Federal Register

Friday,
May 1, 2009

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2009 (RY 2010); Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1495–NC]

RIN 0938–AP50

Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2009 (RY 2010)

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

ACTION: Notice; request for comments.

SUMMARY: This notice updates the payment rates for the Medicare prospective payment system (PPS) for inpatient psychiatric hospital services provided by inpatient psychiatric facilities (IPFs). These changes are applicable to IPF discharges occurring during the rate year beginning July 1, 2009 through June 30, 2010. We are also requesting comments on the IPF PPS teaching adjustment and the market basket.

DATES:

Effective Date: The updated IPF prospective payment rates are effective for discharges occurring on or after July 1, 2009 through June 30, 2010.

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

ADDRESSES: In commenting, please refer to file code CMS–1495–NC. 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 specific issues in this regulation to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' and enter the file code to find the document accepting comments.

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–1495–NC, P.O. Box 8010, 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–1495–NC, 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) 786–9994 in advance to schedule your arrival with one of our staff members.

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

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

FOR FURTHER INFORMATION CONTACT: Dorothy Myrick or Jana Lindquist, (410) 786–4533 (for general information).

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

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

SUPPLEMENTARY INFORMATION: *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 on that Web site to view public comments.

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

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Acronyms

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

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

I. Background

A. Annual Requirements for Updating the IPF PPS

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

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

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

- A description of the methodology and data used to calculate the updated Federal per diem base payment amount.
- The rate of increase factor as described in § 412.424(a)(2)(iii), which is based on the excluded hospital with capital market basket under the update methodology of section 1886(b)(3)(B)(ii) of the Social Security Act (the Act) for each year (effective from the implementation period until June 30, 2006).
- For discharges occurring on or after July 1, 2006, the rate of increase factor for the Federal portion of the IPF's payment, which is based on the rehabilitation, psychiatric, and long-term care (RPL) market basket.
- The best available hospital wage index and information regarding whether an adjustment to the Federal per diem base rate is needed to maintain budget neutrality.
- Updates to the fixed dollar loss threshold amount in order to maintain the appropriate outlier percentage.
- Description of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM) coding and diagnosis-related groups (DRGs) classification changes discussed in the annual update to the hospital inpatient prospective payment system (IPPS) regulations.
- Update to the electroconvulsive therapy (ECT) payment by a factor specified by CMS.
- Update to the national urban and rural cost-to-charge ratio medians and ceilings.
- Update to the cost of living adjustment factors for IPFs located in Alaska and Hawaii, if appropriate.

Our most recent annual update occurred in the May 2008 IPF PPS notice (73 FR 25709) that set forth updates to the IPF PPS payment rates for RY 2009. This notice updates the IPF per diem payment rates that were published in the May 2008 IPF PPS notice in accordance with our established policies.

B. Overview of the Legislative Requirements for the IPF PPS

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

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

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

C. IPF PPS—General Overview

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

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

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

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

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

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

Section 124 of BBRA does not specify an annual update rate strategy for the IPF PPS and is broadly written to give the Secretary discretion in establishing an update methodology. Therefore, in the November 2004 IPF PPS final rule, we implemented the IPF PPS using the following update strategy:

- Calculate the final Federal per diem base rate to be budget neutral for the 18-month period of January 1, 2005 through June 30, 2006.
- Use a July 1 through June 30 annual update cycle.
- Allow the IPF PPS first update to be effective for discharges on or after July 1, 2006 through June 30, 2007.

II. Transition Period for Implementation of the IPF PPS

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

III. Updates to the IPF PPS for RY Beginning July 1, 2009

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

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

Section 124(a)(1) of the BBRA requires that we implement the IPF PPS in a budget neutral manner. In other words, the amount of total payments under the IPF PPS, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the IPF PPS were not implemented. Therefore, we calculated the budget-neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) methodology had the IPF PPS not been implemented.

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

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

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

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

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

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

2. Calculation of the Budget Neutrality Adjustment

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

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

a. Outlier Adjustment

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

b. Stop-Loss Provision Adjustment

As explained in the November 2004 IPF PPS final rule, we provided a stop-loss payment during the transition from cost-based reimbursement to the per diem payment system to ensure that an IPF's total PPS payments were no less than a minimum percentage of their TEFRA payment, had the IPF PPS not been implemented. We reduced the standardized Federal per diem base rate by the percentage of aggregate IPF PPS payments estimated to be made for stop-loss payments. As a result, the standardized Federal per diem base rate was reduced by 0.39 percent to account for stop-loss payments. Since the transition was completed in RY 2009,

the stop-loss provision is no longer applicable, and for cost reporting periods beginning on or after January 1, 2008, IPFs were paid 100 percent PPS.

c. Behavioral Offset

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

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

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

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

1. Market Basket for IPFs Reimbursed Under the IPF PPS

As described in the November 2004 IPF PPS final rule (69 FR 66931), the average per diem cost was updated to the midpoint of the implementation year. This updated average per diem cost of $724.43 was reduced by 17.46 percent to account for standardization to projected TEFRA payments for the implementation period, by 2 percent to account for outlier payments, by 0.39 percent to account for stop-loss payments, and by 2.66 percent to account for the behavioral offset. The Federal per diem base rate in the implementation year was $575.95. The increase in the per diem base rate for RY 2009 included the 0.39 percent increase due to the removal of the stop-loss provision. We indicated in the November 2004 IPF PPS final rule (69 FR 66932) that we would remove this 0.39 percent reduction to the Federal per diem base rate after the transition. For RY 2009 and beyond, the stop-loss provision has ended and is therefore no longer a part of budget neutrality.

Applying the market basket increase of 2.1 percent and the wage index budget neutrality factor of 1.0009 to the RY 2009 Federal per diem base rate of $637.78 yields a Federal per diem base rate of $651.76 for RY 2010. Similarly, applying the market basket increase and wage index budget neutrality factor to the RY 2009 ECT rate yields an ECT rate of $280.60 for RY 2010.

a. Market Basket Index for the IPF PPS

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

Beginning with the May 2006 IPF PPS final rule (71 FR 27046 through 27054), IPF PPS payments were updated using a 2002-based market basket reflecting the operating and capital cost structures for IRFs, IPFs, and LTCHs (hereafter referred to as the rehabilitation, psychiatric, long-term care (RPL) market basket).

We excluded cancer and children's hospitals from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which are implemented in regulations at § 413.40. They are not reimbursed through a PPS. Also, the FY 2002 cost structures for cancer and children's hospitals are noticeably different than the cost structures of the IRFs, IPFs, and LTCHs. A complete discussion of the RPL market basket appears in the May 2006 IPF PPS final rule (71 FR 27046 through 27054).

We seek comments below on the possibility of creating a stand-alone IPF market basket.

b. Overview of the RPL Market Basket

The RPL market basket is a fixed weight, Laspeyres-type price index. A market basket is described as a fixed-weight index because it answers the question of how much it would cost, at another time, to purchase the same mix (quantity and intensity) of goods and services needed 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. 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 that cost weights reflect recent changes in the mix of goods and services that hospitals purchase to furnish patient care between base periods.

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

Table 1 below sets forth the completed FY 2002-based RPL market basket including the cost categories, weights, and price proxies.

TABLE 1—FY 2002-BASED RPL MARKET BASKET COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Cost categories	FY 2002-based RPL market basket cost weight	FY 2002-based RPL market basket price proxies
Total	100.000	
Compensation	65.877	
Wages and Salaries*	52.895	ECI–Wages and Salaries, Civilian Hospital Workers.
Employee Benefits*	12.982	ECI–Benefits, Civilian Hospital Workers.
Professional Fees, Non-Medical*	2.892	ECI–Compensation for Professional & Related occupations.

TABLE 1—FY 2002-BASED RPL MARKET BASKET COST CATEGORIES, WEIGHTS, AND PRICE PROXIES—Continued

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

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

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

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

The RY 2010 (that is, beginning July 1, 2009) update for the IPF PPS using the FY 2002-based RPL market basket and Information Handling Services (IHS) Global Insight's 1st quarter 2009 forecast for the market basket components is 2.1 percent. This includes increases in both the operating section and the capital section for the 12-month RY period (that is, July 1, 2009 through June 30, 2010). IHS Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets.

2. Labor-Related Share

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

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

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

intensive services) is 71.935, as shown in below. The portion of capital that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage used in the FY 1997-based IRF and IPF payment systems.

Since the relative importance for capital is 8.596 percent of the FY 2002-based RPL market basket in RY 2010, we are taking 46 percent of 8.596 percent to determine the labor-related share of capital for RY 2010. The result is 3.954 percent, which we added to 71.935 percent for the operating cost amount to determine the total labor-related share for RY 2010. Thus, the labor-related share that we are using for IPF PPS in RY 2010 is 75.889 percent. Table 2 below shows the RY 2010 labor-related share using the FY 2002-based RPL market basket. We note that this labor-related share is determined by using the same methodology as employed in calculating all previous IPF labor-related shares.

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

TABLE 2—TOTAL LABOR-RELATED SHARE—RELATIVE IMPORTANCE FOR RY 2010

Cost category	FY 2002-based RPL market basket labor-related share relative importance (percent) RY 2009*	FY 2002-based RPL market basket labor-related share relative importance (percent) RY 2010**
Wages and salaries	52.645	53.062
Employee benefits	14.004	13.852
Professional fees	2.895	2.895
All other labor-intensive services	2.137	2.126
Subtotal	71.681	71.935
Labor-related share of capital costs (0.46)	3.950	3.954
Total	75.631	75.889

* Based on 2008 1st Quarter forecast.
** Based on 2009 1st Quarter forecast.

3. One-time Prospective Adjustment to the Standard Federal Rate

As we discussed in the November 2004 IPF PPS final rule, consistent with the statutory requirement for budget neutrality in section 124 of the BBRA, we estimated aggregate payments under the IPF PPS for the IPF PPS implementation year (that is, the 18-month period from January 1, 2005 through June 30, 2006) to be equal to the estimated aggregate payments that would be made if the IPF PPS had not been implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations used the best available data at the time and necessarily reflected several assumptions (for example, costs, inflation factors and intensity of services provided).

We indicated from the inception of the IPF PPS that it was possible for the aggregate amount of actual payments in the implementation year to be significantly higher or lower than the estimates on which the budget neutrality calculations were based to the extent that later, more complete data differ significantly from the data that were available at the time of the original calculations.

Section 124 of the BBRA provides broad authority to the Secretary in developing the IPF PPS, including the authority for establishing appropriate adjustments. Under this broad authority to make appropriate adjustments, we provided in § 412.424(c)(3)(ii) for the possibility of making a one-time prospective adjustment to the IPF PPS rates, so that the effect of any significant difference between actual payments and estimated payments for the first year of the IPF PPS would not be perpetuated in the IPF PPS rates for future years.

The November 2004 IPF PPS final rule implementing the IPF PPS (69 FR 66922), was based upon the broad authority granted to the Secretary under section 124 of the BBRA. In that same final rule, we discussed our authority to make a one-time prospective adjustment to the IPF PPS rates, which was reflected in § 412.424(c)(3)(ii).

Evaluating the appropriateness of the possible one-time prospective adjustment under § 412.424(c)(3)(ii) requires a thorough review of the relevant IPF data. When we established the IPF PPS Federal per diem base rate in a budget neutral manner, we used the most recent IPF cost report data available at that time (that is, FY 2002 data), and trended that data forward to estimate what CMS would have paid to IPFs in the implementation year under the TEFRA payment system if the PPS were not implemented (69 FR 66927). We have since conducted a review of the relevant data. From the cost reports, we have TEFRA and PPS payment data for January 1, 2005 through June 30, 2006, the 18-month period for the implementation of the IPF PPS. These data are drawn from reports with cost reporting periods beginning in FY 2005 and FY 2006. More than 70 percent of the cost reports from FY 2005 were settled. However, only approximately 33 percent of the cost reports from FY 2006 have been settled. The remaining 67 percent from FY 2006 are either as-submitted or have been reopened. Therefore, because we lack a complete set of final cost report data from the IPF PPS 18-month implementation period, we are not making a one-time adjustment to the IPF PPS rates for RY 2010.

We plan to revisit the possibility of making a one-time prospective adjustment to the IPF PPS rates as more cost report data becomes available.

IV. Update of the IPF PPS Adjustment Factors

A. Overview of the IPF PPS Adjustment Factors

The IPF PPS payment adjustments were derived from a regression analysis of 100 percent of the FY 2002 MedPAR data file, which contained 483,038 cases. For this notice, we used the same results of the regression analysis used to implement the November 2004 IPF PPS final rule. For a more detailed description of the data file used for the regression analysis, see the November 2004 IPF PPS final rule (69 FR 66935 through 66936). While we have since used more recent claims data to set the fixed dollar loss threshold amount, we use the same results of this regression

analysis to update the IPF PPS for RY 2009 as well as RY 2010.

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

B. Patient-Level Adjustments

In the May 2008 IPF PPS notice (73 FR 25709), we provided payment adjustments for the following patient-level characteristics: Medicare Severity diagnosis related groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments.

1. Adjustment for MS–DRG Assignment

The IPF PPS includes payment adjustments for the psychiatric DRG assigned to the claim based on each patient's principal diagnosis. The IPF PPS recognizes the MS–DRGs. The DRG adjustment factors were expressed relative to the most frequently reported psychiatric DRG in FY 2002, that is, DRG 430 (psychoses). The coefficient values and adjustment factors were derived from the regression analysis.

In accordance with § 412.27(a), payment under the IPF PPS is conditioned on IPFs admitting ''only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in Chapter Five (''Mental Disorders'') of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM)]'' or in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, (DSM–IV–TR). IPF claims with a principal diagnosis included in Chapter Five of the ICD–9–CM or the DSM–IV–TR are paid the Federal per diem base rate under the IPF PPS and all other applicable adjustments, including any applicable DRG adjustment. Psychiatric principal diagnoses that do not group to one of the designated DRGs still receive the Federal per diem base rate and all other applicable adjustments, but the payment would not include a DRG adjustment.

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

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

Every year, changes to the ICD–9–CM coding system are addressed in the IPPS proposed and final rules. The changes to the codes are effective October 1 of each year and must be used by acute care hospitals as well as other providers to report diagnostic and procedure information. The IPF PPS has always incorporated ICD–9–CM coding changes made in the annual IPPS update. We publish coding changes in a Transmittal/Change Request, similar to how coding changes are announced by the IPPS and LTCH PPS. Those ICD–9–CM coding changes are also published in the following IPF PPS RY update, in either the IPF PPS proposed and final rules, or in an IPF PPS update notice.

In the May 2008 IPF PPS notice (73 FR 25714), we discussed CMS' effort to better recognize resource use and the severity of illness among patients. CMS adopted the new MS–DRGs for the IPPS in the FY 2008 IPPS final rule with comment period (72 FR 47130). We believe by better accounting for patients' severity of illness in Medicare payment rates, the MS–DRGs encourage hospitals to improve their coding and documentation of patient diagnoses. The MS–DRGs, which are based on the CMS DRGs, represent a significant increase in the number of DRGs (from 538 to 745, an increase of 207). For a full description of the development and implementation of the MS–DRGs, see the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175).

All of the ICD–9–CM coding changes are reflected in the FY 2009 GROUPER, Version 26.0, effective for IPPS discharges occurring on or after October 1, 2008 through September 30, 2009. The GROUPER Version 26.0 software package assigns each case to an MS–DRG on the basis of the diagnosis and procedure codes and demographic information (that is, age, sex, and discharge status). The Medicare Code Editor (MCE) 25.0 uses the new ICD–9–CM codes to validate coding for IPPS discharges on or after October 1, 2008. For additional information on the GROUPER Version 26.0 and MCE 25.0, see Transmittal 1610 (Change Request 6189), dated October 3, 2008. The IPF PPS has always used the same GROUPER and Code Editor as the IPPS. Therefore, the ICD–9–CM changes, which were reflected in the GROUPER Version 26.0 and MCE 25.0 on October 1, 2008, also became effective for the IPF PPS for discharges occurring on or after October 1, 2008.

The impact of the new MS–DRGs on the IPF PPS was negligible. Mapping to the MS–DRGs resulted in the current 17 MS–DRGs, instead of the original 15, for which the IPF PPS provides an adjustment. Although the code set is updated, the same associated adjustment factors apply now that have been in place since implementation of the IPF PPS, with one exception that is unrelated to the update to the codes. When DRGs 521 and 522 were consolidated into MS–DRG 895, we carried over the adjustment factor of 1.02 from DRG 521 to the newly consolidated MS–DRG. This was done to reflect the higher claims volume under DRG 521, with more than eight times the number of claims than billed under DRG 522. The updates are reflected in Table 5. For a detailed description of the mapping changes from the original DRG adjustment categories to the current MS–DRG adjustment categories we refer readers to the May 2008 IPF PPS notice (73 FR 25714).

The official version of the ICD–9–CM is available on CD–ROM from the U.S. Government Printing Office. The FY 2009 version can be ordered by contacting the Superintendent of Documents, U.S. Government Printing Office, Department 50, Washington, DC 20402–9329, telephone number (202) 512–1800. Questions concerning the ICD–9–CM should be directed to Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care, Mailstop C4–08–06, 7500 Security

Boulevard, Baltimore, Maryland 21244–1850.

Further information concerning the official version of the ICD–9–CM can be found in the IPPS final rule with comment period, ''Changes to Hospital Inpatient Prospective Payment System and Fiscal Year 2009 Rates'' in the August 19, 2008 **Federal Register** (73 FR 48434) and at *http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp#TopOfPage.*

Tables 3 and 4 below list the FY 2009 new and invalid ICD–9–CM diagnosis codes that group to one of the 17 MS–DRGs for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2009 changes and do not reflect all of the currently valid and applicable ICD–9–CM codes classified in the MS–DRGs. When coded as a principal code or diagnosis, these codes receive the correlating MS–DRG adjustment.

TABLE 3—FY 2009 NEW DIAGNOSIS CODES

Diagnosis code	Description	MS–DRG
046.11	Variant Creutzfeldt-Jakob disease	056, 057
046.19	Other and unspecified Creutzfeldt-Jakob disease	056, 057
046.71	Gerstmann-Sträussler-Scheinker syndrome	056, 057
046.72	Fatal familial insomnia	056, 057
046.79	Other and unspecified prion disease of central nervous system	056, 057

TABLE 4—FY 2009 INVALID DIAGNOSIS CODES

Diagnosis code	Description	MS–DRG
046.1	Jakob-Creutzfeldt	056, 057

We do not plan to update the regression analysis until we are able to analyze IPF PPS data. The MS–DRG adjustment factors (as shown in Table 5) will continue to be paid for discharges occurring in RY 2010.

TABLE 5—RY 2010 CURRENT MS–DRGS APPLICABLE FOR THE PRINCIPAL DIAGNOSIS ADJUSTMENT

MS–DRG	MS–DRG descriptions	Adjustment factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
080	Nontraumatic stupor & coma w MCC	1.07
081	Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnoses of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

2. Payment for Comorbid Conditions

The intent of the comorbidity adjustments is to recognize the increased costs associated with comorbid conditions by providing additional payments for certain concurrent medical or psychiatric conditions that are expensive to treat. In the May 2008 IPF PPS notice (73 FR 25716), we explained that the IPF PPS includes 17 comorbidity categories and identified the new, revised, and deleted ICD–9–CM diagnosis codes that generate a comorbid condition payment adjustment under the IPF PPS for RY 2009 (73 FR 25718).

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

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

The comorbidity adjustments were determined based on the regression analysis using the diagnoses reported by IPFs in FY 2002. The principal diagnoses were used to establish the DRG adjustments and were not accounted for in establishing the comorbidity category adjustments, except where ICD–9–CM ''code first'' instructions apply. As we explained in

the May 2008 IPF PPS notice (73 FR 25716), the code first rule applies when a condition has both an underlying etiology and a manifestation due to the underlying etiology. For these conditions, the ICD–9–CM has a coding convention that requires the underlying conditions to be sequenced first followed by the manifestation. Whenever a combination exists, there is a ''use additional code'' note at the etiology code and a code first note at the manifestation code.

As discussed in the MS–DRG section, it is our policy to maintain the same diagnostic coding set for IPFs that is used under the IPPS for providing the same psychiatric care. Although the ICD–9–CM code set has been updated, the same adjustment factors have been in place since the implementation of the IPF PPS. Table 6 below lists the FY 2009 new ICD diagnosis codes that impact the comorbidity adjustments under the IPF PPS. Table 6 is not a list of all currently valid ICD codes applicable for the IPF PPS comorbidity adjustments.

TABLE 6—FY 2009 NEW ICD CODES APPLICABLE FOR THE COMORBIDITY ADJUSTMENT

Diagnosis code	Description	Comorbidity category
038.12	Methicillin resistant Staphylococcus aureus septicemia	Infectious Disease.
046.11	Variant Creutzfeldt-Jakob disease	Infectious Disease.
046.19	Other and unspecified Creutzfeldt-Jakob disease	Infectious Disease.
046.71	Gerstmann-Sträussler-Scheinker syndrome	Infectious Disease.
046.72	Fatal familial insomnia	Infectious Disease.
046.79	Other and unspecified prion disease of central nervous system	Infectious Disease.
051.01	Cowpox	Infectious Disease.
051.02	Vaccinia not from vaccination	Infectious Disease.
059.00	Orthopoxvirus infection, unspecified	Infectious Disease.
059.01	Monkeypox	Infectious Disease.
059.09	Other orthopoxvirus infections	Infectious Disease.
059.10	Parapoxvirus infection, unspecified	Infectious Disease.
059.11	Bovine stomatitis	Infectious Disease.
059.12	Sealpox	Infectious Disease.
059.19	Other parapoxvirus infections	Infectious Disease.
059.20	Yatapoxvirus infection, unspecified	Infectious Disease.
059.21	Tanapox	Infectious Disease.
059.22	Yaba monkey tumor virus	Infectious Disease.
059.8	Other poxvirus infections	Infectious Disease.
059.9	Poxvirus infections, unspecified	Infectious Disease.
199.2	Malignant neoplasm associated with transplant organ	Oncology Treatment.
203.02	Multiple myeloma, in relapse	Oncology Treatment.
203.12	Plasma cell leukemia, in relapse	Oncology Treatment.
203.82	Other immunoproliferative neoplasms, in relapse	Oncology Treatment.
204.02	Acute lymphoid leukemia, in relapse	Oncology Treatment.
204.12	Chronic lymphoid leukemia, in relapse	Oncology Treatment.
204.22	Subacute lymphoid leukemia, in relapse	Oncology Treatment.
204.82	Other lymphoid leukemia, in relapse	Oncology Treatment.
204.92	Unspecified lymphoid leukemia, in relapse	Oncology Treatment.
205.02	Acute myeloid leukemia, in relapse	Oncology Treatment.
205.12	Chronic myeloid leukemia, in relapse	Oncology Treatment.
205.22	Subacute myeloid leukemia, in relapse	Oncology Treatment.
205.32	Myeloid sarcoma, in relapse	Oncology Treatment.
205.82	Other myeloid leukemia, in relapse	Oncology Treatment.
205.92	Unspecified myeloid leukemia, in relapse	Oncology Treatment.
206.02	Acute monocytic leukemia, in relapse	Oncology Treatment.
206.12	Chronic monocytic leukemia, in relapse	Oncology Treatment.
206.22	Subacute monocytic leukemia, in relapse	Oncology Treatment.
206.82	Other monocytic leukemia, in relapse	Oncology Treatment.
206.92	Unspecified monocytic leukemia, in relapse	Oncology Treatment.
207.02	Acute erythremia and erythroleukemia, in relapse	Oncology Treatment.
207.12	Chronic erythremia, in relapse	Oncology Treatment.
207.22	Megakaryocytic leukemia, in relapse	Oncology Treatment.
207.82	Other specified leukemia, in relapse	Oncology Treatment.
208.02	Acute leukemia of unspecified cell type, in relapse	Oncology Treatment.
208.12	Chronic leukemia of unspecified cell type, in relapse	Oncology Treatment.
208.22	Subacute leukemia of unspecified cell type, in relapse	Oncology Treatment.
208.82	Other leukemia of unspecified cell type, in relapse	Oncology Treatment.
208.92	Unspecified leukemia, in relapse	Oncology Treatment.
209.00	Malignant carcinoid tumor of the small intestine, unspecified portion	Oncology Treatment.
209.01	Malignant carcinoid tumor of the duodenum	Oncology Treatment.
209.02	Malignant carcinoid tumor of the jejunum	Oncology Treatment.
209.03	Malignant carcinoid tumor of the ileum	Oncology Treatment.
209.10	Malignant carcinoid tumor of the large intestine, unspecified portion	Oncology Treatment.
209.11	Malignant carcinoid tumor of the appendix	Oncology Treatment.
209.12	Malignant carcinoid tumor of the cecum	Oncology Treatment.
209.13	Malignant carcinoid tumor of the ascending colon	Oncology Treatment.
209.14	Malignant carcinoid tumor of the transverse colon	Oncology Treatment.
209.15	Malignant carcinoid tumor of the descending colon	Oncology Treatment.
209.16	Malignant carcinoid tumor of the sigmoid colon	Oncology Treatment.
209.17	Malignant carcinoid tumor of the rectum	Oncology Treatment.

TABLE 6—FY 2009 NEW ICD CODES APPLICABLE FOR THE COMORBIDITY ADJUSTMENT—Continued

Diagnosis code	Description	Comorbidity category
209.20	Malignant carcinoid tumor of unknown primary site	Oncology Treatment.
209.21	Malignant carcinoid tumor of the bronchus and lung	Oncology Treatment.
209.22	Malignant carcinoid tumor of the thymus	Oncology Treatment.
209.23	Malignant carcinoid tumor of the stomach	Oncology Treatment.
209.24	Malignant carcinoid tumor of the kidney	Oncology Treatment.
209.25	Malignant carcinoid tumor of foregut, not otherwise specified	Oncology Treatment.
209.26	Malignant carcinoid tumor of midgut, not otherwise specified	Oncology Treatment.
209.27	Malignant carcinoid tumor of hindgut, not otherwise specified	Oncology Treatment.
209.29	Malignant carcinoid tumor of other sites	Oncology Treatment.
209.30	Malignant poorly differentiated neuroendocrine carcinoma, any site	Oncology Treatment.
209.40	Benign carcinoid tumor of the small intestine, unspecified portion	Oncology Treatment.
209.41	Benign carcinoid tumor of the duodenum	Oncology Treatment.
209.42	Benign carcinoid tumor of the jejunum	Oncology Treatment.
209.43	Benign carcinoid tumor of the ileum	Oncology Treatment.
209.50	Benign carcinoid tumor of the large intestine, unspecified portion	Oncology Treatment.
209.51	Benign carcinoid tumor of the appendix	Oncology Treatment.
209.52	Benign carcinoid tumor of the cecum	Oncology Treatment.
209.53	Benign carcinoid tumor of the ascending colon	Oncology Treatment.
209.54	Benign carcinoid tumor of the transverse colon	Oncology Treatment.
209.55	Benign carcinoid tumor of the descending colon	Oncology Treatment.
209.56	Benign carcinoid tumor of the sigmoid colon	Oncology Treatment.
209.57	Benign carcinoid tumor of the rectum	Oncology Treatment.
209.60	Benign carcinoid tumor of unknown primary site	Oncology Treatment.
209.61	Benign carcinoid tumor of the bronchus and lung	Oncology Treatment.
209.62	Benign carcinoid tumor of the thymus	Oncology Treatment.
209.63	Benign carcinoid tumor of the stomach	Oncology Treatment.
209.64	Benign carcinoid tumor of the kidney	Oncology Treatment.
209.65	Benign carcinoid tumor of foregut, not otherwise specified	Oncology Treatment.
209.66	Benign carcinoid tumor of midgut, not otherwise specified	Oncology Treatment.
209.67	Benign carcinoid tumor of hindgut, not otherwise specified	Oncology Treatment.
209.69	Benign carcinoid tumor of other sites	Oncology Treatment.
238.77	Post-transplant lymphoproliferative disorder (PTLD)	Oncology Treatment.
V45.11	Renal dialysis status	Chronic Renal Failure.
V45.12	Noncompliance with renal dialysis	Chronic Renal Failure.

Table 7 lists the FY 2009 revised ICD diagnosis codes that are applicable for the comorbidity adjustment.

TABLE 7—FY 2009 REVISED ICD CODES APPLICABLE FOR THE COMORBIDITY ADJUSTMENT

Diagnosis code	Description	Comorbidity category
038.11	Methicillin susceptible Staphylococcus aureus septicemia	Infectious Disease.
203.00	Multiple myeloma, without mention of having achieved remission	Oncology Treatment.
203.10	Plasma cell leukemia, without mention of having achieved remission	Oncology Treatment.
203.80	Other immunoproliferative neoplasms, without mention of having achieved remission.	Oncology Treatment.
204.00	Acute lymphoid leukemia, without mention of having achieved remission	Oncology Treatment.
204.10	Chronic lymphoid leukemia, without mention of having achieved remission	Oncology Treatment.
204.20	Subacute lymphoid leukemia, without mention of having achieved remission	Oncology Treatment.
204.80	Other lymphoid leukemia, without mention of having achieved remission	Oncology Treatment.
204.90	Unspecified lymphoid leukemia, without mention of having achieved remission	Oncology Treatment.
205.00	Acute myeloid leukemia, without mention of having achieved remission	Oncology Treatment.
205.10	Chronic myeloid leukemia, without mention of having achieved remission	Oncology Treatment.
205.20	Subacute myeloid leukemia, without mention of having achieved remission	Oncology Treatment.
205.30	Myeloid sarcoma, without mention of having achieved remission	Oncology Treatment.
205.80	Other myeloid leukemia, without mention of having achieved remission	Oncology Treatment.
205.90	Unspecified myeloid leukemia, without mention of having achieved remission	Oncology Treatment.
206.00	Acute monocytic leukemia, without mention of having achieved remission	Oncology Treatment.
206.10	Chronic monocytic leukemia, without mention of having achieved remission	Oncology Treatment.
206.20	Subacute monocytic leukemia, without mention of having achieved remission	Oncology Treatment.
206.80	Other monocytic leukemia, without mention of having achieved remission	Oncology Treatment.
206.90	Unspecified monocytic leukemia, without mention of having achieved remission	Oncology Treatment.
207.00	Acute erythremia and erythroleukemia, without mention of having achieved remission.	Oncology Treatment.
207.10	Chronic erythremia, without mention of having achieved remission	Oncology Treatment.

TABLE 7—FY 2009 REVISED ICD CODES APPLICABLE FOR THE COMORBIDITY ADJUSTMENT—Continued

Diagnosis code	Description	Comorbidity category
207.20	Megakaryocytic leukemia, without mention of having achieved remission	Oncology Treatment.
207.80	Other specified leukemia, without mention of having achieved remission	Oncology Treatment.
208.00	Acute leukemia of unspecified cell type, without mention of having achieved remission.	Oncology Treatment.
208.10	Chronic leukemia of unspecified cell type, without mention of having achieved remission.	Oncology Treatment.
208.20	Subacute leukemia of unspecified cell type, without mention of having achieved remission.	Oncology Treatment.
208.80	Other leukemia of unspecified cell type, without mention of having achieved remission.	Oncology Treatment.
208.90	Unspecified leukemia, without mention of having achieved remission	Oncology Treatment.

Table 8 lists the invalid FY 2009 ICD–9–CM codes no longer applicable for the comorbidity adjustment.

TABLE 8—FY 2009 INVALID ICD CODES NO LONGER APPLICABLE FOR THE COMORBIDITY ADJUSTMENT

Diagnosis Code	Description	Comorbidity category
046.1	Jakob-Creutzfeldt disease	Infectious Disease.
051.0	Cowpox	Infectious Disease.
V45.1	Renal dialysis status	Chronic Renal Failure.

For RY 2010, we are applying the seventeen comorbidity categories for which we are providing an adjustment, their respective codes, including the new FY 2009 ICD–9–CM codes, and their respective adjustment factors in Table 9 below.

TABLE 9—RY 2010 DIAGNOSIS CODES AND ADJUSTMENT FACTORS FOR COMORBIDITY CATEGORIES

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

3. Patient Age Adjustments

As explained in the November 2004 IPF PPS final rule (69 FR 66922), we analyzed the impact of age on per diem cost by examining the age variable (that is, the range of ages) for payment adjustments.

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

For RY 2010, we are continuing to use the patient age adjustments currently in effect as shown in Table 10 below.

TABLE 10—AGE GROUPINGS AND ADJUSTMENT FACTORS

Age	Adjustment factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

4. Variable Per Diem Adjustments

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

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

For RY 2010, we are to continuing to use the variable per diem adjustment factors currently in effect as shown in Table 11 below. A complete discussion of the variable per diem adjustments appears in the November 2004 IPF PPS final rule (69 FR 66946).

TABLE 11—VARIABLE PER DIEM ADJUSTMENTS

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

C. Facility-Level Adjustments

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

1. Wage Index Adjustment

a. Background

As discussed in the May 2006 IPF PPS final rule and in the May 2007 and May 2008 update notices, in providing an adjustment for geographic wage levels, the labor-related portion of an IPF's payment is adjusted using an appropriate wage index. Currently, an IPF's geographic wage index value is determined based on the actual location of the IPF in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through § 412.64(C).

b. Wage Index for RY 2010

Since the inception of the IPF PPS, we have used hospital wage data in developing a wage index to be applied to IPFs. We are continuing that practice for RY 2010. We apply the wage index adjustment to the labor-related portion of the Federal rate, which is 75.889 percent. This percentage reflects the labor-related relative importance of the RPL market basket for RY 2010 (see section III.B.2 of this notice). The IPF PPS uses the pre-floor, pre-reclassified hospital wage index. Changes to the wage index are made in a budget neutral manner so that updates do not increase expenditures.

For RY 2010, we are applying the most recent hospital wage index (that is, the FY 2009 pre-floor, pre-reclassified hospital wage index because this is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data (that is, data from FY 2005 hospital cost reports), and applying an adjustment in accordance with our budget neutrality policy. This policy requires us to estimate the total amount of IPF PPS payments in RY 2009 using the applicable wage index value divided by the total estimated IPF PPS payments in RY 2010 using the most recent wage index. The estimated payments are based on FY 2007 IPF claims, inflated to the appropriate RY. This quotient is the wage index budget neutrality factor, and it is applied in the update of the Federal per diem base rate for RY 2010 in addition to the market basket described in section III.B.1 of this notice. The wage index budget neutrality factor for RY 2010 is 1.0009.

The wage index applicable for RY 2010 appears in Table 1 and Table 2 in Addendum B of this notice. As explained in the May 2006 IPF PPS final rule for RY 2007 (71 FR 27061), the IPF PPS applies the hospital wage index without a hold-harmless policy, and without an out-commuting adjustment or out-migration adjustment because the statutory authority for these policies applies only to the IPPS.

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

As was the case in RY 2009, for RY 2010 we will continue to use the CBSA-based wage index values as presented in Tables 1 and 2 in Addendum B of this notice. A complete discussion of the CBSA labor market definitions appears in the May 2006 IPF PPS final rule (71 FR 27061 through 27067).

c. OMB Bulletins

The Office of Management and Budget (OMB) publishes bulletins regarding CBSA changes, including changes to CBSA numbers and titles. In the May 2008 IPF PPS notice, we incorporated the CBSA nomenclature changes published in the most recent OMB bulletin that applies to the hospital

wage data used to determine the current IPF PPS wage index (73 FR 25721). We will continue to do the same for all such OMB CBSA nomenclature changes in future IPF PPS rules and notices, as necessary. The OMB bulletins may be accessed Online at http://www.whitehouse.gov/omb/bulletins/index.html.

In summary, for RY 2010 we will use the FY 2009 wage index data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2005) to adjust IPF PPS payments beginning July 1, 2009.

2. Adjustment for Rural Location

In the November 2004 IPF PPS final rule, we provided a 17 percent payment adjustment for IPFs located in a rural area. This adjustment was based on the regression analysis, which indicated that the per diem cost of rural facilities was 17 percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression. For RY 2010, we are applying a 17 percent payment adjustment for IPFs located in a rural area as defined at § 412.64(b)(1)(ii)(C). As stated in the November 2004 IPF PPS final rule, we do not intend to update the adjustment factors derived from the regression analysis until we are able to analyze IPF PPS data. A complete discussion of the adjustment for rural locations appears in the November 2004 IPF PPS final rule (69 FR 66954).

3. Teaching Adjustment

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

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

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

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

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

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

As with other adjustment factors derived through the regression analysis, we do not plan to rerun the regression analysis until we analyze IPF PPS data. Therefore, for RY 2010, we are retaining the coefficient value of 0.5150 for the teaching adjustment to the Federal per diem base rate.

A complete discussion of how the teaching adjustment was calculated appears in the November 2004 IPF PPS final rule (69 FR 66954 through 66957) and the May 2008 IPF PPS notice (73 FR 25721). Below, in the ''Request for Comments'' section of this notice, we are seeking public input on the FTE Intern and Resident Cap Adjustment.

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

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the county in which the IPF is located. As we explained in the November 2004 IPF PPS final rule, the FY 2002 data demonstrated that IPFs in Alaska and Hawaii had per diem costs that were disproportionately higher than other IPFs. Other Medicare PPSs (for example, the IPPS and LTCH PPS) have adopted a cost of living adjustment (COLA) to account for the cost differential of care furnished in Alaska and Hawaii.

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

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

As previously stated in the November 2004 IPF PPS final rule, we will update the COLA factors according to updates established by the U.S. Office of Personnel Management (OPM), which issued a final rule, May 28, 2008 to change COLA rates.

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

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

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

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

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

(d) Rest of the State of Alaska.

For RY 2010, IPFs located in Alaska and Hawaii will continue to receive the updated COLA factors based on the COLA area in which the IPF is located as shown in Table 12 below.

TABLE 12—COLA FACTORS FOR ALASKA AND HAWAII IPFS

	Location	COLA
Alaska	Anchorage	1.23
	Fairbanks	1.23
	Juneau	1.23
	Rest of Alaska	1.25
Hawaii	Honolulu County	1.25
	Hawaii County	1.18
	Kauai County	1.25
	Maui County	1.25
	Kalawao County	1.25

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

Currently, the IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs. We provide an adjustment to the Federal per diem base rate to account for the costs associated with maintaining a full-service ED. The adjustment is intended to account for ED costs incurred by a freestanding psychiatric hospital with a qualifying ED or a distinct part psychiatric unit of an acute hospital or a CAH for preadmission services otherwise payable under the Medicare Outpatient Prospective Payment System (OPPS) furnished to a beneficiary during the day immediately preceding the date of admission to the IPF (see § 413.40(c)(2)) and the overhead cost of maintaining the ED. This payment is a facility-level adjustment that applies to all IPF admissions (with one exception described below), regardless of whether a particular patient receives preadmission services in the hospital's ED.

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

The ED adjustment is made on every qualifying claim except as described below. As specified in § 412.424(d)(1)(v)(B), the ED adjustment is not made where a patient is discharged from an acute care hospital or critical access hospital (CAH) and admitted to the same hospital's or CAH's psychiatric unit. An ED adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH. If we provided the ED adjustment in these cases, the hospital would be paid twice for the overhead costs of the ED, as stated in the November 2004 IPF PPS final rule (69 FR 66960).

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

For RY 2010, we are retaining the 1.31 adjustment factor for IPFs with qualifying EDs. A complete discussion of the steps involved in the calculation of the ED adjustment factor appears in the November 2004 IPF PPS final rule (69 FR 66959 through 66960) and the May 2006 IPF PPS final rule (71 FR 27070 through 27072).

D. Other Payment Adjustments and Policies

For RY 2010, the IPF PPS includes: An outlier adjustment to promote access to IPF care for those patients who require expensive care and to limit the financial risk of IPFs treating unusually costly patients. In this section, we also explain the reason for ending the stop-loss provision that was applicable during the transition period.

1. Outlier Payments

In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(3)(i) to provide a per-case payment for IPF stays that are extraordinarily costly. Providing additional payments to IPFs for extremely costly cases strongly improves the accuracy of the IPF PPS in determining resource costs at the patient and facility level. These additional payments reduce the financial losses that would otherwise be incurred in treating patients who require more costly care and, therefore, reduce the incentives for IPFs to under-serve these patients.

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

In instances when the case qualifies for an outlier payment, we pay 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay (consistent with the median LOS for IPFs in FY 2002), and 60 percent of the difference for day 10 and thereafter. We established the 80 percent and 60 percent loss sharing ratios because we were concerned that a single ratio established at 80 percent (like other Medicare PPSs) might provide an incentive under the IPF per diem payment system to increase LOS in order to receive additional payments. After establishing the loss sharing ratios, we determined the current fixed dollar loss threshold amount of $6,113 through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target.

a. Update to the Outlier Fixed Dollar Loss Threshold Amount:

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

We believe it is necessary to update the fixed dollar loss threshold amount because analysis of the latest available data (that is, FY 2007 IPF claims) and rate increases indicates adjusting the fixed dollar loss amount is necessary in order to maintain an outlier percentage that equals 2 percent of total estimated IPF PPS payments.

In the May 2006 IPF PPS final rule (71 FR 27072), we describe the process by which we calculate the outlier fixed dollar loss threshold amount. We continue to use this process for RY 2010. We begin by simulating aggregate payments with and without an outlier policy, and applying an iterative process to a fixed dollar loss amount that will result in outlier payments being equal to 2 percent of total estimated payments under the simulation. Based on this process, for RY 2010, the IPF PPS will use $6,565 as the fixed dollar loss threshold amount in the outlier calculation in order to maintain the 2 percent outlier policy.

b. Statistical Accuracy of Cost-to-Charge Ratios

As previously stated, under the IPF PPS, an outlier payment is made if an IPF's cost for a stay exceeds a fixed dollar loss threshold amount. In order to establish an IPF's cost for a particular case, we multiply the IPF's reported

charges on the discharge bill by its overall cost-to-charge ratio (CCR). This approach to determining an IPF's cost is consistent with the approach used under the IPPS and other PPSs. In FY 2004, we implemented changes to the IPPS outlier policy used to determine CCRs for acute care hospitals because we became aware that payment vulnerabilities resulted in inappropriate outlier payments. Under the IPPS, we established a statistical measure of accuracy for CCRs in order to ensure that aberrant CCR data did not result in inappropriate outlier payments.

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

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

To determine the rural and urban ceilings, we multiplied each of the standard deviations by 3 and added the result to the appropriate national CCR average (either rural or urban). The upper threshold CCR for IPFs in RY 2010 is 1.7381 for rural IPFs, and 1.7647 for urban IPFs, based on CBSA-based geographic designations. If an IPF's CCR is above the applicable ceiling, the ratio is considered statistically inaccurate and we assign the appropriate national (either rural or urban) median CCR to the IPF.

We are applying the national CCRs to the following situations:

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

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

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

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

We are not making any changes to the procedures for ensuring the statistical accuracy of CCRs in RY 2010. However, we are updating the national urban and rural CCRs (ceilings and medians) for IPFs for RY 2010 based on the CCRs entered in the latest available IPF PPS Provider Specific File.

The national CCRs for RY 2010 are 0.6515 for rural IPFs and 0.5300 for urban IPFs and will be used in each of the three situations listed above. These calculations are based on the IPF's location (either urban or rural) using the CBSA-based geographic designations.

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

2. Expiration of the Stop-Loss Provision

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

In the implementation year, the 70 percent of TEFRA payment stop-loss policy required a reduction in the standardized Federal per diem and ECT base rates of 0.39 percent in order to make the stop-loss payments budget neutral. As described in the May 2008 IPF PPS notice for RY 2009, we increased the Federal per diem base rate and ECT rate by 0.39 percent because these rates were reduced by 0.39 percent in the implementation year to ensure stop-loss payments were budget neutral.

The stop-loss provision ended during RY 2009 (that is for discharges occurring on or after July 1, 2008 through June 30, 2009). The stop-loss policy is no longer applicable under the IPF PPS.

V. Request for Comments

A. Market Basket Index for the IPF PPS; Costs and Cost Structures of IPF Providers

We are interested in exploring the possibility of creating a stand-alone IPF market basket that reflects the cost structures of only IPF providers. The intent would be to join the Medicare cost report data from freestanding IPF providers (presently incorporated into the RPL market basket) with data from hospital-based IPF providers.

An examination of the Medicare cost report data comparing freestanding and hospital-based IPFs reveals considerable differences in both cost levels and cost structure. We have reviewed several explanatory variables such as geographic variation, case mix (including DRG, comorbidity, and age), urban or rural status, length of stay, teaching status, and presence of a qualifying emergency department; however, we are currently unable to fully understand the differences between these two types of IPF providers. As a result, we feel that further research is required. Having examined the relevant data that is internal to CMS, we welcome any help from the public in the form of additional information, data, or suggested data sources that may help us to better understand the underlying reasons for the variations in cost structures between freestanding and hospital-based IPFs.

B. FTE Intern and Resident Cap Adjustment

As previously mentioned, the IPF PPS imposed a cap on the number of full-time equivalent (FTE) residents that may be used to calculate the teaching status adjustment. The cap is based on the number of FTE residents reported in the IPF's most recent cost report filed before November 15, 2004.

CMS has been asked to reconsider its position under the IPF PPS regulations regarding application of the FTE resident cap when residents in a psychiatry residency program must be relocated from one IPF to another. Specifically, we have been asked to reconsider our current policy and permit an increase in the FTE resident cap when the IPF increases the number of FTE residents it trains due to the acceptance of relocated residents when another IPF closes or closes its psychiatry residency program.

Currently, if an IPF with a psychiatry residency training program agrees to accept residents relocated from another IPF after November 2004, the IPF's FTE resident count would continue to be capped at the number of FTE residents included in the cost report filed before November 15, 2004. Furthermore, according to § 412.424(d)(1)(iii)(D), an adjustment to the FTE resident cap can only be made for those IPFs that begin training residents in a new approved psychiatric residency program after November 15, 2004. For a new program adjustment, the IPF's FTE cap would be revised beginning with the fourth year of the new training program. We included these policies because we believe it is important to limit the total pool of FTE resident cap positions within the IPF community and avoid incentives for IPFs to add FTE residents in order to increase their payments.

We are now assessing how many IPFs have been, or expect to be, adversely affected by their inability to adjust their caps under § 412.424(d)(1) in situations

where residents from a hospital that closed or from a program that closed at a hospital are moved to another hospital to complete their training. To help us access this situation, we specifically request public comment from IPFs to help us understand the impact of this issue on IPFs. At a minimum, we need to know the following information:

1. How many IPFs currently training additional residents from a closed residency program have exceeded their caps because of those residents?

2. How many IPFs have been asked to train additional residents from a closed residency program but have not currently agreed because these additional residents would cause them to exceed the caps?

We will take all comments into consideration as we assess the IPF PPS regulations with respect to the FTE resident cap and the relocation of FTE residents from one IPF to another due to closure of an IPF or an IPF's psychiatry residency training program.

VI. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect. We can waive this procedure, however, if we find good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest and we incorporate a statement of finding and its reasons in the notice. We find it is unnecessary to undertake notice and comment rulemaking for the update in this notice because the update does not make any substantive changes in policy, but merely reflects the application of previously established methodologies. Therefore, under 5 U.S.C. 553(b)(3)(B), for good cause, we waive notice and comment procedures.

VII. Collection of Information Requirement

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

VIII. 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.

IX. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the September 19, 1980 Regulatory Flexibility Act (RFA) (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). Although this notice does not meet the $100 million threshold established by Executive Order 12866, we are considering this notice to be ''economically significant'' because the redistributive effects are estimated to be close to constituting a shift of $100 million. For purposes of Title 5, United States Code, section 804(2), we estimate that this rulemaking is ''economically significant'', and is also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking on the 1,706 IPFs.

The updates to the IPF labor-related share and wage indices are made in a budget neutral manner and thus have no effect on estimated costs to the Medicare program. Therefore, the estimated increased cost to the Medicare program is due to the updated IPF payment rates, which results in an approximate $91 million increase in payments, and the increase to the outlier fixed dollar loss threshold amount, which results in about a $4 million decrease in payments. The distribution of these impacts is summarized in Table 13. The net effect of the updates described in this notice results in an overall estimated $87 million increase in payments from RY 2009 to RY 2010.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that the great majority of IPFs are small entities as that term is used in the RFA (include small businesses, nonprofit organizations, and small governmental jurisdictions). The majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of $7 million to $34.5 million in any 1 year). (For details, see the Small Business Administration's Interim final rule that set forth size standards at 70 FR 72577, December 6, 2005.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IPFs or the proportion of IPFs' revenue that is derived from Medicare payments. Therefore, we assume that all IPFs are considered small entities. The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 13, we estimate that the net revenue impact of this notice on all IPFs is to increase payments by about 2.0 percent. Since the estimated impact of this notice is a net increase in revenue across all categories of IPFs, we believe that this notice would not impose a significant burden on small entities. Medicare contractors are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

Although section 1102(b) of the Act applies to regulations for which a proposed rule is published, the HHS policy is to prepare an analysis of the impact on small rural hospitals for any regulation published. As a result, we are voluntarily determining whether this notice will have a significant impact on the operations of a substantial number of small rural hospitals. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. As discussed in detail below, the rates and policies set forth in this notice will not have an adverse impact on the rural hospitals based on the data of the 317 rural units and 68 rural hospitals in our database of 1,706 IPFs for which data were available.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2009, that threshold is approximately $133

million. This notice will not impose spending costs on State, local, or tribal governments in the aggregate, or by the private sector, of $133 million.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this notice under the criteria set forth in Executive Order 13132 and have determined that the notice will not have any substantial direct impact on State, or local governments, preempt States, or otherwise have a Federalism implication.

B. Anticipated Effects

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

1. Budgetary Impact

As discussed in the November 2004 and May 2006 IPF PPS final rules, we applied a budget neutrality factor to the Federal per diem and ECT base rates to ensure that total estimated payments under the IPF PPS in the implementation period would equal the amount that would have been paid if the IPF PPS had not been implemented. The budget neutrality factor includes the following components: Outlier adjustment, stop-loss adjustment, and the behavioral offset. As discussed in the May 2008 IPF PPS notice (73 FR 25711), the stop-loss adjustment is no longer applicable under the IPF PPS.

In accordance with § 412.424(c)(3)(ii), we indicated that we would evaluate the accuracy of the budget neutrality adjustment within the first 5 years after implementation of the payment system. We may make a one-time prospective adjustment to the Federal per diem and ECT base rates to account for differences between the historical data on cost-based TEFRA payments (the basis of the budget neutrality adjustment) and estimates of TEFRA payments based on actual data from the first year of the IPF PPS. As part of that process, we will reassess the accuracy of all of the factors impacting budget neutrality.

In addition, as discussed in section III.B.2 of this notice, we are using the wage index and labor market share in a budget neutral manner by applying a wage index budget neutrality factor to the Federal per diem and ECT base rates. Thus, the budgetary impact to the Medicare program by the update of the IPF PPS will be due to the market basket update (see section III.B.2.a of this notice) and the increase in the fixed dollar loss threshold amount.

2. Impacts on Providers

To understand the impact of the changes to the IPF PPS on providers, discussed in this notice, it is necessary to compare estimated payments under the IPF PPS rates and factors for RY 2010 versus those under RY 2009. The estimated payments for RY 2009 and RY 2010 will be 100 percent of the IPF PPS payment, since the transition period has ended and stop-loss payments are no longer paid. We determined the percent change of estimated RY 2010 IPF PPS payments to estimated RY 2009 IPF PPS payments for each category of IPFs. In addition, for each category of IPFs, we have included the estimated percent change in payments resulting from the increase to the fixed dollar loss threshold amount, the wage index changes for the RY 2010 IPF PPS, and the market basket update to IPF PPS payments.

To illustrate the impacts of the final RY 2010 changes in this notice, our analysis begins with a RY 2009 baseline simulation model based on FY 2007 IPF payments inflated to the midpoint of RY 2009 using IHS Global Insight's most recent forecast of the market basket update (see section III.2.b of this notice); the estimated outlier payments in RY 2009; the CBSA designations for IPFs based on OMB's MSA definitions after June 2003; the FY 2008 pre-floor, pre-reclassified hospital wage index; the RY 2009 labor-market share; and the RY 2009 percentage amount of the rural adjustment. During the simulation, the outlier payment is maintained at the target of 2 percent of total PPS payments.

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

- The increase to the outlier fixed dollar loss threshold amount.
- The FY 2009 pre-floor, pre-reclassified hospital wage index and RY 2010 final labor-related share. Our final comparison illustrates the percent change in payments from RY 2009 (that is, July 1, 2008 to June 30, 2009) to RY 2010 (that is, July 1, 2009 to June 30, 2010) and includes a 2.1 percent market basket update to the IPF PPS base rates.

TABLE 13—PROJECTED IMPACTS

Facility by type (1)	Number of facilities (2)	Outlier (percent) (3)	CBSA wage index & labor share (percent) (4)	Total with 2.1 market basket (percent) (5)
All Facilities	1,706	−0.1	0.0	2.0
Total Urban	1,321	−0.1	0.0	1.9
Total Rural	385	−0.2	0.1	2.0
Urban DPU	924	−0.2	−0.1	1.8
Urban CAH Unit	14	−0.4	0.3	2.1
Urban hospital	383	0.0	0.1	2.2
Rural DPU	264	−0.2	0.1	2.0
Rural CAH Unit	53	−0.2	−0.1	1.8
Rural hospital	68	−0.1	0.3	2.3
Freestanding IPF by Type of Ownership:				
Urban Psychiatric Hospitals:				
Government	149	−0.1	0.2	2.2
Non-Profit	86	−0.1	−0.1	1.9
For-Profit	148	0.0	0.2	2.3
Rural Psychiatric Hospitals:				
Government	43	−0.1	0.2	2.2
Non-Profit	9	−0.1	0.5	2.5
For-Profit	16	−0.2	0.6	2.5

TABLE 13—PROJECTED IMPACTS—Continued

Facility by type (1)	Number of facilities (2)	Outlier (percent) (3)	CBSA wage index & labor share (percent) (4)	Total with 2.1 market basket (percent) (5)
IPF Units by Type of Ownership:				
Urban DPU:				
Government	158	−0.2	−0.1	1.8
Non-Profit	636	−0.2	−0.1	1.8
For-Profit	130	−0.1	0.0	1.9
Urban CAH:				
Government	7	−0.3	0.8	2.5
Non-Profit	6	−0.5	−0.1	1.5
For-Profit	1	0.0	−0.3	1.8
Rural DPU:				
Government	63	−0.3	0.0	1.8
Non-Profit	154	−0.1	0.0	1.9
For-Profit	47	−0.2	0.4	2.4
Rural CAH:				
Government	23	−0.2	0.0	1.9
Non-Profit	27	−0.2	−0.2	1.7
For-Profit	3	−0.1	−0.2	1.9
By Teaching Status:				
Non-teaching	1,458	−0.1	0.1	2.0
Less than 10 interns and residents to beds	140	−0.2	−0.3	1.6
10 to 30 interns and residents to beds	73	−0.2	−0.2	1.7
More than 30 interns and residents to beds	35	−0.1	0.2	2.2
By Region:				
New England	119	−0.2	0.2	2.1
Mid-Atlantic	287	−0.1	−0.6	1.4
South Atlantic	238	−0.1	−0.3	1.7
East North Central	289	−0.2	−0.5	1.4
East South Central	164	−0.1	−0.2	1.8
West North Central	151	−0.2	0.3	2.2
West South Central	236	−0.2	0.4	2.3
Mountain	85	−0.2	0.1	2.0
Pacific	130	−0.2	1.5	3.4
By Bed Size:				
Psychiatric Hospitals:				
Less than 12 beds	25	−0.2	0.2	2.1
12 to 25 beds	67	−0.1	0.5	2.4
25 to 50 beds	98	0.0	0.0	2.1
50 to 75 beds	83	0.0	0.5	2.6
More than 75 beds	178	0.0	0.0	2.1
Psychiatric Units:				
Less than 12 beds	487	−0.3	0.1	1.9
12 to 25 beds	438	−0.2	0.1	2.0
25 to 50 beds	219	−0.2	−0.1	1.8
50 to 75 beds	59	−0.2	−0.2	1.7
More than 75 beds	52	−0.1	−0.5	1.5

3. Results

Table 13 above displays the results of our analysis. The table groups IPFs into the categories listed below based on characteristics provided in the Provider of Services (POS) file, the IPF provider specific file, and cost report data from HCRIS:

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

The top row of the table shows the overall impact on the 1,706 IPFs included in the analysis.

In column 3, we present the effects of the increase in the fixed dollar loss threshold amount. The overall aggregate effect, across all hospital groups, is projected to be a 0.1 percent decrease in payments to IPFs. All categories of IPFs are projected to receive either a decrease or no change in payments. There are distributional effects of this change among different categories of IPFs. Urban, for-profit freestanding psychiatric hospitals; urban, for-profit IPF units located in CAHs; and psychiatric hospitals with 25 beds or more will experience no changes in their payments. Alternatively, urban, non-profit psychiatric units in CAHs will receive the largest decrease of 0.5 percent.

In column 4, we present the effects of the budget-neutral update to the labor-related share and the wage index adjustment under the CBSA geographic area definitions announced by OMB in June 2003. This is a comparison of the simulated RY 2010 payments under the FY 2009 hospital wage index under CBSA classification and associated labor-related share to the simulated RY 2009 payments under the FY 2008 hospital wage index under CBSA classifications and associated labor-related share. We note that there is no projected change in aggregate payments

to IPFs, as indicated in the first row of column 4. However, there would be small distributional effects among different categories of IPFs. For example, IPFs located in the Mid-Atlantic region will experience a 0.6 percent decrease in payments. IPFs located in the Pacific region will receive the largest increase of 1.5 percent.

Column 5 compares our estimates of the changes reflected in this notice for RY 2010, to our estimates of payments for RY 2009 (without these changes). This column reflects all RY 2010 changes relative to RY 2009 (as shown in columns 3 and 4). The average increase for all IPFs is approximately 2.0 percent. This increase includes the effects of the market basket update resulting in a 2.1 percent increase in total RY 2010 payments, and an approximate 0.1 percent decrease in RY 2009 payments for the fixed dollar loss threshold amount.

Overall, the largest payment increase is projected to be among IPFs located in the Pacific region, which will receive a 3.4 percent increase. IPFs located in the East North Central and Mid-Atlantic regions will receive the smallest increase of 1.4 percent.

4. Effect on the Medicare Program

Based on actuarial projections resulting from our experience with other PPSs, we estimate that Medicare spending (total Medicare program payments) for IPF services over the next 5 years would be as shown in Table 14 below.

TABLE 14—ESTIMATED PAYMENTS

Rate year	Dollars in millions
July 1, 2009 to June 30, 2010	4,531
July 1, 2010 to June 30, 2011	4,745
July 1, 2011 to June 30, 2012	5,005
July 1, 2012 to June 30, 2013	5,320
July 1, 2013 to June 30, 2014	5,656

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

- 2.1 percent for RY 2010.
- 2.8 percent for RY 2011.
- 2.9 percent for RY 2012.
- 3.1 percent for RY 2013.
- 3.2 percent for RY 2014.

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

- 0.1 percent in RY 2010.
- 1.8 percent in RY 2011.
- 2.9 percent in RY 2012.
- 3.1 percent in RY 2013.
- 3.0 percent in RY 2014.

5. Effect on Beneficiaries

Under the IPF PPS, IPFs will receive payment based on the average resources consumed by patients for each day. We do not expect changes in the quality of care or access to services for Medicare beneficiaries under the RY 2010 IPF PPS. In fact, we believe that access to IPF services will be enhanced due to the patient- and facility-level adjustment factors, all of which are intended to adequately reimburse IPFs for expensive cases. Finally, the outlier policy is intended to assist IPFs that experience high-cost cases.

C. Alternatives Considered

The statute does not specify an update strategy for the IPF PPS and is broadly written to give the Secretary discretion in establishing an update methodology. Therefore, we are updating the IPF PPS using the methodology published in the November 2004 IPF PPS final rule.

We note that this notice does not initiate any policy changes with regard to the IPF PPS; rather, it simply provides an update to the rates for RY 2010. Therefore, no options were considered.

D. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 15 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this notice. This table provides our best estimate of the increase in Medicare payments under the IPF PPS notice, as a result of the changes presented in this notice, and based on the data for 1,706 IPFs in our database. All expenditures are classified as transfers to Medicare providers (that is, IPFs).

TABLE 15—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2009 IPF PPS RY TO THE 2010 IPF PPS RY

[In millions]

Category	Transfers
Annualized Monetized Transfers.	$87.
From Whom To Whom?	Federal Government To IPF Medicare Providers.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by OMB.

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

Dated: March 6, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: March 20, 2009.

Charles E. Johnson,

Acting Secretary.

BILLING CODE P

Addendum A--Rate and Adjustment Factors

Per Diem Rate:

Federal Per Diem Base Rate	$651.76
Labor Share (0.75889)	$494.61
Non-Labor Share (0.24111)	$157.15

Fixed Dollar Loss Threshold Amount:

$6,565

Wage Index Budget Neutrality Factor:

1.0009

Facility Adjustments:

Rural Adjustment Factor	1.17
Teaching Adjustment Factor	0.5150
Wage Index	Pre-reclass Hospital Wage Index (FY2009)

Cost of Living Adjustments (COLAs):

Alaska	
Anchorage	1.23
Fairbanks	1.23
Juneau	1.23
Rest of Alaska	1.25
Hawaii	
Honolulu County	1.25
Hawaii County	1.18
Kauai County	1.25
Maui County	1.25
Kalawao County	1.25

Patient Adjustments:

ECT – Per Treatment	$280.60

Variable Per Diem Adjustments:

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

Age Adjustments:

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

DRG Adjustments:

MS-DRG	MS-DRG Descriptions	Adjustment Factor
056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnoses of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Comorbidity Adjustments:

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

Addendum B - RY 2010 CBSA Wage Index Tables

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

Table 1 RY 2010 Wage Index For Urban Areas Based On CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8097
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	0.3399
10420	Akron, OH Portage County, OH Summit County, OH	0.8917
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8703
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8707
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9210
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8130

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9499
11020	Altoona, PA Blair County, PA	0.8521
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8927
11180	Ames, IA Story County, IA	0.9487
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.1931
11300	Anderson, IN Madison County, IN	0.8760
11340	Anderson, SC Anderson County, SC	0.9570
11460	Ann Arbor, MI Washtenaw County, MI	1.0445
11500	Anniston-Oxford, AL Calhoun County, AL	0.7927
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9440
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9142
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9591
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	0.9754
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1973
12220	Auburn-Opelika, AL Lee County, AL	0.7544
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9615
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9536
12540	Bakersfield, CA Kern County, CA	1.1189

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	1.0055
12620	Bangor, ME Penobscot County, ME	1.0174
12700	Barnstable Town, MA Barnstable County, MA	1.2643
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	0.8163
12980	Battle Creek, MI Calhoun County, MI	1.0120
13020	Bay City, MI Bay County, MI	0.9248
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8479
13380	Bellingham, WA Whatcom County, WA	1.1640
13460	Bend, OR Deschutes County, OR	1.1375
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0548
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8805
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8574
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	0.8792
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7148
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8155
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8979
14060	Bloomington-Normal, IL McLean County, IL	0.9323
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9268
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.1897
14500	Boulder, CO Boulder County, CO	1.0302
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8388
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	0.9900
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0770
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2868
15180	Brownsville-Harlingen, TX Cameron County, TX	0.8916
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9567

CBSA Code	Urban Area (Constituent Counties)	Wage Index
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9537
15500	Burlington, NC Alamance County, NC	0.8736
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9254
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1086
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0346
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8841
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9396
16180	Carson City, NV Carson City, NV	1.0128
16220	Casper, WY Natrona County, WY	0.9579
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8919
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9461
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8275
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9209
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9595
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9816
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8878
16940	Cheyenne, WY Laramie County, WY	0.9276
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	1.0399
17020	Chico, CA Butte County, CA	1.0897
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	0.9687
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8298
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8010

CBSA Code	Urban Area (Constituent Counties)	Wage Index
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9241
17660	Coeur d'Alene, ID Kootenai County, ID	0.9322
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9346
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9977
17860	Columbia, MO Boone County, MO Howard County, MO	0.8540
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8933
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8739
18020	Columbus, IN Bartholomew County, IN	0.9739
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	0.9943
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8598
18700	Corvallis, OR Benton County, OR	1.1304

CBSA Code	Urban Area (Constituent Counties)	Wage Index
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.7816
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	0.9945
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8705
19180	Danville, IL Vermilion County, IL	0.9374
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8395
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8435
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9203
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7803
19500	Decatur, IL Macon County, IL	0.8145
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8890
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	1.0818

CBSA Code	Urban Area (Constituent Counties)	Wage Index
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9535
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9958
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7613
20100	Dover, DE Kent County, DE	1.0325
20220	Dubuque, IA Dubuque County, IA	0.8380
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0363
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9732
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9668
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1283
20940	El Centro, CA Imperial County, CA	0.8746
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8525
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9568
21300	Elmira, NY Chemung County, NY	0.8247
21340	El Paso, TX El Paso County, TX	0.8694
21500	Erie, PA Erie County, PA	0.8713
21660	Eugene-Springfield, OR Lane County, OR	1.1061
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8690
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1297
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4061
22020	Fargo, ND-MN Clay County, MN Cass County, ND	0.8166
22140	Farmington, NM San Juan County, NM	0.8051
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9340
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8970
22380	Flagstaff, AZ Coconino County, AZ	1.1743
22420	Flint, MI Genesee County, MI	1.1425
22500	Florence, SC Darlington County, SC Florence County, SC	0.8130
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7871
22540	Fond du Lac, WI Fond du Lac County, WI	0.9293
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9867
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	0.9946
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7697
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8769

CBSA Code	Urban Area (Constituent Counties)	Wage Index
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9176
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9709
23420	Fresno, CA Fresno County, CA	1.1009
23460	Gadsden, AL Etowah County, AL	0.7983
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9312
23580	Gainesville, GA Hall County, GA	0.9109
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9250
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8473
24140	Goldsboro, NC Wayne County, NC	0.9143
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7565
24300	Grand Junction, CO Mesa County, CO	0.9812
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9184
24500	Great Falls, MT Cascade County, MT	0.8784
24540	Greeley, CO Weld County, CO	0.9684
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9709
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9011
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9448
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9961
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3249
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9029
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.8997
25260	Hanford-Corcoran, CA Kings County, CA	1.0870
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9153
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.8894
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1069
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7337
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8976
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.9110
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9008
26180	Honolulu, HI Honolulu County, HI	1.1811
26300	Hot Springs, AR Garland County, AR	0.9113

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26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7758
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	0.9838
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9254
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9082
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9280
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	0.9008
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9483
27060	Ithaca, NY Tompkins County, NY	0.9614
27100	Jackson, MI Jackson County, MI	0.9309
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8067
27180	Jackson, TN Chester County, TN Madison County, TN	0.8523
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.8999
27340	Jacksonville, NC Onslow County, NC	0.8177
27500	Janesville, WI Rock County, WI	0.9662
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8775
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7971
27780	Johnstown, PA Cambria County, PA	0.7920
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7916
27900	Joplin, MO Jasper County, MO Newton County, MO	0.9406
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0801
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0485

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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	0.9610
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9911
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8765
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7743
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	0.7881
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9349
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9758
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9221
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8374
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7556
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0389
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	0.9797
29460	Lakeland-Winter Haven, FL Polk County, FL Winter Haven County, FL	0.8530
29540	Lancaster, PA Lancaster County, PA	0.9363
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9931
29700	Laredo, TX Webb County, TX	0.8366
29740	Las Cruces, NM Dona Ana County, NM	0.8929
29820	Las Vegas-Paradise, NV Clark County, NV	1.1971
29940	Lawrence, KS Douglas County, KS	0.8343
30020	Lawton, OK Comanche County, OK	0.8211
30140	Lebanon, PA Lebanon County, PA	0.8954
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9465
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9200
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9110
30620	Lima, OH Allen County, OH	0.9427
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9759

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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	0.8672
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8765
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8370
31020	Longview, WA Cowlitz County, WA	1.1207
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2208
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	0.9249
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8731
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8774
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9570
31460	Madera, CA Madera County, CA	0.7939
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.0967
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0359
31900	Mansfield, OH Richland County, OH	0.9330
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3940
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9009
32780	Medford, OR Jackson County, OR	1.0244
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	0.9232
32900	Merced, CA Merced County, CA	1.2243
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	0.9830
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9159
33260	Midland, TX Midland County, TX	0.9827
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0080

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33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1150
33540	Missoula, MT Missoula County, MT	0.8973
33660	Mobile, AL Mobile County, AL	0.7908
33700	Modesto, CA Stanislaus County, CA	1.2194
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7900
33780	Monroe, MI Monroe County, MI	0.8941
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8283
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8528
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7254
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0292
34620	Muncie, IN Delaware County, IN	0.8489
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0055
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8652
34900	Napa, CA Napa County, CA	1.1520
34940	Naples-Marco Island, FL Collier County, FL	0.9672

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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	0.9504
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2453
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1731
35300	New Haven-Milford, CT New Haven County, CT	1.1742
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	0.9103
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	1.2885
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9066
35980	Norwich-New London, CT New London County, CT	1.1398

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36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6092
36100	Ocala, FL Marion County, FL	0.8512
36140	Ocean City, NJ Cape May County, NJ	1.1496
36220	Odessa, TX Ector County, TX	0.9475
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9153
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	0.8724
36500	Olympia, WA Thurston County, WA	1.1537
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	0.9441
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9111
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9474
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8685
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.1951
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9332
37380	Palm Coast, FL Flager County, FL	0.8963
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8360
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7867
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8102
37764	Peabody, MA Essex County, MA	1.0747
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8242
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9038
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0979
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0379
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7926
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8678
38340	Pittsfield, MA Berkshire County, MA	1.0445
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9343

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38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4289
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9942
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	1.1456
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9870
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.0920
39140	Prescott, AZ Yavapai County, AZ	1.0221
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	1.0696
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9381
39380	Pueblo, CO Pueblo County, CO	0.8713
39460	Punta Gorda, FL Charlotte County, FL	0.8976
39540	Racine, WI Racine County, WI	0.9054
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9817
39660	Rapid City, SD Meade County, SD Pennington County, SD	0.9598
39740	Reading, PA Berks County, PA	0.9242

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39820	Redding, CA Shasta County, CA	1.3731
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0317
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	0.9363
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1468
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8660
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1214
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8811
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9835

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40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	0.9926
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9031
40660	Rome, GA Floyd County, GA	0.9134
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.3572
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8702
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.0976
41100	St. George, UT Washington County, UT	0.9021
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0380
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	0.9006
41420	Salem, OR Marion County, OR Polk County, OR	1.0884
41500	Salinas, CA Monterey County, CA	1.4987
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9246
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9158
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8424
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	0.8856
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1538
41780	Sandusky, OH Erie County, OH	0.8870
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5529
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4756
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6141

CBSA Code	Urban Area (Constituent Counties)	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	0.4393
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.2441
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1993
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.1909
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6429
42140	Santa Fe, NM Santa Fe County, NM	1.0610
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.5528
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9152
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8333
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1755
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9217
43100	Sheboygan, WI Sheboygan County, WI	0.8920
43300	Sherman-Denison, TX Grayson County, TX	0.9024
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8442
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.8915
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9354
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9761
43900	Spartanburg, SC Spartanburg County, SC	0.9025
44060	Spokane, WA Spokane County, WA	1.0559
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9102
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0405

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44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8424
44220	Springfield, OH Clark County, OH	0.8876
44300	State College, PA Centre County, PA	0.8937
44700	Stockton, CA San Joaquin County, CA	1.2015
44940	Sumter, SC Sumter County, SC	0.8257
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9787
45104	Tacoma, WA Pierce County, WA	1.1241
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8964
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.8852
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9085
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8144
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9407
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8756
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0604
46060	Tucson, AZ Pima County, AZ	0.9229
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8445
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8496
46340	Tyler, TX Smith County, TX	0.8804
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8404
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8027
46700	Vallejo-Fairfield, CA Solano County, CA	1.4359
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8124
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0366

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	0.8884
47300	Visalia-Porterville, CA Tulare County, CA	1.0144
47380	Waco, TX McLennan County, TX	0.8596
47580	Warner Robins, GA Houston County, GA	0.8989
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9904
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	1.0827
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8490
48140	Wausau, WI Marathon County, WI	0.9615
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.8079
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	0.9544
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9757
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6955
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9069
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8832
48700	Williamsport, PA Lycoming County, PA	0.8096
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0696
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9089
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9801
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9016
49340	Worcester, MA Worcester County, MA	1.0836

CBSA Code	Urban Area (Constituent Counties)	Wage Index
49420	Yakima, WA Yakima County, WA	0.9948
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.9432
49620	York-Hanover, PA York County, PA	0.9518
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8915
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1137
49740	Yuma, AZ Yuma County, AZ	0.9281

1 At this time, there are no hospitals located in this urban area on which to base a wage index Therefore, the urban wage index value is based on the average wage index for all urban areas within the state

Table 2 -RY 2010 WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

CBSA Code	Nonurban Area	Wage Index
1	Alabama	0.7587
2	Alaska	1.1898
3	Arizona	0.8453
4	Arkansas	0.7473
5	California	1.2275
6	Colorado	0.9570
7	Connecticut	1.1016
8	Delaware	0.9962
10	Florida	0.8504
11	Georgia	0.7612
12	Hawaii	1.0999
13	Idaho	0.7651
14	Illinois	0.8386
15	Indiana	0.8473
16	Iowa	0.8804
17	Kansas	0.8052
18	Kentucky	0.7803
19	Louisiana	0.7447
20	Maine	0.8644
21	Maryland	0.8883
22	Massachusetts[1]	1.1670
23	Michigan	0.8887
24	Minnesota	0.9059
25	Mississippi	0.7584
26	Missouri	0.7982
27	Montana	0.8658
28	Nebraska	0.8730
29	Nevada	0.9382
30	New Hampshire	1.0219
31	New Jersey[1]	------
32	New Mexico	0.8812
33	New York	0.8145
34	North Carolina	0.8576
35	North Dakota	0.7205
36	Ohio	0.8588
37	Oklahoma	0.7732
38	Oregon	1.0218
39	Pennsylvania	0.8365
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	------
42	South Carolina	0.8538
43	South Dakota	0.8603
44	Tennessee	0.7789
45	Texas	0.7894
46	Utah	0.8267
47	Vermont	1.0079
48	Virgin Islands	0.6971
49	Virginia	0.7861
50	Washington	1.0181
51	West Virginia	0.7503
52	Wisconsin	0.9373
53	Wyoming	0.9315
65	Guam	0.9611

[FR Doc. E9–9962 Filed 4–30–09; 8:45 am]

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