389	$12,573	$12,465	-0.9
Puerto Rico	51	$5,010	$4,994	-0.3
Rural by Region:				
New England	24	$9,856	$9,609	-2.5
Middle Atlantic	70	$7,677	$7,565	-1.5
South Atlantic	171	$7,261	$7,180	-1.1
East North Central	121	$7,601	$7,498	-1.4
East South Central	176	$6,721	$6,704	-0.3
West North Central	103	$7,837	$7,683	-2
West South Central	209	$6,693	$6,597	-1.4
Mountain	72	$8,274	$8,138	-1.6

	Number of Hospitals	Average FY 2009 Payment Per Discharge[1] (2)	Average Proposed FY 2010 Payment Per Discharge[1] (3)	All Proposed FY 2010 Changes (4)
Pacific	32	$10,084	$9,903	-1.8
By Payment Classification:				
Urban hospitals	2,585	$10,250	$10,206	-0.4
Large urban areas (populations over 1 million)	1,417	$10,719	$10,681	-0.4
Other urban areas (populations of 1 million or fewer)	1,168	$9,673	$9,621	-0.5
Rural areas	928	$7,499	$7,400	-1.3
Teaching Status:				
Non-teaching	2,479	$8,433	$8,375	-0.7
Fewer than 100 Residents	800	$9,940	$9,894	-0.5
100 or more Residents	234	$14,425	$14,382	-0.3
Urban DSH:				
Non-DSH	826	$8,729	$8,663	-0.8
100 or more beds	1,552	$10,779	$10,740	-0.4
Less than 100 beds	339	$7,404	$7,352	-0.7
Rural DSH:				
SCH	398	$6,833	$6,733	-1.5
RRC	207	$8,302	$8,200	-1.2
100 or more beds	38	$6,937	$6,884	-0.8
Less than 100 beds	153	$5,782	$5,728	-0.9
Urban teaching and DSH:				
Both teaching and DSH	811	$11,801	$11,766	-0.3
Teaching and no DSH	163	$9,585	$9,507	-0.8
No teaching and DSH	1,080	$8,994	$8,947	-0.5
No teaching and no DSH	531	$8,346	$8,298	-0.6
Rural Hospital Types:				
RRC	187	$8,307	$8,284	-0.3
SCH	338	$7,782	$7,600	-2.3
MDH	181	$6,166	$6,160	-0.1
SCH and RRC	105	$9,420	$9,228	-2
MDH and RRC	14	$8,465	$8,260	-2.4
Type of Ownership:				
Voluntary	2,015	$9,998	$9,938	-0.6
Proprietary	817	$9,015	$8,996	-0.2
Government	578	$10,256	$10,213	-0.4
Medicare Utilization as a Percent of Inpatient Days:				
0-25	241	$13,872	$13,901	0.2
25-50	1,317	$11,150	$11,114	-0.3
50-65	1,423	$8,592	$8,521	-0.8
Over 65	388	$7,628	$7,551	-1
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2010 Reclassifications:				

	Number of Hospitals	Average FY 2009 Payment Per Discharge[1] (2)	Average Proposed FY 2010 Payment Per Discharge[1] (3)	All Proposed FY 2010 Changes (4)
All Reclassified Hospitals FY 2010	864	$9,674	$9,604	-0.7
All Non-Reclassified Hospitals FY 2010	2,649	$9,944	$9,900	-0.4
Urban Reclassified Hospitals FY 2010:	510	$10,328	$10,265	-0.6
Urban Non-reclassified Hospitals FY 2010:.....	2,001	$10,261	$10,224	-0.4
Rural Reclassified Hospitals FY 2010:.....:	354	$8,018	$7,930	-1.1
Rural Nonreclassified Hospitals FY 2010:	562	$6,602	$6,498	-1.6
All Section 401 Reclassified Hospitals:	32	$9,188	$8,983	-2.2
Other Reclassified Hospitals (Section 1886(d)(8)(B))	62	$7,250	$7,130	-1.7
Specialty Hospitals				
Cardiac Hospitals	20	$11,499	$11,536	0.3

[1]These payment amounts per discharge reflect estimates of case-mix increase of 1.6 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 would increase an additional 1.6 percent from FY 2008 to FY 2009 and from FY 2008 to FY 2010 due to the adoption of MS-DRGs.

BILLING CODE 4210–01–C

VII. Effects of Other Proposed Policy Changes

In addition to those proposed policy changes discussed above that we are able to model using our IPPS payment simulation model, we are proposing to make various other changes in this proposed rule. Generally, we have limited or no specific data available with which to estimate the impacts of these proposed changes. Our estimates of the likely impacts associated with these other proposed changes are discussed below.

A. Effects of Proposed Policy on HACs, Including Infections

In section II.F. of the preamble of this proposed rule, we discuss our implementation of section 1886(d)(4)(D) of the Act, which requires the Secretary to identify conditions that are: (1) High cost, high volume, or both; (2) result in the assignment of a case to an MS–DRG that has a higher payment when present as a secondary diagnosis; and (3) could reasonably have been prevented through application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission, unless based on data and clinical judgment, it cannot be determined at the time of admission whether a condition is present. That is, the case will be paid as though the secondary diagnosis were not present. However, the statute also requires the Secretary to continue counting the condition as a secondary diagnosis that results in a higher IPPS payment when doing the budget neutrality calculations for MS–DRG reclassifications and recalibration. Therefore, we will perform our budget neutrality calculations as though the payment provision did not apply, but Medicare will make a lower payment to the hospital for the specific case that includes the secondary diagnosis. Thus, the provision results in cost savings to the Medicare program.

We note that the provision will only apply when one or more of the selected conditions are the only secondary diagnosis or diagnoses present on the claim that will lead to higher payment. Medicare beneficiaries will generally have multiple secondary diagnoses during a hospital stay, such that beneficiaries having one MCC or CC will frequently have additional conditions that also will generate higher payment. Only a small percentage of the cases will have only one secondary diagnosis that would lead to a higher payment. Therefore, if at least one nonselected secondary diagnosis that leads to higher payment is on the claim, the case will continue to be assigned to the higher paying MS–DRG and there will be no Medicare savings from that case.

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 Proposed Policy Change Relating to New Medical Service and Technology Add-On Payments

In section II.I. of the preamble to this proposed rule, we discuss the five applications 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. As discussed in section II.I.4. of the preamble of this proposed rule, we have yet to determine whether any of the five applications we received for consideration for new technology add-on payments for FY 2010 will meet the specified criteria. Consequently, it is premature to estimate the potential payment impact of any potential new technology add-on payments for FY 2010. We note that if any of the five applications are found to be eligible for new technology add-on payments for FY 2010 in the final rule, we would discuss the estimated payment impact for FY 2010 in that final rule.

However, we are providing an estimate of additional payments for new technology add-on payments because such payments would have an impact on total operating IPPS payments in FY 2010. Because we are proposing to continue to make new technology add-on payments in FY 2010 for the Cardiowest™ Temporary Total Artificial Heart System (TAH–t), we are providing an estimate of total payments for the TAH–t 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.

C. Effects of Proposed Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In section V.A. of the preamble of this proposed rule, we discuss our proposed requirements for hospitals to report quality data under the RHQDAPU program in order to receive the full payment update for FY 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 the hospitals that do not meet the requirements for the full hospital market basket increase for 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 is 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 proposed rule, we are proposing 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 would fail the validation requirement for the FY 2010 payment update. We estimate that this proposal would cost

hospitals approximately 12 cents per page for copying and approximately $4.00 per chart for postage. We have found, based on experience, that an average sized medical chart is approximately 150 pages. Hospitals would be required to return all 20 sampled medical records for the four quarters of data from FY 2008. We estimate that the total cost to the 20 impacted hospitals would 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 proposed requirement is necessary so that CMS has all the information it needs to fairly and timely make a decision on the hospital's reconsideration request. We also anticipate that this 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 is 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 would 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 Clinical Data Abstraction Center (CDAC) contractor at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received by the CDAC contractor is approximately 150 pages. Thus, CMS would 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 proposing to modify our validation process for the FY 2012 payment update. We believe that our proposal to validate data submitted by 800 hospitals for the FY 2012 RHQDAPU payment determination would not change the number of hospitals that fail the validation requirement for the FY 2012 payment update from previous years. We have proposed to change 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 have also proposed to validate data for a much smaller number of hospitals each year and proposed to reduce the validation score needed to satisfy the validation requirement. In combination, we believe that these proposed revisions will counterbalance each other and result in no additional impact on 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 proposed rule, we discuss the need to correct the calculation of the FY 2002 hospital-specific rates for MDHs and apply 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 would result in an estimated decrease in operating IPPS payments in FY 2010 of approximately $6 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 Proposed Policy Changes Relating to the Payment Adjustments to Disproportionate Share Hospitals

1. Proposed Change Relating to Inclusion of Labor and Delivery Days in DSH Calculation

In section V.E.2. of the preamble of this proposed rule, we discuss our proposal to amend the regulations so that patient days associated with labor and delivery services are included in both the Medicaid and Medicare fractions of the DPP used for calculating the DSH payment adjustment, regardless of whether the patient occupied a routine bed prior to occupying an ancillary labor and delivery bed. We believe that the impact of the proposed inclusion of these days in the Medicare fraction of the DPP would be negligible because, generally, there are not many labor and delivery patient days among the Medicare population. In addition, with regard to the Medicaid fraction, we are not able to provide a detailed analysis of the potential of this proposed policy change because the impact would 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 are proposing to include in this policy). We expect that the Medicaid fraction for some hospitals would increase while it would decrease for other hospitals. Therefore, we estimate

that the impact of this proposed policy change would be negligible.

2. Proposed Change Relating to Calculation of Inpatient Days in Medicaid Fraction

In section V.E.3. of the preamble of this proposed rule, we discuss our proposal 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 proposed change, we would 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 would be permitted to use only one basis for all of the Medicaid days for the entire cost reporting period. In addition, under the proposal, 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 proposed change in the methodology of counting days in the numerator of the Medicaid fraction of the DPP would result in any increase in aggregate DSH payments.

3. Proposed Change Relating to Exclusion of Observation Beds and Patient Days from DSH Calculation

In section V.E.4. of the preamble of this proposed rule, we discuss our proposal 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 others may expect to receive lower DSH payment adjustments, depending on how the exclusion of observation patient days affects the hospital's overall DPP. 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 would reduce the available beds, increase the resident-to-bed ratio, and, consequently, increase IME payments to teaching hospitals. Based on an analysis from our Office of the Actuary, we believe that any savings associated with proposed changes in DSH payment adjustments would be offset by proposed additional spending for IME payments. Therefore, we anticipate the impact of these proposed policy changes to be negligible.

F. Effects of Proposed Policy Revisions Related to Payment to Hospitals for Direct GME

In section V.G. of the preamble of this proposed rule, we discuss our proposal 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. In addition, we discuss our proposed change to add 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 1 start date of that academic year would 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 proposed provision regarding a new medical residency training program, there is no financial impact on the Medicare program because this is a proposed clarification of existing policy and is not a proposed policy revision or addition of a new policy. Further, there is no financial impact related to the second proposal 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 would otherwise be counted for IME and direct GME at another hospital.

G. Effects of Proposed Policy Changes Relating to Hospital Emergency Services under EMTALA

In section V.H. of the preamble of this proposed rule, we discuss our proposal 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 proposing to revise 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 proposing to amend 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 proposing to make the regulations consistent with the language at section 1135 of the Act 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 are further proposing to make the regulation text consistent with the language at 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 proposed changes would 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 proposed 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 13 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 proposed rule, we are

proposing to satisfy this budget neutrality requirement by proposing to adjust the national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. First, we are estimating the cost of the demonstration program for FY 2010 for the 13 currently participating hospitals. The estimated cost of the demonstration for FY 2010 for 9 of the 13 currently participating hospitals (specifically the 9 hospitals that have participated in the demonstration since its inception and that still are participating in the demonstration) is based on data from their first and second year cost reports—that is, cost reporting periods beginning in CY 2005 and CY 2006. In addition, the estimated cost of the demonstration for FY 2010 for the 4 hospitals selected in 2008 to participate in the demonstration is based on data from their cost reports for cost reporting periods beginning October 1, 2005, through July 1, 2006 (that is, cost reporting periods that include CY 2006). When we add together the estimated costs of the demonstration for FY 2010 for the 9 hospitals that have participated in the demonstration since its inception and the 4 new hospitals selected in 2008, the total estimated cost is $14,613,632. This estimated amount reflects the difference between the participating hospitals' estimated costs under the methodology set forth in Public Law 108–173 and the amount the hospitals would have been paid if they were paid under the IPPS.

Second, because the cost reports of all hospitals participating in the demonstration in its first year (that is, FY 2005) 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. For all 13 hospitals that participated in the demonstration in FY 2005, the amount is $7,179,461.

The proposed budget neutrality adjustment factor applied to the IPPS Federal rate to account for the added $21,793,093 in costs for the demonstration is 0.999790.

J. Effects of Proposed Policy Changes Relating to Payments to Satellite Facilities

In section VII.B. of the preamble of this proposed rule, we discuss our proposed policy change that, effective for cost reporting periods beginning on or after October 1, 2009, in addition to meeting the other criteria in the regulations, 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 proposing 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 proposed § 412.22(h)(2)(iii)(A)(*1*) with respect to that satellite facility in order to retain its IPPS-excluded status. The creation of any satellite facility that would trigger the hospital of which it is a part to comply with the proposed additional criteria would occur at some point in the future. Therefore, we are unable to quantify the impact of the proposed changes.

K. Effects of Proposed Policy Changes Relating to Payments to CAHs

In section VII.C.2. of the preamble of this proposed rule, we discuss our proposal to implement section 148 of Public Law 110–275 (MIPPA). We are proposing 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 (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 proposing that the individual must either receive outpatient services in the CAH on the same day the specimen is collected or that the specimen must be collected by an employee of the CAH. We anticipate that, for FY 2009 through FY 2016, the cost of implementing the provisions of section 148 of Public Law 110–275, would be less than $50 million per year.

In section VII.C.3. of this preamble of this proposed rule, we discuss our proposal 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 reimbursement receive reasonable cost payment for outpatient facility services. We are proposing to revise the regulations to state that CAHs that select the optional method would receive reasonable cost-based payment for outpatient facility services instead of 101 percent of reasonable cost for outpatient facility services. Therefore, those CAHs that elect the optional method of payment would receive reasonable cost payment for the facility portion of outpatient services.

L. Effects of Proposed Policy Changes Relating to Provider-Based Status of Entities and Organizations

In section VII.D. of the preamble of this proposed rule, we discuss our proposal 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 would be paid for services furnished by the laboratory facility under the CAH payment methodology of reasonable cost. If a facility that furnishes only clinical diagnostic laboratory tests does not meet the provider-based status rules, the services furnished in the facility would 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 proposed rule. We believe it would be difficult to quantify the payment impact of these proposed changes because we cannot estimate the number of CAHs that would be affected by this proposal. We are soliciting public comments on these issues.

VIII. Effects of Proposed Changes in the Capital IPPS

A. General Considerations

Fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (*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 proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), payments for most hospitals under the capital IPPS 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, if applicable).

In accordance with § 412.322(d), there is no longer an additional payment for indirect teaching medical education (IME adjustment factor) under the capital IPPS costs for FY 2010 and subsequent years, as discussed in section VI.B.2. of the preamble of this proposed rule. However, we note that the 50-percent reduction to capital IME adjustments for FY 2009 in the current regulations at § 412.322(c) was repealed in section 4301(b)(1) of Public Law 111–5 (ARRA). We discuss below the ramifications of restoring the full IME adjustment in FY 2009 when comparing proposed changes in capital IPPS payments to FY 2010. In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2008 update of the FY 2008 MedPAR file and the December 2008 update of the Provider-Specific File (PSF) that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2008 update of the most recently available hospital cost report data (FYs 2005 and 2006) 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 VI.B.1. of the preamble to this proposed rule, as we established in FYs 2008 and 2009, we are proposing to adjust the national capital rate to account for changes in documentation and coding under the MS–DRGs in FY 2010. As discussed in section VI.B.1.c. of the preamble to this proposed rule, we also are proposing to adjust the Puerto Rico-specific capital rate in FY 2010 to account for changes in documentation and coding resulting from the adoption of the MS–DRGs. Due to the interdependent nature of the IPPS, it is very difficult to precisely quantify the impact associated with each change. We draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the December 2008 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 discuss in section III.A.4. of the Addendum to this proposed rule, payments are no longer made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we no longer use the actuarial capital cost model (described in Appendix B of the August 1, 2001 proposed rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We only included estimated payments for the IME adjustment in our modeling of FY 2009 capital IPPS payments because, under current law, capital IME payments are eliminated beginning in FY 2010 in accordance with § 412.322(d) (as discussed in section VI.B.2. of the preamble of this proposed rule). We then added estimated payments for 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 note that this does not reflect the expected growth in case-mix due to improvement in documentation and coding under the MS–DRGs, as discussed below.)
- 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.A.2.a. of the Addendum to this proposed rule, the proposed FY 2010 update is 1.2 percent.
- In addition to the FY 2010 update factor, the proposed FY 2010 capital Federal rate was calculated based on a proposed GAF/DRG budget neutrality factor of 0.9994, a proposed outlier adjustment factor of 0.9454, and a proposed exceptions adjustment factor of 0.9999.
- For FY 2010, as discussed in section VI.B.1. of the preamble of this proposed rule, the proposed FY 2010 national capital rate was further adjusted by a factor to account for estimated changes in documentation and coding that result in an increase in case-mix under the MS–DRGs. Specifically, as discussed in greater detail in section VI.B.1. of the preamble of this proposed rule, we are proposing a 1.9 percent reduction in the proposed FY 2010 national capital Federal rate for changes in documentation and coding resulting from the adoption of the MS–DRGs. As also discussed in section VI.A.6. of the preamble to this proposed rule, we also are proposing to adjust the Puerto Rico-specific capital rate to account for changes in documentation and coding under the MS–DRGs in FY 2010. Specifically, we are proposing a 1.1 percent reduction in the proposed FY 2010 Puerto Rico-specific capital rate for changes in documentation and coding resulting from the adoption of the MS–DRGs.

B. Results

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2010 on total capital payments per case, using a universe of 3,513 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2008 update of the FY 2008 MedPAR file, the December 2008 update to the PSF, and the most recent cost report data from the December 2008 update of HCRIS. In Table III, we present a comparison of estimated total payments per case for FY 2009 compared to proposed estimated total payments per case for FY 2010 based on the proposed FY 2010 payment rates and 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 1.2 percent update to the capital Federal rate, other changes in the adjustments to the capital Federal rate (for example, the

phase out of the IME adjustment for FY 2010), and the proposed additional 1.9 percent reduction in the national capital rate (and the proposed 1.1 percent reduction in the Puerto Rico-specific capital rate) to account for changes in documentation and coding (or other changes in documentation and coding that do not reflect real changes in case-mix) for implementation of the MS–DRGs. For purposes of this impact analysis, we also account for estimated case-mix growth for FYs 2009 and 2010, as determined by the Office of the Actuary, because, as discussed previously, we believe the adoption of the MS–DRGs will result in case-mix growth due to documentation and coding changes that do not reflect real changes in patients' severity of illness. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that capital payments per case in FY 2010 are expected to decrease as compared to capital payments per case in FY 2009. The proposed capital rate for FY 2010 would decrease approximately 0.8 percent as compared to the FY 2009 capital rate, which contributes to the estimated decrease in capital payments. However, the phase-out of the IME adjustment for FY 2010 is the major factor affecting capital payments in FY 2010 as compared to FY 2009; that is, full capital IME payments in FY 2009 as specified by section 4302(b)(1) of Public Law 111–5 as compared to no capital IME payments in FY 2010, as specified under current law (§ 412.322(d) of the regulations). Countering these factors is the projected case-mix growth as a result of changes in documentation and coding (discussed above). The net result of these changes is an estimated 4.8 percent decrease in capital payments per discharge from FY 2009 to FY 2010 for all hospitals (as shown below in Table III).

The results of our comparisons by geographic location and by region are consistent with the results we expected with the phase-out of the IME adjustment for FY 2010 (§ 412.322(d)). The majority of the estimated decreases in capital payments from FY 2009 to FY 2010 are not a result of any of the proposed changes to policies presented in this proposed rule. Our policy to phase-out capital IME adjustments, such that there would be no adjustment for capital IME beginning in FY 2010, was established in FY 2008, and was based on analyses of capital margins from the past 10 years for which data were available; that is, FY 1996 through FY 2006. These margins clearly demonstrated that capital IME payment adjustments were contributing to the significantly large positive margins experienced by teaching hospitals. We initially implemented a phase-out of the IME adjustment over a 3-year period which included a 50-percent reduction to the capital IME adjustment in FY 2009 and the elimination of the remaining 50 percent in FY 2010. Under that 3-year phase-out, including the elimination of the capital IME adjustment in FY 2010, we expected that capital margins would decrease and be more in line with other hospitals in the system. As discussed in section VI.B.2 of the preamble of this proposed rule, however, section 4301(b)(1) of Public Law 111–5 restored the capital IME adjustment for FY 2009 (that is, it eliminated the 50-percent reduction to the capital IME adjustment), while section 4301(b)(2) of Public Law 111–5 specified that the law has no effect on the established elimination of the capital IME adjustment in FY 2010. The combination of restoring the full capital IME adjustment in FY 2009 and eliminating it in FY 2010 has resulted in larger estimated decreases in capital payments from FY 2009 to FY 2010 in this impact analysis. While the end results in FY 2010 would have been the same had the 50-percent reduction to capital IME adjustments in FY 2009 not have been restored, and had the remaining 50 percent of the capital IME adjustment been eliminated in FY 2010 as planned, the estimated decrease in capital payments from FY 2009 to FY 2010 would have been moderated, such that the somewhat dramatic decreases reflected in Table III in this impact analysis would not have resulted.

To a lesser degree, but nevertheless, a mitigating factor to the estimated decrease in capital payments from FY 2009 to FY 2010 are changes in documentation and coding under the MS–DRGs and the associated adjustments to the capital rates. When we implemented the MS–DRGs in FY 2008, in order to maintain budget neutrality, it was necessary to adjust the capital Federal rate to account for potential increases in aggregate capital payments when there was not a corresponding increase in patients' severity of illness. As discussed in greater detail in section VI.B.1. of the preamble of this proposed rule, the FY 2009 capital Federal rate includes a cumulative −1.5 percent documentation and coding adjustment as determined by our Office of the Actuary. As also discussed in that same section, in this proposed rule, we are proposing to apply an additional documentation and coding adjustment of −1.9 percent to the FY 2010 capital Federal rate, yielding a proposed cumulative adjustment of 3.4 perecent. The proposed additional −1.9 percent adjustment contributes to the larger decrease in capital payments in FY 2010 when compared to FY 2009.

The geographic comparison shows that, on average, all urban hospitals are expected to experience a 5.1 percent decrease 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 6.0 percent decrease in capital IPPS payments per case in FY 2010 as compared to FY 2009. Capital IPPS payments per case for rural hospitals are also expected to decrease, but to a lesser degree, that is, 1.9 percent. This variation in the estimated decreases in payments per case by geographic location is mostly due to the elimination of the IME adjustment. Because teaching hospitals generally tend to be located in urban or large urban areas, we expect that the phase-out of the IME adjustment for FY 2010 would have a more significant impact on hospitals in those areas than hospitals located in rural areas. As discussed above, the magnitude of the estimated decreases, however, is attributable to the phase-out of the IME adjustment occurring in 2 years rather than over 3 years.

All regions are estimated to experience a decrease in total capital payments per case from FY 2009 to FY 2010. These decreases vary by region and range from a 0.3 percent decrease in the Mountain rural region to a 9.4 percent decrease in the New England rural region. Three urban regions are projected to experience a relatively larger decrease in capital payments, with the difference, again, primarily due to the phase-out of the IME adjustment for FY 2010: −8.8 percent in the New England urban region, −8.2 percent in the Middle Atlantic urban region, and −7.0 percent in the East North Central urban region.

By type of ownership, voluntary and government hospitals are estimated to experience a decrease of 5.0 percent and 6.9 percent, respectively. The projected smaller decrease in capital payments per case for proprietary hospitals, 2.0 percent, is mostly because these hospitals are expected to experience a smaller than average decrease in their payments due to the phase-out of the IME adjustment for FY 2010.

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 estimated average capital payments per case for reclassified hospitals for FY 2009. All classifications of reclassified hospitals are expected to experience a decrease in payments in FY 2010 as compared to FY 2009. Urban reclassified and urban nonreclassified hospitals are expected to have the largest decreases in capital payments: −5.3 percent and −5.0 percent, respectively. Rural reclassified and rural nonreclassified are expected to have decreases in capital payments of 1.7 percent and 2.2 percent, respectively. Other reclassified hospitals (that is, hospitals reclassified under section 1886(d)(8)(B) of the Act) are expected to experience the smallest decrease in capital payment from FY 2009 to FY 2010 (−1.3 percent). As discussed above, the variation in the estimated decreases in payments per case is mostly due to the phase-out of the IME adjustment. Because teaching hospitals generally tend to be located in urban areas, we expect that the phase-out of the IME adjustment for FY 2010 would have a more significant impact on both reclassified and nonreclassified hospitals in those areas than reclassified and nonreclassified hospitals located in rural areas.

It is important to note that had our original policy of phasing out the capital IME adjustment over 3 years not been changed by section 4301(b)(1) of Public Law 111–5 subsequent to the implementation of the transition period, the decrease in capital payments from FY 2009 to FY 2010 would not have been as large. Although the end result of the changes to the IME adjustment implemented in FY 2008 would have been the same, the decreases would have occurred over 2 years instead of essentially just 1 year—FY 2010.

BILLING CODE 4210–01–P

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	3,513	786	748	-4.8
Large urban areas (populations over 1 million)	1,386	863	811	-6.0
Other urban areas (populations of 1 million of fewer)	1,149	779	749	-3.9
Rural areas	978	546	536	-1.9
Urban hospitals	2,535	825	783	-5.1
0-99 beds	643	656	648	-1.2
100-199 beds	824	716	699	-2.4
200-299 beds	473	776	753	-2.9
300-499 beds	410	856	807	-5.7
500 or more beds	185	1,005	913	-9.2
Rural hospitals	978	546	536	-1.9
0-49 beds	338	438	434	-0.9
50-99 beds	369	504	498	-1.3
100-149 beds	166	551	544	-1.3
150-199 beds	62	606	595	-1.8
200 or more beds	43	669	641	-4.2
By Region:				
Urban by Region	2,535	825	783	-5.1
New England	119	858	782	-8.8
Middle Atlantic	344	878	806	-8.2
South Atlantic	390	783	755	-3.6
East North Central	395	805	749	-7.0
East South Central	160	742	720	-2.9
West North Central	164	810	768	-5.1
West South Central	361	770	749	-2.8
Mountain	162	839	823	-1.8
Pacific	389	969	936	-3.4
Puerto Rico	51	370	364	-1.7
Rural by Region	978	546	536	-1.9
New England	24	723	655	-9.4
Middle Atlantic	70	556	541	-2.7
South Atlantic	171	538	532	-1.2
East North Central	121	569	559	-1.7
East South Central	176	496	491	-1.0
West North Central	103	569	558	-1.9
West South Central	209	508	498	-1.9
Mountain	72	548	546	-0.3
Pacific	32	690	680	-1.5
By Payment Classification:				
All hospitals	3,513	786	748	-4.8
Large urban areas (populations over 1 million)	1,417	861	810	-6.0
Other urban areas (populations of 1 million of fewer)	1,168	778	748	-3.9
Rural areas	928	545	534	-2.0
Teaching Status:				
Non-teaching	2,479	674	670	-0.6
Fewer than 100 Residents	800	797	766	-3.8
100 or more Residents	234	1,127	965	-14.4
Urban DSH:				
100 or more beds	1,552	852	802	-5.8
Less than 100 beds	339	590	582	-1.3

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
Rural DSH:				
Sole Community (SCH/EACH)	398	476	471	-1.0
Referral Center (RRC/EACH)	207	605	590	-2.5
Other Rural:				
100 or more beds	38	537	515	-4.3
Less than 100 beds	153	451	445	-1.4
Urban teaching and DSH:				
Both teaching and DSH	811	929	850	-8.5
Teaching and no DSH	163	817	770	-5.7
No teaching and DSH	1,080	716	713	-0.5
No teaching and no DSH	531	730	724	-0.7
Rural Hospital Types:				
Non special status hospitals	2,463	829	785	-5.3
RRC/EACH	61	724	717	-0.9
SCH/EACH	37	685	673	-1.8
Medicare-dependent hospitals (MDH)	8	453	451	-0.5
SCH, RRC and EACH	16	799	792	-0.9
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2010 Reclassifications:				
All Urban Reclassified	510	832	787	-5.3
All Urban Non-Reclassified	2,001	825	783	-5.0
All Rural Reclassified	354	591	581	-1.7
All Rural Non-Reclassified	562	478	467	-2.2
Other Reclassified Hospitals (Section 1886(d)(8)(B))	54	558	551	-1.3
Type of Ownership:				
Voluntary	2,015	800	760	-5.0
Proprietary	817	726	712	-2.0
Government	578	779	725	-6.9
Medicare Utilization as a Percent of Inpatient Days:				
0-25	241	1,028	914	-11.1
25-50	1,317	880	823	-6.4
50-65	1,423	696	679	-2.4
Over 65	388	613	602	-1.8

BILLING CODE 4210–01–C

IX. Effects of Proposed Payment Rate Changes and Policy Changes under the LTCH PPS

A. Introduction and General Considerations

In section VIII. of the preamble of this proposed rule, we are setting forth the proposed annual update to the payment rates for the LTCH PPS for RY 2010. In the preamble, we specify the statutory authority for the proposed provisions that are presented, identify those proposed policies where discretion has been exercised, and present rationale for our decisions as well as alternatives that were considered. In this section of Appendix A to this proposed rule, we discuss the impact of the proposed changes to the payment rates, factors, and other payment rate policies related to the LTCH PPS that are presented in the preamble of this proposed rule in terms of their estimated fiscal impact on the Medicare budget and on LTCHs.

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 proposed rates, factors and policies presented in this proposed rule, including proposed updated wage index values and the labor-related share, and the best available claims and CCR data to estimate the change in payments for 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 proposed rule, consistent with our historical practice, we are proposing to update the standard Federal rate for RY 2009 by 0.6 percent in order to establish the proposed RY 2010 standard Federal rate at $39,349.05. Based on the best available data for the 399 LTCHs in our database, we estimate that the proposed update to the standard Federal rate for RY 2010 (discussed in section VIII. of the preamble of this proposed rule) and the proposed changes to the area wage adjustment (discussed in section V.A. of the Addendum to this proposed rule) for the 2010 LTCH PPS rate year, in addition to an estimated increase in HCO payments and an estimated increase in SSO payments, would result in an increase in estimated payments from the 2009 LTCH PPS rate year of approximately $135 million (or about 2.8 percent). Based on the 399 LTCHs in our database, we estimate RY 2009 LTCH PPS payments to be approximately $4.76 billion and RY 2010 LTCH PPS payments to be approximately $4.90 billion. Because the combined distributional effects and estimated changes to the Medicare program payments would be greater than $100 million, this proposed rule is considered a major economic rule, as defined in this section. We note the approximately $135 million for the projected increase in estimated aggregate LTCH PPS payments from RY 2009 to RY 2010 do not reflect changes in LTCH admissions or case-mix intensity in estimated LTCH PPS payments, which would also affect overall payment changes.

The projected 2.8 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 proposed 0.6 percent increase to the standard Federal rate and projected increases in estimated HCO and SSO payments. As Table IV shows, the proposed change attributable solely to the standard Federal rate is projected to result in an increase of 0.5 percent in estimated payments per discharge from RY 2009 to RY 2010, on average, for all LTCHs, while the proposed changes to the area wage adjustment are projected to result in neither an increase nor 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 proposed update to the standard Federal rate, we estimate that the effect of the proposed 0.6 percent update to the standard Federal rate would result in a 0.5 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 proposed change to the standard Federal rate are projected to increase estimated payments from RY 2009 to RY 2010, the proposed changes to the area wage adjustment from RY 2009 to RY 2010 are expected to result in neither an increase nor a 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 proposed rule, we are proposing to update the wage index values for FY 2010 based on the most recent available data. In addition, we are proposing to increase the labor-related share from 75.662 percent to 75.904 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 proposed rule).

We note that the overall percent change in estimated LTCH payments from RY 2009 to RY 2010 for all proposed changes (shown in Column 8) cannot be determined by adding the incremental effect of the proposed standard Federal rate (Column 6) and the proposed 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 proposed change to the standard Federal rate or the proposed 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 proposed change to the standard Federal rate and the proposed 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 proposed changes, including the change in estimated HCO and SSO payments, are reflected in the estimated change in payments for all proposed changes for RY 2010 as compared to RY 2009 (shown in Column 8 of Table IV).

Notwithstanding this limitation in comparing the various columns in Table IV, the projected increase in payments per discharge from RY 2009 to RY 2010 is 2.8 percent (shown in Column 8). This projected increase in payments is attributable to the proposed impacts of the proposed change to the standard Federal rate (0.5 percent in Column 6) and the proposed change due to the area wage adjustment (0 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 of this proposed rule, an analysis of the most recent available LTCH PPS claims data (that is, FY 2008 claims from the December 2008 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 6.1 percent of estimated

total LTCH PPS payments in RY 2009. Consequently, it is necessary to propose 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 HCO payments would result in approximately a 2 percent increase in estimated payments from RY 2009 to RY 2010. 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 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 70 percent) are based on the estimated cost of the SSO case. A thorough discussion of the regulatory impact analysis for the proposed changes presented in this proposed rule can be found below in section V. of the Addendum to this proposed rule.

As we discuss in detail throughout this proposed rule, based on the most recent available data, we believe that the proposed provisions of this proposed rule relating to the LTCH PPS would 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 would result from the proposed changes presented in this proposed rule (that is, the update to the standard Federal rate discussed in section V.A. of the Addendum to this proposed rule and the proposed changes to the area wage adjustment as discussed in section V.B. of the Addendum to this proposed rule) as well as the effect of estimated changes to HCO and SSO payments. This estimated impact is based on the data of 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 estimated change in HCO payments; that is, our current estimate that HCO payments in RY 2009 will be less than 8 percent of total estimated LTCH PPS payments (as discussed in greater detail in section V.C. of the Addendum to this proposed rule), the proposed change to the standard Federal rate (as discussed in greater detail in section V.A. of the Addendum to this proposed rule), and the proposed change in the area wage adjustment (as discussed in greater detail in section V.B. of the Addendum to this proposed rule). We believe that the proposed changes to the area wage adjustment presented in this proposed rule (that is, the proposed use of updated wage data and the proposed change in the labor-related share) would result in accurate and appropriate LTCH PPS payments in 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.

C. Anticipated Effects of Proposed LTCH PPS Payment Rate Change and Policy Changes

We discuss the impact of the proposed changes to the payment rates, factors, and other payment rate policies under the LTCH PPS for RY 2010 (in terms of their estimated fiscal impact on the Medicare budget and on LTCHs) in section VIII. of the preamble of this proposed rule.

1. Budgetary Impact

Section 123(a)(1) of the BBRA requires that the PPS developed for LTCHs ''maintain budget neutrality.'' We believe that the statute's mandate for budget neutrality applies only to the first year of the implementation of the LTCH PPS (that is, FY 2003). Therefore, in calculating the FY 2003 standard Federal rate under § 412.523(d)(2), we set total estimated payments for FY 2003 under the LTCH PPS so that estimated aggregate payments under the LTCH PPS were estimated to equal the amount that would have been paid if the LTCH PPS had not been implemented.

As discussed in section IX.A. of this Appendix A, we project an increase in aggregate LTCH PPS payments in RY 2010 of approximately $135 million (or 2.8 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 proposed changes to the LTCH PPS payments presented in this proposed 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 proposed 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 proposed 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 proposed 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

over 400 LTCHs, the most recent growth is predominantly in for-profit LTCHs that 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 proposed RY 2010 standard Federal rate of $39,349.05, which would 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 proposed 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 of 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 proposed 2010 LTCH PPS rate year payments using the LTCH PPS proposed RY 2010 labor-related share of 75.904 percent (section VIII.C.2. of the preamble of this proposed rule), the proposed RY 2010 wage index values presented in the Tables 12A and 12B of the Addendum to this proposed rule, and the proposed RY 2010 COLA factors shown in the table in section V. of the Addendum to this proposed rule.

As discussed above, our impact analysis reflects an estimated change in payments for SSO cases as well as an estimated increase in payments for HCO cases (as described in section V.C. of the Addendum to this proposed rule). In modeling payments for SSO and HCO cases in RY 2009, we applied an inflation factor of 1.024 percent (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2008 MedPAR files and the best available CCRs from the December 2008 update of the PSF. In modeling proposed payments for SSO and HCO cases in RY 2010, we applied an inflation factor of 1.049 (determined by OACT) to the estimated costs of each case determined from the charges reported on the claims in the FY 2008 MedPAR files and the best available CCRs from the December 2008 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 proposed payment rates and policy changes presented in this proposed rule. Table IV illustrates the estimated aggregate impact of the LTCH PPS among various classifications of LTCHs.

- The first column, LTCH Classification, identifies the type of LTCH.
- The second column lists the number of LTCHs of each classification type.
- The third column identifies the number of LTCH cases.
- The fourth column shows the estimated payment per discharge for 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 proposed changes to the standard Federal rate (as discussed in section V. of the Addendum to this proposed 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 proposed changes to the area wage adjustment at § 412.525(c) (as discussed in section V.B.4. of the Addendum to this proposed 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 proposed changes (and includes the effect of estimated changes to HCO and SSO payments).

BILLING CODE 4210–01–P

TABLE IV: Impact of Proposed Payment Rate and Payment Rate Policy Changes to LTCH PPS Payments for RY 2010 (Estimated 2009 LTCH PPS Rate Year Payments Compared to Estimated Proposed 2010 LTCH PPS Rate Year Payments*)

LTCH Classification (1)	Number of LTCHs (2)	Number of LTCH PPS Cases (3)	Average RY 2009 LTCH PPS Rate Year Payment Per Case[1] (4)	Average Proposed RY 2010 LTCH PPS Rate Year Payment Per Case[2] (5)	Percent Change in Estimated Payments Per Discharge from RY 2009 to RY 2010 for Proposed Changes to the Federal Rate[3] (6)	Percent Change in Estimated Payments Per Discharge from RY 2009 to RY 2010 for Proposed Changes to the Area Wage Adjustment[4] (7)	Percent Change in Payments Per Discharge from RY 2009 to RY 2010 for All Proposed Changes[5] (8)
ALL PROVIDERS	399	132,383	$35,971	$36,991	0.5	0	2.8
BY LOCATION:							
RURAL	26	5,906	$31,230	$32,542	0.6	0.4	4.2
URBAN	373	126,477	$36,193	$37,198	0.5	-0.1	2.8
LARGE	192	76,045	$37,622	$38,698	0.5	0.1	2.9
OTHER	181	50,432	$34,038	$34,938	0.5	-0.3	2.6
BY PARTICIPATION DATE:							
BEFORE OCT. 1983	17	6,762	$31,739	$32,927	0.5	0.6	3.7
OCT. 1983 - SEPT. 1993	44	18,751	$36,297	$37,531	0.5	0.2	3.4
OCT. 1993 - SEPT. 2002	191	66,982	$35,605	$36,528	0.5	-0.1	2.6
AFTER OCTOBER 2002	136	37,643	$36,905	$37,926	0.5	-0.3	2.8
UNKNOWN PARTICIPATION DATE	11	2,245	$41,286	$42,818	0.5	0.7	3.7
BY OWNERSHIP TYPE:							
VOLUNTARY	81	21,914	$36,507	$37,722	0.5	-0.2	3.3
PROPRIETARY	267	100,286	$35,571	$36,486	0.5	0	2.6
GOVERNMENT	12	1,961	$40,606	$42,143	0.5	-0.3	3.8
UNKNOWN OWNERSHIP TYPE	39	8,147	$38,240	$39,881	0.6	0.2	4.3
BY REGION:							
NEW ENGLAND	15	8,102	$31,078	$32,317	0.5	0.8	4.0
MIDDLE ATLANTIC	29	8,368	$37,331	$37,974	0.5	-0.5	1.7
SOUTH ATLANTIC	49	13,592	$40,553	$41,723	0.5	-0.4	2.9
EAST NORTH CENTRAL	66	19,721	$39,896	$40,629	0.5	-0.7	1.8
EAST SOUTH CENTRAL	31	8,385	$36,394	$37,541	0.5	-0.1	3.2
WEST NORTH CENTRAL	21	5,234	$37,605	$38,687	0.5	0.2	2.9
WEST SOUTH CENTRAL	138	50,716	$31,313	$32,178	0.5	-0.2	2.8
MOUNTAIN	25	6,217	$38,642	$40,220	0.5	0.8	4.1
PACIFIC	25	11,973	$43,928	$45,601	0.5	1.3	3.8

LTCH Classification (1)	Number of LTCHs (2)	Number of LTCH PPS Cases (3)	Average RY 2009 LTCH PPS Rate Year Payment Per Case[1] (4)	Average Proposed RY 2010 LTCH PPS Rate Year Payment Per Case[2] (5)	Percent Change in Estimated Payments Per Discharge from RY 2009 to RY 2010 for Proposed Changes to the Federal Rate[3] (6)	Percent Change in Estimated Payments Per Discharge from RY 2009 to RY 2010 for Proposed Changes to the Area Wage Adjustment[4] (7)	Percent Change in Payments Per Discharge from RY 2009 to RY 2010 for All Proposed Changes[5] (8)
BY BED SIZE:							
BEDS: 0-24	42	6,439	$32,811	$34,055	0.6	0	3.8
BEDS: 25-49	191	44,236	$36,366	$37,265	0.5	-0.3	2.5
BEDS: 50-74	82	28,272	$35,983	$37,039	0.5	0	2.9
BEDS: 75-124	48	24,272	$38,076	$39,199	0.5	0.1	2.9
BEDS: 125-199	23	16,799	$34,356	$35,363	0.5	0	2.9
BEDS: 200 +	13	12,365	$34,175	$35,228	0.5	0.4	3.1

[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 proposed payment rates and proposed policy changes presented in the preamble and the Addendum of this proposed 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 proposed changes to the standard Federal rate, as discussed in section V.A. of the Addendum to this proposed rule.

[4] Percent change in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year for proposed changes to the area wage adjustment at §412.525(c) (as discussed in section V.B.4. of the Addendum to this proposed 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 proposed changes presented in the preamble of this proposed rule. Note, this column, which shows the percent change in estimated payments per discharge for all proposed changes, does not equal the sum of the percent changes in estimated payments per discharge for proposed changes to the standard Federal rate (column 6) and the proposed changes to the area wage adjustment (Column 7) due to the effect of estimated changes in both proposed 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.

BILLING CODE 4210–01–C

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 proposed LTCH PPS payment rate and policy changes presented in this proposed rule. The impact analysis in Table IV shows that estimated payments per discharge are expected to increase approximately 2.8 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 proposed payment rate and policy changes presented in this proposed rule as well as estimated increases in HCO and SSO payments. We note that we are proposing a 0.6 percent increase to the standard Federal rate for RY 2010, based on the latest market basket estimate (2.4 percent) and the proposed documentation and coding adjustment (−1.8 percent). We noted earlier in this section that or most categories of LTCHs, as shown in Table IV (Column 6), the impact of the proposed increase of 0.6 percent to the standard Federal rate is projected to result in a 0.5 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 proposed 0.6 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 2.8 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 2.8 (as shown in Table IV) was determined by comparing estimated RY 2010 LTCH PPS payments (using the proposed rates and policies discussed in this proposed 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 majority of LTCHs are in urban areas. Approximately 7 percent of the LTCHs are identified as being located in a rural area, and approximately 5 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 2.8 percent for all proposed changes. For rural LTCHs, the percent change for all proposed changes is estimated to be 4.2 percent, while for urban LTCHs, we estimate this increase to be the average of 2.8 percent. Large urban LTCHs are projected to experience a slightly higher than average increase (2.9 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 slightly lower than average increase (2.6 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 about the average increase (3.8 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 two participation categories where LTCHs began participating in Medicare before October 1983 (that is, the ''Before October 1983'' category and the ''October 1983 through September 1993'' category), LTCHs are projected to experience higher than average percent increases (3.7 and 3.4 percent, respectively) 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 proposed 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 proposed RY 2010 wage index value is greater than the RY 2009 wage index value, and also because the majority of these LTCHs have a proposed 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 higher than average increase in estimated payments because the majority (57 percent) are located in areas where the proposed RY 2010 wage index value would be greater than the RY 2009 wage index value. 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 would increase higher than the average (3.3 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 (2.6 percent) increase 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 higher than the average increase (3.8 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 would have the largest impact on LTCHs in the New England, East South Central, Mountain, and Pacific regions (4.0 percent, 3.2 percent, 4.1 percent, and 3.8 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 most regions is largely attributable to the projected increase in estimated HCO and SSO payments in addition to the proposed increase in the standard Federal rate and the proposed changes to the area wage adjustment. Specifically, for the

New England region, all the LTCHs located in this region have a proposed wage index value of greater than 1.0; and the majority (87 percent) of these LTCHs are located in areas where the proposed 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 East South Central region, as shown in Table IV, is due to the estimated increase in HCO payments, while for LTCHs in the Mountain and Pacific regions, the projected increase in payments is due to both the estimated increase in HCO payments and the significantly higher than average estimated impact from the proposed changes to the area wage adjustment. That is, the majority (60 percent) of the LTCHs located in the Mountain region have a proposed wage index value of greater than 1.0, and in addition, most of these LTCHs are located in areas where the proposed 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 proposed wage index value of greater than 1.0 and are located in areas where the proposed RY 2010 wage index value would be 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 1.7 percent for LTCHs in the Middle Atlantic region is primarily due to the 59 percent of LTCHs located in areas where the proposed 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 proposed 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 proposed changes in the area wage adjustment. For LTCHs in the Middle Atlantic and East North Central regions, the increase in estimated payments is less than the estimated average increase in payments for all providers due to the proposed changes in the area wage adjustment as discussed above. 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, 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 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. Approximately 38 percent of LTCHs are in bed size categories where estimated 2010 LTCH PPS rate year payments per discharge are projected to increase at or near the average increase for all LTCHS in comparison to estimated 2009 LTCH PPS rate year payments per discharge. That is, LTCHs in bed size categories of 50–74 beds, 75–124 beds, and 125–199 beds are projected to experience an overall increase of 2.9 percent. LTCHs in the bed size category of 0–24 beds are projected to experience a higher than the average increase (3.8 percent) in estimated payments per discharge from the 2009 LTCH PPS rate year to the 2010 LTCH PPS rate year due primarily to the estimated increase in HCO payments, while for LTCHs with 200+ beds, the projected increase in estimated payments is largely due to the significantly higher than average impact from the proposed changes to the area wage adjustment. Specifically, 69 percent of LTCHs in this category are expected to have a proposed RY 2010 wage index value of greater than 1.0, and 62 percent of the LTCHs in this category are located in areas where the proposed RY 2010 wage index value is greater than the RY 2009 wage index value. We are projecting a slightly lower than the average increase in estimated 2010 LTCH PPS rate year payments per discharge in comparison to the 2009 LTCH PPS rate year for LTCHs in bed size category 25–49 beds, which is largely due to the 87 percent of LTCHs in this category expected to have a proposed RY 2010 wage index value of less than 1.0. In addition, 54 percent of the LTCHs in this category are located in areas where the proposed RY 2010 wage index value is less than the RY 2009 wage index value.

D. Effect on the Medicare Program

As noted previously, we project that the provisions of this proposed rule would result in an increase in estimated aggregate LTCH PPS payments in RY 2010 of approximately $135 million (or about 2.8 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 proposed rule contains a range of policies. The preamble of this proposed rule provides descriptions of the statutory provisions that are addressed, identifies implementing policies where discretion has been exercised, and presents rationales for our decisions and, where relevant, alternatives that were considered.

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 proposed MS–DRG and wage index changes, and for the wage index reclassifications under the MGCRB. Table I also shows an overall decrease of 0.5 percent in operating payments. We estimate that operating payments will decrease by $586 million in FY 2010. This accounts for the projected savings associated with the HACs policy, which have an estimated savings of $21 million. In addition, this estimate includes the hospital reporting of quality data program costs of $2.39 million, and all proposed operating payment policies as described in section VII. of this Appendix. We estimate that capital payments will decrease by 4.8 percent per case, as shown in Table III of section VIII. of this Appendix. Therefore, we project that the decrease in capital payments in FY 2010 compared to FY 2009 will be approximately $393 million. The proposed cumulative operating and capital payments should result in a net decrease of $979 million to IPPS providers. The discussions presented in the previous pages, in combination with the rest of this

proposed rule, constitute a regulatory impact analysis.

B. LTCHs

Overall, LTCHs are projected to experience an increase in estimated payments per discharge in RY 2010. In the impact analysis, we are using the proposed rates, factors, and policies presented in this proposed rule, including proposed updated wage index values, and the 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 $135 million (or about 2.8 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 proposed rule as they relate to acute care hospitals. This table provides our best estimate of the increase in Medicare payments to providers as a result of the proposed changes to the IPPS presented in this proposed rule. All expenditures are classified as transfers to Medicare providers.

TABLE V—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM FY 2009 TO FY 2010

Category	Transfers
Annualized Monetized Transfers.	$ – 979 million.
From Whom to Whom	Federal Government to IPPS Medicare Providers.
Total	$ – 979 million.

B. LTCHs

As discussed in section IX. of this Appendix , the impact analysis for the proposed changes under the LTCH PPS for this proposed rule projects an increase in estimated aggregate payments of approximately $135 million (or about 2.8 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 we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule as they relate to proposed changes to the LTCH PPS. Table VI provides our best estimate of the proposed increase in Medicare payments under the LTCH PPS as a result of the proposed provisions presented in this proposed rule based on the data for the 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: $135 million.
From Whom To Whom.	Federal Government to LTCH Medicare Providers.

XIII. Executive Order 12866

In accordance with the provisions of Executive Order 12866, the Executive Office of Management and Budget reviewed this proposed rule.

Appendix B: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the MedPAC, recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish update factors recommended by the Secretary in the proposed and final IPPS rules, respectively. Accordingly, this Appendix provides the recommendations for the update factors for the IPPS national standardized amount, the Puerto Rico-specific standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for certain hospitals excluded from the IPPS, as well as LTCHs, IPFs, and IRFs. We also discuss our response to MedPAC's recommended update factors for inpatient hospital services.

II. Inpatient Hospital Update for FY 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, in this proposed rule, we are proposing 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. In addition to updating the base year to reflect more recent data, we also are proposing to make several changes to the structure of the market basket, including three new expense categories and revising several price proxies.

We also are proposing to rebase 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 proposing a labor-related share of 67.1, which is based on the proposed 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 proposed rule.

Consistent with current law, based on IHS Global Insight, Inc. 2009 first quarter forecast, with historical data through the 2008 fourth quarter, of the proposed rebased and revised FY 2006-based IPPS market basket, we are estimating that the FY 2010 update to the standardized amount will be 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, we are estimating that 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)(i) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. For FY 2010, we are proposing to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is estimated to be 2.1 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 estimated to be 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 Pub. L. 106–554, provides the statutory authority for updating payment rates under the LTCH PPS. In addition, section 124 of Public Law 106–113 provides the statutory authority for updating all aspects of the payment rates for IPFs.

Currently, children's hospitals, cancer hospitals, and RNHCIs are the remaining three types of hospitals still reimbursed under the reasonable cost methodology. We are proposing to provide our current estimate of the FY 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 proposed rule, we are proposing an update of 0.6 percent to the LTCH PPS Federal rate, which is based on a proposed market basket increase of 2.4 percent (based on IHS Global Insight, Inc.'s first quarter 2009 forecast of the FY 2002-based RPL market basket increase for RY 2010) and a proposed adjustment of −1.8 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity.

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS. IPF PPS payments are based on a Federal per diem rate that is derived from the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality.

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), and thereafter, the Federal prospective payments to IRFs are based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (69 FR 45721).

III. Secretary's Recommendation

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 first quarter forecast, with historical data through the 2008 fourth quarter, of the proposed 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 proposing to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is estimated to be 2.1 percent.

In addition to making a recommendation for IPPS hospitals, in accordance with section 1886(e)(4)(A) of the Act, we are recommending update factors for all other types of hospitals. Using IHS Global Insight, Inc.'s 2009 first quarter forecast, with historical data through the 2008 fourth quarter, of the proposed 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.

Based on IHS Global Insight, Inc.'s first quarter 2009 forecast of the RPL market basket increase, 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 proposal in section VIII. of the preamble of this proposed rule, we are recommending an update of 2.4 percent to the LTCH PPS Federal rate, which is based on a proposed market basket increase of 2.4 percent (based on IHS Global Insight, Inc.'s first quarter 2009 forecast of the FY 2002-based RPL market basket increase for RY 2010) and a proposed adjustment of −1.8 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, based on IHS Global Insight, Inc.'s first quarter 2009 forecast of the RPL market basket increase, we are recommending a 2.4 percent update to the IRF PPS Federal rate for FY 2010.

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 proposed rule, CMS implemented the MS–DRGs in FY 2008 to better account for severity of illness under the IPPS and is basing the DRG weights on costs rather than charges. We continue to believe that these refinements will better match Medicare payment of the cost of care and provide incentives for hospitals to be more efficient in controlling costs.

We note that, because the operating and capital prospective payment systems remain separate, we are proposing to continue to use separate updates for operating and capital payments. The proposed update to the capital rate is discussed in section III. of the Addendum to this proposed rule.

[FR Doc. E9–10458 Filed 5–1–09; 4:15 pm]

BILLING CODE 4120–01–P